INTERNATIONAL
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INSTITUTE

FINAL REPORT

AN OPERATIONS EVALUATION
OF PROGRESA FROM THE PERSPECTIVE OF
BENEFICIARIES, PROMOTORAS, SCHOOL DIRECTORS,
AND HEALTH STAFF

Michelle Adato
David Coady
Marie Ruel

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Michelle Adato
David Coady
Marie Ruel

International Food Policy Research Institute
Food Consumption and Nutrition Division
2033 K Street, NW
Washington, D.C. 20006, USA
Tel. (202) 862-5600
Fax (202) 467-4439

August 10, 2000
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ACKNOWLEDGEMENTS

All the authors would like to thank Emmanuel Skoufias for his support. We also thank all the staff at PROGRESA for their assistance of many kinds, Ben Davis and Ashu Handa for their hospitality and assistance during our trips to Mexico, and Lourdes Hinayon for providing excellent administrative support.

David Coady has benefited substantially from the continuous cooperation and efforts of PROGRESA staff and, in particular, from the material in the background report titled “Preliminar de la Encuesta de Seguim.” He would also like to thank John Maluccio and other colleagues at IFPRI for helpful discussions, and Habiba Djebbari and Lyla Kuriyan for collaborating so effectively on earlier preliminary drafts of the operations report.

Michelle Adato would like to thank Dubravka Mindek for her assistance with fieldwork supervision, coding and write-up of the focus group work; Haydée Quiroz Malca and Dubravka Mindek for carrying out the semi-structured interviews with clinic and school directors, and for coding and writing up the interview material; and all the staff at PROGRESA who provided intellectual input, advice and logistical assistance in the course of the qualitative research, with special appreciation expressed to Daniel Hernández, Patricia Muñiz and Ana Núñez. For the focus group work she thanks Soledad Rojas and Minerva Garibaye for facilitation; GAUSCC and Luis Mejía for fieldwork logistics, Ana Núñez, Ana Ortiz and Patricia García for assistance in the field; and Rebeca Walker and Marcía Colores for providing translation. For the interview fieldwork she thanks Ben Davis, Ashu Handa, Luis Mejía, Jorge Ruiz Delgado and Eduardo Vargas Sanchez for coordinating logistics. Finally, thanks to Lyla Kuriyan and Ryan Washburn for assistance with quantitative data.

Marie Ruel wishes to thank Roshan Hussain for his help in data analysis and Celine Castillo-Macy for her administrative support.

Haydée Quiroz Malca, who teaches social anthropology at the Escuela Nacional de Antropología y Historia in Mexico City, and Dubravka Mindek, a doctoral candidate in social anthropology at the same university, worked as consultants to IFPRI in writing background documents based on interviews with clinic and school directors, which were drawn upon throughout the writing of this report. All of the authors thank them for their work, and thank Saúl Gonzálèz for translation.

This Research report is part of the PROGRESA Evaluation project of IFPRI. All authors are research fellows at IFPRI.

We, the authors of this report, and not IFPRI or PROGRESA, are responsible for all the contents of this report. Correspondence regarding this report should be sent to Michelle Adato, David Coady, or Marie Ruel, IFPRI, 2033 K Street NW, Washington DC 20006, USA: telephone: 202-862-5600; fax 202-467-4439. Their respective e-mail addresses are: m.adato@cgiar.org; d.coady@cgiar.org; and m.ruel@cgiar.org.
EXECUTIVE SUMMARY

This report focuses on the evaluation of the operational performance of PROGRESA. Essentially well conceived and designed programs, in the sense of having a good understanding of the underlying technical relationships between inputs and outputs, can fail due to poor implementation resulting in poor delivery of inputs. In order to enhance the ability of programs to achieve their objectives it is therefore essential to undertake an “operations’ evaluation” with the objective of identifying elements of the program which are experiencing operational problems. The returns to such an evaluation, in terms of improved performance, are potentially very high, especially in the context of a program as large and as complex as PROGRESA.

Both impact analysis and operations’ analysis are concerned with analysing variations in outcomes (e.g., school attendance or health visits), but whereas the former focuses on the difference in outcomes between beneficiaries and non-beneficiaries (or “control” and “treatment” groups), the latter focuses primarily on the difference in outcomes between groups of beneficiaries experiencing varying levels of operational efficiency. In this report we are concerned with this dimension of PROGRESA, i.e., with evaluating the process that delivers inputs to beneficiaries. The purpose of such an “operations’ evaluation” is to identify, early in the life of the program, any shortcomings in this process with the intention of informing corrective action. However, here we are also concerned with identifying the different channels through which the program can have an impact, the range of impacts (intended or otherwise) on the various program actors and stakeholders, as well as the various ways (anticipated or otherwise) by which these actors and stakeholders can influence program operations and outcomes. To do this we take a broad “systems approach,” which identifies a number of key actors and stakeholders. Using a variety of information-collection mechanisms (i.e., both quantitative surveys and qualitative interviews and focus groups), we identify and analyse their experiences with the aim of identifying operational problems, as well as their causes and their solutions.

Poor program implementation can reflect a variety of shortcomings, which we classify as: (i) design failure; (ii) planning failure; (iii) institutional failure; and (iv) participation failure. This classification reflects an underlying policy hierarchy which is both iterative, i.e., identification of any one failure can feedback into improved program design further up the hierarchy, and inter-related, i.e., failures lower in the hierarchy may reflect shortcomings at higher levels. Therefore, a complete evaluation of the program requires one to consider the various levels of the policy hierarchy.

It is clear from the above that in order to undertake an operations’ evaluation (i.e., to identify operational problems, their sources and provide solutions) one needs to take a broad perspective of the operational environment, which includes all the policy actors as well as other actors and stakeholders who can influence the operational performance of the program or who are affected by the program. Examining the operational performance of the program from the perspective of a single (or narrow set of) actor(s) may help to identify specific operational problems, and the results may even be suggestive of their sources and solutions. However, a more complete analysis requires analysis in other areas of (or actors and stakeholders in) the operational system.
Such a broader “systems approach” can be used to verify and interpret the problems identified by different actors and stakeholders (henceforth referred to as just “stakeholders”), and to identify the sources and solutions more precisely. The long-term sustainability of programs will also depend, in part, on whether the objectives and incentives of the various stakeholders reinforce or compete with each other.

From a policy perspective it is useful to think of three levels at which policy is formulated and implemented: national (federal); state; and local. Given time and resource constraints we decided to focus exclusively on the lowest level, i.e., the local level. This decision is also consistent with the requirement that we first identify how well various operational aspects of the program are performing. The best and most direct way to gauge this is to focus on those stakeholders who experience at first hand the outcomes of program operations (e.g., the beneficiaries themselves) as well as those who are directly involved in delivering program inputs to the beneficiaries (e.g., school teachers and health clinic staff). By analysing the expressed experiences and views of these stakeholders we can expect to be able to identify operational shortcomings and their causes. Although the insights drawn from the analysis may often be suggestive of solutions, it is likely that the development of precise solutions will require going further back through the policy hierarchy (i.e., through the state and national levels). Therefore, the objective of our evaluation is solely to determine how the program is operating and why, but we purposefully refrain from prescribing solutions. We essentially identify crucial areas of program operations where corrective action needs to be taken and where further attention needs to be devoted. What corrective action is taken, and where in the policy hierarchy it takes place, is left to policy makers themselves. But we hope that the insights provided by our evaluation will contribute to this end.

