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# Abstract

Conditional Cash Transfer programs (CCTs) provide money to poor families contingent upon certain verifiable actions, generally minimum investments in children's human capital such as regular school attendance or basic preventative health care. They therefore hold promise for addressing the inter-generational transmission of poverty and fostering social inclusion by explicitly targeting the poor, focusing on children, delivering transfers to women, and changing social accountability relationships between beneficiaries, service providers and governments.

CCT programs are at the forefront of applying new social policy theories and program administration practices. They address demand-side barriers, have a synergistic focus on investments in health, education and nutrition, and combine short-term transfers for income support with incentives for long-run investments in human capital. They also are public sector leaders in program administration, using modern targeting, registering, and monitoring systems along with strategic evaluations. Their impact depends on the supply of quality, accessible health and education services and may increase with strengthened links to the labor market, and a greater focus on early childhood and transient support to households facing shocks. CCT programs are facing a number of challenges as they evolve, from reaching vulnerable groups to fostering transparency and accountability, especially at the community level. Centralized programs have been criticized for limiting the engagement of local governments and civil society and it is clear that in limited capacity environments, a greater reliance on communities is warranted. In sum, though promising, these programs are not a panacea against social exclusion and should form part of comprehensive social and economic policy strategies and be applied carefully in different policy contexts.

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## **Examining Conditional Cash Transfer Programs: A Role for Increased Social Inclusion?**

Conditional Cash Transfer (CCT) programs have been widely adopted as a new approach in social assistance that may hold promise for combating poverty and fostering social inclusion. Their central tenet is the linking of cash to behavior by providing money to poor families contingent upon certain verifiable actions, generally minimum investments in children's human capital such as regular school attendance or basic preventative health care. This focus on beneficiaries and their roles and responsibilities in long-term investments in human capital, as opposed to more traditional models of providing goods and services, represents a considerable departure from past social policy. It recognizes demand-side barriers to investment in human capital including lack of information, the direct costs of access to health and education services such as uniforms and transportation, and the opportunity costs of schooling because of reliance on child labor.

Going beyond traditional social assistance policies, CCT programs seek to address not only short-term consumption needs, but long-term poverty by fostering human capital investments in the complementary areas of nutrition, health and education. They are also seen as a promising avenue for going beyond relief to focus on redistribution and indeed they are among the most effective programs in terms of reaching the poor, notably those outside of the purview of traditional social insurance programs, which are often linked with formal sector employment. These features have made CCTs particularly attractive in countries with high levels of inequality where the extreme poor are characterized by very low levels of income, consumption and human capital.

CCTs are quickly becoming central instruments in many countries' poverty reduction agendas. On the economic side, research has shown that the elasticity of poverty to growth is much lower in countries with higher inequality. Growth is seen as necessary but insufficient to reduce poverty; redistribution also plays important role (Perry et al. 2006). It is hoped that CCTs' contributions to reducing inequality, combined with economic growth, can provide an equitable foundation for broad-based poverty reduction. On the social side, it is hoped that these longer-term investments will reduce vulnerability in the short-run and contribute to breaking inter-generational poverty in the long run by helping today's children become productive members and full citizens of society tomorrow.

CCTs feed into the broader debate on social inclusion on several levels, as they often lead to changes in accountability relationships between central governments, local governments, service providers and beneficiaries, among others. On national social policy level, CCTs are gaining popularity as instruments for reaching excluded groups, notably the extreme poor living outside the reach of social protection programs tied with formal sector employment. Yet many argue that despite efforts at program coordination, CCTs have yet to be adequately inserted within a broader institutional reform of social and economic programs that would bring about effective inclusion and poverty reduction. On a local level, some CCT programs have been criticized for using mechanisms that run

counter to social inclusion goals with respect to local governments and communities. Finally, at an individual level, targeting of households with children and making monetary transfers to women is a hallmark of CCT programs, but many programs have been criticized for not serving the needs of other excluded groups such as the elderly or the disabled or those living too far away from schools and health centers to effectively comply with program conditionalities.

Though CCT programs have achieved quantified success in reaching the poor and bringing about short-term improvements in consumption, education and health, most of them have not been in existence long enough to evaluate their success in reaching their longer-term poverty alleviation objectives. Many programs remain limited in coverage relative to the population of eligible beneficiaries. There is thus an active debate on their actual and potential contributions to social inclusion which is spurring a rich variety of approaches to program design and implementation. Finally, it is not clear how to replicate CCTs' successes to date for other beneficiaries or in other settings, particularly low-income countries with limited administrative capacities.

What has been established is that CCT programs are at the forefront of experimentation in both social policy theory and social program administration. This experimentation includes not only the application of new social assistance paradigms, but also novel approaches to targeting the poor, monitoring conditionalities, involving beneficiaries, transferring funds, incorporating gender issues and rigorously evaluating program outcomes. Many of these features, though not intrinsic to these programs, constitute important advances in the design and administration of social policy and are also key to meeting CCT social inclusion goals.

Part I gives a brief overview of CCT programs including their role in promoting innovations in social protection. In part II, we describe the technical modernizations in social assistance, which these programs have fostered. Part III focuses on their role in social inclusion while part IV concludes by describing some of the challenges faced by countries of varying income and institutional capacities in using this tool to address issues of inclusion.

## **I. Conditional Cash Transfers Overview<sup>2</sup>**

Since the mid-1990's demand side programs linking cash to behavior have been widely adopted across a range of countries. Labor and employment-requirements were introduced to social assistance transfer programs as part of welfare reform through the Temporary Assistance for Needy Families in the USA and the New Deal in the UK<sup>3</sup>. More typical CCT programs have been successfully implemented on a large scale in several middle-income, countries such as Brazil, Chile, Colombia, Ecuador, Jamaica, Mexico, South Africa, and Turkey. In these countries, CCTs often began as programs for

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<sup>2</sup> This section draws largely on Rawlings, 2005.

