BENAZIR INCOME SUPPORT PROGRAMME
GOVERNMENT OF PAKISTAN

Graduation Strategies for Safety Net Beneficiaries

Policy Note

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Executive Summary

i. **The macroeconomic crisis in Pakistan and the unfolding global economic slowdown have made social protection an urgent priority** as well as a strategic opportunity to build systems and institutions for better service delivery. The Government of Pakistan launched a new flagship social safety net program in 2008, the Benazir Income Support Program (BISP) in recognizing the urgent need to protect the poor and the vulnerable. The objective of the BISP is to support inclusive growth through the development and implementation of a financially sustainable, efficiently targeted, and well administered national safety net system in Pakistan. The safety net system will provide the chronic and transient poor with both basic income support and access to opportunities for graduating out of poverty.

ii. **An effective social safety net program can promote human capital development and contribute to inclusive economic growth in Pakistan.** The Government is committed to developing a modern social safety net scheme, as the first step in developing a viable social protection system for the country. As part of this agenda, the Government through Planning Commission has started the process of updating Pakistan's National Social Protection Strategy (NSPS, approved by Cabinet in 2007) with technical assistance from the World Bank. As part of this process and to further develop the BISP as platform for providing targeted social assistance to the poor and vulnerable, the Government seeks to determine how poverty exit/graduation programs can build on the social safety net program.

iii. **This policy note is designed to advise and guide the Government of Pakistan in determining the design of a safety net system that would also provide safety ladders.** The objective would be to provide the poor with a basic safety net program such as BISP and also with access to complementary programs and services (safety ladders) that would help the poor escape from poverty over the medium and longer term.

iv. **The conceptual framework for this study follows the "life cycle" approach to identify the most effective and appropriate interventions for human development and inclusive growth.** A social safety net platform to overcome chronic poverty requires the coordination of effective interventions based on health and education aimed to develop human capital and break the poverty traps that cause chronic poverty. This approach may be also useful to develop the SSN platform gradually and according to institutional and fiscal possibilities. It is suggested to start the life cycle approach by establishing a "minimum" guaranteed set of interventions that are essential for human development.

v. **To design and coordinate interventions along the life cycle approach, it may be divided in 5 stages:** i) Pregnancy and early childhood (infants 0 – 36 months); ii) Childhood (3 – 12 years); iii) Youth (12 – 18 years); iv) Adulthood; and v) Elderly (65+). From a social policy perspective, every stage of life requires different services and represents a different potential. This note considers only the minimum required interventions related to a social safety net. The complete social protection policy and the social policy require a wider array of programs, services and interventions on each and every stage.

vi. **Potentially, BISP could become the Pakistan's social platform to address the causes of poverty** if it manages to focus its efforts on its core business (cash transfers, possibly "conditional") and coordinates effectively with other relevant programs to provide its beneficiaries access to safety ladders. International experience, particularly from developing countries, suggests that income transfers can generate additional value if used as incentive to promote behavioral changes in the family through "conditions" that may contribute to overcome poverty in the medium term. Many developed countries seek to address chronic poverty through an integrated system of social assistance and labor market interventions that help the poor access opportunities in the economy.

vii. **The note proposes a two-phased graduation strategy for BISP, hence providing the building blocks for an integrated social safety net system based on the poverty scorecard targeting system**.

(a) ***First phase:*** ***Combine income support with human capital development of the poor*** through co-responsibilities ('conditions') linked to basic health and education services. To this end, the paper provides the rationale and examples from international experience on the implementation of such programs. BISP as a Conditional Cash Transfer program for Human Development would form the backbone of an integrated social safety net system.

(b) ***Second phase:*** ***Facilitate access to and expansion of complementary development programs*** such as skills development, micro-credit, health insurance, etc. To this end, the paper provides a review of potential, existing programs in Pakistan that could be linked to the safety net system. It is recommended that BISP coordinate and facilitate these complementary measures rather than implement them itself.

I. Rationale for Designing a National Safety Net System for the Poor

1. **The macroeconomic crisis in Pakistan and the unfolding global economic slowdown have made social protection an urgent priority** as well as a strategic opportunity to build systems and institutions for better service delivery. Furthermore, the poor and the non-poor alike remain vulnerable to individual level risks such as health shocks and unemployment, and to community-wide risks such as natural disasters. The malignant effects of these idiosyncratic and covariate shocks are usually greatest for the poorest of the poor who have a limited capacity to manage risk and cope with shocks. These shocks themselves can further catapult households deeper into poverty, making a recovery difficult if not impossible. The situation that locks the poor in poverty are referred to as "poverty traps".

2. **The Government of Pakistan launched a new flagship social safety net program in 2008, the Benazir Income Support Program (BISP**), recognizing the urgent need to protect the poor. The objective of the BISP is to support inclusive growth through the development and implementation of a financially sustainable, efficiently targeted, and well administered national safety net system in Pakistan. The safety net system will provide the chronic and transient poor with both basic income support and access to opportunities for graduating out of poverty.

3. **An effective social safety net program can promote human capital development and contribute to inclusive economic growth in Pakistan.** First, the program provides basic income support to the chronic poor, consistent with the Government's re-distributive goal. The poor households will receive some relief to cope with adverse income effects of the recent crisis. Second, Pakistan will have established a safety net system that can be scaled-up in response to future adverse economic or agro-climactic shocks. Third, in the long run the program can promote access to basic health and education services that can help households accumulate human capital and eventually contribute to economic growth. Later graduation from BISP can be extended to micro-finance and skill development programs also. The institution of an effective safety net system also allows policy makers to take much needed structural reform measures (e.g. reduction of subsidies) while protecting the poor and promoting dynamic efficiency.

4. **The Government is committed to developing a modern social safety net scheme, as the first step in developing a viable social protection system for the country.** The Government's strong commitment to the safety net reform agenda is evident from the rapid introduction of the BISP to address chronic poverty and to protect the poor from the adverse impacts of the recent global economic crisis. The Government's commitment is also evident in the formal adoption of a poverty score card as an objective instrument to identify safety net beneficiaries—a first in the South Asia region. Consistent with international best practice, and again for the first time in South Asia, the Government is developing a targeting system with separated agencies to conduct the enrollment process and determine program eligibility and is instituting major reforms to develop a transparent, verifiable and timely payment system.

5. **The Benazir Income Support Program (BISP) is the largest social protection initiative for the poor in Pakistan.** With its launch in 2008, Federal Government allocations on

social protection jumped 3 fold in the FY 2008-2009 from the previous year and then more than doubled in FY 2009-2010[1]. This is the most explicit demonstration of commitment to social protection on the part of the Federal Government.

6. **BISP was established in response to a severe economic contraction and high levels of food inflation in the country in 2008.** The Rs. 1000 per month per family support provides a supplement to the income-consumption gap for the beneficiaries. It should, therefore, be seen as a supplementary rather than an ameliorative response to high levels of poverty in the country. It should also be considered a temporary measure that would evolve into a national social safety net system.

7. **The recent evolution of BISP signals the intention of the government to move away from general and mostly regressive subsidies to targeted and progressive ones.** The targeting method has evolved from Parliamentarian based selection with NADRA database verification to a more objective targeting methodology- the poverty scorecard based targeting. The poverty score information has been collected in 15 districts in Pakistan though a door to door census in the test phase and the national census is expected to be completed towards the end of CY 2010. Only families having poverty scores below a cut-off point are eligible to receive the benefits. The targeting performance evaluation has shown that most households covered are poor and vulnerable.

8. **When designing a safety net system, it is useful to differentiate between three categories of the poor: the chronically poor, the transient poor and the vulnerable.** The Pakistan Safety Net Survey (PSNS)[2] broadly categorizes these three tiers of poverty and vulnerability in Pakistan, according to living conditions, economic performance and the severity and intensity of poverty (See table 1).

9. **This reality requires establishing priorities and different types of support for the three categories of poverty and vulnerability.** Within this context, BISP role and mission for the first stage may be to support the poorest population in Pakistan, therefore the chronically poor. This option should be based on the need to address chronic poverty through a long-term commitment, a life cycle approach and an integrated intervention to address the critical conditions that create and reproduce the conditions of chronic poverty.