For the purposes of our evaluation we have identified four key stakeholders:

(i) **Beneficiaries**: These are the poor households in the most marginal communities in rural Mexico who benefit from the program but also must meet the conditions set by the program (e.g., ensure regular attendance at school and health clinics). The transfers are given to the mothers of children in the program, or to the female partner in childless households. It is not possible to adequately evaluate how well a program's operations is functioning without understanding how it is perceived through the eyes of the people served by it, and their own explanations of its performance.

(ii) **Promotoras**: These are beneficiaries who have been selected by their fellow beneficiaries to voluntarily serve as liaisons between themselves and PROGRESA’s personnel, providing beneficiaries with information on how the program works, when transfers will arrive, and identifying operational problems. In serving as government-community liaison, facilitator, educator and local problem solver, they are a key link in the operational process. Because they live in the beneficiary communities they are valuable key informants who have intimate knowledge of the social and economic life of beneficiaries and how these factors may influence the operations and outcomes of the program.
(iii) School directors: These are responsible for ensuring that beneficiaries achieve the required level of attendance by providing information to PROGRESA on students’ attendance records. They can help to evaluate the education supply-side of the program, which is one of the program inputs that is outside the direct control of PROGRESA. They can also serve as key informants, providing insights into community life and how not only the education component, but also the other dimensions of the program, are evolving.

(iv) Health-clinic staff: These are responsible for ensuring that beneficiaries adhere to a scheduled list of visits to the health clinics for preventive check-up and health lectures. They also disperse the food supplement to mothers of infants and malnourished children. They must monitor and provide information on this attendance to PROGRESA and can help to evaluate how the supply-side of the program is being delivered. As with school directors, they can also serve as key informants, providing insights into community life and how not only the health component, but also the other dimensions of the program, are evolving.

Although we do not identify non-beneficiaries as one of the key stakeholders for the purpose of this evaluation, we do consider them important stakeholders as they are affected by the program, and also in turn affect program outcomes in ways that are illustrated in this report. Also, their welfare has importance. They were thus included in the focus group research, and the surveys and interviews with school directors and clinic staff include questions related to non-beneficiaries.

Collecting information from the above stakeholders in the program helps us to build up a clear picture of program operations. To collect this information we decided to use a mix of both quantitative and qualitative data collection methodologies. Together it is expected that these information sources will complement each other and thus facilitate the construction of a more comprehensive and insightful evaluation aimed at identifying problems (and successes) and their causes, which also helps policy makers to decide what corrective action to take and where to take it. But we regard actions to reinforce successes to be of equal importance.

The results summarized below used a range of quantitative and qualitative data. Only a brief description is provided:

(i) Quantitative Surveys of Beneficiaries

PROGRESA began implementation in August 1997. The first large survey of beneficiaries relating to program operations was collected in October 1998 along with the ENCEL survey data (i.e., ENCEL98O) used for the analysis of program impacts. This involved a randomly selected sample of 506 localities in total, 320 of which were classified as “treatment” localities (i.e., as having received the program) and 126 as “control” localities (i.e., as not yet having received the program). The questions in the operations module of the survey were asked only of the 7237 beneficiary households in the seven states in which the sample localities were located. A similar survey was collected in June 1999. For the purposes of the present report we combine both these data sets.
(ii) Quantitative Surveys of Schools and Health Clinics

School Directors

In 1997, a total of 620 schools (528 primary and 92 secondary) were identified in the sample of localities included in the 506 localities of the evaluation, implying a ratio of about one primary school per locality and one secondary school for every 5-6 localities.

In 1997, the school director survey questionnaire was applied to a total of 427 schools from the overall pool of 620 (272 PROGRESA and 155 Control). In 1998, the questionnaire was applied to a total of 500 schools, but only 481 actually belonged to either one of the three groups of interest: 1) PROGRESA; 2) Control; or 3) Outside of study area but where some PROGRESA beneficiaries go. In 1999, the total number of schools surveyed from these same three community types was 439. Note that the sample size of secondary schools is rather small in all three surveys, especially among the control communities.

Health Centers

A survey of 317 health centers (175 from the Servicios Estatales de Salud and 142 from IMSS Solidaridad) from the 7 states of the overall evaluation of PROGRESA was carried out in 1999. The main respondent was the doctor or other staff member in charge of the health center. The purpose of the survey was to collect information on the overall conditions of the health centers, and the resources, supplies and equipment available. Information was also collected on the types of services offered, hours of operation, coverage and number of patients attended per day. The survey also included various questions about perceptions and opinions about the impact of PROGRESA on the demand for health services, both curative and preventive, about problems with the use of the forms and reporting system for PROGRESA, about the availability and distribution of the nutritional supplement, and about the health and education talks (pláticas).

(iii) Qualitative, Semi-Structured Interviews With School and Health-Clinic Directors

In order to get a more comprehensive picture of program operations we designed a series of qualitative, semi-structured interviews with school directors and health clinic directors, who are also doctors. The purpose was primarily to gain information on operations related specifically to the education and health components of the program. However, because school directors and doctors provide are ‘outsiders’ but with intimate views on community life, they also serve as valuable key informants on other issues related to program impact on communities and visa-versa.

In selecting the sample for both sets of interviews, we chose to interview 16 school directors (18 were actually interviewed) and 16 doctors in four states: Hidalgo, Querétero, Puebla, and Veracruz. These states and the regions chosen were included in the beneficiary surveys and school and clinic surveys. In selecting communities, we stratified the sample using the criteria of poor and extremely poor; and mestizo and indigenous communities. Because most of the impact of PROGRESA in the educational sphere occurs at the secondary level, we concentrated on
secondary schools. We interviewed just one director of a primary school in each state to get a sense of their perspectives.

The questions in the interview guides were developed based on research interests and new unanswered questions derived from other components of the operations evaluation beneficiary surveys, school and clinic surveys, and the focus groups. The questions and structure of the school director and doctor guides paralleled each other but were tailored for their respective institutions.

(iv) Focus Groups with Promotoras, Beneficiaries and Non-Beneficiaries

A second component of the operations evaluation qualitative fieldwork involved focus groups conducted with beneficiaries, non-beneficiaries and promotoras. This part of the research was critical to understanding the interpretations, attitudes and lived experience of people in PROGRESA communities in relation to the program, and how these in turn affect program outcomes. This could be best accomplished by allowing beneficiaries, non-beneficiaries and promotoras explain, in-depth and in their own words, how they have experienced PROGRESA.

