

NICARAGUA'S RED DE PROTECCIÓN SOCIAL:
**AN EXEMPLARY BUT SHORT-LIVED
CONDITIONAL CASH TRANSFER PROGRAMME**

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Country Study

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NICARAGUA'S RED DE PROTECCIÓN SOCIAL: AN EXEMPLARY BUT SHORT-LIVED CONDITIONAL CASH TRANSFER PROGRAMME *

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ABSTRACT

This country study investigates the history and eventual conclusion of Nicaragua's conditional cash transfer programme, the *Red de Protección Social* (RPS). Specific features of the programme, in both its first and second phase, are described thoroughly to provide readers with an appropriate understanding and appreciation of the details of RPS. A brief overview of the current state of social protection in Nicaragua is also included to enhance understanding of the current environment in the country. In particular, this study discusses the elements that contributed to the programme's successes and eventual discontinuation. Although RPS achieved most of its goals, it was unable to garner enough domestic support to ensure its continuation. While the programme was known internationally for the positive effects it quickly had on children's health and education, its purpose and performance were misunderstood at the domestic level. This lack of appreciation heightened criticisms of RPS and hindered support for the programme within its institutional base. RPS is an example of an efficient and effective conditional cash transfer programme, but it also serves as a warning to officials operating in similar contexts. RPS officials had to balance the demands of domestic and international stakeholders, meeting short-term goals while ensuring the initiative's long-term viability. The Nicaraguan experience usefully illustrates the challenges involved in creating an exemplary programme and ensuring its long-term sustainability.

1 INTRODUCTION

In recent years, economic development agendas have focused on comprehensive plans that meet both macroeconomic and microeconomic objectives. While growth is still important, increasing human capital levels among the poor is also seen as a significant step towards achieving the Millennium Development Goals. Long-term development strategies reflect this perspective, and most developing countries' development agendas include programmes that aim to increase human capital.

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One of the best known types of initiatives with this focus is a conditional cash transfer programme (CCT), in which vulnerable populations are given transfers of cash contingent on their investments in human capital, particularly in education and healthcare. These programmes address short-term income constraints that households face, while ensuring that households invest in areas that will lead to long-term growth and poverty alleviation. CCTs typically direct cash transfers to mothers or female adults within households, in the belief that women are more likely than men to spend the cash in ways that are more helpful to their children. The largest and probably best known CCTs include Mexico's *Oportunidades* and Brazil's *Bolsa Família*, though many similar and smaller programmes have been introduced around the world.

Nicaragua's *Red de Protección Social* (RPS) has been one of the world's most widely recognised CCTs, known mainly for the impact it had in a short period on the education and health of beneficiary children. RPS, however, no longer exists. What first made it so successful, and what ultimately brought about its downfall, are both important matters to address. Other countries that have had similarly successful programmes should take note in order to encourage those initiatives' own success and sustainability. Countries that are beginning their own programmes should take note of the potential and possible vulnerabilities of similar operations.

This study seeks to explain how RPS functioned from its inception to its end. It draws on official loan papers, presentations, journal articles and other documents related to the programme. Understanding of RPS was helped by a mission to Nicaragua in January 2008, on which the author interviewed several individuals who were RPS officials at various points, as well as other government employees who currently work in social protection programmes in Nicaragua. The research included trips to beneficiary communities and interviews with local stakeholders and beneficiaries.

The rest of this paper is organised as follows: Section 2 describes previous social protection programmes in Nicaragua. Section 3 describes the first phase of RPS. Section 4 describes the second phase of the programme. Section 5 gives a brief overview of other social protection programmes in Nicaragua. Section 6 provides an overall evaluation and conclusion.

2 EARLY SOCIAL SAFETY NET PROGRAMMES IN NICARAGUA

Nicaragua's history of social protection programmes reflects the socialist influences that led to extensive civil conflicts in the 1980s. The Sandinista regime, which ruled Nicaragua from the overthrow of the Somoza dictatorship in 1979, placed a high value on providing universal social services in education and healthcare. Other programmes in the 1980s provided in-kind transfers (accompanied by rationing) of food, transport, energy and more (Largaespada Fredersdorff, 2006). Most programmes in the 1980s were consistent with these objectives and sought to reallocate income and property from the rich to the poor (IDB, 2001).

In the early 1990s, when political power was placed in pro-market hands and civil conflicts were halted, the government provided some transfers to compensate those who had suffered in the previous hostilities (Largaespada Fredersdorff, 2006). During most of the 1990s, however, the pro-business and free-market governments prioritised economic and pro-market reforms over social programmes. One change to this approach was the establishment of the Supplementary Social Fund (*Fondo Social Suplementario*, FSS) in 1998 to finance and organise social programmes (Largaespada Fredersdorff, 2006). Additionally, the Emergency Social

Investment Fund (*Fondo de Inversión Social de Emergencia*, FISE), which had been used to build infrastructure destroyed during the conflicts of the 1980s, began to increase national attention to poverty reduction and social protection in the late 1990s. Nevertheless, most social protection activities in Nicaragua centred on improving the supply of basic education and health services by means of more infrastructure and employee training (BID, 1999).

Despite previous efforts to provide social benefits to all Nicaraguans, the country still faced severe human development problems in the late 1990s. Infant mortality was high; stunting affected almost 40 per cent of children in future RPS treatment areas; and almost a third of children were anaemic (IFPRI, 2005). Some 47.9 per cent of Nicaraguans lived in poverty in 1998, and 17.3 per cent lived in extreme poverty. The numbers were on a downward trend but were still too high, and the Central Region's rural poverty levels had actually reached 68.5 per cent and 28.9 per cent, respectively (World Bank, 2003).¹ An adult and youth literacy rate of 54.2 per cent in rural areas indicated that the education system had serious flaws in coverage and quality (BID, 1999). Sanitation, as well as water access and usage, were still dismal in rural areas, contributing to infectious diseases and malnutrition. Nicaragua was one of the poorest and least developed countries in the Western Hemisphere. The devastation caused by Hurricane Mitch in 1998 further exposed the country's inability to adequately help its vulnerable citizens cope with adverse shocks. RPS was created to address these issues.

3 RPS-I

The idea for a social protection programme like RPS arose as long ago as 1998, when the government began discussion of a poverty reduction plan at the encouragement of international institutions. Officials of the Nicaraguan government and the Inter-American Development Bank (IDB) began designing RPS in 1999, borrowing much of the programme's framework from Mexico's CCT, *Oportunidades*.² The IDB loan was approved in March 2000 and was a key part of the Highly Indebted Poor Countries (HIPC) Decision Point Initiative Document, as well as a major component of Nicaragua's Strengthened Growth and Poverty Reduction Strategy (*Estrategia Reforzada de Crecimiento Económico y de Reducción de Pobreza*, ERCERP) (BID, 2002). The personnel entrusted with creating the programme visited Mexico and Honduras to observe their CCTs as they designed RPS. The original director of the programme had worked at senior levels in FISE, where the programme was originally based.

As RPS was formed and established, programme officials worked without rigorous and pre-established ideas as to how it would best function. Even in this early stage, they were faced with the significant challenge that RPS would be used as a political instrument. There was also a strong aversion in government circles to any programme that might be considered "*asistencialista*"—that is, one that provided benefits to the poor without helping them move out of poverty, thus prolonging their dependence on institutional assistance. Officials were concerned that a programme that gave cash to the destitute was paternalistic and might increase the poor's reliance on the government, without encouraging them to try to escape poverty. Aware of these challenges, RPS officials focused on their work in the hope that the programme's results, rather than their arguments, would silence those who were doubtful of the results that the initiative could provide. RPS officials stress that the group working on the programme at that point was extremely professional, unified and dedicated to the goals of RPS.

From its inception, its goal was the accumulation of human capital. Some former RPS officials mentioned that the programme's cash transfer component, rather than being central, was purely a mechanism by which to encourage beneficiaries to invest in their own human capital. Indeed, the project's goals as stated by the financing institution, the IDB, were consistent with the emphasis mentioned by the country counterparts (see Figure 1).

FIGURE 1

Overview of RPS, Phase 1

| General Objective | Specific Objectives |
|--|--|
| To achieve higher levels of well-being among the extremely poor population of Nicaragua, supporting the accumulation of human capital. | <ul style="list-style-type: none"> - Create an initial operating framework of RPS that uses a comprehensive, cost-effective and targeted social protection strategy. - Supplement the income of extremely poor families for a period of up to three years to increase their expenditures on food items. - Increase the care of children under five years old and of women of child-bearing age in beneficiary families. - Reduce the school drop-out rate in the first four grades in programme areas. |

Source: BID, 1999.

RPS was designed to receive external financing through two separate loans, which divided it into two distinct phases. The first phase, referred to as RPS-I throughout the rest of this report, lasted from 2000 to 2002 and covered about 10,000 households. RPS-I was considered a pilot programme. If the first phase proved its worth, the programme would then expand, eventually to the national level. This original programme was financed by a US\$ 9 million loan from the IDB and Nicaraguan counterpart funding of US\$ 1 million (BID, 2006). The final budget of the three-year pilot programme was US\$ 11 million, equivalent to 0.2 per cent of Nicaragua's GDP³ (World Bank, 2001).

3.1 COMPONENTS OF RPS-I

Like other CCT programmes, RPS consisted of payments of cash transfers that were distributed to a female head of household⁴ as long as the household fulfilled prescribed obligations or assumed co-responsibilities. Transfers were given to females because it was believed that they were more likely than men to use them in ways that would benefit their children. When targeted households fulfilled the required programme co-responsibilities in health and/or education, they could receive the corresponding demand-side transfer. The components of RPS-I were mainly related to education and healthcare, as shown by Figure 2.

Food Transfers were given bi-monthly at the household level, regardless of the size and composition of the family, because of fears that giving transfers at the individual level might encourage households to have more children. They were intended to address the food shortages facing many poor households and to supplement households' income, particularly for their consumption expenditures. Receipt of the transfer was contingent on the household's participation in bi-monthly educational seminars for the female titled beneficiaries and on the children's attendance at required medical check-ups, which took place in or near their homes with community health service providers. In RPS-I, children were also required to remain at a healthy weight; if they were below weight for two consecutive check-ups, the household would forfeit their transfer.

FIGURE 2

Components of RPS-I

| Component – Demand Side | Beneficiaries | Benefits in \$US | Co-responsibilities |
|--|---|--|---|
| <i>Bono de Alimentación</i> – Food Transfer | All targeted families | US\$ 224 per household per year, regardless of composition, size and so on | <ul style="list-style-type: none"> - Must attend bi-monthly training sessions - Children from ages 0-5 years must be up-to-date with the Ministry of Health's immunisation requirements. - Must attend required doctor's appointments (children under 2 years must have monthly check-ups via community health service providers; children aged 2–5 must have a check-up every other month through the community health services). - Must maintain adequate weight. |
| <i>Bono Escolar</i> – School Transfer | Beneficiary families that have at least one child between the ages of 7 and 13 who has not completed the fourth grade | US\$ 112 per household per year | - All children aged 7–13 who have not completed first to fourth grade must attend school, with no more than three unexcused absences per month (85 per cent attendance). |
| <i>Mochila Escolar</i> – School Pack | Targeted families with children from first to fourth grade | US\$ 21 per eligible child | - Children must be enrolled in school at the beginning of the school year. |
| Component – Supply Side | | | |
| <i>Bono a la Oferta – Educación</i> Supply-Side Education Transfer | Targeted families with children from first to fourth grade, but they must give this to the local school advisory committee or teacher | US\$ 4.75 per student per year | - The household's eligible children must attend school, and the teacher must participate in the local parent association as sponsored by the Ministry of Education. |
| <i>Bono a la Oferta – Salud</i> Supply-Side Health Transfer | Contracted private health service providers | Estimated to be US\$ 54 per household annually ⁵ | - Paid as specific coverage goals are met by health service providers. |

Source: BID, 1999; Maluccio and Flores, 2005.

The Supply-side Health Transfers were given to the health service providers, conditional on their provision of services to beneficiary households, as discussed in more detail in Section 3.1.3.

In order to receive the bi-monthly School Transfer, beneficiary households with children between the ages of seven and thirteen who had not yet completed fourth grade had to attend classes regularly. If the children missed more than the excused absences, they were required to provide a doctor's note to avoid being penalised. This transfer was given at the household level, so if one child did not attend school while the others did, the household forfeited their transfer for that cycle. As well as ensuring that fertility choices were not tied to benefits, this policy encouraged households to send all children to school and to treat co-responsibilities as a group effort.

The School Pack was an annual transfer given at the individual level rather than at the household level, contingent on eligible children's enrolment in school (IFPRI, 2005). It was a cash transfer, although it was originally specified that the transfer could be given in goods (backpacks, school uniforms, school supplies and so forth). Households were expected to use this money to ensure that their children were appropriately dressed and prepared for classes.

Supply-side Education Transfers were awarded for each beneficiary child enrolled in first to fourth grade. They were distributed to beneficiary households, who were obliged to give the money to local school associations or teachers. This transfer was intended to compensate educators for their increased workload as a result of RPS, and to provide additional funds for the schools. Teachers who collected the transfer were allowed to keep half of it, while the other half was to be used to buy materials that benefited the school (IFPRI, 2005). If local school associations collected the money instead of the teachers, they consulted instructors to determine the needs of the school, and the associations used the funds to buy appropriate supplies for the classrooms. The exact rules about the distribution of this transfer varied by time and location, as the programme resorted to giving transfers to the associations when they had to stop teachers in some areas from keeping the entire transfer for themselves.