<sup>3</sup> Argentina Jefes y Jefas de Hogares Program, which started in 2001, as a response to the crisis also include a labor or training requirement for its beneficiaries.



poor, rural and indigenous families with young children but have expanded to include urban households (Brazil, Mexico) or hard-to-reach groups such as internally displaced (Colombia) or disabled people (Jamaica), as well as an expanded range of sub-programs such as secondary school completion incentives (Mexico), adult education (Brazil), psychosocial assistance (Chile), micro-credit, and housing (Brazil). Finally, some low-income countries such as Bangladesh, Burkina Faso, Cambodia, Kenya, Lesotho, Mongolia, Nicaragua, Honduras and Pakistan are experimenting with the approach, often on a smaller scale, while others, especially in Africa, are considering its adoption (Save the Children, 2005).

#### **A. An Innovation in Social Assistance**

CCT programs belong to the family of social assistance programs that constitute a country's formal, publicly provided safety net. Traditionally, social assistance has focused on transfer mechanisms to redistribute income to the needy, helping them to overcome short-term poverty in periods of crisis. It was distinct from social insurance, not sharing the latter's focus on market failures and long-term solutions to risk management. However, this distinction is fading as social assistance grows to address longer-term challenges of poverty and inclusion, and social insurance grows to include poverty-targeted minimal insurance schemes.

This also reflects a new thinking on the rationale for social protection, which reexamines the presumed trade-off between equity and efficiency by considering the long-term social and economic costs of uninsured risks and unmitigated inequalities and the potential role of safety nets in addressing these issues. Investing in poor people's human capital is seen as a way to promote the virtuous cycle between social protection and human development (World Bank, 2005). Not only is social protection increasingly seen as an investment for development and poverty alleviation, but also a cornerstone for the improved management of social policy and public expenditures (Vakis, 2005). As outlined above, CCTs epitomize this new thinking through their focus on both short-term relief and long-term redistribution. These programs are also playing a growing role in the modernization of social protection.

By supporting minimal levels of consumption and providing incentives for long-term investments in human capital, CCTs and other safety nets may have an important role in compensating for the market failures that perpetuate poverty, particularly in high-inequality settings (Ravallion, 2003). In addition, the conditionalities can help internalize positive externalities of children's education and health which would otherwise not be captured (de Janvry and Sadoulet, 2005, Das, Do and Ozler, 2005).

#### **B. Basic Elements of CCT Programs**

There are two components associated with most CCT programs: education and health/nutrition. The education component consists of a cash grant targeted to primary school age children, and/or in countries with higher educational attainment to secondary school age adolescents. The cash is granted on an individual per-student basis and is

conditional on enrollment and attendance of usually 80-85 percent of school days. The grant generally covers direct costs (school fees and supplies, transportation costs) as well as opportunity costs derived from the income lost as a result of sending children to school rather than to work. To this effect, grants are higher for secondary school students than for primary school students in Colombia and Mexico. They are also higher for girls in Mexico<sup>4</sup> to provide an added incentive for reversing a rural pattern of low female participation in secondary school.

Health and nutrition monies consist of a cash grant usually targeted to pre-school children and pregnant and lactating women. The cash is generally granted to families (not individuals) for food consumption, conditional on household members complying with the country's protocol of preventative basic and reproductive health visits. In Honduras, the grant reflects the value of the time of the mother for the trip to and waiting time at the health center. In Colombia, the amount is equivalent to the mean income required to allow an indigent family to reach the extreme poverty line where they are able to consume an adequate amount of food.

In some countries, CCT programs go beyond the demand-side incentives and also strengthen the supply of health and education. In Nicaragua, teachers receive a modest bonus per participating child, half of which goes to the acquisition of school supplies and private providers are contracted to expand basic health coverage. In Mexico, resources are set aside to cover the cost of additional demand owing to the program. In Honduras, PRAF provides grants directly to schools and health centers. In El Salvador, the CCT program is part of a holistic rural development strategy that includes infrastructure investments in schools, health centers and water and sanitation.

Table 1 provides more details about several of these programs, which have acquired important roles in individual countries' portfolio of poverty alleviation measures and efforts to reform their social protection systems. In Mexico, PROGRESA and its successor program *Oportunidades* were introduced as part of a major reform of social assistance that replaced shorter-term less well-targeted programs such as tortilla subsidies. Likewise Jamaica's PATH and Brazil's *Bolsa-Família* were introduced to replace or consolidate an existing array of income transfer programs, while improving targeting and cost-effectiveness. In Colombia, *Familias en Acción* was introduced as a cornerstone in a new safety net strategy designed to protect the poor during to the worst recession in 70 years.

### **C. Poverty Targeting and Welfare Results**

CCT programs are efficient in reaching the poor: on average 80 percent of the benefits go to the 40 percent poorest families (Coady, Grosh and Hoddinott, 2004, Lindert, Skoufias and Shapiro, 2005). These programs have had reasonable success in meeting their basic welfare objectives, namely reducing short-term poverty through increased total and food expenditures, decreased malnutrition (stunting) among young children,

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<sup>4</sup> In Cambodia the pilot scholarship (Filmer and Schady, 2006) and in Bangladesh, the Female Stipend Program (Khandker, Pitt and Fuwa, 2003) only cover secondary school girls.

higher educational enrollment, lower dropout and repetition, and reduced child labor. Some of these results include (Glewwe and Olinto, 2004, Maluccio and Flores, 2005, Skoufias, 2005, Attanasio *et al*, 2005):

In the area of education:

- An increase in primary school enrollment from 75% in the control group to 93% in the treatment group in Nicaragua, from 82% to 85% in Honduras (and virtually no effect on the already high –94% -- enrollment rates in Mexico and Colombia),
- An increase in secondary enrollment from 70% to 78% in Mexico and from 64% to 77% in Colombia for the control and treatment groups respectively,
- A decrease in school drop-out rates from 13% to 9% in Mexico, from 7% to 2% in Nicaragua and from 9% to 5% in Honduras,
- A decrease in grade repetition from 37% to 33% in Mexico and from 18% to 13% in Honduras,
- However, impacts on attendance and learning are mixed.