Research questions were developed through a review of previous quantitative and qualitative research, which revealed partially answered questions in need of further investigation; and iterative meetings with PROGRESA stakeholders to reveal concerns and interests related directly and indirectly to program operations. Questions were field-tested and further revised.

The focus groups were conducted in six states. In five of these states, beneficiary localities were selected nearby the treatment communities in the ENCEL surveys, but not in these communities in order to avoid overburdening them. Promotoras participated from communities surrounding the towns near communities where the beneficiary/non-beneficiary groups were held. The one exception was Estado de México where no promotora group was held. Two of the eight communities were primarily indigenous, monolingual communities. Additional monolingual communities were represented by promotoras in these regions.

Twenty-three focus groups were conducted involving 230 participants: 80 beneficiaries, 80 non-beneficiaries and promotoras representing 70 communities from 7 regions. A group of beneficiaries and a separate group of non-beneficiaries were convened in each of 8 communities in 6 states.

Focus group facilitators used structured questionnaires so all groups were asked the same questions. Beneficiaries, non-beneficiaries and promotoras were asked parallel questions to collect views of each group on the same issues. Promotoras were asked to comment (as key informants) on the experience of women in their communities, as well as on their personal experience.

The general findings of our analyses are now summarized by chapter and subsections of the report.
CHAPTER 2 — BENEFICIARY SELECTION AND INDUCTION

PROGRESA’s process of beneficiary selection is aimed at making the best use of scarce resources by targeting households living in extreme poverty. To this end, it uses a census to gather household level data. The purpose of this method is to determine which households most need assistance, and to avoid discretionary decision-making at the local, state or national level. While people in PROGRESA communities are not intended to know how families are chosen, it is the intention of the program that they are satisfied with the outcomes. The issue of beneficiary selection emerged as a critical one in our research in PROGRESA communities. Most people know that selection involves a survey, and that PROGRESA is for poor people. However, they do not understand or agree with much of the outcome. This issue emerged as a significant source of discontent and perhaps the strongest criticism of the program from beneficiaries, non-beneficiaries, promotoras, doctors and school directors. The main criticism is that poor people are wrongly excluded because of operational failures of the census, or wrong determinations of who needs assistance and who does not.

Local Understandings of Why People are Included in or Excluded from PROGRESA: Relative Poverty, Problems with the Census, and other Explanations

Problems identified by the above stakeholders related to use of the census related to 1) inadequate implementation and 2) social and cultural barriers. In the first category the problems were that: people were not home when the enumerators came by and enumerators did not return (the main problem); enumerators did not go to remote areas where poor people live due to advice from people who did not know the area or who may have a political agenda; the person who answered did not know the household’s conditions; the enumerator could not speak the local language well enough. In the second category, the problems were that: people did not want to answer the census because they were distrustful, afraid (rumors spread about what will happen) or tired of government surveys of questionable benefit; people over-reported their resources due to shame over admitting their poverty. A better balance needs to be struck between giving sufficient information to reduce distrust, and not giving out so much information that incentives are created to overstate poverty. A better job at establishing more basis for trust might be done before entering the community using local contacts. However, taken together with administrative problems raised above, these problems that reflect local historical, social and cultural conditions may mitigate against the use of poverty targeting via a census. These issues should be weighed into a cost-benefit analysis of different forms of targeting (geographical, household, and self-targeting), paying attention to social as well as economic costs and benefits.

Other ways in which beneficiaries and non-beneficiaries explain inclusion and exclusion is that it is luck: those who were excluded had bad luck and hope they will be luckier next time. Some are told by promotoras or others that it is a lottery. Many are waiting in the hope that PROGRESA will come back and include them. In trying to understand the basis for exclusion or inclusion in PROGRESA, the most frequent response was that people do not understand how the decisions were made, and they want to know why. This uncertainty appears to instill frustration and a sense of insecurity. This, and the problems cited above with the census, highlights the importance of good communication between the program and communities. Effective communication of PROGRESA’s principles and operations are essential for ensuring that
beneficiaries comply with its requirements, but also shapes local attitudes toward the program. Ineffective communications can lead to misunderstandings and discontent that spreads to other communities through rumors. People re-interpret meanings of program features in ways that make sense to them and are affected by social and cultural phenomena that are beyond the control of the program. This makes good and persistent communications with communities all the more crucial.

Local Perceptions of the Fairness of the Selection Process

In the June 1999 survey, 45% of beneficiaries said that many families who need the benefits do not receive them, falling to 36% in November 1999, possibly as a result of “densification.” Approximately 16% said that benefits are received by families who do not need them. In the focus groups, when participants were asked whether they thought the beneficiary selection process was fair, the question generated a great deal of response across all the groups, about 10% of which said that they thought the process was fair. Beneficiaries and promotoras raised the issue of lack of fairness far more frequently than non-beneficiaries, indicating they are affected by this exclusion too. The surveys, focus groups, and interviews with doctors and school directors were consistent in their primary concern that there were many poor people who needed PROGRESA and had been wrongly excluded, and the secondary concern that there were people who received PROGRESA but did not need it. With regard to the latter concern, the focus was on professionals such as teachers, or people with cars or shops. With regard to people who need the benefits and do not get them, in addition to the problems raised with the census, the main reason that beneficiaries, non-beneficiaries, and promotoras feel that the selection is unfair is that they perceive everyone to be poor, “equal,” and in need of the benefits. Beneficiaries and non-beneficiaries feel bad when some are elevated and others are left behind.

Doctors and school directors do not think that everyone is equal but instead think that the selection is done poorly and the results are wrong. In addition, beneficiaries, non-beneficiaries, promotoras, school directors and doctors all raise the issue of tensions and divisions created in communities between beneficiaries and non-beneficiaries as a result of the program’s including some and excluding others. The ‘success’ of anti-poverty programs must also be judged by how its beneficiaries and others in poor communities evaluate it, and like the program. While all local stakeholders have strong positive feelings about its health, education and nutrition dimensions, they have strong negative feelings about beneficiary selection.

This again points to the need for a better system of communication between PROGRESA and community members and local service providers (doctors and school directors) so that people at the local level better understand the methods for selecting beneficiaries. However, if equal treatment is more important to households than relative poverty distinctions, then better communications or more accurate assessments may not sufficient. Although by economic criteria the targeting system may be performing well, the unmeasured social costs are high. Once again, the program should weigh these social costs in a reassessment of its targeting system.

Regarding the issue of political influence, very few comments in the focus groups indicated that people believe the selection is influenced by a local individual such as a local official. However, some promotoras expressed concern that they were blamed, and a number of school directors
said that beneficiaries and non-beneficiaries attacked the teachers, holding them responsible for the selection. Doctors and school directors made the point that the selection should be made or reviewed by local people who knew the communities well and could make sure that the enumerators did not miss areas and that the final list was fair. However, this kind of guidance would have to be approached carefully so as to avoid political influence. Some school directors said that municipal officials influence the process for political ends by guiding where the enumerators go and through other means. This may be a real concern in some areas, but the extent of their concern about municipal influence indicated a lack of information on the part of school directors about how the selection process works.

