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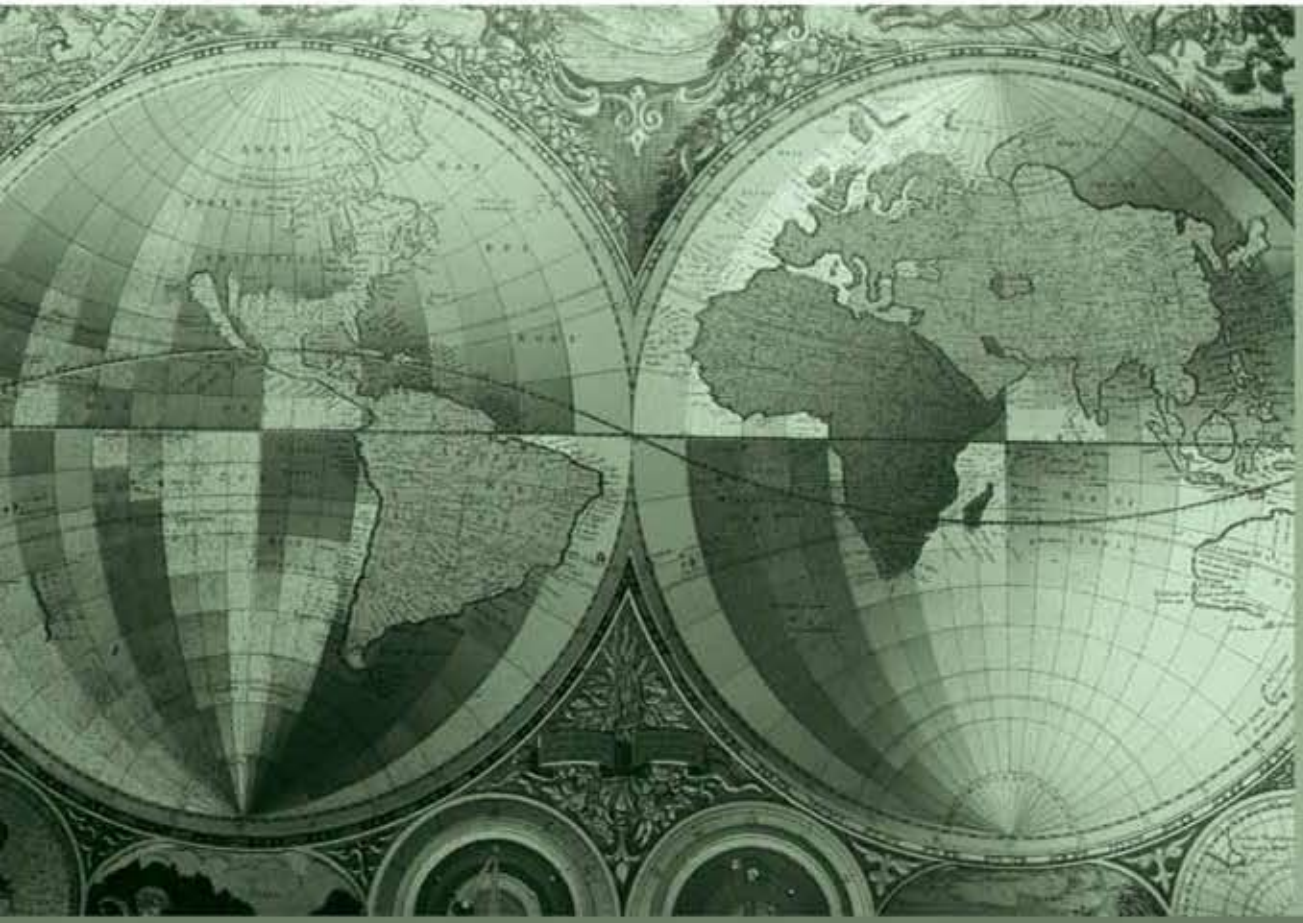

Discussion Paper:

Conditional Cash Transfer Schemes for Alleviating Human Poverty: Relevance for India

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Conditional Cash Transfer Schemes for Alleviating Human Poverty: Relevance for India

'Conditional Cash Transfer Schemes for Alleviating Human Poverty: Relevance for India' presents an analytical review of the design and implementation of Conditional Cash Transfer (CCT) schemes, particularly in Latin America; juxtaposing it with those schemes in India that have similar characteristics. The objective is to promote informed discussion among various stakeholders on the desirability and feasibility of introducing multi-sectoral CCT schemes for alleviating human poverty and achieving the Millennium Development Goals (MDGs) in India.

The core concept of conditional cash transfers originated in Latin American countries mainly in response to the macroeconomic crisis of the 1990s when the demand from poorer households for social services like education and health was perceived to have declined drastically. Typically, such schemes aim at reducing extreme poverty in the short-run while protecting the formation of human capabilities in the long-run. They provide cash directly to poor households in response to the household/individual fulfilling specific conditions such as minimum attendance of children in schools, and/or attendance at health clinics, participation in immunization and the like. These programmes represent a shift in government's approach of focusing on the supply-side to a demand driven approach. The evidence across countries indicates that the schemes provide incentives to households to adjust their behaviour towards nationally accepted social goals in situations where supply constraints are not serious.

'Conditional Cash Transfer Schemes for Alleviating Human Poverty: Relevance for India ' is part of a series of discussion papers that the United Nations Development Programme (UNDP) is bringing out on a range of development issues in India. The endeavour is to share information and experiences from within the country and from other parts of the world and provide a platform for further dialogue.

Contents

ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ASHA	Accredited Social Health Activist
BPL	Below Poverty Line
BSY	Balika Samriddhi Yojana
CARE	Cooperative for Assistance and Relief Everywhere
CCTs	Conditional Cash Transfers
CHC	Community Health Centre
CSG	Child Support Grant
CSS	Centrally Sponsored Schemes
FFE	Food For Education
FIDSL	Social Investment Fund for Local Development
GDP	Gross Domestic Product
HDI	Human Development Index
HIV	Human Immunodeficiency Virus
IADB	Inter-American Development Bank
ICDS	Integrated Child Development Services
IMR	Infant Mortality Rate
IFS	Institute for Fiscal Studies
IFPRI	International Food Policy Research Institute
IPC	International Poverty Centre
IPG	Indice de Prioritization Geographia (Geographical Prioritization Index)
JNNURM	Jawaharlal Nehru National Urban Renewal Mission
JSY	Janani Suraksha Yojana
KGBVS	Kasturba Gandhi Balika Vidyalaya Scheme
LIC	Life Insurance Corporation
MDG	Millennium Development Goals
MDMS	Mid-Day Meal Scheme
MMR	Maternal Mortality Ratio
M&E	Monitoring and Evaluation
NMBS	National Maternity Benefit Scheme
NPEGL	National Programme for Education of Girls at Elementary Level
NREGA	National Rural Employment Guarantee Act
NRHM	National Rural Health Mission
OBC	Other Backward Classes
PATH	Programme for Advancement through Health and Education
PDS	Public Distribution System
PHC	Primary Health Centre
PMGSY	Pradhan Mantri Grameen Sadak Yojana
PRAF	Program de Asignacion Familiar
PKH	Program Keluarga Harapan
RPS	Red de Protection
SC	Schedule Caste
SISBEN	Beneficiary Selection System for Social programmes
SSA	Sarva Shiksha Abhiyan
ST	Schedule Tribe
UNDP	United Nations Development Programme
UNESCO	United Nations Educational Scientific and Cultural Organization
UNICEF	United Nations Children's Fund
WB	World Bank

Conditional Cash Transfer Schemes for Alleviating Human Poverty: Relevance for India[1]

1. Introduction

Conditional Cash Transfer (CCT) schemes provide cash directly to poor households in response to the household/individual fulfilling specific conditions such as minimum attendance of children in schools, and/or attendance at health clinics, participation in immunization and the like. The schemes create incentives for households to adjust their behaviour towards nationally accepted social goals. In technical terms, the objective of such programmes is 'to correct for market failures associated with non-internalized positive externalities' (Janvry and Sadoulet, 2004, p.1). In other words, they are used (a) to incentivize private behaviour to secure positive externalities such as enhanced consumption of merit goods like health and education (b) target vulnerable groups who are unable to access merit goods due to negative income effects caused by cyclical downturns and/or exogenous shocks. These schemes have typically been used to improve school attendance by children, boost attendance at health clinics and enhance participation in immunization programmes.

Conditional cash transfers are different from unconditional cash transfers — grants to vulnerable persons/groups on the basis of certain pre-determined eligibility criteria. Social transfers such as pensions to senior citizens, the physically challenged, children, etc., are the most common unconditional cash transfers. The main difference as compared to CCT schemes is that they are unconditional programmes and do not attempt to influence individual/household consumption preferences. They recognize the vulnerability of those whom the scheme addresses and make a provision of a cash grant to enable individual/group coping mechanisms, often in response to guaranteed human rights. These constitute protective social security measures.

The concept of CCT schemes originated in Latin American countries mainly in response to the macroeconomic crisis of the 1990s when the demand for social services such as education and health from poorer households was perceived to have declined, drastically. These programmes thus represent a shift in governmental approach that earlier focused on the supply-side delivery of basic services. Instead they focus on the demand-side, by protecting the consumption of merit goods. These programmes also represent a shift from general subsidies to more sharply-targeted programmes that aim to improve human capital formation and, thereby, increase efficiency in the long-run.

1 This paper has been prepared by K. Seeta Prabhu, Senior Assistant Country Director, UNDP-India, with research assistance from Ragini Sahay. Comments provided by Rathin Roy and Claudia Vinay, Bureau of Development Policy, UNDP, on an earlier version of the paper are gratefully acknowledged.

The multi-sectoral and integrated nature of most CCT schemes and the prospects of tackling short-term poverty while protecting the formation of human capital/ capabilities (and thereby addressing long-term poverty) have led governments in Africa and Asia to implement such schemes as a response to reducing the daunting deprivations in multiple dimensions of human development

For these demand-side interventions to work, the conditions associated with cash transfers must demonstrate that the transfers protect the consumption of the chosen merit goods by households who receive them. This responds to the (largely middle class) concern that distributing cash to poor households would lead them to act 'irresponsibly' and spend 'handouts' on demerit goods (non-essentials like alcohol or 'wasteful' consumption). While this does reflect an element of paternalistic judgement about the relative 'responsible' behaviour of poor vs non-poor households, it is ultimately the household that can choose to receive these transfers by 'deciding' to act in a socially 'desirable' way. In the Indian context, such schemes avoid the negative incentives associated with subsidies such as 'free power' to poor agricultural households.

Such subsidies may raise the overall household consumption possibility frontier but do not impact the slope of the frontier by increasing relative expenditure on merit goods. The increasing popularity of CCT initiatives as a policy instrument is also attributed by some observers to their conspicuous nature that allows governments to demonstrate pro-poor delivery of public resources.

