



Contribution of cash transfers to poverty reduction: Children's access to schooling and household health services in Tanzania

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Abstract

The purpose of this study was to assess the contribution of cash transfers (CTs) to poverty reduction through the improvement of children's schooling and household health status in Tanzania. CTs are considered a popular social policy instrument to address the widespread poverty and encourage human capital investments in the education of children and household health. However, few studies have rigorously assessed their effectiveness in sub-Saharan Africa, especially in Tanzania. To fill the information gap, a case study was conducted by which both primary and secondary data were respectively collected through the administration of field data collection instruments and desk review of various documents on CTs in connection with children's education and household health status. Both qualitative and quantitative approaches were employed to collect data from households receiving CTs and some key informants. Content analysis was used for the qualitative data while the quantitative data were analysed by the help of IBM SPSS Statistics computer programme version 22. Descriptive statistics was computed to obtain frequencies and percentages. Cross tabulation was also employed to establish the relationship between variables at 5% level of significance. The study results showed a positive relationship between the average amount of CTs provided and the amount spent on children's education. Furthermore, it was found that all the respondents registered their households' members with Community Health Fund by using the CTs provided. The paper concludes that CTs play a vital role in improving children's schooling and health status of the household members, thus contributing to poverty reduction. It is recommended that Cash Transfer Programmes (CTPs) should go beyond giving CTs to the targeted households.

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1.0 Introduction

The world has made great strides in poverty reduction in the past three decades. For instance, the rate of extreme poverty declined from nearly 36% of the world's population in 1990, to 10% in 2015 (World Bank, 2018a). However, poverty and poor human capital indicators still characterised many developing countries at the beginning of the 21st century. Although the extreme poverty declined reasonably, approximately 736 million people were living in extreme poverty, below the international poverty line, using less than US\$1.90 in 2011 purchasing power parity a day in 2015. Among these, 413 million people are in sub-Saharan Africa (SSA) (United Nations, 2019; World Bank, 2018a). As noted by to Ferreira *et al.* (2016), the projected profile of global poverty in 2030 show that the vast majority of poor people will live in SSA. Unfortunately, children in these countries are said to be more vulnerable and most severely deprived along different dimensions of wellbeing, including health and education (Garcia & Moore, 2012; Barrientos & DeJong, 2006). An estimated 385 million children in developing countries lived in extreme poverty in 2017. According to the United Nations Children's Fund (UNICEF) and Global Coalition to End Child Poverty (2017), poverty prevents these children from realising their rights, including access to quality basic education. Consequently, the goal of ending extreme poverty by 2030 will be very ambitious, especially in the SSA region.

The persistence of poverty world-wide, necessitates the need to design and implement social protection (SP) systems, which are a fundamental component of the way societies manage to leave no one behind. It is unfortunate that only 27 per cent of the global population have access to comprehensive social protection systems, whereas 73 per cent are covered partially or not at all (UN, 2016). It has been argued that, poverty cannot be reduced by just lifting up those who are currently poor out of poverty, but also by implementing some relevant policies. Some of the policies that have shown to achieve poverty reduction goals include social safety net (SSN) programmes to safeguard the vulnerable from sinking into undesirable situation (Dang & Dabalen, 2019). In Tanzania, the National Social Protection Framework identifies several vulnerable groups whose rights are unprotected. According to the United Republic of Tanzania (URT) (2010), the groups include: street children, widows, people living with HIV and AIDS, youths, orphans, young mothers, people with disabilities, and eligible elders over the age of 60.



SSNs, a component of broader SP system is designed to provide regular and predictable support to targeted poor and vulnerable people. The system strives to maximize the efforts of developing countries to combat the persistence of poverty and protect individuals from falling back into poverty. It enables them cope with chronic poverty, destitution, and vulnerability through investment in children's human capital, specifically in the provision of health and education services (Boyden *et al.*, 2019; Dang & Dabalen, 2019; Ajwad *et al.*, 2018; World Bank, 2018b; Devereux *et al.*, 2015; Evans *et al.*, 2014; Garcia & Moore, 2012; Fiszbein *et al.*, 2009).

Most SSNs (also referred to as *social assistance* or *social transfers*) programmes include conditional cash transfers (CCTs), unconditional cash transfers (UCTs), public works, noncontributory social pensions, food and in-kind transfers, school feeding programmes and fee waivers (World Bank, 2018b; Devereux *et al.*, 2015; Garcia & Moore, 2012; Bastagli, 2011). SP schemes, especially CTs, have increased significantly in recent decades. Their main objectives largely remain in the realm of poverty and vulnerability reduction, as well as increasing material wellbeing, food security, and human capital. CTs are thus considered among government social policy instruments in the pursuit of poverty reduction (Boyden *et al.*, 2019; Handa *et al.*, 2018; Bastagli, 2011).