Program Induction: Community Participation

Early PROGRESA policy envisioned community participation in reviewing the beneficiary list for fairness through the establishment of a system of social comptrollership. The induction assembly was to be an opportunity for claims to be registered concerning both households who it is thought should have been selected to participate but were not, and those who were but should not have been. These claims are to be investigated by PROGRESA and a decision made to add or drop families. From the focus groups and key informant interviews (school directors and doctors), we found no examples of assemblies were being used for this purpose. Non-beneficiaries did not attend, making it less likely that the assemblies would be used for seeking changes to the list, particularly since beneficiaries and non-beneficiaries do not know that this is supposed to be one of the functions of the assembly. Another reason to invite non-beneficiaries to the assembly is so that they understand the principles of the program and why they are not included, which might help to defuse some of the reported tensions.

The rights of communities to review and challenge the selection of beneficiaries is stated by PROGRESA, so practice should be squared with policy. PROGRESA should thus reintroduce this function of the assembly, if this is the best place available for communities to comment on the list and organize a petition. Given the problems identified in this report regarding the potential for mistakes to be made through use of a census, some type of systematic and reliable mechanism for reviewing and revising results is needed. We did find cases where communities had submitted petitions, either without success or they were awaiting an answer. Promotoras who addressed this issue said it was not possible to change the list. A further research effort should attempt to determine the extent to which petitions are being submitted in communities with complaints, and the outcomes. Given the extent of the belief among stakeholders at the local level (beneficiaries, non-beneficiaries, promotoras, doctors and school directors) that there are mistakes and fairness problems, it would be important to 1) revisit ideas for effective community participation; 2) consider geographic or self-targeting rather than household level targeting.

Program Induction: Information Provision

It appears the aspects of program induction covered by the quantitative survey, specifically receiving the booklet and explanation of its contents, is performing quite well in spite of concerns regarding its effectiveness. The are very few problems in relation to receipt of the induction booklet which contains information on the operation of the program and beneficiaries’
responsibilities, and the few that exist seem to be highly concentrated by locality. Similarly, virtually all beneficiaries report having had the booklet either read or explained to them, or both. Those households that do not seem to be spread relatively evenly across localities and states. This pattern manifests itself through most beneficiaries having “adequate” knowledge of the program requirements with no evidence of any outlying states in this regard. However, the fact that the level of “excellent” knowledge is relatively low suggests room for improvement. In this regard, reading and explaining program requirements at induction seems to have had a high return in terms of knowledge. Just handing out the information booklets is not enough. Also, the increase between the surveys in the percentage of households exhibiting excellent knowledge for each component surveys suggests the presence of some learning by doing and diffusion of information. The structure of the program induction thus seems to be important in ensuring beneficiaries know what is required from them to be eligible for receipt of benefits.

CHAPTER 3 — EDUCATION COMPONENT

Enrollment, Registration, and Forms

From the quantitative surveys of beneficiaries, we find that the distribution of the E1 forms required by the household to register at school as a PROGRESA beneficiary has worked well. As one would expect, the percentage of households reporting that they did not receive the E1 form has decreased over time from 6.2% to 3.6%. This mainly reflects a relatively big improvement in Querétero where the percentage not receiving the form decreased from 17% to 6.4%. All states exhibited an improvement over time, an important trend since non-receipt may have important consequences for the observed impact of the program, e.g., both in terms of schooling outcomes or receipt of cash transfers. Few report problems when registering and these also appear to be concentrated in a few localities in each state.

The non-receipt of the registration form is associated with a lower average enrollment rate of nearly 6.4 percentage points. But this average hides substantial variation across age groups. Non-receipt of the form does not appear to be associated with lower enrolment rates for primary school children in 1998, but is associated with a lower enrolment of 7.1 percentage points in 1999. Over both surveys, non-receipt of the form is associated with substantially lower enrolments, at between 27-34 percentage points, for secondary school children. However, given the low proportion of households not receiving the form, one can conclude that the resulting operational failure is relatively small: ensuring everyone receives the form would increase the average enrolment rate by no more than 1.7 percentage points.

So the program appears to have had a substantial impact on enrollment rates, especially in secondary schools. The results from the quantitative survey of school directors also verify that enrollment impacts have been especially large in secondary schools, sufficiently so that teachers are now even more concerned about space and resource constraints and education quality. Directors identified the introduction of PROGRESA as the main reason for this increase. The results from the qualitative survey of directors attribute the large increase in enrollment more to increased continuation rates and less to the decrease in dropout rates. In some cases this increase has enabled some schools to survive where previously they may have closed due to inadequate demand. There is some evidence that the initial decrease in dropout rates later reversed as
students primarily motivated by the transfers (as opposed to the benefits of further education) failed to keep up and thus decided to discontinue in spite of losing the transfers, or because the benefits of working, particularly involving migration, were perceived to be greater than staying in school, despite the transfer. This was probably more true of older children.

As expected, we also find (in 1999) that those not registering their children at school have a very low probability of receiving the scholarship. In all, 26% of the beneficiaries report not receiving the scholarship, either because they were ineligible or it was never delivered. This has obvious implications for the actual impact of the program on poverty alleviation and on consumption and nutrition impacts. Non-receipt was noticeably higher in one of the states at 39%. It is important to get a deeper understanding of this phenomenon and it is hoped that in a later report we can to analyse the cash transfer data recently made available by PROGRESA to shed light on these findings. Also, only 60% report receiving school supplies, this being 34 percentage points lower for those not receiving the registration form. Those not wanting the form or not taking it to school also have a 36% and 12 percentage point lower probability of receiving these supplies.

**Attendance**

We do not find any strong evidence of an adverse impact of non-receipt of the relevant forms by beneficiaries on attendance levels (conditional on enrolment), but these levels increase over the surveys from an average of 0.76 days per month in 1998 to 2.14 days in 1999, possibly reflecting seasonal differences since the 1999 survey was in June and the 1998 one was in November. We do find, however, some evidence in 1998 that those not receiving the form have 3.4% and 7.4 percentage points lower probabilities of reaching “adequate attendance levels” for primary and secondary school children respectively. No impact was found in 1999, but it was noticeable that attainment of adequate attendance seems exceptionally low in some states, particularly Guerrero where only 45% reached the required attendance levels. This problem thus seems to have its origin in a design failure rather than an operational failure, i.e., income opportunities for children may be much higher in certain seasons so that larger grants would be required to persuade parents to keep their children in school. Attainment of adequate attendance was much higher in the earlier survey, possibly reflecting such seasonal patterns. The small impact on attendance relative to enrolment may reflect the initial high attendance levels: essentially students who decide to enrol generally attain adequate attendance levels. Consistent with this, the program seems to have had a greater impact on attendance levels in localities where initial levels were relatively low.