These transfers were given to households rather than directly to the schools, for a variety of reasons. The practice may have reflected the initial weak inter-institutional coordination between RPS and the Ministry of Education, or a desire to promote local cooperation. It is more likely, however, that this transfer mechanism was used because it was a common practice in rural areas for parents associations to collect money from parents whose children were in the local school. There was already significant local control and input in these schools, and this practice allowed households to continue to influence school spending and priorities.

The annual amount of the cash transfers was the equivalent of up to 18 per cent of a typical beneficiary household's expenditures (Maluccio and Flores, 2004),⁶ a level similar to that of *Oportunidades* in Mexico. The School Transfer had been set at about the opportunity cost of school attendance multiplied by the average number of eligible children in extremely poor households. The total of the School Transfer and the Food Transfer was set at two-thirds of the extreme poverty gap⁷ (Maluccio and Flores, 2005). The amount of the transfers was not adjusted for inflation throughout RPS-I; hence the transfer values decreased by about 20 per cent throughout the life of the programme. This figure probably errs on the high side, since the inflation in the goods purchased by beneficiaries was less than the overall inflation level of 20 per cent (IFPRI, 2005). Most households received the maximum amount of the transfers available to them; 10 per cent of households failed in some component of the programme and did not receive either the School Transfer or Food Transfer in the first two years of RPS-I (Castro and Regalia, 2007).

3.1.1 Targeting of RPS-I

RPS-I was implemented in rural areas of the country that were known to have high poverty rates and low human development levels. Rather than strictly implementing the programme in the areas with the highest poverty levels, RPS was launched in the departments of Madriz and Matagalpa, which already had adequate supply-side supports (all targeted communities had primary schools).⁸ These areas did have significant levels of poverty: close to a third of households in these municipalities were classified as extremely poor.

The programme was originally implemented in six municipalities, whose locations were chosen partly because of their easy accessibility from the capital city of Managua and their existing levels of local coordination and capacity, developed through the *Micro-planificación Participativa* (Participatory Micro-Planning) project directed by FISE. This programme's goal was to train municipality leaders to plan and execute investment in educational and healthcare infrastructure, and it emphasised the involvement of local stakeholders

(Maluccio and Flores, 2005). RPS also tried to include municipalities that showed interest in developing their capacity to organise themselves (BID, 1999).

RPS-I had two separate stages with different types of targeting. The first, geographic targeting, began by using national census data from 1995 to construct a marginality index using weighted variables of the family's size, access to water, access to a latrine, and level of illiteracy—all known to be highly correlated to extreme poverty levels (BID, 2006). The 42 census areas in the six chosen municipalities that fell into the highest two priority levels, on the basis of the marginality index, would become the treatment and control communities for RPS-I.

After the 42 potential treatment communities were identified, programme targeting was randomised by randomly selecting 21 treatment communities and 21 control communities. The control communities would be brought into the programme after an initial evaluation was complete.⁹

Technically, all households within the treatment communities were eligible to receive RPS-I benefits. In practice, households that were found to be less “deserving” of a CCT were excluded. Officially, it was decided to exclude households that owned a vehicle or that owned 14.1 hectares of land or more. Some 2.5 per cent of households in the geographically targeted treatment communities were excluded on the basis of these criteria (IFPRI, 2001a).

The geographic targeting reached about 6,000 households. Other households were excluded on an *ad hoc* basis¹⁰ if it was found that they had extensive economic resources or a business, were composed solely of able-bodied single men or women, if their members did not attend the assemblies to join the programme, or if they had falsified information. In total, 12.1 per cent of households were excluded in this stage of RPS-I (IFPRI, 2001a).

Maluccio (2008) concluded that undercoverage in geographically targeted areas (that is, households that were excluded but were poor or extremely poor and should have been in the programme) for the poor was 3 per cent (given the *ad hoc* exclusions), and leakage was 14 per cent to the non-poor, although most of these households that received benefits were not wealthy.

The second stage of RPS-I targeting refined the geographic approach by targeting at the household level within the geographically selected areas. This process involved choosing 4,000 additional households in the 17 census areas classified in the lower priority levels by the original marginality index.¹¹ Household eligibility in this targeted group was determined using a proxy means test based on households' per capita expenditures. The proxy means model was constructed from RPS-I's “baseline survey” of 1,758 households in the geographically targeted areas¹² (IFPRI, 2001a). This survey contained questions necessary to estimate a proxy means model of per capita expenditures. It included demographic, income, health, education, anthropometric, and socioeconomic information. Data from the survey was used to determine which variables best predicted per capita expenditures¹³ (Maluccio, forthcoming).

Next, using data from a population census that covered all census areas targeted by RPS-I, households' per capita expenditures were predicted using the proxy variables model. Households with predicted per capita expenditures of less than 5,326 córdobas (C\$) were eligible for RPS; those with predicted expenditures above this level, the poverty line, were not. These levels would potentially exclude 8 per cent or less of the extremely poor, and about 50 per cent of the poor with expenditures near the poverty line. Given that the goal of RPS-I was to provide benefits to the extremely poor, this cut-off was deemed adequate. Leakage to the

non-poor in the household-level targeted areas fell to 6 per cent, and undercoverage was 10 per cent (Maluccio, forthcoming).

The targeting posed several problems that had to be tackled. The first population census conducted for RPS did not find and register a substantial number of households. A second and third round of the census had to be conducted to capture more of these households (IFPRI, 2001b). The original plan had been to target 5,000 households using geographic methods and 5,000 households using household-level targeting. This complication caused these numbers to shift to 6,000 and 4,000 households, respectively. These errors caused significant difficulties at the beginning of the programme.

Another source of confusion was that the municipality-level delineation of *comarcas* was not consistent with the official census demarcations of the *comarcas* (here, census areas), which were used to determine if communities were eligible for RPS. This caused confusion when some members of beneficiary *comarcas* (as outlined at the municipal level) were told they did not belong to a beneficiary community.¹⁴ Programme officials tried to explain these discrepancies to local leaders but could not dispel the confusion. They eventually decided to review and make decisions on these issues on a case-by-case basis. Despite the efforts made to explain the targeting process, it appears that beneficiaries remained confused about it throughout RPS-I (Adato and Roopnaraine, 2004).

3.1.2 Programme Initiation

Important activities were completed before RPS began the cash transfers. Population censuses were conducted in 2000 and 2001 to gather the data needed to register households as RPS beneficiaries, as well as the information required to predict per capita expenditure levels using the Living Standards Measurement Survey 1998 (LSMS98) proxy means model for the areas using household targeting. It was also used to learn how many households would be beneficiaries of the programme (IFPRI, 2001b).

In order to inform treatment communities about the programme, RPS-I officials organised community assemblies that took place over the course of two months before the programme began. The assemblies provided potential treatment households with information about the benefits of RPS and the co-responsibilities required of the titled beneficiary¹⁵ and her household, as well as the protocol that would be used. The qualitative evaluation of RPS-I found that beneficiaries clearly understood the components and benefits, and thus the assemblies appear to have been effective (Adato and Roopnaraine, 2004).

At the assemblies, beneficiary women signed a document or marked it with their fingerprint to verify their commitment to participate in RPS. The programme was able to incorporate targeted households extremely quickly: more than 10,000 targeted households were covered within about eight months of the start of RPS activities (BID, 2006). The 6,000 geographically targeted households had been incorporated by the end of 2000, while the 4,000 households targeted using the proxy means test were incorporated by mid 2001 (Castro and Regalia, 2007).

The assemblies were also used to organise the communities into smaller groups of about 20 women¹⁶ on the basis of social and geographic delineations. These groups then selected one female to be the group's *promotora* (promoter). The women proposed and elected their own promoter within their small group, although the RPS officials had to ratify their decision.

The assemblies also gave community members a chance (and exerted significant pressure on them) to exclude themselves from the programme if they knew they were not poor enough to be in RPS. While the self-exclusion process was not successful in the assemblies themselves, it was not uncommon for women to approach officials after the assembly and inform them that a neighbour should be excluded on these grounds. RPS officials would then visit that woman's home to verify the claims; if they were correct, the household was excluded from the programme.

3.1.3 Supply-side Supports

As mentioned earlier, phase I of RPS was implemented in areas that already met certain supply-side criteria. In addition to these initial requirements, RPS provided incentives to teachers with beneficiary children in their classes.¹⁷ Since teacher absenteeism is a significant problem in rural Nicaragua, the teachers could only receive these incentives if they missed fewer than an approved number of school days. Their absences were monitored by beneficiary families, who paid the teacher from the Supply-Side Education Transfer that they received from RPS.¹⁸ This helped to address low teacher salaries, which were a major disincentive to educators. Since many treatment communities contained a large proportion of beneficiary households, educators in these communities saw significant improvements in both community support and funding. Teachers working in treatment communities also received bi-monthly training sessions covering topics ranging from the basics of RPS to nutrition and healthcare, teaching methods, ways of dealing with or motivating difficult children or children with developmental issues, and proper care for the environment. By all accounts, these impacts improved teacher morale significantly.

The higher number of students enrolled in and attending schools sometimes called for greater educational support. Some schools had so many new students that they began providing another daily school session. In at least one community, beneficiary households contributed money to pay for an additional teacher, while non-beneficiary households made in-kind contributions (Adato and Roopnaraine, 2004).

Supply-side supports in healthcare were more extensive than those in education. All healthcare services were provided to beneficiary households free of charge, and they were intended to be used to train households in nutrition and healthcare practices, to meet the correct vaccination levels, and to monitor and aid the growth and development of children under five years of age (BID, 1999). The community healthcare protocol was modelled on the Comprehensive Attention to Community Children (*Atención Integral a la Niñez en la Comunidad*, AIN-C) scheme in Honduras's CCT, the Family Allowances Programme (*Programa de Asignación Familiar*, PRAF) (Maluccio and Flores, 2005). The programme provides well-child visits in the homes or communities of beneficiaries with children under the age of five, rather than requiring that the families travel to clinics.

Instead of relying on the Ministry of Health to provide healthcare to beneficiaries, RPS-I opted to work through private health service providers to offer care to beneficiary communities. This decision was taken because the Ministry of Health claimed it would have been unable to arrive at the households of many beneficiary families, which were in remote locations. Despite its limitations, the Ministry of Health did provide extensive support to health service providers that worked directly with beneficiaries. For instance, it supplied vitamin supplements, vaccines, and additional necessary supplies to the providers (Castro and Regalia, 2007).

The health service providers were expected to reach beneficiaries' homes and communities, a task in which they had more experience than the Ministry of Health. Each municipality in the programme had at least one provider, either a private for-profit or non-governmental organisation (NGO) that had placed a bid and won the RPS contract in an open competition (Castro and Regalia, 2007). When providers were selected to participate in RPS-I, they had to undergo a training and certification process through the Ministry of Health. Once certified, the providers travelled throughout treatment areas, visiting homes and providing healthcare to treatment households. They were remunerated on the basis of the number of patients they had visited within specified age ranges, and by the types of consultations they provided. RPS-I remuneration was also based on growth targets for children (BID, 2006). A set cost was determined for each procedure or consultation, and payments were given on the basis of the number of times each specific service was provided.

The requirements to receive payment were strict. Providers were not paid for services rendered to a given age group and in a particular period if they could not prove that they had provided services to 98 per cent of the targeted age group during a given pay period. They could appeal decisions by providing proof that they had met this criterion. They would then receive payment through the next payment cycle. Before any services were rendered, the providers were paid 3 per cent of the value of their annual contract with RPS. Castro and Regalia (2007) report that this payment method was an effective way of reaching beneficiaries. Usually, 93 to 95 per cent of households received the services due to them, and all providers eventually received their payments in full for their services.¹⁹

These providers also arrived at each treatment house to enrol households, determine which services the households would need, and to ascertain baseline health levels to provide further information on longer-run programme impacts. This also helped planning in the Ministry of Health, which could ensure that adequate supplies would be on hand (Castro and Regalia, 2007).

The typical healthcare provider hired groups of medical teams that were required to travel to their specified locations in a group of one doctor and two nurses. A psychologist or social worker was also available to help in treatment communities. Each doctor was expected to attend to 28 people a day and to work a total of 20 days a month.²⁰ Teams often left the municipal seat by 6:00 a.m. and they worked 10 to 11-hour days, arriving at very remote locations. Children between zero and two years of age had to receive monthly check-ups, while consultations for children between two and five years old were bi-monthly. There are some claims that at the beginning of the programme the medical teams did not receive the time off that they were legally due, although this issue was resolved. The travelling medical brigades' work was obviously very demanding; their salaries were 30 to 50 per cent higher than that of Ministry of Health providers (Castro and Regalia, 2007). Despite this, there are some reports that the bulk of profits went to the heads of these NGOs rather than to the medical teams.

Since the healthcare providers were paid on the basis of the services they rendered, they had an incentive to address the local forces that opposed their community involvement. In particular, some adult males living in treatment communities were opposed to allowing providers to hold medical consultations with their wives or partners. In some communities, men refused to allow male doctors to provide consultations to their female partners. To address this issue, female doctors were brought in to provide services to these households until acceptance levels were higher. In other areas, healthcare providers gave training to local

men in an effort to help them understand the logic behind the programme and the reasons they should allow their partners to receive medical treatment. The mobile brigades often had to stay in treatment communities overnight, a measure that eventually seems to have increased trust and camaraderie between treatment communities and healthcare providers.

The providers also gave educational seminars to beneficiary families in treatment communities (IFPRI, 2005). Among other issues, these seminars covered topics such as nutrition, healthcare, cooking healthy meals using alternative foods such as soy, natural medicinal remedies, family planning, breastfeeding, and female reproductive health. The seminars were dynamic in the sense that they responded to local needs that providers saw within treatment communities. In some areas, for example, local men in treatment households were not pleased with the idea that seminars were being held for women. The seminars were then opened to the men to assure them that they need not be preoccupied by the education that females received. Moreover, since receipt of programme benefits was contingent on women's participation in the bi-monthly seminar, make-up seminars were held to accommodate beneficiaries who were unable to attend the original seminar.