It has been argued that, CCTs, which are a recent innovation in the field of SP, provide CTs to low-income households, conditional on pre-specified investment in household human capital, usually children (Kabeer *et al.*, 2012). CCT programmes specifically, were first introduced in Latin America, then expanded to Africa, Asia, and the Middle East (Beegle *et al.*, 2018; Devereux, 2016; Fiszbein *et al.*, 2009). According to Devereux (2016) and Fiszbein *et al.* (2009), conditionalities on CTs are usually applied to uptake of health and education services among the children to develop their human capital. Essentially, CTs are expected to lessen the impact of poverty in the short run, while breaking the intergenerational cycle of poverty in the long term by increasing children's productivity as adults. This will adequately be realized when the current generation of children who have benefited from CCTs grow up and join the labour force (Dang & Dabalen, 2019; Beegle *et al.*, 2018; Kabeer *et al.*, 2012; Gassmann & Behrendt, 2006).

Generally, social transfers/assistance are associated with improvements in the human capital of current and future generations. In realising this, developing countries are



continually expanding their social assistance programmes (World Bank, 2019). Given the achievements of CCT elsewhere in the world, the government of Tanzania, via Tanzania Social Action Fund (TASAF), launched the implementation of a pilot CCT programme in 2010. The pilot was the first strictly CCT in Africa, complemented by a comprehensive set of evaluations and assessments, which eventually showed its effectiveness. TASAF was established by the government since 2000, as a multi-sectoral programme that provides direct funding to small scale public investments targeted at meeting the needs of the poor (Evans *et al.*, 2014).

Later on, in 2012, the government began the implementation of the Productive Social Safety Net (PSSN) programme under TASAF. The PSSN programme covered all the households in extreme poverty with an aim of breaking the intergenerational transmission of poverty through enhancing and protecting the human capital of children. It was based on two integrated interventions: a labour-intensive public works (PW) programme and targeted CCTs (the core of PSSN). It was the second largest Government-run CCT programme in Africa, following Ethiopia's Productive Safety Net Programme (Ulriksen, 2016; World Bank & National Bureau of Statistics - NBS, 2016). The coverage of the programme in the country increased from 0.4 percent of the population in 2013 to 10 percent in 2016. Although, in most cases, cash transfer programmes (CTPs) cannot raise the consumption of children directly, they supplement the incomes of families with children. By so doing it is assumed that the standard of living of children in these households will also improve, thus reducing child poverty (World Bank, 2019; Ulriksen, 2016; Evans *et al.*, 2014; Garcia & Moore, 2012; Barrientos & DeJong, 2006).

In an attempt to meet the Sustainable Development Goals (SDGs) by the year 2030, CTPs are seen as the most effective means of tackling poverty and social exclusion for marginalised groups. The cash given under CTPs enables poor families to enrol their school going children as well as paying visits to health centres. It is particularly argued that CTs are fundamental in achieving SDG1, which seeks to end extreme poverty in all its manifestations by 2030 (Handa *et al.*, 2018; Masunzu, 2014; Baird *et al.*, 2009). More specifically, CCTs have become one of the most prevalent SSN programmes in low- and middle-income countries. CCTs are extremely popular in Latin America, but much less common in Africa (World Bank, 2019; Devereux, 2016; Garcia & Moore, 2012).



As argued by Barrientos and DeJong (2006), CTPs targeting children in poor households are an effective way of reducing poverty. CCT programmes in particular have shown significant achievements in both the developed and developing world. In the SSA countries specifically, CCTs have improved the wellbeing of children in terms of health and education outcomes (Baird *et al.*, 2013; Baird *et al.*, 2009). For instance, CCTs in rural Zimbabwe increased school enrolment and improved orphans and vulnerable children's access to health care (Robertson *et al.*, 2013). In Tanzania, the National Strategy for Growth and Reduction of Poverty (NSGRP) includes some SP for vulnerable groups of the population which include among others, street children, young mothers, youths and orphans. The net enrolment ratios in primary and secondary schools in the country were 81.3 % and 26.5 %, respectively, in 2018 (World Bank, 2020). As argued in World Bank and NBS (2016), financial constraints have been identified as the most significant barrier to school enrolment among households receiving transfers from PSSN. CTPs specifically through investment in human capital have been useful in reducing the intergenerational transmission of poverty. The government has made considerable amendments to strengthen the SP system in the country as a whole, but challenges remain (Ajwad *et al.*, 2018; Garcia & Moore, 2012; URT, 2010; Gassmann & Behrendt, 2006). Poverty is usually viewed and measured through different indicators, under both income/monetary and non-income dimensions. This study concentrates on the non-income dimensions of poverty, specifically education and health. The education indicators of poverty include years of schooling and child school attendance, while the health care indicators include child mortality and nutrition (Alkire & Santos, 2014).