CCT schemes have also been positioned as instruments that directly impact income and consumption. This is an important dimension in an era of widening inequalities and the growing realization that the response of poverty to economic growth is much lower in countries with a high degree of inequality. Since conditional transfers are instruments that compensate for market failures, a successful CCT programme can contribute to a reduction in inequality and enhance investment in human capabilities that in turn can halt or reverse the intergenerational transmission of poverty (de la Brier and Rawlings, 2006).

Such transfers are of particular contemporary policy relevance in India which despite its high growth performance lags with respect to alleviation of various dimensions of human poverty. The situation of people belonging to Scheduled Castes and Scheduled Tribes groups with respect to education, health and nutritional attainments is particularly low (see Table 1). The disparity among regions between rural and urban areas as well as between social groups is widely seen as a constraint in the achievement of Millennium Development Goals by the year 2015.

Table 1: Selected Indicators on Poverty, Health & Education – Category & Area Wise

S.No	Indicator	SC	ST	Rural	Urban	All
1.	Percentage of population below poverty line (2005)	-----	-----	28	26	**27**
	Percentage of population below poverty line					
	(Rural) (2005)	37	47	-----	-----	**27**
	(Urban) (2005)	40	16	----	----	**27**
2.	Infant Mortality Rate (Urban) 1,000 per live birth (2005)	66	62	62	42	**57**
3.	Under Five Mortality (2005-06)	88	96	82	52	**74**
4.	Percentage of children age (12-23 months) received all vaccines (2005-06)	40	31	39	58	**44**
5.	Percentage of underweight children (< five-years) (2005-06)	48	55	46	33	**43**
6.	Percentage of anaemia among children(six to 59-months) (2005-06)	72	77	72	63	**70**
7.	Percentage of anaemia among women (15-49 years) (2005-06)	58	69	57	51	**56**
8.	Percentage anaemia among men (15-49 years) (2005-06)	27	40	28	18	**24**
9.	Percentage of live births delivered in health facility (2005-06)	33	18	29	68	**39**
10.	**Literacy Rate (2001)**	**55**	**47**	**59**	**80**	**65**
11.	Literacy Rate (2001) Male	67	59	71	87	**76**
12.	Literacy Rate (2001) Female	42	35	47	73	**55**

13. 14.	Gross Enrollment Ratio Secondary Education (IX-X) 2004-05	45	37	-----	-----	**52**
	Gross Enrollment Ratio Secondary Education (Female) 2004 -05	38	31	-----	-----	**45**
15.	Dropout Rate at Elementary-level Grades I to VII					
	Overall	57	66			**51**
	Boys	55	65	-----	-----	**50**
	Girls	60	67			**51**

Source: Planning Commission 2008 and IIPs 2007

Cash transfer schemes are also being advocated in the Indian context as a measure of enhancing the efficiency of delivery of government programmes. It is well-known that the administrative cost of delivery of services in the country is high, there are substantial leakages and inter-sectoral coordination is not optimal[2]. It has been argued by some that the amount of Rs. 2,000 billion that is spent annually on food, fuel and fertilizer subsidies may be better utilized by providing cash directly to the beneficiaries or to the Gram Panchayats (locally-elected village councils) who in-turn can implement schemes for the poor.

To cite from Kapur, et al, (2008, p.38) who make a case for cash transfers: "According to the Economic Survey 2007-08, about 27.5 percent of India's roughly 1.13 billion people are below the poverty line (BPL), i.e., about 310 million people or 70 million households. If the Rs.1,80,000 crore spent on centrally sponsored schemes and food, fertilizer and fuel subsidies were distributed equally to all these 70 million households, it would mean a monthly transfer of over Rs.2,140 per household[3]. This is more than the poverty line income for rural households and more than 70 percent of the urban poverty line income. Indeed, if the government simply gave eligible households the amount of money it spends on the Public Distribution System, this alone would entail a monthly transfer of more than Rs.500 to each household, i.e., about 40 percent of the entire food budget for a household at the poverty line. Alternately, if the amount was to be made available to Gram Panchayats, the estimated amount available per Gram Panchayat would be about Rs.1,00,000 crore per annum."

2 The most often cited figures in this respect are that the government spends Rs.3.65 to transfer one rupee worth of food, indicating a leakage of 70 percent (Text of Finance Minister P. Chidambaram at the National Development Council meeting held on 19 December 2007, cited in Kapur et al, 2008).

3 It needs to be recognised that the impact of each of these subsidies on households would be different.

These suggestions, however, have been criticized as being a demonstration of 'fallacy of misplaced concreteness' by Shah (2008, p.77). The problem, he argues, is not one of money but of translation of money into concrete outcomes. Similar views have been expressed by Freeland (2007) who considers that improving the supply-side of services holds the key to better education and health outcomes rather than assuming that demand is a constraint. The supply-side issue has been recognized in the 11th Five-Year Plan document of the Planning Commission which emphasizes the need to move from 'outlays to outcomes'.

Additionally, in the current slowdown in economic growth as a result of the global economic crisis, CCT schemes may also be seen as a measure to ensure a modicum of protection to the formation of human capital/capabilities of the poor. This is especially true in urban areas, where the income effect of the downturn is likely to impact the poor by reducing the affordability of basic social services and in areas where schemes like the National Rural Employment Guarantee Scheme (NREGS) and the Pradhan Mantri Grameen Sadak Yojana (PMGSY) do not provide a compensatory employment cushion. Here, it is the affordability rather than the availability of merit goods that becomes the binding constraint which is now further accentuated by the global crisis. CCT schemes, therefore, can be seen to offer an attractive potential countercyclical policy instrument.

It is against this background that the paper examines the rationale for CCT schemes, outlines their main provisions and challenges, and documents their impact. It also highlights the main cash transfer schemes prevailing at the level of Government of India as well as in states and relates the same to the ideology behind such schemes with a view to initiating a more informed debate on the issue in the context of the current Indian situation.

2. Evolution of CCT Schemes, Objectives and Design

Evolution

Conditional Cash Transfer schemes originated in middle-income Latin American countries that had good infrastructure and supply systems. They were positioned as formal, publicly provided safety net programmes that essentially supplied cash to the needy and helped them tide over the period of economic crisis. The earliest of such programmes, Progresa, was initiated in 1997 in Mexico with a new approach integrating interventions in health, education and nutrition. It was based on the understanding that these important dimensions were direct correlates of human welfare. In Brazil the first CCT programme was started in 1996 with a focus on child labour. While some more programmes based on the CCT philosophy were introduced

to address specific areas, these were integrated in 2004 into the now well-known programme -- Bolsa Familia. Other countries that initiated CCT programmes include Chile, Colombia, Ecuador, Jamaica, South Africa and Turkey. In Asia, Bangladesh had a Female Stipend Programme as early as 1982 followed by a Food for Education Programme in 1993. Food grants were later converted to cash grants in 2002. Indonesia launched a pilot CCT programme called Programme Keluarga Harapan (PKH) in 2007. Its beneficiaries are very poor households that have pregnant women and/or zero to 15-years-old children. The PKH requires them to access education and health services to be eligible for the cash transfer.

The main features of CCT programmes in select countries have been provided country-wise in matrix form in Annexure I.

Objectives and Design

CCT schemes represent a shift in the focus of social policy from supply-side provisioning to addressing demand-side constraints. They typically have multiple objectives that foster the virtuous cycle between social protection and human development. The early CCT schemes had two main objectives -- to reduce poverty and to enhance capabilities of the poor. While these appear as two distinct objectives, in reality they constitute two phases of the single objective of poverty reduction, with the cash transfer part addressing poverty in the short-run, and the conditionality component addressing poverty in the long-term through building of human capital/human capabilities[4] and thereby reducing the intergenerational transmission of poverty.

The focus of the initial CCT programmes was on the urban poor in Brazil and rural poor in Mexico. The schemes which were implemented in low-income countries (such as Nicaragua and Honduras in Latin America) focused on the rural poor.

The CCT programmes have also been used to address the needs of vulnerable sections of the population such as internally displaced persons (Colombia), physically-challenged persons (Jamaica) and households affected by HIV/AIDS (Zambia). In Chile, the programme makes psychosocial assistance available to all beneficiaries in an attempt to help them acquire the social skills and training needed to escape poverty.

The scope of the programmes has also expanded beyond school enrollment and immunization to cover aspects like secondary school completion (Mexico) and adult education, microcredit and housing (Brazil) (de la Brière & Rawlings, 2006).

4 The usage of the term human capital is yielding its way to the term human capabilities in recognition of the fact that human beings are not only a 'means' to an end but also constitute the ends themselves. Human beings as the end of all development efforts is highlighted by the human development approach of UNDP.

Main Features

The CCT schemes address demand-side factors on the assumptions that:

1. The lack of adequate income is what prevents parents from sending children to school or make use of health/immunization facilities resulting in inadequate demand;
2. Schools and public health facilities exist, are functioning and are accessible to the poor; and
3. Attendance improves learning outcomes and, therefore, life chances of children. Similarly, immunization and attendance at health facilities improves health outcomes and thus life chances of children and mothers.

In countries where poverty is high and the supply-side constraints severe, CCT schemes have been supplemented by wider social programmes that include these components. Thus, PRAF II in Honduras that was specifically aimed at rural areas, where the supply constraints were the most severe, included components in social programmes that address these constraints[5]. Similarly, the programmes in El Salvador initiated in 2005, include generation of income on the supply-side of services. In the Red Solidaria programme of El Salvador, for example, there are three distinct components, that is, a CCT, a programme for infrastructure development and a third component that supports income-generation.

Transfers are made in cash rather than in-kind, the reason cited being that cash transfers provide greater discretion to the poor households to spend on items they consider important, allowing the decision-making power to be with the households. Cash transfers are also relatively simple to administer than in-kind transfers. Generally, cash transfers are made to the woman in the household as the literature on the subject indicates that women spend a greater proportion of the money under their control on children's education, health and nutritional requirements[6].

The term 'conditionality' in the CCT schemes should be interpreted differently from the common usage of the term in policy debate. Conditions in the case of a CCT

5 In PRAF II in Honduras, the efforts to improve supply side aspects in health included reduction in preventable illnesses, improving the quality of basic health services, giving primary health centres necessary resources and medicines, training healthcare professionals in quality improvement etc. In the education sector similarly the supply side goals were to improve quality of schools, improve educational material, train parents to support educational programmes and manage financial resources and train teachers in pedagogical methods and techniques and improve the quality of education provided by teachers (Moore, 2008).

