

# **Conditional Cash Transfers: The Latin American Experience**

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# Presentation overview

- Description of common features of CCTs
- Why CCTs? Evolving trends in development
- Key issues in CCT program design
- Program overviews
- Evaluation design and rationale
- Evaluation results
- Future directions for CCTs and information gaps
- Final comments on design issues

# Main common features of a CCT program

- Means-tested cash benefit given to households under poverty line
- Designated “beneficiary” receiving cash is the mother
- Sometimes includes nutritional supplements
- Conditioned on household participation in services, usually:
  - Children’s school attendance (about 80%)
  - Preventative health care such as pre-natal and post-natal check-ups, vaccinations, growth monitoring
  - Mothers participation in health and nutrition training
- Often includes ‘supply-side’ components improving health and education infrastructure and services
- \*Volunteer beneficiary as program-beneficiary liaison

# Gender-focused approach

- Woman is official designated beneficiary and receives cash
  - Accompanied by message that she should control it
  - New collective activities, freedom of movement
- Focus on women's health
- Training for women in health and nutrition
- Cash transfer often higher for girls than boys, and for secondary school when girls more likely to drop out

About 20 countries now have or are planning to pilot a CCT program

40 countries are considering or have expressed interest

Why?

# Why CCTs? Evolving evidence on poverty reduction

- Growth alone insufficient for poverty reduction
- Social protection can contribute to growth
- Importance of basic social safety net to mitigate shocks and reduce chronic poverty
- Shift from social protection providing relief to that which contributes to long-term development
- Major cause of intergenerational transmission of poverty is low levels of education, health and nutrition of children
  - Early childhood interventions key to long-term prospects for escaping poverty

# CCTs and trends in development

- Response to low performance of demand-driven approaches for targeting poorest
- Obligation not entitlement: 'co-responsibility' of beneficiaries
- Targeted rather than universal benefits-redistribution under fiscal constraints
- Exploit synergies between health, nutrition, and education and promote inter-sectoral coordination

# CCTs and trends: Gender and development

- Increasing attention to the crucial role that women play in household welfare
  - Programs that strengthen women's position within the household, community, and labor market reduce inequality and improve women's well-being
  - Income controlled by women more likely to translate into higher household food expenditures and calorie intake and expenditures on health, education, and household services than income controlled by men

# Some country examples

- *Progresas/Oportunidades* (Mexico)
- *Bolsa Alimentação* (Brazil)
- *Programa de Asignación Familiar, PRAF-Fase II* (Honduras)
- *Red de Protección Social* (Nicaragua)
- *Familias en Acción* (Columbia)
- *Jefes y Jefas* (Argentina)
- *Red Solidario* (El Salvador)
- *Bono Solidario* (Ecuador)

Starting with PROGRESA in Mexico in 1998, scientific evaluations of CCT programs have found that they achieve significant improvements in health, nutrition, education, poverty, and other indicators

**But they are not a panacea or magic bullet for reducing poverty**

How effective depends on many factors related to:

- Program design
- Context (economic, institutional, sociocultural)

**And they are only one among many approaches to reducing poverty**

# Key questions and issues in CCT program design

- What is the objective—what indicators need improvement?
  - Primary or secondary school participation?
  - Girls and boys?
  - Micronutrient deficiencies?
  - Care, hygiene, diet diversity?
  - Health and disease?
  - Transition to work?
- What are the factors constraining improvement?
  - Cash?
  - Supply and quality of services?
  - Sociocultural?
- How to structure incentives to respond?
- Can supply be improved?

