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# Conditional Cash Transfer Programmes in Latin America: comparing their targeting mechanisms and target population

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## Abstract

Conditional Cash Transfer Programmes (CCTs) are social policies aimed to fight poverty. These programmes were implemented in Latin America for the first time in the mid 90's. CCTs are focused on families in poverty and extreme poverty, but also in certain household members. In general, CCTs give household a cash transfer. However, beneficiaries must fulfill certain conditionalities to continue receiving the monetary transfer. In this research, we analyze the different targeting mechanisms and target populations of twenty-six CCTs from twenty countries in the Latin American region. There are several targeting mechanisms used by CCTs to identify beneficiaries. In the first part, we focus on categorize and describe these targeting mechanisms. Afterwards, we classify each CCT program according to its target population. In addition, in the second part, there is a description of the main vulnerable sectors targeted by CCTs. In the last part, we present the final considerations.

**Keywords:** poverty, cash transfer, conditionality, targeting mechanisms, target population.

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**Introduction**

The Conditional Cash Transfer Programmes (CCTs) have become one of the main poverty fighting tools used by Latin American governments. These programmes were created for the first time in the mid-90's (Cena; Chanbenderian, 2015). This research analyses twenty-six CCTs from twenty countries[1] in Latin America and the Caribbean.

These programmes are the following: *Asignación Universal por Hijo para Protección Social* (AUH), *Building Opportunities for Our Social Transformation* (BOOST), *Bolsa Familia* (BF), *Bono Juancito Pinto* (BJP), *Bono Juana Azurduy* (BJA), *Ingreso Ético Familiar* (IEF), *Más Familias en Acción* (MFA), *Red Unidos* (RU), *Avancemos*, *Progresando con Solidaridad* (PS), *Bono de Desarrollo Humano* (BDH), *Comunidades Solidarias* (CS), *Bono Social* (BS), *Ti Manman Cheri* (TMC), *Bono Vida Mejor* (BVM), *Programme of Advancement Through Health and Education* (PATH), *Programa de Inclusión Social Prospera*[2] (Prospera), *120 a los 65*, *Ángel Guardián* (AG), *Red de Oportunidades* (RO), *Abrazo*, *Tekopora*, *Juntos, Targeted Conditional Cash Transfer Program* (TCCTP), *Asignaciones Familiares- Plan Equidad* (AFAM-PE) and *Tarjeta Uruguay Social* (TUS).

Table 1 summarises the studied programmes according to date of creation and legal instrument when available.

[1] Nowadays, Nicaragua does not have any CCT programme, but from 2000 to 2006, this country implemented the *Red de Protección Social II* (RPS II) programme, and from 2005 to 2006 had the *Sistema de Atención a Crisis* programme.

[2] According to its current Operating Rules, another programme will replace *Prospera* during fiscal year 2019.

**Table 1- Conditional Cash Transfer Programmes in Latin America**

| Country | Programme | Creation |
|---|---|---|
| **Argentina** | AUH | Decree 1602/2009 |
| **Belize** | BOOST | August 2011 |
| **Brazil** | BF | Law No. 10836 of January 9, 2004 |
| **Bolivia** | BJP | Supreme Decree No. 28899 of October 26, 2006 |
| | BJA | Decree 0066-2009 |
| **Chile** | IEF | Law No. 20595 of May 11, 2012 |
| **Colombia** | MFA | 2001 |
| | RU | 2007 |
| **Costa Rica** | Avancemos | Decree No. 33154, 2006 |
| **Dominican Republic** | PS | Decreto 488-12 |
| **Ecuador** | BDH | Executive Order No. 347, 2003 |
| **El Salvador** | CS | Executive Decree No. 56 of October 9, 2009 |
| **Guatemala** | BS | Ministerial Agreement No. DS-150-2018 |
| **Haiti** | TMC | May 27, 2012 |
| **Honduras** | BVM | Executive Agreement No. SEDIS-003-2015 |
| **Jamaica** | PATH | Pilot programme |
| | | 2001 |
| **Mexico** | Prospera | Decree published on September 5, 2014. |
| **Panama** | 120 a los 65 | Law No. 15 of September 1, 2014 |
| | ÁG | Law No. 39 June 14, 2012 |
| | RO | April, 2006 |
| **Paraguay** | Abrazo | 2005 |
| | | Since 2008 is coordinated by SNNA |
| | | Presidential Decree 689/2008 |
| | Tekopora | Pilot programme |
| | | 2005 |
| **Peru** | Juntos | Supreme Decree No.032-2005-PCM of April 7, 2005 |
| **Trinidad and Tobago** | TCCTP | August, 2006 |
| **Uruguay** | AFAM-PE | Law No. 18.227 of December 22, 2007 |
| | TUS | May, 2006 |