Table 1: Categories and Characteristics of the Poor in Pakistan

Vulnerability Profile	Characteristics
Chronically poor	- No/very low level of physical assets

[1] Federal Government Spending on social protection increased from Rs. 11 billion in FY08 to Rs. 34 billion in FY 2008-2009 and subsequently to Rs. 70 billion in FY 2009-2010.

[2] Formulation based on Phase II of Pakistan Safety Net Survey. The survey was designed to assess household's risk coping, the role of informal transfers, and the effectiveness of formal safety net programs. For a detailed discussion on the survey and its methodology see Social Protection in Pakistan – World Bank Report No. 35472-PK

	- No/very low levels of human capital - Likely to remain poor
Transient Poor	- Income/expenditure is volatile - Low levels of physical assets and/or human capital - Highly vulnerable to shocks - Likely to transition in and out of poverty
Vulnerable	- Low/moderate levels of physical assets and human capital - Acceptable levels of current income/consumption - High risk of future income-consumption volatility

Source: Based on PSNS details provided in World Bank (2007).

10. **Chronic poverty is a condition that does not change in the medium to long term but is frequently transmitted to future generations.** While the poverty situation of a family is negatively affected by crisis and shocks, it is generally much less impacted by economic growth due to geographical and structural characteristics that create barriers and generate the intergenerational transmission of poverty. As such, redressal of this form of poverty requires well designed, targeted and coordinated interventions.

11. **Chronic poverty is passed on to the next generation.** It starts before birth in mothers that lack appropriate nutrition and give birth to children with low weight. It is followed by chronic malnutrition in the form of retarding growth in infants. It is deepened when children and youth since chronically poor households tend to have higher drop out rates and have less years of education. These conditions increase the probability of such individuals never attaining the capacity to earn an income that lifts them out of poverty and vulnerability in their adult age.

12. **The chronic poor are not only poor by income**. Most of the poor lack the conditions and capabilities to seize opportunities and to overcome poverty by their own effort. Most of extreme poverty households measured by income are chronically poor. Even some households in poverty, living in rural areas and isolated areas, with precarious and low access to education, health and housing are chronically poor. Figures 1, 2 and 3, show the correlation between income poverty and low grades of education enrolment and vaccination.

Figure 1: Net Primary Level Enrolment Rate (Excluding Katchi Class) - by Quintiles

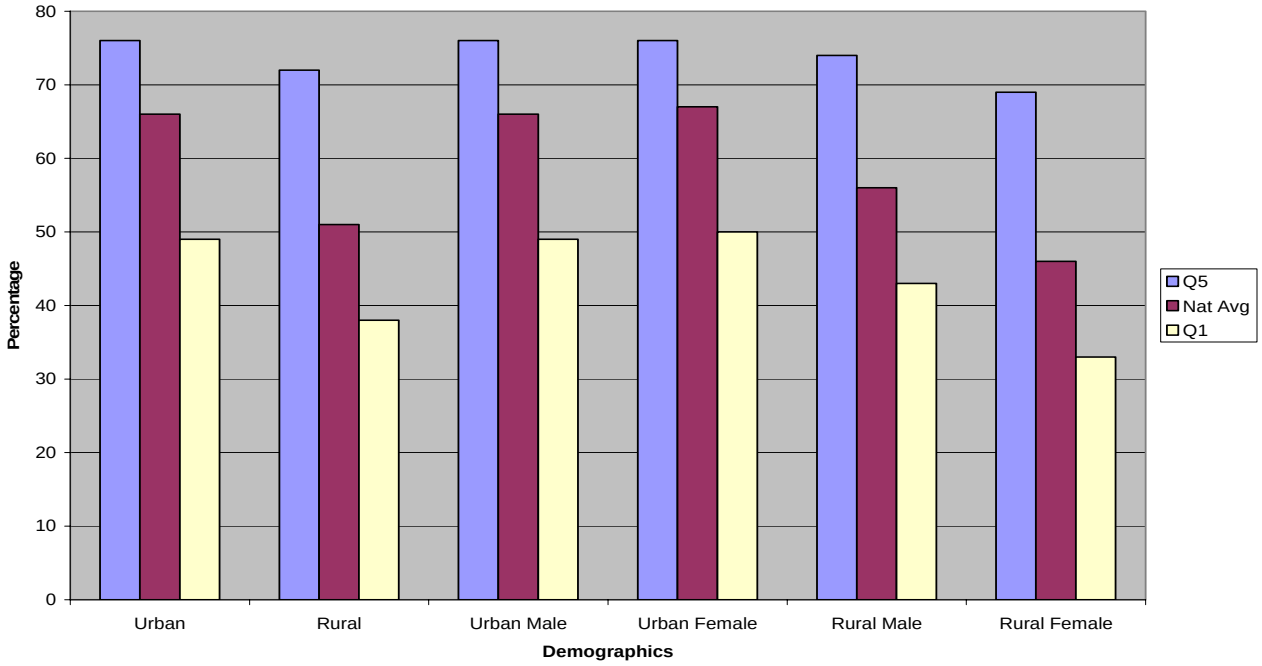


Figure 2: Net Enrolment Rate at the Middle Level (Age 10-12) - by Quintiles

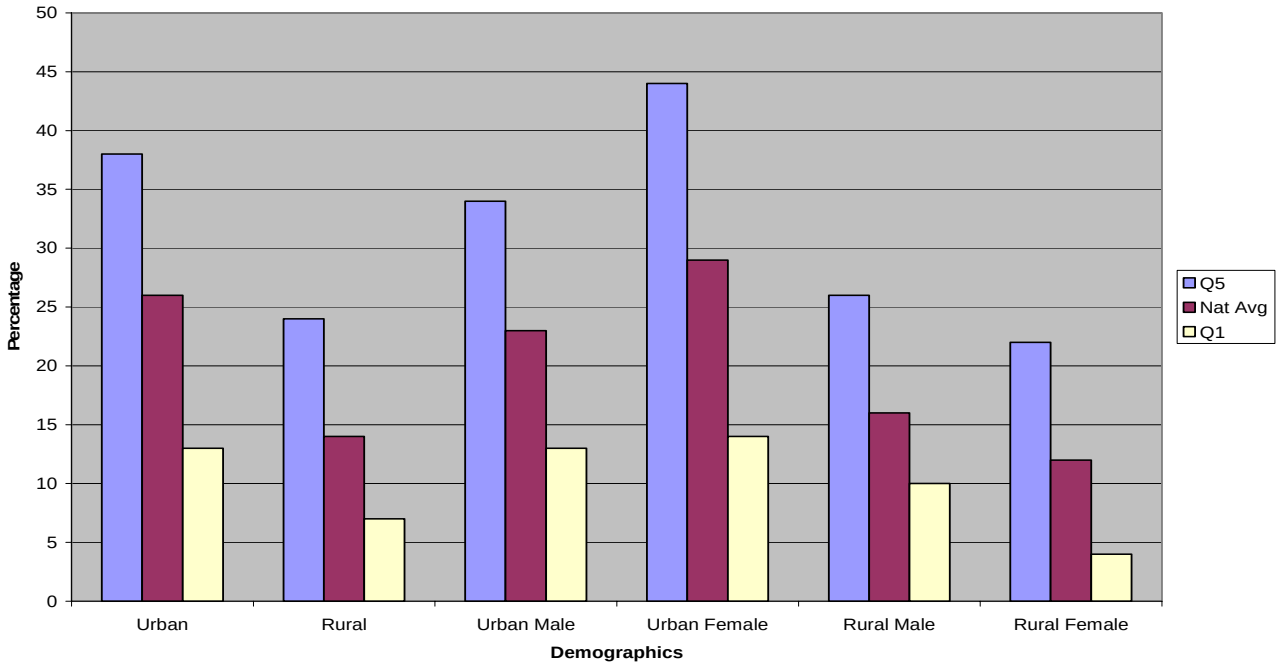
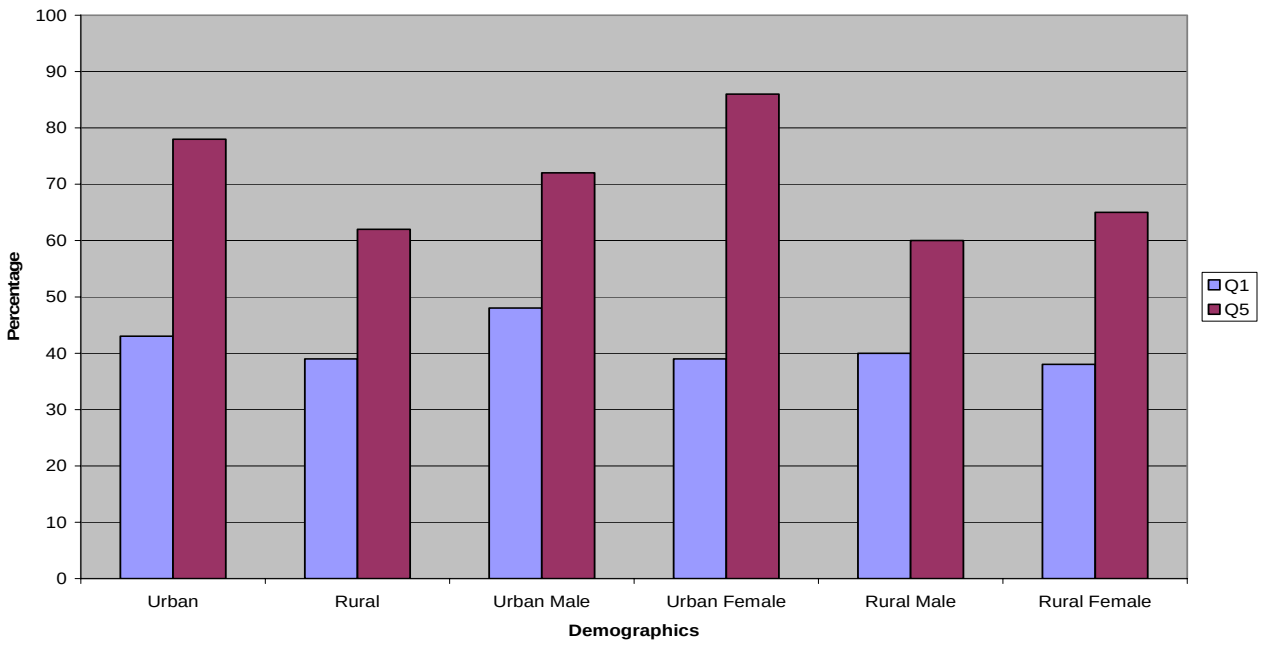