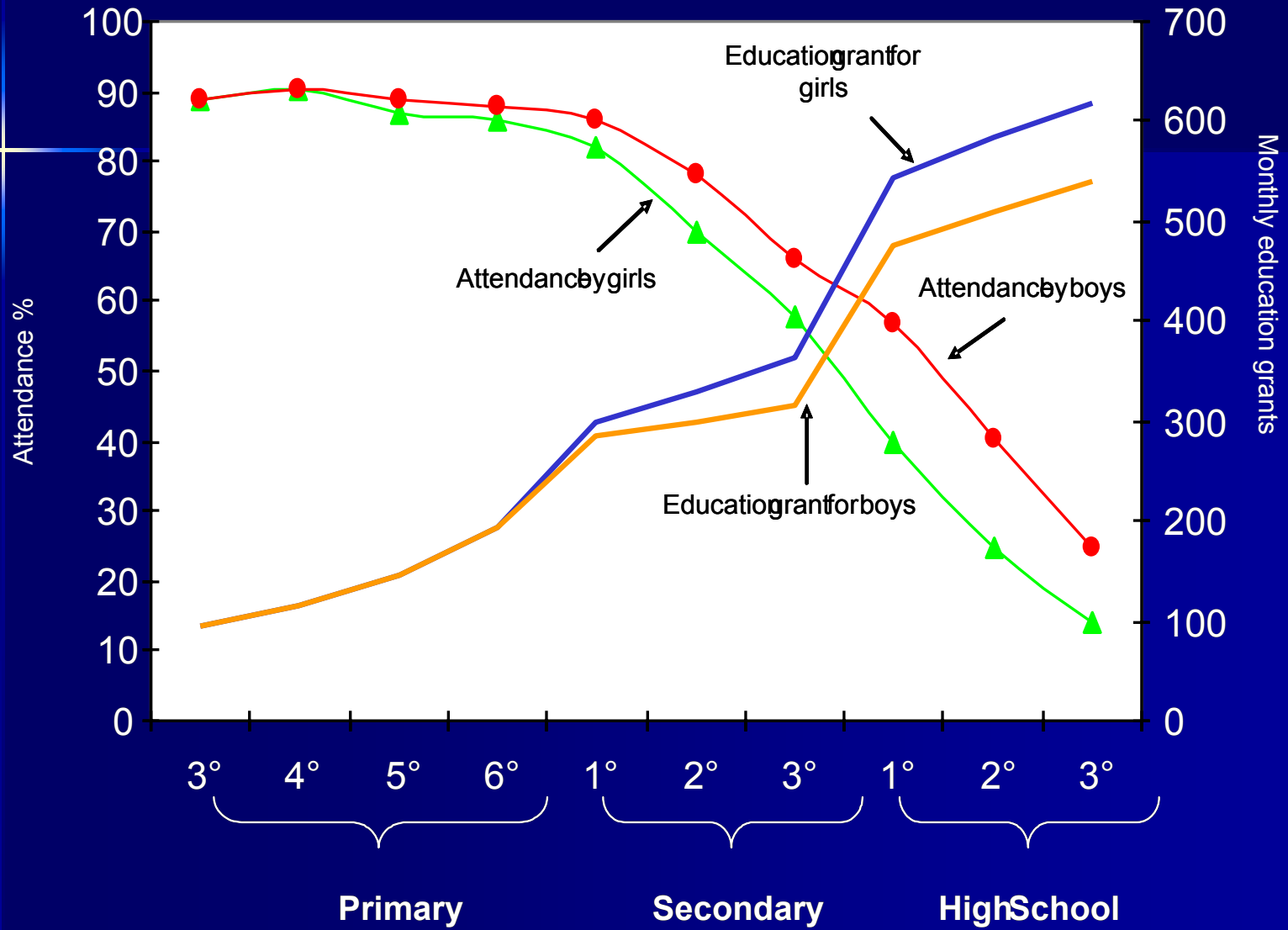
# More key questions/issues in design

- Target groups
- Targeting methods
- Size of transfer
- Administrative capacity
- Cooperation between Ministries and departments
- Role for NGOs
- Governance structures: How centralized and where to decentralize
- Who finances?
- What programs replaced?
- When to phase out? Transition into what?
- How to measure impact

# **Program overviews in Mexico and Nicaragua**

# Mexico: OPORTUNIDADES/PROGRESA

- As of 2004, 5 million families, 25 million individuals
  - Budget of US\$ 2.5 billion or 0.3% of GDP
- Average benefit received by beneficiary households: or 20% of the value of consumption expenditure before program
- Education component
  - A system of educational grants (details below)
  - Monetary support for the acquisition of school materials/supplies conditioned on 85% attendance
  - Improved schools and quality of educations (teacher salaries)



# PROGRESA/Oportunidades

## description & benefits (continued)

- Health and Nutrition Component
  - basic package of primary health-care services
  - Food support (cash)
  - Nutritional supplements: 6 packs/child/mo; 20% of caloric requirements and 100% of necessary micronutrients)
- Benefits conditioned on attendance at health visits  
Benefits conditioned on attendance at “platicas”—  
information and training on health and nutrition
- Improved supply and quality of health services  
(medicine availability etc.)

## Annual frequency of health care visits, Mexico

| Age group                       | Annual frequency  |
|---------------------------------|---|
| <b>_ Children</b>               |   |
| Newborn to one year of age      | 7 check-ups: 7 and 28 days; 2, 4, 6, 9 & 12 months        |
| One to two years                | 4 check-ups: one every three months                       |
| Three to five years             | 3 check-ups: one every four months                        |
| Six to eleven years             | 2 check-ups: one every six months                         |
| <b>_ Women</b>                  |   |
| Of childbearing age             | 4 check-ups: one every three months                       |
| Pregnant                        | 5 check-ups during prenatal period.                       |
| During puerperium and lactation | 2 check-ups: in immediate puerperium and during lactation |
| <b>_ Adults and youths</b>      |   |
| Young adults                    | One check-up per year                                     |
| Senior citizens                 | One check-up per year                                     |

## Components of the Basic Health Service Package, Mexico

1. Basic sanitation at the family level
2. Family planning
3. Prenatal, childbirth and puerperal care
4. Supervision of nutrition and children's growth
5. Vaccinations
6. Prevention and treatment of outbreaks of diarrhea in the home
7. Anti-parasite treatment
8. Prevention and treatment of respiratory infections
9. Prevention and control of tuberculosis
10. Prevention and control of high blood pressure and diabetes mellitus
11. Accident prevention and first-aid for injuries
12. Community training for health care selfhelp

# Red de Protección Social (RPS) in Nicaragua: Program overview

- Benefits
  - Cash transfer = 13-21% of household expenditures
  - Mochila of school supplies
- Bono a la oferta for the schoolteachers
- Conditions/services
  - Health services and nutritional status monitoring for children under age five
  - School enrollment and attendance for grades 1-4
- Targeted to six poor rural municipalities in Central Region of Nicaragua

# **Program impact evaluation**

# Why impact evaluation?

- Determine effectiveness of program and efficiency of investment
- Identify design and implementation issues requiring change or improvement to increase effectiveness
- Understand how people respond to program
- Increase transparency and accountability
- Contributes to decisions around reauthorization, redesign
- In Mexico, IFPRI evaluation played key role in decision of new administration to expand PROGRESA, maintain some features and adjust others