According to Higgins (2012, p.91), the CCTs “are monetary transfers focused on poor families and require a specific level of investment on human capital in household with children”. However, CCTs have other elements to highlight. These social programmes integrate assistance in the short term with overcoming poverty in the long term (Villatoro, 2007, p.5). CCTs are highly effective in short-term reduction due to monetary transfers given to beneficiaries (Villatoro, 2007; Skoufias and McClafferty, 2001). One of the main CCTs’ characteristics is conditionality. To maintain the cash transfer is necessary that beneficiaries complain certain educational and health conditionalities (Cecchini y Madariaga, 2011). In addition, CCTs are highly focused programmes and the benefit is mainly given to women (Gasparini, 2010).

The importance of CCTs in combating poverty is quite significant. There are programmes with a reduced coverage of 4,3 % of the total population of the country (year 2014), as is the programme *TMC* (Haiti); or those that have reached more than a third of the total population, an example is the case of the programme *BDH* (Ecuador) with 40.67% (year 2009). Regarding the budget for the support of this type of programmes, what governments invest is not usually higher than 0.5% of Gross Domestic Product (GDP). However, there are exceptions such as the programme *BDH*, which has reached almost 1% of GDP (year 2011).

## Targeting mechanisms

Targeting refers to give priority to certain groups within the population for the delivery of social benefits. The recipients are usually part of the poorest population or specific groups considered priority in society (Candia *et al*., 2010). According to Coady *et al*. (2004), targeting mechanisms are classified in: 1) individual / familiar evaluation (means test, proxy means test and community-based), 2) categorical (geographic and demographic) and 3) self-selection.

In the Latin American region, the most used targeting mechanism is the proxy means test. Nowadays, more than 80% of CCTs use it. However, this targeting mechanism is usually accompanied by some categorical targeting mechanism (geographic and demographic), and to a lesser extent by the community-based one. On the other hand, the only programme using means test is *BF* in Brazil. As for the self-selection mechanism, some programmes can be considered using this one, but not necessarily.

## Individual/ Familiar evaluation

### *Means Test*

The Means test targeting mechanism is a form of individual assessment that compares resources such as the income that an individual or household has with some threshold or limit value (Coady *et al*., 2004; 51). The cost implied by this mechanism is high, due to the fact that it involves the collection and verification of data obtained from households or individuals. Furthermore, it is not commonly used in developing countries (Coady *et al*., 2004; Candia *et al*., 2010). We find that the interview and the home visit are used to verify living conditions. These programmes that use this mechanism generally are distinguished by granting cash transfers.

Although there are some limitations in its implementation, we must highlight one in particular. This mechanism does not consider the income obtained in the informal market. If we take into account that in Latin America the poorest families and individuals obtain their income mainly from this market, this could be an obstacle to consider before its implementation. For instance, BF (Brazil) uses this method of targeting considering as poor people whose income is from 89.01 BRL (23.2 USD) to 178 BRL (46.3 USD); and in extreme poverty those with a monthly income of less than 89 BRL (23.2 USD).

**Table 2 - Targeting mechanisms**

| Country | Programme | Targeting mechanisms |
|---|---|---|
| **Argentina** | AUH | Proxy means test |
| **Belize** | BOOST | Proxy means test |
| **Brazil** | BF | Geographic, Means Test |
| **Bolivia** | BJP | Demographic |
| | BJA | Demographic |
| **Chile** | IEF | Proxy means test |
| **Colombia** | MFA | Geographic, Demographic , Proxy means test |
| | RU | Demographic , Proxy means test |
| **Costa Rica** | Avancemos | Geographic, Demographic, Proxy means test |
| **Dominican Republic** | PS | Proxy means test |
| **Ecuador** | BDH | Geographic, Demographic, Proxy means test, Community-based |
| **El Salvador** | CS | Geographic, Demographic, Proxy means test |
| **Guatemala** | BS | Geographic, Demographic, , Proxy means test |
| **Haiti** | TMC | Geographic , Demographic, Proxy means test |
| **Honduras** | BVM | Geographic ,Demographic, Proxy means test, Community-based |
| **Jamaica** | PATH | Proxy means test, Demographic |
| **Mexico** | Prospera | Geographic, Demographic, Proxy means test, Community-based |
| **Panama** | 120 a los 65 | Geographic, Demographic |
| | AG | Demographic, Proxy means test |
| | RO | Geographic, Proxy means test |
| **Paraguay** | Abrazo | Demographic, Proxy means test |
| | Tekopora | Geographic, Demographic, Proxy means test, Community-based |
| **Peru** | Juntos | Geographic, Demographic, Proxy means test, Community-based |
| **Trinidad and Tobago** | TCCTP | Demographic, Proxy means test |
| **Uruguay** | AFAM-PE | Demographic, Proxy means test |
| | TUS | Demographic, Proxy means test |