Despite the vital role played by CTPs in attaining sustainable economic growth and reducing poverty around the world, Tanzania has not given it due priority. Nevertheless, there has been some substantial moves towards developing SP in the past few years as elaborated in the preceding paragraphs (Ulriksen, 2016; Evans *et al.*, 2014; Masunzu, 2014; Garcia & Moore, 2012). CTP was established in Tanzania in Nachingwea District since 2014. Despite the long existence of the programme in the area, information on its role in improving household health status and schooling outcome of children for poverty reduction is scarce. Studies conducted on poverty reduction in Tanzania (Kavenuke, 2016; Rutenge, 2016; Elisha, 2013) concentrated on the provision of loans through revolving fund rather than CTs. Therefore, this paper



aims at determining the contribution of CTs to poverty reduction in terms of improving children's schooling and household health status in Nachingwea District, Tanzania. Specifically, it firstly examines the influence of CTs on children's schooling (in terms of attendance) among the beneficiaries' households and secondly, assesses the role of CTs in improving health status in terms of attendance to health facilities among the beneficiaries' household members.

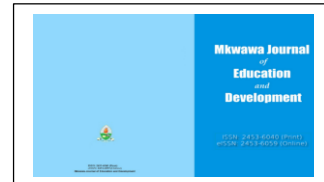
2.0 Methodology

2.1 Study area, design and methods

The study to assess the contribution of CTs to poverty reduction through the improvement of children's schooling and household health status was conducted in Nachingwea District in Lindi region, Tanzania. The region is among the most deprived regions in the country, with low level of socio-economic status. Nachingwea District specifically experiences, among other challenges, poor income, poor education facilities and lack of health facilities. Primary and secondary schools in the district experience major shortage of school infrastructures (World Bank, 2016; Nachingwea District Council, 2014).

The study employed a case study design, whereby both qualitative and quantitative approaches were used. The design involves an empirical investigation of a particular contemporary phenomena (or simply, a specific fact being studied) within its real-life contexts using multiple sources of evidences (Adam & Kamuzora, 2008). In this study, the phenomenon studied was the CT programme whose contribution to poverty reduction through promoting access to education and health services was assessed in Nachingwea District, which was the case. The relevance of the selected design rests on the fact that CT programme was implemented in different districts in Tanzania but this study focused on Nachingwea District only.

The sample comprised 50 respondents who were CTs beneficiaries (identified as poor) and 16 key informants (KIs) in the study area. The KIs included District Tanzania Social Action Fund (TASAF) Coordinator (1), village leaders (5), school heads/academic teachers (5) and health facility supervisors (5). The KIs included District Tanzania Social Action Fund (TASAF) Coordinator, village leaders, school heads/academic teachers and health facility supervisors. Purposive and simple random sampling techniques were employed. Purposive sampling was employed in



selecting the KIs and the wards (those implementing the CT programme). The criterion for selecting the KIs and the wards was their link with CT programme. So, all the wards that were implementing CT programmes and the KI involved in the programme were selected. Simple random sampling was used to select villages from the selected wards, and the respondents from each of the selected villages as detailed hereunder.

Five (5) wards were randomly selected from the 10 wards which were implementing the CT programme. This was followed by a selection of two (2) villages from each of the five wards, using the same technique. Five (5) CTs beneficiaries were thereafter randomly selected from each of the 10 villages from a list given by TASAF coordinator, to make a total of 50 respondents. Simple random sampling is relevant when the subjects of the population are homogeneous in terms of certain characteristics, which warrant each of them an equal opportunity to be selected to the study (Riffe *et al.*, 2014). Of all the probability sampling techniques, simple random sampling has been proved to provide the most generalisable inferences because of high external validity (Bhattacharjee, 2012; Weisburd & Britt, 2014). In this study, simple random sampling was adopted because the beneficiary households from the wards and villages implementing the CT programme were homogeneous in terms of the eligibility criterion. The eligibility criterion for any household was the inability of the household to afford three meals per day and incur the cost of health insurance through any of the legal service providers. Health insurance is nationally provided by the National Health Insurance Fund while at community level, the same service is provided by the local government like Nachingwea District Council through Community Health Fund.