The quantitative survey of school directors supports the above view regarding high initial attendance levels with some program impact in reducing absenteeism. The qualitative interviews with school directors attributes the decreased absenteeism to the conditioning of transfers and the strict monitoring of absences. They also highlight the fact that the requirement to regularly fill out attendance forms puts pressure on finances and time resources since, at least initially, directors seem to have had to travel long distances to pick up the forms at their own expense. The decision to send the forms directly to schools may have helped in this regard, but some directors still see it as a problem. This is not helped by the perceived tightness of the deadlines for filling out forms, especially as they seem to arrive insufficiently in advance. But the forms themselves are easy to fill out and have been simplified with this in mind over time, e.g.,
teachers now only have to report the absences of students not achieving the necessary attendance levels rather than the attendance of all students. However, school directors complained that they were not informed properly about the operational details of, and motivations for, the program so that much had to be learned by a costly process of trial and error.

Our concerns about the willingness of teachers to monitor and report absences truthfully and consistently (e.g., due to social pressures or to understandable concerns for the consequences for very poor households) have been somewhat allayed by the responses of teachers, although we must emphasise that this issue requires continued and further analysis. It appears that a combination of the commitment of teachers to the educational goals of the program, the monitoring of the process by children and parents who actually meet the attendance conditions, and external monitoring by education departments, may be sufficient to ensure truthful and consistent monitoring. The exact (or potential) role of parent committees is unclear, but this could be a useful avenue through which to reinforce this monitoring process (e.g., by requiring the parents committee to validate attendances and absences). Any deviations from the strict application of the conditions that occur seem to reflect a recognition of the severe economic plight of some families, but it also seems that efforts are made to keep such departures to a minimum.

Supply

Analysis of the beneficiary surveys suggests that, on the supply side, the increased demands generated by the program has at least not led to a degeneration in the quality of education services suggesting that resources have been increased. In many cases, there seems to have been an improvement. This view is also consistent with evidence from the quantitative survey of directors, with most schools reporting some improvements in infrastructure and other resources, albeit from a poor initial position. It is clear from the qualitative interviews that the process of acquiring extra resources is time and resource intensive for teachers and school directors. But some teachers still complain that they lack such basic resources as televisions for telescendaries. It will be interesting to compare this picture of the supply side with other data sources. Although most directors in the qualitative interviews report improvements in education outcomes, they attribute most of this to improved attendance, student interest and nutrition, rather than improvements in the supply side.

Attitudes Towards Education and Program

Both the quantitative analysis of the school directors’ survey and the qualitative analysis of the focus group interviews support the general perception that PROGRESA has led to improvements in the attitude of beneficiary students and their families towards education. The program is viewed as allowing those parents and children who were always motivated to acquire education, but who faced severe economic hardship thus being unable to incur travel and other educational expenses and needing any income that children could contribute, to continue to send their children to school. The fact that lack of resources (or poverty) seems to be a major factor in explaining non-attendance at school, especially for older children, is consistent with the program design and initial estimates of program impact (Schultz, 2000) since the education subsidy (or scholarship) seems to have been effective in increasing demand. New evidence (Coady, Parker,
and Hernandez 2000) also suggests that the medium- to long-term impact of the program on human capital is in terms of increasing continuation rates (i.e., decreasing drop-out rates) as opposed to increasing return rates for those who had already dropped out.

Particularly from the focus-group analysis, there is evidence that families place a strong emphasis on school attendance and homework and that, where possible, parents attempt to adjust to these demands if children attend school. This was seen to be an acceptable trade-off, with others in the family willingly substituting for school-going children’s time especially during the week. But children, in general, appear to have to continue to contribute to household chores, especially at the weekend and during the peak agricultural season. For some children, possibly those from the poorest families or those who have long distances to travel to secondary school, the balancing of the demands of school and work are very demanding.

But children’s lack of interest in school is also an important factor in explaining non-attendance at school, especially for older children, although this appears to be at least in part indirectly motivated by poverty and the desire of older children to contribute to the family, and the lure of migration which is seen as “progress.” In the case of older female children, concern for their safety when they have to travel long distances is also an issue.

One of the common complaints in the qualitative interviews with school directors was that teachers were never consulted about the objectives and design of the program nor informed how it would function. In particular, many could not understand why some “deserving” students were excluded, why some who need it do not receive it, and why they could not have had a role in the selection of beneficiaries. Also, parents often blame teachers for their children not being included, for delays in transfers or for their child not receiving transfers due to poor attendance. Non-beneficiaries in some communities are reluctant to contribute towards school resources arguing that beneficiary families should be relied upon more. They also argue that the demands on them for school supplies should be less than for non-beneficiaries. Finally in some cases the school directors point out that the increase in demand has brought in some students from remote areas who were given poor quality education and thus require more input from teachers.

In the qualitative interviews with teachers we asked them for their overall view of the program. Their answers suggested that, on the whole, teachers saw the program as being beneficial for the communities and were in favour of greater participation. They invariably agreed with the objectives of the program as well as the conditioning of transfers. Some even suggested attaching extra conditions such as linking scholarships to academic performance. Most were in favour of money transfers, although concern for how households spent their money were behind some suggestions that food or education coupons be introduced. The general perception was that the supply side was not sufficient to deal with the increase in demand, although better attendance and attitudes to schooling made teaching easier and more rewarding. Also some schools that would have shut down due to insufficient demand could now remain open. While in some cases the promotoras were viewed as an asset to the school, in others there seemed to be some friction possibly because of her perceived “interference” in educational matters.
CHAPTER 4 — HEALTH AND NUTRITION

The health and nutrition component includes the following inter-related sub-components:

(i) A basic package of primary health-care services;
(ii) Education and training for families and communities;
(iii) Improved supply of health services (including annual refresher courses for doctors and nurses; and
(iv) Nutrition supplements for mothers and young children.

In order to receive their benefits, families have to comply with a set of requirements, which includes attending a series of regular visits to the health center for check ups and preventive care, and regular attendance at health and nutrition talks. A specific schedule of appointments is set up at the health center for the different members of each beneficiary household. While the general focus is on improving the health and nutritional status of all household members, special emphasis is placed on the welfare of mothers and children.

Registration and Forms

The quantitative survey indicates that there has generally been an increase in registration rates over time, from 89% to 97%, reflecting mainly an increase in states with previously low rates, namely Querétaro (66% to 93%) and Guerrero (80% to 94%). Surprisingly, although 47% report that their locality is visited by a mobile health unit (MHU), only 10% report being registered at such a facility. It is not clear whether this reflects a registration process or a perception of low quality or unreliability of mobile units. Access to a MHU is associated with 4.6% points higher registration rates, suggesting that distance may explain a lot of the non-registration that remains. Earlier problems regarding receipt of appointment booklets (especially in Querétero) seem to have become much less acute, although the problem still exists in some places.