In the area of household consumption and nutrition:

- Average consumption in the treatment group was higher by 13% in Mexico and 15% in Colombia than in the control group,
- In Colombia, children under 2 years grew taller by 0.78 cm in urban areas and 0.75 cm in rural areas. Rural children age 2-6 grew 0.62 cm taller. In rural areas, children age 2-4 of age gained an additional 300 grams while same age urban children gained nearly 500 grams. In Nicaragua, stunting prevalence (low height for age) in children under age 5 decreased by 5.3%.

In the area of child labor:

- In Nicaragua, the percentage of children age 7-13 in first through fourth grade who were working decreased by 4.9%. In Mexico, labor force participation for boys showed reductions as large as 15-25 % relative to the probability of participation prior to the program.

Other verified impacts include linkage effects in the local economy (Coady and Harris, 2001), multiplier effects through self investments (Gertler, Martinez and Rubio, 2006), spill-over on the non-poor (Bobonis and Finan, 2005), protection against shocks (Maluccio, 2005, de Janvry *et al*. 2005).

## **II. Modernization in Operations**

CCTs have introduced a number of modernizations in program administration that have helped establish these programs as among the more effective and efficient in the array of social assistance transfers. These are important to furthering goals of social inclusion as they allow for improvements in management. Taking advantage of technological advances, they seek to reduce clientelism and corruption through modern systems for beneficiary selection, registration, payment and monitoring of program conditionalities. Some programs have also used systematic evaluations strategically to provide empirical

evidence about program performance that has been crucial to generating support for the programs across party lines and political administrations. Finally, in many countries, the introduction of a CCT program is part of a broader reform of social assistance linked to the reduction or elimination of less well-targeted and effective programs in order to keep social assistance expenditures budget neutral and more results-focused. Program proponents emphasize these features as important elements of a reformed approach to social assistance, based on administrative efficiency, transparency, fiscal responsibility and results. Several of these features are discussed below.

### **A. Unified registries of beneficiaries**

To decrease overlap and duplication of benefits, large-scale programs are using unified electronic registries of beneficiaries, which generally assign program recipients a unique social identification number that allows beneficiaries to be tracked over time and across programs (Castañeda and Lindert, 2005). The administration of these registries varies, with completely centralized operations in Mexico and decentralized administration in Brazil, Turkey and Argentina that is consolidated into a centralized national database. These databases are sometimes cross-checked with other databases from formal employment, deaths registry and pensions to bring them up to date and ensure compliance with program regulations. As program operations stabilize, the quality of the registries tend to improve, but concerns have been raised about their overall reliability and the risks associated with privacy, the potential for manipulation, and the ‘high stakes’ nature of errors of inclusion and exclusion.

### **B. Strategic use of evaluations**

Unlike most traditional social assistance and development interventions, CCT programs tend to include evaluations, notably impact evaluations conducted by external evaluators, as an integral part of their design. The evaluations serve a technical purpose by providing an empirical basis for program expansion and modification, as well as a political purpose by providing policy-makers with credible evidence to scale-up effective programs and protect them during political transitions. In Mexico (Skoufias, 2005), Nicaragua (Maluccio and Flores, 2005), and Honduras (Glewwe and Olinto, 2004), the programs used gradual geographic expansion to randomly incorporate beneficiaries, taking advantage of logistical complexities, fiscal constraints and uncertainties about programs’ impacts to introduce methodologically solid evaluations based on experimental designs. More recently, programs are increasingly using quasi-experimental designs with matching methods such as in Jamaica, Colombia and Brazil. Most countries combine quantitative and qualitative analysis to gain a better sense of beneficiaries’ perceptions and of community dynamics and processes.

### **C. Strengthened monitoring systems**

Another area where CCTs have introduced innovations is in the monitoring of program conditionalities. Effective monitoring is intrinsically linked to program credibility, as illustrated by the drop in school attendance, which followed the collapse of the

monitoring during the programs' unification in Brazil and the subsequent increase as the new monitoring system became functional. As much as monitoring contributes to program effectiveness, most countries still face numerous institutional challenges in setting-up their systems and following up on the results. Mexico, Colombia and Nicaragua centrally manage extensive records of all beneficiaries while others such as Brazil use a system where only households who are not fulfilling are reported. Colombia complements its basic monitoring approaches with random audits of school and health centers to check records and attendance and Argentina uses its quarterly household survey to monitor compliance with the work requirement on a macro-level.

These integrated monitoring and evaluation systems provide policymakers with a useful set of tools for program design and implementation, based on data collected from the field and reported up to program administrators. The element that has received less focus are devolution to and community-based monitoring and evaluation. These approaches--which range from community score cards to the publication of public expenditures--foster beneficiary engagement and transparency by using information that is either generated and managed locally or transmitted from program administrators down to beneficiaries .

#### **D. Improved payment systems**

In some countries, CCTs have been at the forefront of adopting new payment technologies to reach out to populations, many of whom had not participated previously in the financial sector. These advances are also important elements of improved program administration. For example, through the use of debit cards, several countries (Argentina, Brazil, Mexico) have improved their payment performance and their agility in disbursing the benefits to intended beneficiaries. Electronic transactions are easier and faster to verify and enable a better timing of program outlays. Also, financial data can be consolidated and placed on the internet (Brazil discloses transfers to municipalities), giving beneficiaries and local program managers tools for greater accountability.

Many of these administrative modernizations first introduced in CCT programs have been expanded and applied to other programs. In Mexico and Colombia, evaluations are now mandated for many social assistance programs and in a number of countries, unified beneficiary registries are allowing for the coordination of benefits from an increasing array of programs.