6 However, in paternalistic societies such as South Africa it has been observed that women have to face several constraints in accessing the programme particularly in terms of time consuming application process. For example, 'proof of residence needs to be obtained from the tribal authority and affidavits of various kinds have to be secured at police stations which are very masculine domains' (Lund et al, 2008, p.16). It has also been observed that in the case of cash transfers for assets like housing, the control rests largely with men.

are specific rather than holistic; they do not prohibit but incentivise — thus they do not require a household to reduce its consumption of demerit goods but allow it to supplement the consumption of merit goods. This is because the transfer of cash is conditional on certain requirements, e.g. school attendance (minimum attendance norms), and/or visits to health clinics, immunization of children and so on. The objective is to induce households to change their behaviour in a manner that contributes to the realization of a nationally accepted consensus that the achievement of common social goals requires the protection of a minimum-level of merit good consumption by all households. It is interesting that more recently the concept of — 'co-responsibility' rather than 'conditionality' — is being increasingly used in the policy literature on CCT schemes. Co-responsibility signals that there is a responsibility on the part of the government as well as households to ensure the success of the CCT. The government's responsibility is to ensure that supply-side constraints do not impede the success of the cash transfer programmes and the responsibility of the households is to adhere to the conditions agreed upon. For example, in Red Solidaria, the main beneficiary as a co-responsible person has to sign an agreement that spells out the responsibilities of the beneficiary family as well as that of the government[7] (Soares and Britto, 2007).

3. Implementing CCT Schemes: Operational Issues

Targeting

In most of the CCT schemes under review, targeting on geographical basis has been a common feature, for example, in Tekapora in Paraguay and Red Solidaria in El Salvador. The selection of areas where the CCT would be implemented has often been done using indices computed through multi-variate techniques[8]. The identification of beneficiaries in most countries is through a census which might be a general census or confined only to the geographical area being covered[9]. It is also quite commonplace to involve the communities in the identification of beneficiaries, at least in the programmes of more recent vintage[10]. Increasingly, unified electronic

7 Some of the co-responsibilities read as follows: use benefit to purchase food, undertake visits to a health centre for diagnosis of health and nutritional condition of children younger than 15-years-old and of each pregnant woman; guarantee the children are not delayed in the immunization schedule; and use the education stipend to buy school related material.

8 For details on the indicators comprising the indices please see Annexure II.

9 In Paraguay census only in the neighbourhood of selected districts while in El Salvador the census was in the whole municipality.

10 In El Salvador there was a participatory process involving local community in the mapping process whereas in Paraguay the process was initially centralized in the National Statistical Office and later outsourced to private firms.

registers of beneficiaries are being used in large-scale programmes. These registers assign a unique identification number to the beneficiaries that enable systematic tracking over time and across programmes (de la Braire and Rawlings, 2006). The administration of the registers is highly centralized in Mexico, whereas decentralized systems are in use in Argentina, Brazil and Turkey.

Efficiency of Targeting?

The experience regarding efficiency in targeting is mixed. The inclusion error in Bolsa Familia is calculated to be 49 percent as compared to 36 percent in Oportunidades in Mexico (Soares, Ribas and Osorio, 2007; Medeiros, et al, 2008) observe that as per the National Household Survey (PNAD) in 2004, Bolsa Familia was highly targeted at the poor and exclusion errors have been minimized overtime. Errors of inclusion, however, continue to be somewhat high with 21 percent of the income in Bolsa Familia delivered to families whose per capita income was higher than R$100 in Brazilian currency with about 12 percent of the benefits accruing to beneficiaries whose family income exceeded R$130 in 2004. However, given the high fluctuations in income of households that render identification of beneficiaries at any given time somewhat inappropriate at a later point in time, and the fact that the leakages were to those who are just above the poverty threshold, the programme effort focussed more towards minimizing exclusion errors. Inclusion errors were more serious in Honduras where in PRAF I, a survey conducted by CARE in 1996 found that 30 percent of beneficiaries of a scheme giving school fee vouchers and 40 percent of the beneficiaries of a scheme giving maternal and child health care vouchers belonged to the richest two income quintiles of the population (Moore, 2008). Targeting errors have been found to be high in both centralized as well as decentralized systems. The only recourse to reduce targeting errors seems to be to resort to public oversight networks/social audits. Such tools have been gaining in popularity across countries.

Setting the amount of benefits received at a lower amount is a way of limiting the attractiveness of the CCT schemes for richer households and thereby reducing leakages. This was the strategy followed in Honduras PRAF II where the benefits were limited so as to avoid adverse selection. The evaluation of PRAF II indicated the success of this strategy with 71 percent of beneficiaries identified being those living in extreme poverty. Though this was efficient in terms of targeting, it meant that the programme was resorting to low-level of benefits to encourage self-selection that is typically seen in workfare programmes (Moore 2008).

Financing and Costs of Administering the CCT schemes

CCT schemes have varied modalities of funding. Many such schemes in Latin America have been supported by international agencies such as the Inter-American

Development Bank (IADB) and the World Bank. In Mexico, initially it was funded completely through government resources, with partial funding from the IADB since the year 2000. In Brazil, Colombia, El Salvador and Honduras there is greater reliance on loans from international organizations, particularly for funding the infrastructure component. But the CCT schemes per se may be funded through domestic resources. Donor funding has its implications for costs, duration, exit strategy as well as sustainability of CCT schemes and complementary programmes. Details regarding the share of funding from different sources are given for select countries in the country sheets in Annexure I.

The CCT schemes have not been very resource intensive. For example, in Honduras, PRAF I and II accounted for 0.2 percent of GDP in early 2000s. In Nicaragua, the scheme accounted for 0.2 percent of GDP in the year 2000. The CCT schemes in Brazil accounted for 0.36 percent of GDP in 2005, in Mexico, it accounted for 0.32 percent of GDP in 2002 and in Colombia 0.12 percent in 2005 (de la Briere and Rawlings, 2006, p.24).

Given the complexity of the CCT schemes it was expected that administrative costs of implementing will be fairly high, at least initially. It is possible to identify four types of costs: Administrative costs related to geographical targeting; costs associated with household proxy or means targeting; costs associated with making transfers conditional on household actions; and costs of monitoring ongoing programmes (Coady, Grosh and Hoddinott, 2002).

Contrary to expectations, however, the costs of administering the CCT schemes as a proportion of GDP has been less than one percent in all the countries reviewed except in the initial period where setting them up means incurring certain fixed costs[11]. In fact, the small size of programmes and opting for in-kind transfers rather than cash transfers increases the costs of administration considerably as is evident from the experience of Nicaragua and Bangladesh[12]. Contrarily, use of information technology, for example, electronic transfers for payments, as in Brazil, has enabled costs of administration in Bolsa Familia to be low. The use of geographical targeting, and involving the community in identification and monitoring are also effective in keeping administrative costs low. Apart from costs incurred by the government, there are also private costs incurred by households, that is, for participating in the programme in terms of foregone income in workfare programmes, financial and time

11 For example, in Mexico during 1997, the first year of implementation of Progresa, the cost of targeting was 65 percent of the cost of the programme which subsequently declined to 11 percent by 2000. However, the reverse was the case with the costs associated with the monitoring of the conditionality which rose from eight percent in 1997 to 24 percent by 2000. Whereas in 1997, the actual delivery of transfers to beneficiaries was only eight percent, it increased by 2000 to 41 percent.

12 In Nicargua's Red de Protection Social (RPS), the administrative costs were much higher than that of Mexico and other countries on account of the small size of the programme. Bangladesh — Food for Education programme — administrative costs amounted to 37 percent of total cost (Kakwani & Soares, 2005).

costs of obtaining necessary certifications which are not trivial[13]. Some programmes, such as PRAF II are considering the amount of benefits that households receive on the basis of both direct costs as well as the opportunity costs (Moore, 2008).

4. Impact of CCT Schemes

The impact of the CCT schemes can be assessed from the point of view of its main objectives, that is, alleviating poverty, and human capital formation. The other benefits associated with these programmes are that of empowering women, enabling the inclusion of people belonging to marginalized groups, improving accountability, reducing inequality, and others.

The multiple objectives of these schemes make an assessment of their impacts rather complex. The spread of CCT programmes across countries since the 1990s indicates that they have been well received and perceived to have an impact on at least some of the objectives that they have set out for themselves.

The programmes have been evaluated by international agencies such as the International Food Policy Research Institute (IFPRI), the Programme for Advancement Through Health and Education (PATH), the Institute for Fiscal Studies, the World Bank and the International Poverty Centre of the United Nations Development Programme. The main results of the evaluations are discussed herein under:

a) Income inequality and poverty
b) Education, health and nutrition
c) Social inclusion
d) Governance

a) Income Inequality and Poverty

- In countries that have high initial levels of inequality and have been implementing CCT schemes for a fairly long period, it has been observed that the programmes contribute to reduction in inequality. A decomposition of the gini coefficient between mid 1990s and mid 2000s in three countries, that is Brazil, Chile, Mexico, indicated that "with a share of about 0.5 percent of total income in Brazil and Mexico and much less in Chile, the CCT schemes were responsible for 21 percent of inequality reduction in Brazil and Mexico

13 For example in Honduras, the female beneficiaries of PRAF were to commit to participating for six hours each week for six months in order to receive benefits under the Comprehensive Female Development Programme. Most women found this commitment of time too much to comply with. The poor families also had difficulties in fulfilling requirements to receive credit and loans under PRAF as they had to comply with requirements including written business plans (Moore, 2008, p. 6).

and 15 percent in Chile" (Soares, et al, 2007, p.17). The income transfers under Oportunidades and Bolsa Familia were large enough to result in a significant reduction in inequality whereas in Chile the quantum of transfers was too small to be able to make a difference.

- CCT programmes have been fairly successful in reducing acute distress and increasing consumption levels of the poor in the countries in which they have been operating. The impact of these schemes on the depth and severity of poverty has been more pronounced than on the headcount ratio of poverty[14]. They have contributed to an increase in the income of the poor households substantially as the cash transfers accrue directly to households. For example, in Mexico and Brazil, the income from CCT schemes formed 25 and 50 percent of the income of the poorest households respectively. In Mexico, the poverty gap declined by 12 percent and severity of poverty by 19 percent as compared to a five percent reduction in the headcount ratio of poverty (Zepeda, 2006). In Paraguay, the functioning of the Tekapora programme between September 2005 and April 2007 led to an increase in the income of the households by 31 to 36 percent. Such an increase led to a reduction of 17 percentage points in the incidence of extreme poverty among beneficiaries.
- The impact on food consumption of poor households has been significant. For example, in Colombia, between September 2002 and April 2003, the consumption of protein rich food increased rapidly in both rural and urban areas with children benefiting more than adults (Attanasio, et al, 2004, 2005).

b) Education, Health and Nutrition

CCT schemes are often labelled as education programmes on account of their focus on increasing school attendance and the relatively high proportion of the education budget that they are allotted[15].

- **Primary Education:** A UNESCO review (Reimers, et al, 2006) of the impact of CCT schemes across five countries indicates that while these schemes have a positive impact on school attendance rates and consequently in the number of years of schooling attained. Though not a CCT, the Food for Education (FFE) programme in Bangladesh in operation from 1993 to 2002, led to an increase in overall attendance in schools. Attendance in FFE schools was higher (70 percent)

14 If is assumed that 20 percent of the population in Mexico was poor prior to the Oportunidades programme, the transfers reduce poverty to about 19 percent. In Brazil, the reduction is from 13 - 15 percent (Zepeda, 2006).

