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A Comparative Study on the Conditional Cash Transfer Programs in Latin America and the Caribbean

라틴아메리카 및 카리브 조건부 현금급여 비교 연구

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ABSTRACT

A Comparative Study on the Conditional Cash Transfer Programs in Latin America and the Caribbean

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This thesis is a comparative case study of nationwide Conditional Cash Transfer (CCT) programs in Brazil, Colombia, Jamaica and Mexico. These four countries were chosen on the basis that each one of them have vastly different political, social and economic backgrounds yet all have implemented standardized CCT programs. The main reasons for employing CCT programs are the same and twofold: first, to create a safety net for the poor so that the cash transfer could alleviate some of the immediate effects of poverty; and second, to reduce the transmission of intergenerational poverty by promoting the accumulation of human capital development through improved education and health performances. In order to accomplish these feats, the CCTs impose specific

health and education conditions upon program recipients in exchange for cash transfers. After the first generation of CCT programs yielded glowing international reviews, many Latin American countries rushed to adopt their own programs. As a result, the programs have become widespread in the region and demands for them show no signs of abating.

The CCT programs attained positive short-term results as the stipends granted by the programs effectively soothed immediate effects of poverty such as starvation. Furthermore, the majority of recipients adhered to the health and educational conditions, which was a gain for certain factors such as increased enrollment rates. However, the long-term effects on poverty reduction are not so clear. Thus, the quick spread of CCT programs during the early 2000s may be more of a concern since the outcomes of the CCT programs may not correlate to advancements in human capital development, through education and health gains, as expected.

This study is guided by the premise that the recipients of CCT programs in countries that hold at least an upper-middle income level will experience larger improvements in health and education performance than those from lower income levels. These differences in health and education outcomes appear despite the fact that the programs have been implemented similarly with standard conditionalities. To elaborate, an upper-middle income level is essential to guarantee the availability of adequate educational, health and financial resources in the country. This is because the lack of the necessary services will result in a negligible and disappointing outcome in terms of the health and education performances. Moreover, the availability of adequate resources

should be pervasive within the country so that there are not large disparities amongst different regions.

Keywords:

Conditional Cash Transfer (CCT), Latin America, Poverty, Conditionality, Education, Health

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LIST OF ACRONYM

BB	Basic Benefit
BF	Bolsa Família
BRL	Brazilian Reals
CCT	Conditional Cash Transfer
CONEVAL	Consejo Nacional de Evaluación de la Política de Desarrollo Social
FA	Familias en Acción
IADB	Inter-American Development Bank
IMF	International Monetary Fund
PATH	Program of Advancement Through Health and Education
PROGRESA	Programa de Educación, Salud, y Alimentación
SAP	Structural Adjustment Program
Senarc	Secretaria Nacional de Renda de Cidadania
SISBEN	Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales
VB	Variable Benefit
VYB	Variable Youth Benefit
WB	World Bank

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I. Introduction

The nationwide CCT programs of Brazil, Colombia, Jamaica and Mexico were chosen in this study on the basis that they all have significantly varied political, social and economic backgrounds. Despite such stark and significant dissimilarities, each CCT program was implemented indiscriminately with standard health and education conditionalities. Mexico and Brazil pioneered the first generation of CCT programs and are currently operating the largest programs. On the other hand, the Colombian and Jamaican CCTs are of a smaller scale and were adopted at a later stage. Each of the chosen countries and their respective CCT programs provide a meaningful contribution in understanding the impact of CCTs.

The findings of this study demonstrates that the compliance rates in terms of the required health or education conditions were higher after the CCTs were employed. However, it is equally important to note that the improvement was often limited since compliance rates were, in many cases, already high before the conditionality from the CCT program was imposed. Moreover, the increased compliance to health and educational conditionalities failed to correlate to improvements in health and educational performance for half of the countries. For instance, the Jamaican CCT program demonstrated that the attendance rate condition resulted in a predictable increase in attendance rates among the program recipients. However, further analysis also demonstrated that the higher attendance rates did not translate into improved grades or an

improved likelihood of progressing to the next grade level for the beneficiaries of the CCT program.

The prevailing academic material on CCT programs favor a narrative focused on the CCTs themselves or impact studies. The majority of the studies show a general and support for the CCT programs due to the aforementioned fact that CCTs do positively impact the specific health or educational factors that had been conditioned by the program. In some studies, there is evidence that the improvement in the chosen health or education conditions did mirror an improvement in the health or education performance outcomes. However, even the research that show performance improvements via the chosen indicators, are focused on a limited picture that centers around the CCT programs themselves.

This thesis endeavors to contribute to the literature of the CCT programs in Latin America by providing a big-picture analysis that look beyond the design of the CCT programs themselves in order to understand external factors that can influence the success or failure of the programs. Furthermore, this thesis establishes the fact that the narrowly focused literature on the individual CCTs and impact studies could be misleading and may misguide countries into adopting programs that they are not prepared to implement. Consequently, in contrast to the existing literature, this thesis presents the argument that factors beyond the design of the CCT programs themselves, such as country income levels, can impact the health and education performances of the CCT program beneficiaries.

1. CCT Background

CCT programs have successfully enamored and captivated Latin American audiences since they were established in the latter half of the 1990s. These programs have been replicated repeatedly after the first programs were inaugurated in countries like Brazil and Mexico, and are now multiplying across the Latin American region like wildfire. In fact, all but two of the sovereign Latin American countries have, at one point, adopted CCT programs. The popularity of the CCT programs even managed to catch the attention of countries beyond the Latin American region that have subsequently taken steps to initiate their own programs. Given their attractiveness, it is clear that these programs can be expected to continue to remain in existence. This is especially true for countries with popular nation-wide programs like Brazil, where the Bolsa Família (BF) CCT program garnered up so much public support that even criticizing the program, not to mention abolishing it, is widely considered a political suicide for politicians (Hall, 813). Given the fact that the CCTs are here to stay, it is important to analyze whether or not they are accomplishing the goals they were created to achieve and hence, able to justify their existence.

The popularity of the CCT programs can be attributed to their core purpose; namely, that they are social welfare programs created to tackle the short and long-term effects of poverty. Governments are careful to strike a delicate balance in providing benefits for beneficiaries. The aim of the CCT programs is to ensure that families living under the poverty line receive enough to ensure their survival but not so much that they may become dependent on the stipend. The program attempts to alleviate the effects of

poverty in the short run by simply providing direct cash transfers to the poor, who are expected to use the money to improve their harsh living conditions. The short-term function of the CCT can be seen as a type of safety net for those that are living under the poverty line. However, it is important to note that the people that are enrolled in the program must comply with education and health conditions set up by the government in order to receive this stipend. In other words, conditions like attendance rates and vaccination requirements are imposed to promote the development of human capital. For instance, the government requires that the children of beneficiaries be enrolled in school in the hopes that this would lead to an improvement in their academic performance. An improved academic performance is treated as a gain in human capital since the increase in the quantity of education translates as a growth in economic potential. Children that receive more education and are healthier are expected to perform better economically as adults; thus, the point of the CCT program is to ensure that recipients continue to improve their economic situation in the long run by using the human capital gains accumulated through the conditions of the program. In this way, the programs attempt to reduce the transmission of intergenerational poverty by conditioning the cash transfers with health and education requirements to foster an improvement in education and health statuses.

Conditionality plays a central role in the operation of the CCT programs. Conditionalities are mainly targeted towards children, mothers, and pregnant women. For women, conditionality mainly manifests in the form of pre and post-natal care and educational seminars to improve their role as primary caregivers. For children, there are health requirements such as vaccinations and education requirements like enrollment or

attendance rates. Conditionalities placed upon the receipt of the financial benefits, were created with intent to ensure that the children born into poverty would have the best tools to overcome it. Moreover, CCTs are unique and distinct from many other welfare programs in that they are preferentially granted to women. For example, approximately 94 percent of the recipients of the Brazilian BF program in 2010 were women (Holmes et al., 17). This is primarily because the program seeks to empower women in the poor communities and give them a voice in how they run their households. In other words, the programs are designed to give women an opportunity to become key decision-makers, a role more often reserved for men. The program also takes previous international experiences into consideration. Such experiences have suggested that women are more likely to invest in their family welfare than men (Lindert et al., 17). Thus by transferring the money to the woman head of the family, the CCT programs send a signal to the country that the women and children are vital protagonists in the journey to improve immediate living conditions in poor neighborhoods and to reduce intergenerational transmissions of poverty.

2. Conceptualization

This study will apply the method of conceptualization in order to develop and clarify the pertinent concepts and ideas of this study. Thus concepts that are used frequently throughout the research will be given precise definitions in an effort to minimize confusions in this study. Firstly, the idea of *conditionality* will be conceptualized as the conditions imposed upon beneficiaries of CCT programs in

exchange for the cash transfer benefits. Furthermore, *country-income levels,* which play a central role in this thesis refers to the World Bank's income level classifications that classifies country economies based on gross national income per capita estimates (Updated Income Classifications). Equally important to this thesis is the notion of *unbalanced country development*, which has been conceptualized, to refer to countries that have a severe disparity in development levels within the country. For instance, in the case of Brazil, the rural agricultural northeastern regions are far less developed than the urban and industrial central and southern regions. In such cases, the poverty is concentrated around the rural areas with a low level of health, education and financial services when compared to the more urban regions.

The conditionalities play a central role in the operation of CCT programs and function to reduce severity of poverty in both the short and long run. The notion of *short-term poverty* is used repeatedly and in this study it refers to the short run effects of poverty. For instance, short-term poverty reduction refers to the alleviation of immediate poverty symptoms like starvation. This terminology is used heavily to describe the short run goals of the CCT to relieve the immediate effects of poverty by providing cash transfers. On the other hand, the notion of *long-term poverty* is more complex in this study. In this study it is conceptualized as the long run effects of poverty, or intergenerational poverty to be more specific. Governments create the CCT programs with a vision to reduce long-term poverty and in this study; this refers to the use of health and educational conditionalities to improve health and education performances. The term *performances* is also conceptualized in this study to distinguish it from the education and

health conditionalities themselves, so that performances refer to the accomplishment in education and health conditionalities. To explain further, in the case of education conditionalities, the enrollment rate is the conditionality while the performance is the academic achievement. The CCT programs operate under the assumption that factors like improved academic performances are a gain in human capital development. The increase in human capital development is important since naturally, people with higher human capital levels often earn more than those who are uneducated and unhealthy. Therefore, the improvements in human capital development for children are promoted through the CCT programs to try to reduce the intergenerational transmission of poverty. This thesis will focus primarily on the health and education performance outcomes rather than the overall reduction in the transmission of poverty.

3. Research Hypothesis

There are two hypotheses that guide the research of this thesis. The first is that recipients of CCT programs in countries that hold at least upper-middle income levels will experience larger improvements in health and education performance than recipients from lower income level countries because of the existence of adequate health, education and financial services. This is largely because of the fact that conditions on health and education alone are often not enough to ensure improvements in health and education performances. This is especially true in cases where there is a lack of adequate health, education and financial services. For example, a program beneficiary child will experience improvements in attendance rates because of the conditional requirements but

this will not translate into improvements in academic performance if the educational facility is inadequate or if the teacher is unqualified. Consequently, countries must possess at least an upper-middle income level to ensure that adequate health, educational and financial services are available.

The second hypothesis is that there must also be a balanced development level within the countries employing CCT programs in order to ensure the health and education performance improvements. This is largely due to the fact the existence of adequate health, education and financial services cannot be guaranteed in countries with an unbalanced development level even if they have a high income level. To explain further, the poorest regions require the financial benefits of the CCT programs the most but in cases where there is an unbalanced development level within the country, the health, education and financial services in these poorest regions of the country may be inadequate. This in turn leads to the reduced education and health performance levels.

4. Methodology and Research Design

This qualitative study uses a bottom-up inductive approach in an effort to develop a new finding from reviewing previous works in the field of CCT programs. The bottom-up inductive approach is apparent in the fact that this study aims to look at individual findings from a variety of studies in order to find a common pattern to formulate a conclusion. This thesis will conduct a comparative case study on the CCT programs of four vastly different countries and their respective CCT programs to point out relevant patterns. Given the broad nature of the subject, the focus of the study has been narrowed

down to consider factors that would improve the health and education performances of the recipients of the CCT programs. In order to provide a comprehensive analysis of the programs, the investigation in this study will cover the programs' health and educational conditionalities, eligibility criteria, implementation mechanisms, and the short and long run impacts on poverty. Relevant political, social and economic development backgrounds will also be analyzed to demonstrate that factors beyond the CCT programs themselves, will contribute to the success or failure of improving the education and health performances. There will also be a country comparison analysis that will serve to further emphasize the importance of income and balanced development levels that must work in conjunction to the CCT programs.