# Methods used for impact evaluations

- Panel surveys
- Semi-structured interviews
- Ethnographic case studies
- Focus groups
- Other:
  - School, clinic, and nutrition surveys
  - School and clinic administrative data
  - Student achievement test scores
  - Record of payments distributed to beneficiary households

# Evaluation design

- Experimental designs: program randomized at locality level
- PROGRESA:
  - 186 control localities; 320 treatment localities
  - 24,077 households
  - Compared > 650 variables at locality and household levels
- RPS:
  - 21 treatment localities; 21 control localities
  - 1,581 households
- Baseline with follow-up panels

# Evaluation design

- Good control group is key to determining impacts
- Ethical issues and program roll-out

$E(Y)$

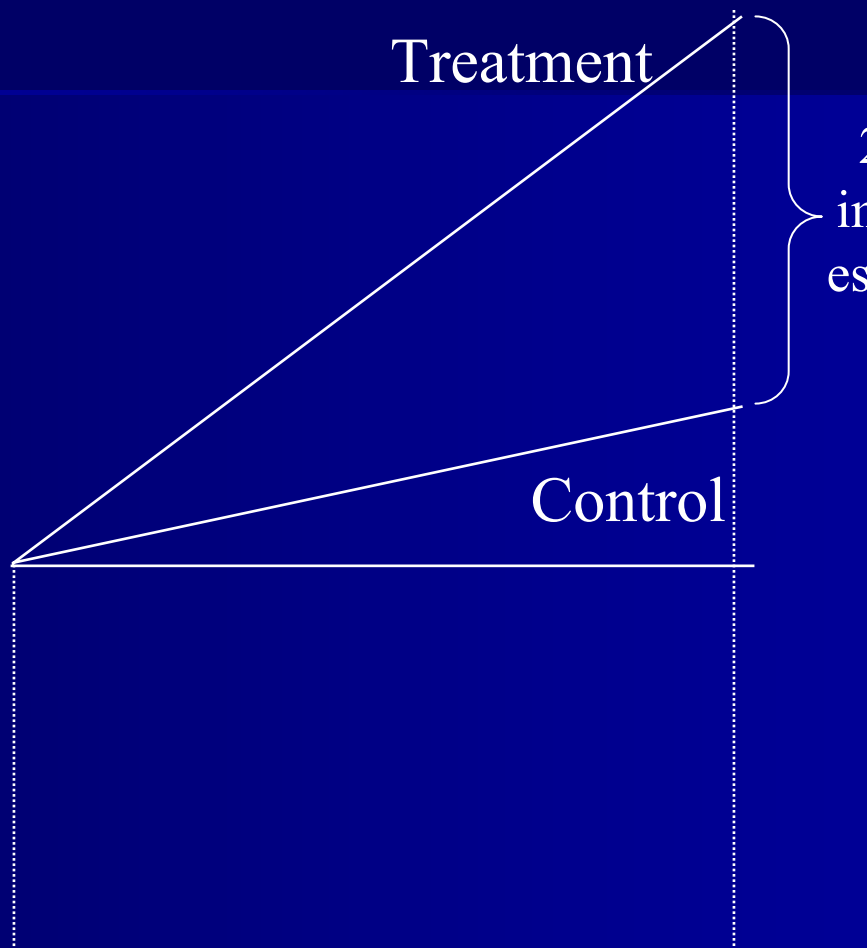
Treatment

2DIF  
impact  
estimate

Control

Before

After



# Evaluation results

Based on IFPRI evaluations in Mexico, Nicaragua, Brazil, and Honduras; other evaluations in Colombia, Brazil and Ecuador