The survey of health centers and interviews with doctors, (the quantitative and qualitative research), confirm that doctors do not see major problems with receiving and filling out the forms for the registration and reporting of PROGRESA beneficiaries (S1 and S2) and the appointment booklets. Doctors did indicate, however, that there used to be problems with the S2 forms in the past, but that they have been largely resolved now that PROGRESA sends a supply for one year and that the forms have been simplified.

Compliance of Beneficiaries with Scheduled Visits

The findings of the quantitative survey of beneficiaries confirm that possession of an appointment booklet is an important operational factor for beneficiaries’ compliance to their scheduled appointments. Beneficiaries without the booklet are substantially more likely to report not being seen at an appointed day, not being available on the appointed day, not finding the appointment convenient, and more likely not to make their required monthly trip to the health clinic. The improved availability of booklets is thus expected to have led to improvements in all these aspects. The program also appears to have had an important impact in terms of getting
those who previously did not bring their infants for measuring and weighing (growth monitoring) to the clinic to do so. Being registered at the clinic is also associated with greater probability of attending the growth monitoring sessions. In contrast to the above, possession of an appointment booklet is not in general associated with higher vaccination rates, but these are generally high to start with and vary very little by place of registration. In fact, only for tuberculosis do those not registered have lower vaccination rates. This may reflect the effectiveness of vaccination campaigns, which are often well advertised and involve fewer visits than participation in growth monitoring.

The interviews with doctors indicate some problems with the control of beneficiary compliance with the required visits. One problem relates to discrepancies between the actual compliance of families and the receipt of their benefits. Doctors report situations where beneficiaries attend all their visits and do not receive their benefits, as well as instances where beneficiaries do not comply and do not have their benefits cut. In general, however, the majority of doctors say that they have not come across problems with beneficiaries’ compliance that would have forced them to exclude them from the program. They do mention that they have to be flexible though, changing appointments when necessary and having a system in place to remind beneficiaries of their appointments and of the importance of complying with PROGRESA requirements. Promotoras are an important help in this respect. Doctors are also unanimous in saying that it is fair to exclude families who do not comply with the rules out of disinterest and they would do it if necessary, irrespective of whether the family is a relative or a friend. However, if families have problems with compliance, but show interest and are making the effort to attend, they consider that they have to be flexible because of the poor conditions in which people in their communities live.

Impact of PROGRESA on Clinic Attendance and the Demand for Health Services

There is no doubt that the objective of PROGRESA of increasing the coverage of health services, particularly preventive services, has been met. There is also a general consensus that this is largely due to the requirements of PROGRESA that beneficiaries attend a pre-determined number of visits in order to maintain their eligibility in the program. Doctors appear satisfied by this increase, especially with respect to the increased use of preventive health services. They are also optimistic about the apparent positive changes brought about by PROGRESA in the population’s general attitude and awareness towards preventive health care. Doctors do not generally complain about the resulting increase in work load, except for the increase in administrative work. There is, however, a certain concern that the increase in demand stretches the already scarce resources, especially relative to medicines and personnel.

Nutrition and Health Education

All four research methods used in our study concur in showing that the health education is both widely available and very popular among beneficiaries, promotoras and health professionals. The different research methods also bring up many of the same issues, positive or negative. For example, the focus groups with promotoras, beneficiaries and non-beneficiaries identified a potential problem with promotoras being asked to give the pláticas, and feeling that they were not necessarily qualified to do so. The health centers survey confirms that the pláticas are given
by a wide variety of people, including people with minimal training and even possibly limited formal education such as the primary health care technicians (14% of the clinics) and community workers or assistants (20% of the clinics). Another point raised in both qualitative studies (interviews with doctors and focus groups with promotoras, beneficiaries and non-beneficiaries) is the problem of male doctors giving lectures on the pap smear test or on family planning. This seems to be a well-understood issue at the level of the health staff and some clinics have already taken measures to have these themes discussed by female staff members. In some cases, however, it appears to fall on the promotoras, who do not necessarily feel (and are not) qualified for this assignment. There is also some consistency in the point about the lack of participation of non-beneficiaries, which is said to vary significantly between communities. The focus groups reveal a highly positive attitude from the population towards the pláticas, in spite of the fact that it may be time consuming for mothers and other family members to attend. As indicated by the quotes, mothers and promotoras also seem to have learned a lot of information from the pláticas, especially in the much needed areas of hygiene, disease prevention, and early detection and treatment of illnesses. Finally, the focus group participants and doctors strongly agree on the importance of health education for men, which would help men in a variety of ways but also make women’s lives easier and enable women to put into practice what they learn through the pláticas (e.g., family planning, the importance of health care for the entire family).

The Supply and Quality of Health Services

There is some evidence from the various data sources that the quality of health services and the supply (of personnel in some cases) has improved, at least to some extent as a result of PROGRESA. The focus groups with beneficiaries, non-beneficiaries and promotoras, however, reveal that there are still many unresolved problems with the quality of the attention provided by the health staff in some clinics, as well as with the cost of the services and availability and cost of medicines and with the convenience of the services. Some delicate cultural issues also still need to be addressed with more caution, especially the detection of cervical cancer with the pap smear test and the family planning discussions. The quantitative survey of beneficiaries also suggests that more than 50% of the beneficiaries report improvements since PROGRESA started in various aspects of the health services, such as the disposition and attention of the staff, the availability and cost of medicines, the waiting time and the cost of services. To remain on the positive side, up to 98% of the beneficiaries reported no deterioration in any of these aspects since PROGRESA started.

From the point of view of doctors, resources and supplies have not paralleled the increases in demand for health services. Although some significant increases in staff were observed in some communities, they seem to be more the exception than the rule and doctors feel that more resources are needed to meet the growing demand for health services.

Nutritional Supplements

From the evidence provided by the quantitative beneficiary survey, it seems that the distribution and intake of nutritional supplement by the targeted group might be the most serious operational problem of the health component of PROGRESA. Although the type of data provided in this survey generate only indirect estimates of the potential deficits in supplement intake of the targeted groups, they do strongly suggest that the targeted infants and young children probably
receive only a fraction of the nutrients that the program intends to provide them on a daily basis. This is due to a combination of two main problems. First, that many mothers appear to run out of supplement and fail to refill immediately. The reason for this is not entirely clear. A probably even more serious problem is the widely admitted sharing of the supplement within the household. This should not come as a surprise because food sharing is strongly entrenched in the Mexican culture and is basic to their hospitality principles. As noted by one doctor, families do not hesitate to offer him a glass of supplement when he visits, showing that they have no sense of guilt for non-compliance with the program rules when they share the supplement. Thus, the program should seriously consider what would be an adequate approach to make the supplement available to other household members (all preschool children in particular), so that the targeted child could still receive the amount of extra daily nutrients he/she needs from the supplement to ensure adequate growth and health.