While the local promoters were beneficiaries of RPS, they also provided invaluable supply-side support to the programme. Promoters were trained so that they could appropriately carry out their duties, which included monitoring the use of the Supply-side Education Transfers, informing their groups when cash transfer days and training sessions would occur, and organising their groups to participate in these events. Since promoters were not paid for their work, they sometimes asked group members for a small amount of money to compensate them for the trips they had to make to the municipality seat in order to discharge their duties as promoters.

By all accounts, promoters took their duties very seriously. Some even imposed additional co-responsibilities on their group members, requiring that they provide proof that they had spent their cash transfers on food (Adato and Roopnaraine, 2004).²¹ If the beneficiary had spent the money on something the promoter did not approve of, the promoter would sometimes reprimand the beneficiary. Some promoters also organised additional community activities, such as community clean-up efforts.

3.1.4 Banking System

RPS-I hired several national security companies to distribute cash transfers. The companies went to municipality seats on cash transfer days and personally handed the cash to the beneficiaries. They were responsible for ensuring their own safety, although local police forces provided additional support on transfer days. The companies also decided where to hold cash transfer deliveries, but RPS staff had to give final approval of the location. Employing these companies, with their expertise, seems to have been a good method of maintaining independence and efficiency in the delivery of the transfers. The total cost of delivering the cash transfers was 3 per cent of the value of the transfers (Largaespada Fredersdorff, 2006).

3.1.5 Administration of Cash Transfers

The exact date of the cash transfers was not revealed far in advance of the transfer day, although households were able to plan for the general timeframe on the basis of the frequency of transfers. General announcements that the transfer day was approaching were

made over the radio, and the exact date and time that each group of 20 women were supposed to arrive to receive their money was given to the local promoters, who passed the information to their groups. This arrangement with the promoters allowed the transfers to proceed more efficiently and limited the time that the women spent waiting for their transfers. Arriving in groups was also a security measure for beneficiaries as they travelled to and from the municipal seat. While former beneficiaries reported several cases in which other beneficiaries had been robbed en route from a cash transfer, these cases appear to have been limited.

Cash transfers were distributed in a school or other community facility in the municipal seat. Transfer days were every two months. This schedule was maintained regularly except for the period when RPS was in transition from its first IDB loan to the second one—that is, from RPS-I to RPS-II (Castro and Regalia, 2007). Transfers were given first to groups that had arrived from furthest away, to pregnant women, and to the elderly. Beyond that, transfers were administered in the order specified to the promoters.

The delivery of a cash transfer was well controlled. Typically, two RPS officials supervised the distributions while another addressed complaints or helped beneficiaries who did not have a national identification card. Between four and six employees of the hired security company were present to assist in the transfer. Information about the transfers was contained in a list with each woman's name, national identification number, and the amount to be given to her. If the female head of the household was no longer alive, a male could be designated as the beneficiary; these cases, however, were rare. The contracted employees had to verify the woman's identity by comparing her signature or digital fingerprint against the one on her national identification card, and they counted the transfer money for her. When women received their cash transfers, promoters stood by to ensure that they were satisfied with the administration and quantity of the transfer.

The beneficiary also received a receipt that divided her payment by the transfer given to show where she fulfilled or did not fulfil her co-responsibilities. If she disagreed with the transfer amount, she could file an appeal for the decision to be reviewed. If there truly was a mistake in the payment, the beneficiary would receive the correct remaining balance in the next cycle of cash transfers (Castro and Regalia, 2007).

Depending on the number of women receiving benefits, transfers could last between one and three days. Anecdotal evidence suggests that early cash transfers were somewhat disorganised but that they quickly became orderly and efficient.

Transfer days were also times of heightened economic activity in the municipal seat. The qualitative evaluation of RPS-I by the International Food Policy Research Institute (IFPRI) found an incident of price hikes on these days, but this activity does not seem to have been widespread (Adato and Roopnaraine, 2004).

Since benefits were issued with reference to each woman's national identification number, all titled beneficiaries needed their own national identification card. It was quickly discovered that many women did not have one. To address this issue, RPS began issuing temporary photo identification cards that could be used in place of the national identification card. The temporary card contained a barcode identifying the beneficiary. The cards were easy to make and inexpensive,²² providing a convenient solution to the dilemma.

3.2 MONITORING IN RPS-I

RPS-I had an extensive monitoring system, with checks and balances to ensure that all those involved were discharging their duties. Health service providers and school councils used official forms to record whether households had fulfilled their co-responsibilities in health and education. Information on co-responsibilities was given to local RPS employees, who passed it to the central office, or it was submitted directly to the central office. Once the information was received in Managua, workers entered it into RPS's information system.

RPS-I had a thorough and efficient monitoring mechanism, known as the Programme Performance Monitoring and Evaluation System (*Sistema de Monitoreo y Evaluación de Desempeño del Programa, SMEP*) (LeCayo, 2004), which allowed it to monitor activities from fulfilment of co-responsibilities to the health outcomes of beneficiary children. It also aided in the selection of beneficiary households and created official invitations for them, decided the benefits for which households were eligible, calculated the list of supplies that should be requested from the Ministry of Health, and monitored whether health service providers were fulfilling their duties. It began as a basic programme but, as the need for other data grew, the system was expanded to contain additional information (BID, 2006).

This information system was also used to produce bi-monthly reports that allowed the central office to monitor indicators such as children's nutritional status and school attendance (BID, 2002). RPS officials had easy access to this data, and it appears that they frequently checked results using the system. If a health service provider claimed to have achieved certain positive results, the official could verify the claim using the information management system. The system was recognised for its high capacity and quality, and it was later shared with other Latin American countries.²³

Health service providers were audited every six months to ensure they were in full compliance with RPS rules (Castro and Regalia, 2007). Various programme officials made surprise visits to rural treatment communities in order to verify that RPS was functioning properly. They verified that providers were present and meeting their responsibilities, and that children were in school with the backpacks and uniforms that should have been purchased with their School Pack.

Many stakeholders in RPS-I had roles to play, and thus there was a complex web of monitoring. Local teachers and medical providers were required to fill out forms indicating whether households fulfilled their co-responsibilities. The signature of the female beneficiary in the household validated data collected on services supplied by health service providers. The female beneficiary retained this form, while the provider submitted it to RPS officials to be fed into the information management system (Castro and Regalia, 2007). Promoters offered strong incentives for beneficiaries at the local level, who often mentioned that they would be reprimanded if they did not fulfil their co-responsibilities. Apparently this threat provided sufficient incentive to ensure that most beneficiaries fully participated in the programme.

Despite all the checks and balances that were created to ensure the programme functioned properly, there were groups that attempted to cut corners and thereby validated the need for the extensive monitoring. Although health service providers had been thoroughly screened to ensure they were able to provide the desired quantity and quality of service required by RPS, this did not mean that they did not have to be monitored. It was discovered that some medical teams hired by health service providers sometimes did not visit the most

remote homes, or sometimes a doctor did not arrive for a scheduled shift. While the provider was able to feign compliance for a time, random field visits by local coordinators and later by central staff found and confirmed this non-compliance. It was also found that some training sessions, which were supposed to be given to 12–15 women at a time, were being given to much larger groups. Following this discovery, the provider was reprimanded and closely monitored to ensure future compliance with RPS protocol. Additionally, some RPS personnel were trained healthcare professionals who could verify the quality of the work performed by providers in their field visits. In general, shirking was not tolerated and payments were halted if it was discovered. In one case, an NGO's service was not renewed for the second phase of the programme, RPS-II.

Some 90 per cent of beneficiaries complied with all programme co-responsibilities in RPS-I, and thus 10 per cent of beneficiaries did not receive part or all of their transfer at least once because of non-compliance with co-responsibilities. If a household was found to have misreported information, to have a child with more than 27 unexcused school absences, to have failed to collect transfers on two or more consecutive occasions, or to have failed repeatedly to have complied with co-responsibilities, the household could be expelled from RPS. This happened to less than 1 per cent of beneficiary households in the pilot phase²⁴ (Maluccio and Flores, 2005).

Most of RPS-I's complex monitoring system functioned as intended. The first phase of the programme, however, involved several policies that had to be modified later in order to avoid the creation of any perverse incentives. The pilot nature of RPS-I encouraged officials to exercise flexibility by addressing these issues and modifying the monitoring protocol as needed.

3.3 EXIT STRATEGY OF RPS-I

The first phase of RPS did not have a clearly articulated exit strategy, given that it was a pilot programme of limited duration. Beneficiary households were aware that they would receive transfers and supply-side supports for the length of the programme, but it was not clear that they would receive benefits beyond the life of RPS-I. The short length of the initiative did not obviate the need for an exit strategy: significant benefits were provided every two months for three years, and programme reliance may have developed. RPS-II addressed this issue.

3.4 INSTITUTIONAL FRAMEWORK OF RPS-I²⁵

From its inception, RPS aimed to use existing institutions and organisations to help it achieve its goals. As it began, it relied on support from the Coordinating Councils of FSS and FISE, on mayors and municipal technical units in municipalities, as well as on community-level school councils and health service providers (BID, 1999). As mentioned earlier, RPS-I was located in FISE, which is rightly known throughout the country as a very professional organisation. Unlike most other Nicaraguan institutions, FISE has managed to keep a distance from excessive political involvement and politicisation. Part of the reason that RPS-I was placed within FISE is that one of the programme's first champions, who helped bring RPS to the country, held a senior position in the organisation. During its time in FISE, RPS-I was allowed to exercise significant autonomy.

FISE created a new Programme Operating Unit to accommodate RPS-I and all things related to it. The director of RPS-I was the head of the unit, and special divisions were created

to manage the programme. The Technical Management group was in charge of programme targeting, registering beneficiaries and coordinating the evaluations and external reviews of the programme. The Operations Management group was responsible for ensuring that services were provided to beneficiary communities, paying health service providers, monitoring co-responsibilities and cash transfers, outsourcing services as needed and coordinating activities among various entities. RPS-I used FISE's existing Administrative and Finance Management Unit and its Information Technology Unit (BID, 1999).

Local committees were set up at the municipal level to maintain certain standards and ensure that RPS-I entered the municipality and remained there. A delegate from the Ministry of Health, another from the Ministry of Education,²⁶ the coordinator of the Municipal Technical Unit and two locally elected members of the municipality (such as religious or civil leaders) sat on the local committees. The coordinator of RPS's Local Operating Unit also sat on the committee as its secretary and acted as its link to the central RPS offices. This coordinator, however, did not have voting power on the committee. Among other things, the committees were entrusted with ensuring that targeting was carried out correctly, organising community assemblies, overseeing cash transfers, and finding ways to improve health and education services in the municipality's most isolated communities (BID, 1999). They also were supposed to support the *Comarca* Operating Units and the promoters (BID, 2002).

Finally, at the community level, *Comarca* Operating Units consisted of a coordinator, a representative of a local school council and the local health service provider, and the promoters who lived in the community. The coordinator was very involved in connecting RPS with beneficiary families, leading local promoters, collecting information to monitor co-responsibilities, confirming the proper distribution of cash transfers, and other general programme monitoring, particularly in education and healthcare services. Basically, the coordinators ensured that RPS was functioning properly within their jurisdictions of about 1,000 households. Other members of the *Comarca* Operating Unit were responsible for monitoring the households' compliance with co-responsibilities and submitting this information to RPS's central offices (BID, 1999).

At the highest levels, RPS-I officials tried to develop substantial coordination between RPS, the Ministry of Health and the Ministry of Education. This process was not painless. The ministry employees tended to view their relationship with RPS as one based on competition rather than cooperation. These biases were eventually overcome, and agreements were signed with the ministries to affirm their joint effort in verifying fulfilment of beneficiary co-responsibilities in education, and in providing support to health service providers.

Official agreements did not completely diffuse the tension between the Ministry of Health and RPS staff, since ministry employees had to assume additional responsibilities to plan for and provide supplies to the RPS personnel and the hired health service providers. This problem was compounded by the fact that the ministry's staff received no extra compensation for their increased workloads, while health service provider employees received higher salaries than ministry staff. The pay differences were a source of constant tension between the two groups. Workloads for the ministry workers also may have risen because of increased referrals from the hired medical teams, further exacerbating the issue.

Fortunately, this conflict was not present at all localities and levels. In particular, some local relationships between RPS and ministry officials were positive, especially once working relationships had developed. Over time, much of this sense of competition subsided as RPS

and ministry staff found that they had similar goals and their work could be complementary. Ministry staff also trained health service providers in the standards they had to meet in their services to beneficiaries. Ministry staff came to see that RPS could help them meet their goals in remote rural areas, which lessened the limitations imposed by the ministry's budget constraints.²⁷ Some former local programme coordinators reported positive relationships with local education and health officials, and other Ministry of Health employees indicated that they were grateful that RPS-I had relieved them of some of their workload.

Further interactions between RPS and government ministries included coordination between some local RPS officials and the Ministry of Education to provide basic adult literacy classes for beneficiaries. Additionally, RPS officials worked with local authorities and lawyers to help beneficiaries enrol in the civil registry, so that they could receive permanent national identification cards. Local officials also reported that there were weekly interinstitutional meetings between low-level ministry officials, RPS employees and healthcare providers.

