from EVIDENCE to POLICY

THE WORLD BANK

Learning what works, from the Human Development Network

February, 2013

75655

Do Grants to Communities Lead to Better Health and Education?

Conditional cash transfer programs have proven to be an effective tool for helping reduce poverty. As use of such programs grows, development experts and policymakers are considering how to successfully promote better health and education in large countries with diverse and often remote communities. In some cases, they are rethinking traditional cash transfer programs to create grant programs that target communities instead of families. One question is whether linking grants to performance, similar to conditional cash transfer programs, can promote better results than giving grants that are not performance-tied.

The World Bank is at the forefront of efforts to reduce poverty and create shared prosperity. As part of this, the World Bank is helping countries create and implement programs to reduce maternal and child mortality and increase school enrollment, both of which are crucial for countries working towards meeting the United Nations Millennium Development Goals. In Indonesia, the World Bank worked with the Government of Indonesia on a community grant program to boost the use of health and education services. The impact evaluation built into the program found that cash transfers to rural communities led to positive impacts on average across health and education indicators, with a strong decline in malnutrition. Communities whose grants were linked to performance-based incentives did even better than those whose grants weren't linked to incentives. This suggests that conditioning grants can produce positive results. **Because of the measured impacts, the Government of Indonesia is expanding the community grant program to eight provinces from five and focusing attention on combating malnutrition. And a portion of all grants will now be based on performance.**

SOCIAL PROTECTION

Context

Indonesia, like many middle income countries, has difficulty providing universal access to education and adequate access to healthcare, particularly in poor and rural areas. While national government programs have been effective in raising primary school enrollment, other health and education indicators still lag, and huge geographical disparities remain. In 2007, the year that the government embarked on its sweeping anti-poverty programs, maternal mortality was 228 per 100,000 live births, among the worst in Southeast Asia, while close to 20 percent of children under the age of five were underweight. Other surveys found that enrollment rates dropped precipitously between primary and middle schools, going from 94 percent to 65 percent.

To tackle these problems, the Government of Indonesia launched two large-scale programs in 2007. The programs both relied on cash transfers, but one targeted households and one targeted communities. In both cases, the transfers were designed to encourage families to meet basic health and education indicators, including prenatal visits for pregnant women, childhood immunization, regular weight monitoring, and school attendance.

The first, called the Hopeful Family Program, known as PKH, provides conditional cash transfers to extremely poor households with children or pregnant women. Households in the program have shown significant positive gains in multiple health areas, such as significant increases in pre-natal, post-natal, and delivery care; in vaccinations and treatments for diarrhea; and in child growth monitoring and health service provider visits in general. While the effect on education has been more muted, the government is expanding the program from 810,000 households in 2010 (itself an increase from 432,000 households when the program was launched) to 3 million by 2014.*

The second poverty alleviation program, known as the National Community Empowerment Program—Healthy and Smart Generation, or PNPM Generasi, gives block grants to poor, rural communities. The program takes the idea of conditional cash transfers and redesigns it to enable communities and local health and education providers to work together to decide what needs to be done to increase schooling and use of critical health services. Trained facilitators help communities decide how to best address bottlenecks using the community grants from the project to improve the targets indicators. Communities can focus on stimulating demand by giving people cash transfers or scholarships to use certain services, or they can focus on supply problems that might be limiting access, such as too few health clinic workers or overcrowded classrooms.

To push communities to focus on the most effective policies, a portion of subsequent year grants is based on how well communities do in meeting the previous year's health and education targets. In this way, the program takes aspects of conditional cash transfer and pay-for-performance programs and reformulates them to encourage community-wide performance and accountability. In order to test the effectiveness of linking grants to the previous year's performance, a second version of the program was carried out in which communities received the money irrespective of the previous year's performance. The grants have ranged from an average of $8,500 in 2007 to $18,200 in 2009. This World Bank-supported program now reaches about 5.4 million people.

*For further information see: "Program Keluarga Harapan, Main Findings from the Impact Evaluation of Indonesia's Pilot Household Conditional Cash Transfer Program", World Bank Office Jakarta, June 2011

Evaluation

The World Bank-supported Generasi program included a built-in impact evaluation component partially funded through the SIEF trust fund. The Generasi program was initially focused on rural areas in five provinces chosen by the government. After researchers eliminated the wealthiest 20 percent of districts, based on malnutrition rates, school transition rates and poverty rates, 20 districts were randomly picked from the remaining eligible districts. Within these, 300 target subdistricts were picked based on their eligibility for a previous anti-poverty program or because they were classified as less than 67 percent urban. Using a lottery system, these were equally divided between the control group, the performance-linked block grant group and the unlinked block grant group. With over 2,100 villages randomized to receive either the incentivized or non-incentivized version of the Generasi program (plus some 1,000 villages in control subdistricts), and over 1.8 million target beneficiaries in treatment areas, to the best of our knowledge, this represents one of the largest randomized social experiments conducted in the world to date.

Surveys were conducted at baseline, prior to the program being implemented after August 2007; one year into the program in October through December 2008, and two years into the program in October through December 2008. Resurvey rates were 95 percent and better.

The Findings

Giving communities block grants to help them devise programs to boost use of basic health services and increase school enrollment and attendance works.

Overall, the Generasi program improved use of crucial health services and boosted school enrollment and attendance, especially in the second year of the program. The program showed a statistically significant impact across all 12 indicators when compared with the control group. Changes included a 6.8 percent increase in weight checks for children, and a 4.7 percent increase in iron supplements given to pregnant women.