15 For example, in the five countries where the CCT schemes were reviewed for their educational impact by the UNESCO, the cost accounted as 'education spending' exceeds eight percent of all education spending, a sizeable share in a sector in which typically 80 to 90 percent of all spending goes to salaries (Reimers, et al, 2006). In Mexico, CCT schemes represent one-fifth of the education budget not committed to salaries.

as compared to schools not offering FFE (58 percent). In Mexico, secondary school enrollment increased from 70 to 78 percent between the year 1998 and 2000 (Skoufias, 2005).

- **Secondary Education:** The programmes also facilitate the transition of children from primary to secondary education. In Mexico, Progresa resulted in increased enrollment of children who had completed Grade VI into junior secondary schooling (middle school in Indian parlance). The enrollment increased by 11.1 percentage points for both girls and boys, with a larger increase of 14.8 percentage points for girls and 6.5 percentage points for boys. This represents over 20 percent increase in secondary school enrollment for girls and about 10 percent increase for boys (ibid).
- **Learning Outcomes:** The impact of increased enrolment on learning outcomes, however, is limited and inconclusive and thus their impact on improving human capital, which is one of the chief objectives for the introduction of CCT schemes, is also not clear. In Progresa, the results pertaining to educational achievement were termed as "dismaying" as they indicated that beneficiary students did not obtain better test scores as compared to non-beneficiary students. Similarly, the results for Brazil's Bolsa Familia indicated that "beneficiary children are almost four percentage points more likely than non-beneficiaries to fail at school" (Soares, et al, 2007).
- **Child Labour:** CCT schemes have been found to have a marked impact on reducing children's participation in the labour market. In Progresa, programme between 1997 and 1999-2000, when the evaluation was conducted by IFPRI, it was observed that labour force participation for boys declined between 15 to 25 percent, relative to the probability of participating prior to the programme. Lower incidence of child work due to Progresa was found to account for 65 to 82 percent of the increase in enrollment of boys in school (Skoufias, 2005). Similarly, in Bangladesh, the implementation of the Food for Education Programme was found to account for 25 percent increase in the enrollment of boys in school.
- **Health Check-Ups:** CCT schemes have been observed to promote more regular health check-ups among pregnant women and children in countries with good and functioning health infrastructure. In El Salvador, in 2005-07, health check-ups by children and mothers increased by 47 and 42 percent, respectively. Results have not been as encouraging in countries which are yet to sort out their supply-side problems. For example, in Paraguay where the Tekapora programme is in operation, results with respect to the updating of vaccination cards for children as well as the number of visits to health centres have been less than anticipated on account of supply-side problems (Soares, et al, 2008). In fact, it has been observed that the co-responsibilities in the health sector are more difficult to enforce than in the education sector on account of the

reluctance of poor households to change their attitudes towards preventive health care.

- **Food Security:** With respect to food security, the impact of CCT schemes is more encouraging with most programme evaluations indicating an increase in food acquisition. Its translation into better nutrition depends on several other factors including intra-household food distribution. Nonetheless, the relaxation of the budget constraint seems to have resulted in more favourable outcomes. In Brazil, where the functioning of the Bolsa Familia was evaluated from 1995-2004 by the Ministry of Health and Welfare found that 82.4 percent beneficiaries reported eating better and the prevalence of stunting in children was 29 percent lower compared to non Bolsa families. In Mexico, Progresa participants reported a 16 percent increase in mean growth rate per year (1 cm) for children who received treatment in critical 12-36 months age (Skoufias, 2005). In Colombia, it was observed that 12 month old boys grew 0.44 centimetres more than those who had not participated in the CCT programme.

c) Impact on Social Inclusion

An important benefit of CCT schemes is with respect to their ability to focus on marginalized regions as well as communities through the use of two stage procedure for selection.

- The programmes are empowering marginalized communities through their involvement in increased consumption of merit goods, its incentives for their immediate assistance as well as building long-term capital by adhering to its conditions. They have moved from being a paternalistic programme to emphasise a rights-based approach to development[16].
- CCT programmes have also been sensitive to gender dimensions and incorporated specific elements to make the programmes inclusive. Most programmes include women/mothers as the main participants/recipients of the cash in addition to providing higher cash incentives for the girl child. They have also aided women in having a greater role in decision-making, in improving self-confidence and in enabling them to participate more effectively in community meetings (Skoufias, 2005).

d) Impact on Governance – Implementation and Delivery Mechanisms

CCT schemes have enabled the forging of the much needed horizontal coordination and strengthening of synergies across government departments through inter-

16 For example, in Brazil, the managers of Bolsa Familia emphasize that education and health are basic rights of people and conditions encourage the poor to realize their rights.

institutional coordination[17]. The Bolsa Familia in Brazil promotes local synergies by linking the beneficiaries to housing, micro-credit, business development programmes, etc.

- These programmes have changed the way in which governments interact with people and have led to the emergence of an accountability relationship between providers and poor participants. The programmes mark a transition from a paternalistic approach to a partnership based on co–responsibilities specifying obligations of both parties. For example, in El Salvador and Paraguay where the participants sign an agreement specifying the obligations agreed upon, the programme has acted as a bridge between locals and the government.
- Monitoring and evaluation systems are being streamlined to be more effective due to the operationalization of CCT schemes as the initiation of these programmes requires that M&E systems are in place. Impact evaluation by external evaluators conducted in Mexico (Skoufias, 2005); Nicaragua (Maluccio & Flores, 2005), El Salvador (Britto, 2007),Colombia (Attansio et al, 2005), Paraguay (Soares, et al, 2008) have been used by the respective countries as useful tools for understanding programme gaps and devising improved strategies.
- Several countries have also developed specific tools to ensure that the most disadvantaged areas and households are benefited[18]. CCT schemes have resulted in special efforts being made to identify the most marginal regions, communities and households and focused attention on their plight.
- The use of modern electronic systems like debit cards (Brazil, Mexico and Argentina) or other ways of electronic management of cash used for transferring cash to the poor has fostered a result based culture promoting efficiency and transparency in incurring public expenditure. In Brazil, a website gives the details of payments made to beneficiaries by the municipalities and the information is publicly available. It is a marked departure from limited attention paid in the past in Latin American countries to issues of public accountability.

17 This feature is of particular interest in India where the lack of coordination between various line departments for successful implementation of programme had always been an issue. The oft repeated solution to this problem has been the adoption of a Mission approach bypassing the regular institutional architecture.

18 For example, a marginality index was developed for identifying most backward communities in Mexico. In Honduras the selection within poorer municipalities was done on the basis of stunting of Grade I children, and in Brazil the identification was done at the decentralized level by municipalities involving various stakeholders.

5. Constraints and Challenges of CCT Schemes

1. **Policy Dilemmas in Design:** The CCT schemes pose several policy dilemmas that need to be resolved. The dilemmas arise on account of the multiple objectives that the programmes set out to achieve.
    a. The transfer of benefits under CCT schemes is generally quite small. This is deliberate so as to ensure that they are sufficient disincentives to the creation of a dependency syndrome and participation in the labour market is not affected. This implies that the amount of transfers through any one scheme may be insufficient to enable households to cross the threshold of poverty.
    b. Another dilemma is regarding the timeframe. If the objective is to enhance human capital of the next generation, the duration of the programme must be long enough to enable this objective to be fulfilled. If the primary objective is enabling the poorer households to crossover the poverty line, then a shorter time horizon may suffice.
    c. CCT schemes are relatively expensive to implement and also make huge demands on human resources. At a time of the present financial crisis with declining GDP growth rates, it might be very difficult to find the necessary fiscal space to implement these programmes. This is, however, precisely the time when such programmes are most needed as they provide a direct transfer of cash to needy households and help generate/protect demand for merit goods and services.
    d. Another dilemma arises on account of the different age groups that the programmers seek to address. The South African example illustrates that in order for nutritional interventions to ensure results, the focus needs to be on children below age of two. If transition from primary to secondary education is the goal, the focus would shift to older children in primary education or even secondary education. What this highlights is that a clear hierarchy of goals needs to be established to ensure focus and results, which is not often the case. CCT schemes run the risk of raising expectations which may later be difficult to meet.
2. **Limited Impact:** The main limitation of the CCT schemes is that they assume that the easing of the demand constraint will lead to desirable outcomes with respect to human capital formulation. The evidence clearly shows that this is true only in areas where the supply-side constraints are not severe. For example, the assumption is that attendance in schools leads to better learning has been disproved in many countries. Similarly, the assumption is that better schooling will result in enhanced employment opportunities. Unless the macroeconomic environment is conducive to job creation, the enhanced human capabilities translating into higher earnings and therefore moving out of poverty may not materialize.

3. **Opportunity Costs Ignored:** Often the implementation of CCT schemes could mean resources are drawn away from other programmes which could benefit the social sectors more generally. For example, a CCT focusing on increasing school attendance may replace programmes that can directly improve instructional quality. What is not realized is that for CCT schemes to be successful, they need to be supplemented where required by supply-side programmes that improve the school environment and quality of education imparted in schools. Programmes to improve selection and training of teachers, instructional quality, facilities in schools would be necessary for the educational component of CCT schemes to bear results.
4. **Duration and Exit strategy:** One of the main constraints of CCT schemes is the short duration of three years that a beneficiary family is generally supposed to be in the programme. Given the minimal objectives of addressing short term poverty and enhancing human capabilities in the long-run, the programme duration is grossly inadequate to meet this challenge. The response to this constraint has differed across countries. In Colombia for instance, the three year limit has been effectively abandoned as long-term considerations of enhancing human capabilities acquired priority. In Paraguay the response was to initiate "complementary activities" so as to enable households to overcome poverty within three years. In most countries the exit strategy for households is not clearly articulated. In the absence of such strategies, the programme is likely to encourage a dependency syndrome on the part of beneficiaries.
5. **Capacity Constraints:** The initial CCT schemes were all initiated in countries with relatively well-developed infrastructure and capacity to implement such schemes. As the schemes began to be adopted by low-income countries, they have faced severe constraints of capacities — both financial as well as administrative. CCT schemes are complex in design and require administrative skills of a high order to design, implement and monitor the progress of schemes. The identification of beneficiaries is itself a complex task which is heavy in data requirements. Countries with poorly developed data gathering mechanisms are at a disadvantage in this respect. Similarly, the monitoring and evaluation requirements are also very demanding and unless the country has a well developed evaluation system already in place, it would be difficult to adhere to the needs of the scheme. Several countries which have introduced CCT schemes more recently (Paraguay and El Salvador) have adopted community identification and monitoring systems which could ease the constraint. Similarly, the use of information technology can also contribute towards better management. Both these alternatives, however, assume either the existence of requisite quantum and quality of social capital or the existence of technological prowess of the required nature in order to be able to comply with the needs of CCT schemes.