II. Literature Review

The popularity and the subsequent expansion of the CCT programs throughout the Latin American region has drawn much academic interest to the subject matter despite the fact that CCT programs are relatively new.[1] Governments, international organizations and academics all gathered to scrutinize the CCTs. For instance, institutions such as the WB (World Bank) and the IADB (Inter-American Development Bank) thoroughly investigated CCT programs since they often funded large portions of the programs. Governments and the academia were also interested in making their own investigations to decide if the programs were indeed the magical silver bullets they seemed to be.

Unsurprisingly, the extant research in the topic of CCTs are often more readily available for the first generation of pioneer programs, such as the case of Mexico and Brazil, or early adapter countries. In the same vein, the first generation programs have a longer operational history and so researchers were able to amass more information. It is equally important to note that the early research conducted on the first generation CCTs were limited by the lack of a large data set because of the novelty of the programs. In fact, prominent researchers like Behrman and Parker analyzed both the current Mexican CCT Program Oportunidades (most recently rebranded as Prospera) in combination with its predecessor, PROGRESA (Programa de Educación, Salud, y Alimentación). This is mostly because the essence of the program remained unchanged throughout the

[1] The earliest CCT programs in Latin America, specifically in Mexico and Brazil, were inaugurated in the latter half of the 1990s.

rebranding. Therefore, studying both the programs provides a more substantial research since Oportunidades only commenced in 2002, but PROGRESA was implemented in 1997. The same applies to Hall's research on the BF program of Brazil that utilizes data from before the creation of the BF in 2002 by observing the corresponding CCT programs such as the Bolsa Escola, which later combined with other CCT programs to form the BF program.

Fiszbein, Schady, Ferreira, Grosh, Kelleher, Olinto, and Skoufias conducted the widest and most comprehensive study of CCT programs that ran in various different countries. In fact, this report was not geographically confined to Latin America, but rather it succeeded in encompassing CCT programs in the Asian and African continents as well. This report provides research on the broadest of topics such as the benefits of the CCT programs and goes all the way down to minute details like the impact of pilot programs. This report concludes with suggestions on the best ways to design the most effective CCT programs and follows up with specifics on topics like the selection method for the best target population or the conditionalities. But most importantly, the report states that CCTs should be considered as an additional measure that should be taken to boost services and not as a silver bullet that can end the socio-economic ills of a country.

The country-specific research is generally available in the form of impact studies that focus deeply on particular conditionalities. For instance, Lindert, Linder, Hobbs and De La Brière from the World Bank delve into the deep inner workings of the BF program with the principal purpose of informing international policy makers. More specifically, the study is aimed at policy makers from different countries that are seeking to closely

emulate the Brazilian example in their own version of a CCT program. Hence, this study is aptly named "The Nuts and Bolts of the Bolsa Família Program: Implementing Conditional Cash Transfers in a Decentralized Context", since it takes apart the BF program to observe the individual factors that constitute the BF program. The researchers attach a heavy value to the targeting mechanism of the program and commend the Brazilian program for its strength in its registry program. The study also briefly mentions the potential future research areas. Specifically regarding a series of programs or systems that could operate in conjunction to the CCT program in order to ensure that recipients have an exit door with which they can graduate from the program so that they do not become dependent. The authors touch upon a very big concern as many have criticized CCT programs for generating dependency.

The Colombian CCT program, FA (Familias en Acción), is thoroughly covered by Attanasio, Battistin, Fitzsimons, Mesnard and Vera-Hernández's paper on "How Effective are Conditional Cash Transfers? Evidence from Colombia". As the title suggests, the paper deals with the impact of the FA program and how the conditionalities affect nutrition and health status, attendance rates and household consumption. So the paper reviews the impacts on the short-term inequality and poverty reduction as well as the impacts on the specific health and education conditions that were created to assess the improvements in potential health and education performance. This paper discovers evidence that shows that certain indicators, such as attendance rates, were not improved dramatically. This can be explained by the fact that the initial school attendance rates were already reasonably high to start with. In fact, this finding also appears across various

other CCT programs including the Jamaican CCT PATH (Program of Advancement Through Health and Education). The authors also demonstrate that despite the large-scale scope of the FA program, it is only operated in regions that have the required health, educational and financial facilities in place. The selection mechanism based on the existence of adequate facilities is reasonable but also points to a different set of issues. This is because of the fact that the regions that need the welfare programs the most are often barred from accessing these same programs since they do not have the basic required facilities.

Levy and Ohls dominated the impact evaluation studies on PATH in Jamaica. This program was created out of a necessity to reduce the government expenditure in the midst of an economic downturn. Jamaica was running various redundant social welfare programs; so all these social welfare programs were reassembled into one nation-wide CCT through the PATH program. The authors of this study determined that the majority of conditioned indicators improve based on their compulsory nature. In fact, the conditionality, again, increased values such as attendance rates, which were also already considerably high in Jamaica. However, there were no signs that the program was fostering improvements in health and education performances, despite the fact that the conditioned indicators had improved.

III. MEXICO CASE STUDY

1. Political, Social and Economic Background

Mexico currently encompasses the second largest population in Latin America after Brazil and is the largest Spanish speaking country of the world. This is because it had been colonized by the Spanish despite being originally inhabited by indigenous Mexicans; the colonial history provides a heritage of both Spanish and indigenous cultures in the country. Mexico is comprised of a mestizo majority, which accounted for approximately 62 percent of the total population. This is due to the fact that the original indigenous population has been diminished and presently comprises of only 7 to 28 percent of the population.[2] The indigenous population dwindled significantly after the Spanish invasion and was further reduced throughout the colonization of the region. Even still, there are a significant number of indigenous people as Mexico holds the largest indigenous Amerindian population amongst the Americas. However, the descendants of the indigenous population in present-day Mexico are mostly residing in rural areas where they are socially marginalized. They face a variety of hardships including discrimination in the labor force and a high illiteracy rate that stem from the fact that they speak their indigenous language but not Spanish. On the other hand, approximately 10 percent of the Mexican population identifies as being primarily of European descent and unlike their indigenous counterparts, are among the most affluent members of the Mexican

[2] Even presently, there are 62 different types of indigenous communities within Mexico. 7 percent of Mexicans identified themselves as Amerindian while 21 percent claimed that they were of mostly Amerindian roots ("Mexico").

community ("Mexico"). In the Mexican case, it is clear that the colonial legacy left serious problematic consequences in a society that exhibits entrenched signs of inequality along racial divides.

Mexico is an upper-middle income level economy, which maintains a high degree of poverty and inequality over the years. Mexico reached the height of its economic growth in the 60s and 70s that fueled its heavy borrowing habits, which lead to some serious consequences. Mexico, as well as various other Latin American countries, accumulated a colossal debt and the effects of an economic recession made it clear to investors that Mexico was not able to repay its loans. Panic ensued and eventually in 1982, the Mexican government was forced to declare a default on its loans. This era of the 1980s came to be known as the lost decade in Latin America when growth became stagnant and a host of severe socioeconomic problems took hold of Mexico, among which were severely diminished income per capita and an increase in economic inequality. The Mexican default in 1982 was a first of a series of economic problems in Latin America that eventually opened the door for the IMF in the region. The IMF attempted to halt the crisis by restructuring the Mexican economic system and adopting a set of SAPs. The SAPs lead to some critical problems such as a high concentration of wealth, which exacerbated the income inequality, and eroded the social welfare benefits for the poor.[3]

[3] Social spending cuts required by the SAPs lead to the slashing of health care spending and causing problems such as the tripling of the infant mortality rate from 1980 to 1992 ("Structural Adjustment Programs").

2. PROGRESA/Oportunidades

The erosion of social welfare benefits, the increasing poverty levels and the high inequality rates in Mexico prompted the creation of the PROGRESA program. Unsurprisingly, the CCT program was very well received in light of the severe socio-economic issues that plagued Mexico. The Mexican CCT program was established in mid 1997 and was administered by the federal government but the creation of the program was only possible after a small-scale pilot program that occurred a year earlier. The official program was called PROGRESA and due to experiences gleaned from the smaller test case, the government was able to immediately start in a larger scale.[4] PROGRESA, along with its Brazilian BF counterpart, is a first generation CCT program and truly was a pioneer that paved the way for the creation of other CCTs in Latin America. PROGRESA's beginnings, although bigger than the pilot program, was much more modest in scope than its current nationwide state. The program was initially treated as a social experiment, in which the government was able to study the impacts of the programs by comparing similar recipient and non-recipient households (Skoufias, xi). The first phase of the PROGRESA program included approximately 140,000 families (Skoufias, 1). More recent 2011 figures show that the program had expanded to become one of the largest CCT programs in the world as it included 20 percent of the Mexican population, which is equivalent to about 5.8 million households (Altangerel and Henao, 1). PROGRESA later expanded its coverage to remote rural areas on the condition that the communities had the necessary educational and health services (Tuya and Henao, 9).

[4] PROGRESA reached approximately 10 times more people than the initial pilot program (Altangerel and Henao, 4).

Presently, PROGRESA has evolved greatly and has become the standard exemplary CCT program that many different countries have mimicked.

The Mexican CCT program evolved and adjusted to the changing political background. The CCT program was created under the PROGRESA name but was rebranded as Oportunidades due to political problems. To elaborate, the program was initially established by a party plagued by corruption scandals and so the new incoming ruling party changed the program's name in order to distance it from the failures of the previous government (Altangerel and Henao, 5). The essence of the CCT program remained unchanged as the primary focus was still centered on conditionalities in education, health and nutrition.

2-1. Implementation

The PROGRESA/Oportunidades is administered and funded by the Mexican federal government. The CCT program is provided for those that are in the lowest rungs of the socioeconomic ladder and are identified using data gathered by CONEVAL (Consejo Nacional de Evaluación de la Política Social). CONEVAL is responsible for providing data about the poorest families in Mexico and it observes various factors such as family income and education level, which are deemed to be essential in measuring the well being of a family ("Medición de la pobreza"). These indicators are put together to identify those that were the most deprived and are then targeted by the PROGRESA/Oportunidades CCT programs. The families that are eligible for the program must register in the designated health clinics and schools (Altangerel and Henao,

5).[5] After they have been registered, the education and health staffs track the family to ensure that they have complied with the designated conditions.

A common concern regarding CCTs is that the sudden increase in demand for services will inevitably lower the quality of the health care that was available. This preoccupation stems from the notion that the existing service centers will not be able to absorb the sudden increase in demand and this would mean that schools and health care centers would suddenly have to take in many more people than they are equipped to look after. The Mexican government correctly predicted that the use of services would increase following the implementation of the program and quickly assessed strategies to avoid the decrease in the quality of services. For instance, in regards to the health care services, the Mexican government reacted quickly by requiring health clinics to provide at least the minimum set of services. This requirement was enforced to ensure that the CCT program's health conditionality could be complied with in every health care center. Furthermore, the government also coordinated with local ministries that were to participate in the CCT programs to ensure that the quality of health care did not worsen with the introduction of the program. In doing so, the government effectively guaranteed an adequate level of health care by increasing the use of services like mobile clinics (Barham and Rowberry, 2). In other words, the Mexican government correctly anticipated the increase of demand of health services and responded by increasing supply of health services so that they could ensure that beneficiaries could comply with the conditionalities of the CCT program (Barham and Rowberry, 12). Another fact about the

[5] The rate of enrolment among those that were deemed eligible is extremely high at a value of approximately 90 percent (Fernald, Gertler and Neufeld, 829).

Mexican CCT program is that it is only set up in communities that have access to primary and secondary school and health care center (Rawlings, 22). This means that the beneficiaries of PROGRESA/Oportunidades are guaranteed adequate health and education services through the program itself.

The Mexican CCT program also contains a mechanism that is used to allow the beneficiaries to voice their opinions back to the government through the elected representatives of each community. Furthermore, the programs also employ the use of complaint and suggestion boxes that ensure the anonymity of the person who is raising concerns regarding the programs. This furthers the direct line of communication between the government and the program recipients.