Primary data were collected through questionnaire administration and interviews, while secondary data were collected through documentary reviews. The collection of primary data was aimed to obtain first-hand information from the CT beneficiaries and the KIs while the secondary data were collected to provide evidence documented from previous studies and performance reports. Questionnaires consisting of both close-ended and open-ended questions were administered to cash transfer beneficiaries. This method was used because a large number of respondents could be reached relatively easily and economically. Although it is not universally justified to ascertain whether sample size of 50 from among the CT beneficiaries is large enough or not, it is generally agreed that a sample size greater than 30 is accepted for



quantitative data analysis (Field, 2013). An in-depth interview guide (or simply, interview guide with a list of questions was used to collect information from the KIs. As opposed to questionnaires, in-depth interviews are more relevant to KIs because they can generate detailed data that can provide meanings and insights leading to establishment of evidence from what people say (Field, 2013). This is because the KIs are well informed about the CT working environment.

The focus of the questions was guided by Human Capital (HC) Theory, which encourages the society to achieve both economic and non-economic benefits of investing in HC development. Generally, HC investment encompasses such components as education and health, but the former is considered the prime HC investment as it can contribute to the latter (Didenko, 2007). Thus, non-economic benefits of HC investment include good health and increased application of the attained skills independent of monetary rewards (Vila, 2000). Due to the close relationship between the attainment of education and health benefits through HC investment, this study focused on the promotion of education and health as promoted by the CT programme in Nachingwea District, Tanzania.

The qualitative data collected were transcribed and the transcriptions from the 16 KIs were assigned identifiers ranging from KI1, KI2, KI3 ... to KI16). The transcribed data were then summarised through coding to enable qualitative analysis. Coding was followed by thematic content analysis that helped to reduce a variety of responses by grouping them into categories. The quantitative data obtained were analysed with the help of IBM SPSS Statistics computer programme version 22. This programme, which is simply known as SPSS can handle a variety of quantitative analysis techniques (Field, 2013). Descriptive statistics was computed in order to obtain frequencies and percentages. Correlational analysis was also run to establish the relationship between variables at 5% and 1% levels of statistical significance.

2.2 Ethical issues and consideration

Ethics observation is important in any social science research. Thus, in conducting this study, various steps were taken to ensure ethical consideration. After the approval of the research proposal by Mzumbe University, a letter of introduction to the field was issued by the University. A research permit was then sought from the Office of the Nachingwea District Executive Director. The research permit was sought to obtain



access to the research participants for the exercise of data collection to be effected. Before embarking on the actual data collection exercise, the study participants were asked for their consent before being interviewed. Additionally, the participants were informed about the study objectives and what was expected from them in order for them to participate voluntarily. Anonymity of the participants and the confidentiality of their responses were given utmost attention. Furthermore, the participants were informed about their freedom to withdraw from the interview and FGDs at any time when they found it necessary.

3.0 Results and discussion

3.1 Influence of cash transfers on children's schooling

In determining the influence of CTs on children's schooling in terms of attendance, two criteria were used. They include determining the proportion of money spent on children's education and the correlation analysis between the amount of CTs and the amount spent on children's education. As discussed in the introduction, CTs have proven to be effective in combating poverty, improving health status and raising school attendance for children around the world (Boyden *et al.*, 2019; Dang & Dabalen, 2019; Ajwad *et al.*, 2018; Masunzu, 2014; Baird *et al.*, 2013; Baird *et al.*, 2009; Bastagli, 2009; Fiszbein *et al.*, 2009).

3.1.1 Percentage of cash spent on education

The study respondents were required to select among the four options provided by the researchers (0%, 25%, 50%, and 75%) regarding expenditure of the cash provided on education. The study results in Table 1 show that 26 (52%) respondents did not spend any amount of the cash delivered to them on education activities. This is because their households had no school-going children, hence they were not eligible to receive the education package.

The remaining, 24 (48%) respondents received the education package. Among these respondents, 5 (10%) spent 25% of the cash for education purposes, while 16 (32%) and 3 (6%) respondents respectively, spent 50% and 75% of the cash delivered to them for the same purposes. The reason behind the differences in proportions used for education purposes is that the education package differed depending on the number of school-going children in a particular household.