3.5 EVALUATION OF RPS-I

IFPRI, an independent third party, was commissioned to evaluate RPS-I. The evaluation was extremely thorough. It consisted of several surveys through the life of RPS-I's pilot phase, as well as a qualitative evaluation of the programme in 2003 as RPS-I became RPS-II. A survey of both the treatment and control communities was conducted in 2000, 2001, and 2002. As mentioned earlier, 21 randomly selected communities had been chosen to be treatment communities, while 21 similar communities comprised a control. The baseline survey of this panel contained 962 households in RPS-I treatment areas, and 773 areas in RPS-I control areas, yielding 1,735 households (IFPRI, 2001b). The evaluation also included a community questionnaire and a diagnostic evaluation of all schools in the evaluation area (IFPRI, 2001a).

The original evaluation was supposed to last for one year, after which time control communities would also become beneficiary communities. However, because of a delay in funding to RPS (through no fault of its own),²⁸ control communities were not brought into RPS until 2003, when RPS-II had begun (Maluccio and Flores, 2005). These postponements allowed the initial programme impacts to be assessed over a longer period. This change was helpful, since RPS-I had not been implemented as quickly as was originally planned. Health interventions had not begun until June 2001 because the hiring and training of health service providers had taken longer than anticipated. The repeat surveys in 2001 and 2002 began in October, while the baseline survey in 2000 began in August. This change offered time for the demand transfers to take effect, given the funding delays experienced (IFPRI, 2002). Seasonal differences were controlled for so they did not affect the results of the evaluation.

3.5.1 Impact Evaluation and Scholarly Articles Evaluating RPS-I

The impacts of RPS-I were overwhelmingly positive. They were enhanced by their typically stronger effects among the poorest households in the programme, which reduced inequality in the indicators measured (Maluccio and Flores, 2005). Maluccio et al. (2005) suggest that since all RPS-I beneficiaries faced the same co-responsibilities and had access to the same level of supply-side services, the impacts were greatest for those whose binding constraint had been most relaxed. This was exemplified by the extremely poor, who were previously limited by their lack of assets.

The cash transfers increased a typical RPS household's expenditures by 18 per cent, and the vast majority of this increase was devoted to food purchases (Maluccio and Flores, 2005). Much of this spending protected households from the lost incomes they may have faced during the economic downturn that occurred in Nicaragua during this period. Food consumption also became more diverse, though the improvement was mainly in areas already familiar to beneficiaries rather than in foods introduced through the training sessions, such as soy (Adato and Roopnaraine, 2004). In particular, spending on meats, fruits and vegetables all increased significantly.

Education impacts were positive, and they too were strongest for the poorest households. The rise in households' education expenditures exceeded the amount of the School Pack (IFPRI, 2005). The programme increased average school enrolment by 13 percentage points for eligible children in first to fourth grades (Maluccio and Flores, 2005). Of the beneficiary children who were already in school before RPS-I began, there was a seven percentage-point increase in children who had advanced two grades within two years and had remained in school. This increase included children who had graduated the programme requirements to fourth grade and continued to fifth or sixth grade.

This result led some to suggest that households believed they were obliged to send their children to school up to sixth grade in order to receive benefits. This hypothesis was not confirmed. Almost, if not all, beneficiaries and programme officials were aware that the programme only required participation to fourth grade (Adato and Roopnaraine, 2004). IFPRI's final evaluation of the programme confirmed that beneficiaries clearly understood their education-related co-responsibilities in RPS-I.

The impacts on health were possibly the most admirable, and they too were strongest among the poorest households. IFPRI's qualitative evaluation suggested that much of the hygiene-related education had been assimilated into the communities (Adato and Roopnaraine, 2004). Stunting was a significant problem in children in RPS-I communities, at close to 40 per cent in both treatment and control communities before the programme began. Within two years, RPS-I had decreased the rate of stunting by more than five percentage points (IFPRI, 2005), an unexpectedly high amount and one that was unparalleled. The rate of children under three years old who had a recent well-child check-up through the RPS's healthcare programme increased by a net average of 16 percentage points (Maluccio and Flores, 2005), and correct vaccination coverage of 12–23 month-old beneficiary children grew in both treatment and control communities through coordination with the Ministry of Health (BID, 2002). Barham et al. (2007) conclude that RPS lessened the impact that distance and living with a less educated mother had on beneficiary children's vaccination rates.

The most dismal result was that, despite the distribution of nutritional supplements (iron and antiparasites), anaemia in children under five years old still affected about a third of all children in intervention households. This was similar to the pre-programme level (BID, 2006). The qualitative evaluation revealed that this was probably due to mothers' reluctance to give the supplement to their children, since some had reacted poorly to it (Adato and Roopnaraine, 2004).

Some observers were concerned that delivering cash transfers to poor households would cause a fall in beneficiaries' labour force participation. At the individual level, no disincentives for labour force participation were observed. More specifically, RPS-I did not affect an individual's propensity to participate in the labour force in the previous week (Maluccio and Flores, 2005).

There were indications, however, that RPS-I had protected beneficiary households from the coffee crisis that occurred during the time of the programme (Maluccio 2005). Men in treatment households did not work fewer hours than in the pre-programme period, but they worked less than control group counterparts. Men in non-beneficiary households may have spent more time searching for a job, perhaps far from home, in order to cope with the economic downturn. It appears that beneficiary households did not need to compensate for this downturn because of the transfers from RPS-I (IFPRI, 2005). Men in beneficiary households may have been able to work close to their homes, while men outside the programme still had to commute or migrate to their jobs. Similarly, women could dedicate more time to raising their children than to earning additional income (Adato and Roopnaraine, 2004).

A final concern that was monitored was child labour force participation. RPS brought about an almost six percentage-point decline in the labour force participation of children aged between 7 and 13 in first to fourth grades between 2000 and 2002 (Maluccio and Flores, 2005).

Concerns about the productive activities available in RPS communities caused some to examine the impacts of RPS on the local economy. Adato and Roopnaraine (2004) suggest that RPS may have increased investment in livestock, although this result is not conclusive. It may also have encouraged local production, such as in sewing the school uniforms needed by RPS beneficiaries. The receipt of transfers did not increase demand for credit in treatment households, probably because of the high marginal propensity to consume the transfers (Hernandez et al., 2008). Transfers did not seem to crowd out remittances, although there was evidence that food transfers and transfers from NGOs may have been crowded out in RPS treatment communities (Olinto and Nielson, 2006).

3.6 OVERALL EVALUATION OF RPS-I

RPS-I met or exceeded most expectations of its potential impact. It was also concluded that RPS-I had effectively targeted benefits. Some 81 per cent of beneficiary households hailed from the poorest 40 per cent of the Nicaraguan population. While 15 per cent of beneficiary households were not considered extremely poor, most of these households were certainly not wealthy, living on about US\$ 2 per capita a day (BID, 2006). The targeting methodology that had been used during RPS-I led officials to conclude that household-level targeting would be helpful as RPS expanded into areas with more diverse consumption or expenditure distributions. In the qualitative evaluation of RPS, beneficiaries did not mention any concerns with politicisation of programme targeting (Adato and Roopnaraine, 2004).

Major difficulties that the programme had encountered were mainly in initial implementation, which took longer than the loan agreement had anticipated. Once the programme was in place it was refined as deemed necessary, but functioned fairly smoothly.

One continuing problem lay in the interinstitutional coordination between central-level officials. These working relationships were characterised by a lack of cooperation and interest on the part of some institutions. Some tensions also developed between FISE and RPS-I because of their shared use of several of FISE's departments (BID, 2006).

An evaluation of the costs of several CCTs included information on RPS-I. While it concluded that 40 per cent of RPS-I's budget was absorbed by administrative costs, compared to 33 per cent for PRAF and 9.6 per cent for *Progresá*,²⁹ these numbers should not be directly compared (Caldés et al., 2004). The most expensive programme components for *Progresá* were

beneficiary identification, transfer of benefits and enforcement of conditionalities. Those for PRAF were beneficiary identification and the external programme evaluation. For RPS-I, the greatest costs were the external evaluation and the supply-side transfers, a component not even present in *Progresa*, which was a demand-side only programme. These costs also reflected the start-up costs of RPS-I (BID, 2006). Later evaluations of RPS's overhead show its costs falling significantly (LeCayo, 2004). Caldés and Maluccio (2005) determined that the programme's continuing costs were cut in half if one-time costs of the pilot were excluded.

By the end of 2002 the IDB loan had been disbursed and the pilot programme had run its course. In accordance with the original intentions behind RPS, the pilot phase would now be rolled out on a more widespread level through RPS-II.

4 RPS-II

Given RPS-I's significant achievements, a second phase of the programme was created with the aim of fine-tuning various aspects of RPS and expanding the refined programme. This phase, RPS-II, began in 2002. It was financed by the IDB, the Central American Bank for Economic Integration (*Banco Centroamericano de Integración Económica*, BCIE) and the government of Nicaragua. Since RPS had technically "passed" the trial stage of the first loan, the loan resources for RPS-II were increased. This project was funded by US\$ 20 million from the IDB, US\$ 5 million from the BCIE, and US\$ 2.2 million from the Nicaraguan government (BID, 2002).

The overall rationale of the programme remained unchanged, as can be seen in Figure 3. The wording of RPS-II's specific objectives differed from that used in RPS-I. The most obvious change is the absence of any reference to supplementing households' incomes, which was originally more prominent in RPS-I's documents. While this change was purely semantic, it reflects programme officials' understanding of the controversy surrounding RPS. Officials may have been concerned that RPS should not be perceived as "welfaristic", a deprecatory label applied to RPS by some of its opponents in Nicaragua.

FIGURE 3

Overview of RPS-II

| Overall Objective | Components/Specific Objectives |
|---|--|
| To achieve higher levels of well being in the extremely poor population of Nicaragua, supporting the accumulation of human capital. | <ul style="list-style-type: none"> - Fortify the programme's operating framework through institutional strengthening. - Improve nutritional care and vaccinations of children under five years old; promote the growth and development of children under five years old. - Encourage the incorporation, continued attendance, and academic progress of children in the first four grades of primary school. - Establish objective and transparent criteria in the selection of beneficiaries, and conduct an impact evaluation of the programme. |

Source: BID, 2002.

Although some of the terminology or focus associated with RPS changed with the birth of RPS-II, most of the programme was fundamentally unaltered. In several areas, however, there were changes that were reflected in a new operating manual. The modifications to RPS

encompassed the programme's components, targeting, supply-side supports, exit strategy and institutional setting. Only the altered facets of the programme will be discussed here.

RPS-II was intended to reach more communities, providing benefits to 30,000 by 2004. It continued providing cash transfers to the 10,000 households of RPS-I until the households' initial three-year period had ended;³⁰ thereafter, only supply-side benefits were given to these households for an additional two years (BID, 2002). The 21 census area communities that comprised the control group in the impact evaluation of RPS-I were enrolled in RPS-II. RPS-II also expanded into three new municipalities, in addition to the original six municipalities served by RPS-I. This addition was no small feat, since the municipalities included in the programme were more remote than the original six.

4.1 COMPONENTS

One significant change in the programme stemmed from the positive results found in RPS-I. It was believed that since the programme's impacts had been so overwhelmingly positive, it might be possible to lower the transfer amounts and still have significant positive, albeit potentially dampened, results. In an effort to conserve costs and extend the programme to more households, RPS-II transfer levels were lowered. It was not clear exactly how this decline would affect the programme's effects, but the impact evaluation of RPS-II would reveal if the change was merited. The transfers, still given every two months, were set at levels that amounted to a 30 per cent reduction from RPS-I (BID, 2002). Figure 4 explains the components.

The Education Transfer fell from US\$ 112 per household to US\$ 90 per household. The value of the School Pack did not decline; it was raised from US\$ 21 to US\$ 25 per eligible child in order to align it with the supplies that the Ministry of Education provided through another programme (BID, 2002). The health transfer, renamed the Food Security Transfer (*Bono de Seguridad Alimentaria*), had a graduated structure. Instead of remaining at US\$ 224 per household for all three years of the programme, it began at US\$ 168 for the first year. It was reduced to US\$ 145 throughout the second year and to US\$ 126 throughout the third and final year (IFPRI, 2005).

The supply-side transfers were also altered. The Supply-Side Education Transfer for local schools and teachers increased from US\$ 4.75 to US\$ 8 per student per year. The mode of delivery remained unchanged: families still received the transfers and were obliged to give them to either the teacher or the local school association. The supply-side health programmes expanded their repertoire of services as well as their reach, as discussed in more detail in Section 4.1.2.

A new component of the programme, known as Vocational Training (*Formación Ocupacional*), began with RPS-II. This differed significantly from previously established components. It was created to address the lack of educational and productive activities available to youths who had completed primary school.

To be eligible for the Vocational Training transfer, individuals had to have participated previously in educational seminars offered by RPS for youths, covering topics such as self-esteem, drugs and sexual health. Beneficiaries had to be between 14 and 25 years old,³¹ have completed primary school and/or be literate,³² and have finished all schooling they planned to complete. Youths also had to request entry into the programme.