The actual amount granted to each family depends on the composition of each beneficiary family. Families that comply with the health and nutritional requirements receive approximately $34.52 USD, which can be increased by $8.95 USD for each child under 9 years old. In regards to the benefits for complying with the educational condition, families can receive stipends for up to three children that amounts from $12.79 USD to $81.83 USD. This amount also depends on factors such as the level of education and the gender of the child ("Medición de la pobreza").[6] The Oportunidades also provides a small sum of cash transfers for food, which is the same amount for all families, and for some energy costs, which is provided to counter the rising prices (Ulrichs and Roelen, 11). Furthermore, the program also makes an ambitious attempt to deal with family members

[6] There is a positive gender bias where girls are given more to continue to attend school than to drop out. For instance, the recipient boys were given approximately $60 USD while recipient girls were given $69 USD in the third grade in 2006.

that are older than 70. The elderly are also eligible to receive benefits of up to $26.85 USD per month ("Medición de la pobreza").[7] This is despite the fact that providing cash transfers for elders does not directly aid in the human capital development of the Mexican youth, which is what is deemed necessary to escape long-term inter-generational poverty.

2-2. Conditionality

The main conditionalities of the Oportunidades program are on education, health and nutrition. The education stipend is provided to children that are enrolled in 3rd to 12th grade and under the age of 22 years old. The size of the payments differs depending on the beneficiary child's gender and level of education. For instance, children that are in higher educational levels receive a larger stipend. On the other hand, the health conditionality has been created so that the entire family will have to receive some preventative health care on a regular basis. Furthermore, there are measures that attempt to improve the family nutrition by providing nutritional supplements that are earmarked for children of 2 to 4 years old. The health conditionality also requires that the female head of household visit the health care facilities on a monthly basis to attain the monthly nutritional supplements.[8] The conditionality on health also requires compulsory attendance at monthly seminars that focus on matters regarding health issues (Behrman and Parker, 5).

There have been several concerns regarding the conditionality aspect of the Oportunidades program. Conditionalities are very strict in the case of the Oportunidades

[7] The benefits for the elderly are provided only to families that are already part of the Oportunidades program (Behrman and Parker, 6).
[8] The obligatory number of visits to health care facilities increase to more than once a month if the women are pregnant or have small children (Behrman and Parker, 5).

program and repeated non-compliance can lead to a penalty. In extreme cases, an entire family can lose out by being barred from receiving further cash transfers. It is important to note that the regulations are unforgiving even in cases where the health and educational facilities are sparse or hard to reach (Ulrichs and Roelen, 11). This creates a situation in which it is more likely that those who are marginalized by society, who really require the benefits from the CCT program, are more likely to lose out because they cannot meet the strict conditionalities.

3. Impacts

3-1. Short Run Impacts on Poverty and Inequality

Many countries and international institutions have hailed Oportunidades as a resounding success in reducing the immediate short run poverty. Indeed, short run poverty is reduced in most cases since the CCT program provides the essential immediate cash relief. In the same way, the Oportunidades program is responsible for increasing family incomes by approximately 20 to 30 percent (Benderly, 1). Furthermore, another interesting benefit that rose from the Oportunidades program is that the use of banking institutions, which deliver the cash transfers, created a new habit of saving that was not always present prior to the program (Levy, 48). The improvements that lead to the relief of poverty rates also demonstrate, to a certain extent, that the program funds are being spent appropriately and are targeting the poor families instead of being misappropriated.

Household consumption is a good indicator of how the program has affected the families. In the case of Oportunidades, the average consumption expanded by 15 percent

and approximately 72 percent of that increase was spent on food. In fact, the caloric intake had increased by 8 percent more for recipients than non-recipients (Levy, 44-45). This also demonstrates that the cash transfer was not squandered by adults but was spent appropriately in improving the lives of children as consumption of food, school material, and clothes increased while adult consumption of wine or cigarettes remained unaffected by the influx of cash.

3-2. Long Run Impacts on Education and Health Performances

3-2-1. Education Performance

The impact of the Oportunidades program on education is always positive but the size of the impact depends on the level of education that is being considered. In terms of the Primary School, there was already a high enrollment rate in both the rural and urban areas that surpassed 90 percent. This effectively explains why the school enrollment rate in primary school children was limited to only a 1.07 percent maximum increase for boys and a 1.45 percent maximum increase for girls (Levy, 58-59).

The impact of the Oportunidades program was much larger for the secondary school. Research demonstrate that children, especially girls, are more likely to drop out of school by secondary school and so the educational conditionality did play a significant role in this instance. To be more specific, for children of beneficiary families, the enrollment rate increased by 7.5 percent on average for boys and by an average of 11 percent for girls. Most importantly, the estimated income rise due to the increased education level translated to a 6 percent increment for the girls and 3 percent increase for boys. This demonstrates that the educational conditionality in the Mexico, lead to the

improvement in health and educational performances that eventually translated into income growth. The Mexican case also presents another interesting outcome, in which children of less educated mothers were experiencing the greatest impact, as they were 75 percent more likely to be attending secondary school (Levy, 59).[9] These results are extremely positive and demonstrate reasons why the support for education conditionalities persists.

The Oportunidades program also extended the educational conditionality to include high school students in 2001, which also provided positive results. In fact, when comparing the immediate enrollment rates before and after the conditionality took place, there was an increase of approximately 85 percent in enrollment rates in rural Mexico and a more modest but still significant 10 percent in the urban areas (Levy, 60). The large positive effect on the high school enrollment rates is due to the fact that high school children, especially from the rural areas, were much more likely to drop out of school in order to help the family generate an income. In conclusion, the high school enrollment conditionality is highly welcome since the benefits of the program, which was on par to what the high school aged children would have earned outside of school, covered the opportunity costs.

3-2-2. Health Performance

The Oportunidades program was largely successful in achieving its goal of improving the health status of the beneficiaries. To begin, the program generated a 30 to 50 percent increased demand for health services in the rural areas. This meant that

[9] The less educated mothers were identified as those that have had an average of three years of education, while those that were more educated averaged around nine years (Levy, 59).

families that were unable to afford health services changed their behavioral pattern considerably after the program implementation, as they could now afford visits to the health centers. Naturally, the conditions on health center visits were met as well as the conditions on monitoring the nutritional status of children under 2 years old, which increased by an amount of 30 to 60 percent. There was also an increased growth monitoring of 25 to 45 percent for children in the 2 to 5 year age group. But more interestingly, the Oportunidades program was also responsible for a 58 percent decline in visits to the hospital by children under 2 years old. This demonstrates that the increase in preventative care through regular checkups was able to lower the instances of diseases (Levy, 49-50). Due to the clear benefits and the positive results of the program, it can be said that the use of conditionalities for improving health of the recipients is justified.

The Oportunidades program also spurred positive effects in other portions of the population. Beneficiary pregnant women were more likely to seek regular health care check ups by a 6 percent increase, which amounted to a total of 89 percent of pregnant recipients, while the non-beneficiaries only experienced an increase of 1.5 percent, which amounted to approximately 85.5 percent (Levy, 50-51). Equally important was the improvement in the maternal mortality rate which decreased by an average of 11 percent in groups that received benefits compared to the non-beneficiaries that only experienced a much smaller, 2 percent, decline (Levy 56). Therefore, it is possible to conclude that in the Mexican case, the benefits and gains of the program for adults are just as significant as they were for the children.

IV. COLOMBIA CASE STUDY

1. Political, Social and Economic Background

Colombia's current population is a representative image of its history. Before the Spanish invasion and subsequent colonization, Colombia was and continues to be home to 80 different indigenous tribes. Currently, these same tribes are marginalized to areas with low population density and make up only 3.5 percent of the entire population ("Colombia" 122). The Colombian demographic profile largely consists of mestizo and European descended peoples that appeared during the Spanish invasion in the 1500s. It was during this time that the Spanish colonized the area and created a vastly extractive economy that focused on exporting precious metals. Eventually, enough people of the indigenous community began to perish in the face of severely harsh working conditions and this lead the importation of African slaves to Colombia. This was the beginning for the African descended population in Colombia, which now comprise approximately 5 percent of the population and are similarly marginalized and mostly living along the coastal regions.

Colombian history is also marked heavily during the 1970s, when unfortunately, the demand for illicit drugs from the United States cultivated an extensive growth in the production and the trafficking of illegal drugs. Such circumstances naturally encouraged the growth of prosperous cartels, which in turn brought problems of corruption, internal displacement and violence. Another significant development during the 1970s was the formation of the leftist rebel group known as the Fuerzas Armadas Revolucionarias de

Colombia (FARC) and in response right wing paramilitary groups formed to oppose their pressures. Unfortunately, this lead to the a violent climate in which many civilians became victims caught in the middle of the aggressions. The continuing turmoil eventually invited the presence of the United States. The United States and Colombia maintain very close and eventually the United States became heavily involved in Colombia in an attempt to win the war on drugs. However, the assistance was more significantly directed against the FARC and other leftist groups, which lead many to question the purpose of the United States' position in Colombia. It is important to note that while leftist governments, most noteworthy of which is its Venezuela neighbor, largely surround Colombia it has been governed by pro-US presidents and has maintained a very positive relationship with the United States.

The Colombian economy had been based heavily on extractive industries focused in precious metals during the colonial era. Currently Colombia has a high production of oil and agricultural products such as coffee. Unlike the majority of Latin American countries, the Colombian economy expanded rapidly. However, this economic growth was quickly followed by a significant recession in 1996-1999, which increased inequality and poverty rates and lowered GDP. Fortunately, the Colombian economy bounced back to grow in the early 2000s.

2. Familias en Acción

The Colombian CCT program called the Familias en Acción (FA) was established in 2001. This program was modeled after the Mexican CCT program,

PROGRESA, and its conditionalities were on education and nutrition. Given the popularity of the CCT programs elsewhere in Latin America, the WB and the IADB funded the creation of the FA program by providing a loan to the government of Colombia (Attanasio et al., 2). This also allows the FA program to run with a low cost for the Colombian government at approximately 0.27 percent of the Colombian GDP (Zavakou, xli). The FA was created under the Red de Apoyo Social (RAS), which functioned in line with three programs: the FA program, a training program for young workers, and a program dedicated to generating employment (Ayala, 2).[10] The FA, along with its two partner programs, initially served as a response mechanism to the severe economic crisis in the late 1990s, which was the worst in a period of 60 years. In fact, between 1997 and 1999, when the economic crisis struck the hardest, there was approximately 65 percent of Colombians living under the national poverty line (Ayala, 2). So the FA program was launched in order to mitigate some of the immediate repercussions of the crisis (Zavakou, ii). The primary concern and goal of the FA was the welfare of the children; the government wanted to ensure that in the midst of the economic crisis, children would not be subjected to a decrease in nutrition or education (Soares and Silva, 26).[11] The creation of the FA was very standard and it used the

[10] The RAS translates to the Social Support Network and the other two components of the RAS besides the FA is the Empleos en Acción, which is dedicated to aiding the unemployed, and the Jóvenes en Acción which is a program created to help lower the youth unemployment rates (Soares and Silva, 25-26).

[11] To clarify, the decrease in nutrition would occur mainly because families would have to minimize the amount that they spent on food. The second educational concern is created because of the fact that families may be induced to force children to work to contribute the household income (Soares and Silva, 26).

examples of previous CCT programs such as PROGRESA in order to minimize costly failed attempts.

Similar to the cases of other CCT programs, it initially operated at a much smaller scale in small municipalities with few people. In order to ensure that the system functions properly, the trial cases were conducted in areas that had both health and education facilities and a bank (Soares and Silva,, 25).[12] The success of the smaller cases eventually garnered enough interest and support to expand the FA program. The FA program started gaining momentum in 2007 and it expanded into the more urban regions in an attempt to reach more families in need. By 2009, the program grew drastically and effectively covered approximately 2.9 million families, which amounted to roughly 20 percent of the country's entire population (Soares and Silva, 25). Notwithstanding, the FA program is still largely faithful to its original target audience, which include the poorest of the society as well as some of the more marginalized indigenous communities in Colombia.