Figure 3: Percentage of children aged 12-23 months that have been fully Immunised - by Quintiles



Source: Pakistan Social & Living Standards Measurement Survey 2007-08

13. **There are "demand side" constraints related to income that generate the conditions of chronic poverty.** The figures above show the gap between those living in poverty and those with higher incomes. These data suggest that besides the "supply side" constraints of lack of schools and medical facilities, there are important "demand side" constraints that keep children from going to school and parents from visiting health centers for infant and child visits. International evidence suggests that these constraints are mostly economic constraints (lack of money to buy books, shoes, uniforms, etc), but also due to cultural and social barriers.

14. **Health and economic shocks are the most prevalent triggers for slipping into poverty,** accounting for 54 and 28 percent of all such occurrences respectively[3]. The Pakistan Safety Nets Survey (PSNS) also reports that conditional on suffering a shock, however, ultra-poor and poor respondents are more likely to suffer health shocks than non-poor respondents.[4]

[3] Estimates based on data from Phase II of Pakistan Safety Net Survey

[4] World Bank (2007). "Social Protection in Pakistan," Report No.35472-PK, Human Development Unit, South Asia Region, World Bank

* The percentage of households vulnerable to poverty is calculated over a 2 year period.

II. The Life Cycle Approach for Human Development: A Conceptual Framework for Building a Social Safety Net System

15. **Pure income transfers cannot break poverty traps and develop human capital as they do not address the causes of poverty.** As international experience shows, income transfers are not the best and most effective way to address poverty. Most countries in the world are moving from general subsidies or direct income transfers to programs and interventions that may contribute to affect behavioral change and break the poverty traps that affect the poor. In the developed countries "welfare to work" programs have been launched and tested successfully. In developing countries, especially in middle-income economies, "Conditional Cash Transfer" programs are growing and have been evaluated as an effective intervention to address chronic poverty conditions.

16. **The "life cycle" approach sets a comprehensive conceptual framework to identify effective interventions for human capital development.** A social safety net platform to overcome chronic poverty requires the coordination of effective interventions based on Health and Education aimed to develop human capital and break the poverty traps that cause chronic poverty. This approach may be also useful to develop the SSN platform gradually, given institutional and fiscal constraints. The life cycle approach may start by establishing a "minimum" guaranteed set of interventions that are essential for human development, starting with initial stages that are crucial for the entire life of each human.

17. **To design and coordinate interventions along the life cycle, it is useful to differentiate between 5 stages of life**: i) Pregnancy and early childhood (infants 0 – 36 months); ii) childhood (3 – 12 years); iii) youth (12 – 18 years)[5]; iv) adulthood (19- 65 years); and v) elderly (65 and more). The following paragraphs describe the strategic intervention that could be combined with cash transfers during the different stages of the life cycle, based on international experience. The largest effects of investments in human capital development, however, are to be expected during the early stages of life.

(i) Pregnancy and early childhood stage

18. **Pregnancy and early childhood (infants) require preventive health services and nutrition.** The purpose of these interventions is to avoid chronic malnutrition, as well as high infant and maternal mortality as prevalent in Pakistan. International experiences show that this may be one of the most important and cost – effective poverty reduction interventions, with long lasting effects through the entire life cycle. Negligence in the early stages can create a handicap that is irreversible and constitutes one of the main factors of the probability to remain poor. **Global attention has been increasing to dedicate more and better resources to this stage of life.** In fact, three out of seven Millennium Development Goals (MDGs) are directly related to this purpose. Pakistan along with 175 other countries in the world is committed to achieve these goals that include the following objectives:

- Reduce chronic malnutrition by half (MDG 1. Objective 1.c)

[5] This age definition is not in line with official definitions by the UN, but it reflects the reality in many developing countries and is useful for the purpose of outlining the life cycle approach.

- Reduce infant mortality by ¾ (MDG 4. Objective 4a)

- Reduce maternal mortality by ¾ (MDG 5. Objective 5a)

All three goals may be achieved with a feasible and timely intervention through Health services.

19. **According to WHO and UNICEF, a package of basic health care during pregnancy has proven to be effective.** The package includes prenatal care aimed at mothers/child nutrition and to detect risk in birth delivery. It may be achieved with few actions with limited resources such as: Weight monitoring, micronutrient supplementation with iron, vitamin C, folic acid, calcium and zinc and the timely detection of the symptoms for risk at birth delivery like hypertension.

20. **During early childhood, human development requires nutrition, health services and age-appropriate stimulation.** The main actions to be delivered at primary health care units are mostly preventive and some basic curative: height and weight monitoring, timely and complete vaccination, prevention and timely treatment of acute diarrheic episodes and of acute respiratory infections, nutritional counseling (exclusive breast feeding for the first 6 months , complementary and diversified feeding from month 6, water care) and micronutrient supplementation with vitamin C, zinc and iron.

21. **This kind of "nutrition and health package" is one of the main components of most Conditional Cash Transfer Programs in the world.** In these programs, cash transfers are given to mothers as the incentive (and also as a resource to cover transportation costs) to regularly report to health units to access services. Evidence shows that availability of the services at health units is not enough to guarantee infants and pregnant women of poor families the required attention. Frequently in these poor families, health services are used only for curative treatment after diseases (mostly diarrhea and respiratory infections). The incentive is important because members of chronic poor families are the population at risk for malnutrition and for infant and maternal mortality.

(ii) Childhood (3-12) and Youth (13-18)

22. **Children and young members of poor households require support to advance and achieve educational outcomes.** Historical and recent evidence confirms that education is one of the most effective interventions to create human capital. Also it is a major contributor to develop citizenship and democratic governance.

23. **Childhood requires pre-school education (from 3 to 5 years) and elementary (primary) education (from 6 to 12).** International evidence suggests that pre-school education contributes to better and higher education achievements afterwards. In order to overcome demand side barriers mentioned earlier, SSN intervention should cover some of the actual costs of schooling, just as an incentive, especially for upper grades and for grade transition.