Source: Elaborated by the author with data from CEPAL <https://dds.cepal.org.bpsnc/ptc>

***Proxy means test***

According to the Proxy means test targeting mechanism a score is calculated for each household based on a small number of characteristics and a weighting. Eligibility is determined by the comparison of scores with a predetermined limit value (Coady *et al*., 2004, p. 52). This mechanism aims to determine the socioeconomic situation of households and individuals, and is the most used in Latin America (Candia *et al*., 2010). The cost involved is similar to the Means test. Regarding to the variables that are used, these should be correlated with poverty. In addition, their measurement and observation must be accessible, and prevent possible manipulation of households. In this research, there are twenty-two CCTs using this kind of targeting mechanism.

For instance, the *Avancemos* programme (Costa Rica) uses a Social Information Card (FIS), applied to communities through home visits. After that, the Target Population System (SIPO) is used as a targeting instrument. The SIPO uses the following poverty measurement methods: 1) Poverty Line (LP), 2) Integrated Poverty Method (IPM), 3) Score (SIPO method) (M. Víquez, 2005). Another programme as *PS* (Dominican Republic) classify families according to a Quality of Life Index (ICV) belonging to the Single Beneficiary System (SIUBEN). Families in extreme poverty condition have an ICV-I category and those with a moderate poverty condition an ICV-II category. Even, there are programmes such as AFAM-PE or TUS (Uruguay) that use an Index of Critical Deficiencies (ICC).

***Community-based***

In this targeting mechanism, a leader or a group of community members, whose main community functions are not related to the transfer programme, decide which member of the community should receive the benefit. (Coady *et al*., 2004, p. 53). It is applied in rural areas or in urban ones

with well-defined segments. The disadvantage of its implementation in urban areas is that communities do not keep a close relationship among them, which hinders its use. In terms of maintenance, the cost of this mechanism is low (Coady *et. al*., 2004).

Among the CCTs in Latin America that consider the community-based targeting mechanism, we find *BDH* (Ecuador), *BVM* (Honduras), *Prospera* (Mexico), *Tekopora* (Paraguay) and *Juntos* (Peru). For instance, the *Juntos* (Peru) programme corroborates the chosen households through Community Validation Assemblies (ACV). The assembled community reviews the selection of beneficiary households to confirm or modify it. On the other hand, in the *Tekopora* programme (Paraguay) we find Citizen Participation Meetings (MPC) that also validate the entry of new beneficiaries into the programme. According to Sosa (2017)[3], in these meetings participate figures such as the municipal mayor, the district coordinator of the programme, the director of social action, representatives of the commission of parents, adolescents and young people with disabilities, municipal councilors, a local health representative, neighborhood commissions and even members of the religious institution of the area.

## Categorical targeting

In this classification, we find two targeting mechanisms: 1) geographic and 2) demographic.

### *Geographic targeting*

The place of residence determines the eligibility to obtain the benefit. This method uses existing information, from basic needs surveys or poverty maps[4] (Coady *et al*., 2004, p. 54). It should be noted that its costs are low.

[3] Case study in the Tte. 1º Manuel Irala Fernández district of the western region of Paraguay.

[4] Understanding poverty in terms of access to basic services. However, consumption is also used as a poverty indicator.

targeting mechanism is present in thirteen CCTs such as *BF* (Brazil), *MFA* (Colombia), *Avancemos* (Costa Rica), *BDH* (Ecuador), *CS* (El Salvador), *BS* (Guatemala), *TMC* (Haiti), *BVM* (Honduras), *Prospera* (Mexico), *120 a los 65* and *RO* (Panama), *Tekopora* (Paraguay) and *Juntos* (Peru). However, it is usually accompanied by the Proxy means test targeting mechanism.