# Findings on Education

# Education results: PROGRESA in Mexico

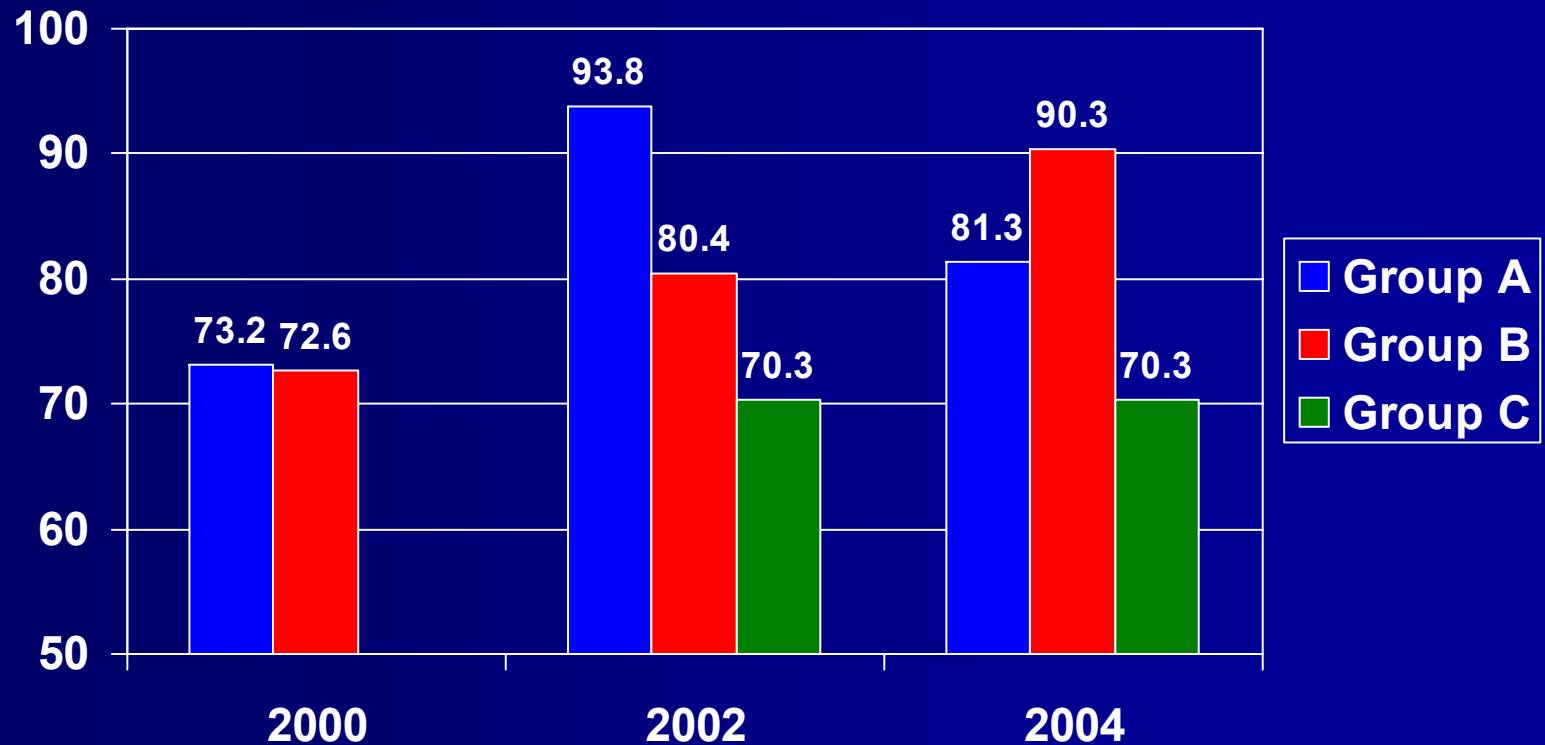
- PROGRESA has a positive effect the school attendance of both boys and girls in primary and secondary school
  - Boys in secondary: increase by 8 %
  - Girls in secondary: increase by 14%
- Negative impact on children's labor market participation (especially boys)
- No observed increase in
  - attendance rate
  - achievement on standardized tests

# PROGRESA, Mexico

- Program promoted earlier entry ages, less grade repetition, better grade progression
- Program effective in keeping children in school especially during the critical transition from primary to secondary
- Less effective in bringing back to and keeping in school children who were out.

# Education results: RPS, Nicaragua

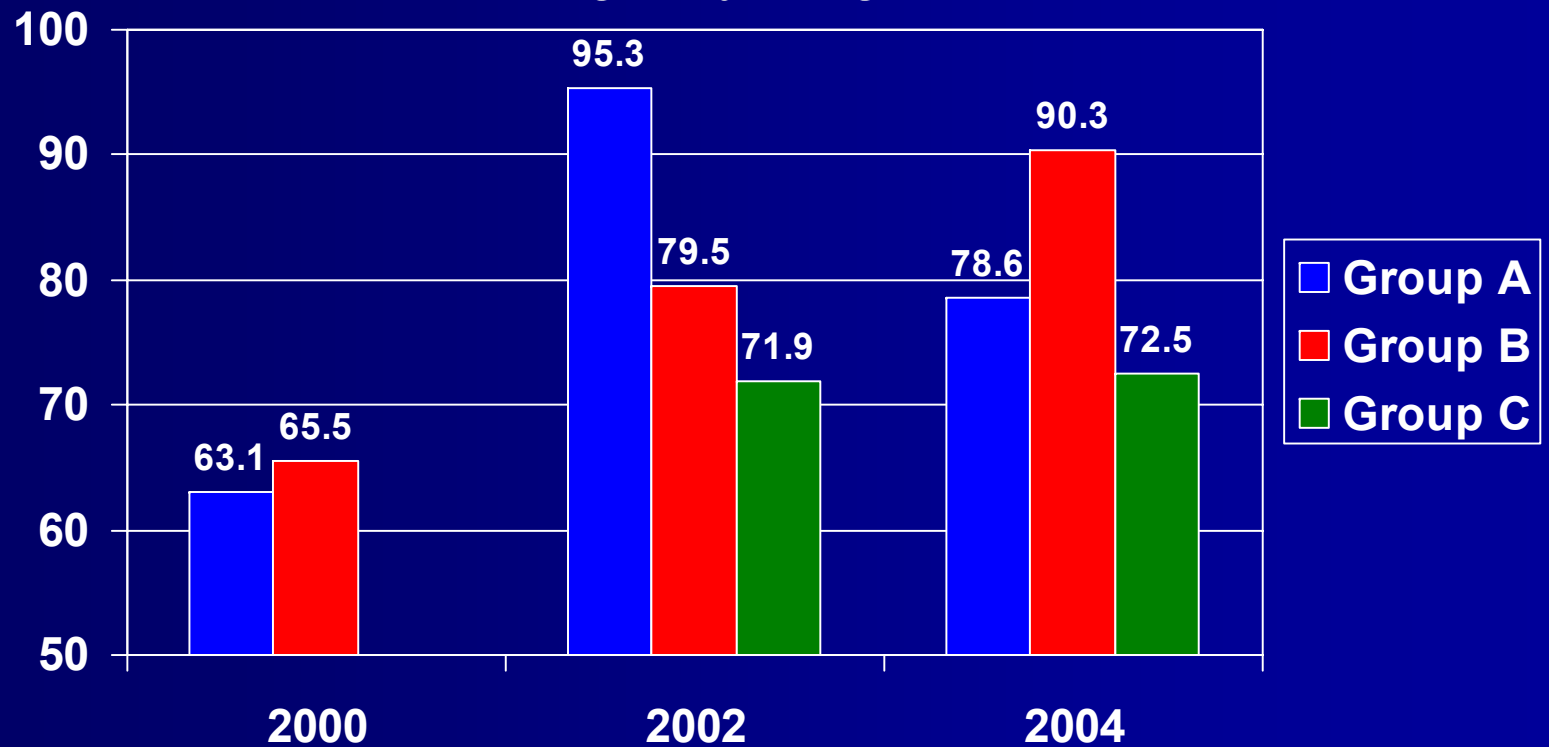
Average impact on % of children age  
7-13 who enrolled 1-4 grades