24. **Youth require secondary education.** Secondary education may be a step towards tertiary education but also for some of them, vocational and technical education may be a better option. The purpose of education at this stage is to develop the capabilities for a productive life. Technical education in conjunction with secondary education is required to break the

intergenerational transmission of poverty as it is the route through which capacity to achieve better jobs and higher incomes is created

25. **Although there may be some shortfalls and deficits in elementary schools in some districts, many children living in extreme poverty have access to schools.** There are also alternatives to improve the access to education services to cover far flung locations with few children. Colombia's "Escuela Nueva" (New School), for example has demonstrated good results through multi-grade and self learning methodologies applied in small and isolated rural areas in charge of a local "monitor" or "instructor" who in turn gets monitored by the authorities.

26. **The availability of schools is a prerequisite to promote secondary and technical education, but for the extreme poor it may not be sufficient.** To cover the supply side of secondary education there are also successful models like "TV Secondary School" in Mexico and other countries. The relevance and pertinence of the education offered by secondary and technical schools serving deprived regions and areas of poverty concentration may be the major challenge to effectively attend this life stage. It is the case that due to the economic pressure young men are forced to abandon school to contribute to family income in temporary jobs at low wages and low productivity activities. Also some young women in chronically poor households are taken out of school to help at home and taking care of small children. Marriage may be another cause of school dropout for young women.

27. **The purpose of a SSN intervention in these two stages of life is the retention of children at school to prevent dropouts and the promotion of grade advancement.** This is especially important to promote the transition from primary to secondary education and the advancement to higher secondary grades[6]. In many countries elementary education is not enough to overcome poverty in the adult stage. Therefore the advancement and completion of secondary schooling, and better if it has a technical approach to develop capabilities, have a higher probability of overcoming poverty.

28. **Fostering the educational attainment is the other main feature and objective of almost all of the Conditional Cash Transfer Programs in the world.** Cash transfers are used as an incentive to promote enrolment, attendance and advancement in school and it is conditioned on compliance. To be used as incentives, cash transfers should cover not only the educational costs (e.g. transport, for the countries that have fee waivers in public education) but also the opportunity cost of upper grades. The possibility of delivering a differentiated cash transfer scheme for families with secondary students according to their grade may generate better impacts than a "one fixed sum" of cash transfer independent of the demographic composition of the family.[7]

[6] Avancemos in Costa Rica is a CCT dedicated to promote secondary school enrolment, attendance and advancement for students of families below the poverty line.

[7] The *Oportunidades* Program in Mexico delivers one-sum basic cash support to every family in the Program conditioned on their attendance to the health and nutrition attention and adds another variable cash transfer for every student in the family. The amount of the transfer increases according to the promotion of grade, starting on less than US$10 on 4th grade of elementary school and going up for more than $60 for young students in 12 th grade in high school. PATH in Jamaica has recently differentiated the transfer for students, adding more benefit for students at secondary education. *Bolsa Familia* in Brazil has recently created a new set of transfers for young students attending from 10th to 12 grade. Previously it only supported children up to 15 years old.

(iii) Adulthood

29. **Adult women in fertile ages (15-40) require specific health attention linked with reproductive health.** Family planning practices are one of the most effective actions to decrease maternal mortality and prevent chronic malnutrition. On the contrary, continuous birth spacing (less than 2 years), more than 3 pregnancies and adolescent pregnancy are the main factors of maternal mortality and chronic malnutrition. The prevention of transmission of sexual diseases and of cervix and mammal cancer are also very important as they are some of the main causes of adult women deaths. The main purpose of these interventions is to avoid maternal mortality and prevent specific diseases related to women's reproductive role. Some Conditional Cash Transfer Programs have demonstrated positive impacts for women health and for the complete family. This may happen when the Programs include the obligation for women to attend regular health visits for check-ups and gain access to family planning methods in culturally adequate ways.

30. **Income-generation projects based on entrepreneurship development in poor regions depend, among others, on government policy, subsidies, microcredit and technical assistance.** Markets and economic factors are crucial for the success of new businesses, especially for entrepreneurial ventures. Also it has been demonstrated that microcredit is not an option for most of the chronic poor, especially in rural areas. Moreover, some productive activities may become actual poverty traps due to their low productivity and low return on investment.

31. **Remedial education and assistance for income generation is always more costly and complex than timely participation education.** Adults outside of the labor market and those involved in poorly productive activities require "tailor made" combination of education and employability interventions, some of them require also financial assistance (credits). On the side of education, adults and youth out of school may need a combination of some of the following services to improve employability and get a job: literacy, basic skills for life and work learning; employability capacities; technical training. Technical training should be designed to meet labor market requirements. For potential entrepreneurs the requirements are even more complex. They need basic business management skills and assistance to develop business plans. And on the side of economy, income-generating activities require access to credit and financial assistance with low transaction costs. Access to a potential market should be the considered the most important technical assistance for these productive initiatives.

32. **The required interventions to improve productivity and income for the poor are generally not seen as part of a social safety net** and most of them are not even part of social policy of social programs. Therefore, policy decisions and government programs need to be carefully designed and rigorously evaluated to make the best decisions for budget allocation. International experience shows that temporary income transfers may be given to adults to access to employability programs. In dynamic markets with a permanent technological change, training is accompanied with temporary income transfers and is an effective way of improving skills of labor force to get the new jobs (technical training to use computers and new technologies is one of the examples). It needs to be emphasized that the complexity and the amount of resources needed for this set of interventions require the participation of many entities of the government and also from the private sector and the NGOs.

33. **In a context of growth and economic change, some adult employability interventions may be included in a SSN,** but that may not advisable in case of Pakistan in the short term. In that potentially future context, an agency like BISP should not be responsible for these interventions and may act only as a facilitator and advocate in order to promote the responsible entities (public or private) may give priority to the poor, using the "Central Registry of Beneficiaries" created by BISP based on the poverty scorecard.

(iv) Elderly

34. **Elderly members of extreme poverty families need health attention and income support.** Countries that have not a complete pension system in place are considering the creation of a non-contributory pension pillar in the system to support the elder in poverty. This is the only stage of life when income support may be considered an option. It is a field for social assistance that requires careful planning because of its potential pressure for fiscal resources. Therefore in the present situation of Pakistan this may be considered a future step to evaluate according to the future assessment of the economy and the fiscal capacity of the State.

III. The First Stage of Graduation: Transforming BISP into a Conditional Cash Transfer Program[8] for Human Development

35. **Enhanced targeting has been started in BISP by changing the previous selection methods to the poverty scorecard as targeting methodology.** As soon as the poverty scorecard is rolled out and the Registry or Database of the eligible households is finished, the graduation to the Program is ready to start. It seems better to carry a gradual transition in order to move the beneficiaries from the current program to the new one. Therefore a gradual phase out from current scheme and a gradual phase in and coverage increase for the new program needs to be planned.

36. **The first stage for graduation is to let the BISP evolve into a safety net program that links cash transfers to basic health and education services: a Conditional Cash Transfer Program for Human Development.** In this new Program, cash transfers will become incentives for the use of the services and the actual delivery of the transfer may be conditioned upon

[8] For more information on Conditional Cash Transfer Programs, see **Annex 1**.

compliance. The Health and Education services in the first stage may be concentrated in a few effective interventions focused on the most vulnerable on these households: pregnant women, infants, children and young persons to develop human capital. Relevant and effective services should be provided by the Health and Education Ministries. It does not cover the complete life cycle; it is focused on the main vulnerable stages that can be transformed by a set of "minimum" interventions.

37. **Three considerations may help to define the coverage of BISP as a conditional cash transfer (CCT) program:** fiscal and budgetary options that better achieve the expected outcomes and the institutional and administrative capacity of BISP and of health and education services. The fiscal and budgetary planning sets the yearly objectives and reach of the new Program. Most of the countries in the world have reached "total" coverage of the target population in several years.[9] To achieve the social goals of the Program, international experience suggests that a "package" of minimum required interventions guaranteed to all the target population may the best option, instead of large benefits for some and none for others. This is especially important for the "health package". Capacity assessment of the supply side in Health and Education Ministries is part of the strategic design. Where no coverage exists, health and education services need to be expanded gradually and in a coordinated manner. Gradual expansion also is useful to develop the institutional and administrative capacities in BISP as the coordinating agency and in the Health and Education Ministries to develop sufficient space in schools and health units' capacity to provide the required services for the Program beneficiaries.

