IFPRI Discussion Paper 01994

December 2020

Do Cash Transfers Reduce Trust and Informal Transfers within Communities?

David K. Evans

Katrina Kosec

Development Strategy and Governance Division

INTERNATIONAL FOOD POLICY RESEARCH INSTITUTE

The International Food Policy Research Institute (IFPRI), a CGIAR Research Center established in 1975, provides research-based policy solutions to sustainably reduce poverty and end hunger and malnutrition. IFPRI's strategic research aims to foster a climate-resilient and sustainable food supply; promote healthy diets and nutrition for all; build inclusive and efficient markets, trade systems, and food industries; transform agricultural and rural economies; and strengthen institutions and governance. Gender is integrated in all the Institute's work. Partnerships, communications, capacity strengthening, and data and knowledge management are essential components to translate IFPRI's research from action to impact. The Institute's regional and country programs play a critical role in responding to demand for food policy research and in delivering holistic support for country-led development. IFPRI collaborates with partners around the world.

AUTHORS

David K. Evans (devans@cgdev.org) is a Senior Fellow at the Center for Global Development (CGD), Washington, DC.

Katrina Kosec (k.kosec@cgiar.org) is a Senior Research Fellow in the Development Strategy and Governance Division of the International Food Policy Research Institute (IFPRI), Washington, DC.

Do Cash Transfers Reduce Trust and Informal Transfers within Communities?

David K. Evans Katrina Kosec*

December 30, 2020

Abstract

Cash transfer programs enter communities with existing informal safety nets that function through inter-household transfers. Formal transfers may reduce inter-household transfers by reducing needs, or perceived needs, among the vulnerable households, or they may increase inter-household transfers by giving more liquidity to poor households to provide transfers in response to idiosyncratic shocks experienced by other households in the community. If inter-household transfers affect trust levels within the community, then introducing a cash transfer program could affect community trust. We use a randomized controlled trial to test the impact of cash transfers on various measures of trust and informal safety nets within communities in Tanzania. We find evidence that the introduction of a cash transfer program increased trust as well as certain types of assistance across households (e.g., childcare). Although cash transfers reduced transfers from non-beneficiary households in the community to beneficiary households in the short run (after 1.75 years of transfers), those effects had disappeared by an endline survey conducted 2.75 years after transfers began. Taken together, our evidence suggests that formal cash transfer programs do not necessarily crowd out informal safety nets, and they may in fact boost trust and support across households.

JEL Classification: H31, H55, I38, O12, O15

Keywords: Conditional cash transfers, informal safety nets, service delivery, trust

*This study benefitted at various stages from experts at the World Bank, the International Food Policy Research Institute (IFPRI), the Tanzania Social Action Fund (TASAF) and elsewhere. At TASAF, the evaluation has been supported by the Executive Director Ladislaus Mwamanga, as well as the former Executive Director Servacius Likwelile. Amadeus Kamagenge led TASAF input to the evaluation, and his entire team has contributed with substantive and logistical support. Brian Holtemeyer and Amina Mendez Acosta provided research assistance. We received financial support from the CGIAR Research Program on Policies, Institutions, and Markets led by IFPRI, the International Initiative for Impact Evaluation (3ie), the Strategic Impact Evaluation Fund (SIEF), and the Trust Fund for Environmentally and Socially Sustainable Development (TFESSD). Author affiliations and contacts: Evans (Center for Global Development: devans@cgdev.org) and Kosec (IFPRI: k.kosec@cgiar.org).

1 Introduction

More and more countries are implementing formal cash transfer programs as a safety net to protect households from extreme poverty. Some of these programs come with conditions on household behaviors and others do not, but almost none restrict how money is spent. Yet the transfer of cash and other goods to protect the well-being of households that experience poverty and adverse shocks extends far back in history, largely through informal transfers from household to household. One concern with formal cash transfer programs is that they may crowd out informal transfers, such that—if formal systems are disrupted, or if households experience an idiosyncratic shock—households may be left without access to consumption smoothing mechanisms and other forms of assistance. The introduction of formal safety nets may reduce the need for households to rely on each other for non-monetary assistance. Additionally, the mere act of government targeting an individual for transfers may reduce information asymmetries about a household's poverty level. And cash transfers could reduce trust within communities because they reduce interactions among individuals or activate feelings of jealousy in non-beneficiaries. As previous researchers have hypothesized, "government intervention can break down the fragile social fabric that maintains some form of social insurance among related individuals" (Attanasio and Ríos-Rull, 2000).