Table 1: Distribution of respondents according to the percentage of cash spent on education (n = 50)

Village*	Expenditure of cash delivered on education by percentage							
	0%		25%		50%		75%	
	Frequency	%	Frequency	%	Frequency	%	Frequency	%
Mkukwe	3	6	1	2	1	2	0	0
Chiwindi	3	6	1	2	1	2	0	0
Litandamta ma	1	2	0	0	3	6	1	2
Nangowe	3	6	0	0	1	2	1	2
Songambebe	1	2	0	0	4	8	0	0
Kilimarond o	5	10	0	0	0	0	0	0
Mitumbati B	2	4	1	2	1	2	1	2
Mwananya mala	4	8	0	0	1	2	0	0
Lionja B	0	0	2	4	3	6	0	0
Ruponda	4	8	0	0	1	2	0	0
Total	26	52	5	10	16	32	3	6

Source: Field data, 2018.

*Five CT beneficiaries from each village were involved

Education packages under CCTs are normally given to the recipients with some conditions attached to them. The education conditions usually include school enrolment and attendance at 80 or 85 percent of school days, and occasionally some measures of performance (Baird *et al.*, 2013; Fiszbein *et al.*, 2009). The conditionality attached to the transfers bring about large impacts on school enrolment and attendance among children (Baird *et al.*, 2009; Fiszbein *et al.*, 2009). This is because the conditions usually apply to uptake of education services, whereby school-going children should attend school, otherwise CTs could be withheld from eligible households. Conditionality stimulates demand for services among the beneficiaries' households (Devereux, 2016; Fiszbein *et al.*, 2009). As argued by Son (2011), CT by itself will not suffice to increase school attendance significantly, thus conditionality is imperative to CT programmes.

As per TASAF guidelines, school going children were required to attend schools for at least 80% of school days per month. To make some follow-up, compliance forms are used in schools, whereby the heads of schools or academic teachers are supposed to



fill them in to assure the attendance of children from the beneficiaries' households (TASAF, 2013).

3.1.2 Cash transfers and amount spent for children's education

The amount of CTs offered by TASAF has been reviewed regularly according to inflation and other relevant considerations (TASAF, 2013). The amount offered to the beneficiary households during this study had the following structure: basic transfer per month is TZS 10,000 (US\$ 4.3) per household with additional cash to households with children, depending on their level of schooling. Children up to 5 years were paid TZS 4,000 (US\$ 1.7), while children attending primary and secondary education were paid TZS 8,000 (US\$ 3.5) and TZS 12,000 (US\$ 5.2), respectively.

Based on the households given CTs which included education package, further analysis was done to show minimum and maximum amount spent on education. The findings are as shown in Table 2. It was found that 24 households with school-going children received different amounts of CTs, ranging from TZS 28,000 (US\$ 12.1) to TZS 58,000 (25.1). It was further found that the minimum expenditure on education was TZS 5,000 (US\$ 2.2) (17.9% of the minimum amount given) whereas the maximum expenditure was TZS 42,000 (US\$ 18.2) (72.4% of the maximum amount given). As explained earlier, the difference in the amount of cash given is based on the number of school-going children in the household and education level.

Table 2: Distribution of respondents according to the cash given and the amount spent on education (n = 24)

Cash given and amount spent on education	Minimum	Maximum	Average
Amount of cash given	28,000	58,000	29,100
Amount used on education in TZS.	5,000	42,000	17,614
Percentage of the amount used in education	17.9	72.4	60.5

Source: Field data, 2018.

The study findings in Table 2 show that, among the households that were receiving the educational package, the proportion of the maximum amount (TZS 58,000) of cash spent on education was 72.4%. However, based on the average amount (TZS 29,100) of the cash given per households, it can be argued that the average proportion of the



cash used on education activities among the households getting the education package was a bit low (60.5%). The correlational analysis between the average amount of the cash given to respondents with school-going children and the average amount spent on education shows a positive relationship ($r=0.793$). Statistically, the relationship was significant at 0.01 level. This implies that higher amount of CTs could increase children's school enrolment and participation. CTs has been suggested by Kuépié *et al.* (2015) to be among educational policy targeted actions to keep children enrolled in and attending school.

3.1.3 Education level and expenditure on education

The study also established the relationship between the level of education of the CTs beneficiaries and the amount of cash spent for education purposes. Based on that, descriptive analysis between amounts spent on education with amount given to respondents as per their education level was computed. The study results in Table 3 show that 25% of the respondents with informal education spent a minimum amount of TZS 5,000 (US\$ 2.2) and a maximum of TZS 25,000 (US\$ 10.8) for education purposes. The majority (75%) of the respondents with primary education level spent a minimum amount of TZS 7,500 (US\$ 3.25) and maximum of TZS 42,000 (US\$ 18.2) for the same purposes.