For instance, the targeting mechanism of the *Tekopora* programme (Paraguay) is based on the Geographical Prioritization Index (IPG), which combines criteria of monetary poverty and unsatisfied basic needs. Another programme such as *MFA* (Colombia) is focused on localities with a Multidimesional Poverty Index (IPM) of 70% or higher and the *BVM* programme is based on a Marginality Index (IM).

Meanwhile, the *Juntos* programme (Peru), in its first stage, manages a geographic targeting focusing on districts, which are chosen through poverty maps of the Cooperation Fund for Social Development (FONCODES) and the National Institute of Statistics and Informatics (INEI). The household must be located in a district with a poverty level equal to or greater than 40% according to the Index of Geographical Priorization (IPG). Another programme is *RO* (Panama) that also uses poverty maps, but the population is focused on *corregimientos*.[5]

### *Demographic targeting*

In this targeting mechanism, eligibility is determined by age, gender and demographic characteristics (Coady et al., 2004; 54). We could say that it focuses on vulnerable groups, among them: pregnant women, nursing mothers, elderly, children, young people, etc. The administrative cost is low and similar to the geographical one.

There are multiple CCTs using this targeting mechanism. However, we can highlight programmes such as *BJP* and *BJA* (Bolivia), *120 a los 65* and *AG* (Panama). For instance, the *BJP* programme (Bolivia) is focused on children

[5] In Panama a *corregimiento* is a subdivision of a district.

and young people under 21 years of age that are studying. On the other hand, the *BJA* programme (Bolivia) targets only pregnant and nursing women. Both of them are CCTs implemented in the same country but focused on different vulnerable sectors. We have another example in Panama, the *AG* programme (Panama) targets people with severe disabilities in conditions of dependence and extreme poverty, while the *120 a los 65* programme (Panama) is focused on elderly people (65 years of age or over).

**Self-selection**

According to Coady *et al*. (2004), self-targeting means that a programme is open to all people. However, it is designed in such a way that accession incentives will be greater among the poor people, due to participation costs, social stigma and people quality preferences. For CCTs, it is not enough for a person to consider himself as poor and apply for the benefit to become a recipient. CCTs have other targeting mechanisms (verification tools). For instance, the *BJA* program (Bolivia) allows people to register voluntarily. However, there is a documentary review prior to the acceptance of the beneficiary. Then, self-selection could be not considered as a targeting mechanism for this kind of programmes.

**Target population**

In general, the CCTs have as their target population families in poverty and extreme poverty. However, they are focused on vulnerable sectors such as pregnant women, nursing mothers, children and adolescents, unemployed people, elderly, disabled people and others. The next step is try to identify and explain these groups for each CCT program. For instance, in Argentina we find the *AUH* programme that is focused on children under 18 years of age and pregnant women. Other countries in Latin America seek to make the coverage of their programmes even more specific. In the case of Guatemala, the *BS* programme (Guatemala) not only covers mothers or pregnant women,

**Table 3 - Target population**

| Vulnerable sector | Programme |
|---|---|
| Families in poverty and extreme poverty | RO[6] |
| Indigenous families | MFA, RU, Tekopora |
| Pregnant women or nursing mothers | AUH, BOOST, BF, BJA, PS, CS, BS, BVM, PATH, Prospera, Tekopora, Juntos, TUS |
| Trans people | TUS |
| Child labor (children) | Abrazo |
| Working women | IEF |
| Unemployed people | CS, PATH, Prospera |
| Children and adolescents | AUH, BOOST, BF, BJP, BJA, IEF, MFA, Avancemos, PS, BDH, CS, BS, TMC, BVM, PATH, Prospera, Abrazo, Tekopora, Juntos, TCCTP, AFAM-PE, TUS |
| Disabled people | AUH, BOOST, BDH, PATH, AG, Tekopora, AFAM-PE |
| Elderly people | BOOST, IEF, BDH, CS, PATH, Prospera, 120 a los 65, Tekopora, Juntos |
| Homeless people | IEF |
| Displaced families | MFA, RU |
| Rural and urban households | CS, BVM, Juntos |

Source: Elaborated by the author with data from CEPAL. https://dds.cepal.org.bpsnc/ptc

## Vulnerable sectors

### *Children and adolescents*

Children and adolescents are a key element in the development of CCTs. The strategy used by Latin American governments in the fight against poverty, considers them as one of the main instruments for combating

[6] In the case of the programme RO (Panama), it has conditionalities focused on children and adolescents and pregnant women. However, there is not a specific component and cash transfer given to these groups, but to household.

intergenerational poverty through investment in human capital. Therefore, CCTs are focused on this sector through components related to education, health and nutrition.