Impact: Phase I (2000-02) 13 p.p.\*  
Phase II (2002-04) 10 p.p.\*

# RPS, Nicaragua

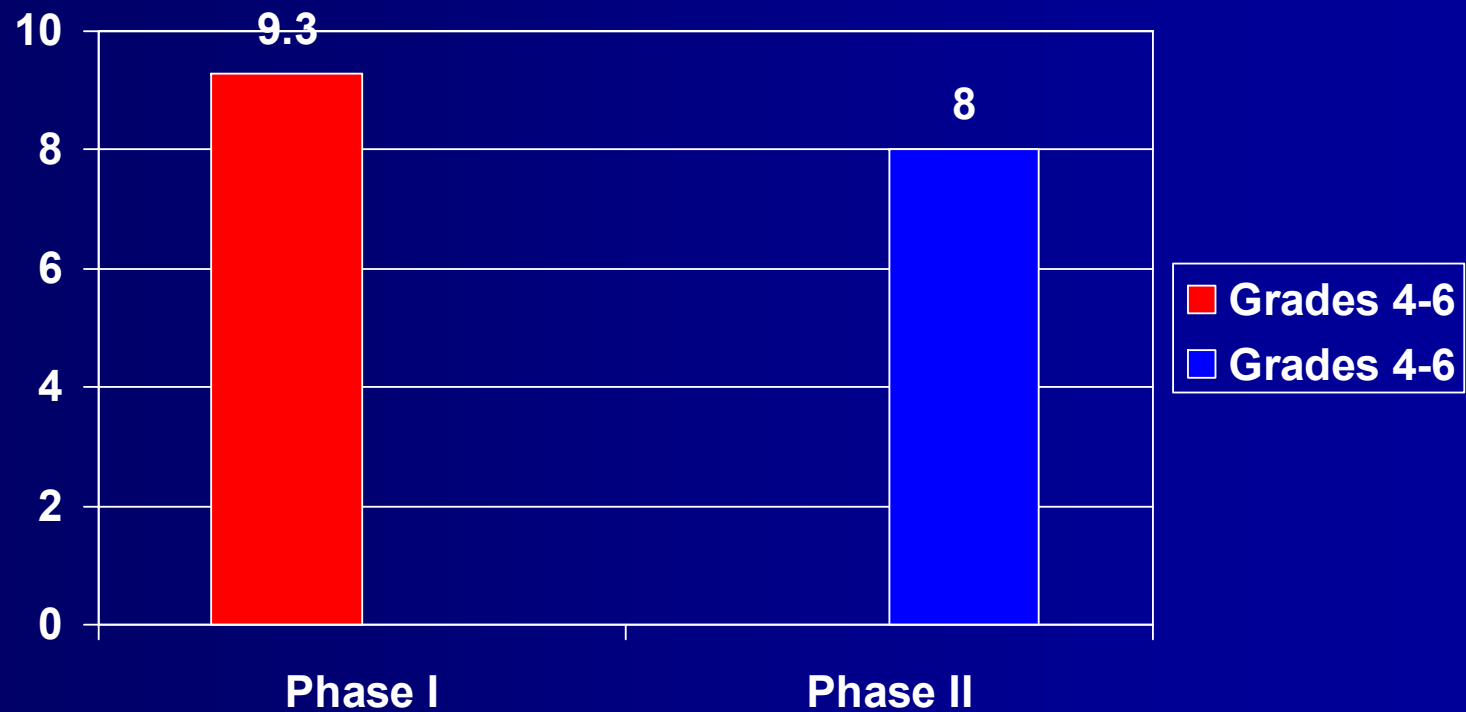
Average impact on % of children age 7-13  
who attend regularly 1-4 grades



Impact: Phase I (2000-02) 18 p.p.\*  
Phase II (2002-04) 10 p.p.\*

# RPS, Nicaragua

Impact on percentage of children 7–13 of age who advanced from 4<sup>th</sup> to 6<sup>th</sup> grade



## CCT impacts on school enrollment, other Latin American cases

| Program                       | Impact     | Age of students   |
|-------------------------------|------------|---|
| Mexico (Rural)                | 2.7 (11.1) | 1 <sup>st</sup> -5 <sup>th</sup> grade (6 <sup>th</sup> ) |
| Nicaragua (RPS)               | 17.7       | 7-13  |
| Honduras (PRAF)               | 3.3        | 6-12  |
| Ecuador (BDH)                 | 10         | 6-17  |
| Colombia (Familias en Acción) | 2.1 (5.6)  | 8-13 (14-17)  |
| Brazil (Bolsa Escola)         | 3.0        | 10-15   |

# **Findings on Health, Nutrition, Poverty, Targeting, and Costs**

# Health and nutrition impacts

- Mexico:
  - Reduced stunting among children 1-3 years of age
  - 12% lower incidence of illness in children ages 0-5
- Nicaragua: Reduced stunting by 6.3%
- Effects on growth monitoring
  - Colombia: +23-33%
  - Honduras: +20%
- Honduras: No significant effect on child height
- Colombia: Reduced stunting by 6.9% for children <2, but no effect on children 3-7 years
- Brazil: Negative effect on height and weight
  - Perverse incentives?