In this paper, we evaluate the impact of the randomized introduction of a pilot cash transfer program in Tanzania in 2010 on trust and informal safety nets across households. We utilize data from two follow-up surveys to analyze the effects of the program after 1.75 years of transfers and after 2.75 years. We consider both measures of formal and informal transfers into and out of households as well as more subjective measures of trust in and feelings of being supported by other community members, thus providing a relatively nuanced look at the impacts of the program. We then put these findings in the context of the wider literature on the interplay between formal safety nets and informal safety nets.

2 Experiment

Tanzania's pilot CCT program began delivering transfers in January of 2010. Its aims were to increase investments in health for young children (ages 0–5) and the elderly (over 60) and to increase educational investments for children aged 7–15. Eighty eligible communities in three districts (Chamwino, Bagamoyo and Kibaha) were randomized into treatment and control groups of 40 communities each, stratified on community size and district. The program was implemented for a period of three years in treatment communities and then extended to all 80 communities after our last round of data collection. In each community, prior to randomization into treatment and control, a locally-elected committee identified the roughly half of households they considered poorest and gathered data on their living conditions. These data were fed into a formal algorithm to select the most vulnerable households. Throughout our study period, the median beneficiary household received a bi-monthly transfer equal to about 13 percent of household expenditures over the same period.

3 Data and empirical strategy

We evaluate the impacts of the CCT program using three waves of data collected on beneficiaries in treatment communities and would-be beneficiaries in control communities. In total, 1,764 households (883 in treatment communities and 881 in control communities), including a total of 6,918 individuals, participated in a baseline survey in early 2009 (a random subset of households identified as sufficiently poor to receive transfers). No data were collected from households not identified as sufficiently poor. Table A1 presents the chronology of the program and impact evaluation. Payments began in early 2010, a midline survey was conducted during July–September 2011 (about 1.75 years after transfers began), and an endline survey was conducted during August–October 2012 (about 2.75 years after transfers began).

As noted by Evans et al. (2019a), there is no evidence of differential attrition of either individuals or households across the treatment and control groups in our study. This is true

for both survey rounds, and is robust to various specifications, including those interacting treatment with various individual- and household-level characteristics and checking for the joint significance of those interactions and treatment in predicting attrition. The rate of household attrition was 8.5 percent at midline, and 13.0 percent at endline.[1]

We recover causal intent-to-treat estimates from the following empirical specification:

$$Y_{it} = \beta_0 + \beta_1 2011_t + \beta_2 2012_t + \delta_1 T_i \times 2011_t + \delta_2 T_i \times 2012_t + \alpha_i + \epsilon_{it} \quad (1)$$

where i indexes individuals and t indexes the survey round (baseline in 2009, midline in 2011, or endline in 2012). Y_{it} is an outcome, α_i are individual fixed effects, T_i is an indicator for one's community being assigned to treatment, 2011_t is an indicator for midline, and 2012_t is an indicator for endline. For some outcomes, we only gathered data at endline, and thus our analysis of them utilizes a sample that is roughly one third the size of that used for other outcomes; we regress the outcome on T_i, district fixed effects, a control for logged community population, and a vector of household-level controls measured at baseline.[2]

We compare treatment and control households to ensure comparability on observable characteristics (Table 1). Of 27 variables compared, we observe only a handful of significant differences. Treatment households are six percentage points less likely to have an improved floor and six percentage points less likely to state that people in the community can be trusted. They are also slightly less likely to receive assistance from other individuals, which is reflected in both the binary (whether or not they received any assistance) and the continuous (how much assistance they received) outcome variables. Because we include household fixed effects, these modest differences at baseline should not affect our estimates.

[1] For households in treatment communities, these figures were 8.3 percent and 11.8 percent, respectively. For households in control communities, they were 8.6 percent and 14.1 percent, respectively. Of the 1,764 households surveyed at baseline, four declined to be interviewed at baseline; our analysis of attrition by midline and by endline omits these four observations in order to consider attrition *since* baseline.

[2] These include head age, age squared, gender, education level, and literacy status; dummies for the number of household members; dummies for an improved roof, improved floor, toilet, and piped water; and an asset index that is the first principle component from a principle components analysis using indicators for 13 durable assets.