In middle-income countries, these modernizations in operations have required substantial upfront investments particularly given their links to advances in technology. These costs are amortized over the life of the program, as demonstrated by Mexico PROGRESA/*Oportunidades* program which administrative costs went from 51.5 percent of total budget in 1997 to 6.0 percent in 2003 (Lindert, Skoufias and Shapiro, 2005). More than the technological innovations, these changes may also be helping to foster a results-based management culture and a focus on the efficiency of public spending, a marked departure from the limited attention paid to these issues in the past, especially in Latin America. However, these innovations, because of their heavy information

technology and institutional capacity requirements, may well represent one of the greatest challenges for the implementation of these programs in low-income settings. In these settings, a stronger reliance on community monitoring (as in the Kenyan pilot) may prove to be more feasible than the rapid introduction of technological innovations to foster increased inclusion and accountability.

### **III. Social Inclusion**

The role of CCTs with respect to social inclusion touches on many issues and foments considerable debate. In certain areas, such as the targeting of poor households, research results are available and point to both notable success and potentially troubling concerns. Other areas of the debate, particularly with respect to long-run inclusion and poverty alleviation objectives, will only be clarified in hindsight several years from now. We attempt to address these issues of inclusion from three perspectives: (i) implementing national social policy, notably with efforts to target the poor and coordinate social assistance policy; (ii) changing accountability relationships between different levels of government, service providers and beneficiaries; and (iii) reaching typically excluded groups, notably women.

#### **A. National efforts to target the poor and coordinate social assistance policy**

**Targeting the poor.** Probably more than any other widespread social assistance program to date, CCT programs have employed explicit selection of beneficiaries through targeting mechanisms in order to maximize coverage of the poor with limited fiscal resources. This strategy is seen as particularly relevant in settings where demand-side stimuli are needed to ensure access to existing social services, notably health and education. As such CCTs are being employed to redress the exclusion of poor and vulnerable groups who have historically not benefited from public social programs.

Operationally, most CCT programs combine geographical and household targeting in two steps (Castañeda and Lindert, 2005). First, priority areas are selected based on marginality (Mexico, Nicaragua, Panama) indexes, using micro-area poverty maps when available. Then, programs collect information on household characteristics either through a census (Mexico rural areas) or on-demand in other areas (urban areas in Brazil and Mexico).

The programs then apply some sort of household eligibility criteria. In the United States and the United Kingdom, verified means-testing is the rule. It is generally not possible in developing countries because of seasonality, informality and costs. At the other extreme, Brazil uses unverified self-declared income. Most other countries in Latin America use proxy-means tests, which allow for a broader, multi-dimensional notion of poverty (more politically palatable). Eligibility is based on a weighted index of selected characteristics, which are easy to observe, difficult to manipulate and associated with poverty. As mentioned in Part I, these have fairly impressive results in terms of targeting efficiency.

While these methods improve the overall targeting of the program and boost the registration of poor households, they raise several issues which may run counter to social inclusion goals. First, they favor mostly variables associated with structural poverty, making it difficult for households to join the program when they face a shock (loss in income, illness of a family member). Second, since the formula for the scores are generally centrally managed and kept secret to avoid manipulations by households and local officials, they result obscure and difficult to understand for individual families and have caused tensions within communities where households are divided into beneficiaries and non-beneficiaries (Adato, 2000 and Adato *et al*, 2000a) (see also III.C.). Finally, in settings of generalized poverty or low implementation capacity, household level targeting may be neither desirable nor feasible. There, it may be possible to experiment with block transfers to communities, adapting the experience of community-driven development initiatives supported by social funds. Indeed in the new CCT program introduced in El Salvador or under design in Panama, all eligible households within communities with indices of pervasive extreme poverty will receive transfers, without resorting to proxy means tests to estimate the poverty level of individual households.

**Coordinating social assistance policy.** As mentioned earlier, the introduction of CCT programs is often pivotal to a more broad-based reform of social assistance policy, often in the wake of fiscal crises. In these cases, which include Mexico, Colombia and Jamaica, this has entailed the rationalization of other less well-targeted or cost-effective programs, a feature that has contributed to CCT's financial sustainability and to the overall harmonization of social assistance policy.

Additionally, CCT programs are being increasingly coordinated with other social programs in order to strengthen synergies in poverty alleviation. For example, Chile's *Programa Puente* targets the 100,000 poorest and most excluded families in urban areas and provides beneficiaries with the support of a social worker for two years. While the monetary value of the transfer is relatively low (US\$ 22 PPP 2003 per family per month), the program aims at inserting families into the wider safety net through a tailored plan of conditionalities. Similarly, *Bolsa-Familia* in Brazil seeks to promote local synergies by linking the beneficiaries to preferential housing, micro-credit and local business development, and *Oportunidades* in Mexico piloted various expansions to the basic program through the *Plataforma Oportunidades* – albeit with limited success to date,-- as well as credits for secondary school graduates that can be used for micro-enterprise, further education or housing.

Yet many argue that despite efforts at inter-institutional coordination, CCTs have yet to adequately fit within broader institutional reforms of social and economic policies that would allow for effective inclusion and poverty reduction to take place. Two concerns are often raised. The first is the need for a more comprehensive social protection reform, notably of pension and health insurance systems, which often pose substantial problems of fiscal sustainability and inclusion of the poor, and whose scale in terms of expenditures and coverage typically dwarfs social assistance programs. The second area of concern is the need for CCTs to strongly link with programs that support labor market

insertion and employment to provide incentives for graduation and opportunities for moving out of poverty.

