

Evaluation of the BOTA Foundation's programmes, Kazakhstan

Summary note 4:

The impact of the Conditional Cash Transfer Programme

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FURTHER INFORMATION

This briefing note is issued by Oxford Policy Management as part of its independent evaluation of the BOTA Foundation's programmes. The findings are not attributable to BOTA.

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THE SERIES

This is the fourth summary note from the evaluation of BOTA's programmes. The others are:

1. Findings from the baseline survey of the CCT programme
2. Findings from the first round of the operational evaluation of the CCT
3. Overall conclusions from the qualitative research

Introduction

The BOTA Foundation has been running a Conditional Cash Transfer (CCT) programme in Kazakhstan since 2009, providing regular monthly cash transfers to support low-income households that contain any of four categories of beneficiary: (i) children aged 4+, until they start school; (ii) children with disabilities; (iii) pregnant women or women with infants under six months old; and (iv) school-leavers aged 16–19 who are starting work. Households receive the transfer provided that they meet conditions relevant to the beneficiary group such as attendance at antenatal appointments, pre-school or training courses.

BOTA commissioned Oxford Policy Management (OPM) to conduct a rigorous impact evaluation of the CCT in one of its provinces, Almaty *oblast*. The focus was on families eligible for the pre-school benefit, though information was also collected in relation to other categories of beneficiary if they were also present in the household. This note summarises the findings¹.

The study design

The study design is detailed in Summary Note 1. In brief, the team randomly selected 108 rural *okrugs*—communities of a small group of villages headed by a mayor or *akim*—out of the 226 in Almaty *oblast*. Of these, 54 were randomly assigned to the 'treatment' group and were enrolled in the CCT. The other 54, the 'control' group, did not join the CCT until after the evaluation had finished. At the start a baseline survey demonstrated that the characteristics of the two groups were broadly the same. Any differences that emerged between the groups a year later could be attributed to BOTA. This is termed a clustered randomised control trial.

The baseline survey in 2011 interviewed 1,173 households, selected randomly from among all those that were eligible for the programme as they contained a child of pre-school age and were classified as poor according to BOTA's criteria. The sample was evenly split between treatment and control locations.

¹ For the full evaluation results see OPM (2013), 'The impact of BOTA's Conditional Cash Transfer (CCT) Programme'.

In 2012 a follow-up survey took place to establish the differences between the treatment and control groups. Some 2,289 households, and over 350 pre-schools attended by the sampled children, were interviewed.

The random assignment of communities to the treatment and control groups, and the random selection of households for interview within those communities, means that the results that follow are statistically representative of all households in Almaty *oblast* that are eligible for BOTA's CCT for children of pre-school age for at least a year.

Household characteristics

The CCT has not caused households to alter their living arrangements. A typical household eligible for the benefit has six members, three children and three adults. Nearly nine in every 10 children live with both parents. This is important because cash transfers elsewhere are sometimes found to incentivise families to give birth to more children, to look after their relatives' children or to migrate. In the short one-year interval between the baseline and follow-up surveys BOTA has not had this effect.

Experiences of pre-school

More children in pre-school

One of BOTA's main objectives for pre-school-age children is to increase enrolment and attendance at pre-school, which are conditions of receiving the transfer. The CCT has had a considerable influence here.

There is a natural increase between baseline and follow-up surveys in the rate of children ever enrolled at pre-school because they are now one year older. At baseline in 2011, before BOTA had given any transfers, fewer than half had enrolled in pre-school; by the follow-up survey in 2012 this had risen to more than three-quarters (78%). BOTA has significantly affected the size of the change. In CCT areas some 84% of children have now attended a pre-school, compared with 70% in control areas.

The rate of dropout in our sampled age group is very low in all locations regardless of BOTA.

Different types of pre-school

Children are going to different types of pre-school because of the CCT. Out of the three most common types of pre-school for five- and six-year-olds—kindergartens, zero classes and mini-centres—there has been a noticeable surge in demand for mini-centres: 27% of children in CCT areas have attended these, vs. 14% in control areas. Demand for kindergartens and zero classes has not been substantially affected. The CCT has also led to a new type of informal pre-school that respondents often call a 'BOTA group'. These are centres set up by communities to meet the CCT conditionality in locations where facilities did not exist or had no available places. They often use spare rooms in buildings such as schools. Over 10% of children in CCT areas who are eligible for the benefit have been to this type of facility.