Table 3: Distribution of respondents by level of education and the amount of cash spent on education (n = 24)

Level of education	Frequency	Percent	Minimum (TZS)	Maximum (TZS)	Average (TZS)
Informal education	6	25	5000	25,500	14,375
Primary education	18	75	7500	42,000	18,694

Source: Field data, 2018.

Descriptive analysis shows that, the difference on average expenditure in education between the household heads with informal education (TZS 14,375 (US\$ 6.23)) and those with primary education (TZS 18,694 (US\$ 8.1)) is statistically insignificant at 5%. The findings are contrary to other researchers like Huisman & Smits (2015) who found that if the father has a higher education level than primary education, the odds of staying in school for both girls and boys are 157% higher than if the father has no



education. However, in absolute figures, the household heads with primary education outweighed those with informal education (TZS 18,694 (US\$ 8.1) vs. TZS 14,375 (US\$ 6.23)). Therefore, based on the absolute figures of the amount of cash spent on education, it can be argued that, the level of education of respondents could determine more expenditure on education and thus increases school attendance for the children. This could be due to realisation of the importance of education by the parents with formal education.

Several studies have shown a positive relationship between parental education and children's schooling. For instance, Huisman & Smits (2015) argue that higher education level of parents is positively associated with children staying in school. Similarly, a study conducted in Ethiopia by Terfassa (2018), on parental education and children's schooling found that the more the parents are educated, the more they become supportive for their children's education. Bastagli *et al.* (2016) also argue that, more highly educated households may be more likely to reinvest in their children's education.

3.1.4 Breakdown of expenditure and school attendance

The breakdown of the respondents' expenditures on education was also computed. The findings in Table 4 shows that a significant proportion of money (95.8%) was spent on buying school uniforms and learning materials such as exercise books, pens and pencils. The remaining (4.2%) was spent on direct school contributions such as paying for porridge and lunch for nursery and primary school pupils, respectively. The proportions of school contributions seem to be very small due to the fact that primary education in Tanzania is fee-free. The fifth-phase government declared the abolition of school fees and some other school contributions at primary and O-level secondary education, commencing January 2016.

Table 4: Distribution of respondents by expenditure on education (n=24)

Expenditure in education	Frequency	Percent
Buying school uniforms and learning materials	23	95.8
School contributions	1	4.2
Total	24	100

Source: Field data, 2018.



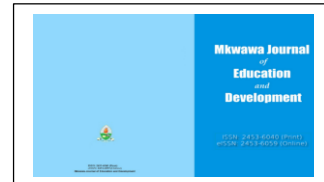
During an interview session with the key informants, one of them had the following to say with regard to school attendance:

For sure, we are experiencing changes in attendance and smartness among the school going children especially those in poor families since their parents and guardians afford to give them school needs like uniforms and stationaries. Children who were not attending school due to lack of uniforms and other school materials are now back to school as a result of the introduction of the cash transfer programme in our area. The programme offers CTs to the parents under the condition that the children of school-going age attend school regularly (80% of school days per month) (KI5).

The above interview extract implies that the CTP contributes to child poverty reduction in terms of education access since it enables children in poor households to attend school on regular basis. The CTs made even those who had dropped out to go back to school. Similar results were reported by Masunzu (2014) who conducted a study in Tanzania and Jamaica on CCT and poverty alleviation. The author argues that, CTP is an effective solution in reducing the magnitude of poverty for marginalised groups as it enables poor families to enrol their children of school-going age into schools.

Provision of basic school requirements to the poor children is a good motivation for schooling. This observation is in line with Evans *et al.* (2014) who find that CTP under TASAF in general had dramatic positive impacts on school attendance. Likewise, de Janvry *et al.* (2006) reveal that CCT programmes can provide an additional benefit to recipients in acting as safety nets for the schooling of the poor. As such, CCT programmes around the world have been used to convince poor parents to send their children to school. Direct transfers to the household have been suggested by Barcena-Martin *et al.* (2018) as one of the institutional mechanisms through which public policies may influence child poverty. The authors argue that the transfers increase household income and thus reduce the intergenerational transmission of poverty.

The findings of the current study imply that CTP contributes to access to education by providing schooling basic needs to the children from poor households. Through education acquisition, it is assumed that, children from beneficiary households could improve their human capital, linking them to income generating activities. Consequently, they will be enabled to graduate from poverty as argued by TASAF (2013). One of the aims of CTs is to encourage accumulation of human capital so as to break the vicious cycle and halt intergeneration transmission of poverty among the



children. As argued by various authors (Dang & Dabalen, 2019; Ajwad *et al.*, 2018; Evans *et al.*, 2014; Robertson *et al.*, 2013; Baird *et al.*, 2013; Garcia & Moore, 2012; Fiszbein *et al.*, 2009), CTs have been successful in developing human capital of children, hence poverty reduction. Barcena-Martin *et al.* (2018) argue that direct transfers to households increases household income as well, thus reducing the intergenerational transmission of poverty.