2-1. Implementation

The target audiences of the FA, as well as most CCTs, are the poor households that have children. In the inception of the program, it had a much more urgent call in reducing the human capital damages felt by the children of the poorest households. The urgency of the program was relieved with the improving economy, yet the FA program remained as a method of getting a handle on issues regarding the structural inter-generational poverty. The poorest Colombian families with children under 17 years old

[12] The bank was a necessary precondition for the initial trial cases in Colombia due to the fact that the lack of a bank would complicate the cash transfer (Attanasio et al., 3).

are eligible for the program. The government must prioritize in favor of the lowest per capita income earners because of the fact that the Colombia, despite the fact that it was a middle-income level country, had a very high poverty rate as nearly half of its population was under the poverty line (Soares and Silva, 8).[13] Ultimately, the eligibility is determined by a government program called the Sistema de Identificación de Potenciales Beneficiarios de Programas Sociales (SISBEN).[14] The SISBEN is used to categorize families into different welfare levels that demonstrate where each family stands in comparison to the rest of the population, based on their income level. The FA program deals with families registered as level 1 in the SISBEN, which are the families that are in the poorest 20 percent of the country (Attanasio et al., 2-3). Fortunately, the majority of the funds 85 percent were used appropriately as a transfer to the beneficiary families (Ayala, 1). This meant that the funds were reaching those that the SISBEN marked as their target demographic. [15]

The FA program, similar to the BF program in Brazil, relies heavily on the role of the smaller municipalities to operate the program successfully. The local government takes on the responsibility of the FA program only after accepting a deal in which they must comply with strict responsibilities. The first of which is to become the source of a focal point for the program and provide a local headquarter for the program. The municipality must also hire staff members that will be in charge of the program's local

[13] The poverty rate in Colombia was 46.8 percent in 2005 (Soares and Silva, 8). The poverty rate has improved drastically and more recent 2013 data revealed that it was now at 30.6 percent ("poverty headcount ratio").
[14] The SISBEN is the main tool that the Colombian government uses to efficiently identify the citizens that are in need of government social assistance.
[15] The remaining 15 percent is said to have gone to administration costs (Ayala, 1).

headquarter and guarantee that the local focal point will be occupied full time with working on relevant program matter. Furthermore, the municipalities are notified that the targeting mechanism as well as the operation of the program is not to be altered. This remains true even for the municipalities that produce their own funds to co-sponsor the program (Soares and Silva, 27). This can account for the reason why different municipalities may have some slight disparities in regards to the amount of funds provided. The cogent instructions are universally applied in all participating municipalities and it simplifies the process of dealing with local municipal authorities.

The FA program also mimicked the Mexican CCT in that they had set up strict selection criteria in choosing municipalities that could run the CCT program. To clarify, the selection criteria require that municipalities have an adequate supply of education, health and financial facilities. This means that the government expected the increase in demand for CCTs and effectively avoided having to deal with potential problems regarding the reduced quality of services due to a sudden increase in demand following the implementation of the CCT program. This is largely because FA programs were only inaugurated in municipalities that already had the capacity to deal with the increase in the demand for health, education and financial services.

The FA provides benefits for families based on two different categories. The first category is that of health and nutrition and is provided to families with children under 7 years old. The conditionalities were created in order to discourage the families from sending their children to work instead of studying, so the benefits had to cover the opportunity costs of the child receiving an education. This meant that families with

children under 7 were receiving approximately 15,000 Colombian Pesos (COP) by 2007. The second is for families with older children of between 7 to 18 years old and due to the fact that they would earn more if they were not in school, the stipend had to cover this and was placed at 30,000 COP (Zavakou, viii). The FA program originally had an interesting clause in which there is a 5-year limit on the receipt of the benefits (Ayala, 2). In other words, after five years of being on the FA program, the family would no longer be eligible to receive further stipends. More recently though, that clause of the program was modified and so families are not given time limits after which they will lose the benefits as long as they comply with the conditionalities that are imposed through the FA program (Soares and Silva, 27).

2-2. Conditionality

The primary goals of the FA program has shifted slightly since its inception as it is no longer simply about providing an immediate safety net for the poorest Colombians after the economic crisis in the late 1990s. The goals are now equally focused on implementing conditionalities that would best encourage the human capital development to escape the long-term problems of inter-generational poverty. The FA program has chosen three key subject matters that were deemed essential for fostering human capital growth, which are family awareness, education and health (Soares and Silva, 26). The amount of funding a family can receive depends largely on the composition of the family in terms of the age of the children.

There are clear components to the educational conditionality that must be observed by recipients that wish to receive benefits from the FA program. The

educational conditionality is granted for families with school age children from 7 to 18 years old. Unlike the BF program of Brazil, the FA program does not discriminate between younger and older children in regards to the attendance rates, despite the fact that older children are more likely to drop out of school because the opportunity cost of attending school is much higher at that stage. Indeed, the FA program mandates that the recipients must ensure that all children in the particular age range should be missing more than 20 percent of their classes annually (Ayala, 2).[16] However, the program does provide a bit of a distinction between younger and older students by granting different amounts to children of different age groups. To specify, families with children attending primary school are granted approximate 15,000 COP per child while families with children in secondary school receive twice that amount at 30,000 COP per child (Soares and Silva, 27).[17] It is interesting to note that the educational grant was limited to a maximum of three children for each family with small variances depending on the municipality. Despite the restrictions, the program is clear in granting a preference for indigenous families or for those that have been displaced (Paes-Sousa, Regalia and Stampini, 6). The educational conditionalities are seen as a co-responsibility in which the parents are held just as responsible as the government in securing the benefits of the FA program since they must provide the pertinent paperwork to demonstrate compliance.

[16] This number is calculated every two months, as the children of recipients may not have more than 8 absences during this time span (Soares and Silva, 27).

[17] Primary school is considered to be from 2nd to 5th grade while secondary school counts children from the 6th to 11th grade (Ayala, 2). Also note that the equivalent of 15,000 COP is approximately $8 USD and likewise, 30,000 COP amounts to approximately $16 USD (Soares and Silva, 27).

The FA health conditionality, just like the educational conditionality, differs based on the composition of the family. In families with children under 7, it does not matter how many children the family has, as the benefit is limited to one provision of approximately a monthly stipend of $17 USD are provided per family. Again, similar to the educational conditionality, compliance to rules set by health authorities of the Colombian Ministry of Health on growth and development instruments was necessary in order for families to receive benefits (Ayala, 2). The rules included clinic visits that vary depending on the age of the child and can entail up to a total of four visits per year (Soares and Silva, 27). The health conditionalities are rather straightforward and the parents were greatly involved in an attempt to ensure that their children were receiving the required medical health conditions. The FA program is unique and different from most CCT programs in Latin America, in that there are no health conditionalities in respect to pre and postnatal care of pregnant women. This means that pregnant women are not required to get regular checkups or attend seminars, however, the FA program does include a very active female role in other areas of the program.

The FA program is similar to the many CCT programs in its effort to empower women by providing cash transfers directly to the female head of households. However, the FA program goes one step further by including a component known as the madres líderes.[18] This was created in an intention to provide beneficiary mothers with the ability to voice their opinions effectively. Recipient mothers elect among themselves a representative to voice any issues or concerns regarding the FA program to the program

[18] Madres líderes means mother leaders.

managers (Soares and Silva, 27-28). This mechanism inevitably creates a sense of accountability as it means that the program is willing to listen to feedback from the recipients and adjust in response to the needs of the recipients. The madres líderes also convenes for care and family meetings, which are places that mothers can use to speak about topics such as health and education and learn together (Soares and Silva, 28). Furthermore, the madres líderes may form a sense of solidarity among the recipient mothers that gather together. The madres líderes is a creation very unique to the FA program and is a way to ensure that there is a higher level of communication throughout the program.

3. Impacts

The FA program has been well received by the public and was deemed to have positive overall effects and has improved the lives of the poorest of the Colombian society.

3-1. Short Run Impacts on Poverty and Inequality

The significance of the original role of the FA program to reduce the immediate poverty rates after the economic crisis in the late 1990s was reduced once the Colombian economy returned to a more positive growth track. According to the World Bank's poverty headcount ratio at National Poverty Lines, the more recent measures of the Colombian poverty rate in 2013 were at 30.6 percent. This was a very large improvement from previous poverty rate measurements which were around half of the entire population just in 2005. It is important to note that it is not possible to assess whether or not the FA

program played a role in the improvement in the poverty ratio. However, it is possible to analyze the effect the program had on matters such as basic consumption, which may provide an insight into the effect of the FA program on the living conditions of the recipients.

Naturally, the basic household consumption shows an increase after receiving the benefits from the FA program. This increase in spending varied largely depending on the region of the country; the rural areas increased household consumption by 19.5 percent while the urban households increased consumption by around 9.3 percent. However, the key was to see if the cash transfer promoted increased spending on desirable commodities, such as healthy food or education or undesirable ones, like alcohol (Attanasio, 5). In Colombia, the result was generally positive in the sense that the basic household consumption of the beneficiary families was increasing spending on desirable commodities. This positive change manifested as the increase of consumption of nutrient rich foods such as meat and milk, and an increase in the purchase of children's clothing. To further the point, it was clear that the funds from the FA program did not significantly affect the consumption of undesirable adult commodities. This is why it is clear that the program succeeded in its primary mission to improve the lives of children and increase their human capital development by observing the behavioral purchasing patterns of recipient families (Attanasio et al., 5-6). The fact that the benefits of the program are reaching its intended targets is a significant testament to the positive potential of CCTs like the FA program.

3-2. Long Run Impacts on Education and Health

3-2-1. Education

The educational enrollment rates as well as the attendance rate in both the rural and urban regions of Colombia were initially very high. In fact, attendance rates were already about 90 percent for children in primary school. This provides a bit of insight into the reason why the FA program did not provide an overwhelming positive impact from the educational conditionality for this specific group of beneficiaries. However, the same cannot be said for children in the secondary school, of 12 to 17 years of age.[19] The older children have a higher opportunity cost of going to school because they would make more immediate profits by working. The FA program effectively addressed the low attendance rates of secondary school students and the impact is seen very clearly as the attendance rate increased by 5.2 percent for children residing in urban regions and 10.1 percent for children in rural Colombia (Attanasio et al., 5). Despite the fact that the Colombian attendance rate was high for primary school students that was not the case once the children entered secondary school; thus the FA program became an effective tool in targeting the problematic component in the Colombian educational sector.

Research on the FA program also demonstrated that despite the fact that children of recipient families may have entered the education system later than their non-recipient counterparts, the children performed equally as well as the non-recipient children (Zavakou, xxxv). Furthermore, the children of beneficiaries were also less likely to drop out of school. This stands at a stark contrast to the Brazilian BF program case, which

[19] The attendance rate is lowest for children in the rural areas where the attendance rate was less than 50 percent before the FA program was implemented (Attanasio et al., 5).

demonstrated that children that were enrolled in school to fulfill the educational conditionality of the CCT program were very likely to experience failing grades. The main difference between the two cases may have been caused by the fact that Brazil's BF was offered to all poor regions regardless of whether there were appropriate educational facilities, while the Colombian FA program only provided the CCT programs in municipalities that already had approved educational facilities. In other words, had the FA program offered its benefits widely including to areas that lack educational resources and facilities like the BF program did, the resulting improvement in attendance rates may not have been as stark.

3-2-2. Health

The health conditionality of the FA program generally shows a positive effect on the health status of the recipient children. The first instance in which the FA program contributed in progress in terms of health issues was regarding the children of less than two years old that reside in rural areas (Ayala, 3). The signs of malnourishment manifest in children in the form of stunted growth. Children that are malnourished are frequently significantly shorter than those that are not. Before the FA program, the malnourished children under 7 years old were approximately 21 percent. Research demonstrates that for children under two years old in the rural regions benefited the most from the FA program in terms of growth. In fact there is evidence that young boys under two years old that resided in the rural area and received the FA benefits grew 0.44 centimeters more than they would have had they not received benefits (Attanasio et al., 7-8). This is clearly a significant feat by spurred by the health conditionalities imposed by the FA program.

The second substantial benefit that manifested was in regards to the children under 4 years old in the rural areas receiving benefits from the FA program. Research demonstrates that the FA program effectively lessened the incidences of diarrhea in children under 2 years old from rural areas to 22 percent. This is a significant improvement worth a 10.6 percent decrease, which contrasts significantly with the children of non-recipients that was at a 32.6 percent. Furthermore, program beneficiary children from 2 to 4 years old also experienced similar improvements as their incidences of diarrhea decreased from 21.3 percent to 10.4 percent (Attanasio, 7). The advances that were spurred by the creation of the FA program in terms of child diarrhea is significant as children are more susceptible to diarrhea, which can be dangerous for young children and can seriously threaten the possibilities of the child's future survival.

V. JAMAICA CASE STUDY

1. Political, Social and Economic Background

Jamaica is an island country that had been claimed by Spain until the British took over the island and colonized it. Jamaica, like many countries in the region was rich in natural resources and was subsequently forced into an exploitative economy that was mostly focused on agricultural goods. The sugar industry was thriving, and so Great Britain brought in a large number of slaves to encourage production.[20] Despite the rich natural resources, Jamaica faced a history of economic downturn. The economic troubles were compounded by the fact that in order to improve the living conditions of the Jamaicans, more loans were taken from the IMF and the country effectively ran on a constant budget deficit. Jamaica was plagued by a multitude of socioeconomic issues including persistent issues of corruption in the government and high unemployment rates in the public. In terms of the poverty statistics, an 80 percent of the people residing in the rural areas were poor which is a stark comparison to only 10 percent of the poor in the urban areas. Furthermore, there was a high incidence of families with a female head of 44 percent of which 66 percent were poor (Levy and Ohls 2007, 2). Jamaica is also the only country in this study that is not at least an upper-middle income country. In 2002, such poor socioeconomic conditions pushed the government to merge the various ineffective social welfare programs into a representative nationwide CCT program.