FIGURE 4

Components of RPS-II

| Component – Demand Side | Beneficiaries | Benefits in \$US | Co-responsibilities |
|---|---|--|--|
| <i>Bono de Seguridad Alimentaria</i> – Food Security Transfer | All targeted households | US\$ 168 per household in first year US\$ 145 per household in second year US\$ 126 per household in third year | <ul style="list-style-type: none"> - Women and adolescents must attend bi-monthly training sessions. - Children from ages 0–9 must be up-to-date with the Ministry of Health's immunisation requirements. - Children, adolescents and women of childbearing age must attend required doctor's appointments. |
| <i>Bono Educativa</i> – Educational Transfer | Beneficiary households that have at least one child between the ages of 7 and 13 who has not completed the fourth grade | US\$ 90 per household per year | <ul style="list-style-type: none"> - All children aged 7–13 who have not completed first to fourth grade must attend school, with no more than three unexcused absences per month (85 per cent attendance). - Household must turn in Supply-side Education Transfer as specified. |
| Mochila Escolar – School Pack | Targeted households with children from the first through fourth grade | US\$ 25 per child per year | <ul style="list-style-type: none"> - Children must be enrolled in school at the beginning of the school year. |
| Component – Supply Side | | | |
| Bono a la Oferta – Educación Supply-Side Education Transfer | Targeted households with children from the first through fourth grade, but the benefit must be given to the local school advisory committee or teacher | US\$ 8 per child per year | <ul style="list-style-type: none"> - Household's eligible children must attend school, and the teacher must participate in the local parent association as sponsored by the Ministry of Education. |
| Bono a la Oferta – Salud Supply-Side Health Transfer | Contracted private health service providers | Up to US\$ 90 per household per year | <ul style="list-style-type: none"> - Paid as specific coverage goals are met by health service providers. |
| New Component | | | |
| Formación Ocupacional Vocational Training ³³ | Youth between 14 and 25 years old who have completed primary school and/or are literate, have finished all planned schooling, and request entrance into the programme | About three months of classes (amount varied by vocation) are given free of charge, opportunity cost transfer of US\$ 15 per month, and one time transfer of US\$ 200 at end of training | <ul style="list-style-type: none"> - Beneficiaries must attend vocational training classes to receive opportunity cost transfer. - Create approved business plan to receive one-time productive transfer. - Must use cash transfer at end of training for investment in the start-up costs of a microenterprise in the selected vocation. |

Source: BID, 2002; IFPRI, 2005; Largaespada Fredersdorff, 2006.

Participation in the Vocational Training component required that beneficiaries attend classes that lasted for about three months, depending on the vocation pursued. The beneficiaries travelled to the municipality seats for the sessions. Upon completion of the

training, the youths³⁴ received a one-time cash transfer that was to be used to invest in the start-up costs of a microenterprise in the field in which they had received training. Vocational training encompassed occupations as varied as carpentry, cosmetology, floral arrangement, mechanics and more.

There was no strict follow-up to ensure that participants purchased appropriate items with their transfer, though some local coordinators tried to encourage youths to use the money correctly. There were widespread reports that most beneficiaries did not use the transfers to begin their vocational activities. Instead, many purchased clothing, appliances, an animal or another good. This lack of follow-up by participants may have stemmed less from deliberate deceitfulness than from a lack of information on how to start their businesses. It is unclear whether the training provided was sufficient in quality and quantity, despite being provided by the National Technological Institute (*Instituto Nacional Tecnológico*). More encouragement, accountability and direction on how to use the transfers productively were needed. Some communities tried to avoid this misuse by together purchasing goods with the transfer money, such as sewing machines, which could be used by those who had been trained through the programme.

Despite the negative reports, some young individuals that began small enterprises using this transfer still have functioning businesses, and they found the transfer to be extremely helpful. While it did not have the impact desired, adjustments could have been made to provide greater incentives to youths to exercise their newly attained professions. If RPS had not ended, these necessary changes would probably have been made.

It appears that the Vocational Training was more of an afterthought to RPS; it was not outlined in plans for RPS-II or included in evaluation plans. The programme may have helped to suppress complaints that RPS did not address the constraints on productive activity in RPS communities. The Vocational Training, however, while providing practical technical training and even relevant business training, seems to have lacked the instruction necessary to help youths begin any productive activity. Although vocational training may have helped some youths insert themselves productively into society, other factors to support their insertion were absent. Unless the training filtered applicants to ensure that trainees had concrete plans to work in their trained vocation, and provided additional business training and direction in capital formation, the money spent on this project could probably have been used more effectively elsewhere.

4.1.1 Targeting in RPS-II

Targeting in RPS-II was refined beyond the level achieved in RPS-I, particularly in order to address errors of inclusion. It was based on the newest national poverty map, created in 2000. Municipalities with extreme rural poverty levels of more than 35 per cent and at least 500 rural, extremely poor households were initially selected. The new municipalities chosen for inclusion were those with the lowest net and gross enrolment rates for children in first to sixth grade, low availability of basic health services, and productive capacity or opportunities in sectors identified by the Nicaragua government (BID, 2002). The final requirement reflected the Nicaraguan government's request that RPS-II be directed towards areas with greater potential for productive activities, which would help beneficiaries to capitalise better on programme benefits (BID, 2006).

Targeted *comarcas* were chosen using a new instrument created by IFPRI and RPS's Executive Operating Unit. Rural *comarcas* without access to basic health services, but with educational services available, were chosen. In *comarcas* with extreme poverty levels exceeding 45 per cent, geographic targeting was used (BID, 2006).³⁵ All households in these localities were eligible to receive the benefits of RPS-II. In *comarcas* with extreme poverty levels of less than the threshold amount, household-level targeting was used to complement the geographic targeting. A proxy means test based on household consumption variables was used to determine which households were eligible to receive all RPS-II benefits. Those households deemed not destitute enough did not receive the Food Security Transfer, School Transfer or School Pack, but they did receive the supply-side supports of RPS-II (BID, 2002).

4.1.2 Supply-side Supports

One of the major changes to RPS-II was its expansion of supply-side health services to allow and require visits by children over five years old and adolescents, as well as women of childbearing age. Pre-natal and post-partum interventions were introduced into the health services, having been precluded from RPS-I by request of the Ministry of Health, which was concerned about the possible effects of tying benefits to fertility. These services were added without any new co-responsibilities (BID, 2006). Additional reproductive healthcare for females was provided, including the provision of contraceptives to women and adolescents. The vaccination protocol was also extended to cover children between six and nine years old, instead of only those aged five and under (Castro and Regalia, 2007).

The educational seminars provided to beneficiaries expanded their topical coverage beyond the initial list. They were also improved upon to ensure they were being taught in a manner that suited their audience's lack of education. There is evidence that some training seminars were opened to community non-beneficiaries to narrow the distinction between RPS households and non-RPS households, as had been suggested by IFPRI's qualitative evaluation (Adato and Roopnaraine, 2004). Health service providers and the Ministry of Health were also required to train local promoters in basic healthcare (RO, 2005).

In treatment communities, the Supply-Side Education Transfer was now available to all households that fulfilled the education co-responsibilities. In the areas with household targeting, however, only the selected beneficiary households could also receive the Education Transfer and School Pack (RO, 2005). Similarly, all households in targeted communities could receive free healthcare if they fulfilled the health co-responsibilities. In areas with household targeting, only selected households could also receive the Food Security Transfer. These steps were taken to increase effectiveness and reduce costs through economies of scale.

Another major change to RPS in its second phase was the extension of supply-side benefits to households that no longer received the demand-side transfers. Households that completed their three years of programme transfers were now eligible to continue receiving the supply-side benefits free of charge if they continued to comply with co-responsibilities. This benefit was provided in both the education and health components (BID, 2002).

In RPS-II, health service providers were paid solely on the basis of the services they provided to households; payment was no longer tied to the growth goals that had been met. This practice avoided any collusion between households and health service providers, given their similar interest in children's growth. Providers who worked in areas where beneficiary

households no longer received the demand-side services were eventually paid in a different manner than those who worked in areas where households received all programme benefits. Instead of being paid only if they had provided benefits reaching a 98 per cent coverage rate of each group, they were paid on the basis of the population that they had served (Castro and Regalia, 2007).

4.1.3 Exit Strategy of RPS-II

Allowing former beneficiaries to continue receiving supply-side transfers was seen as a way to gradually help households successfully exit the programme while encouraging them to continue investing in their own human capital. While not receiving cash transfers for their own use, they still received regular, free medical care and training sessions to encourage them to invest in education, proper nutrition, healthcare, sanitation and more, provided they complied with health co-responsibilities. If they continued sending their children to school, they would benefit from the financial support given to local educators. The extension of the supply-side benefits was also seen as a way of decoupling the supply-side impacts of RPS from the demand-side impacts, and of understanding them better. The extent to which households would respond to this gesture was not yet clear.

4.2 INSTITUTIONAL FRAMEWORK OF RPS-II

The most consequential change in the transition from RPS-I to RPS-II was the transfer of its institutional base from FISE to the Ministry of the Family (*Ministerio de la Familia*) before the advent of RPS-II in 2002. This change was made at the request of the Nicaraguan government and it entailed moving all personnel, infrastructure and so forth from FISE headquarters to the Ministry of the Family's headquarters. Originally, it was believed that RPS could continue much as it had in the past, except that it would be housed in the Ministry of the Family and report to the Coordinating Council of FSS, which had been strengthened slightly (BID, 2002). Nonetheless, the impacts of this change were the most far-reaching of the differences between RPS-I and RPS-II; they will be discussed in greater detail in Section 6.

The move to the Ministry of the Family was also made to capitalise on the potential synergies of social protection programmes in Nicaragua. RPS-II was designed to share appropriate information with other government programmes that could complement the services it provided. Similarly, RPS wanted to strengthen its long-term impacts by giving beneficiaries information about the benefits available through other programmes (RO, 2005).

4.3 IMPACT EVALUATION OF RPS-II

IFPRI conducted the impact evaluation for RPS-II as well as RPS-I. While the evaluation of RPS-I was experimental in design—that is, there was both a treatment and a control group—the evaluation of RPS-II was not designed as rigorously. The second-phase evaluation had a quasi-experimental design. The pseudo-control group was simply considered a comparison group, such that its outcomes could not be directly compared to treatment outcomes using simple mean differences. Since RPS-I had been so successful in improving health, nutrition, and education outcomes, it was not considered appropriate to exclude new communities randomly from the programme as was done in the experimental set-up of RPS-I's evaluation (Castro and Regalia, 2007).

The two groups originally used in the evaluation of RPS-I were still included in the assessment of RPS-II. The original treatment group that was now receiving only supply-side support was considered the first treatment group. The original control group of 21 census areas from the RPS-I impact evaluation became the new treatment communities, and they were considered a second treatment group. Finally, a comparison group comprised a little fewer than 700 households in 21 additional census areas. These areas were close to those where RPS was operating, and they were surveyed in 2002.

The comparison communities were chosen on the basis that they and the treatment communities had received similar levels of health and education interventions before RPS-II began. These comparison communities were a part of municipalities adjacent to RPS municipalities. None of them were municipality seats, which would have differed substantially from the rural communities targeted by RPS. Communities with marginality indices similar to those of treatment communities were chosen (IFPRI, 2005).³⁶

Ideally, this comparison group should have been virtually identical to the treatment groups. It was discovered, however, that the comparison and treatment communities had several fundamental differences. First, the comparison communities tended to be wealthier than RPS treatment communities. Second, they were subject to significant health interventions during the time of the evaluation, confounding the results and limiting the conclusions that could be drawn in these areas (IFPRI, 2005). The interventions that occurred after the evaluation began targeted children between zero and three years old, and focused on children's health and nutrition.

Households within the comparison communities were selected randomly, with calculations made on the basis of the number of households projected to live in these census areas³⁷ (IFPRI, 2005). Surveyors would interview every x^{th} household within a given y^{th} area, depending on the projected number of households in the community, to arrive at about 42 households within each census area, the same number per census area within the other evaluation groups.

IFPRI's evaluation of RPS-II used household surveys conducted in 2002 and 2004 in the households in the first and second treatment groups, as well as the comparison group. The work included an assessment of RPS-II, as well as additional conclusions about RPS's continued impacts on beneficiary households from RPS-I.

4.3.1 Impact Evaluation of RPS-II Households

Although the results of the evaluation of RPS-II should be viewed with the aforementioned caveats in mind, the impacts are still clearly apparent. RPS-II increased annual per capita expenditures in beneficiary households by about 25 per cent on average (IFPRI, 2005). Once again, a significant amount of the increased spending was on food purchases, and the increase included fruit and vegetable products. School enrolment and attendance rose, and expenditures on education-related items grew. There was a 15 percentage-point increase in the number of children under the age of five who had been to a preventive check-up in the previous six months. Unfortunately, wasting increased by 1.9 percentage points. Stunting decreased by 7.4 per cent in the new treatment group, but this effect was not significant compared to the larger reductions in stunting in the comparison community.³⁸ Improvements in children's use of local health services were greatest in the poorest households. Use of maternal health services

increased, as did family planning in households with older women. As with RPS-I, it was found that RPS-II did not significantly reduce labour force participation (IFPRI, 2005).

4.3.2 Impact Evaluation of RPS-I Households

IFPRI again conducted a thorough evaluation of the households that had benefited from RPS-I and now were only eligible to receive supply-side transfers. The evaluation reported that regular school attendance and enrolment in these households was higher than it had been in 2000, before the programme began. These levels, however, were not as high as they had been when they received the demand-side transfers. When the demand-side transfers were removed, about half of the gains in enrolment and attendance achieved during RPS-I were lost. This resulted in an eight percentage-point increase in school enrolment and a 16 percentage-point increase in school attendance over pre-programme levels (IFPRI, 2005). Castro and Regalia (2007) suggest that this result may reflect the high costs of maintaining school attendance.

The use of healthcare services by former RPS-I households was still high at the time of the evaluation, which was between eight and ten months after these households ceased receiving the demand-side transfers but could still receive supply-side transfers. In fact, usage remained at the levels they had reached in 2002. In 2004, the number of children under five who had attended a medical check-up in the previous six months was 18 percentage points higher than it had been in 2000 (IFPRI, 2005). Coverage of vaccinations even improved during this time. Between 2002 and 2004, stunting levels decreased by an additional 8.2 percentage points in the original RPS-I group.