Another problem that was revealed mainly in the interviews with doctors is the fact that families do not prepare the supplement according to the recommended recipe. One doctor even recommends diluting the supplement more than recommended in order to avoid gastrointestinal problems. The formulation of the supplement was carefully designed by a group of health professionals from Mexico, who have extensive knowledge of the nutrient requirements of young children, of the appropriate mix of nutrients they can tolerate, and of the optimal dilution of the product (Rosado et al. 2000; and Rivera et al. 2000). By increasing the amount of water, the nutrient density of the product is reduced thereby also reducing the child’s total nutrient intake. This in turn is likely to reduce the potential benefits of the supplement and its measurable impact on children’s health and nutrition.

Problems with the Nutrition and Health Component of PROGRESA

Doctors in qualitative interviews were asked to comment on their overall perception of the problems with the health and nutrition component of PROGRESA. In the quantitative health clinics survey, doctors were also asked a few specific questions about the problems they had experienced with PROGRESA beneficiaries.

The types of problems doctors reported with PROGRESA beneficiaries include the complaints about the unavailability of medicines (reported by more than one third of the doctors) and problems with beneficiaries being charged for some medicines and other services. Surprisingly, most other problems reported were related to compliance of the beneficiaries with their visits, or with the attendance at pláticas. Up to one third of the doctors actually reported the problem of beneficiaries requesting to be falsely registered as having attended all their visits when they in fact had not fully complied. This result was somewhat surprising because, the qualitative interviews with doctors (discussed earlier) suggested that attendance and request for falsification of records was not really a problem. This discrepancy may be related to the selection of clinics for the qualitative interviews (only 16 clinics from 4 states were included in this data collection), and the fact that this was truly not a problem in these communities. It may, however, indicate that doctors did not feel comfortable about elaborating on this issue in the more in-depth interview.

Other problems that were mentioned by doctors in the qualitative interviews include the scarcity of supplies and equipment, which they feel in some cases may limit the quality of the services
they offer and their impact. The problems with non-beneficiaries feeling left out of the program and refusing to participate in some communities was mentioned by some. The difficulties they have with men’s reluctance to participate in the activities of the health clinics was deplored by many doctors who feel that, not only would it be good for men to attend their check ups and the pláticas, but they would also like to take the opportunity to touch on other delicate subjects such as alcoholism and domestic violence with them. Finally, as mentioned in other sections as well, the problem of male doctors discussing issues of family planning and the preventive pap smear test to detect cervical cancer with women was reiterated.

Suggestions for Improvements of the Health Component and Other Aspects of PROGRESA

With regard to the requirements of the program, doctors made no suggestions to reduce the number of visits or any of the other requirements related to attendance at health clinics. On the contrary, they believe that the requirements simply conform with the basic package of primary health care that all the population should receive. They even go as far as saying that they would like to receive some judiciary help to force the population to comply with some of the requirements to improve sanitation in the communities, such as building latrines. They also recommend that beneficiaries of PROGRESA should be obliged to attend literacy classes if they are illiterate. Doctors really appreciate the work of the promotoras, but they suggest that it would be useful if they were better trained and received more accurate and timely information about the program. Doctors also had some suggestions about how to improve the control of attendance, and the importance of trying to avoid errors in the forms so that beneficiaries do not lose their benefits when they have complied, because this tends to demoralize them.

Two other aspects of the program were discussed by the doctors: 1) the money transfers; and 2) the beneficiary selection. Various doctors expressed that providing cash transfers to the population is a bad idea. They strongly recommend that food baskets be provided to avoid beneficiaries making inappropriate use of the money that they receive or to reduce the possibility of problems with the husbands who use the money for alcohol. Finally, the beneficiary selection process is criticized by many of the doctors who feel that in a lot of their communities there are many families who receive the benefits and do not need them, whereas other extremely poor families have been excluded from the program for unclear reasons. Doctors also consider that the process of selection has a negative effect on the interaction between families within communities.

CHAPTER 5 — OTHER ISSUES

The Community Promotora

Every PROGRESA community has a community outreach worker called the promotora, a beneficiary chosen by other beneficiary families to work on a voluntary basis as the liaison between beneficiaries and PROGRESA. In serving as government-community liaison, facilitator, educator and problem solver, they are a key link in the operational process. The overall findings of the research with beneficiaries, doctors and teachers indicate that the promotoras are very useful and important, that they are meeting their main responsibilities, and that the promotora system is generally working well, with some locale-specific exceptions.
Contact with Beneficiaries and Frequency of Meetings

Almost all beneficiaries reported that they knew the *promotora*. In all three surveys, over 75% of beneficiaries said they met the *promotora* at least once a month, indicating that this feature of the program is working as intended. We found the lower frequency of meetings being associated with meeting at the *promotora*’s place, so meetings held at community venues may be more conducive to greater contact. There is variation in frequency of meeting across states with room for improvement in Guerrero and San Luis.

Functions of the *Promotora*

The most common type of information received from the *promotora* concerned the date of receiving benefits followed by information on how the program works and program requirements. A number of beneficiaries said they received information on composition of transfers. Almost all beneficiaries turn to the *promotora* with questions about the program with a small group saying they ask doctors (probably related to health issues). They could be more helpful to beneficiaries if they were able to provide additional types of information, for example, on the composition of their transfers. Increasing the types of issues they could assist with would involve additional training.

In addition to providing information related to the program, women in the focus groups said that *promotora* meetings are sometimes used as a forum for women to talk to each other, where they learn to speak more, share problems and offer each other solutions. Although only about a quarter of beneficiaries surveyed report meetings being used in this way, very good feedback from women where this does take place suggests that *promotoras* could be encouraged in their training to facilitate the use of monthly meetings in this way.

Beneficiary attitudes toward *promotoras* present an overwhelming picture of the *promotoras* system fulfilling a crucial role and doing so effectively. This does, however, raise potential concerns about the impact of the initial intention to rotate *promotoras* and the consequent loss in terms of capacity building. This issue has not been ignored by program officials, since it appears that the term of office of *promotoras* is to be extended.

Doctors are also very positive about the *promotoras*, who facilitate beneficiary participation in the health services and *faenas*, and keep doctors informed of the problems of beneficiary families. School directors report less contact with *promotoras*, though some say that *promotoras* help in answering their questions and also organize beneficiaries for *faenas*. Some tensions were reported where *promotoras* have attempted to monitor school attendance by children and, in some cases, teachers. This suggests the need for clarifying to *promotoras*, teachers and school directors their respective roles and responsibilities with regard to beneficiary children’s attendance.