[20] The importation of slaves into the country left Jamaica with a majority 90.9 percent black population (Robinson).

2. Program of Advancement Through Health and Education

In 2001, Jamaica followed the steps of many other countries and launched a small pilot CCT program in the parish of St. Catherine (Levy and Ohls 2007, 7). This was before the Jamaican government launched a full nation-wide program in the following year called the Program of Advancement Through Health and Education (PATH). The primary motivation behind its creation was the fact that the government was becoming acutely aware of the fact that its previous social welfare programs were largely ineffective and many were redundant. So the government decided to abolish the existing ineffective welfare programs in favor of one that would function as one coherent entity in an effort to create a more coherent social welfare program and improve the targeting mechanism (Levy and Ohls 2007, 1). Thus, the nation-wide CCT program in Jamaica was formed mostly in response to the economic constraints which required the need to limit the government spending as the it was running a variety of ineffective and costly welfare programs.

2-1. Implementation

The PATH program targets the recipients of the three former social welfare programs, which are the public assistance programme, the poor relief programme, and the food stamps programme, that it replaced. PATH's target audience is much larger than the other CCT programs since it ambitiously aims to focus on various facets of poverty by targeting children, pregnant mothers, the extremely poor, the elderly and the disabled.[21]

[21] The beneficiaries are poor adults between 18 to 59 years old, pregnant or lactating women, people that are disabled, elderly people who are over 60 years old but do not receive a pension and any child from birth to the end of the secondary education is covered ("PATH").

Each household receives a stipend based on the composition of the family and the number of eligible people that they encompass. However, the children may only receive either the health or the education stipend and may not receive both benefits. All the grants are the same in terms of monetary value so that each eligible family member will bring in the same amount for the family in terms of cash transfers (Levy and Ohls, 6).

The registration system is also quite clear and straightforward. In order to be considered for the program, the family must apply in the appropriate local Parish Offices of the Ministry of Labour and Social Security available in each parish. The parish office requests information on its present economic condition. After the parish office receives the relevant information, the data is provided to a central governmental office where it is processed in the management information system. Once the data reaches the central office, the household is finally notified regarding their eligibility status.

The Jamaican government improved measures of government interoperability by creating a single management information system. This system is used to determine the eligibility of all applicants. However there are many concerns regarding the application process including the fact that it is still a very slow system. The process of applying for the program and waiting to hear back from the government was a slow process. Another major concern was the application form itself which judges eligibility based on unreasonable questions such as whether or not the family owns basic appliances and sanitation services, since the answers can be misleading and not indicative of the current status of the family in question (Levy and Ohls 2007, 22). Furthermore, it has been

determined that it is possible to provide fraudulent information in an attempt to gain the benefits.

The biggest concern in the operation of PATH is that the health and education services are inadequate and it is a more serious problem for the poor who have a lower quality of and accessibility to services like health care when compared to those that are better off. The lack supply in terms of education and health has become especially clear as the government vowed to reduce the national budget by 20 percent. This reduction in the budget is expected to negatively impact the health care access of the poor. In fact, data shows a consistent descending trend in the financing of health care (Jamaica Country Cooperation, 28). To make matters worse, many positions in the Jamaican ministry of health are vacant and this has also negatively impacted the quality of health care services (Jamaica Country Cooperation, 26). The quality of the education in Jamaica is equally dismal as the provision of good quality education is expensive. Furthermore, the economic difficulties worsened the provision of the necessary and adequate space, materials and equipment. The misallocation of resources is also present in dealing with teachers. In fact the situation is even worse in the rural areas, which were receiving lower education qualities than the urban counter parts (Jamaica – Education for All, 4). This demonstrates that although the demand for the health and educational services increased after the CCTs were implemented, they were not met with an adequate supply from the government. This is the primary reason behind why the increased demand for the health and educational services did not translate into an increased health and education performance level in Jamaica.

2-2. Conditionality

The health and educational conditionality requirements are divided into the categories of eligible people. The health conditionality dictates that children under 6 months old must go to a health facility once every two months and ensure that the child's vaccination schedule is updated. Likewise, children between the spans of 12 to 17 months are also subjected to a health conditionality of having to visit the health center two times in one year. Pregnant women must also be going to health care centers for regular checkups once every two months, while lactating women must go at week 6 and 14 after giving birth. The last health benefit is for people with disabilities, the elderly, or other poor adult recipients that are conditioned to go to a health center two times a year, every six months. It is important to note that the PATH program strongly encourages the elderly of fulfilling their health conditionality, yet they do not punish the elderly for failing to comply. There is only one educational conditionality, which stipulates that children between 6 to 18 years old must attend school at least 85 percent of the time ("PATH Frequently Asked Questions").

Both of the educational and health conditionalities are exposed to a fair amount of criticism as PATH benefits were often easily suspended. In fact approximately one in 10 students of recipient families that were receiving educational benefits were terminated from the program. This high suspension rate was due to instances such as missing school due to an illness but the benefit is suspended because the child was not able to provide a doctor's note. The opportunity cost of going to the doctor is often too high since many of the families receiving the benefits are not able to afford to go to a doctor and parents are

not able to miss work to take them to the doctor in the first place (Levy and Ohls 2007, 23). Furthermore there were cases in which the benefits were suspended when children transferred to a different school. This particular problem occurred due to the fact that the children were mistakenly reported as having not attended and the records failed to acknowledge the move. The issues surrounding the health conditionality were equally severe, as many family members were not informed on how the health benefits work. Furthermore the opportunity cost of taking children to the hospital is often costly for families that are very poor. There were also cases in which hospitals did not recognize the health card provided by PATH, which is supposed to be utilized to gain access to services (Levy and Ohls 2007, 23-25). The issues surrounding the implementation of the PATH program were cumbersome and the lack of clarity in the program's coordination and operation lead to severe problems.

3. Impacts

3-1. Short Run Impacts on Poverty and Inequality

Jamaica struggles with economic growth, as it remains heavily indebted and has a host of socioeconomic problems that include persistently high unemployment rates and a high-income inequality rate. The PATH program itself also encompasses a range of coordination and operational issues. However, even still, the PATH has been able to identify the poorest members of society as four out of five beneficiaries are from families that scored the lowest in terms of consumption levels (Levy and Ohls 2007, 33). Keeping in mind the fact that the PATH's funding power is limited to reach only about 45

percentage of beneficiaries even if it was fully funded and identified each poor family successfully, its actual coverage rate of 20 percent of the poor is understandable (Levy and Ohls 2007, 35-36). This demonstrates that the program is doing considerably well, especially in its targeting mechanism.

3-2. Long Run Impacts on Education and Health

3-2-1. Education

PATH had a positive effect on attendance rates by an increase of 0.5 days in a month but was not successful in translating the high attendance rate into an equally high achievement level (Levy and Ohls 2010, 29). In fact, the attendance of the child did not seem to affect the grades of the student or the child's ability to graduate into the next level. Furthermore, PATH also had no significant impact on child labor in that it was not able to diminish the number children that are working (Levy and Ohls 2010, 20-21). In conclusion, the PATH program was able to reach its more superficial goal of increasing the attendance rates of program beneficiaries, but was unable to achieve an impact on matters beyond simple attendance rates.

3-2-2. Health

The program was able to achieve its superficial goal as beneficiaries increased the use of health care centers more than non-beneficiaries. In fact, the program spurred an increase worth 38 percent of visits among the group of recipient children under 6 years old (Levy and Ohls 2010, 29-30). But similar to results on the impact of deeper educational benefits, PATH was also unable to significantly improve health care statuses.

But this may be largely attributed to the fact that Jamaica's health system is subsidized there was an already high level of favorable health practices such as the vaccination rates.

VI. Brazil Case Study

1. Political, Social and Economic Background

The Portuguese colonized Brazil and had consequently given it a unique lusophonic heritage in a continent primarily dominated by Spanish speakers. However, the distinctive characteristics of Brazilian society go beyond mere differences in language to encompass more significant matters such as its unique population composition.[22] This population composition is especially important when it is studied in conjunction with the regional development trajectory.

Brazil maintains the largest economy of Latin America yet it cannot be said that the growth has been maintained in a stable trajectory. After declaring its independence from Portugal in 1822, Brazil initially remained focused on the exportation of agriculture and primary products. This specialization on volatile primary products created a state of dependency to the developed countries, resulting from the declining terms of trade. As a result, Brazil and many other Latin American countries set out to reduce their dependency in the 1950s by using an economic model of Import Substitution Industrialization. The Import Substitution Industrialization entailed a grueling process in which Brazil attempted to produce its own manufactured goods instead of importing them. Unfortunately, the new policy failed to deliver expected results and left a legacy of heavy indebtedness. This era was followed by a continual decline in the Brazilian economic

[22] Brazil is largely comprised of people of European, Amerindian, and African ancestry. Unlike many of its neighbors, Brazil encompasses a significantly large African diaspora population that was created during the Portuguese colonial era when African slave labor was heavily used.

growth combined with high inflation rates of the 60s. Eventually, this dissatisfaction became a foot in the door for the military leadership, which took over and commanded center stage.

The authoritarian government took over in 1964 and employed a stabilization program that induced growth and exports in manufacturing and primary products increased considerably (Pinheiro et al., 20). However, the economic expansion of this authoritarian era permitted a distorted growth trajectory. This resulted in the industrial sector, which is concentrated around the central and southern regions of Brazil, becoming much more profitable and also more developed than the northeastern, more agricultural region of Brazil.

The disparity between the agricultural northeast and the industrial central and southern region is still evidenced today; long after the conclusion of the authoritarian era. However, these differences are more significant when considered alongside with the context of the population composition of the country. The Brazilians with African ancestry are predominantly residing in the less developed northeastern regions while those of European descent are dominant in the developed southern region of Brazil (Parra et al., 180). Furthermore, the inequality between the Brazilians of European descent versus those of African descent are further highlighted by actual poverty level measures. Indeed, when observing per capita income levels, this disparity becomes unambiguously clear as Afro Brazilians were earning a meager 50 percent of what their European descended counterparts were earning (Gradín, 1). International institutions such as the World Bank also support such observations as they note that there are persistent extreme

regional disparities with the Northeast underperforming in terms of important indicators such as health, nutrition, and infant mortality.

These measures of inequality are a concern for the Brazilian government and so the social welfare programs, like the BF, are used as a method of targeting these issues by creating a safety net for the poorest and most disadvantaged portions of the population. It can be inferred from the higher rates of poverty in the Northeast region of Brazil, that a majority of the CCT target population will be from that region. Indeed, according to a 2008 study, approximately half of the families in some areas of the Northeast receive benefits from the BF program (Hall, 813). It is clear that the BF is targeting the people that need the welfare the most, but the program has also drawn criticism from political conservatives of Brazil that claim that the program encourages dependency in those who cannot seem to 'graduate' from the program.

2. Bolsa Família

The BF program was formally established in 2003, however its roots run much deeper. The program has its beginnings in the combination of 5 different welfare programs, the earliest of which was formed in 1995.[23] The CCT programs that eventually became the BF program were some of the first generation CCTs to be created and true pioneers of their kind. Naturally, in the initial stages, the programs were running in a much smaller scale as they were mostly based in municipalities like Campinas (Lindert et

[23] The current BF program is formed from an amalgamation of five welfare programs, which are the Bolsa Alimentação, Bolsa Escola, Auxílio Gas, the Programa de Erradicação do Trabalho Infantil and the Programa do Cartão Alimentação (S. Soares, 2).

al., 11). However, the programs were considered mostly successful and came to garner vast public and governmental support. The appeal and interest in the CCT programs was not unexpected when considering the context of the 1990s. Brazil held a rather high-income inequality rate, even in comparison with its Latin American neighbors.[24] Additional support came from the fact that the CCTs were expected to counterbalance the adverse socio-economic repercussions generated by the harsh SAPs imposed by the World Bank and the IMF (Santos, 3). Hence, various programs were created and were allowed to evolve given their widespread approval and popularity.

By late 2003, many programs flourished and President Luíz Inácio da Silva announced his decision to combine the programs. The amalgamation of the various programs created a sense of consistency and clarity in the operational management of the CCT. In fact, the creation of a single program effectively reduced some redundancies and even improved the targeting mechanism of the program. It is important to note that despite the merger, the core purpose of the CCT programs have endured as the health and educational conditionalities are ever-present.