The educational component present in some CCTs generally is aimed at children and adolescents. We have to emphasize that a programme can have one or several benefits to the educational field. However, there are multiple differences among these benefits. For instance, some CCTs have a gradual increase of the monetary transfer as the children or adolescents advance in grade or educational level. Here we find programmes such as *MFA* (Colombia), *Avancemos* (Costa Rica), *PS* (Dominican Republic), *CS* (El Salvador), *BVM* (Honduras), *PATH* (Jamaica), *Prospera* (Mexico), *AFAM-PE* (Uruguay). Additionally, there are CCTs such as *CS* (El Salvador), *PATH* (Jamaica), *Prospera* (Mexico) that also determine the cash transfer amount based on gender. For instance, the *Prospera* programme (Mexico) gives more money to women studying compared to men. Inversely, the *PATH* programme (Jamaica) has an amount 10% higher for men, and it grows 50% for secondary and 75% for higher levels of high school.

Even, there are educational cash transfers that seek to reward or incentive beneficiaries. For instance, In Chile, the *IEF* programme has the called *Bono por logro escolar*. This benefit grants a monetary transfer as an incentive to study. Among the 30% most vulnerable of those enrolled from the 5th basic level to the 4th medium level, half of students with the best performance receive a single payment of 59,087 CLP (87.1 USD)[7], and the other half get 35,453 CLP (53.3 USD). Another example is the *Prospera* programme (Mexico) that provide the so-called *Jóvenes con Prospera* that is a monetary benefit to young people of 6,333 MXN (321.1 USD)[8] . However, the beneficiaries must have finished high school before age 22.

[7] Benefits of all programs except those specified in the text are updated to the year 2019. It has been applied July 3, 2019 exchange rate.
[8] Amount for the year 2017, using December 31, 2017 exchange rate.

On the other hand, health component is addressed to all household members including children and adolescents. However, some CCTs have certain components focused on this vulnerable sector that give a cash transfer for health protection. For instance, the *IEF* programme (Chile) has the component *Bono por control niño sano*. This benefit is targeted on households with children from zero to six years of age. The payment of the monthly cash transfer is of 6000 CLP (8.8 USD) for each child. Another programme is *CS* (El Salvador); it has a health component focused on pregnant women and children from zero to four years of age. The household receive a bimonthly cash transfer of 30 USD.[9]

In programmes having these health components targeted on children, households have to fulfill conditionalities such as children scheduled medical checkups, register in a health unit, vaccination, nutritional control, etc. Health and nutrition components or conditionalities focused on children and/or adolescents are usually related in CCTs. However, there are programmes such as *BF* (Brasil), *MFA* (Colombia), *BS* (Guatemala), *BVM* (Honduras) and *Prospera* (Mexico) having specific nutritional components targeted on this vulnerable sector. For instance, the *BS* programme has the component *Intervención crecer sano*. This benefit is targeted on poverty families with children from zero to two years of age and its main objective is prevent chronic malnutrition. The amount of the monthly cash transfer is of 500 GTQ (64.8 USD).

However, the most representative programme focused on household nutrition (including children and adolescent) could be *TUS* (Uruguay). This CCT programme sends household a monetary transfer through a magnetic card. The beneficiaries must use these resources to buy food, hygiene and cleaning articles in the programme's stores. In addition, this programme has a component focused on pregnant and nursing women and children under three years of age. The programme gives to households iron fortified milk powder.

[9] Amount for the year 2016.

***Pregnant women and nursing mothers***

Pregnant women and nursing mothers are one of the main vulnerable sectors that are taken into account by the CCTs. The programmes that provides a benefit during pregnancy are *AUH* (Argentina), *BOOST* (Belize), *BF* (Brazil), *PS* (Dominican Republic), *CS* (El Salvador), *BS* (Guatemala), *BVM* (Honduras), *PATH* (Jamaica), *Prospera* (Mexico), *Tekopora* (Paraguay), *Juntos* (Peru) and *TUS* (Uruguay). The protection that Latin American governments provide to this sector is followed by the requirement of conditionalities referring mainly to health care and nutrition.