Table 1: Baseline balance

	Treatment (T)		Control (C)		Difference (T-C)	
Outcome	Mean	N	Mean	N	Mean	S.E.
Panel A: Household and community characteristics						
Household characteristics						
Dummy - household has improved roof	0.33	880	0.37	878	-0.04	(0.06)
Dummy - household has improved floor	0.03	880	0.09	878	-0.06**	(0.02)
Dummy - household has toilet facilities	0.69	880	0.76	879	-0.07	(0.04)
Dummy - household has piped water	0.30	880	0.32	879	-0.01	(0.08)
Dummy - head of household is male	0.63	879	0.59	878	0.04	(0.03)
Share of households reporting a ... exists in village						
Parent association	0.14	40	0.13	40	0.01	(0.02)
Health committee	0.61	40	0.59	40	0.02	(0.04)
Panel B: Outcomes at baseline						
Trust						
Dummy - leaders can generally be trusted	0.81	878	0.80	873	0.01	(0.03)
Dummy - most people can be trusted	0.26	875	0.23	874	0.03	(0.03)
Dummy - community people can be trusted	0.59	876	0.53	873	0.06*	(0.03)
Dummy - received ... gifts/assistance from individuals						
Dummy - cash	0.24	874	0.28	876	-0.04	(0.03)
Dummy - food	0.21	869	0.27	874	-0.06**	(0.03)
Dummy - other in-kind	0.22	875	0.26	872	-0.04	(0.03)
Dummy - received ... gifts/assistance from NGOs						
Dummy - cash	0.01	879	0.01	879	-0.01	(0.01)
Dummy - food	0.01	880	0.03	879	-0.02	(0.02)
Dummy - other in-kind	0.03	880	0.05	878	-0.02	(0.02)
Dummy - received ... gifts/assistance from government						
Dummy - cash	0.01	880	0.00	879	0.01	(0.01)
Dummy - food	0.02	879	0.02	879	0.00	(0.01)
Dummy - other in-kind	0.03	880	0.02	879	0.01	(0.01)
Amount (1000s Tsh) of transfers received from...						
Anyone	18.31	883	25.40	881	-7.09**	(3.43)
Individuals	16.85	880	23.62	879	-6.77*	(3.48)
Government or TASAF	0.83	880	0.46	879	0.37	(0.22)
NGOs	0.70	880	1.38	879	-0.68	(0.49)
Amount (1000s Tsh) of transfers given in...						
Any form	1.32	880	1.73	879	-0.41	(0.67)
Cash	0.42	880	0.41	879	0.009	(0.22)
Food	0.48	880	0.66	879	-0.17	(0.25)
Other in-kind	0.41	880	0.66	879	-0.25	(0.50)

Notes: Treatment indicates assignment to treatment. Standard errors are clustered at the village level. Outcome variables only available at endline are not shown. *** indicates p<0.01; ** indicates p<0.05; and * indicates p<0.10.

4 Results

First, we examine impacts of transfers on trust. We find that beneficiary households report a slightly lower likelihood of trusting "most people" after 1.75 years of transfers (they experience a marginally significant decline of 6.2 percentage points) (Table 2). But after an additional year (i.e., 2.75 years of transfers), this initial erosion of trust is gone. Beneficiary

households report greater trust in people in general, in community members, and in shopkeepers and teachers. Point estimates for nurses and doctors, and even strangers, are also positive, but smaller and statistically insignificant. Thus, we see a broad pattern of increased trust in others after the program has been in place for a significant period of time.

Table 2: Communal Trust

	Dummy - ... can be trusted		Dummy - trust in ... has improved over last 3 years		Dummy - trusts ... to a great/very great extent			
	Most people	Community members	People in general	Community members	Shopkeepers	Teachers	Nurses & doctors	Strangers
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Treatment × 2011 (midline)	-0.062*	-0.040						
	(0.034)	(0.030)						
Treatment × 2012 (endline)	0.016	0.028	0.031**	0.039***	0.095***	0.053**	0.044	0.031
	(0.042)	(0.043)	(0.015)	(0.012)	(0.033)	(0.025)	(0.028)	(0.021)
2011 (midline)	0.301***	0.198***						
	(0.026)	(0.021)						
2012 (endline)	-0.106***	0.115***						
	(0.028)	(0.028)						
R^2	0.169	0.042	0.023	0.027	0.033	0.036	0.026	0.029
Baseline mean	0.242	0.556						
Observations	4996	4993	1594	1594	1594	1594	1594	1594

Source: Authors' calculations based on baseline (2009), midline (2011), and endline (2012) household survey data.
Notes: Columns 1 - 2 include household fixed effects. Columns 3 - 8 are outcomes only available at endline, and thus these specifications include only one round of data and do not use household fixed effects. Instead, they utilize controls including district fixed effects and household-level controls measured at baseline capturing head age, age squared, gender, education level, and literacy status; dummies for the number of household members; dummies for an improved roof, improved floor, toilet, and piped water; and an asset index that is the first principle component from a principle components analysis using indicators for 13 durable assets. Treatment estimates are estimates of the effect of living in a treatment village (intent to treat). Standard errors are in parentheses and clustered at the village level. *** indicates p<0.01; ** indicates p<0.05; and * indicates p<0.10.