Today, the BF program has secured a nationwide influence and is currently one of the biggest active CCT programs worldwide. This is especially impressive when monitoring the trajectory of its growth since the earlier years of the program. In early 2005, closer to the initial launching stage, the BF was covering approximately 6.6 million families (Lindert, 67). But more recent figures in late 2014, demonstrate that the program is now responsible for covering 13.9 million families (Alcobia). In other words, the

[24] In 1995, the Gini index indicates that Brazil was at 59.6 percent (GINI Index).

number of beneficiary families more than doubled in a time span of less than one decade. The BF thrived with the support of international institutions as the World Bank and the Inter-American Development Bank became active supporters of the program. [25]

2-1. Implementation

The BF program is run in order to support the poorest members of society. In this regard, the eligibility criteria are divided in two types. The first eligibility criteria covers those that fall under the category of extreme poverty and is described as any family that has a per capita monthly income of less than 77 Brazilian Reals (BRL). The second type covers the families considered poor; these are families with children under 17 years of old that earn a monthly per capita income somewhere in between of 60.01 to 120 BRL (Hellmann, 9). The BF program has different arrangements for different types of families based on the total monthly income and the family composition.

There are three types of benefits that can be combined in multiple ways in order to categorize families appropriately based on the level of their needs. In total, the possible combinations for families in extreme poverty can leave them with a sum that ranges from 77 to 335 BRL while the families in poverty may receive an amount between 35 to 259 BRL. The three benefits are the Basic Benefit (BB), the Variable Benefit (VB), and the Variable Youth Benefit (VYB) and these classifications determine how much a family will attain from the program. The BB is provided for all families that are earning less than 77 BRL and considered to ben in an extremely poor economic situation. Families that are

[25] The World Bank sought to bolster the BF program by supplying it with a $572 million US dollar loan while the Inter-American Development Bank went even further to provide a loan amounting to $1 billion US dollars (Doctor, 164).

earning more than the 77 BRL, although they are still technically considered poor, are not eligible to receive this sum as it is earmarked for those in most dire need. The second benefit package is the VB, which grants 35 BRL for both poor and extremely poor families that encompass pregnant or lactating women and children under 15 years old. The last benefit package is the VYB, which grants 42 BRL for families classified as poor or extremely poor that has children under 17 years old. The families can attain up to two VYBs but the benefits stop when the child reaches 18 years (Hellmann, 14).[26] The added value of even the largest possible sum attainable from the BF program is 335 BRL. This amount would be for a large family with, for instance, 6 children and a pregnant mother. The stipend is still very small and considering that it is below the monthly minimum wage, which is at 724 BRL,[27] however it is a significant and a welcome contribution to those that are in the lowest rung of the economic ladder.

The benefits are of vital importance to the BF program however targeting mechanisms are just as important for the program's smooth operation. It is clear that without proper targeting mechanisms, the money would be easily squandered. This also partially the motivation behind the combination of the various CCT programs under one large BF program in 2003. The BF program functions in conjunction with the Cadastro Único, which refers to the single registry system that is a combination of other databases. The use of the Cadastro Único effectively minimized the issues regarding duplication of data entries, administration costs as well as fraudulent behavior. There is a standardized

[26] The BF payment benefits data are for 2014.
[27] The monthly minimum wage is for 2014 in order to maintain consistency with the 2014 BF payment benefits data provided previously.

report that must be completed with the help of regional offices and individual social workers that interview the people who wish to register (Dulal, 214). The efficient use of the single registry system allowed the BF program to successfully target 73 percent of the program's benefits to the most impoverished 20 percent of the Brazilian society (Hall, 807). This single registry system has gained the BF program the reputation of the best CCT in Latin America in terms of its targeting by the World Bank.

The targeting mechanism of the BF program has been widely praised, however the coverage of the program remains as a problem. The BF program reached its goal of providing 44 million poor families at the end of 2006, and although this is a great progress, this still leaves much to be desired. To clarify, the 44 million Brazilians that were granted the benefits of the BF program were merely 40 percent of those that were eligible (Hall, 806). This is because of the crucial fact that the BF program is provided based on an allocated budget, which means that eligibility does not guarantee the receipt of the benefit due to the budget limitations. There are two ways in which a family can be covered by the program after they have been denied due to the budget limitation; one, the budget is increased by the government thereby accepting more families into the program or two, a recipient leaves the program (Dulal, 214).[28] The program naturally prioritizes in favor of the poorest families and those with the most children less than 17 years of age.

The problem with the BF program is similar to the one found in the PATH program in that the quality of the health and educational services are inadequate. This low quality of education is seen as Brazilian children score lower when compared to average

[28] The BF program has no limits to how long a family can stay in a program. This also means that if a family escapes poverty but later falls back to the poverty line, they can be readmitted.

Latin American countries. Furthermore, the In the case of Brazil, the low quality of services is more severe in the poor rural northeastern region, which is also where most of the beneficiaries of the BF program reside (Stahlberg, 7-9). This is similar for the case of health services as the northeastern region performed worst in the country in satisfaction measurements regarding health services. Another substantial health service issue is coverage since the number of doctors per 1000 people was estimated to be only 0.31 in the worst off Northeastern districts. Furthermore, the life expectancy and the infant mortality rates in the northeastern regions are also dismal (Stahlberg, 11). The lack of development in the education and health services points to the fact that the government is not able to match the demand for the services with a parallel supply. This is especially true in the case of the poor Northeastern region of Brazil in which the supply of the health and education services are much lower than in other parts of the country. This is the primary reason why the increase in demand for the education and health services has not resulted in an improvement in health and educational performances. The Brazilian case effectively demonstrates that the CCT programs fail to result in improved education and health performances alone and so must be followed paired with an increase in the supply of health and education services from the government.

2-2. Conditionality

Education and Health conditionalities are central to the BF program. The conditionalities play such a large role due to the fact that the pervasive popular opinion among the Brazilians is that the poor struggle to escape poverty alone and thus require

assistance (Lindert and Vincensini, 11).[29] When the CCTs were being developed in the 1990s, the public discourse was heavily focused on using education to stop the cycle of intergenerational poverty. Therefore, such popular support for education effectively cemented the placement of the educational conditionality as a permanent component of the BF program.

The educational conditional requirements are fairly straightforward and easy to comprehend. This conditionality applies to the children of the recipients that require that children between the ages of 6 to 15 must be enrolled in school. Moreover, the children must have a monthly attendance rate of 85 percent. Similarly, children of 16 to 17 years old must also be enrolled in school and maintain a monthly attendance rate of 75 percent. The conditions are strict and dictate that if a child misses school, a parent is obligated to inform the school of the reason why they were absent on the particular day. Furthermore, if the child in question relocates to a different school, then the parent must also notify the BF program coordinator accordingly (Lindert et al., 18). These educational requisites make up an important half of the requirements underlined in the BF program.

The BF program also encompasses a number of health conditionalities. The health requisites begin with pregnant and lactating mothers that are required to get regular pre and post-natal checkups and participate in various classes on topics such as nutrition, which are promoted by local health teams. The beneficiaries must also ensure that children under 7 years old are on track with the necessary vaccination requirements,

[29] 75.7 percent of Brazilians believe that an unjust society is the reason why the poor remain poor. Furthermore, 70.5 percent of the population believes that the poor have very few opportunities to escape poverty (Lindert and Vincensini, 11).

attend their scheduled health checks, and submit to the growth monitoring conducted by professionals (Lindert et al., 18). The health conditionalities, just like education requirements, are seen as a vital factor in the construction of the human capital necessary for escaping intergenerational poverty.

The conditionalities on health and education are enforced rigorously and there are penalties associated with failing to satisfy the necessary requirements. Naturally, the penalties get harsher with persistent lack of compliance to the conditionalities. The culmination of non-compliance is in the instance of the fifth instance of non-compliance in which the family is effectively terminated from receiving the benefits from the program (Lindert et al., 69). The conditions that are required in the CCTs are occasionally targets of heavy criticisms, which stem from reasoning that state that conditionalities are unnecessary and do not serve their function to improve significant human capital development (Medeiros et al., 41). Other arguments against the BF programs arise from suggestions that the program fosters a state of dependency and fail to nurture development or that they are too heavily politicized (Hall, 812-814).[30] In fact, critics because of the fact that the BF program has no limit in granting benefits heavily emphasize the issue of dependency. This means that a recipient may receive benefits for as long as they live if they do not succeed in escaping poverty. These are serious concerns

[30] The BF program very strong ties to the leftist leaning Labor party and this generates concern that the promotion of the program is used to buy votes from the poor popular majority. President da Silva has associated himself closely with the BF program and effectively aligning himself with the poor majority in the process (Hall, 812-813).

that can be explained further by further analysis of the impacts of the effects of the BF program.

3. Impacts

The BF program is one of the first generation CCT programs, and thus the academic community has heavily scrutinized it. The main purpose of CCTs is to tackle the short-term problem of immediate poverty and the long-term problem of intergenerational poverty and thus the impacts of the BF are studied separately.

3-1. Short Run Impacts on Poverty and Inequality

The BF program has accomplished its short-term goal and it is seen as a safety net for those who are in dire need of immediate financial assistance. To provide some perspective, those who are classified as extremely poor and thus able to receive the BB from the BF program are living on less than 2.6 BRL per day.[31] This amount is clearly under the World Bank poverty line of $1.90 US dollars (USD) and also effectively classifies them in the world standard as extremely poor.[32] Thus the immediate short term poverty relief provided by the BF program is a lifesaver for some of the poorest beneficiaries.

The positive impact of the BF program on poverty manifest clearly in the growth in the mean real household per capita income in Brazil. In 1995, the mean real household per capita income averaged at around $220 USD and remained low throughout the next 8

[31] Those who are extremely poor must earn under 77 BRL per month, which is approximately 2.6 BRL per day.
[32] $1.90 US dollars is the poverty line is a 2015 measure provided by the World Bank (FAQs: Global Poverty Line Update).

years and only grew slightly to about $245 USD in 2003. However, after the pivotal establishment of the BF program in 2003, there is a clear growth in the mean real per capita income. This is shown as the mean real per capita income grows to approximately $370 dollars by 2009, which is achieved over a shorter period of merely 6 years (De Souza, 12-14). It is interesting to note that according to the Brazilian governmental data, the absolute number of those classified as poor were increasing and eventually hit the highest level in history in 2003. But more interestingly, the number of people living under the poverty line decreased from 61 million to 40 million from the period of 2003 to 2009 (Higgins, 89-90). This strengthens the notion that the BF created real improvements in terms of a decrease in poverty.

In terms of the improvements on the inequality measures, in the same time period of 1995 to 2009, the GINI index dropped from a value of 59.9 percent to 53.9 percent.[33] However it is important to note that although this is an impressive feat, it is unclear how much of the improvement can be fairly attributed to the BF program. This is largely due to the fact that the Brazilian economy in the 2000s was already growing significantly just as it was for its Latin American neighbors regardless of the BF program (De Souza, 12-14). Furthermore, during the 1990s there was an increase in the access to education, a growth in the demand for unskilled labor, as well as the rise of the minimum wage that all could have all contributed to the reduction of poverty (Higgins, 90-91). Ultimately, this means that the impact that the BF program had on the short-term poverty reduction is

[33] The ratio between the top to the bottom 20 percentile of the earnings dropped from 27 times to 18 times, which amounts to a value of 32 percent. The ratio of 18 times is unfortunately also very high but is yet undeniably a significant improvement from the 1995 figures (de Souza, 11).

murky due to various other factors. Even still, the defined significance in growth in the mean real per capita income and the reduction of the number of people living under the poverty line, which started in 2003, does suggest that BF has had some significant influence in the poverty reduction.

3-2. Long Run Impacts on Education and Health

3-2-1. Education

The direct impact of the BF program on impact and enrollment rates shows a clear but modest improvement. The children of BF recipients were less likely by 3.6 percent to be absent than those who were not beneficiaries. Furthermore, the educational impact also extended to the reduction of dropout rates by 1.6 percent, with children of recipients dropping out less than the non-recipient children. It has also been estimated that although there was an initial enrollment rate of children between 10 to 15 years of 94 percent in Brazil, the BF is estimated to add about 40 percent of those that are still not enrolled to enroll in school. This number is naturally higher for the poorest of the population as the percentage of the newly enrolled rises from 40 to 60 percent (Bourguignon et al., 239). The increase in enrollment rates is an important feat in the fight towards obtaining the goal of universal primary and secondary education.