IFPRI (2005) concluded that RPS-II had been as successful as RPS-I, despite the limitations of the less rigorous impact evaluation. Unfortunately, the second evaluation of RPS-I households was unable to elucidate a symbiotic relationship between supply and demand transfers. The study could not distinguish between long-run impacts of the demand-side transfers and the continued impacts of the supply-side supports (Castro and Regalia, 2007). Thus it was also unable to determine how the supply-side transfers affected the RPS-I and RPS-II communities differently.

5 THE END OF RPS AND ITS “DESCENDENTS” IN NICARAGUA

RPS came to an end as a social protection programme during the government of Enrique Bolaños of the Constitutional Liberal Party. Some observers note that the next government, that of Daniel Ortega and the Sandinista National Liberation Front (*Frente Sandinista de Liberación Nacional*, FSLN), would have discontinued RPS had it persisted into his term. The collapse of RPS is ironic, given the international recognition it received as an effective tool in fighting poverty and accumulating human capital. There had previously been discussions of making RPS a major component of a broader social safety net initiative known as the Solidarity for Development Programme (*Programa de Solidaridad para el Desarrollo*) (LeCayo, 2004).³⁹

While many have opinions on why RPS ended, the “how” of the matter is fairly clear. RPS was technically discontinued because of events in July 2005. The then-Family Minister had to make a formal approach to the Nicaragua Congress to request funds to support a third phase of the programme. She did not do this, although the IDB had the funds for another phase, to be used to expand programme coverage. In September or October of the same year, however,

when the domestic funds had to be committed, they had not been allocated for this purpose. In 2006, RPS continued to operate at a reduced level using a minimal budget, and eventually the process of closing the programme began.

Perhaps somewhat anticlimactically, RPS was not renewed and would have to be discontinued since domestic funds alone could not support it.⁴⁰ The current government claims that it now supplies the services that RPS used to provide through its line ministries: the Ministry of Education gives a School Pack and provides school lunches and nutritional supplements to children; and the Ministry of Health continues to expand the healthcare services it provides in remote rural areas as the government's budget allows. Several other programmes have provided Nicaraguans with benefits similar to those that RPS delivered. Sections 5.1 and 5.2 offer a brief review of these programmes.

5.1 CRISIS ATTENTION SYSTEM

Although RPS was destined to end, there was hope that a similar programme could continue. In July 2004 there were landslides in the northern part of Nicaragua and many people were killed or displaced. The World Bank provided an emergency cash transfer to those affected by the landslides. Maluccio (2005) had confirmed that RPS-I helped beneficiaries cope with the collapse of world coffee prices better than non-beneficiaries, suggesting that CCTs may be helpful in times of adverse shocks. A programme very similar to RPS, known as the Crisis Attention System (*Sistema de Atención a Crisis, SAC*), addressed this possibility. SAC was known as the "Little Red" (short for *Red de Protección Social*), and it drew on the same principles as RPS. It was located in the government's new National Social Protection System's Solidarity for Development Programme (Largaespada Fredersdorff, 2006).

SAC was smaller than RPS in reach and resources. It ran from November 2005 until December 2006 and reached 3,000 households during its one-year pilot. Its aim was to assimilate the best practices of RPS, improve on them, and perhaps motivate the Nicaraguan government to allow social protection programmes to play a larger role in the country. There was even hope that the government would want to start a programme of its own, to which those who were experienced in Nicaragua's CCT programmes could provide technical assistance. Additionally, SAC was going to be used to determine how a CCT programme could protect households in times of adverse shocks. Like RPS, SAC gave periodic cash transfers to female household heads, contingent on the households' fulfilment of co-responsibilities.

SAC differed from RPS in that it grew out of times of crisis and was intended to provide relief to households in circumstances of systemic (and, later, idiosyncratic) adverse shocks. Moreover, it wanted to capitalise on the synergies available through its support for both human capital and productive activities.

SAC was implemented in six municipalities in Nicaragua's northern dry zone, comprising extremely poor areas prone to and recently affected by droughts. Once the municipalities were chosen, targeted communities were selected at random. A proxy means test, used to predict household consumption levels, determined whether households were then allowed into the programme. About 10 per cent of households were excluded in the targeted areas through this method (Macours and Vakis, 2008).

SAC was composed of the four demand-side cash transfers given in RPS-II, in addition to a new cash transfer with corresponding co-responsibilities. The new transfer was known as the

Productive Transfer. Although the transfers were still given to the female head of the household, the Productive Transfer and the Occupational Training component were often directed to household members other than the female head.

The “basic” package of cash transfers consisted of the Food Security Transfer, the Educational Transfer and the School Pack; these were almost identical to the same transfers provided by RPS. All 3,000 households within the programme received this transfer. Two-thirds of beneficiary households received one of two additional benefit packages.

Some 1,000 households were randomly selected to receive a Productive Investment Grant, which provided two transfers of US\$ 100 each, given two months apart. This amount was arrived at by reviewing quantities of micro-loans granted in the targeted area. Beneficiaries of this transfer had to form a business plan. They received training on the formation of their business plan, how to maintain a small business and other matters. Beneficiaries could form individual or group businesses. Many beneficiaries within communities focused on developing businesses with which they were already familiar. Thus members of the same communities tended to invest in only one type of business venture. SAC officials recognised this tendency and tried to promote diversification through their support activities.

Finally, an additional 1,000 households were randomly selected to receive the Vocational Training transfer, which was similar to the Vocational Training component of RPS-II. Beneficiary households selected a household member to take vocational training courses on weekends at their municipality seat. Beneficiaries received US\$ 30 every two months in exchange for their participation. The courses lasted from three to six months, depending on the vocation chosen. Like RPS’s Vocational Training component, some courses required that beneficiaries be functionally literate. Figure 5 gives a basic outline of SAC’s components.

SAC encompassed some of the extensions that RPS officials had hoped to implement in the future. In particular, SAC staff worked with the Ministry of Health to provide healthcare supply-side services. They also required children to attend school to sixth grade rather than fourth grade, so as ensure greater consistency with the Millennium Development Goals.

The protocol for the administration of cash transfers was similar to that established in RPS. SAC had very few staff, and the same four employees oversaw the cash transfers. The latter were outsourced to a Nicaraguan company, as in RPS.

There was no full monitoring of SAC’s co-responsibilities because of implementation problems. There were delays in concluding an agreement with the Ministry of Health, and one was only reached at the end of the year-long programme. Thus there was no monitoring of the health transfers co-responsibility and health services were not expanded as planned. Education co-responsibilities, however, were monitored with the help of local educators. Teachers completed forms reporting whether students arrived at school with their uniforms and supplies purchased from the School Pack. As with RPS, the SAC team also randomly arrived at schools to verify that co-responsibilities were being met.

A thorough impact evaluation of SAC has been conducted by a team composed of researchers from the World Bank, Johns Hopkins University, and the Nicaraguan Centre for Rural and Urban Research and Studies (*Centro de Investigaciones y Estudios Rurales y Urbanos de Nicaragua*, CIERUNIC) (World Bank, 2008). Baseline data were collected in April and May 2005. A follow-up evaluation was completed in July and August 2006, and another was finished during the same months in 2008. The World Bank (2008) reported that nine months after the

programme began there were significant improvements in healthcare, nutrition, and educational participation and attainment. Other programme impacts included the creation of assets and productive opportunities, as well as households' improved ability to control and confront risk. Macours, Schady, and Vakis (2008) have shown that the programme improved the cognitive development of beneficiary children, particularly in language skills. Macours and Vakis (2008) also found "social spillover" effects, whereby the proximity of beneficiary leaders⁴¹ with the productive investment package to other beneficiaries increased the programme's impacts; greater similarities between leader and non-leader benefits improved beneficiaries' aspirations and outlook on the future.

FIGURE 5

Synopsis of Components of the Crisis Attention System

| Component | Beneficiaries | Benefits in US dollars | Co-responsibilities |
|--------------------------------------|--|---|---|
| Basic CCT | | | |
| Food Transfer | All households | US\$ 145 per household per year | Same as in RPS |
| Education Transfer | Households with children ages 6–14 who have not completed first to sixth grade | US\$ 90 per household per year | Same as those in RPS |
| School Pack | All eligible children | US\$ 25 per child per year | Same as those in RPS |
| Supply-Side Education Transfer | Intended for local educators/schools | US\$ 8 per child per year | Same as those in RPS |
| Supply-Side Health Transfer | Households, through the Ministry of Health | US\$ 90 per household per year | Same as those in RPS |
| Vocational Training Component | | | |
| Opportunity Cost Transfer | Selected beneficiary households with a willing/eligible household member | Up to US\$ 90 per household per year (\$15 per month, for the length of the course) | Attend vocational training courses |
| Course Costs | Paid to the course providers | \$140 per household per year | Provide training to beneficiaries |
| Technical Assistance | Paid to technical assistance provider | \$40 per household | Provide technical assistance to programme |
| Productive Investment Grant | | | |
| Matching Grant Transfer | Selected beneficiary households with a willing/eligible household member | \$200 per household upon creation of business development plan. | Create business development plan Invest final grant towards business venture |
| Technical Assistance | Paid to technical assistance provider | \$40 per household | Provide technical assistance to programme |

Source: Macours and Vakis, 2008; Largaespada Fredersdorff, 2006; World Bank, 2008.

5.2 THE CURRENT STATE OF SOCIAL PROTECTION IN NICARAGUA

The current FSLN government has its own vision of social protection, one in which RPS does not play a part. The government began its own social protection programme, *Hambre Cero* (Zero Hunger), which emphasises its non-"welfaristic" and rehabilitative nature. It aims to eliminate chronic hunger in Nicaragua by increasing food production so that households can meet and exceed subsistence levels, and then go on to contribute to local economic activities.

Zero Hunger is directed at poor Nicaraguan households but not the most indigent. To be eligible for the programme, households must have 1.4 or more hectares of land and access to a

source of water. This requirement obviously eliminates many extremely poor Nicaraguans. To receive benefits, households must also show that they are willing to honour their commitment to work in productive activities.

Beneficiary households receive in-kind transfers worth about US\$ 1,500 in the form of a cow, pig, birds, chickens and a rooster, and feed for the animals.⁴² The programme also encourages the cultivation of fruit trees and other plants. Supposedly, households that do not meet the land requirements may receive seeds for community gardens and other aid. Technical assistance, as well as other types of training and education, are planned to teach households how to maintain and reap the gains from these plants and animals. There is also a strong emphasis on involvement in community groups, such as productive associations.

Most of the programme's funds come from the Nicaraguan national treasury, but about a third are donations from other countries or organisations. Households that benefit from Zero Hunger must commit to invest their transfers in productive activities. Then they must repay the government for the benefits they have been given within 18 months of receipt of the transfer.

The government plans to take the Zero Hunger programme to 150,000 households, half of which should be reached by the end of the president's current term in 2012. The close connections between Zero Hunger and the FSLN have spurred criticism that the programme will become highly politicised. Programme officials, as well as President Ortega, emphasise that the programme benefits will not be awarded on the basis of the political affiliations of potential beneficiaries. The stipulations of external donors will increase the programme's accountability and perhaps sustainability. The general consensus, however, is that this programme will not outlive Ortega's term in office.

5.3 THE PROSPECTS FOR RPS-III

Hopes for a resurrection of RPS have not completely faded in Nicaragua. In November and December 2006, the RPS team began collecting data in order to expand the programme into areas of the country marked by high levels of immigration and capital flight. The third phase of RPS, in addition to greater coverage, would also incorporate lessons learned from RPS-II and SAC. Many RPS communities had expressed interest in receiving support for productive activities, similar to that given by SAC's Productive Transfer. RPS-III would probably have included a component to address this issue.

While there have been occasional rumours that another phase of RPS is being planned, the programme has not re-started. Certainly, the view of the current government does not allow room for RPS or a programme like it to operate in the short run. The government does not have a positive opinion of CCTs. Although Zero Hunger officials planned to travel to the Dominican Republic to learn about its cash transfer programme, which emphasises productive capacity, they commented that CCTs encouraged robbery and corruption.

Whether this opinion will change in the medium or long term is unclear. The current political consensus is that Ortega's government is now taking on the responsibilities previously assumed by RPS, and thus RPS is no longer needed. Political leaders say that the governments in power when RPS was being implemented did not commit to social protection, and thus RPS was useful in those years. These comments highlight the lack of ownership that the current government sensed with regard to RPS.

Although the discontinuation of RPS has not been an ideal development, a further danger is that the gains made in RPS households will diminish over time. In some areas, before the introduction of RPS, households could only arrive at rural health clinics by way of river travel, and the trip could last many hours and be prohibitively costly to poor families. RPS was able to increase rural health coverage significantly, but these gains may be lost. The Ministry of Health was unable to guarantee the sustained supply of healthcare services in RPS communities beyond those agreed upon in the second IDB loan (Castro and Regalia, 2007). Similarly, educators in former RPS communities point out that many of the gains achieved during RPS's lifetime have been lost; school attendance and motivation is lower, and civic participation has waned since its peak in the days of RPS.

6 OVERALL EVALUATION OF RPS

It is clear that the results achieved by RPS were not purely serendipitous; they were planned for and exemplify a CCT of perhaps unparalleled efficiency and effectiveness. Hence it is useful to outline some of the key features of RPS that led to its early success.

Many of its exemplary results can be attributed to the high calibre of the programme's staff. Officials were hired on the basis of their technical experience rather than party affiliations, but their attainments went beyond this professional expertise. RPS officials' commitment to the purpose and excellence of the programme was commendable. Many ascribe some of the officials' dedication to the dynamic leadership of RPS's founding director. Programme officials, both at the highest and lowest levels, spent much time in beneficiary communities. Local officials reported visiting beneficiary communities almost on a daily basis. These efforts emphasise the enthusiasm engendered by the programme; the beneficiaries and programme officials both felt they were part of a project greater than themselves.