38. **The role of BISP in the evolved design would be** targeting and enrolment of beneficiaries, the coordination with health/nutrition and education services for monitoring compliance as well as managing the payments. Targeting is the process to identify the chronically poor and select them as eligible households. Enrolling is the inclusion of the eligible households in the new Program to start receiving the benefits. This process creates the coverage for the new Program. Coordinating with the Health and Education Ministries is mainly a process of information exchange to verify compliance: about students' enrollment and about regular attendance to school and about women and infants registered in health centers and about their regular attendance in established periods.[10] To send the cash transfers, an outsourced partner like the Post Office may take care of the logistics and responsibility of the delivery.

39. **Coordination with health and education services (at federal, provincial and local levels) is required to guarantee the access to the services for beneficiaries and to collect information on compliance.** In some countries the CCT Program is defined as an inter-sector and inter-Ministerial coordinated Program. That is the best option because the essential services to create human capital for the chronically poor are a responsibility of the "line" Ministries:

[9] Bolsa Familia in Brazil started by concentrating disperse cash transfers programs aimed for poor families in one Program that covered almost 40% of the target population. The next 2 years, Bolsa Familia increased its coverage to achieve the total target: 11 million families. "Familias en Accion" (Families in Action) in Colombia) increased coverage in 5 years, starting from the rural communities, then enrolling families in small and medium size cities and at the end, the 2 or 3 major cities in the country. That is the same process taken by *Oportunidades* in Mexico, during 7 years (with 2 years without coverage increase), starting from the most isolated and small rural communities and ending 7 years later in the big metropolitan areas with more than 2 million inhabitants.

[10] E. g. According to UNICEF and WHO the best frequency of periodic attendance to health units is monthly during pregnancy and for children 0 -12 months, every two months for children from 13 to 24 months, and quarterly for children 25 to 36 months old.

Education and Health. The agency in charge of the new Program is responsible of the coordination process with the Ministries to collect the information about the capacity of school and health units to provide the "package" of services of the Program. The coordination process must also take care of the procedure to collect the information about compliance, in order to know about enrollment and attendance of the beneficiaries to schools and health units.

40. **The delivery of payments is a responsibility of the coordinating agency that may be outsourced to a specialized agency,** like payment agencies, etc. In all the CCT Programs, the delivery of the cash transfer is outsourced to a specialized agency that guarantees the transparency, the efficiency and the security of the cash delivery.

41. **Monitoring the Program's performance and evaluating impact through an independent "third-party" has been a best practice** to demonstrate the Program's efficacy and to inform the debate on its outcomes. The reform in social policy to adopt objective targeting and subsidies as incentives often raise political and academic controversy. Most of the CCT programs in the world have established a monitoring and evaluation system that fosters transparency, increases accountability and informs the debate on outcomes and impacts. The impact evaluation carried out by an independent, prestigious academic institution gives the Government the critical information to inform the public and decision makers like the Parliament and it gives the Program management the tools for continuous improvement in design and operations.

IV. The Second Stage of Graduation: Linking BISP to Complementary Interventions[11] as Safety Ladders

42. **A platform for a comprehensive and effective social safety net requires other programs and interventions to address the life cycle requirements of the poor and vulnerable.** After the stabilization and initial consolidation of the first stage of the graduation strategy, BISP may consider developing a second stage to facilitate the access of other programs and services for poor and vulnerable households. These new interventions do not need to be coordinated through an integrated program as health and education are required on CCTs, but they require strong top down coordination.

43. **The poverty scorecard provides information to target other interventions aimed for poor households and specific benefits can then be geared towards different cohorts of the poor.** As the "package" of health and education are just a minimum guaranteed access, other existing subsidies and programs may and should also be targeted to the chronically poor such as infrastructure for communities, e.g. water and energy supply, roads connection; housing improvements and also adult education and training. Delivery of these programs should, however, not be carried out by BISP, but by other entities and institutions that have acquired the necessary knowledge to deliver these services in an effective and participatory way. In an iterative round of the scorecard, even those households that BISP has been able to lift out of poverty as well as those who do not qualify for BISP income transfer but are in the category of

[11] For a more detailed description of existing, potential complementary programs in Pakistan, see **Annex 2.**

transient poor or the vulnerable can be targeted for new specific provisions. These provisions will broadly constitute provision of skill development, micro credit and other potential employment programs. Based on its targeting mechanism, BISP can play an important role in facilitating such service provision.

44. **BISP could be a facilitator that ensures access of the poor to these programs rather than be responsible for the delivery and coordination of the complementary services and programs.**.Other programs and services directed to the poor should not be responsibility of BISP. BISP may serve as a facilitator in two ways: by sharing the database or Registry information that may be useful for other programs and by supporting the operational first contact and basic organization of the beneficiaries at the local level.

Waseela-e-Haq: Some Considerations

BISP has started a new scheme named *Waseeal-e-Haq* under which a loan of Rs.300,000 will be provided to 750 families every month. The families will be selected through a random draw from a pool of 2.2 million BISP beneficiaries. The aim of the scheme is to help families start their own business by providing them interest-free loans. *Waseela-e-Haq* in its current form has the following three main short-comings:

- **The program provides loan to beneficiaries who already have low human capital conditions and fall in the Ultra-poor and Poor income groups**. Without providing services to improve their health and education conditions, the program effectively becomes an extended 'consumption subsidy' boosting only the income stream of beneficiaries. They can only run successful businesses if their human capital conditions are improved and/or once they are out of chronic poverty.
- **The beneficiaries are selected through a random draw and are spread all over Pakistan, so there is no feasible way to provide technical assistance.** No extension services such as vocational training and enterprise development can be provided to the few and disperses beneficiaries. The provision of these support services would achieve economies of scale only if the beneficiaries are located in a concentrated area which would otherwise be too costly to provide individually.
- **The method of recovering the loans is not specified.** The terms and conditions on which the loans have to be repaid by the beneficiaries should not be very stringent. The repayment of a loan of this size may become a problem in itself for many beneficiaries. The monitoring of loan recovery may also be difficult for BISP as the beneficiaries may be spread out.

Bottom line: The design of *Waseela-e-Haq* scheme should be revisited. The cash amount seems excessive and the coverage is consequently low. As it comprises the equivalent of 300 months (or 25 years) of income transfers in one installment and it is only dedicated to .0003% of the beneficiaries every month, thus benefiting .004% every year and needing 25 years to cover at least 10% of the current 2.2 beneficiaries. It resembles more the "lottery" more than a sound safety net intervention.

Consideration on Health Insurance Program

BISP plans to start a Public Health Insurance program on the lines of *Rastriya Swasthiya Bima Yojana* (RSBY) program in India. Under RSBY Health Insurance Scheme, every family below the poverty line would be given insurance amounting to Indian Rupees 30,000 for maximum five family members. Insurance would cover pre-existing diseases as well as health services related to hospitalization and certain surgical procedures, which can be provided on a day-care basis. The coverage for hospitalization will be mostly cashless with a few exceptions. The insurance also covers pre and post hospitalization expenses. Moreover, a transport allowance up to Rs.1000 would be given to participants as part of the benefits.[1] While this is a commendable initiative of BISP certain issues need to be addressed when designing a Public Health Insurance program.

The Public Health Insurance program does not address preventive health problems but only covers health shocks that involve hospitalization. Hence, beneficiaries who suffer from health problems would only be able to avail health insurance if they are hospitalized. The program does not look to improve health outcomes of participants, which could reduce the occurrence of health shocks for many beneficiaries.

The supply gap in health service delivery is larger in Pakistan as compared to India. Neither the public health service delivery system nor the private counterparts are in a position to competitively provide the required services, if health insurance was provided to the poor. However, no substantial steps are being taken to bridge this gap yet. Government of Pakistan is not investing to improve supply of health service provision for the purpose of this program. The private sector cannot be expected to fill the void completely, especially when private sector participation in health care provision is already so small. The demands for health services is always high and even the poorest are willing to put all their assets on the line, still we see very little private sector health care provision in Pakistan. In such a situation, the supply of health care provision cannot be expected to meet the increased demand on its own.

There is not a large network of private sector health insurance companies in Pakistan. A nation-wide health insurance program cannot rely on a few private health insurance companies that do not have the required capacity to serve a large number of people. Furthermore, contracting a small number of private health insurance companies could lead to creating health insurance monopolies in many areas of Pakistan. Such monopoly in the health insurance sector is very likely to lead public funded premiums flow into the insurance sector without effective service utilization by the beneficiaries.