# Effects on poverty

- Increases in consumption of program vs. control groups:
  - Mexico: 13-18%
  - Nicaragua: 13% (40% among extreme poor)
  - Colombia: 15%
  - Ecuador: No effect; partly explained by 17% decrease in child labor
- Could understate impact: In Mexico, 25% of each peso from CCT invested in microenterprises and agricultural production
- No reduction in adult labor in Mexico or Nicaragua
- In 2000-02, RPS served as a social safety net during coffee crisis

# Targeting process and effectiveness, PROGRESA

- Step 1: geographical targeting
  - Identify localities of highest marginality; used census data
- Step 2: Household-level targeting
  - Based on collection of socio-demographic data and information on housing characteristics that are consistent and standard nationwide.
  - Used data to estimate the probability of being poor (Inc per cap < Standard Food basket).
  - Discriminant analysis applied and score of each household compared to a threshold value
- Geographic targeting of the program in rural areas is good
- Method of selecting poor households within localities is generally accurate (undercoverage of 7% )

# Qualitative findings on targeting, PROGRESA

- Little understanding of reasons for inclusion/exclusion
- Fearful of losing benefits
- Do not agree with fine poverty distinctions: *‘Here we are all poor. We all have nothing’*
- Creates social tensions: resentment, envy, gossip
- Need transparency of targeting system, and well-functioning mechanism for community review of list, appeals

# Finding on program costs, PROGRESA

- 8.2 of every 100 pesos allocated to the program are administration/program costs
- Targeting and conditioning of the program makeup 56% of program costs

# **Findings on gender relations**

# Findings on gender relations, PROGRESA

- Program increases joint decisionmaking on some expenditures (rather than male only)
- Reduces need to ask husband for money
- Reduced strain on relations due to new household resources

# Gender relations, PROGRESA and RPS

- New/heightened discourse on importance of women & girls education
- Increased knowledge on health and nutrition, but platicas must be well implemented
  - Need education for men
- Increased social interaction in meetings, collective activities, and organizations
- Increases in women's self-confidence, social awareness
  - But more limited than other approaches
  - Varies significantly by program, depending on design and effort to promote empowerment

# Future directions for CCTs

- Narrower targeting to specific groups
- Improving supply and quality of services
- Early childhood development
- Incentives to children, not adults
  - Savings accounts and scholarships for high school graduates
  - Disease testing and prevention
- Training and work activities
- Access to microcredit, housing improvements, adult education and access to social/health insurance
- Look to other programs that have been successful in achieving other desired objectives and think about designing incentives

# Issues needing further research and consideration

- Net benefits of conditioning
- Special groups for which cost of conditions is too high
- Optimum size of transfer to achieve different objectives
- Effectiveness of monitoring conditions
- Increased achievement or teachers induced to lower grade-passing standards?
- CCT programs compared to what?
- Benefits of household targeting compared to economic and social costs?
- Adapt to new capacity, economic and sociocultural contexts
- Flexibility in crisis
- Sustaining political and financial support
- Long-term impacts

# Reiteration of some key issues in designing a CCT

- Avoid using a blueprint: Think carefully about objectives. What are the main problems (e.g. in human capital) that need improvement?
  - For whom? (age, boys/girls, indigenous, etc.)
- Sound analysis of reasons for those gaps
  - Supply or demand?
  - Reasons for demand problem
- How to structure incentives to respond?
- Cash incentive to parents or children—depends on age
- Be sure household targeting benefits outweigh costs; transparency and legitimacy of targeting process
- What cooperation needed between departments for service delivery? What role for NGOs?

# Thank you

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Or see

[www.ifpri.org](http://www.ifpri.org)

References:

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qualitative: Adato et al. 2000