Similar findings were reported in a study by Wanjohi (2014) on the role and sustainability of CTPs in poverty reduction in Nairobi City County. The author argues that, the beneficiaries used the CTs they received to provide basic needs, such as paying for school fees for their children and buying school materials. Moreover, children that had completed primary education had been trained in vocational skills such driving, hairdressing beauty and tailoring, so as to provide more livelihood options for the households, hence poverty reduction.

Additionally, CTs were reported to be beneficial to children by Baird *et al.* (2009) in a study on designing cost-effective CTs programmes to boost schooling among young women in SSA. The authors find that the re-enrolment rate among the children who had already dropped out of school before the start of CT programme increased by two and a half times. They further discover that the dropout rate among those in school at baseline decreased from 11% to 6%. Additionally, Bastagli (2009) argues that Mexico's CCTs led to reductions in repetition and dropout rates in primary and secondary school and increase in years of schooling completed. Furthermore, Baird *et al.* (2013) found that on average, school enrolment rose by 41% and 25% respectively, across CCT and UCT programmes.

CTs can be an important complement to direct education investments. Increased income security enables households to pay fees and other costs associated with schooling. It also reduces the burden on children to contributing to family income, thus enabling them to participate effectively in schooling for the betterment of their future life. It has been argued by Barcena-Martin *et al.* (2018) that direct transfers to households increases household income and thus reduce the intergenerational transmission of poverty.

It is crucial to concentrate on reducing child poverty because children are vastly overrepresented among the world's poorest people. It has been argued that breaking



the intergenerational cycle of poverty can only be achieved through priority attention to children living in poverty (UNICEF and Global Coalition to End Child Poverty, 2017). Additionally, Barrientos and DeJong (2006) argue that appropriate policy responses to childhood poverty and vulnerability are important because children are disproportionately represented among the income-poor, many suffer from severe deprivation, and their poverty and vulnerability have cumulative and long-term consequences for their future and that of their children.

3.2 Cash transfers and health status improvement

The study also determined the role of cash transfers in improving health status of the household members. To reveal the situation, the researchers asked some questions on attendance to health facilities, household members registered with Community Health Fund (CHF) and the sources of funds for CHF registration. Tanzania uses a mixture of financing sources to support the health system. The CHF is among the government's supported initiative to assist some vulnerable segments of the population in accessing health services. Under this initiative, the government finances a basic package of public preventive health services for the entire population and a minimum level of financial protection against catastrophic illness (NBS, UNICEF and REPOA, 2009). With regard to access to health services, the responses are as shown in Table 5.

Table 5: Distribution of respondents according to attendance to health facilities, CHF registration and source of funds (n=50)

Parameter	Frequency	Percent
Attendance to health facilities		
Always	50	100
Rarely	-	-
Household members registered by CHF		
Up to 6 members	47	94
More than 6 members	3	6
Source of funds for CHF		
TASAF	50	100
Other	-	-

Source: Field data, 2018.

3.2.1 Attendance to health facilities and CHF registration

According to TASAF guidelines, households with children under two years and living in areas where health services are available, the children should undergo a routine



health check once a month. In areas where health services are unavailable, caretakers of children under 60 months of age should attend health and nutrition training sessions every two months. Moreover, TASAF provides CTs to pregnant women equivalent to US\$6, disbursed every two months on condition that they attend at least four antenatal medical exams, or health and nutrition sessions every two months, depending on availability of services, and present their children for regular medical routine checks. To make some follow-up, compliance forms are used in clinics whereby health supervisors in respective areas were supposed to fill them to assure the attendance of children from the beneficiaries' households (TASAF, 2013).

Respondents were asked whether they go to health facility close to them always or rarely each and every time they fall sick. It was found that, 100% of the CT beneficiaries were attending the health facility always when they get sick as shown in Table 5. The findings imply that household members on the households receiving CTs had access to health services.

With regard to the proportion of households who were registered with the Community Health Fund (CHF) services, 100% of the respondents said that all their family members were registered with CHF, regardless of household size. Being members of CHF assured the household members of getting health services in any government hospital within their district. They were also eligible to get the health services in private hospitals within the district, which were in partnership with the district council.