Strong communication within RPS gave employees a unified view of the purpose of the programme. Officials commented that the aim of RPS was to accumulate human capital, and that the cash transfer component was a mechanism to do this, rather than an end in itself. There also appeared to be a good understanding of the complexities of poverty. Former RPS officials spoke of how poverty was caused by many issues, including lack of money, human capital, productive activities, and even education among some who may be influenced by a "culture of poverty". They saw RPS as a long-term solution to poverty in Nicaragua rather than a quick fix.

Community members and local supply-side stakeholders were expected to have, and maintained, strong commitment to RPS. Promoters took their responsibilities seriously, and they fomented a sense of community responsibility at the grassroots level. Medical teams travelled to remote locations through difficult terrain, spending long periods in the field. Teachers increased the number of school sessions, and most still reported that they wished RPS could have continued, despite the increased workload it generated. Part of educators' willingness to increase their workload may reflect the improved support and involvement that they received from parents as a result of RPS.

At the end of RPS-I, IFPRI's qualitative evaluation concluded that local-level ownership of RPS was lacking (Adato and Roopnaraine, 2004). In response to this, it appears that an effort was made to encourage local initiatives related to RPS. These efforts led to the organisation of local cleaning groups, adult and youth education classes, and more. Despite some reports

of growing distance between RPS and non-RPS households, overall community solidarity increased. Almost a third of the interviewed beneficiaries in the qualitative evaluation reported sharing their benefits with a relative or friend.

RPS was able to effectively align its stakeholders' incentives, which improved its monitoring capacity and increased programme ownership at all levels. The interest that individuals had in RPS's mission increased their enthusiasm to engage in the complex web of programme monitoring, thereby helping to improve RPS's efficiency over time. While these processes initially needed adjustment, officials expressed enough flexibility to alter details in protocol to stay true to the programme's goals.

Because of this flexibility, some co-responsibilities were not enforced. For instance, it was discovered that children were often automatically sent to the next grade, so the grade-promotion conditionality in RPS-I was not imposed. Receipt of the correct vaccinations was also not enforced at the beginning of RPS, since some vaccines were not available as expected. Similarly, a co-responsibility that children maintain adequate weight was dropped after RPS-I because of the perverse effects or incentives associated with it (Maluccio and Flores, 2005). The poorest households or those with recently ill children were the most likely to be punished, and some households overfed children before well-child visits in order to avoid penalties.⁴³ Flexibility was also shown by some health service providers, who employed female doctors when local men did not want male doctors to provide medical care to their wives and partners.

There was less discussion of RPS's adult educational seminars in most evaluations, but their influence appears to have been a major part of the programme's success. Educators reported that they benefited from training sessions provided by RPS. They learned how to recognise learning disabilities and other problems, and how to deal better with difficult children. Obviously, these results were not universal, but it appears that the impact of the educational portion of the programme was beneficial in many regards.

Perhaps even more important are the impacts of RPS's adult education component for beneficiaries. In all CCT programmes, there will always be beneficiaries who comply with co-responsibilities simply in order to receive the cash transfers. However, many female household heads involved with RPS seem to have had a positive awareness-raising experience through RPS and the educational seminars. Years later, when asked to describe the impact that RPS had had on their lives, former beneficiaries made a rather surprising response. Rather than speaking predominantly of the cash benefits and the amelioration of poverty, many randomly-selected beneficiaries emphasised the education they received in the training sessions. They discussed learning how to cook with soy or locally available herbs, learning of their own worth as a person, and discovering how to stand up for themselves and take initiative in their families and communities. Some even commented that although they were still poor and could always use financial assistance, RPS had given them benefits in education and awareness that could never be taken from them regardless of their lack of income.

Programme officials also commented extensively on the changes they saw in beneficiary women. Arriving at remote communities where women first hid from any visitors, they saw a transformation over the life of the programme, whereby the women began to take pride in themselves, appearing in public and taking pains to look more "respectable". These changes did not occur overnight but unfolded gradually as the mentality of the beneficiaries changed.

Although a few mentioned that this newfound self-esteem led to domestic conflict, others remarked that domestic violence, once prevalent, was reduced through RPS. This may have resulted from a gain in females' intra-household bargaining power through their increased incomes, but it may also have been due to attitude changes in females and males. The formal qualitative evaluation of RPS-I suggested that in a significant number of cases, intra-household relations had improved as a result of the programme. Men approved of giving the transfers to women, whom they viewed as the more appropriate individual to be in charge of the household's nutrition and food (Adato and Roopnaraine, 2004). Gitter and Barham (2008) concluded that relatively more powerful male household heads⁴⁴ in RPS-I were not compensating for cash transfers to women by moving their spending from shared public household goods to their own private consumption, confirming that females exercised authority over transfer spending.

Many former RPS officials believed that some of the changes in beneficiaries had become long-lasting habits for them. Former group promoters have remained community leaders, working with local NGOs. However, not all reports of long-term post-programme results are as rosy. Some teachers reported a lack of interest in learning and school attendance once RPS was discontinued. There were greater levels of responsibility and better attitudes when the programme was operating.

Top-down support and acceptance was another crucial factor in RPS's success. When RPS-I began, it functioned under the auspices of FISE. The latter had experience in implementing projects, and it had trained municipalities in planning and implementing social investment programmes in its Municipal Technical Units, something RPS was also able to capitalise on (BID, 1999). Previous World Bank and IDB projects had helped train local leaders in project evaluation and had accustomed them to working in cross-functional teams with health and education officials. Some of this previous training may have made it easier for communities to carry out the RPS requirements. The selection of communities that already had experience in community development projects may have made programme implementation easier, but the extent to which this may have impacted RPS, if at all, is unclear.

RPS had significant successes but its demise certainly detracts from its gains. The crucial question, therefore, is: why would a programme that was perceived to be so successful among international circles ultimately be discontinued? Certainly it cannot be argued that the problem was simply that someone missed a deadline to apply for more domestic funds; the issue runs much deeper. The IDB claimed that Nicaragua should have been able to secure funds through the highly indebted poor countries (HIPC) initiative and soft money to expand RPS so that it could cover all extremely poor households in rural Nicaragua (about 80,000 households) within eight years of the start of RPS-II. This could be accomplished at a cost of about 4 per cent of the amount that the government of Nicaragua then spent on education and healthcare (BID, 2002). In short, Nicaragua could have continued and expanded RPS if the political will existed. Obviously, RPS did not command the necessary support for this. The lessons that can be learned from the demise of RPS, outlined here, are crucial for others who are directing similar programmes.

One former RPS official put the programme's ultimate collapse aptly. She said that RPS's greatest weakness was its failure to educate domestic stakeholders on its components and positive impacts. There had been much scepticism about RPS from its inception. Programme staff believed that, rather than wasting their time arguing with government officials, it would

be more profitable to prove that the programme could work. RPS staff did not ignore the public relations aspect of the initiative, but it is clear that the efforts they made to educate the public and politicians of RPS's purpose, components and successes were inadequate. The resistance to a CCT like RPS was so strong in Nicaragua that an all-out marketing campaign was probably necessary. Unfortunately, the stretched budgets and schedules of RPS staff did not allow such an operation.

The structure of the loan programme that financed RPS is probably part of the reason why domestic perceptions were not addressed. The IDB exerted significant pressure for programme execution, regardless of the sacrifices that had to be made. Within a year of the first loan disbursement, RPS had to have functioning departments, have completed the beneficiary registration as well as a baseline and evaluation survey, and show a more than 10 per cent improvement over the control group (using double-difference methodology) in healthcare provision, vaccination coverage, households with increased food consumption, school enrolment and school retention in first to fourth graders (BID, 2006).

Nonetheless, programmes often need more than one year to become established and make substantial progress toward their goals. In retrospect, officials agreed that some of the requirements placed on RPS, particularly their targeting goals and the timeframes allowed to hire health service providers and create and implement the information system, had been too demanding (BID, 2006). There was room for learning and mistakes, but RPS officials felt pressure to meet the strict standards that they were called upon to uphold.

The duration of the loans did not allow much time for mistakes or unexpected changes, not to mention changes in government, staff turnover, legal or political changes and so forth. RPS was under both international and domestic scrutiny, and it would have been beneficial if RPS officials had had more time to meet the demands of the lender and to deal with "soft" issues such as a domestic marketing campaign.

To ensure that they continued to receive their external funding, RPS officials had to deal with criticisms of the programme from outside Nicaragua. There were external concerns that the programme would be politicised and was marred by cronyism. These criticisms were not unfounded, since there were definite efforts within Nicaragua to influence and politicise RPS. One programme leader was approached and told that all RPS employees had to donate half of their salaries to support the ruling party. The official pointed out that the IDB would close the programme if they complied with the request, assuming that it was endangered whether RPS complied or not. Expecting to be fired after this altercation, the official was surprised to find that this non-compliance was respected. It was later reported that RPS employees were the only individuals within their larger institution who were not making these regular contributions to the party, even though other groups had complied. Thus, although relying on external financing increased RPS pressure to perform, it also helped protect programme staff from some of the politicisation that was feared.

A domestic public relations campaign would have been helpful, but the ideas it would have been combating were deeply entrenched. Nicaragua's unique history has made some of its citizens suspicious of programmes supported by certain capitalist countries. Others were mistrustful of programmes that appeared to be *asistencialista*. This term implies that a programme is "welfaristic" and encourages reliance on the state, and it was the main charge against RPS from within Nicaragua. It was claimed that RPS encouraged reliance on the government's social services while keeping beneficiaries trapped in poverty. Others said

that RPS reduced labour force participation, although this was disproven in the impact evaluations. This concerns underlying this criticism, however, do not seem to have been completely dispelled.

Other negative opinions and misunderstandings about RPS circulated in Nicaragua. A current senior official in the Ministry of the Family reported that RPS only gave cash to people, and husbands were waiting for wives to return in order to take the money and spend it on alcohol. She contrasted RPS with current programmes in Nicaragua, which she said actually educate the poor, unlike RPS. This official, so closely tied to RPS, was entirely unfamiliar with its purpose and achievements.

Public opinions of RPS may have improved if the Vocational Training component had been strengthened. If RPS had continued, necessary adjustments would most likely have been made to enhance post-disbursement monitoring and the incentives to invest in a small business. Another component that would have improved RPS's image would have been a productive transfer, much like that found in SAC. Since RPS-III would have taken the best practices of RPS-II and SAC, however, it is probable that it would have included some type of productive stimulus.

In addition to being deemed "*asistencialista*", RPS was criticised for being too costly.

Part of this criticism stemmed from RPS's use of health service providers to supply the healthcare services for beneficiary households. This step was considered vital for the programme's viability, given the Ministry of Health's initial inability and reluctance to provide services to remote areas served by RPS. However, it did increase programme expenses.

Others criticised RPS's cost because of the expenses involved in its rigorous impact evaluations. This is a paradoxical issue. It could certainly be argued that RPS could not have existed without these costs, because of the IDB loans and the conditions attached to them.

The highest costs were clearly those incurred at the start of the programme. Caldés and Maluccio (2005) calculated a cost-transfer ratio, which is defined as the administrative and private costs per unit given to beneficiary households. The cost-transfer ratio in the first year was US\$ 2.54 to US\$ 1 of benefits, which include both the demand transfers and supply-side supports. The ratio in the second year was 0.49, and in the third year it was 0.46. Castro and Regalia (2007) estimate that this fell to 0.20 by 2005, when the programme had continued to expand. Former RPS officials react to the criticisms of the programme costs by pointing out the long-term savings the initiative generated, and by arguing that its impacts outweighed its costs. Increases in programme costs and losses in efficiency that may have spurred more criticism of RPS near the end of its existence are related to the second major factor in its downfall: its transfer from FISE to the Ministry of the Family.

The move to the Ministry of the Family was the other major, perhaps most obvious, factor in its eventual failure. FISE was characterised by efficiency, professionalism and non-politicisation. When RPS was located within FISE, it was able to operate with significant autonomy. The Ministry of the Family, by contrast, was weak and subject to interventions by senior domestic officials. It also experienced significant turnover in its head post, the Minister of the Family. Some of these ministers were capable and supported RPS, while others did not understand RPS the programme the international organisations with which it worked. The Family Ministers' support was essential, as they represented RPS to the FSS, which would be able to secure additional soft money for it if necessary.

When it first moved to the Ministry of the Family, RPS was able to maintain a substantial degree of independence while undergoing gradual assimilation into the ministry. But a restructuring of the ministry took place and many functions of RPS were consolidated with other, similar programmes financed by international institutions. Decision-making became very centralised and fewer employees were responsible for more duties (Castro and Regalia, 2007). RPS officials found themselves in charge of other programmes (PAININ and SAC) and were stretched extremely thin.⁴⁵

RPS officials were also forced to “share” their technical and administrative employees within the Ministry of the Family. Even their vehicles and purchased goods were no longer under their jurisdiction. Additionally, salary discrepancies between those financed by international and domestic funds caused tension, jealousy and eventually a lack of cooperation between domestic officials and RPS staff. These factors obviously did not allow the administrative costs to be reduced, further tarnishing the programme’s image.

Transferring RPS to the Ministry of the Family was not an inappropriate step per se. RPS should have been functioning within the Ministry of the Family, which was the institution charged with managing all of Nicaragua’s social protection programmes. However, this move also caused RPS to lose its autonomy, efficiency and credibility, in an atmosphere already marked by scepticism of it. Perhaps if a concerted domestic marketing campaign had continually educated the general public and politicians on the purpose, components and achievements of RPS, there would have been more support for it within the ministry. There may also have been a stronger political will to see it supported and expanded throughout the country. As it is, Nicaragua has once again begun at square one in social protection, designing new programmes to aid the poor. It is not capitalising on the lessons learned, infrastructure created, or capacity developed through RPS.