6. Social Transfers in India

Social transfers have a rich tradition in India with both the central as well as state governments implementing a range of measures broadly comprising socio-economic security since the initiation of planning in 1951[19]. More recently, a range of programmes have been initiated by both the central and state governments in an attempt to fulfil some of the commitments made under the Directive Principles of State Policy, the Fundamental Rights guaranteed under the Constitution of India and the commitments made to the international community on the Millennium Development Goals. These schemes cover both promotional economic security, such as the National Rural Employment Guarantee Scheme (NREGS), as well as protective social security such as pensions to the aged, widows and physically-challenged. The design and delivery mechanisms for the national schemes have been influenced to a great extent by the experience of welfare schemes in the pioneering states such as Kerala and Tamil Nadu in the case of pensions and Maharashtra in the case of the NREGS.

Interestingly, the provisions of some of the national schemes, that is, those relating to maternity benefits and the survival and education of the girl child resemble the provisions in the CCT schemes currently in vogue globally. The main difference is that the orientation in the Indian schemes is more towards the individual rather than the household which is the focus in CCT schemes.

We provide below a brief overview of select national and state level schemes that have similarities with CCT schemes implemented globally. Details of individual schemes are provided in Annexure III.

National Schemes

Dhanalakshmi, 2008: Marking a shift to a more integrated scheme that formally adopts the CCT approach, the Ministry of Women and Child Development, Government of India, launched a pilot in March 2008 called Dhanalakshmi or the Conditional Cash Transfer Scheme for Girl Child, with Insurance Cover. Cash transfers are provided under the scheme to the family of the girl child (preferably to the mother) on fulfilling the following conditions; birth registration of the girl child, progress of immunization, enrollment and retention in school. In addition, the girl child born on or after the cut-off date to be notified is entitled to an insurance cover/ maturity benefit to the tune of Rs.100,000 through the Life Insurance Corporation of India, provided she does not get married before attaining the age of 18 years. The scheme would be implemented in eleven blocks across seven States, Andhra Pradesh, Bihar, Chhattisgarh, Jharkhand, Orissa, Punjab and Uttar Pradesh.

19 For a detailed review of the concept of socio-economic security and its translation into schemes in the Indian context, see Prabhu, 2001.

Janani Suraksha Yojana (JSY), 2005: It was a revamped version of the National Maternity Benefit Scheme introduced under the National Social Assistance Programme in 1995. The scheme, implemented by the Ministry of Health and Family Welfare, Government of India, is aimed at reducing maternal and neo-natal mortality through institutional deliveries. A cash benefit of Rs.500 is provided for every live birth to a woman from poor households. An additional amount of Rs.100 in rural areas and Rs.200 in urban areas is provided to poor women if she delivers in an institution. In addition, some amount is provided as transport assistance in case the woman uses her own transport to reach the institution.

Balika Samridhi Yojana, 1997: This scheme is one of the older and more important schemes that was initially a centrally sponsored scheme and subsequently transferred to states. It is very close in concept and implementation to the CCT schemes. It aimed at creating an enabling environment for the girl child to be born and become an educated and healthy adult. The scheme was initiated in 1997 (and recast in 1999) by the Ministry of Women and Child Development, Government of India, and provides for periodic cash transfers to the girl child at various stages of her life beginning with birth when a post delivery grant of Rs.500 is given to the mother for a surviving girl child. This is followed with annual scholarships at various stages of their education up to Grade X[20]. The scholarship is available to the girl child as long as she is unmarried and attends school regularly, given the high prevalence child marriages in the country.

National Programme for Education of Girls at Elementary-Level under the Sarva Shiksha Abhiyan (SSA) 2003: In the sphere of education, the focus of cash transfers has been on enhancing enrollment and retention of the girl child. The major centrally sponsored scheme that focuses on universalizing elementary education, the SSA[21] implemented by the Ministry of Human Resource Development, Government of India, has components that provide for cash transfers to girl children subject to their meeting specific requirements. In 2003, as a component under the SSA, the National Programme for Education of Girls at Elementary-level was introduced for out-of-school girls who are over-age but not completed elementary schooling, working girls, girls from marginalized social groups and those with low attendance and low achievement levels. The scheme provides direct incentives like free books, uniforms, stationery. There is a cash transfer of Rs.150 per child per annum.

20 The scholarship amount is Rs.300 per annum for education in Grades I-III, Rs.400 and Rs.600 per annum for education in Grades IV and V, respectively, Rs.700/- per annum for Grade VIII and Rs.1,000/- per annum for Grades IX and X.

21 The SSA, in operation since 2000-01 focuses on universal enrollment, access, retention and achievement for children in the age group of six-to-14. The scheme seeks to enhance enrollment through the provision of services, some of which are free distribution of text books for primary and upper primary classes, curriculum and textbook development, recruitment of additional teachers, particularly women. The SSA is being implemented in partnership with state governments to cover the entire country and address the needs of 192 million children in each 1.1 million habitations.

Kasturba Gandhi Balika Vidyalay Scheme, 2004: Initiated by the Ministry of Human Resource Development, Government of India, and merged into the SSA in April 2007, the scheme is aimed at arresting the dropout rate of girls in secondary education and ensuring their retention up to age of 18. This supplements the scheme of cash transfers for elementary education mentioned above. There is provision of a one time cash transfer of Rs.3,000 deposited in the name of the girl child once the girl child is enrolled in class nine and is not married.

The plethora of specific beneficiary-oriented schemes is supplemented by numerous other large national schemes that are aimed at strengthening the quantum and quality of services supplied for enhancing attainments in social sectors. Some of the more important schemes include the Integrated Child Development Scheme that caters to the nutritional requirements of zero to six-year-old children, the Mid-Day Meal Scheme (STET) aimed at providing nutritious meals to children in primary schools and the pension scheme under the National Social Assistance Programme for people above 65. The more recently launched schemes like the Sarva Shiksha Abhiyan, the National Rural Health Mission (NRHM) and the Jawaharlal Nehru National Urban Renewal Mission (JNNURM) aim at improving supply of services in education, health and urban infrastructure sectors, respectively.

State-level Schemes

Several state governments have been implementing schemes to provide specific incentives to ensure universal enrollment and retention of girl children.

The most recent scheme on the lines of a CCT is the Ladli scheme of the Delhi government launched in 2008. The scheme is aimed at curbing female foeticide and enhancing the social status of the girl child through promoting their education and protecting them from discrimination and deprivation. The government would deposit Rs.10,000 in the name of girl child at the time of her birth and subsequently deposit an amount of Rs.5,000 each at the time of her admission to Grade I, Grade VI, Grade IX, Grade X and XII. An accumulated amount of approximately Rs.100,000 would become payable to the girl child on attaining the age of 18-years and passing out of the Grade X. The amount could be utilized for her higher studies or marriage. The eligibility condition under this is that the applicant would have to be a bona fide resident of Delhi for at least three years preceding the date of application and the annual income of the parents of the girl child should not exceed Rs.100,000.

Southern Indian states of Kerala and Tamil Nadu have been pioneers in implementing several social transfer schemes. Kerala pioneered the implementation of pension schemes which were initiated as early as in 1960 and cover not only the elderly but also widows, the destitute, agricultural workers and various other categories of informal sector workers. Tamil Nadu pioneered the MDMS, under which free textbooks, uniforms and nutritional support are provided on a massive scale. Pensions

to the elderly, destitute women and other vulnerable groups have also been a long-standing feature of social protection schemes in Tamil Nadu. In Karnataka, a gamut of schemes such as Vidya Vikas programme and Akshara Doshala aim at ensuring universal enrollment through providing children in elementary schools with free textbooks and uniforms as part of the MDMS. In West Bengal, Shishu Shiksha Karmasuchi was introduced by the Government of West Bengal in 1997 to provide education to five to nine-year-old children who are unable to enrol due to difficult access to schools.

All these schemes have focused on providing free services in terms of access to schools, textbooks, stationery, etc. In the health sector too there is a plethora of schemes being implemented by state governments; many of them include cash transfers. For example, in Gujarat under Chiranjivi Yojana, a scheme introduced to contract out private providers for delivery care and management of obstetric complications, cash incentives provided for the purpose. In Haryana, a couple aged 60-years with only one girl child is being given a pension of Rs.300 per month in addition to an amount of Rs.500 per month to the girl child under the Ladli scheme.

7. Issues in the Indian Context

The detailed review indicates that both the national and state governments are increasingly adopting either explicitly or implicitly CCT-like approaches, with the programmes initiated in the last couple of years actually adopting the CCT methodology of imposing conditions for receiving cash transfers. The schemes thus far have focused mainly on expectant mothers and on survival and education of girl children.

There is a wide range of national schemes mentioned above that aim at improving the facilities and quality of existing social infrastructure. An elaborate administrative structure implements the schemes. Some of the schemes such as NREGS have successfully involved the Panchayats and local community in social audits in locations where the conditions were more conducive to such an exercise. Use of bank accounts and post offices has also become more common for transfer of cash in a bid to reduce leakages.

While several initiatives have been undertaken to boost the supply of social services, there is not much evidence of steps to stimulate and, in the current macroeconomic context, protect demand. To expect a general rise in incomes to lead to enhanced demand for services is not only time-consuming but also assumes the adoption of more broad-based development strategies. The existing literature has shown that cash incentives are effective in generating demand in countries where the demand constraint is severe. As the review of Indian schemes shows, several national and state schemes are already adopting cash incentives to induce behavioural change.

CCT schemes could be considered as part of wider social policy which aims to enhance the capabilities of households.

The introduction of CCT schemes however, implies a formidable capacity development challenge. The government has greater familiarity in delivering physical goods and services to enhance well-being and there has been considerable evolutionary learning in doing so. The limited success of large centrally-administered national programmes for poverty reduction in the 1980s has led to more flexible schemes implemented at a lower-level of government with greater participatory and political oversight. Flagship centrally sponsored schemes like NREGS and SSA , are increasingly, financed and macro-monitored centrally but micro-monitored locally. Hence there is improved capacity for coordinating central finance and local delivery — however, there is very little experiential learning on providing and monitoring income transfers closer to the point of impact. Financing, whether of national programmes or of subsidies, continues to be highly centralized. This represents a formidable capacity challenge for CCT design, and an area where all levels of government could use technical assistance and benefit from international learning.

Targeting the urban poor — an area where CCT schemes have internationally proven to be very effective — is another issue in India given the dismantling of the PDS and the limited experience of urban local bodies (compared with their rural counterparts) in administering the delivery of national schemes.

Further, existing schemes initiated thus far are generally confined to the realms that are the mandate of an individual ministry; schemes have not yet been devised on a sufficient scale or range to transcend departmental/ministerial boundaries. With increasing realization that the attainment of the national and international development goals depends on convergence of line ministries, the CCT schemes may serve as a useful tool in forging this. There is also not much evidence of improved monitoring and evaluation systems being in place for the new generation CCT-like schemes.

It may now be useful to debate more seriously on the role of such schemes as an element of wider social policy in addressing the multiple deprivations in human development that the poor face and examine their feasibility on a more systematic basis.