## **B. New accountability relationships**

In both intended and unintended ways, CCT programs are changing accountability relationships between national and local governments, social service providers and poor households. These dynamics are manifested both ‘downstream’ between service providers and beneficiaries, as well as ‘upstream’ between local agents and central governments. The dynamics vary considerably with program design, notably with respect to the degree of program decentralization and the level of engagement of civil society. These accountability relationships are key to fostering social inclusion, yet they have not been studied as closely as other aspects of CCT programs. Several of these accountability relationships are discussed below.

**Between central governments and beneficiaries: conditionalities, co-responsibilities or rights?** Central to CCT’s approach is a new focus on “co-responsibilities” between the state and citizens where the state lessens its paternalistic role, time limits are placed on benefits and beneficiaries are required to comply with certain requirements. This relationship is re-enforced through the provision of cash directly to beneficiaries, which allows the national government to forge a one-to-one relationship with poor households, without the intermediation of service providers or in the case of centralized programs, local government. Some have argued that this ‘short-route’ approach to social service delivery undermines efforts at needed reforms of existing programs and is detrimental to local democratic processes (World Bank, 2004).

In Mexico, the central government issues identification documents and numbers, verifies compliance and delivers cash transfers. By requiring families to take responsibility for schooling and health of their children, the program seeks to foster a culture of co-responsibility between the government and families and emphasizes the contract aspects with penalties for non-compliance. *Oportunidades* beneficiaries perceive that these co-responsibilities help keep the program “honest” and see them as a “benefit”, they appreciate the responsibility and positive outcomes associated to increased health care and schooling (Lindert, 2005).

In Brazil, the federal managers of *Bolsa Família* argue that health and education are basic “rights” and that the conditionalities encourage the poor to “realize” these rights. This contract or rights approach is supposed to depart from traditional, more paternalistic approaches to social assistance and is used to counter criticisms of CCT as hand-outs. The relevance of this approach critically hinges on adequate, high-quality supply of services.

While the systems are technocratically transparent, certain features –notably centralized confidential formulas for selecting beneficiaries and lack of consultation at the local level--contribute to confusion regarding program operations, perceptions of program arbitrariness, and frustration among beneficiaries (Adato, 2000). Among the criticisms



voiced under these more centralized systems are the lack of transparency in the selection of beneficiaries, the limited engagement of local governments and civil society, the lack of appropriate appeals mechanisms, and problems with verification and enforcement of program norms and conditionalities.

**Between beneficiaries and service providers.** More recently and notably among the more decentralized programs, CCT programs have implemented a number of mechanisms designed to improve inclusion by addressing the accountability of service providers to beneficiaries through strengthened appeals mechanisms, community participation and civil society engagement.

These efforts often involve engaging civil society and/or local government. At the central government level, several programs such as those in Argentina, Brazil and Chile have established boards that include civil society representatives. Civil society is often engaged at the local level as well, through participation in consultative councils (in Argentina, Brazil and Chile) or via elected beneficiaries (in Mexico and Colombia) who serve as conduits between their communities and the program providers.

In decentralized settings, the effective provision of social services requires the accountability of local providers, often elected mayors, to the program's potential beneficiaries. In Brazil's *Bolsa Família* program beneficiary selection and conditionality monitoring are delegated to municipal governments, which operate social councils to which stakeholders can appeal to claim their rights.

Many of these mechanisms are still in their infancy and have yet to function as anticipated. A study of 261 municipalities in the Northeast (de Janvry *et al.* 2005) shows that Social Councils' performance is extremely uneven. Many municipalities don't form the council (even though it is a program requirement). Even when they exist, the councils do not function because they meet irregularly or lack information about the beneficiaries. However, when the councils function properly, they positively impact on program implementation.

**Between local and central governments.** An increasing number of countries are decentralizing part or all of the delivery of social assistance services to states, provinces (USA, Argentina) or municipalities (Brazil, Bolivia, Colombia). In the USA, reporting relationships between the federal government and the states has dramatically changed from the Food Stamps directed implementation model to the results-based management of the Temporary Assistance to Needy Families (TANF) program with block funding linked to audits and impact evaluations. States have more autonomy in implementation, provided they respect basic eligibility criteria and maintain adequate performance in targeting, cost-efficiency and outcomes (GAO, 2001). In these situations, the challenge of inclusion becomes a shared goal between central and local authorities.

In Brazil, after a first wave of directed implementation where municipalities were executors, *Bolsa-Família* is experimenting with "pacts" with states and municipalities. The pacts seek to better coordinate the activities and coverage of local and federal level

programs and provide larger benefits or greater coverage in a more cost-efficient and transparent way. To strengthen program accountability, the executive is also involving the federal and state “Ministerio Público” public attorney offices.

In Colombia, the central government administers the *Familias en Acción* program in coordination with municipalities and program performance reflects both national government and local governments’ capacity. For example, the program uses a targeting system operated by municipalities, but the wide variation in municipalities’ administration of the proxy-means test resulted in mixed targeting outcomes at the earlier stages of the program. Additionally, the CCT program operates only in municipalities with an adequate supply of health and education services – primarily a local responsibility under Colombia’s system of decentralized social service financing -- which acts as an incentive for municipalities to address health and education service provision problems.

### C. Including the excluded

**Women: the key to human capital development?** Perhaps more than any other type of social programs, CCTs have incorporated gender dimensions into their operations as a strategy for promoting higher investments in children’s human capital and for redressing the legacies of gender-based discrimination.

Intra-household analysis in the fields of economics (Haddad *et al.* 1997), sociology, and anthropology provides ample evidence across a range of cultures that women tend to invest more in children. Acknowledging this finding, CCTs provide grants to mothers, in a much-noted departure from the traditional social assistance focus on the household head.

CCTs have also applied differential payments based on gender, often providing higher payments for enrolling girls in school, as is the case in Bangladesh’s Female Stipend Program (Khandker, Pitt and Fuwa, 2003) and Mexico’s *Oportunidades* program. As noted by Das, Do and Ozler (2005), if social norms are driving gender discrimination, CCTs offer the government scope to positively discriminate in favor of women and induce a community-wide change of preferences.