For instance, the *AUH* programme (Argentina) provides a universal pregnancy allowance. The cash transfer has a value of 2652 ARS (63.1 USD), 80% of this amount is delivered monthly and the remaining 20% is paid annually. Another example is the *BF* programme (Brazil), which has two components to highlight. The first one is the *Benefício Variável Vinculado à Gestante*, which consists of a cash transfer of nine consecutive monthly payments of 41 BRL (10.7 USD) given to pregnant women. The second one is the component *Benefício Variável Vinculado à Nutriz*, which focuses on nursing mothers with children from zero to six months of age, and this benefit consists of six consecutive payments of 41 BRL (10.7 USD).

However, there are programmes designed specifically for the attention of this sector such has *BJA* (Bolivia). This programme not only protects women during pregnancy. The *Bono control prenatal*, gives pregnant women a cash transfer of 50 BOB (7.2 USD), with the conditionality that women comply prenatal check-ups one every two months to get a maximum of four payments. Once delivery (institutional) and postnatal control (ten days), women receive a single monetary transfer of 120 BOB (17.4 USD). In addition, the *BJA* grants the family a bimonthly benefit of 125 BOB (18.1 USD) for 24 months (twelve payments) for the care of children from birth to two years of age.

## Elderly people

Some CCTs have benefits directed to elderly people. However, the age range considered may be different among them. For instance, the *Prospera* programme (Mexico) focuses on elderly people aged 70 years and over. This CCT programme gives the household a monthly cash transfer of 370 MXN (18.8 USD)[10] for each older adult[11].

On the other hand, programmes such as *IEF* (Chile), *BDH* (Ecuador), *120 a los 65*[12] (Panama), *Tekopora* (Paraguay), take into account elderly people aged 65 years and over. For instance, the *BDH* programme (Ecuador) specify a monthly cash transfer of 100 USD. Instead, the *Tekopora* programme stipulates a monthly monetary transfer of 40,000 PYG (6.7 USD)[13].

The *120 a los 65* programme is a special case. This one is specifically designed to help elderly people. This CCT programme establishes a monthly cash transfer of 120 PAB (1 PAB is equivalent to 1 USD). However, the money is transferred bi-monthly (240 PAB). According to the programme, this cash transfer must be used to purchase food, clothing, housing, medicines or health services. To be a beneficiary of the *120 a los 65* programme (Panama), it is necessary to be in a condition of vulnerability, marginalization, social risk or poverty, and not be a retired person.

Even, there are programmes such as *BOOST* (Belize), *CS* (El Salvador), and *PATH* (Jamaica) considering elderly people aged 60 years and over. For instance, the *Nuestros Mayores Derechos* programme is complementary to the *CS* programme (El Salvador). This one stipulates a monthly cash transfer

[10] Amount for the year 2018, using December 31, 2018 exchange rate.
[11] Generally, this benefit is an individual cash transfer.
[12] The programme *120 a los 65* (Panama) became operational in 2009 under the name of *120 a los 70*. However, through Law No. 15 of 2014, the age range of the beneficiaries was extended to people of 65 years or older.
[13] Amount for the year 2018, using December 31, 2018 exchange rate.

of 50 USD to elderly people. Another programme is *PATH* (Jamaica) that has a bimonthly cash transfer indicated to some vulnerable sectors among them elderly people.

Programmes such as *IEF* (Ecuador), *Juntos* (Peru) do not have a specific monetary transfer reserved to elderly people, but to the household. Instead, the *BOOST* programme (Belize) establishes a monetary transfer determined by the number of household members. However, they consider elderly people as a target population. The components directed to elderly people are followed by the requirement of conditionalities referring mainly to health care.

### *Disabled people*

This kind of programmes also consider disabled people as one of the main vulnerable sectors. For example, the *AG* programme (Panama) specifically cares for people with a severe disability, in condition of dependency and extreme poverty. For this, it grants a monthly benefit of 80 PAB (1 PAB is equivalent to 1 USD) to the beneficiaries. However, the benefit is delivered bimonthly.

CCTs such as *AUH* (Argentina), *BDH* (Ecuador), *PATH* (Jamaica), *Tekopora* (Paraguay), *AFAM-PE* (Uruguay) have at least one component focused on disabled people. For instance, the *AUH* programme (Argentina) is aimed at children with disabilities. This programme gives household a cash transfer of 8,642 ARS (205.6 USD) for each disabled child (maximum five benefits per family). In the case of the *BDH* programme (Ecuador), it targets people with a disability of 40% or more determined by the Ministry of Public Health. The beneficiaries receive a monthly cash transfer of 50 USD.