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Annexures

Annexure I: CCT Schemes in Select Countries

BRAZIL – Bolsa Familia (2003)

Genesis:

- Bolsa Familia programme started in 2003 with merger of existing conditional and unconditional cash transfer schemes.
- It unified four major programmes: Bolsa Escola, a minimum income grant to primary education; Fome Zero and Bolsa Alimentaco, two income grants related to food security; and Vale Gas, a subsidy scheme for buying cooking gas.

Objectives:

- To alleviate the income deprivation of poor households.
- To break the intergenerational transmission of poverty.

Population in 2008	**196 million**
Percentage urban population	**84**
GDP (2008)	**USD1.314 trillion**
HDI (2005) Rank	**70/177**
Value	**0.80**
Source	**World Fact Book**

Features:

Participants	• Extremely poor households • Households with pregnant or lactating women and children/adolescent up to 15-years of age • Eligibility threshold -- R$60(USD33) per capita for extremely poor and R$120 (USD66) per capita for poor household
Type of conditions	• 85 percent attendance for six to 15-years-old children • Regular health check-up, Immunization for up to six-year-old children and for pregnant women
Amount	• Max transfer for extremely poor household is R$112 (USD61) • For poor household R$54 (USD30)
Periodicity	• Monthly
Coverage	• Urban: 11 million (19 percent of population or 44 million Brazilians per year)
Implementing Agency	• The Ministry of Social Development and Eradication Against Hunger • 5,565 Brazilian municipalities
Sectors and Beneficiaries	• Education of children (six to 15-year-old) • Health of pregnant and lactating mothers, and \up to six-year-old children
Selection Process (Decentralised mechanism)	• Coverage through estimation of poor families according to national socio-economic data (poverty line estimated by the Institute de Pesquisa Economica Aplicada (IPEA), 2004 • Targeting is the responsibility of municipal government which varied locally. In some places the identification of beneficiaries was carried out by schools Some municipalities implemented geographical targeting and others implemented self targeting • Enrollment of beneficiaries through national register system
Transfer of cash	• To female head of households through 'Citizen Cards' • The card was issued by Caixa Economica Federal, a government-owned saving bank with 14,000 outlets

Monitoring and Evaluation	• Money transfer through card system, therefore, corruption reduced • Name of every person enlisted in programme and amount given can be found online at Portal da Transparencia, a website
Impact (2004-2007)	Brazilian Gini Index fell by 4.7 percent between1995-2004. A 21 percent fall due to Bolsa Familia • Positive effect on school attendance and decreasing dropout rates Probability of dropping out was 1.6 percent lower and probability of absence was 3.6 percent lower in children under the programme as compared to others • Labour force participation rate of treated adults was 2.6 percent higher than non-treated ones -- the participation rate of beneficiary women was 4.3 percent
Fiscal	• Annual Investment USD3.9 billion • 91percent fund from Brazilian Federal funds for alleviation of poverty and other Brazilian funds • USD 350 million loan from World Bank in 2005 • 0.4 percent of Brazilian GDP in 2007 • 2.5 percent of total government expenditure

COLOMBIA – Familias en Acción (2000)

Genesis:

- In 2000, the Government of Colombia launched a CCT-based programme called Programma Familias en Accion for providing nutrition and education subsidy to children.
- Under this, each beneficiary receives a cash transfer based on the condition that their school age children attend school regularly and their younger children attend regular health visits

Objectives:

- To increase the human capital investment among extremely poor families and serve as a safety net.
- To reduce school dropout and low attendance of children in primary and secondary school.
- To augment the income of families in extreme poverty with children under the age of seven and increase expenditure on food.
- To focus attention on the health of children under seven and to promote healthier practices in health, nutrition care and prevention of domestic violence.

Population in 2008	**145 million**
Percentage urban population	**73**
GDP (2007)	**USD171.6 billion**
HDI (2005) Rank	**75/177**
Value	**0.791**
Source	**World Fact Book**

Features:

Participants	• Families in extreme poverty (poorest 20 percent of population) • Poor households with seven to 18-years-old children years enrolled in school • Poor households with zero to six-years-old children not participating in health programmes • Only municipalities which can guarantee adequate social services were eligible to participate in the programme

Type of conditions	• Education: At least 80 percent school attendance in a two month cycle • Health: Regular health visits for child's health and development monitoring
Amount	• Education: Primary school USD8/child/month, secondary school USD16/ child/ month • Health: USD15 per family per month
Periodicity	• Bimonthly
Coverage	• 58 percent of municipalities and 84 percent of departments • 4.6 percent of total population (2005)
Implementing Agency	• National Coordination Unit in cooperation with Regional Coordination Units and Municipal Liaison Offices • Housed in the Ministry of Health and Family Welfare
Sectors and Beneficiaries	• Health and education of children
Selection Process (initially centralized now decentralizing)	• Geographic targeting of municipalities, then proxy-means targeting using the SISBEN (Beneficiary Selection System for Social programmes used in Colombia) indicator • Household were targeted if ranked by SISBEN as Level 1 and had at least one family member below 18-years of age • Within these households all children from birth to six-years of age were targeted for nutrition transfer and all children aged seven to 18-years were targeted for education grants • 90 percent of eligible households registered for the programme
Transfer of cash	• Cash transfer to mother
Monitoring and Evaluation	• Internal monitoring (assessing the physical and financial progress of programme) • External sample monitoring through spot checks (provision of transfers on the field) • Social Control (Supervision of beneficiary community) • External Impact Evaluation
Impact (2002-2005)	• Increased total food consumption in both rural (19 percent) and urban (nine percent) • 13 percent increase in enrollment rates of 14 to 17-year-old children in urban and 5.5 percent in rural areas • Significant increase in consumption of proteins, cereals, fats and oils, fruits and vegetables • Mean height for age significantly decreased (0.2 z scores) in children aged zero-24 months
Fiscal	• Annual Investment USD336 million • Funding: USD150 million loan from WB,USD106 million from national government • Administrative cost USD5 million - 0.1 percent of GDP (2005)

EL SALVADOR – Red Solidaria (2005)

Genesis:

- President Saca Government Plan (2004-09) envisaged creation of social safety net for El Salvadors' most vulnerable population.
- The programme envisaged assistance to poor families, through short-term improvements in child and maternal health and nutrition, basic education as well as improvements in the supply of drinking water, sanitation, electricity and roads to poorest rural communities.
- Family solidarity network, network of basic services and family sustainability network were the tools to broaden opportunities for the disadvantaged.

Objectives:

- To improve health and nutrition for population ages zero to five-years-old.
- To improve education of the school age population six to 14-years-old.
- To improve conditions amongst extremely poor mothers.
- To provide appropriate tools that allow for financial sustainability of the household through productive work-related training and micro-credit.

Population in 2008	**7 million**
Percentage urban population	**60**
GDP (2007)	**USD20.37 billion**
HDI (2005) Rank	**103/177**
Value	**0.735**
Source	**World Fact Book**

Features:

Participants	• Extremely poor with children under age of 15-years or with pregnant women
Type of conditions	• Family agreement has to be signed as a co-responsible person, compliance with the basic protocol concerning preventive health • Register family in health programme, ensure check-up of child and mothers • To attend family training sessions • School enrollment and attendance of five to 14-year-old children • Use transfers provided under programme on food consumption
Amount	• Health stipend USD15/month for families with pregnant women and children below five-years • Education stipend USD15/month for families with children from five to 15-years-old who have not completed Grade VI • If a family is entitled to both it would receive only USD20/month
Periodicity	• Bimonthly
Coverage	• Rural as well as urban municipalities • 2004-2009 goal – 1,00,000 extremely poor • 2010-2015 goal – 220,000 households
Implementing Agency	• Coordination of the social area at the president's office • Social investments fund for local development of El Salvador (FISDL) • Sectoral ministries
Sectors and Beneficiaries	• Health and education of children • Health of women • Geographical targeting to rank municipalities according to their poverty level • 100 municipalities ranked as very high extreme poverty (32 municipalities) and high extreme (68) poverty were targeted

Selection Process	• Geographical targeting to rank municipalities according to their poor in low income areas • 100 municipalities ranked as very high extreme poverty (32 municipalities) and high extreme poverty (68 municipalities) were targeted
Transfer of cash	• Sub-contracted to banking institution which organizes the logistics of payments including transfer of funds, maintaining security and providing cashiers • Local coordination is important in the organization of the event • Payment schedule is set up and beneficiaries are lined up according to schedule and exact placement
Monitoring and Evaluation	• The Social Investment Fund for Local Development (FIDSL) is the implementing agency whose technical and political coordination falls under the technical Secretariat of Presidency and a Directive Council • Technical coordination is the responsibility of Executive Directorate which coordinated with FIDSL • At local-level representatives of FIDSL, mayor – a municipal liaison and an NGO coordinator forms the focal point • NGOs are in-charge of monthly monitoring and are the link between beneficiaries and programmes
Impact (2005-2007)	• Enrollment increased by 23 percent in pre school — six percent in Grade I to III and nine percent in Grades III and VI • Children health check-up increased by 47 percent • Maternal health check-up increased by 42 percent
Fiscal	• Annual budget: USD150-200 million, approximately USD50 million per year (for transfer payments and measures to improve provision of basic services and productive programmes) • Government funding; contributory loan of IDB USD57 million and USD21 million

HONDURAS – Program de Asignación Familiar (PRAF-II (1999)

Genesis:

- In 1990 Program de Asignación Familiar (PRAF) was launched to mitigate the social effects of structural adjustment. It distributed money vouchers to vulnerable groups.
- In 1999 PRAF-II was started in order to overcome the failures of PRAF, i.e., poor targets, leakage of benefits and incapacity of programme impact on fighting poverty.

Objectives:

- To strengthen the human capital of poorest community by offering health and education services, training mothers in better nutritional and hygienic practices and ensuring a cash transfer to improve nutritional intake.
- To increase the performance in mathematics and language of children enrolled in Grades I to IV.