The election of mothers as local representatives to serve as conduits between beneficiaries and the CCT program officials (as is done in Mexico and Colombia) contributes to the greater visibility of women in local affairs, a major change in most rural and especially indigenous communities. Just as individuals learn from their neighbors, their preferences may change according to the behavior of others in their community.

What has been the result of these efforts? Long-term results are pending, but results from early programs show that concerns about increased domestic violence did not materialize (Adato and Roopnaraine, 2004 for Nicaragua). On the contrary, in Mexico, men reported

feeling relieved of not being nagged by their wives for money they could not provide (Adato *et al.*, 2000b).

On the economic front, after nine years of program operations in Mexico, recent evidence (Gertler, Martinez and Rubio, 2006) reveal investments of a substantial part of the transfers (25%) in productive activities (with an estimated rate of return between 32 and 49%). Some of these investments occur in non-agricultural women enterprises activities, further improving the long-term prospects of beneficiary households beyond the transfer, through diversification of income generation sources. In the long-run, these investments may also yield to significant changes in women's empowerment and insertion in economic networks.

**CCT's focus on children.** CCTs have focused on holistic investments in children's human capital as the key element of a long-term strategy for promoting social inclusion. CCT programs actively promote established synergies between health, nutrition and education and many programs recognize the need to begin these interventions as early as possible and include pregnant and lactating women as program beneficiaries. These investments point to inclusion as a long-term goal that will best be realized within a generation, given adequate investments in the young.

By linking transfers to the presence of children, CCT may inadvertently increase the desirability of having children. Stecklov *et al.* (2006) examine the general impact of three programs – Mexico PROGRESA, Nicaragua *Red de Protección Social* and Honduras *Programa de Asignaciones Familiares* --on fertility. They also show that differences in the interpretation of the programs' eligibility rules explain their differing impacts on fertility. Fertility first increased with PRAF through an increase in marriages – apparently because of incentives to childbearing by allowing parents to join the program by having children after the program had begun. In contrast, RPS and PROGRESA had no impact on fertility, despite an increase in contraceptive use. In both programs, households are not able to join the program after the initial roster is set (for a three-year period in PROGRESA) and benefits are capped to a certain amount. In the Mexican case, the increase in contraceptive use may have been offset by the increased exposure to pregnancy due to lesser migration and spousal separation (Stecklov *et al.*, 2005). PRAF managers altered the eligibility rules to mirror those of RPS and *Oportunidades* in December 2003.

In conclusion, by shifting the focus of social safety nets from short-term assistance to long investment in the human capital of the poor, CCTs have a potential to help address unmitigated market failures which perpetuate poverty and exclusion. CCTs have met with success in reaching the poor—notably the extreme poor—and with generating investments in the human capital of the young. However, it remains to be seen whether long-term goals of breaking patterns of exclusion and the inter-generational transmission of poverty can be realized. What seems evident is that reaching these lofty ambitions clearly depends on more than just the implementation of CCT programs and much of the work on CCTs today involves ensuring their successful articulation within broader social protection policies.

CCTs are also changing social accountability relationships between beneficiaries, governments and social service providers. These dynamics often depend on the degree of centralization or decentralization of the program and many recent efforts have included the stronger engagement of local government and civil society. CCTs also rely on intra-household allocation of responsibilities, potentially strengthening the role of women in their households and communities. Through all these mechanisms, CCTs can help alleviate social exclusion. However, there remain a vexing number of issues to address so that CCT contribute to greater social inclusion in different country contexts.

#### **IV. The unfinished agenda of CCT programs**

As programs evolve and countries with very different institutional and financial capacities consider the approach, new issues are emerging regarding the sustainability and replicability of CCTs and efficiency gains yet to be realized.

##### **A. Graduation and exit strategies**

A test of CCT program effectiveness is families' ability to graduate from the program and exit out of poverty through increased investment in health, nutrition and education of young generations. Yet there is an increased recognition among policymakers that this type of emancipation is not contingent solely upon access to CCT programs, but depends on insertion into the wider economy, notably through rural development and labor market policies. Chile has set-up *Programa Puente* (the "Bridge Program") to support extremely poor families' insertion into the wider economy through the coordinated use of social safety net programs. Other programs, like *Bolsa Familia*, seek to foster synergies with local development interventions and micro-credit or business development plans. The implementation of these complementary programs in conjunction with a CCT program is still incipient (Handa and Davis, 2006). Many programs similarly face the question of how to design procedures which encourage graduation and do not create new dependencies. The USA, Mexico, Nicaragua and Chile have set-up time limits and/or declining benefits.

##### **B. Timing and focus: missing child care and pre-school interventions?**

Young children in developing countries suffer not only from deficits in nutrition and health but also in fine and gross motor skills, cognitive and socio-emotional development (Schady, 2005). Early childhood development (ECD) outcomes are an important part of a child's welfare. In addition, poor outcomes have long-lasting effects through decreased school readiness. School-based interventions may therefore be less effective. A government concerned with equity may more effectively equalize initial endowments through ECD interventions than compensate for cumulative differences in outcomes later in life (World Bank, 2005).

While most CCT programs recognize the link and synergies between health/nutrition and education, the first component is generally less funded and the transfer is at family-level (Table 1). Gertler and Fernald (2004) show that children in the evaluation sample of *Oportunidades* appear to have very serious cognitive deficits. Matching with communities that were not eligible for *Oportunidades*, they report significant differences in motor skills and fewer socio-emotional problems. On the other hand, they find no evidence of the duration of program exposure on any of these outcomes. This suggests that on its own the program may not lead to improvements in child cognitive developments.