The BF program does deliver some positive impact on enrollment rates and attendance rates. However, critics suggest that this may not be enough. There is evidence that the BF program failed to have a significant impact on child labor as it was clear that the amount that BF provided, was smaller than the amount children could make by

working out of school (Hall, 808). However, the deeper issues arise when considering the fact that the conditionalities may not induce a long-term improvement in human capital development. This is a signal that the main vision behind the BF imposing educational conditionalities is experiencing a disconnect with its goal of reducing long run inter-generational poverty by improving human capital development. Such a disconnect occurs due to the fact that there needs to be a parallel and equal focus on improving educational services along with the enrollment and attendance rates (Bourguignon et al., 245). This notion is also heavily supported by various researchers including Sánchez-Ancochea and Mattei (2011), who conclude that the impact of the BF depend on the government provision of in the educational sector, just as much as the initial conditionalities. To provide a more solid example, although the attendance rates improved, the children of BF program recipients were more likely to be unsuccessful in making progress in school by almost 4 percent (F. Soares, 5). This serves as evidence that increasing the number of students does not increase the quality of education; and so children that are newly enrolling due to the BF program's conditionality clause are struggling to catch up in school and failing more frequently than those who have always been enrolled.

3-2-2. Health

The BF conditionality on health has been lauded for the improvements that it engendered. The most important concern was the limited health services that the beneficiaries could use since recipients were willing to use the health services that were provided (Bassett, 20). Furthermore, there have been clear improvements since BF took

over the previous CCT programs in charge of providing nutritional health incentives.[34] The improvements eradicated dangerous unforeseen consequences that included cases in which mothers reduced the food intake for the children enough to ensure that the family could continue to receive the benefits from the CCT programs, despite the fact that there was an improvement on food consumption.[35] The fact that the BF program provides consistent benefits that depend solely on family composition and complying with existing conditionalities readjusted the program and eliminated unfortunate intake manipulations (Basset, 19-20). In fact, after the BF was established in 2003, there is evidence that children of recipients had an improved measure of both weight and height than children of the non-beneficiaries (Paes-Sousa, 498). Consequently, on the matter of nutrition, the BF program contributed to both an improvement in nutrition as well as an added benefit of fixing a previous CCT's overlooked mistake.

The health conditionality of the BF also includes vaccination schedules that must be followed. However, the impact of the BF program on vaccination is not as clear as its impact on nutrition. This is largely because of the fact that both recipients and non-recipients of the benefits of BF experienced an improvement in terms of vaccination. Initially in 2005, 9 percent of children of BF benefits were unvaccinated, while 11

[34] Before the formation of the BF program in 2003, the Bolsa Alimentação was the CCT that provided the conditionality on nutritional health.

[35] Initially, children of CCT recipients were gaining weight faster than those who were not receiving benefits. However some administrative errors resulted in children that were previously recipients to be excluded from receiving further benefits. After this, results demonstrate that beneficiary children were slower in gaining weight than the non-beneficiary children. This suggests that there have been manipulation from the families or from the health professionals that were helping to avoid the family from becoming ineligible from receiving benefits in the future (Bassett, 20).

percent of the children of those that were not receiving benefits were unvaccinated. By 2009, only 2 percent of children from both the benefit recipient and non-recipient groups were unvaccinated (De Brauw, 8).[36] This makes it difficult to identify if the BF program was responsible for the improvements.

The impacts on the health conditionality of pre and post-natal health care were also not easy to identify. This is also because there were no significant differences in recipients and non-recipients. By 2009, BF recipients were going to 4.4 prenatal care visits which increased from 3.5 in 2005. The non-recipients were going to approximately 4.3 prenatal care visits in 2009, which was very similar to the number of recipients' visits. In fact, in the case of the non-recipients, the number increased much higher, since in 2005, the number of average prenatal care visits was at a much lower 2.9 times. Furthermore, in terms of the percentage of women that were receiving prenatal care, by 2009, both shares increased to approximately 94.3 percent (De Brauw, 12). In such instances, it is again, difficult to properly determine the BF's impact on health.

[36] Even though approximately 98 percent of all Brazilian children were receiving vaccines, it is important to note that in about 50 to 70 percent of the cases they did not receive vaccinations on time. This reduces efficacy of the vaccines.

VII. RESULTS AND CONCLUSION

This thesis examined the CCT programs of Brazil, Colombia, Jamaica, and Mexico, which all encompass a diverse set of economic and political backgrounds, in order to better comprehend the characteristics of each. More specifically, my goal was to understand how the conditionalities impacted the short term and long-term poverty and inequality in each country. Overwhelmingly, it is seen that there are improvements in the short run reduction of poverty since the cash transfer is provided to alleviate the immediate problems. Families also mostly complied with the health and education conditions imposed through the program, which naturally lead to an immediate positive effect on those particular conditions. However, the degree of improvement varied depending on a variety of factors. For instance, beneficiary enrollment rates increased much more for high school aged children than for primary school children. On the other hand, the long-term impact was not so analogous throughout the country cases. The research demonstrates that as expected, Jamaica was unable to stimulate a long-term human capital development in the country. It was also interesting to see that despite being an upper-middle income level country, Brazil also could not successfully spur human capital development through its program since the development levels in the country was heavily unbalanced between the rural northeast and the industrial central and southern regions. Colombia and Mexico was more successful than the Brazilian and Jamaican cases despite the fact that the Mexican CCT is much larger than its Colombian counterpart. But the success can be mostly attributed to the fact that both programs held

the existence of adequate health, education and financial services as a prerequisite for implementation.

The Brazilian BF CCT is a first generation CCT that has flourished under the rule of leftist politicians. The popularity of the BF program can be attributed largely to the fact that it delivers an observable decrease in the poverty rate and an increase in the mean real household per capita. Furthermore, despite the fact that the BF is one of the largest CCT programs in the world, its targeting mechanism of the Cadastro Único is excellent and reduced all sorts of problems including duplication, administration costs, and fraudulent behavior. However, the results were not as impressive when observing the long-term goals. This is because there was no significant effect on the improvement of level of grades or dropout rates. The result implies that the funding in the educational sector, in terms of teaching services, infrastructure, etc. are not as grandiose as the BF program. In fact, in the Brazilian case it is clear that the government is not able to match the large demand for services with a parallel supply in the Northeastern region. This is also why the increase in demand for education and health services has not resulted in a parallel improvement in health and educational performances in the Northeast. In fact, the program failed to foster health and education performance improvements despite the fact that Brazil is an upper-middle income country. This can be attributed to the fact that there was an unequal development level in Brazil where the rural northeast, which is where the majority of CCT beneficiaries live, are much less developed than the central and southern regions of Brazil. The lack of a balanced development implies that the necessary services in the northeast lagged behind that of the southern and central regions. This is severely

problematic since this means that the poor are not able to build up the human capital necessary to escape the long-term poverty. In fact, the lack of an exit door to graduate from the program is another significant concern as critics claim that the program makes the poor dependent on handouts.

The Mexican CCT program PROGRESA/Oportunidades is similar to the BF program in that it is a first generation, nation-wide program. Mexico, like Brazil is also an upper-middle income country but in the case of PROGRESA/Oportunidades, there was an essential difference. Mexico's CCT program was dealt much more as a test case. In fact, the Mexican CCT was much more cautious and observational than the BF program was, and it launched many pilot programs with built in observational mechanisms in order to learn from each pilot program. This means, that even in the eventual nation-wide coverage of the CCT program, the program still remained limited to communities that had an adequate form of basic social services. This then, lead to the success of the short-term improvements in income, as well as an increase in saving habits through the use of banks. Moreover, the Mexican government anticipated that the implementation of the CCT program would increase the demand of services. Therefore the government effectively boosted the supply of services before the program was inaugurated in order to meet the high demand. Most importantly, the government stepped in to guarantee that beneficiaries could meet the conditionalities. In fact, the educational conditionality significantly improved the enrollment and attendance rates of secondary and high school students, especially for girls and those residing in rural areas and increased the attainment levels of the students and increased health statuses of beneficiaries. However, it is also important

to note that the fact that the Mexican CCT program is limited to places with access to educational, financial and health facilities is also a cause for concern since Mexicans living in extremely poor communities without access to proper services are effectively excluded from the CCT program.

The Colombian case is similar to the Mexican case, although it is of a much smaller size. The Colombia CCT program also started out at a much smaller scale through a beta test, which later garnered much support. In Colombia, the central government reaches out the local community and the local government to ensure that the local government will uphold strict responsibilities regarding the FA program. This strict monitoring garnered much success as short-term poverty indicators such as basic household consumption rose considerably. The FA program is similar to the Mexican Oportunidades/PROGRESA program in that it has strict selection criteria in choosing municipalities. To be more specific, the FA program is only run in municipalities that have adequate health, education and financial services. Similar to the Mexican CCT, this selection criteria serves to guarantee that beneficiaries of the program will be able to comply with conditionalities. In other words, the Colombian government understood that the introduction of the FA program would increase the demand of the health and education services, so it only provided the program to areas that already had the adequate health, education and financial facilities in place. Therefore, the municipalities that were allowed to run the FA program did face an increase in demand for services but the existing supply of adequate health, education, and financial facilities had already been able to cover the increase in demand. This selection mechanism provided long term

benefits in education and health performances as children that entered school later as a means to fulfill the condition of the program actually performed equally as well as students who had always been enrolled. This is a stark contrast to the Brazilian BF program, in which the low educational service qualities frequently left children with failing grades.

The Jamaican case was another clear example of an excellently implemented case in terms of the targeting mechanism. There were coordination issues between the government and the educational and health facilities but the targeting mechanism was advanced enough to ensure that a significant portion of the poor population was targeted despite the limited funds. However, the Jamaican case also demonstrated that the failure to have adequate health and educational facilities will result in the disconnect between the superficial conditionality requirements and the long-term human capital development. To be more specific, the governmental supply of quality education and health services were not enough to meet the increased demand for these services after the implementation of the PATH program. This means that in the Jamaican case, the lack of a parallel development in education and health service sectors meant that the increased demand for these services were not leading to improved health and education performances. For instance, the conditionality did indeed increase attendance levels, but this failed to translate into better grades or the progression into the next grade level. Furthermore, the health visits were increased due to the health conditionality but there was no improvement in the health care status. This demonstrates that in the case of Mexico, Jamaica, Colombia and Brazil, the level of development in terms of the availability and

adequacy of educational, financial and health services played a large role in the long-term human capital development.

List of References

Altangerel, Tuya, and Fernando Henao. "Poverty Reduction Scaling Up Local Innovations for Transformational Change." (2011): n. pag. *United Nations Development Programme*. Special Unit for South-South Cooperation, Nov. 2011. Web. <http://www.undp.org/content/dam/undp/library/Poverty%20Reduction/Participatory%20Local%20Development/Mexico_Progresa_web.pdf>.

Attanasio, Orazio, Erich Battistin, Emla Fitzsimons, Alice Mesnard, and Marcos Vera-Hernández. "Food and Cash Transfers: Evidence from Colombia*." *The Economic Journal* 122.559 (2011): 92-124. Institute for Fiscal Studies, 2005. Web. <http://www.ifs.org.uk/bns/bn54.pdf>.

Ayala, Francisco. N.p.: n.p., 2005. *Overseas Development Institute*. Overseas Development Institute, Feb. 2006. Web. <http://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/1690.pdf>.

Barham, Tania, and Jacob Rowberry. "Living Longer: The Effect of the Mexican Conditional Cash Transfer Program on Elderly Mortality." *Journal of Development Economics* (n.d.): n. pag. Web. <http://www.colorado.edu/ibs/hs/barham/PAPERS/Barham_Rowberry_JDE_2013.pdf>.

Bassett, Lucy. "Can Conditional Cash Transfer Programs Play a Greater Role in Reducing Child Undernutrition?" 0835 (2008): n. pag. The World Bank, Oct. 2008. Web. <http://siteresources.worldbank.org/SOCIALPROTECTION/Resources/SP-Discussion-papers/Safety-Nets-DP/0835.pdf>.

Behrman, Jere R., and Susan W. Parker. "The Impact of the PROGRESA/Oportunidades Conditional Cash Transfer Program on Health and Related Outcomes for the Aging in Mexico." *University of Pennsylvania*. N.p., 7 Oct. 2011. Web. <http://repository.upenn.edu/cgi/viewcontent.cgi?article=1033&context=parc_working_papers>.

Bourguignon, François, Francisco H.G. Ferreira, and Phillippe G. Leite. "Conditional Cash Transfers, Schooling, and Child Labor: Micro-Simulating Brazil's Bolsa Escola Program." *The World Bank Economic Review* 17.2 (2003): 229-54. Web. <http://www.fundacaoitausocial.org.br/_arquivosestaticos/FIS/pdf/conditional_cash_transfers_schooling_and_child_labor.pdf>.