Population in 2008	**7.6 million**
Percentage urban population	**46.5**
GDP (2008)	**USD12.28 billion**
HDI (2005) Rank	**115/177**
Value	**0.70**
Source	**World Fact Book**

Features:

Participants	• Pregnant and nursing mothers, children age three and younger, six to 12-year-olds who are extremely poor and have not finished Grade IV
Type of conditions	• Families were limited to two subsidies per household, i.e., for two children • Five antenatal checkups, perinatal check-up within 10 days of delivery and monthly GMP and health check-up for young children • Children not missing more than 20 days of school per year and not repeating a grade more than once
Amount	• Education: Educational voucher -- L$828 (USD58) per child per year; average supply incentive: L$57,940 (USD4,000)/school/year • Health: Health voucher -- L$660 (USD46.3) per family per year; average supply incentive: L$87,315 (USD 6,020)/facility/year
Periodicity	• Semi annually
Coverage	• Urban • 70 municipalities with total population of 660,000
Implementing Agency	• Ministry of Public Health, Ministry of the Presidency of Hondura
Sectors and Beneficiaries	• Health and nutrition of all members of poor households • Education of children
Selection Process (Centralised)	• Targeting was done geographically by ranking municipalities by average rates of stunting observed in 1997 National Census of height of first graders • 70 municipalities were randomly assigned in four groups in ratio 2:1:2:2 • Four groups were household level package only, service level package only, both packages and standard services
Transfer of cash	• Private national bank -- BANHCAFE -- had 39 offices in local area • On day of cash transfer PRAF employees and bank reconciled the figure on transferred amounts. Bank employees help beneficiaries by providing transport services and food
Monitoring and Evaluation	• Through regional community offices linked to the programme who identified the accreditation of beneficiaries through forms processed through an electronic optical reader • Indicators collected included school attendance and enrollment, health centre attendance and institutional birth delivery
Impact (1999-2003)	• 17 percent increase in school enrollment, 4.3 - 4.6 percent increase in attendance • 15-21 percent increase of children's visit to health centres • Health check ups increased by 17 and 22 percent points • 4-7 percent increase in the number of children with vaccination cards • 18-20 percent increase in number of pregnant women that received five or more prenatal check-ups. Post natal check-up did not rise significantly • Birth rates were two-four percent higher in PRAF families compared to control groups. Receipt of transfer encouraged couples to speed up conception/ pregnancies
Fiscal	• USD45.2 million loan from IDB and USD5.1 million from the Government of Honduras • USD10 million (0.2 percent of GDP) 2006 • 49 percent of project budget on targeting and supply-side services

MEXICO – Oportunidades (2002)

Genesis:

- In 1996 a national census was taken to launch Progresa. In 1997 first phase was launched and reached 140,000 household. By 2000 it reached 2.6 million households in all 31 states. In 2002, the name was changed to Oportunidades
- Progresa which was based on the result of a successful pilot project (1995) which was launched in three cities using the database of two existing subsidy based programmes with multi-sectoral focus. That were experimental in nature and provided excellent material for evaluation.

Objectives:

- To improve the health and nutritional status of all members of poor households especially mothers and children.
- To ameliorate school enrollment, attendance and educational performance.

Population in 2008	**109 million**
Percentage urban population	**76**
GDP (2008)	**USD893.4 trillion**
HDI (2005) Rank	**52/177**
Value	**0.82**
Source	**World Fact Book**

Features:

Participants	• Poor families with zero-18-years-old children
Type of conditions	• Every family member to receive preventive health services • Five pre-natal check ups for pregnant women • Two health check-ups in a year for lactating mothers • Visits to health clinics for children less than five, once in two months • All adult household members required to participate in health related meetings • School enrollment and minimum attendance rate of 85 percent, both monthly and annually of children between eight to 18-years
Amount	• Education: primary: Varies by grade USD8-17/child/month + USD11/year/child for school materials; secondary: varies by grade and gender USD25-32/child/month + USD20 /year /child for school materials • Health: USD13 per household per month (1999) and an allowance for older adults in the household
Periodicity	• Bimonthly
Coverage	• Started with highly marginal rural communities and then expanded to rural and urban areas throughout the country • Five million households (2006)
Implementing Agency	• Secretariat for Social Development
Sectors and Beneficiaries	• Health and nutrition of all members of poor household • Education of children
Selection Process (Centralised)	• Communities were first selected using a marginality index based on census data • Within selected communities households are chosen using socio economic data collected for all households in the community • Eligible households were informed using door-to-door methods

Transfer of cash	• Transfer was received through an electronic card which is given to mother. It was made through Progresa office which were outside normal bureaucracy • Disbursements were made by banks and telegraph offices
Monitoring and Evaluation	• Through Scheme of Guardian (Centinela) Monitoring points • Baseline data collected using random sampling of eligible households with children under five-years in 1998 and 1999 • Evaluation of nutritional impact was conducted in a random selection of 202 from 302 communities scheduled to enrol in the programme at the end of 1998 and 142 randomly selected from 185 communities enrolled a year later
Impact (1998-2000)	• Increase in secondary enrollment between 70-78 percent • Average household consumption and nutrition was higher by 13 percent • Labour force participation for boys was reduced by15-25 percent (Briere and Rawlings 2006, Social protection, World Bank, page 10) • Increase in number of first visits in first trimester of pregnancy by eight percent • 16 percent increase in mean growth rate per year (one cm) for children who received treatment under Progresa in critical 12-36 months age
Fiscal	• Annual Investment USD1.8 billion (2002) • Complete funding by the Government of Mexico • 0.66 percent of GDP (year 2005) • 10.6 pesos of administrative costs for every 100 peso

NICARAGUA – Red de Protection Social (RPS) (2000)

Genesis:

- Based on the success of Progresa in Mexico, Red de Protection Social (RPS) was launched in Nicaragua in 2000. The pilot phase supported by the Inter American Development Bank (IADB) loan lasted for three years and had a budget of USD11 million, representing 0.2 percent of the GDP.
- In 2002, the government and the IADB gave three year extension with a budget of USD 22 million.

Objectives:

The overall objective is to promote human capital accumulation among households living in extreme poverty. Specific objectives are:

- To supplement household to increase expenditure on food.
- To reduce dropout rates during the first four years of primary school and to improve the healthcare and nutritional status of children under age five.

Population in 2008	**5 million**
Percentage urban population	**58**
GDP (2008)	**USD5.723 billion**
HDI (2005) Rank	**120/177**
Value	**(0.69)**
Source	**World Fact Book**

Features:

Participants	• Poor six to 13-years-old children enrolled in primary school Grades I to IV • Poor households and children under five years • Adolescents 10-19 years • Women 20-49 (potential mothers)

Type of conditions	• Education: School enrollment; less than six days of unexcused school absence in a two-month period school; and school grade promotion • Health: Regular health care visits for child's growth monitoring; up-to-date vaccinations; and attendance of health and nutrition training
Amount	• Education: USD17 every two months per family, school material support USD20 per child per year, supply incentive of USD0.7 per student every two months • Health: USD34 per family every two months. Mineral and vitamin supplements
Periodicity	• Bimonthly
Coverage	• 30,000 households (2006)
Implementing Agency	• Ministry of Family Welfare
Sectors and Beneficiaries	• Rural as well as urban municipalities
Selection Process	• Geographic: Marginality Index score calculated for all Comarcas (administrative areas within a municipality, typically including between one and five communities averaging 100 households each) • The index was created based on average family size, the percentage of household without piped water at home, the proportion without a latrine, and the level of literacy • In chosen areas all resident households were eligible for benefits. For health and nutrition children between ages of birth and nine years, adolescents aged 10-19 yrs and women aged 20-49 (potential mothers) were included
Transfer of cash	• M&E system was designed. A base line study was conducted and evaluation was conducted comparing indicators before and after intervention in both treatment and control communities
Monitoring and Evaluation	• Through Scheme of Guardian (Centinela) Monitoring points • Baseline data collected using random sampling of eligible households with children under five-years in 1998 and 1999 • Evaluation of nutritional impact was conducted in a random selection of 202 from 302 communities scheduled to enrol in the programme at the end of 1998 and 142 randomly selected from 185 communities enrolled a year later
Impact (2000-2002)	• Programme supplemented per capita annual total expenditures by about 18 percent • Average increase of USD41 per capita in annual food expenditure and improvement in diet of beneficiary • Decline in percentage of stunting from 42 to 37 among children aged six to 59-months • Percentage of working children age seven to 13-years in Grade I decreased by 4.9 • Decrease in school dropouts from seven to two percent • Increase in school enrollment of 13 percent and larger effect of 20 percent on current attendance for target • Children in Grade I to IV who advanced two grades between 2000-02 increased by 7.3 percent • Average net increase of 16 percent in participation of children below three-years in vaccination programme in health care programmes
Fiscal	• 31 percent of budget was devoted to targeting and supply side interventions • Cost transfer ratio was 0.212, i.e., 79 cents for the recipient • USD3.7 million (0.7 percent of GDP) for phase I (10,000 households)

PARAGUAY – Tekopora (2005)

Genesis:

- The government of Paraguay signed the Millennium Declaration in 2000 and took the decision to support the design of a National Strategy for Fighting Poverty that would encompass a set of actions and programmes in the social sector but would also have a focus on poverty reduction.
- An international conference was held on July 2004 where National Strategy for Fighting Poverty and discussion on various CCT schemes in Latin America was held.
- Tekopora programme was started in 2005.

Objectives:

- To contribute to reduction in extreme poverty and increase of human and social capital of beneficiary families.
- To increase expenditure on food items.
- To increase expenditure on inputs required to maintain an adequate level of nutrition for children and ensuring school attendance.

Population in 2008	**6.8 million**
Percentage urban population	**58**
GDP (2007)	**USD10.87 billion**
HDI (2005) Rank	**95 /177**
Value	**0.755**
Source	**World Fact Book**

Features:

Participants	• Families with children aged zero-14 and pregnant women in extreme poverty
Type of conditions	• Education: Attendance of educational centres (early stimulation) for children 25-60 months, attendance of basic schooling for children five to 14-years • Health: Visits to health centre for growth/development monitoring for children zero to 24 months, for growth monitoring for children 25-60 months, and for medical check-ups and preventative dental care for children five to 14-years. Visits to health centre for pregnancy check-ups and post-partum control for pregnant and lactating women
Amount	• Food bonus: USD10 per child • Health and education bonus: USD5 per child aged zero to 14-years-old, up to four children per household. Minimum amount: USD15 (family with one child); maximum amount: USD30 (family with four or more children)
Periodicity	• Bimonthly
Coverage	• Goal : 162,600 households by 2008
Implementing Agency	• Social Action Secretariat under the President's Office
Sectors and Beneficiaries	• Health and education of children • Health of women
Selection Process (Centralised system with co-responsibilities of communities)	• Geographical targeting based on Indice de Priorización Georgráfica – the Geographical Prioritization Index (IPG) • Each district would enter the programme according to its ranking by IPG and number of household to be selected in the district would be given by the estimated proportion of the extremely poor • IPG combines both monetary and non-monetary indicators as estimated by unsatisfied basic needs • A multi dimensional index was used to prepare a list of potential beneficiaries*

Transfer of cash	• Mobile units with cashiers of a state bank – Banco Nacional de Fomento – which go to programme districts on various dates
Monitoring and Evaluation	• Coordination between national implementation agency which would generate lists of beneficiaries by school and health posts and department units for further distribution among corresponding school and health posts • Unit sends bimonthly report to national agency • Participation of local family guides as a link between beneficiaries and institutional authorities is introduced for participatory monitoring and evaluation • Madries lideres, the Tekopara leaders from community, is elected by women who function as liaison officers within the programme. They receive no monetary benefits and provide assistance to family guides
Impact (2005-2007)	• Positive impact on vaccination for moderately poor, treated children was 10-15 percent higher • School attendance and grade progression were higher for boys; six to 11 percent and five to 10 percent, respectively • Per capita consumption was higher for extremely poor 13-21 percent • Beneficiaries in rural areas have an eight to 10 percent point higher access to credit than non-beneficiaries • Among extremely poor social participation increase by seven to nine percent
Fiscal	• Annual budget: USD1.7 million for fiscal year 2006 • Funding: Until 2006 complete financing by country budget but scaling up will be financed by the IADB

Note: Multi-Dimensional Index or Quality of life index combines several sub indices:

- Access to services: water, electricity, fuel to cook, rubbish collection
- Health: health insurance, health care for sick or injured (past three months), children vaccination status
- Education: Language spoken at home, household head education level, spouse education level, years of schooling lost by children aged six to 24-years
- Occupation: Household head occupation
- Housing Condition: Crowding, ceiling, wall and floor material, separate toilet and sanitation
- Possession of durable goods – ACs, heater, truck, refrigerator and washing machine
- Number of zero to 15-year-old children

SOUTH AFRICA – Child Support Grant (1998)

Genesis:

- In 1995 the new democratic government of South Africa established a committee to evaluate the existing system of state support and to explore new alternative policy options targeting children and families.
- In April 1998, the cabinet approved the implementation of the National Cash Transfer Programme called Child Support Grant (CSG).