On the other hand, Schady, 2005 points to the potentially important and complementary role of early childhood stimulation and improved parenting behaviors. While there is a large body of evidence in the US, little information is available in developing countries. In Central America, several countries run large *Atención Integral a la Niñez Comunitaria* (AIN-C) programs. El Salvador is considering including it in the supply-side of its new CCT. If deficits in cognitive development are cumulative, CCTs are perhaps missing an important opportunity by not directing more resources to pre-school children and pregnant women.

### **C. Reaching special vulnerable groups: indigenous people, disabled, elderly, those out of the reach of services**

By design, CCT programs require minimum access to schools and health centers. This leaves aside households in communities, which are severely underserved and maybe among the poorest. Programs like the Red de Protección Social in Nicaragua have used innovative contracts with private providers and non-governmental organizations to expand basic health coverage to extreme poor populations.

In countries with significant indigenous populations, CCTs face concerns about the pertinence of some of the education and health conditionalities, and the targeting of nuclear households rather than extended families or communities, which may undermine some solidarity and risk-sharing arrangements. Some programs adapt the conditionality menu to respect indigenous schools and traditional health practices but there is scant evidence about the performance of CCTs in these contexts.

Little evidence is available as to the success of CCTs in reaching disabled people, which may constitute up to 10-15% of the most vulnerable in post-conflict environments. PATH in Jamaica explicitly includes them as eligible but information is missing on whether they manage to comply with conditionalities.

When CCTs focus on poverty for eligibility, they also potentially cover some of the elderly, who then receive the basic food transfer with the preventive health coverage. While this may provide basic social pension coverage for some, there is scope for improvements in coverage and efficiency by improving coordination with social insurance programs, when they exist.

In Colombia, *Familias en Acción* now seeks to include internally displaced households, which requires innovations for identifying and following households as they re-settle temporarily or permanently and specific services to help them overcome conflict-related social exclusion issues.

While the challenges in reaching the extreme poor and vulnerable are serious, CCTs impacts are larger on the poorest of their beneficiaries (Schady and Araujo, 2005 and de Janvry and Sadoulet, 2005). This will certainly require complementary interventions both on the supply-side and for children of uneducated parents. In Africa, countries will face the issue of reaching orphans.

#### **D. Institutional coordination with the supply-side ministries**

Most CCT programs have not resolved the difficult issue of balance between demand-side and supply-side investments. PRAF in Honduras planned an experiment with variations on the provision of transfers and supply-side investments but the latter were delayed. In Mexico, de Janvry and Sadoulet (2005) show the importance of distance to school in explaining drop-out pointing to the fact that for children living 3 km away from a school, a supply-side transportation subsidy would achieve the same gains as the CCT. For children living further away, construction of additional schools would be necessary.

A related issue is the quality of services provided. Without greater attention to the provision of quality services, CCT programs run the risk of condemning poor households to use low and worsening -quality services, as demand increases.

#### **E. Financing and implementation in low-income countries**

To date, CCT programs have been implemented mainly in middle income, high inequality countries with substantial institutional capacity. To what extent this model can be successfully adapted to other settings, notably in low-income countries with limited administrative capacity remains to be seen. Using simulations, Kakwani, Veras and Son (2005) show that pure cash transfers would result in little increase in school attendance in fifteen African countries. CCTs would not make much difference on poverty unless unsustainably large resources were committed but the programs might increase school attendance, provided supply issues were resolved and that transaction costs for eligibility, enforcement of conditionality and payments delivery were not prohibitively high.

Caldès, Coady and Maluccio (2005) and Lindert, Skoufias and Shapiro (2005) show that despite their operational complexity, CCTs are administratively efficient. While operating costs can be high at the onset of the program (PROGRESA) or if the provision of services is included (Nicaragua *Red de Protección Social*), they decrease as the program matures (around 6% for *Oportunidades*). Low-income countries with supply shortages will face similar issues. Since the highest costs are targeting and conditionality monitoring, countries will have to experiment with using only geographical targeting, relying on communities for determining eligibility and verifying compliance and use innovative low-cost technologies to deliver payments.

## **F. Risk-coping and CCTs**

As mentioned in part II, CCT programs illustrate the shift of social assistance from redistribution and assistance for short-term poverty shocks to long-term investments to address fundamental market failures. However, CCTs have provided beneficiary households with protection against short-term shocks, both systemic and idiosyncratic. Maluccio (2005) shows that the Nicaragua Red de Protección Social protected household's total and food expenses and children's school attendance against the effect of the Central America coffee crisis in 2000-2001. Given the variety and frequency of natural disasters facing the country, the program is presently running a pilot including some training and non-agricultural activities to diversify income sources. Similarly, de Janvry et al. (2005) show that PROGRESA fully protected children schooling from shocks due to unemployment and illness of the household head as well as natural disasters in the community. This is doubly important since short-term school drop-out has long-term consequences due to irreversibility. The program however did not prevent children from working more when their household was hit by a shock.

As a result of their focus on structural poverty, existing CCTs are not designed to easily incorporate households, which face shocks driving them into poverty. To adapt more readily to the cyclical nature of poverty, CCTs could consider expanding counter-cyclically during times of crisis and employing mechanisms such as on-demand applications and shorter recertification periods. They could also be used to protect vulnerable groups when shocks affect their household, such as incorporating children whose families have been affected by HIV/AIDS. Existing program structure could also be used to provide specific crisis-related services to a wider range of beneficiaries than the program's recipients.

## **V. Conclusions**

CCT programs have shown considerable achievements under a variety of circumstances. They are at the forefront of a new thinking on social protection, which reexamines the presumed trade-off between equity and efficiency by considering the long-term social and economic costs of uninsured risks and unmitigated inequalities and the potential role of safety nets in addressing these issues. By providing incentives to parents to invest in the long-term human capital development of their children, they have promise for addressing issues of deep-seated exclusion and the inter-generational transmission of poverty.