Likewise, the program overall boosted primary school attendance by 0.8 percentage points, raising total enrollment

This policy note is based the World Bank report: "Indonesia's PNP Generasi Program: Final Impact Evaluation Report," June 2011, Benjamin A. Olken (M.I.T.), Junko Onishi (World Bank), Susan Wong (World Bank)

for ages 7-12 to 98.5 percent, which is near-universal enrollment. When the impact on school enrollment and attendance was broken down by poverty levels, the block grants showed their biggest impact on families in the bottom 40 percent income levels. Among these households, there was an overall increase of 2 percentage points for school enrollment and attendance for children ages 7-12, and a 7.5 percentage point increase for children aged 13-15.

The program's biggest effect was in cutting malnutrition and stunting.

Childhood malnutrition was reduced by 2.2 percentage points, or nearly 10 percent over the control group. This was particularly strong in areas where malnutrition was a bigger problem, such as the Nusa Tenggara Timur Province, where severe underweight rates dropped by 33 percent, or 5.5 percentage points, and severe stunting declined by 21 percent, or 6.6 percentage points. In addition, in the first year, there was a drop in neonatal deaths, but this didn't carry over into the second year. The reason may be that the rate dropped sufficiently that it was difficult to bring it down any further.

Although enrollment and attendance rose in many communities that received block grants, there was no corresponding improvement in learning.

The evaluation reviewed math and Indonesian tests given to children aged 7-12 and those aged 13-15. There was no measurable impact on test scores, which either means that the project didn't improve student learning, or that the tests weren't structured in a way that could capture that achievement. Another possibility is that the program wasn't underway long enough to result in better test scores.

Communities spent the majority of the grants on education, and most of the money went for individual assistance, such as school supplies and uniforms.

The majority of spending, 56 percent, went to education, with a majority of that money being spent on school materials, supplies and uniforms. Another 31 percent was used for financial assistance for families, 8 percent went to infrastructure, 4 percent on teacher incentives and 1 percent on training.

Forty-four percent of the grant went to heath activities, with 41 percent of that used for supplementary feeding activities (such as fortified snacks for children), 27 percent for financial assistance for pregnant women to use health services, 26 percent for infrastructure and equipment, 4 percent for health worker incentives and 3 percent on training.

Linking the amount of the block grant to how well communities did in meeting health and education goals in the previous year did raise health results. But basing a portion of the grants on performance did not lead to any effects on communities meeting education targets.

When it came to meeting health indicators, communities whose grants were tied to performance generally outperformed communities whose grants were not linked to performance. Prenatal visits

were 5 percent higher in communities where the money was partly allocated based on performance, compared with the other communities, and immunization rates were 3 percent higher.

But this was only the case in meeting health targets. There was no gain seen in reaching education indicators. Researchers suggest a number of reasons why the incentive-linked grants didn't work for education targets: among them, health baseline figures were lower than education ones, making it easier to improve and reaching education indicators requires the involvement of more people, from teachers, to parents, to community officials and students, making it more challenging to improve.

Generasi's structure pushed communities to develop solutions together, which may be one reason why villages that received the grants did show increased community effort and participation in other ways.

Beneficiary villages had a 6.6. percent increase in the number of health volunteers supporting the health providers. There also was some increase in the number of high school (junior secondary school) parent-teacher committee meetings although not for primary school. Spillover effects included an average increase of 2.7 hours per household—or 7.2 percent—in the time women spent in women's community groups.

The program's biggest impact was in communities with the most need.

In areas where health and education indicators were at the lowest —10th percentile of service provision at baseline—the program on average was twice as effective, possibly because there was more room for improvement.

Conclusion Making policy from evidence

Indonesia's decision to give communities block grants to improve basic health and education services has proven to be an effective tool for working in areas where use of services is constrained not just by demand, but also by supply and access. By linking part of the grant to performance, the Generasi program attempted to replicate the conditionality of cash transfers on a community-wide levels. The gains seen in use of health services in communities that received a portion of the money based on performance show that the positive effects of individual conditional cash transfers, at least for some indicators, can be replicated when grants are community- wide. Indonesia has recognized the success of the program and is expanding it further. Later results from the traditional conditional cash transfer PKH program will help us learn more about the use of such programs on the individual versus community level. For policymakers and development experts considering using block grants to communities to increase use of basic health-care services and encourage school enrollment and attendance, this evaluation shows that in some cases, linking community money to performance can work.

For policymakers and development experts considering or designing similar programs, some issues to consider are:

- How can block grant programs be structured to ensure that impacts are seen in health and education indicators?
- Targets should be regularly adjusted to reflect development priorities and realized gains.

Generasi Program Target Indicators

Health Indicators

1. Four prenatal care visits
2. Taking iron tablets during pregnancy
3. Delivery assisted by a trained professional
4. Two postnatal care visits
5. Complete childhood immunizations
6. Adequate monthly weight increases for infants
7. Monthly weighing for children under three and biannually for children under five
8. Vitamin A twice a year for children under five

Education Indicators

9. Primary school enrollment of children 6-to-12 years old
10. Minimum attendance rate of 85 percent for primary school-aged children
11. Junior secondary school enrollment of children 13-to-15 years old
12. Minimum attendance rate of 85 percent for junior secondary school-aged children

The Human Development Network, part of the World Bank Group, supports and disseminates research evaluating the impact of development projects to help alleviate poverty. **The goal is to collect and build empirical evidence that can help governments and development organizations design and implement the most appropriate and effective policies for better educational, health and job opportunities for people in developing countries.** For more information about who we are and what we do, go to: http://www.worldbank.org/sief.

This Evidence to Policy note series is produced by SIEF with generous support from DFID.

THE WORLD BANK, HUMAN DEVELOPMENT NETWORK
1818 H STREET, NW WASHINGTON, DC 20433

Produced by Office of the Chief Economist, Human Development Network, Communications/Aliza Marcus