Second, we examine whether beneficiary households are more likely to report engagement in informal safety nets (Table 3). These include measures of monetary and other support from community members. While households do not report any change in knowing someone from whom they could borrow a significant sum of cash, they do report positive, significant impacts on two other measures of informal safety nets. On the receiving end, they are significant more likely (9.3 percentage points) to report knowing someone who could provide childcare suddenly. On the providing end, they are 4.4 percentage points more likely to have had someone with a personal problem turn to their household for assistance.

Table 3: Informal Safety Nets

	Dummy - knows someone outside the household willing to provide...		
	15k TSH suddenly	Childcare suddenly	Dummy - someone with a personal problem has turned to HH for assistance
	(1)	(2)	(3)
Treatment × 2012 (endline)	0.046	0.093***	0.044**
	(0.029)	(0.032)	(0.021)
R^2	0.053	0.039	0.068
Observations	1594	1594	1594

Source: Authors' calculations based on endline (2012) household survey data.
Notes: These outcomes were only available at endline, and thus specifications include only one round of data and do not use respondent fixed effects. All specifications use controls including district fixed effects and household-level controls measured at baseline capturing head age, age squared, gender, education level, and literacy status; dummies for the number of household members; dummies for an improved roof, improved floor, toilet, and piped water; and an asset index that is the first principle component from a principle components analysis using indicators for 13 durable assets. Treatment estimates are estimates of the effect of living in a treatment community (intent to treat). Standard errors are in parentheses and clustered at the community level. *** indicates p<0.01; ** indicates p<0.05; and * indicates p<0.10.

Table 4: Assistance Received From Individuals, Government, and NGOs by Type

	Dummy - received gifts/assistance from ... in the past 12 months								
	Individuals			Govt or TASAF			NGOs		
	Cash	Food	Other in-kind	Cash	Food	Other in-kind	Cash	Food	Other in-kind
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Treatment × 2011 (midline)	-0.070*	-0.029	-0.012	0.880***	-0.001	-0.001	-0.002	-0.011	0.014
	(0.037)	(0.038)	(0.037)	(0.017)	(0.010)	(0.016)	(0.007)	(0.020)	(0.017)
Treatment × 2012 (endline)	-0.047	0.001	-0.017	0.902***	-0.002	-0.002	-0.004	0.006	0.016
	(0.035)	(0.041)	(0.034)	(0.018)	(0.008)	(0.010)	(0.008)	(0.020)	(0.021)
2011 (midline)	0.198***	0.188***	0.087***	-0.000	-0.003	-0.005	-0.001	0.000	-0.029**
	(0.031)	(0.031)	(0.027)	(0.004)	(0.006)	(0.008)	(0.006)	(0.017)	(0.014)
2012 (endline)	0.142***	0.108***	0.039	-0.003	-0.014***	-0.012***	0.009	-0.006	-0.030*
	(0.027)	(0.029)	(0.026)	(0.003)	(0.005)	(0.005)	(0.007)	(0.017)	(0.018)
R^2	0.040	0.041	0.010	0.805	0.005	0.003	0.002	0.002	0.007
Baseline mean	0.257	0.243	0.242	0.009	0.017	0.023	0.010	0.020	0.039
Observations	5026	5019	5022	5033	5034	5035	5034	5035	5034

Source: Authors' calculations based on baseline (2009), midline (2011), and endline (2012) household survey data.
Notes: All specifications include household fixed effects. Treatment estimates are estimates of the effect of living in a treatment village (intent to treat). Standard errors are in parentheses and clustered at the village level. *** indicates p<0.01; ** indicates p<0.05; and * indicates p<0.10.

Third, we examine monetary and in-kind transfers across households and from other sources. We find very little evidence of impacts on the extensive margin—i.e., whether or not households receive transfers (Table 4). There is a marginally significant decline of 7.0 percentage points in cash from other individuals after 1.75 years of transfers, but the coefficient is smaller in magnitude and insignificant after 2.75 years. The only other significant effect in

any survey round is that households are much more likely to report receiving transfers from the government at both midline and endline, as expected (i.e., households are receiving the formal cash transfers they are due to receive). We see no evidence of a change in transfers from non-government organizations (NGOs).