For the graduation strategy the cost of Health Insurance may compete with the budget requirements of the Health Ministry to deliver the basic preventive health care interventions. If there are fiscal constraints to guarantee the supply side interventions from the Health Ministry for pregnant women, infants 0 -3 years old and women in fertile ages, the most cost-effective option for long-term benefits regarding poverty and health indicators is the preventive health package, rather than the health insurance.

With regard to Health Insurance, given the requisites of setting up a viable health insurance model and the role of provincial governments in service delivery, BISP is required to initiate a comprehensive dialogue with both federal and provincial players. Such a dialogue may result into a consensus based model worth piloting in districts where poverty scorecard data is available. The pilot would require a well designed evaluation to among others, weigh the viability and timeframe of national implementation.

V. Complementary Programs under BISP: Imperatives for Sequencing & Strategic Partnerships

45. **BISP will graduate from simple cash transfers to Conditional Cash Transfers (CCTs) in two phases.** The phasing of CCTs is proposed keeping in mind possible resource, capacity, and supply side constraints that can come in the way of introducing all conditionalities simultaneously. Hence, it will be prudent if BISP moves towards CCTs in a phase wise manner. The phasing proposed below is based on prioritization of needs presented in the previous sections:

a) CCT Phase 1: Primary School Enrollment & Health Access for Women and Children

46. **The first phase will concentrate on creating CCTs for existing beneficiaries of BISP**. As demonstrated earlier, low levels of human capital formation and health risks, especially for women and children, are the primary causes for inter-generational transmission of poverty. Since existing beneficiaries will by definition fall in the category of the chronically poor, salient needs of this cohort will be addressed.

47. **As such CTs will be conditional on school enrollment and health related outcomes.** The Poverty scorecard will enable the detection of those school going age children who are not at school. Determining health needs is more complex. Initially, institutional deliveries for pregnant mothers and requisite ante and post natal visits to health facilities and vaccinations for newly born babies and children can be monitored. This information can be gathered from a combination of the poverty scorecard as well as through the Lady Health Workers' records.

48. **Since both health and education provisioning are provincial subjects, the relevant provincial departments will have to ultimately provide these services.** However, it must also be mentioned that the supply of such facilities from the provincial governments is not complete and in the case of health, institutional deliveries are not even part of the services provided by the lowest tier of health outlets, i.e. the Basic Health Units (BHUs). Hence, the assessment of supply capacity would be a critical step to determine the type of conditionalities/co-responsibilities considered for such groups.

b) CCT Phase 2: Adult Education, Micro Credit and Skills Development

49. **It is important to remember that aim of Phase II is to facilitate access to and expansion of complementary development programs such as skills development, micro credit, adult education** etc. In this phase BISP will not impose any conditions but will only help in making these facilities accessible to beneficiaries who are considered eligible to avail these facilities.

ii) Strategic Partnerships in Service Provision

50. **Given the existing supply bottlenecks by provincial level service providers, it is proposed that BISP enlists the services of other semi-governmental and non-governmental providers. BISP should simultaneously incentivize the provincial departments to provide requisite facilities so that their capacity is also developed.** Incentives can be in the form of providing a subsidy for the number of BISP beneficiaries enrolled (or treated) and/or sharing in the cost of building facilities or the salaries of personnel. In the meantime, facilities of the following can be drawn upon to provide services where government service does not exist.

a) Collaborations for Service Provision in Phase I

Primary Education

51. **Pakistan Poverty Alleviation Fund[12] (PPAF)** will be working on Primary Education in Phase I of the program. PPAF is an umbrella organization working with other civil society organizations to improve the living conditions of poor communities in rural and urban areas since 1997. PPAF through its partner organizations works on providing primary education to children. For example, the National Rural Support Program[13] (NRSP), one of the PPAF partner organizations, runs a large network of schools in areas where government schools do not operate. Since 1997, NRSP has established 231 Community Schools in villages where Community Organization (CO) members have identified access to education as a priority.

52. **National Commission for Human Development[14] (NCHD)** terms itself as a fast-track initiative to improve social sector outcomes at the grass-roots. NCHD will also provide services in Primary Education in Phase I of the program. NCHD currently runs 9000 schools and works with an additional 8000 government schools by providing them additional teachers.

Primary Health

53. **The Federal Ministry of Health[15] (MoH)** is responsible to deal with matters of health and health care in Pakistan. MoH will work in Primary Health sector through its Lady Health Workers (LHW) program. The program aims to deliver basic health services to poor women at their doorsteps through deployment of LHWs living in their own localities. The program has strength of 96,000 LHWs nationwide with concentration in rural areas and urban slums of the country. These workers are providing services to their communities in the field of child health, nutrition, family planning and treatment of minor ailments. MoH also runs the Expanded Program on Immunization (EPI). It aims at protecting children by immunizing them against Childhood Tuberculosis, Poliomyelitis, Dpitheria, Pertussis, Measles, Tetanus and also their mothers against Tetnaus.

[12] Pakistan Poverty Alleviation Fund website: http://www.ppaf.org.pk/Core_components.asp#HE

[13] National Rural Support Program website: http://nrsp.org.pk/sectoral_activities.htm

[14] National Commission for Human Development website: http://www.nchd.org.pk/ws/index.asp

[15] Ministry of Health website: http://www.health.gov.pk/

54. **The Federal Ministry of Population Welfare[16] (MoPW)** is the government department responsible for population control initiatives in the country. MoPW has been included as a service provider because it provides reproductive health care to participants through its Family Welfare Centers (FWCs), Reproductive Health Service Centers (RHSCs) an Mobile Service Units (MSUs).

NCHD's primary healthcare extension program is designed to strengthen the promotive and preventive health care in remote areas not covered by the National Lady Health Worker (LHW) Program. The project activities covered 13 districts in 2006. A total of 2,573 field staff members participated in the project implementation.

b) Collaborations for Service Provision in Phase II

Micro Credit

55. **Pakistan Poverty Alleviation Fund (PPAF)** will be involved in providing Micro Credit in Phase II of the program. PPAF through its partner organizations works on Skills Development. The Credit and Enterprise Development (CED) Unit provides micro credit by identifying capable partner organizations to provide sustainable delivery of micro credit to the beneficiaries.

Adult Literacy

56. **National Commission for Human Development (NCHD)** has launched a scheme to establish 98,100 Adult Literacy Centers in 134 districts. Through these centers, 2.4 million adults acquire basic literacy skills. In the second phase of CCTs, adult literacy programs will be significant in preparing the illiterate adult population for advanced human capital development programs.

Skills Development

57. **National Vocational & Technical Education Commission (NAVTEC)** [17] is the apex body for skill development in the country. NAVTEC works on human resource development with a focus on technical and vocational education and training. NAVTEC coordinates with and sets the agenda for provincial Technical and Vocational Training associations or TEVTAs. Moreover, it intends to move into basic training, such as handicrafts, etc. which is relevant to our cohort.

58. **Pakistan Poverty Alleviation Fund (PPAF)** also works through its partner organizations to provide skill development services to people.

VI. Recommendations for Implementing the Graduation Strategy

[16] Ministry of Population Welfare website: http://www.mopw.gov.pk/

[17] National Vocational & Technical Education Commission website: http://www.navtec.gov.pk/

59. **BISP needs institutional strengthening if it is to transition to become the umbrella safety net platform in Pakistan and develop the graduation strategy.** For this purpose, it will need to move towards a gradual and stepwise expansion of its institutional and operational capacity and roles.

60. **The process of institutionalization of the CCT program and other graduation measures requires strong management and coordination.** The capacity will need to be strengthened for creating and managing the registry of beneficiaries, coordinating with health and education services, delivering the cash transfers and having operational capacity on the field. In a second stage, the role as facilitator should also be created as part of BISP's role. To create and manage the Registry of Beneficiaries, BISP needs appropriate institutional arrangements and staffing to develop planning and database administration. Statistical and geographic analysis (poverty maps, poverty headcount estimates at the village level) will have to be coordinated with the Federal Bureau of Statistics (FBS). To coordinate with health and education services, a system should be developed, both for the operation and logistics in the field and for its management through Information and Communications Technology. Coordination also requires a legal mandate and a detailed agreement between BISP and the Provincial Governments e.g. Education and Health Departments. For cash distribution, a Management Information System (MIS) is required and the possibility to overview the operation of the agency in charge of cash transfer delivery. Staff and expertise for the monitoring system is also required and experts to coordinate with the independent evaluation agency. BISP is already performing these functions and it should consolidate its institutional capacity to perform this task appropriately. The professional capacity and the technology should be enhanced to perform these processes efficiently.