By introducing modernizations in their operations, including adopting unified beneficiary registries, credibly enforcing poverty targeting and conditionalities, and using evaluations in a strategic way, these programs have introduced many innovations in social assistance policies. Thanks to strong political support from the highest levels, they have been used to promote transparency in social policy and counter legacies of paternalism and clientelism.

They are contributing to social inclusion in several complementary ways: recognizing and explicitly targeting the poor, focusing on children and delivering transfers to women, and changing social accountability relationships between beneficiaries, service providers and local and central governments. Despite clear success in reaching the poor and fostering investments in human capital, concerns have been raised about CCT program norms that may run counter to inclusion goals. These include lack of transparency in the selection of beneficiaries, community-level discord associated with the targeting of individual households, the limited engagement of local governments and civil society under more centralized CCT programs, and the lack of appropriate appeals mechanisms.

These programs are not a panacea against social exclusion and their limitations should be recognized and addressed by focusing on more comprehensive social policy reforms that include, but are not limited to, CCT programs. Broader reforms of social protection systems will be needed to tackle more fundamental issues of exclusion in most middle income countries and CCTs may not be appropriate in many settings. CCTs' effectiveness may increase by strengthening links to the labor market, shifting the balance between their early childhood and school-age components, and making eligibility more flexible to include households facing shocks. Even CCT programs' more narrowly defined objective of fostering long-term investments in human capital is contingent upon the supply of quality, accessible health and education services. The programs also need to improve their coverage of hard-to-reach groups. Finally, in limited institutional and financial capacity environments, operations will also certainly have to be simplified, relying more on communities to safeguard transparency and social accountability.



**Table 1: Basic information on selected programs**

Country	Mexico	Brazil	Jamaica	Colombia
Year of the data (introduced)	2002 (1997) <sup>5</sup>	2005 (2001) <sup>6</sup>	2004 (2002)	2005 (2000)
Number of beneficiaries	4.2 million hh (20% pop.)	8.7 million hh (22% pop.)	63,000 hh (8% population)	340,000 hh (4.6 % pop)
Average unit transfer (US\$ PPP 2003/month/hh <sup>7</sup> )	\$62 education \$21 health-nutrition	\$64 total	\$27 education \$27 health- nutrition	\$53 education \$31 health-nutrition
Annual Budget (US\$)	\$ 2.6 billion	\$ 3.0 billion	\$ 18.3 million	\$ 100 million
% of GDP	0.32	0.36%	0.32	0.12
Education benefits	<ul style="list-style-type: none"> <li>• Education grant</li> <li>• School materials</li> <li>• Supply and quality strengthened</li> <li>• Savings account for graduates</li> </ul>	<ul style="list-style-type: none"> <li>• Education and nutrition grant</li> </ul>	<ul style="list-style-type: none"> <li>• Education grant</li> </ul>	<ul style="list-style-type: none"> <li>• Education grant</li> </ul>
Health and nutrition benefits	<ul style="list-style-type: none"> <li>• Food grant</li> <li>• Basic healthcare</li> <li>• Nutrition and health education</li> <li>• Nutrition supplements</li> <li>• Improved supply</li> </ul>		<ul style="list-style-type: none"> <li>• Health grant</li> <li>• Health education</li> </ul>	<ul style="list-style-type: none"> <li>• Health and nutrition grant</li> <li>• Nutrition and health education</li> </ul>
Grant periodicity	Bi-monthly	Monthly	Bi-monthly	Bi-monthly
Target group for education grants	Poor households with children 8-18 enrolled in primary and up to 20 years old in secondary school	Extreme poor and poor households with children 6-15 years old	Poor households with children 6-17	Poor households with children 7-17 enrolled in school (2 <sup>nd</sup> to 11 <sup>th</sup> grades)
Target groups for health and nutrition grants	<ul style="list-style-type: none"> <li>• Poor households</li> <li>• Nutrition supplements to pregnant and lactating women, children 4-24 months and malnourished children 2-5 years old</li> </ul>	Extreme poor households and poor households with children 0-15 years old, pregnant and lactating women	Poor households with children 0-5, pregnant and lactating women, people over 65, persons with disabilities, destitute adults under 65.	Poor households with children 0-6 not participating in other programs

<sup>5</sup> Progresa (Programa de Salud y Educación) started in 1997 and was expanded in 2002 through the Oportunidades program

<sup>6</sup> Bolsa Escola started in 2001, Bolsa Alimentação and Auxílio Gas in 2002, Cartão Alimentação in 2003 and they were merged in Oct. 2003 into Bolsa Família

<sup>7</sup> From Lindert, 2005.

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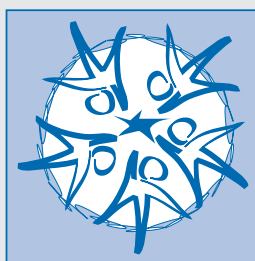
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- Red de Protección Social (Nicaragua)  
<http://www.mifamilia.gob.ni/web/index.asp?idPgW=44&idSbM=36&idPpW=93>



Conditional Cash Transfer programs (CCTs) provide money to poor families contingent upon certain verifiable actions, generally minimum investments in children's human capital such as regular school attendance or basic preventative health care. This approach addressed demand-side barriers, has a synergistic focus on investments in health, education and nutrition, and combines short-term transfers for income support with incentives for long-run investments in human capital. These programs have often also introduced modern administrative practices including poverty targeting, beneficiary registries, monitoring systems and strategic evaluations. CCT programs are facing a number of challenges as they evolve, from reaching vulnerable groups to fostering transparency and accountability, especially at the community level. Centralized programs have been criticized for limiting the engagement of local governments and civil society and it is clear that in limited capacity environments, a greater reliance on communities is warranted. In sum, these programs are promising but are not a panacea against social exclusion and should form part of comprehensive social and economic policy strategies and be applied carefully in different contexts.

#### HUMAN DEVELOPMENT NETWORK

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