On the intensive margin, households report somewhat smaller transfers (measured in constant, 2009 Tanzanian Shillings (TSH)) from other individuals after 1.75 years of the program, but no effect after 2.75 years (Table 5).[3] Even after 1.75 years, the crowd-out is relatively small: the reduction in transfers from individuals is under 12 percent of the increase in formal government transfers. At the same time, households are no more likely to provide assistance to other households (Table 6). Both of these results hold if we winsorize the top one percent of observations to account for outliers (Tables A2 and A3).

Table 5: Amount of Assistance Received From Individuals, Government, and NGOs

		Total transfers from ... in the past 12 months		
	Total	Individuals	Govt or TASAF	NGOs
	(1)	(2)	(3)	(4)
Treatment × 2011 (midline)	70.96***	-10.09*	86.31***	-0.69
	(6.389)	(5.194)	(4.343)	(0.640)
Treatment × 2012 (endline)	57.40***	-1.53	63.21***	-0.51
	(6.333)	(5.550)	(2.589)	(0.857)
2011 (midline)	13.30***	17.89***	0.19	0.25
	(4.223)	(4.664)	(0.496)	(0.571)
2012 (endline)	8.05*	14.50***	-0.42***	0.56
	(4.310)	(4.566)	(0.127)	(0.707)
R^2	0.155	0.018	0.400	0.001
Baseline mean	21.853	20.229	0.648	1.038
Observations	5374	5035	5033	5035

Source: Authors' calculations based on baseline (2009), midline (2011), and endline (2012) household survey data.
Notes: Transfer amounts are measured in constant 2009 Tanzanian Shillings (TSH). All specifications include household fixed effects. Treatment estimates are estimates of the effect of living in a treatment village (intent to treat). Standard errors are in parentheses and clustered at the village level. *** indicates p<0.01; ** indicates p<0.05; and * indicates p<0.10.

Among beneficiaries, the short term reductions in transfers from other individuals that fade out over time are driven by the poorest beneficiaries (Table A4), with sizeable, significant negative effects on whether or not the poorest received transfers of cash from other households and near-zero, insignificant effects among the less poor beneficiaries. (Remember that all

[3]We use consumer prices index averages for Tanzania for 2009, 2011, and 2012 from World Bank (2020) to convert all transfer amounts into constant, 2009 Tanzanian Shillings (TSH).

recipients were targeted by poverty status.) Among the poorest, there is some suggestion that the reductions in transfers of cash from other households endure through 2.75 years, although the point estimates are about half the size of those at 1.75 years. We observe a similar pattern in the amount of transfers received (Table A5). We observe no pattern of difference between the poorest and the less poor in whether they provide assistance to other community members (Table A6).

Table 6: Amount of Assistance Given to Community Members by Type

		Assistance given in the past 12 months in ...		
	Total	Cash	Food	Other in-kind
	(1)	(2)	(3)	(4)
Treatment × 2011 (midline)	0.65	0.21	-0.14	0.59
	(0.656)	(0.228)	(0.419)	(0.399)
Treatment × 2012 (endline)	0.20	0.04	-0.15	0.01
	(0.633)	(0.289)	(0.375)	(0.420)
2011 (midline)	0.06	-0.09	0.66*	-0.53
	(0.598)	(0.150)	(0.370)	(0.391)
2012 (endline)	0.94*	0.18	0.76**	0.47
	(0.487)	(0.201)	(0.307)	(0.389)
R^2	0.003	0.001	0.005	0.003
Baseline mean	1.523	0.411	0.572	0.536
Observations	5035	5035	5035	5035

Source: Authors' calculations based on baseline (2009), midline (2011), and endline (2012) household survey data.
Notes: Transfer amounts are measured in constant 2009 Tanzanian Shillings (TSH). All specifications include household fixed effects. Treatment estimates are estimates of the effect of living in a treatment village (intent to treat). Standard errors are in parentheses and clustered at the village level. *** indicates p<0.01; ** indicates p<0.05; and * indicates p<0.10.

5 Discussion

This paper provides evidence that the introduction of cash transfers does not eliminate existing, informal safety nets: rather, transfers may boost trust and retain other safety nets. Our trust findings confirm lab-in-the-field findings from Colombia, in which residents of a neighborhood targeted for conditional cash transfers demonstrated a higher level of cooperation than residents in a neighborhood without access to such a program (Attanasio et al., 2009). At the same time, they present a modest contrast with recent estimates in Kenya, finding no impact (positive or negative) on trust (Haushofer and Shapiro, 2016). Taken together, these findings suggest that cash transfers at least tend not to reduce trust in community

members, as some may have feared. In other work, we find that cash transfers boost trust among beneficiary households in elected government officials as well (Evans et al., 2019b).[4]

This work contributes to a larger literature on the impact of social safety nets on inter-household transfers. Most recently, Nikolov and Bonci (2020) review nine studies of social assistance programs and informal transfers and find a wide range of estimated crowd-out effects (from zero crowd-out in Vietnam to a reduction in informal transfers of 88 percent in Mexico) of formal safety nets on informal transfers in low- and middle-income countries.