61. **The next step will be to start the pilot test of the CCT by designing the incentives scheme and the service "packages" and all the new Program features to be launched in some districts**. The selection of the pilot districts may have enough scale to test the complete operation and obtain lessons for the scale up process. Some of the aspects to consider are the availability of health units and schools, the activity of the women health worker program, the poverty scorecard and the database registry.

62. **After the pilot phase, a scale up process may be launched with a target population to be covered in few years (hopefully 2-3 years).** The scale up requires solid institutional arrangements; professional staffing for the technical procedures and for the field; and proved ICT systems, like the MIS.

63. **A last step will be for BISP to facilitate to link up with other entities (public and private) to further enhance human capital and facilitate the development of physical capital, with priority to the poorest families in Pakistan**. The poverty scorecard database as well as the field presence of BISP, directly or indirectly, will enable the BISP to coordinate this kind of activities. This may only be achieved at the expansion and scale up phase of the new Program.

64. **To develop these different functions, BISP needs to develop the institutional capacity** in the following areas in addition to its existing capacity:

- Systems Management (IT and operational) to integrate, update and give access to the Registry of Beneficiaries database for different users that BISP intends to link up with.
- Coordination with both government and non-government service providers starting from Health and Education for the new Program. With each service provider, BISP will have to develop the capacity to draw appropriate agreements with each and then coordinate and monitor the links.
- BISP will also have to develop presence in the field. There are several reasons for developing field presence. Already BISP requires presence in the field for grievance redressal. Once income transfers are rolled out on the poverty scorecard, for purposes of validation field presence will be required. And then once CCTs are introduced, to monitor compliance with services on which the cash transfer is conditional. Ideally BISP presence in the field should be substantial and all the way down to the union council level. Since there are roughly 6000 union councils in Pakistan, BISP will require two to three staffers at that level to have an effective presence on the ground.[18]
- Financial and administrative capacity has to be developed with appropriate professional staff and requisite equipment.
- Periodic independent evaluation of management systems, information flows, targeting system and impact assessment should also be developed over time.

[18] The next issue is whether this capacity should be developed by BISP itself or not? This is for BISP and other levels of government to determine. It is also possible to harness existing resources that are present in the semi government and NGO sectors. NCHD and NRSP are two such organizations with large numbers of social mobilisers already in the field.

Annex 1

Learning from International Experience: Conditional Cash Transfer Programs

Conditional Cash Transfer Programs (CCTs) have been multiplied in many countries because they are part of social policy reform. CCTs were designed and implemented in developing countries like Mexico and Brazil. Currently more than 40 countries are implementing in big scale or at least testing such kind of programs.[19] In many countries, CCTs are part of a social reform that phase out ineffective and regressive subsidies and programs.

Table 2: CCT Programs at the National Level

Country	Name of CCT program
Mexico	Programa de Desarrollo Humano Oportunidades (Human Development Program Opportunities)
Brazil	*Bolsa Familia* (Family Transfer)
Colombia	*Familias en Accion* (Families in Action)
Jamaica	Program of Advancement through Health and Education (PATH)
El Salvador	*Comunidades Solidarias* (Solidarity Communities)
Turkey	Conditional Cash Transfer Program of the Social Risk Mitigation Project
Costa Rica	*Avancemos* (Let's go)
Honduras	*Programa de Asignaciones Familiares* (PRAF) (Family Grants Program)
Dominican Republic	Solidaridad (Solidarity)
Panama	*Red de Oportunidades* (Network of Opportunities)
Uruguay	*Programa de Asistencia Nacional de Emergencia* (National Assistance Emergency Program
Paraguay	*Tekopora* (Partners)
Guatemala	*Mi Familia Progresa* (My Family improves)
Argentina	*Familias por la Inclusion Social* (Families for Social Inclusion)
Ecuador	*Bono de Desarrollo Humano* (Human Development Grant
Peru	*Juntos* (Together)

Source: Authors and Fiszbein (2009)

Comparative studies show that CCTs in Latin America and the Caribbean are the better targeted and the best income-distribution programs. The World Bank has evaluated different CCT programs in the Caribbean and Latin America. [20]. Efficiency of these programs in terms of

[19] Table 2 presents a list of countries that have introduced income transfers based on CCTs at a national level in the recent past. Progresa/Oportunidades in Mexico, which started in 1997 is perhaps the most successful of such programs

[20] Rawlings, Laura B. 2004. "A New Approach to Social Assistance: Latin America's Experience with Conditional Cash Transfer Programs." *Social Protection Discussion Paper Series No. 0416*, Social Protection Unit - Human Development Network, World Bank, Washington, DC.

targeting and cost-effectiveness is very good and the best compared to other safety net or poverty assistance programs. On average, 81 percent of CCT program benefits go to 40 percent poorest families. Almost all of the Programs use a Proxy Means Test applied through a "census" as the targeting methodology, like in Pakistan.

CCTs have demonstrated impacts in human capital development. Evaluation results for Mexico, Brazil, Nicaragua and Colombia show that not only have CCT programs demonstrated a positive effect on enrollment for both boys and girls but have also improved child health and nutrition. Evaluation of nationwide CCT programs of Colombia, Ecuador, Jamaica and Mexico show that conditional cash transfer programs have a positive effect on school enrollments and health center visits for children in these countries. Evaluation of regional/narrow - target population and small scale/pilot CCT programs in Chile, Honduras and Nicaragua also show positive effects on school enrollment and health center visits in the areas where they were implemented.[21] Evaluations in Mexico show positive impacts in infants nutrition. All the programs that have looked upon behavior impacts show that CCTs contribute to decrease child labor and to a better food consumption, e. g. increasing vegetables and animal protein in the house diet. Also evaluations from Mexico show that CCTs do not have impact on negative behavior increase e. g. violence against women, tobacco and alcohol consumption, dependency and decrease on labor.

International experience about CCTs show that coordination between the "poverty-targeting and cash transfer delivery agency" with the Health and Education Ministries is essential for implementation. In Mexico, Colombia, El Salvador and Jamaica coordination with the "line" Ministries is a major achievement and is part of the Program's design. In Brazil, Ecuador, Panama and Dominican Republic the Program actively seeks for the coordination with Health and Education services at the local level. Programs that lack or postpone coordination with Health and Education services demonstrate the importance of this aspect for the effectiveness of CCTs.[22]

Sustainability of the CCTs is based in design features, transparency and independent evaluation. Political sustainability of the CCTs is fostered by objective targeting (as an option *vs*. discretionary or politically biased selection), on "conditionality" as a "shared responsibility" between State and citizens because cash transfers are delivered upon compliance of established family commitments and on transparency. The worst scenario for a CCT is to be denounced as politically biased. Objective targeting, cash transfer delivery through and outsourced specialized agency and independent evaluation are the key features to avoid political aggressions. Public information and transparency standards to access the Programs' information are best practice to deter that scenario. Evaluation through a "third-party" independent and prestigious academic institution has become a standard that has demonstrated added value in controversial and political debates.

CCTs may be the "backbone" of a comprehensive social safety net strategy. In Brazil, Jamaica, Mexico and Colombia, the evolution of the CCT programs has developed as a

[21] Fiszbein, 2009

[22] Recent preliminary evaluations of Programs in Panama and Peru demostrate that impacts are less due to insufficient coordination of the Programs with Health and Education services

"backbone" of a more comprehensive Social Safety Net strategy. In Colombia "*Juntos*" (Together) is promoting the access of "*Familias en Accion*" beneficiaries to other benefits and rights that are important for human development and citizenship of the poor like: identity (identity card/number/documentation access), adult literacy, access to microcredit or other productive supports, access to banking services (savings, credits), health services for other family members or for an enhanced health "package", housing improvements or access to housing and other benefits according to prioritized needs. In Jamaica, a "Steps to Work" initiative is being tested to promote adult labor incorporation or to promote new income-generating initiatives. The Chilean model of a comprehensive social protection system is the model for the evolution of the Programs and for social policy decision makers.