In the case of the *Tekopora* programme (Paraguay), it did not contemplate any benefit to people with disabilities. However, in 2009 it extended its coverage to elderly people, indigenous communities and disabled

people. This programme allocates a bimonthly benefit of 150,000 PYG (26.1 USD)[14] to people with severe disability (maximum two benefits per family). Instead, the *AFAM-PE* programme (Uruguay) establishes a monthly cash transfer of 2,307.48 UYU (54.9 USD) per beneficiary with disability. However, to continue receiving the benefit is necessary an evaluation of the disability every three years.

Other programmes such as *BOOST* (Belize) and *PATH* (Jamaica) do not have a specific component for people with disabilities. However, these programmes considers them within the vulnerable sectors that can obtain some benefit. For instance, in the *PATH* programme, people with disabilities can get a health benefit.

***People living on rural and urban areas***

Programmes such as *CS* (El Salvador), *BVM* (Honduras) and *Juntos* (Peru) prioritize poverty people living in rural and urban areas. For instance, the CS programme (El Salvador) distinguishes two interventions: *Comunidades Solidarias Urbanas* and *Comunidades Solidarias Rurales*. The first one considers 412 precarious urban settlements. While the second one is focused on 100 rural municipalities.

In addition, some monetary benefits granted by CCTs programmes are differentiated according to the area (urban and rural). For example, the *BVM* programme (Honduras) provides a basic monetary benefit for families living in a rural area of 2,040 HNL (91.8 USD)[15], while the basic monetary transfer for a family living in an urban area is of 1,020 HNL (45.9 USD) payment for the year 2015). On the other hand, the cash transfer of the *Juntos* programme (Peru) does not differ according to the area. However, because targeting mechanisms, the rural families are mainly focused by this programme.

[14] Amount for the year 2016, using December 30, 2016 exchange rate.
[15] Amount for the year 2015, using December 31, 2015 exchange rate.

### *Other vulnerable sectors*

There are several vulnerable sectors targeted by the CCTs, and the fact that these programmes share the objective of reducing poverty does not mean that they focus the same sectors. Programmes such as *IEF* (Chile), *Abrazo* (Paraguay) and *TUS* (Uruguay) have components targeting very specific populations. For instance, the *IEF* programme (Chile) has a monetary benefit focused on working women aged 25 to 59, this annual cash transfer tries to improve the income of women belonging to the 40% most vulnerable of the population. This same CCT programme also considers homeless people to obtain a benefit. Instead, the *Abrazo* programme (Paraguay) is specifically focused on child labor. Even, there is a programme such as *TUS* (Uruguay) that has a component that addresses Trans people (transsexuals, transvestites and transgender) as a vulnerable sector.

In Colombia, programmes such as *MFA* and *RU* (Colombia) are focused on helping displaced households, indigenous families and households in poverty condition and vulnerability. In both cases, to become a beneficiary of these programmes, a displaced family must be registered in the *Unique Victim Registry* (RUV) and an indigenous family in the indigenous census. In both programmes, households receive a bimonthly cash transfer. Even, the *Tekopora* programme (Paraguay) incorporates a component focused on indigenous families in poverty condition based on the *Quality of Life Index* (ICV). The targeted indigenous families are composed of pregnant women, children from zero to fourteen years of age, adolescents from fifteen to eighteen years of age and/or disabled people.

## Final Considerations

CCTs are usually classified under the same denomination. However, there are great variations among them, regarding targeting mechanisms, target population, coverage, financing, conditionality, amount of the monetary

transfer, etc. In addition, it is complicated to classify them, due to their multiples changes every year. In this article, we have analyzed only targeting mechanisms and target population. In the first case, the most used targeting mechanism by these programmes is the proxy means test. Nowadays, there are twenty-two CCTs using this targeting mechanism. On the other hand, we identify four main target populations focused by CCTs. In order of importance: children and adolescents, pregnant women and nursing mothers, elderly, and disabled people focused by twenty-two, thirteen, nine and seven CCTs, respectively. However, there are programmes focused on very specific sectors. According to its economic, political and social situation, each country decides which vulnerable sectors should be targeted.

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