"Colombia." International Work Group for Indigenous Affairs, 2015. Web. <http://www.iwgia.org/images/stories/sections/regions/latin-america/documents/IW2015/Colombia_IW2015_web.pdf>.

De Brauw, Alan, Daniel O. Gilligan, John Hoddinott, and Shalini Roy. "The Impact of Bolsa Família on Child, Maternal, and Household Welfare." International Food Policy Research Institute, 31 Oct. 2010. Web.

De Souza, Pedro H.G. Ferreira. "Poverty, Inequality and Social Policies in Brazil, 1995-2009." *POVERTY, INEQUALITY AND SOCIAL POLICIES IN BRAZIL, 1995-2009* (n.d.): n. pag. IPEA, Aug. 2011. Web. <http://www.ipc-undp.org/pressroom/files/ipc631.pdf>.

Doctor, Mahrukh. "Inequality, Social Policy and State Welfare Regimes in Developing Countries: The Case of Brazil." *The Withering of the Welfare State: Regression*. Ed. James Connelly and Jack Hayward. N.p.: Palgrave Macmillan, 2012. N. pag. Print.

Dulal, Hari Bansha. Poverty Reduction in a Changing Climate. N.p.: Lexington, 2013. Print.

“FAQs: Global Poverty Line Update." *The World Bank*. N.p., 30 Sept. 2015. Web. 2015.

Fernald, Lia C H, Paul J. Gertler, and Lynnette M. Neufeld. "Role of Cash in Conditional Cash Transfer Programmes for Child Health, Growth, and Development: An Analysis of Mexico's Oportunidades." *The Lancet* 371.9615 (2008): 828-37. *The Lancet*. 8 Mar. 2008. Web. <http://www.who.int/management/country/mex/RoleofCashConditionalCashTransferMexicosOportunidades.pdf>.

Fiszbein, Ariel, Norbert Schady, Francisco H.G. Ferreira, Margaret Grosh, Nial Kelleher, Pedro Olinto, and Emmanuel Skoufias. "Conditional Cash Transfers: Reducing Present and Future Poverty." *A World Bank Policy Research Report* (n.d.): n. pag. *The World Bank*. 2009. Web. <http://siteresources.worldbank.org/INTCCT/Resources/5757608-1234228266004/PRR-CCT_web_noembargo.pdf>.

"GINI Index." *The World Bank*. The World Bank, n.d. Web. <http://data.worldbank.org/indicator/SI.POV.GINI?page=4>.

Gradín, Carlos. "Why Is Poverty So High Among Afro-Brazilians? A Decomposition Analysis of the Racial Poverty Gap." Journal of Development Studies 45.9 (2009): 1426-452. Institute for the Study of Labor. Web.

Hall, Anthony. "Brazil's Bolsa Família: A Double-Edged Sword?" *Development and Change* 39.5 (2008): 799-822. John Wiley and Sons, Ltd, 2008. Web. <http://eprints.lse.ac.uk/21258/1/Brazil's%20Bolsa%20Familia%20(LSERO).pdf>.

Hellmann, Aline Gazola. "How Does Bolsa Familia Work? Best Practices in the Implementation of Conditional Cash Transfer Programs in Latin America and the Caribbean." Inter-American Development Bank, Sept. 2015. Web. <https://publications.iadb.org/bitstream/handle/11319/7210/How_does_Bolsa_Familia_Work.pdf?sequence=5>.

Higgins, Sean. "The Impact of Bolsa Família on Poverty: Does Brazil's Conditional Cash Transfer Program Have a Rural Bias?" (n.d.): n. pag. May 2012. Web. <http://www.helvidius.org/wp-content/uploads/2012/05/Higgins.pdf>.

Holmes, Rebecca, Nicola Jones, Rosana Vargas, and Fabio Veras. "Cash Transfers and Gendered Risks and Vulnerabilities: Lessons from Latin America." *Overseas Development Institute* (2010): 1-6. UNDP International Policy Centre for Inclusive Growth, Oct. 2010. Web.

"Jamaica Country Cooperation Strategy 2010 – 2015." (n.d.): n. pag. PAHO/WHO. Web. <http://www.who.int/countryfocus/cooperation_strategy/ccs_jam_en.pdf>.

"Jamaica - Education for All 2015 National Review." *Foreign Law Guide* (n.d.): n. pag. *Ministry of Education*. UNESCO, May 2015. Web. <http://unesdoc.unesco.org/images/0023/002300/230020E.pdf>.

Levy, Dan, and Jim Ohls. "Evaluation of Jamaica's PATH Conditional Cash Transfer Programme." *Digital Access to Scholarship at Harvard*. Journal of Development Effectiveness, Dec. 2010. Web. <http://nrs.harvard.edu/urn-3:HUL.InstRepos:4908084>.

Levy, Dan, and Jim Ohls. "Evaluation of Jamaica's PATH Conditional Cash Transfer Programme: Final Report." (2007): n. pag. Ministry of Labour and Social Security, Mar. 2007. Web. <http://www.mathematica-mpr.com/~/media/publications/PDFs/jamaicapath.pdf>.

Levy, Santiago. *Progress against Poverty: Sustaining Mexico's Progresa-Oportunidades Program*. Washington, D.C.: Brookings Institution, 2006. The Brookings Institution, 2006. Web. <http://www.brookings.edu/global/progress/pap_total.pdf>.

Lindert, Kathy, Anja Linder, Jason Hobbs, and Bénédicte De La Brière. "The Nuts and Bolts of Brazil's Bolsa Família Program: Implementing Conditional Cash Transfers in a Decentralized Context." Social Protection 0709 (2007): 1-143. The World Bank, May 2007. Web.

Lindert, Kathy. "Brazil: Bolsa Familia Program – Scaling-up Cash Transfers for the Poor." MfDR Principles in Action: Sourcebook on Emerging Good Practices (n.d.): n. pag. Managing for Development Results. Web.

Lindert, Kathy, and Vanina Vincensini. "Social Policy, Perceptions and the Press: An Analysis of the Media's Treatment of Conditional Cash Transfers in Brazil." (n.d.): n. pag. The World Bank, Dec. 2010. Web.

Medeiros, Marcelo, Sergei Soares, Pedro Souza, and Rafael Osorio. "Inequality, Poverty, and the Brazilian Social Protection System." *Brazil Emerging: Inequality and Emancipation*. Ed. Jan Nederveen Pieterse and Adalberto Moreira Cardoso. N.p.: Routledge, 2014. N. pag. Print.

"Medición De La Pobreza En México Y En Las Entidades Federativas 2014." (2015): n. pag. *CONEVAL*. CONEVAL, July 2015. Web. <http://www.coneval.gob.mx/Medicion/Documents/Pobreza%202014_CONEVAL_web.pdf>.

"Mexico." *The World Facbook*. Central Intelligence Agency, 28 Oct. 2015. Web. <http://free-proxyserver.com/browse.php?u=QzT7NyJ4e1qQxdT7p0FHasTr5DjQDL81tu4Ob3XLWTZk3D4ukVpl4257qXbDZf4M9ueUyrO%2FMUR5CrXYTq6iVpCZFWM%3D&b=29>.

Paes-Sousa, Romulo, Ferdinando Regalia, and Marco Stampini. "Conditions for Success in Implementing CCT Programs: Lessons for Asia from Latin America and the Caribbean." (2014): 347-48. *Inter-American Development Bank*. Inter-American Development Bank, 2013. Web. <http://www10.iadb.org/intal/intalcdi/PE/2013/11990.pdf>.

Paes-Sousa, Rômulo, Leonor Maria Pacheco Santos, and Édina Shisue Miazaki. "Effects of a Conditional Cash Transfer Programme on Child Nutrition in Brazil." *Bulletin World Health Organization* (2011): 496-503. Web. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3127265/pdf/BLT.10.084202.pdf>.

Parra, Flavia C., Roberto C. Amado, José R. Lambertucci, Jorge Rocha, Carlos M. Antunes, and Sérgio D.J. Pena. "Color and Genomic Ancestry in Brazilians." (2002): n. pag. Web.

"PATH." *Ministry of Labour and Social Security*. Ministry of Labour and Social Security, n.d. Web. <http://www.mlss.gov.jm/pub/index.php?artid=23>.

"PATH Frequently Asked Questions." *Ministry of Labour and Social Security*. Ministry of Labour and Social Security, n.d. Web. <http://www.mlss.gov.jm/pub/index.php?artid=59>.

Pinheiro, Armando Castelar, Indermit S. Gill, Luis Servén, and Mark Rowland Thomas. "Brazilian Economic Growth, 1900-2000: Lessons and Policy Implications." Inter-American Development Bank, May 2004. Web.

"Poverty Headcount Ratio at National Poverty Lines (% of Population)." *The World Bank*. The World Bank, n.d. Web. <http://data.worldbank.org/indicator/SI.POV.NAHC/countries/CO?display=graph>.

Rawlings, Laura B. "A New Approach to Social Assistance: Latin America's Experience with Conditional Cash Transfer Programs." (n.d.): n. pag. The World Bank, Aug. 2004. Web. <http://info.worldbank.org/etools/docs/library/250795/session7ANEW.PDF>.

Robinson, Alonford James Jr. "Jamaica." *Oxford African American Studies Center*. Oxford University Press, n.d. Web. <http://www.oxfordaasc.com/public/samples/sample_country.jsp>.

Sánchez-Ancochea, Diego, and Lauro Mattei. "Bolsa Família, Poverty and Inequality: Political and Economic Effects in the Short and Long Run." *Global Social Policy* 11.2-3 (2011): 299-318. Web.

Santos, Luiz Marcelo Vídero Vieira. "Bolsa Familia Programme: Economic and Social Impacts under the Perspective of the Capabilities Approach." (n.d.): n. pag. June 2010. Web. <http://www.ids-uva.nl/wordpress/wp-content/uploads/2011/07/10_Videira.pdf>.

Skoufias, Emmanuel. *PROGRESA and Its Impacts on the Welfare of Rural Households in Mexico*. Washington, DC: International Food Policy Research Institute, 2005. International Food Policy Research Institute, 2005. Web. <http://cdm15738.contentdm.oclc.org/utils/getfile/collection/p15738coll2/id/80436/filename/80437.pdf>.

Soares, Fábio Veras, and Elydia Silva. "Conditional Cash Transfer Programmes and Gender Vulnerabilities: Case Studies of Brazil, Chile and Colombia." 69 (2010): n. pag. International Policy Centre for Inclusive Growth. Web. Sept. 2010. <http://www.ipc-undp.org/pub/IPCWorkingPaper69.pdf>.

Soares, Fábio Veras, Rafael Perez Ribas, and Rafael Guerrero Osório. "Evaluating the Impact of Brazil's Bolsa Família: Cash Transfer Programmes in Comparative Perspective." *IPC Evaluation Note* (2007): n. pag. *UNDP*. International Poverty Centre, Dec. 2007. Web. <http://www.ipc-undp.org/pub/IPCEvaluationNote1.pdf>.

Soares, Sergei, Rafael Perez Ribas, and Fábio Veras Soares. "Targeting and Coverage of the Bolsa Família Programme: Why Knowing What You Measure Is Important in Choosing the Numbers." (2010): n. pag. International Policy Centre for Inclusive Growth. Web. <http://www.ipc-undp.org/pub/IPCWorkingPaper71.pdf>.

Stahlberg, Stephanie Gimenez. "Going Beyond Bolsa Família to Solve Underdevelopment Problems in the Brazilian Northeast." (n.d.): n. pag. Web. <http://cddrl.fsi.stanford.edu/sites/default/files/Stahlberg_-_Going_Beyond_Bolsa_Familia_to_Solve_Underdevelopment_Problems_in_the_Brazilian_Northeast.pdf>

"Structural Adjustment Programs at the Root of the Global Social Crisis: Case Studies from Latin America." *World History Archives*. The Development GAP for the Social Summit in Copenhagen, Nicaragua and Mexico, 1995. Web. <http://www.hartford-hwp.com/archives/40/003.html>.

Ulrichs, Martina. "Equal Opportunities for All? - A Critical Analysis of Mexico's Oportunidades." *IDS Working Papers* 007th ser. 2012.413 (2012): n. pag. *Institute of Development Studies*. Centre for Social Protection, Dec. 2012. Web. <https://www.ids.ac.uk/files/dmfile/wp413.pdf>.

"Updated Income Classifications." *Updated Income Classifications*. The World Bank, n.d. Web.

Zavakou, Alkistis. "An Evaluation of the CCT Program Familias En Acción on Grade Failure and School Drop-out Rates." (n.d.): n. pag. Web. <http://www.vsfs.cz/prilohy/konference/3_sc_f_1_zavakou.pdf>