Although RPS had a disappointing conclusion, all is not lost. The Nicaraguan experience provides others with an excellent example of a well-designed CCT that achieved significant results in a few years. Its design, characterised by technical efficiency, significant involvement of all stakeholders and an emphasis on changing long-entrenched patterns in poor households, can serve as a standard for other programmes. Similarly, the issues that RPS had to deal with in its own uniquely complex environment can remind policymakers to be aware of the balance they must keep in performing well for international stakeholders while securing domestic acceptance of their own programmes.

APPENDIX A

FIGURE A1

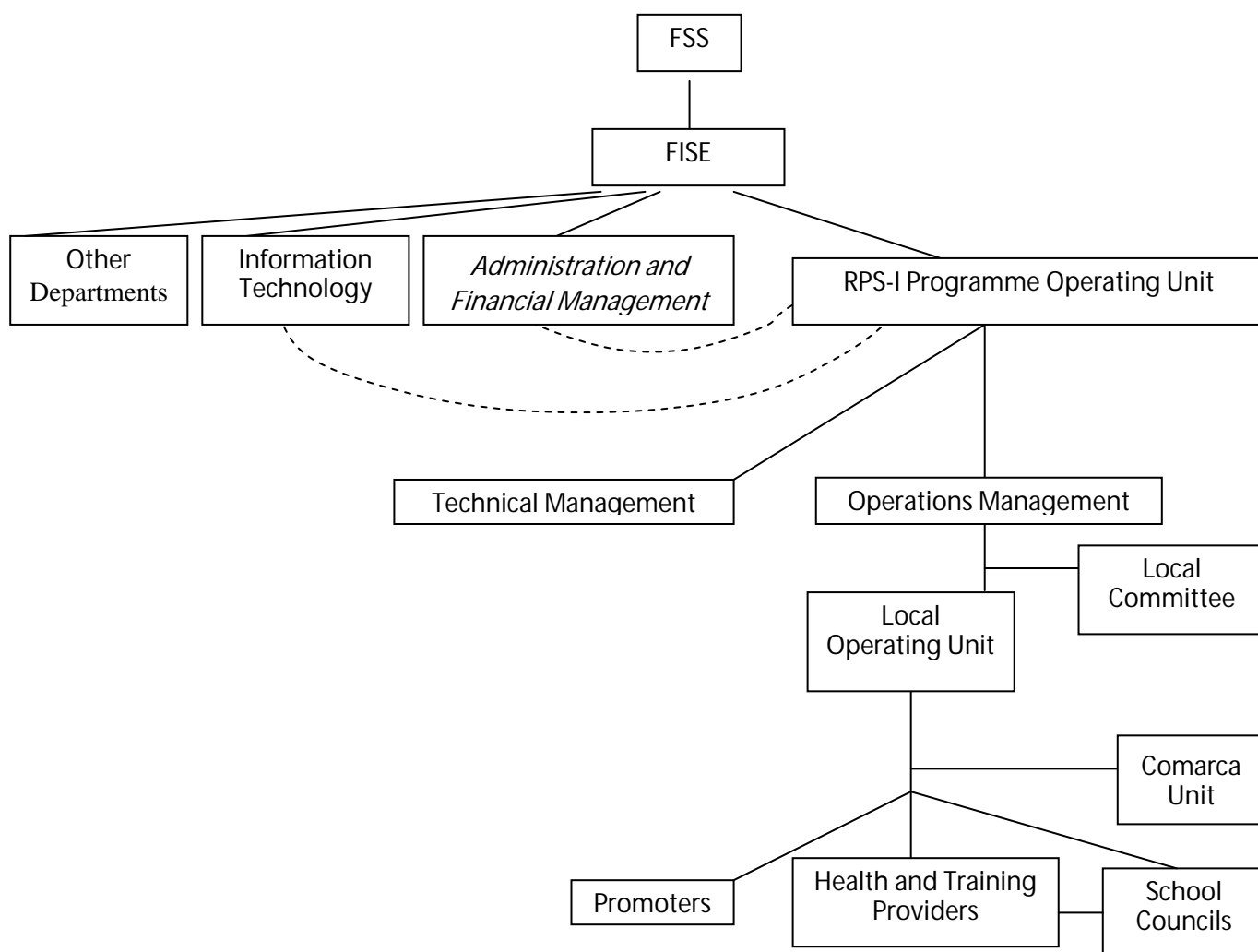
Interviews Completed During Mission to Nicaragua, January 2008

| International level | Senior Country Operations Officer, World Bank, Nicaragua |
|---|--|
| RPS: Central level | Technical Manager/Programme Director Operational Manager/General Director of Programmes and Projects Targeting and Evaluation Technician Information Systems Technician Health and Training Session Technician Operational Technician |
| RPS: Municipal and local (<i>comarca</i>) level | Coordinator for the Local Operative Unit for El Tuma-La Dalia, Terrabona/Occupational Training Technician Coordinator for the Local Operative Unit for Ciudad Darío/El Tuma-La Dalia Totogalpa: <ul style="list-style-type: none"> - Teachers (8) - Doctor and nurse in local health centre (Centro de Salud Che Guevara) - Community members (Beneficiary and non-beneficiaries) (6) Ciudad Darío <ul style="list-style-type: none"> - Promoters (4) - Vocational Training beneficiary - Teachers (2) - NGO (Fundación Médica Nicaragüense) training session facilitator/Surveyor for RPS-I and RPS-II - Medical personnel (2) - Local Vocational Training official - NGO health service provider (Darian Association): <ul style="list-style-type: none"> o General Coordinator of Social and Productive Projects o Project Manager - Beneficiary/president of local school association - Other beneficiaries (3) |
| <i>MiFamilia</i> /Ministry of the Family | General Director of Social Protection for the Ministry of the Family Director of PAININ |
| <i>Atención a Crisis</i> /SAC | Coordinator/Director |
| <i>Hambre Cero</i> /Zero Hunger | Implementation Coordinator, Advisor Director of External Cooperation |

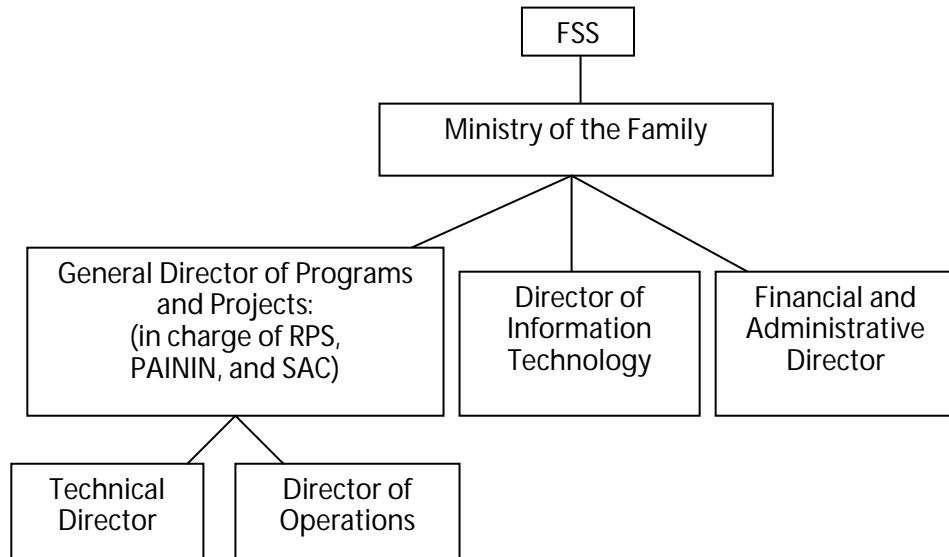
APPENDIX B

ORGANISATIONAL CHARTS

RPS-I



**RPS-II
CENTRAL LEVEL ORGANISATION, NEAR THE END OF ITS TENURE**



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NOTES

1. The extreme poverty lines were calculated by determining the amount of money needed per year to consume 2,187 kilocalories per day. The poverty line was this amount plus an additional 41.1 per cent allowed for non-food consumption. In 1998, these calculations equalled US\$ 237 for the extreme poverty line and US\$ 402 annually for the poverty line (World Bank, 2003).
2. Then known as *Progresa*.
3. This was also equivalent to 2 per cent of the Nicaraguan government's regular annual expenditures on health and education (World Bank, 2001).
4. More than 95 per cent of the titled beneficiaries were females (IFPRI, 2005).
5. Transfer amounts were based on the quantity in US dollars, and then converted to *córdobas* just before the distribution of transfers began in September 2000 (C\$ 12.85 = US\$ 1) (Maluccio and Flores, 2005).
6. A household with one child receiving an education transfer would receive 21 per cent of total annual household expenditures. The actual average transfer in the pilot phase was 17 per cent of total annual household expenditures (Maluccio and Flores, 2005).
7. The extreme poverty gap is the quantity between the extreme poverty line and the average expenditure of the extremely poor, based on the Nicaraguan LSMS survey of 1998 (World Bank, 2001).
8. Healthcare services were not available in all areas, but because of the programme's arrangements with health service providers, this did not pose a problem.
9. The original plan was to incorporate the control communities after one year of providing benefits to the treatment communities; delays caused this date to be postponed until closer to the beginning of RPS-II (Maluccio and Flores, 2005).
10. These *ad hoc* exclusions took place because census data had not originally captured all potential beneficiary households, so the numbers of potential beneficiaries were higher than originally anticipated.
11. Four *comarcas* were randomly selected to continue using the geographic targeting, so that all households were eligible within these communities, but the remaining 13 *comarcas* were targeted using household-level selection.
12. The baseline was expanded to 2,010 households to capture possible biases from households missed in the incomplete first census, but these households were not administered the anthropological segment of the survey (IFPRI, 2001a).
13. A previous model using the LSMS98 had been constructed, but this model was considered more appropriate given that it was restricted to a more similar geographic area; it was also more current and would reflect recent changes (i.e., due to Hurricane Mitch).
14. A *comarca* contained anywhere from one to five small villages of about 100 households each (Maluccio, forthcoming).
15. As already stated, this was typically the female head of the household.
16. The mean size of these groups was 17, but the groups ranged from 5 to 30 beneficiaries (Maluccio and Flores, 2005).
17. Note that in many schools in poor rural areas, a local school has one or two teachers. Teachers often led multi-grade classrooms that contained beneficiary children of all levels and ages from their community.
18. As already discussed, this cash transfer was sometimes given by beneficiaries to local school associations instead of the educators to avoid abuse of programme funds by teachers.
19. The difference between the 93–95 per cent and the 98 per cent figures mentioned here reflect changes in households and eligibility.
20. This requirement was mentioned in an interview and may have varied depending on the location, time and organisation used.
21. Perhaps a testimony to the programme is that some beneficiaries interviewed mentioned that some other beneficiaries used the transfers for "inappropriate" items, such as for clothes or household goods. These are not inappropriate in their own right but they are not the food that RPS encouraged households to buy.
22. Cards were created using just a camera, computer and plastic laminating machine.
23. Agreements were established with different institutions in Paraguay, the Dominican Republic and El Salvador to provide them with the programme and technical expertise to implement it (Largaespada Fredersdorff, 2006).
24. An additional 5 per cent left RPS by choice—through migration and so on (Maluccio and Flores, 2005).
25. A simple organisational chart of RPS-I can be found in Appendix B.
26. Technically, this ministry is named the *Ministerio de Educación, Cultura y Deportes*, or the Ministry of Education, Culture and Sport.
27. The Ministry of Health had previously only been able to arrive at some of these locations to provide vaccinations to these households; it could not yet provide other services in many areas.

28. This delay was the result of a government audit that was unrelated to RPS.
29. The programme is now known as *Oportunidades*. The designation here follows the authors' usage.
30. The end of the three years of benefits was pushed into the time when RPS-II had already begun operating.
31. The age requirement varied slightly by community.
32. Year-long adult education classes were provided to potential beneficiaries of the Vocational Training component who did not meet the literacy requirements.
33. The lack of official documentation on the Vocational Training component makes it difficult to discern whether the details of the component were designed as specified here or if they evolved to these specifications by the time the programme ended.
34. Sometimes these transfers were given to the titled beneficiary (female household head) to ensure they were used properly.
35. RPS-II's operating manual states that for communities with 55 per cent or more of extreme poverty, geographic targeting would be used. For those with less than 45 per cent extreme poverty, household targeting would refine the geographic targeting. Decisions on communities with between 45 and 55 per cent extreme poverty levels would be made on a case-by-case basis (RO, 2005).
36. The marginality index was calculated from the 1995 National Census data (IFPRI, 2005).
37. Using 1995 National Census Data again.
38. This result may be a good example of how the interventions in the comparison communities confounded conclusions that could be drawn about RPS-II.
39. Plans for a *Registro Unico de Beneficiarios* (Single Beneficiary Registry) were in place by 2003 (LeCayo, 2004).
40. In theory, RPS still exists. There is still a very small programme within the Family Ministry known as RPS, but it only participates in minor activities such as providing school children with backpacks.
41. Beneficiaries were considered leaders if they held some sort of leadership responsibility in the community—programme promoter or otherwise.
42. Beneficiaries will receive a transfer of US\$ 1,500, while US\$ 500 will be sent to organisations within the municipality which provide programme support.
43. Unfortunately, it seems that some households still did not understand that this requirement was dropped at the end of RPS-I, which caused them more than a little stress (Adato and Roopnaraine, 2004). It appears that this confusion was later dispelled.
44. Relative power was calculated using the ratio of female years of education (plus one) to male years of education (plus one) (Gitter and Barham, 2008).
45. See the second organisational chart in Appendix B for a simple visual representation of this structure.



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