Nicaragua: Descriptive and quantitative: Maluccio and Flores 2005;  
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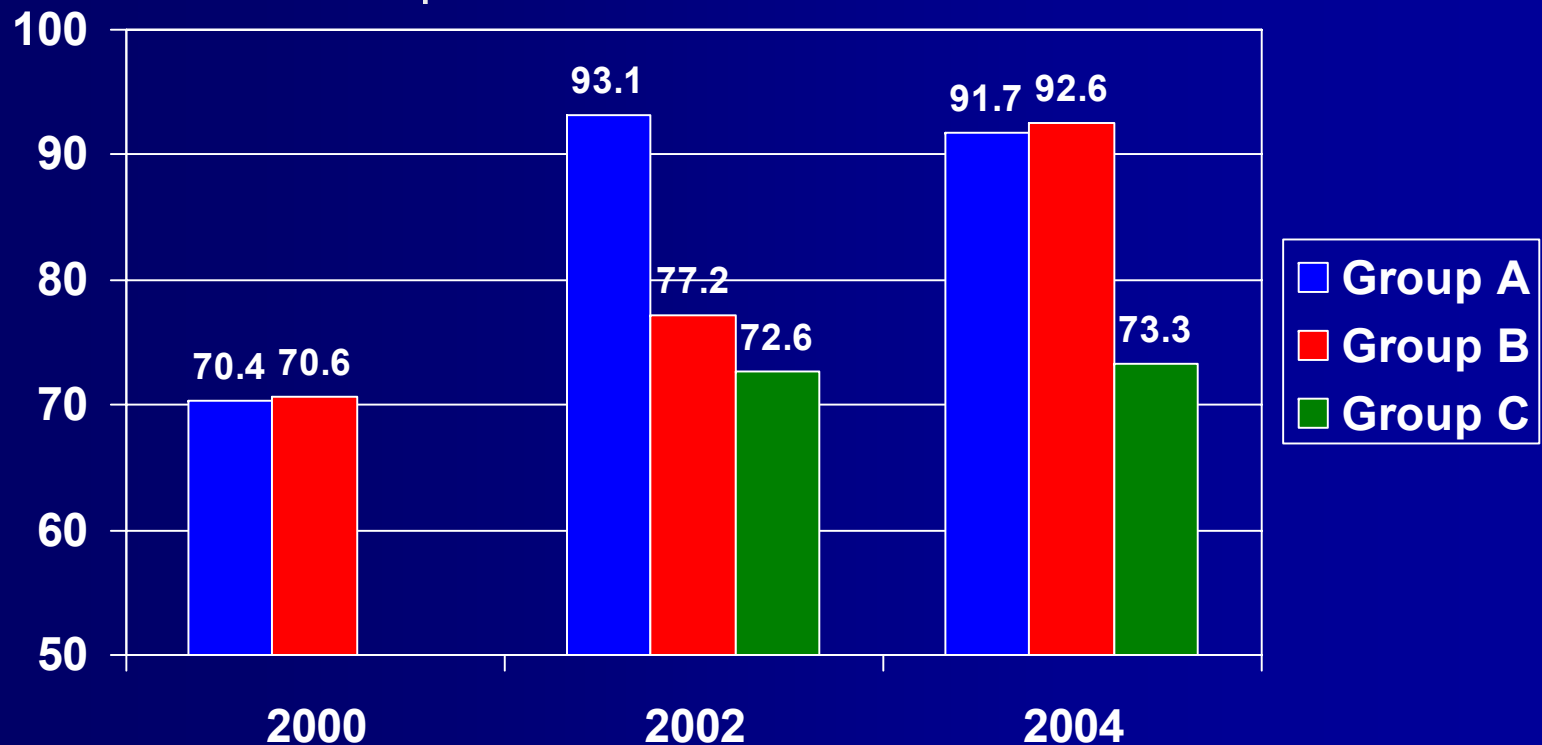
**Appendix:  
Additional findings on health and  
nutrition**

# Health results: PROGRESA

- Increase in nutrition monitoring visits, immunization rates and prenatal care in 1<sup>st</sup> trimester
- No substitution between private and public facilities
- Significantly positive effects on adult health