During the study time, CHF guidelines only allowed a group of six household members to access health services through one card provided, which costs TZS 15,000 (US\$ 6.5). As such, households with more than 6 members were obliged to incur additional cost to access health services. They could either pay extra TZS 15,000 to get another card for those not covered in the first card or opt to pay cash whenever they visit a health facility. Normally, children in the household are given the first priority in terms of CHF registration. Hence, in comparison with other household members, they were basically benefitting more from the CTs in terms of improving their health status and reducing child poverty and more importantly, breaking the vicious cycle and halting intergenerational transmission of poverty. In stressing on the importance of SSN programmes, Dang & Dabalen (2019) contend that it is crucial to invest in the early years of children of the poor as well as providing a basic package of health services. The authors argue that some of the policies that have been shown to achieve poverty



reduction goals include safety net programmes and building the assets, especially human capital of the poor and the vulnerable.

3.2.2 Source of funds for CHF registration

Respondents were asked to give the sources of funds used to register for CHF. The study findings show that all the respondents depended on the CTs provided by TASAF as the only source of funds to pay for CHF registration. This implies that, the CTP has contributed to increased access to health services among the beneficiaries' household members. During an interview with one of the key informants, it was exposed that:

Not only that households benefiting from CTP understand the importance of buying health insurance, but also mothers have developed tendencies to send their children to the dispensaries and health centres whenever they fall sick and for vaccination process as compared to the past, before the implementation of the programme. The tendency of CTs beneficiaries sending their children to health centres has decreased the cases of malnutrition. For sure, CTs stimulates the health seeking behaviours to most households in this area. Most mothers are highly motivated to send their children to health centres (KI10).

Furthermore, another key informant said that:

Beneficiaries' households are now capable of buying the health insurance, something that was not affordable before the introduction of the CT programme. This scenario supports the idea that poor people are now escaping the out of pocket expenditures in cases of illness, hence increases the probability of being able to combat health problems whenever they encounter them. In general, the programme has improved people's access to health services in our area (KI7).

The two quotations above indicate that CTs have contributed to improvement in health seeking behaviour among the beneficiaries. This manifests in increased visits to health care facilities among the household members. More importantly, the mothers were sending their children to health centres for vaccination as required. This implies that the health status of children in the beneficiary's households is as well improved, thus reducing child poverty and intergeneration transmission of poverty. Similar findings were reported by Fiszbein *et al.* (2009) in a study on CCTs where the authors argue that CTs have resulted in improvements in child attendance at health clinics, among others. Furthermore, Bastagli (2009) argues that, studies on CCTs in Nicaragua, Colombia and Honduras show increases in health check-ups for household members. Similarly, Masunzu (2014) reports that CT enables poor families pay visits to health centres.



The findings are also in line with those of a study conducted by Vincent and Cull (2009) on the impacts of CTs. The authors revealed that, receiving CTs improves access to basic health care and promotes better health status of household members. It allows recipients' households to afford treatment when they get sick. For instance, through cash transfer programme in Zambia, the incidence of illnesses decreased from 42.8% to 35%; and incidence of partial sightedness decreased from 7.2% to 3.3%, potentially due to the fact that beneficiary households could afford minor eye surgery.

4.0 Conclusions and recommendation

This paper aimed at assessing the contribution of CTs on the improvement of children's schooling and household health status in Tanzania, using Nachingwea District as a case study. Cash transfers to the respondents improved school attendance among school-going children. However, the CTs benefited only the children who were living within the household during the study period as per TASAF guidelines. Furthermore, the introduction of CTP in the study area has contributed to improved health status among the members in beneficiary households. In the similar vein, as per TASAF guidelines, children outside the household were not considered under the CTP. It can thus be concluded that, CTs provided to the respondents were perceived to play a vital role in improving children's school attendance and health status of members in the beneficiary households, thus contributing to poverty reduction. The beneficiaries used the CTs to pay for various schooling requirements for their school-going children, thus the children were motivated to attend school regularly. Moreover, since beneficiaries' household members were registered with the CHF, they were guaranteed of getting health services from both the government and private hospitals within their district. However, there was no assurance of getting quality education and health services from the providers.

Based on the above conclusion, CTPs should go beyond giving CTs to the targeted households only. This is because other marginalised groups of the society like the street children are likely to be excluded since they are not living in any of the targeted households. As such these children might be excluded in terms of access to education and health services. To make ensure inclusion of such children, the government should think of increasing the budget for social protection. Complementary programmes to manage the quality of teaching is also recommended to enhance the effectiveness of CTPs in reducing poverty. This will ensure that children are not just attending school



but learning is also taking place for them to acquire quality education in terms of skills and knowledge required for human capital development. Further research is recommended on the contribution of CTs to learning outcomes (as measured by test scores) and cognitive development outcomes.

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