We unexpectedly find that some 15% of sampled children in treatment areas and 9% in control areas are already in Class 1 or 2 of school, although they are not yet obliged to be. BOTA has had a significant impact in this respect. For BOTA beneficiaries we estimate that attendance of the surveyed children at primary school is some 10 percentage points higher than it would have been without the CCT. This suggests that the consequence of the CCT's encouragement of pre-school education is not so much that children are spending longer in pre-school but rather that they are moving up to school sooner. Only a longer term study of this cohort will be able to show the impact of this early school start on their eventual outcomes in education.

The increased enrolment brought about by the CCT has been noticeable to professionals working in pre-school education. In treatment areas two-thirds of our respondents for the facility survey—who were mainly directors, deputy directors or teachers—considered that most of the children aged four to six in their okrug were now enrolled in a pre-school facility,

while only about 40% of respondents in control areas were of this opinion.

Children enrolled in pre-school in CCT areas typically spend less time there than those in control areas (4.8 days per week compared with 5.0 days). This indicates that informal facilities, in which children in treatment areas are more often enrolled, have reduced opening times compared with the more formal equivalents.

This change in the pre-school experience has not led to major shifts in perception of the quality of any aspect of the facility such as the teaching, buildings or management.

Conditions at pre-school

The type of facility that children go to makes a big difference to their experience of pre-school.

State-run kindergartens tend to be large establishments with at least 20 staff and many amenities including hot water and indoor toilets, outdoor play areas, toys and games, a library, musical instruments and sometimes a computer. All those we interviewed are open for at least eight hours a day. They offer a wide range of lessons and recreational activities. They serve breakfast and lunch, and often other meals.

Zero classes are generally smaller, with an average of six staff. They usually teach children for half- rather than whole days, and focus on academic preparation for school. Fewer have recreational play equipment, toys, televisions or musical instruments than kindergartens do, whereas they are just as likely to have a library. Mini-centres can be much more flexible in how they operate, so they fall in between these two types. Some are run like kindergartens, with full days of academic and play activities; others have a shorter timetable similar to zero classes.

'BOTA groups' are the least well endowed with utilities and recreational equipment and have an average of just two staff members, reflecting the fact that they are usually small single groups. Most of the interviewed BOTA groups are open for no more than two hours at a time so they necessarily cannot cover the same range of activities as a kindergarten.

The huge variation in opening times and amenities offered by different facilities has two important consequences for the CCT. First, it is difficult to predict the long-term impact of the CCT-induced increased enrolment on educational outcomes, since a child that attends an informal group for two hours per week will have a very different experience to one who spends 40 hours at a formal kindergarten. Second, BOTA's requirement for an attendance record of 85% is difficult to justify if households are suspended from the CCT for attending 'only' 30 hours a week at a kindergarten while others are paid fully for attending less.

BOTA has not altered the mean enrolment in kindergartens, zero classes and mini-centres: their size is largely fixed by regulation. So if enrolment among the target population has increased, where are the extra children? We noted above the creation of new (informal) facilities, and the displacement of children into Class 1. A third hypothesis is the exclusion of better-off children who are not eligible for BOTA. We cannot confirm this quantitatively as we did not interview ineligible households, but it seems credible because pre-schools now commonly cite being in receipt of a benefit as a primary reason for selecting a child for enrolment.

The cost of pre-school education

The cost of pre-school also varies by facility, so households can use the transfer differently depending on the type attended. The CCT is calculated as a percentage of the minimum value required to meet basic food and non-food needs, but its aim is to cover part of the cost of pre-school while encouraging families to invest a small amount of their own resources to cover the remainder. In 2012 its value for pre-school beneficiaries was KZT 3,600 (\$24) a month.