The wide variation in results suggests that crowding out will depend on the structure of the program (e.g., size of transfers, completeness of coverage, and duration of program): Olinto and Nielsen (2006) find differences in crowding out across cash transfer programs in Nicaragua and Honduras and attribute the difference to the relative size of the transfer. It will also depend on the context in which the program intervenes (e.g., how large are existing informal transfers, and how deep are poverty levels): Albarran and Attanasio (2003) find that crowing out of private transfers in Mexico is larger in communities with lower baseline income variance. In a recent addition to that literature, Gulesci (2020) finds significant crowd-out of informal transfers from a large anti-poverty program that transferred both assets and skills.[5]

Our findings of limited crowd-out after 1.75 years and no crowd-out after 2.75 years contrast with the existing literature. Most evaluations are relatively short term, which may explain the difference with the studies reviewed in Nikolov and Bonci (2020). The time path of these effects may not be constant. In addition, the size of the transfer in our study is more modest than that studied in Gulesci (2020). Many cash transfer programs offer relatively modest support, and those may do little to crowd out informal transfers, leaving longstanding systems of inter-household safety nets intact.

[4]In Peru, conditional cash transfers boosted trust in the part of government that dealt with cash transfers for recipients, but for non-recipients, it decreased in the part of government that dealt with grievances around the program (Camacho, 2014).

[5]Our findings also relate to the even broader literature on how formal risk-sharing institutions affect informal risk-sharing institutions: for example, church members in Ghana contributed less to their church after being randomly assigned to enrollment in a formal insurance program (Auriol et al., 2020).

References

Albarran, P. and O. P. Attanasio (2003). Limited commitment and crowding out of private transfers: Evidence from a randomised experiment. *The Economic Journal 113*(486), C77–C85.

Attanasio, O., L. Pellerano, and S. P. Reyes (2009). Building trust? Conditional cash transfer programmes and social capital. *Fiscal Studies 30*(2), 139–177.

Attanasio, O. and J.-V. Ríos-Rull (2000). Consumption smoothing in island economies: Can public insurance reduce welfare? *European Economic Review 44*(7), 1225–1258.

Auriol, E., J. Lassebie, A. Panin, E. Raiber, and P. Seabright (2020). God insures those who pay? Formal insurance and religious offerings in Ghana. *The Quarterly Journal of Economics 135*, 1799–1848.

Camacho, L. A. (2014). The effects of conditional cash transfers on social engagement and trust in institutions: Evidence from Peru's Juntos Programme. *German Development Institute Discussion Paper 24/2014*.

Evans, D. K., B. Holtemeyer, and K. Kosec (2019a). Cash transfers and health: Evidence from Tanzania. *The World Bank Economic Review 33*(2), 394–412.

Evans, D. K., B. Holtemeyer, and K. Kosec (2019b). Cash transfers increase trust in local government. *World Bank Economic Review 114*, 138–155.

Gulesci, S. (2020). Poverty alleviation and interhousehold transfers: Evidence from BRAC's graduation program in Bangladesh. *The World Bank Economic Review*.

Haushofer, J. and J. Shapiro (2016). The short-term impact of unconditional cash transfers to the poor: Experimental evidence from Kenya. *Quarterly Journal of Economics 131*(4), 1973–2042.

Nikolov, P. and M. Bonci (2020). Do public program benefits crowd out private transfers in developing countries? A critical review of recent evidence. *World Development 134*.

Olinto, P. and M. E. B. Nielsen (2006). Do conditional cash transfers crowd out private transfers? evidence from randomized trials in Honduras and Nicaragua. *World Bank*.

World Bank (2020). World Development Indicators: Consumer Price Index – Tanzania, $https://data.worldbank.org/indicator/fp.cpi.totl?end = 2012\&locations = tz\&start = 2009$.