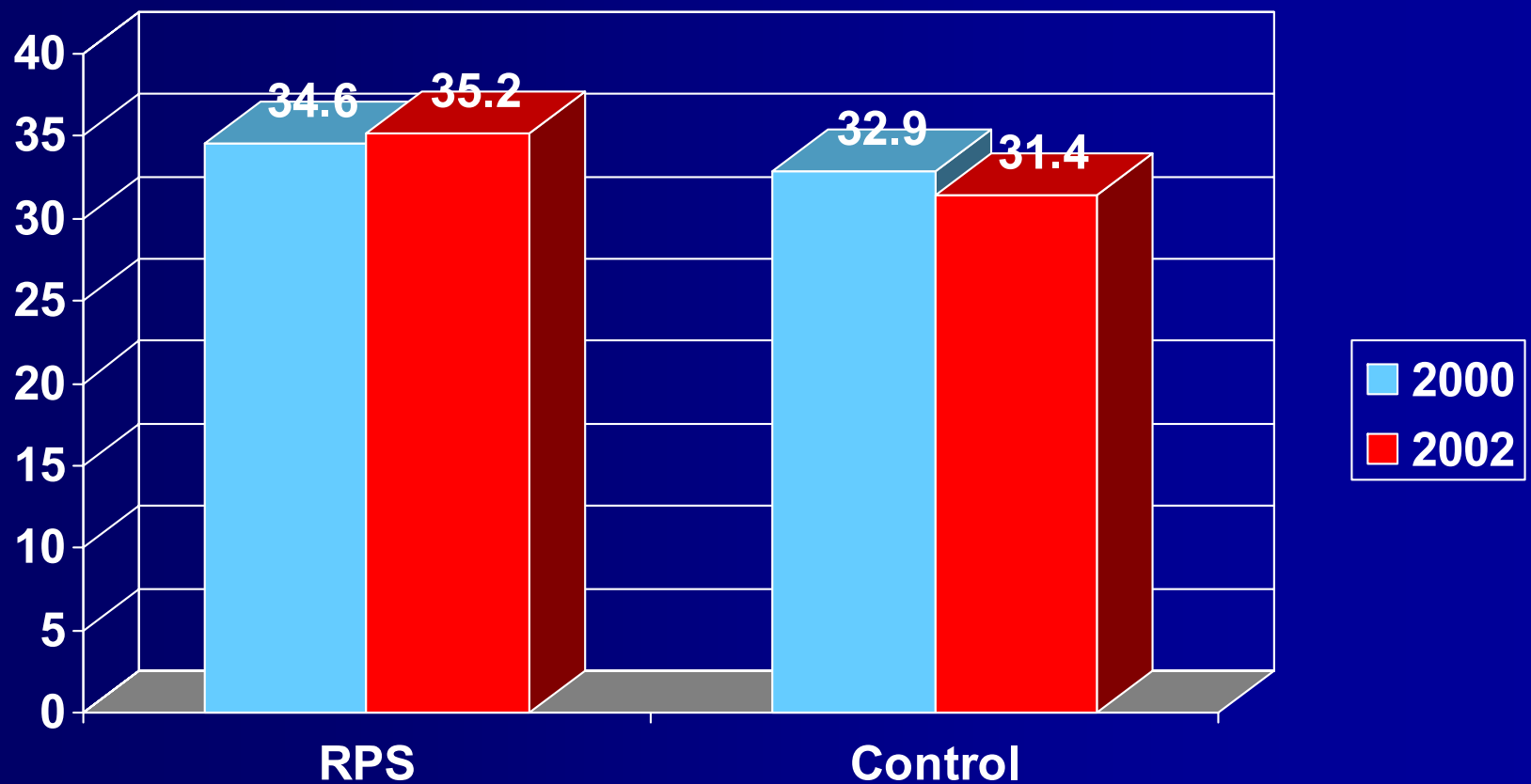
# Health and nutrition, RPS

Impact on % of children under 5 who had attended preventive growth monitoring in the previous six months



Impact: Phase I (2000-02) 16 p.p.\*  
Phase II (2002-04) 15 p.p.

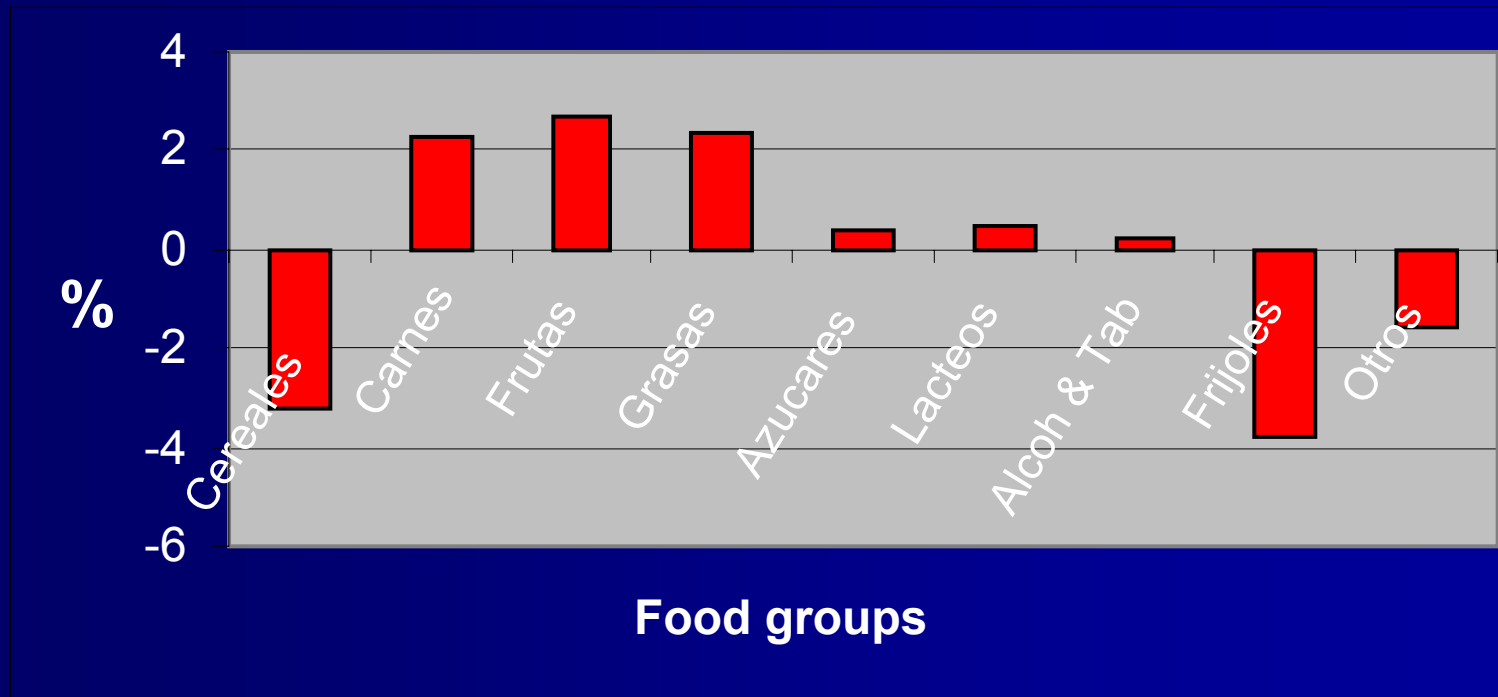
## Impact on % of **anemia** in children from 6-59 months of age, RPS



# Qualitative findings on iron supplements, RPS

- Mothers say that they give the supplement, and that it is important for their children's health
- But case studies found that many do not give them to young children because supplements
  - Tastes bad to the children
  - Upsets children's stomachs
  - Believe it adversely affects children's teeth

## Average impact on % of the household budget dedicated to different food groups, RPS (Phase I)



Changes were less marked in Phase II

# Qualitative findings on nutrition intervention, RPS

- Effort to improve nutritional intake by promoting new foods: soy products and certain vegetables
- But not that successful—difficult to change food consumption practices
- But households now afford greater quantities and familiar but more expensive food with greater frequency