All kindergartens and three-quarters of mini-centres charge a monthly fee—at an average of almost KZT 7,500 (\$50) for the former and a little over KZT 5,000 (\$33) for the latter—so for these facility types the CCT achieves its aim. But families with a child at a zero class do not need to spend the transfer on school fees because

attendance is free. BOTA groups mostly charge a modest sum, typically less than KZT 1,000.

Support for early learning

At home nearly all children have toys and a television, but fewer than two-thirds have at least three age-relevant books and there is no significant improvement in CCT areas.

Most children (97%) had participated in at least four learning activities (such as reading, writing, story-telling) at home in the previous week. The proportion of beneficiary households reporting this is about five percentage points higher than we might have expected without the CCT.

Child care arrangements

The main carer of pre-school-age children—who ensures the child is fed, bathed and taken care of when ill—is almost always female. In CCT areas the average main carer is now slightly younger than in control areas, suggesting that parents are relying less on older relatives for the care of young children. Grandparents continue to play a substantial role in children's upbringing as secondary carers, looking after the child when the main carer is absent. The CCT has led to few changes in secondary arrangements other than a small but significant decline in aunts and uncles looking after the child.

Overall, very few children are ever left alone or with a child under 10 years old (4% in the week prior to the survey). This low rate is even lower in treatment than control households, suggesting that the CCT has reduced the need to resort to inadequate care.

Household consumption

We might expect the CCT to increase the consumption of households that receive it. However, the impact evaluation was not able to detect a significant change. This may be because the transfer is too small to be discernible compared with overall consumption. A typical household eligible for the CCT has a

consumption of about KZT 93,000–94,000 (\$625) a month. BOTA's contribution of an extra \$24 per beneficiary, or slightly more for pregnant women, adds less than 4% to the total.

Households who receive the CCT are not substantially changing the mix of items that they buy. The proportion of consumption that is devoted to food is quite high in both treatment and control areas, at around 57%. This is because the surveyed households are all eligible for the CCT and therefore relatively less well off.

Food security

The impact evaluation confirms the baseline findings that poverty in Kazakhstan is not strongly associated with food insecurity. Only 7% of households reported at least one month in the previous year when they did not have a full and varied diet; this rate is unaffected by the CCT.

Children eligible for the CCT already eat a regular and diverse diet and the transfer has had no impact on either the frequency or diversity of children's meals. They continue to eat an average of three meals and three snacks a day, eating products from an average of eight out of 12 food groups on the day before the survey.

How households earn a living

Households earn income from many sources such as formal salaried employment, casual labour, running their own business such as farming, or receiving cash or in-kind transfers. Often they combine several sources.

The CCT has caused transfers to become a much more important source of income: some 77% of eligible households in CCT areas now cite transfers as one of their top three income sources, compared with 67% in control areas. These transfers are more often a useful supplement to the main income rather than the single most important source.

By offering funds that are additional to earnings they were already receiving through other

activities, the CCT helps households to diversify their income, which is useful for managing risk.

Employment

Over half of all adults (aged 15+) living in families eligible for the CCT are economically inactive, neither working nor seeking work. Most of these are housewives or pensioners; about 18% are in education and 4% have a disability. This results in a large pool of adults who are potentially at home and able to look after children.

The CCT has not altered this: looking across all household members we do not find that it has encouraged previously economically inactive adults to look for a job. This is in line with expectations as the CCT was not designed to affect the work choices of everyone including teenagers and pensioners.

However, focusing on the child's main carers alone, the CCT seems to have led to a small but significant increase in the proportion in paid employment outside the household (28% in CCT areas vs. 21% in control areas). These are the people whose time might be expected to be freed up most by having a child now enrolled in pre-school. Despite this, most carers (67%) remain economically inactive as they are often still looking after other young children at home.

Institutional and informal transfers

Families in Kazakhstan may receive a wide range of state benefits, targeted either at individuals such as children or the elderly, or at households such as the targeted social assistance for destitute households.

Almost two-thirds of households that are eligible for the CCT receive a state transfer, often a pension or child benefit. The CCT has had no significant impact on this rate: it has neither made households ineligible for state benefits nor encouraged them to apply for additional ones.