Objectives:

- To contribute to the cost of raising children in very poor households.
- A child-focused benefit emphasizing on children and their means of support, it had the motto "follow the child".

Population in 2008	**48.7 million**
Percentage urban population	**57**
GDP (2007)	**USD282.6 billion**
HDI (2005) Rank	**121/177**
Value	**0.674**
Source	**World Fact Book**

Features:

Participants	• Poorest 30 percent of children one care giver could get six CSG
Type of conditions	• No conditions
Amount	• Amount of grant was roughly 15 - 20 percent of participants household income
Implementing Agency	• Federal government of South Africa • Department of Social Welfare
Sectors and Beneficiaries	• Health, nutrition and education • All children of household below 14-years of age • District welfare officers received applications from participants which was entered in central database
Selection Process	• When applying at district welfare offices the primary care givers declare their monthly income. There were penalties for not disclosing full household income • Household: means testing. In urban areas <USD127/year in rural areas <USD 174/year
Transfer of cash	• Grant is paid to the adult and also the "primary care giver" usually a woman • Beneficiaries accessed their payments through separate pay centres — either post offices, banks or private contractors providing cash payments
Monitoring and Evaluation	• M&E system was not put in place and the scheme was introduced without randomized control trials or baseline surveys
Impact (1993-2004)	• CSG payments have bolstered early childhood nutrition as signalled by child height for age • 26 percent of children were reportedly attending some form of preschool or crèche. Attendance was higher among CSG beneficiaries

BANGLADESH – Food for Education (1993)

Genesis:

- The Food For Education (FFE) scheme was originally launched on a large-scale pilot basis.
- Instead of cash, food is transferred to needy families on a monthly basis.

Objectives:

- Overall it intended to foster the accumulation of human capital among poor families by providing monthly free rice and wheat rations to poor households to encourage children to attend schools.

Population in 2008	**153 million**
Percentage urban population	**25**
GDP (2007)	**USD72.42 million**
HDI (2005) Rank	**140 /177**
Value	**0.547**
Source	**World Fact Book**

Features:

Participants	• Poor households with focus on children
Type of conditions	• 85 percent of attendance maintenance by students

Amount	• Monthly transfer were equal to amount a child would eat in two to 4.5 days
Periodicity	• Monthly
Coverage	• 27 percent of all primary schools (2000) • 5.2 million children enrolled in FFE schools - 2.1 million students received FFE food grains (2000)
Implementing Agency	• Public Food Distribution System (PFDS), Government of Bangladesh
Sectors and Beneficiaries	• Nutrition and education
Selection Process	Two step method: • First areas that were economically backward and had low literacy rates were selected • Secondly, poor households with primary school age children through indicator based targeting criteria were selected
Transfer of cash	• No cash transfer, only provision of grains • School head teacher prepared a list of students who met the attendance requirement in previous month, and sent the list to program administrators for food allocation • Till 1998 a school management lifted food from local PFDS warehouse, carried it to the school premise once a month on a designated day • In 1999, the government gave the food distribution responsibility to private grain dealers
Monitoring and Evaluation	• Random inspection of schools verified attendance • Overall monitoring and management done at school level
Impact (1992-1996)	• Overall attendance is 70 percent in FFE and 58 percent in non FFE • For ages six to 10-years, enrolment increased from 70 to 73 percent for girls and 53 to 70 percent for boys • Negative impact on test scores of students in FFE who did not receive benefit—through peer effects rather than through classroom crowding effects • In 2002, the government replaced the FFE with the Primary Education Stipend scheme
Fiscal	• Annual cost: USD77 million (2000), accounting for 1.5 percent of total government expenditures • Cost per beneficiary student was about USD37/year • Funding by the Government of Bangladesh

Annexure II: Quality of Life Index Used for Targeting in Tekapora Porgramme in Paraguay

Sub Indices:

(1) Access to services: Water, electricity, fuel to cook, rubbish collection, and telephone.

(2) Health: Health insurance, healthcare for the sick or injured in past three months, and children's vaccination status.

3) Education-level: Years of schooling 'lost' by the children aged six to 24-years.

(4) Occupation: The occupation of the household's head.

(5) Housing condition: Crowding, ceiling, wall and floor material, separate toilet, and sanitation.

(6) Possession of durable goods: Air-conditioner, heater, truck, cars, refrigerator and washing machine.

(7) Number of children aged zero to 15-years-old: Data from 2001 Household Survey, separately for rural and urban areas.

Households were divided into four categories based on scores on the Quality of Life Index. Those households with a score of 25 or less on the index were the extreme poor. Since the number of targeted poor was not met by the inclusion of only the extreme poor, those belonging to the next category of moderately poor with a score of 25-40 points were also included in the programme.

Annexure III: Select Programmes of Education, Health & Nutrition In India

S. No.	Name of Programme	Objectives	Services provided	Eligibility	Conditions
1.	Integrated Child Development Scheme (1975)	■ Holistic development of children up to the age of six years. ■ Healthcare for expectant and nursing mothers.	■ Health check-up, immunization, referral services, supplementary feeding, non-formal pre-school education and advice on health and nutrition.	■ Pregnant and lactating mothers. ■ Children (zero to six-years-old).	No
2.	Mid Day Meal Scheme (1995)	■ For universalization of primary education by increasing school enrollment, retention and attendance.	■ Provision of nutritional support to children.	■ All children in primary school. ■ Low income group in rural as well as urban areas.	No
3.	Sarva Shiksha Abhiyan (2000)	■ Universalization of elementary education. ■ Universal access, enrollment, retention, through provision of various services like infrastructure, text materials, etc. ■ Special focus for girls, children belonging to SC/ST.	■ Free distribution of text books for primary and upper primary schools, computer-aided learning, etc. ■ Recruitment of additional teachers especially female.	■ All children in the age group of six to 14-years.	No

4.	Kasturba Gandhi Balika Vidyalaya Scheme (2004)	■ To reduce dropout and to promote the enrollment of girl child in secondary schools and ensure their retention till they reach 18-years.	■ Provision of residential schools at upper primary level for girls predominantly belonging to SC/ST,OBC and minorities. ■ Rs.3,000 as one time deposit (announced in 2006 budget speech).	■ All girls belonging to ST/SC who pass Grade VIII and girls who pass Grade VIII examination from Kasturba Gandhi Balika Vidyalayas and enroll for Grade IX in government-aided or local body schools in the academic year 2008-09 onwards.	Girl is to be unmarried for availing benefits.
5.	National Maternity Benefit Scheme renamed Janani Suraksha Yojana (2005)	■ To reduce maternal and neonatal mortality. ■ To promote institutional delivery.	Assistance package to mother and the ASHA: i) In low-performing states: Rs.700/Rs.600 in rural / urban areas. Rs.600/Rs.200 in rural/urban areas. ii) In high-performing states: Assistance package of Rs.700 to mother both in rural/urban areas.	■ BPL family. ■ Pregnant mothers (19 and above) who deliveries in an institution.	Institutional delivery.
6.	Jawaharlal Nehru Urban Renewal Mission (JNURRM) 2005	■ To encourage cities to initiate steps to enhance existing services in financially sustainable manner. ■ It includes mainly two missions -- urban infrastructure and governance, and provision of basic services to urban poor.	■ Security of tenure at affordable prices. ■ Improved housing and water supply, sanitation, delivery of other existing universal services of government for education, health and social security.	■ 12 percent of housing cost to be borne by the beneficiary. ■ In case people belonging to SC/ST/OBC/PH groups the amount will be 10 percent of housing cost.	No

7.	National Rural Health Mission (NRHM) 2005	■ It aims to provide accessible, affordable and accountable quality health services to the poor and vulnerable section of population. ■ To bridge the gap in rural health care through creation of a cadre of accredited social health activists (ASHA) in each village and improvement in hospital care, decentralization of programme to district-level to improve intra- and inter-sectoral convergence, and effective utilization of health resources. ■ The Mission is expected to achieve the goals set under the National Health Policy and the MDGs.	■ Promoting access to services through ASHA. ■ Strengthening existing health infrastructure like PHC,CHS and provide 30-50 bed CHC per 100,000 population. ■ Inter-sectoral District Plans. ■ Develop capacities for preventive healthcare at all level for promoting healthy lifestyles, reduction in consumption of tobacco, alcohol, etc.	■ Rural population. ■ Coverage is 18 states.	No
8.	Dhanalakshmi (2008) Pilot CCT scheme introduced in March.	■ A CCT scheme for the girl child, with insurance cover to provide cash transfers to the family of the girl child (preferably to the mother).	■ Girl child born on or after the cut-off date is entitled to an insurance cover/maturity benefit to the tune of Rs.100,000 through the Life Insurance Corporation.	■ Birth registration of the girl child. ■ Full immunization. ■ Enrollment and retention to school. ■ Coverage is 11 blocks in seven states.	Marriage age of girl to be 18 years for availing insurance benefits.
9.	Balika Samridhi Yojana (1997, recast in 1999) Now transferred to state governments.	■ To create positive family and community attitude towards the girl child at birth and also towards her mother. ■ To improve enrollment and retention rate of girls in schools. ■ To increase the age of marriage of girls. ■ To assist the girls to undertake income generation activities.	■ Post delivery grant of Rs.500. After recasting of scheme in 1999 the benefits are: ■ Annual scholarship of Rs.300 (Grade I-III), Rs.500 (Grade IV) Rs.600 (Grade V), Rs.700 (Grade VI-VII), Rs.800 (Grade VIII), Rs.1,000 (Grade IX and X)	■ Family to be below poverty line. ■ Girl child born on or after 15 August 1997. ■ Only for two girl children per household.	Girl is to be unmarried and alive for availing all benefits till 18 years.

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Discussion Paper

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