Online Appendix

Table A1: Timeline of CCT program and impact evaluation

Timing	Activity
November 2007 - September 2008	Program design
September - November 2008	Sensitization at regional, district, ward, and community levels
January - May 2009	Baseline survey
September - October 2009	Enrollment of beneficiaries
January 2010	First payments made to beneficiary households
July - September 2011	Midline survey and first round of qualitative data collection
August - October 2012	Endline survey
July - August 2013	Second round of qualitative data collection

Table A2: Amount of Assistance from Community Members, Top 1 Percent of Observations of Outcome Winsorized

		Total transfers from ... in the past 12 months		
	Total	Individuals	Govt or TASAF	NGOs
	(1)	(2)	(3)	(4)
Treatment × 2011 (midline)	70.64***	-6.90*	82.58***	-0.20
	(5.130)	(4.114)	(3.477)	(0.357)
Treatment × 2012 (endline)	57.02***	-0.85	63.26***	-0.20
	(5.275)	(4.187)	(2.589)	(0.410)
2011 (midline)	12.17***	15.92***	-0.11	-0.15
	(3.338)	(3.562)	(0.228)	(0.291)
2012 (endline)	7.48**	13.08***	-0.41***	-0.07
	(3.414)	(3.332)	(0.127)	(0.343)
R^2	0.229	0.025	0.604	0.002
Baseline mean	20.655	18.615	0.648	0.804
Observations	5374	5035	5033	5035

Source: Authors' calculations based on baseline (2009), midline (2011), and endline (2012) household survey data.

Notes: Transfer amounts are measured in constant 2009 Tanzanian Shillings (TSH). The highest 1 percent of observations are winsorized. All specifications include household fixed effects. Treatment estimates are estimates of the effect of living in a treatment village (intent to treat). Standard errors are in parentheses and clustered at the village level. *** indicates p<0.01; ** indicates p<0.05; and * indicates p<0.10.

Table A3: Amount of Assistance to Community Members, Top 1 Percent of Observations of Outcome Winsorized

		Assistance given in the past 12 months in ...		
	Total	Cash	Food	Other in-kind
	(1)	(2)	(3)	(4)
Treatment × 2011 (midline)	-0.06	0.09	-0.19	0.09
	(0.387)	(0.100)	(0.290)	(0.059)
Treatment × 2012 (endline)	-0.47	-0.01	-0.42	0.10
	(0.395)	(0.123)	(0.264)	(0.074)
2011 (midline)	0.70**	0.02	0.66***	-0.06
	(0.315)	(0.062)	(0.223)	(0.045)
2012 (endline)	1.14***	0.16*	0.83***	0.08
	(0.306)	(0.084)	(0.189)	(0.058)
R^2	0.008	0.002	0.010	0.006
Baseline mean	0.947	0.238	0.444	0.102
Observations	5035	5035	5035	5035

Source: Authors' calculations based on baseline (2009), midline (2011), and endline (2012) household survey data.
Notes: Transfer amounts are measured in constant 2009 Tanzanian Shillings (TSH). The highest 1 percent of observations are winsorized. All specifications include household fixed effects. Treatment estimates are estimates of the effect of living in a treatment village (intent to treat). Standard errors are in parentheses and clustered at the village level. *** indicates p<0.01; ** indicates p<0.05; and * indicates p<0.10.

Table A4: Assistance from Community Members, by Baseline Asset Wealth

	Dummy - received gifts/assistance from ... in the past 12 months								
	Individuals			Govt or TASAF			NGOs		
	Cash	Food	Other in-kind	Cash	Food	Other in-kind	Cash	Food	Other in-kind
	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
Treatment effect for less-poor (midline)	0.044	0.008	0.008	0.842***	-0.022*	-0.030*	-0.006	-0.014	0.013
	(0.049)	(0.055)	(0.045)	(0.031)	(0.012)	(0.017)	(0.012)	(0.025)	(0.021)
Treatment effect for less-poor (endline)	-0.001	0.041	0.006	0.877***	-0.019*	-0.006	-0.000	0.019	0.024
	(0.043)	(0.057)	(0.050)	(0.027)	(0.010)	(0.016)	(0.011)	(0.028)	(0.027)
Treatment effect for poorest (midline)	-0.172***	-0.0664	-0.0303	0.908***	0.0174	0.0223	0.00189	-0.00870	0.0140
	0.0406	0.0441	0.0459	0.0134	0.0132	0.0239	0.00830	0.0181	0.0168
Treatment effect for poorest (endline)	-0.0884**	-0.0377	-0.0376	0.921***	0.0134	0.000	-0.00822	-0.00584	0.00850
	0.0482	0.0448	0.0417	0.0193	0.0121	0.0131	0.0120	0.0168	0.0201
Observations	5,025	5,018	5,021	5,032	5,033	5,034	5,033	5,034	5,033
R-squared	0.046	0.044	0.010	0.806	0.008	0.009	0.003	0.003	0.008
p-value of difference (midline)	0.000	0.233	0.480	0.0372	0.0191	0.0695	0.588	0.758	0.938
p-value of difference (endline)	0.140	0.176	0.479	0.139	0.0451	0.798	0.636	0.246	0.488