We do, of course, find a big increase in households reporting help from non-state sources: 55% of households eligible for the CCT in areas where BOTA is working have received cash or goods from a non-government source

over the last year, compared with only 1% in control areas. The share of eligible households in treatment areas that receive money from an NGO is not 100% because not all of them have enrolled onto the CCT.

Friends and relatives have not reduced the amount of financial and non-financial support they give as a result of BOTA. Kazakhstan does not in any case have a strong culture of informal transfers as other countries in the region do. About 19% of eligible households have received support from their acquaintances in the last year, while 6% have given support to others.

Savings and credit

By opening a bank account for every beneficiary household, BOTA has introduced households to a form of financial service that almost none had previously used. But we see no significant change in the proportion using formal banking to save money. Indeed, only about 5% of households report having any savings at all.

One might expect debt to decline among CCT recipients as the regularity of the transfer should allow households to smooth their income throughout the year. However, the opposite has occurred. Households in CCT areas are significantly more likely to have debt (65%, compared with 59% in control areas), and they have more of it. This suggests that creditors may feel reassured about lending to households whom they know to have a reliable income stream. Most indebted households (60%) use debt to fund current consumption (buying food, groceries or clothes, paying for utilities), while fewer than a third (27%) invest loans in a more productive way (buying durables, setting up a new business or house refurbishment).

Findings on other BOTA categories

Pregnant and lactating women

Coverage of antenatal care was already high in Kazakhstan even before the CCT. It would be virtually impossible for BOTA to improve on the

99% rate of attendance at antenatal care among pregnant women. The CCT had no effect on either the date at which women first attended an antenatal appointment—in the 11th week of pregnancy, on average—nor the number of appointments attended.

However, there is a significant improvement in the proportion of women having recently given birth who report having taken iron supplements during pregnancy, at 78% in CCT areas compared to 69% in control areas. This is a reflection of BOTA's training programme for pregnant and lactating women which emphasises anaemia prevention.

Children with disabilities

The team administered BOTA's knowledge test on home-based care for children with disabilities to the 79 interviewed households for whom it was relevant. Understanding of appropriate behaviour towards children with disabilities was very variable and was not noticeably better among those in treatment areas than those in control areas. This may be illustrative of the difficulties of designing a curriculum that suits the needs of households that are faced with widely differing challenges, looking after children of varying ages with a range of disabilities.

Programme take-up

Within treatment areas beneficiary households are very significantly different to those that are also eligible but do not take up the benefit. Households that become beneficiaries have, on average, more children—including of pre-school age—and fewer working-age adults and pensioners.

We also see a reduced likelihood of take-up of the CCT by heads of households who are female, elderly or highly educated, by households with a smaller dependency ratio and by Russian speakers (proportional to their prevalence in the eligible population). These are either not being targeted for inclusion in the programme or are less likely to choose to apply.

Conclusions

The impact of the CCT

The short-term nature of the CCT, and its small size compared with the consumption of its target households, mean that it is not an instrument for poverty reduction: its ability to have a substantial material impact on households is limited.

Nonetheless, considering its very small contribution to household budgets it is remarkable that, when we examine its effect on the people for whom it is directly intended—pre-school-age children and their carers—we see a number of significant changes in behaviour. These include the substantial effects on both demand for, and supply of, pre-school education; and the slight shift in the type of economic activity undertaken by some working carers.

Implications for future programming

Any programme wishing to have a substantial and immediate impact on the economic condition of this particular target group of households in Kazakhstan may need to consider providing larger sums of money, or for longer periods.

At the same time we see that even small sums of money, conditional on pre-school attendance, can attract a big change in behaviour among eligible households. The fact that the extra enrolment has fallen largely upon less traditional facilities indicates that kindergartens and zero classes may be less able to respond rapidly to changing demand. If 'BOTA groups' are to be continued once the CCT programme draws to a close in its current form in 2014 it may be worth considering whether and how to bring them more into line with other pre-school facilities.

Continued demand-side incentives for pre-school alongside the government's supply-side programme of expansion should work well to improve the quantity of pre-school education; as for quality, a cash transfer aimed at households cannot have a direct influence, so the government's ongoing measures to improve quality, such as improving the qualifications of teaching staff, will continue to be important.