Cash Transfers to Mothers or Fathers: Educational and Health Impacts of a Randomized Experiment in Burkina Faso

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Extended Abstract

We conducted a unique randomized experiment to estimate the impact of alternative cash transfer delivery mechanisms on educational and health outcomes in rural Burkina Faso. The two-year pilot program randomly distributed cash transfers that were either conditional or unconditional and were given to either mothers or fathers. In this paper, we focus on the comparison of the results obtained when the transfers are given to mothers vs. fathers.

Conditional cash transfer (CCT) programs have become one of the most popular social sector interventions in developing countries.[1] While the program design details vary, all programs transfer resources to poor households conditional on the household taking active measures to increase the health and human capital of their children (enrolling their children in school, taking them for regular health care visits, and receiving necessary immunizations). In making transfers conditional, this type of intervention seeks to encourage human capital accumulation and break a vicious cycle in which poverty is transmitted across generations. In

[1] A growing number of countries, in particular in Latin America, but also in Asia have implemented such programs. As of 2009, the following countries in Latin America have implemented CCT programs: Argentina, Bolivia, Brazil, Chile, Columbia, Costa Rica, Dominican Republic, Ecuador, El Salvador, Guatemala, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, and Peru, while these Asian countries have started CCT programs: Bangladesh, Cambodia, India, Indonesia, Pakistan, Philippines, and Turkey (Fiszbein and Schady 2009). In Africa, two CCT pilot programs (in South Africa and Kenya) have been implemented, but both focus exclusively on orphans and HIV households and neither has yet been rigorously evaluated.

addition, these programs attempt to provide poor households with a consumption floor and to improve a household's asset base and income generating potential. Most CCT programs transfer funds to the mother rather than the father, with the hope that mothers use the funds more wisely.

Burkina Faso Nahouri Social Protection Program: Program and Impact Evaluation Design.

The pilot cash transfer program was conducted in Nahouri province in southern Burkina Faso, located approximately 100 miles from the capital, Ouagadougou. The 75 villages in Nahouri province that each have a primary school were randomly allocated to the following five groups: (i) conditional cash transfers given to the father (CCTF), (ii) conditional cash transfers given to the mother (CCTM), (iii) unconditional cash transfers given to the father (UCTF), (iv) unconditional cash transfers given to the mother (UCTM), and (v) a control group.[2] There were 15 villages in each treatment arm and in the control group, and only poor households were eligible to receive a cash transfer.[3] Once villages were randomly assigned to the five groups defined above, poor households in the treatment villages were randomly assigned to receive that particular type of cash transfer.

In our three rounds of surveys (baseline, one-year follow-up, two-year follow-up) conducted in June 2008, June 2009, and June 2010, we interviewed all poor households that were

[2] Due to the low primary school enrollment rates in Burkina Faso, the program intervention focused exclusively on primary schooling as opposed to also covering secondary schools.

[3] Immediately prior to the intervention and baseline survey, we conducted an extended household census in every village to collect information from each household about household living structure (cement or mud brick walls, metal or straw roof, flooring, access to latrine), household asset ownership (plow, cart, draft animals, motorcycle, radio), whether the head of household ever attended school, whether the household grows cotton, and whether there was a weekly market in the village. This information was combined with a Burkina Faso nationally representative household survey to calculate a predicted consumption level for each household and compare that with the national poverty line to determine whether a household is considered poor or non-poor, and subsequently is eligible to receive the cash transfer.

eligible to receive a transfer in each of the treatment villages and who were randomly selected to receive the transfer. In each of these four groups of 15 villages, we interviewed approximately 540 poor households randomly selected to receive transfers. The control group consisted of 615 randomly selected poor households that did not receive a cash transfer in the 15 control villages where no households received cash transfers.

For households randomly assigned to a CCT scheme, for their children under age six, receiving the transfer required quarterly visits to the local health clinic for preventive health care (growth monitoring and vaccinations), while for children age seven to fifteen, receiving the transfer required school enrollment with an attendance rate above 90 percent each quarter. For families randomly assigned to a UCT program, the mother or father received a quarterly stipend for each child, and there were no requirements or conditions linked with receiving the stipend. For each child under age six, in the CCT and UCT programs, the mother or father would receive 4000 FCFA per year, distributed in four quarterly payments. Using the exchange rate during the 2008 baseline of 415 FCFA = $1 USD, the annual transfer would be worth approximately $9.64, which is 9 percent of household per capita expenditures. For each child age 7 to 10 (or in grades 1 to 4), the mother or father would receive 8000 FCFA per year, while for each child age 11 to 15 (or in grades 5 or higher), the mother or father would receive 16,000 FCFA per year, distributed in four quarterly payments. The program design assumes that each of the treatment groups would receive equal amounts of resources per capita over the two-year transfer program period, if households randomly allocated to the conditional cash transfers fully satisfied the conditionality. In practice, because there was not full compliance with conditionality, the households under the UCT programs, on average, received more resources per capita.

Preliminary results

We verify that baseline socio-demographic characteristics and outcome variables are well balanced across the four cash transfer groups and the control group.

For the educational outcomes, cash transfers given to the mothers have generally significantly larger impacts in increasing enrollments of school-going age children than cash transfers given to fathers. Results are similar when enrollment is measured using self-reports by the household and information collected from the school registers. No significant impacts of the cash transfers are found for school attendance and test scores.

The cash transfers also have positive impacts on the health status of children aged 0 to 60 months as measured by anthropometric measurements (weight-for-age z-scores, arm circumference-for-age z-scores, height-for-age z-scores), reports of illness episodes and health clinic utilization in case of illness. For those health outcomes, transfers to mothers do not have a significantly larger impact than transfers to fathers and in some cases, for the anthropometric outcomes, it is the transfers to fathers that have a statistically larger impact.