Annex 2

Building an integrated Safety Net System: BISP as facilitator for Complementary Services

In Table 3, the list of service providers chosen at a preliminary stage to link up with BISP is presented. Before the characteristics of different service providers listed in the table are elaborated, the criteria used for choosing programs needs to be understood. In this context, the first and foremost criterion is to harness existing initiatives in Pakistan. A number of initiatives – with carrying levels of capacity and success – exist in the country and by bringing them together under the umbrella of BISP will serve to reduce the high level of fragmentation in social protection provisioning.

The criteria on which these programs will be evaluated are presented below;

- *Transparency in Financial Flows and Budgeting*
- *Existing and Potential Coverage within the given universe*
- *Potential to Scale Up, where initiatives are at a lower level of disaggregation*
- *Effective Targeting Method Employed; especially the ability of the method to transparently target appropriate Beneficiaries.*

Table 3: Select List (Matrix) of Programs

Area of Activity	Entity/ Organization	Nature of Program (Government Program/ NGO)	Coverage (National/Provincial/Local)	Estimated Beneficiaries	Target
Primary Education	National Commission for Human Development	Government Program	**National**	7.8 million children	5-7 year old children
	Pakistan Poverty Alleviation Fund	Semi Autonomous	**National**		
Livelihood Investments	Pakistan Poverty Alleviation Fund	Semi Autonomous	**National**		

Area of Activity	Entity/ Organization	Nature of Program (Government Program/ NGO)	Coverage (National/Provincial/Local)	Estimated Beneficiaries	Target
Microfinance	Pakistan Poverty Alleviation Fund	Semi Autonomous	**National**		
Technical & Skills Education	National Vocational & Technical Education Commission	Government Program	**National**	96,000 people	
	Pakistan Poverty Alleviation Fund	Semi Autonomous	**National**		
Adult Literacy	National Commission for Human Development	Government Program	**National**	2.4 million adults	Illiterate adults
Preventive Health Care for Women & Infants	Ministry of Health	Government Program	**National**	5.5 million children, 6 million women / year	Children (0-11 months) and pregnant mother
	Ministry of Population Welfare	Government Program	**National**	9 million women	

Source: Author's compilation

Description of Potential Partners

1. Pakistan Poverty Alleviation Fund: The Pakistan Poverty Alleviation Fund (PPAF) is an umbrella organization working with other civil society organizations to improve the living conditions of poor rural and urban communities since 1997. Recently PPAF secured a funding of US$ 250 million from the World Bank for a period of 5 years. In the past, PPAF has concentrated heavily on provision of micro credit and thereby its focus has not been the chronically poor. However, its latest project funding stipulates that its concentration will now shift to the most vulnerable and poorest households. [23]

The fact that PPAF is an umbrella organization makes it appropriate for linkage with BISP as such a linkage will reduce transaction costs of monitoring and accountability for BISP. Presently, there are 75 civil society organizations that are being funded by PPAF. [24] Since PPAF is the largest – at times the exclusive – funder to these organizations. On the other hand, the government is represented on the board of the PPAF, which makes it accountable to the government also.

PPAF provides loans and grants to its partner organizations through the following units:

a. Credit and Enterprise Development (CED)
b. Community Physical Infrastructure (CPI)
c. Human and Institutional Development (HID)
d. Health and Education Unit (H&E)
e. Water Management Centre (WMC)
f. Reconstruction and Rehabilitation Program (RNR)

Benefits accrue directly to the vulnerable through income generation, improved physical and social infrastructure, and training and skill development support.[25] PPAF has been included as a service provider to BISP for the following activities it sponsors:

- Skill Development: PPAF through its partner organizations works on skill-development
- Employment: PPAF works on developing community physical infra-structure and also has a specialized water management center which focuses on irrigation related problems facing communities.[26] These two PPAF initiatives can be used to create an employment program through which community members are able to participate in developing community infrastructure and also earn a living.

[23] PPAF – Directors' Report and Financial Statements June 2009. http://www.ppaf.org.pk/db/Directors%27%20Report%20and%20Financial%20Statements%20June%202009.pdf

[24] The national as well as all provincial RSPs as well as a number of other innovative civil society initiatives in our areas of operation receive their major funding from PPAF. NRSP, in particular, is the largest Rural Support Program in the country in terms of outreach, staff and development activities.

[25] Pakistan Poverty Alleviation Fund. http://www.ppaf.org.pk/

[26] Core Components – Pakistan Poverty Alleviation Fund. http://www.ppaf.org.pk/Core_components.asp#ced

- Microfinance: The Credit and Enterprise Development (CED) Unit focuses on the identification of credible and capable partner organizations to provide sustainable delivery of micro credit and other financial services to the beneficiaries[27]
- Primary Education: PPAF through its partner organizations works on providing primary education. NRSP in particular runs a large network of schools in areas where government schools do not operate.

2. National Commission for Human Development: The National Commission for Human Development (NCHD) terms itself as a fast-track initiative to improve social sector outcomes at the grass-roots. The goal of the Commission is to fill the implementation gaps and improve public sector delivery mechanisms to achieve the *Millenium Development Goals (MDGs)*. After having remained dormant for the last one year, the Commission has been revived and funding for Rs. 8.5 billion for 3 years has also been approved.

NCHD has been included as a service provider with BISP because it is working in the following areas:

- Primary Education: NCHD currently runs 9000 schools and works with an additional 8000 schools by providing them additional teachers.
- Adult Literacy: NCHD has launched a scheme to establish 98,100 Adult Literacy Centers in 134 districts. Through these centers, 2.4 million Adults will acquire basic literacy skills.
- Volunteer Program: NCHD has started a volunteer program with 350,000 volunteers whom they will train in the areas of education, health and other forms of service provision.

3. National Vocational & Technical Education Commission: The National Vocational & Technical Education Commission (NAVTEC) is the apex body of skill development in the country. NAVTEC works on human resource development with a focus on technical and vocational education and training. As the umbrella organization, NAVTEC coordinates with and sets the agenda for provincial Technical and Vocational Training associations (TEVTAs). Moreover, it intends to move into basic training, such as handicrafts, etc. which is relevant to our cohort. NAVTEC has been included as a service provider with BISP to provide vocational and technical training to beneficiaries.

4. Federal Ministry of Health: The Federal Ministry of Health (MoH) is responsible to deal with matters of health and health care in Pakistan. MoH is being enlisted as a service provider with BISP for the purpose of preventive health care of mothers and children.

The main vehicle for this purpose will be the Lady Health Workers (LHW) Program. The Program aims to deliver basic health services to poor women at their doorsteps through deployment of LHWs living in their own localities. The program is currently being implemented in all the districts of the country. The program has strength of 96,000 LHWs nationwide with concentration in rural areas and urban slums of the country. Each LHW covers 1000 population or 150 houses. These workers are providing services to their communities in the field of child health, nutrition, family planning and treatment of minor ailment. The LHW program has been in

[27] Ibid.

operation since 1994 and having continuously delivered good results it is a much consolidated program.
MoH also runs the Expanded Program on Immunization (EPI). It aims at protecting children by immunizing them against Childhood Tuberculosis, Poliomyelitis, Diphtheria, Pertussis, Measles, Tetanus and also their mothers against Tetanus.

5. Federal Ministry of Population Welfare: The Ministry of Population Welfare (MoPW) at the federal level is the government department responsible for population control initiatives in the country. MoPW has been included as a service provider with BISP because it provides reproductive health care to participants through its Family Welfare Centers (FWCs), Reproductive Health Service Centers (RHSCs) and Mobile Service Units (MSUs).

Annex 3

Regional and Sectoral Distribution of Potential Complementary Partners/Programs

Sector wise Distribution of Organizations (Regional & Sectoral Mix)

S.No	Organization	Education	Health	Skill Development	Livelihood/ Microfinance	Employment
1	NCHD	Y				
2	NRSP	Y			Y	
6	PPAF				Y	
8	NAVTEC			Y		
9	MoH		Y			
10	MoPW		Y			

Province-wise Distribution of Organizations

S.No	Organization	Sindh only	Punjab only	NWFP only	Baluchistan only	National
1	NCHD					Y
2	NRSP					Y
6	PPAF					Y
8	NAVTEC					Y
9	MoH					Y
10	MoPW					Y