Source: Authors' calculations based on baseline (2009), midline (2011), and endline (2012) household survey data.
Notes: All specifications include household fixed effects. Treatment estimates are estimates of the effect of living in a treatment village (intent to treat). Poorest is defined as a household have baseline asset wealth at the median or below, while less-poor is defined as having above-median baseline asset wealth. Standard errors are in parentheses and clustered at the village level. *** indicates p<0.01; ** indicates p<0.05; and * indicates p<0.10.

Table A5: Amount of Assistance from Community Members, by Baseline Asset Wealth

		Total transfers from ... in the past 12 months		
	Total	Individuals	Govt or TASAF	NGOs
	(1)	(2)	(3)	(4)
Treatment effect for less-poor (midline)	72.468***	-9.331	85.480***	-0.370
	(10.400)	(8.269)	(6.952)	(0.906)
Treatment effect for less-poor (endline)	59.322***	-0.938	61.645***	-0.211
	(8.211)	(7.409)	(3.259)	(1.011)
Treatment effect for poorest (midline)	69.73***	-10.71**	86.88***	-0.986
	(6.439)	(4.407)	(4.478)	(0.677)
Treatment effect for poorest (endline)	55.22***	-2.520	64.45***	-0.831
	(7.487)	(6.233)	(3.022)	(1.058)
Observations	5,369	5,034	5,032	5,034
R-squared	0.156	0.019	0.400	0.001
p-value of difference (midline)	0.806	0.861	0.850	0.509
p-value of difference (endline)	0.659	0.839	0.437	0.606

Source: Authors' calculations based on baseline (2009), midline (2011), and endline (2012) household survey data.
Notes: Transfer amounts are measured in constant 2009 Tanzanian Shillings (TSH). All specifications include household fixed effects. Treatment estimates are estimates of the effect of living in a treatment village (intent to treat). Poorest is defined as a household have baseline asset wealth at the median or below, while less-poor is defined as having above-median baseline asset wealth. Standard errors are in parentheses and clustered at the village level. *** indicates p<0.01; ** indicates p<0.05; and * indicates p<0.10.

Table A6: Amount of Assistance to Community Members, by Baseline Asset Wealth

		Assistance given in the past 12 months in ...		
	Total	Cash	Food	Other in-kind
	(1)	(2)	(3)	(4)
Treatment effect for less-poor (midline)	-0.050	0.356	-0.482	0.093
	(1.013)	(0.485)	(0.709)	(0.173)
Treatment effect for less-poor (endline)	0.296	0.412	-0.357	0.083
	(1.190)	(0.574)	(0.678)	(0.476)
Treatment effect for poorest (midline)	1.268	0.0665	0.149	1.061
	(0.864)	(0.146)	(0.323)	(0.744)
Treatment effect for poorest (endline)	0.114	-0.286	0.0125	-0.0317
	(0.531)	(0.252)	(0.341)	(0.607)
Observations	5,034	5,034	5,034	5,034
R-squared	0.003	0.002	0.005	0.004
p-value of difference (midline)	0.326	0.579	0.363	0.208
p-value of difference (endline)	0.887	0.275	0.621	0.870

Source: Authors' calculations based on baseline (2009), midline (2011), and endline (2012) household survey data.
Notes: Transfer amounts are measured in constant 2009 Tanzanian Shillings (TSH). All specifications include household fixed effects. Treatment estimates are estimates of the effect of living in a treatment village (intent to treat). Poorest is defined as a household have baseline asset wealth at the median or below, while less-poor is defined as having above-median baseline asset wealth. Standard errors are in parentheses and clustered at the village level. *** indicates p<0.01; ** indicates p<0.05; and * indicates p<0.10.

ALL IFPRI DISCUSSION PAPERS

All discussion papers are available **here**

They can be downloaded free of charge

INTERNATIONAL FOOD POLICY RESEARCH INSTITUTE
www.ifpri.org

IFPRI HEADQUARTERS

1201 Eye Street, NW
Washington, DC 20005 USA
Tel.: +1-202-862-5600
Fax: +1-202-862-5606
Email: ifpri@cgiar.org