Contributions to Promotoras

Nearly 37% (40%) of beneficiaries in the June 1999 (October 1998) survey report being asked to contribute at meetings or to the *promotora*’s activities, this being highest in San Luis and
Guerrero. It is not clear whether this is good or bad: presumably whether the contribution is voluntary or not, or in payment for expenses incurred, is important. The most common contribution was the payment of either a monetary or in-kind entrance fee, but other payments to the promotora and helping the promotora with tasks was also important. There is some evidence that this is more likely to occur when meetings are held using community facilities. In the June 1999 survey some beneficiaries said they are being forced to pay. There are, however, indirect ways in which beneficiaries are compelled to pay where they may or may not want to, as seen in the qualitative research. Some beneficiaries say they do not mind contributing to the promotoras expenses. In the focus groups and interviews with school directors, the main reason promotoras charge appears to be that they have transportation and other expenses that are not covered by PROGRESA, probably because these are not part of their regular expected responsibilities; for example, trips to the municipality related to miscellaneous paperwork or delivering forms for the teacher. They usually charge a few pesos per beneficiary. It is not clear to what extent they may be charging for trips that are covered by PROGRESA. Since the program is supposed to cover promotoras’ necessary transportation expenses, PROGRESA operations should investigate the claims of promotoras that they incur expenses that are not covered. Although efforts should be made to prevent promotoras from charging for transportation where that is already paid, they may have other expenses that need to be covered.

Pressure from the Community

As members of communities and the representatives of a program that brings benefits and problems, promotoras are vulnerable to social pressure and have to absorb the frustrations of people in their communities. As the link between PROGRESA and beneficiaries, promotoras face pressure from beneficiaries when things do not go as expected, for example if transfers are late or are less than expected. They are also sometimes held responsible for non-beneficiary exclusion from the program. Promotoras thus ask that PROGRESA put more effort into explaining to beneficiaries the reasons for these problems and that promotoras are not responsible in these areas. From an operational standpoint, this underscores the importance of clear communication with beneficiaries regarding how PROGRESA works and relative roles and responsibilities.

Promotora Training

Although promotoras are well trained enough to receive very good evaluations from beneficiaries and doctors in terms of how they perform their jobs, promotoras and doctors both say that promotoras need more training then they currently receive. PROGRESA is demanding in terms of the complexities of beneficiary rights and responsibilities, as well as the human and social issues confronted in the course of doing community work. Promotoras in some areas exhibit a lack of understanding of how the program works, and are unable to explain some things to beneficiaries, such as reasons for delayed or deducted payments, or why non-beneficiaries are not in the program. Doctors imply that promotoras do not have sufficient information about the program, and stress that it is important that they receive updated information in a timely manner. Promotoras and doctors propose that promotoras receive more health training, and skills training to help them to deal better with people. Additional health training could be helpful in enabling promotoras to answer questions that beneficiaries have related to what they learn in the pláticas,
but they should not be giving *pláticas*, as this is not their responsibility. The short period of training currently given to *promotoras* appears to be insufficient. Finally, trainers need to use forms of pedagogy that encourages more participation and ensures that *promotoras* have absorbed the material.

**Faenas**

The vast majority of PROGRESA and poor non-PROGRESA communities have *faenas* and most people in the community are said to participate. *Faenas* are not part of PROGRESA operations and are not formally associated with the program. Although the survey data suggest that PROGRESA has not increased the number of *faenas* or women-only (i.e., PROGRESA beneficiary) *faenas*, many of the focus groups and interviews with doctors indicates ways in which *faenas* and the program are being associated, as a means of getting people to participate in communal work. Doctors and teachers both mention that *promotoras* are helpful in organizing participation in the *faenas*. Although this form of reciprocity was not intended by PROGRESA, the opinion of the doctors is that there are good reasons for requiring these obligations.

There are positive and negative dimensions to *faenas*, as well as to their association with PROGRESA. *Faenas* produce important physical and social benefits in communities. Doctors are particularly strong advocates of *faenas* because of the role they play in promoting hygiene and other dimensions of well-being. However, they also increase time and energy demands on people. Also, in some communities non-beneficiaries will not participate in *faenas* because they do not get PROGRESA benefits. In other communities, non-beneficiaries do participate either because the work is not associated with PROGRESA, they are convinced that they should work anyway, or because they hope that by participating they will get included in the program.

The list of environmental, health, aesthetic, and social benefits that doctors believe are derived from *faenas* should be taken into consideration along with the drawbacks, in PROGRESA’s decision to either try to discourage this practice or allow it to continue at the discretion of the doctor, school director or *promotora*. If the policy remains that PROGRESA should not be associated with these activities in any way, this needs to be restated and explained at the community level. Linking participation in *faenas* to PROGRESA benefits may also be a good way of introducing elements of self-targeting to the program, and for reinforcing the responsibilities of beneficiaries.

**CHAPTER 6—SUMMARY OF FINDINGS AND IMPLICATIONS FOR PROGRAM IMPACT AND POLICY**

The key findings regarding the operational performance of the program, as presented above in the summaries of the program components, are gathered together in a matrix so as to identify potential implications for program impacts and alternative policy issues. This matrix is presented below.
## ES1 — Summary of Key Findings and Implications for Program Impact and Policy

### A. Program Induction and Beneficiary Selection

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<th>Key Findings</th>
<th>Implications For Program Impact</th>
<th>Implications For Policy</th>
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<td>(1) Local understandings and assessments of the selection process: The issue of beneficiary selection emerged as a significant source of dissatisfaction and perhaps the strongest criticism of the program from beneficiaries, non-beneficiaries, promotoras, doctors and school directors. The main problem raised is that poor people are wrongly excluded because of operational failures of the census, or wrong determinations of who needs assistance and who does not.</td>
<td>Same as (2-5) below.</td>
<td>Same as (2-5) below.</td>
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<td>(2) Administrative problems with the census: (a) people were absent from their homes at time of census and enumerators not returning; (b) enumerators were not advised to go to remote areas where clusters of extreme poor live, due to advice from people who do not know the area well enough or who may have a political agenda; (c) enumerators survey a person who does not know the household’s conditions; and (d) enumerators cannot communicate well enough in the local language</td>
<td>Extreme poor and poor who should be included in the program may be missed, reducing the program’s targeting effectiveness and poverty reduction impacts.</td>
<td>It is important that the program ensures sufficient training, monitoring and control of enumerators and enumeration process, so that they make the required number of return visits; do not allow people who do not know household conditions to answer the survey; and can communicate well in the appropriate language. It may be possible to develop a more effective system of return visits. It is also important to disseminate a more systematic approach to obtaining good local advisors to map out area to be enumerated, while avoiding political influence.</td>
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<td>(3) Socio-cultural issues in use of the census: Some people do not answer the census or give incorrect information due to: (a) distrust of unknown intent of the survey; (b) rumors spread about consequences of giving information; (c) fatigue from surveys of questionable benefit; and (d) shame to admit their poverty.</td>
<td>Same as (2) above.</td>
<td>It would be beneficial to clarify policy as to what information the enumerator can reveal to family about the intention of the survey. A better balance could be struck between giving sufficient information to reduce distrust, and not giving out so much information that incentives are created to overstate poverty. A better job at establishing more basis for trust might also be done before entering the community using local contacts, e.g., community leaders. However, taken together with administrative problems raised above, these problems that reflect local historical, social and cultural conditions may mitigate against the use of poverty targeting via a</td>
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### Key Findings

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<th>(4) Other local explanations of selection: Other ways in which selection is understood is that those excluded had bad luck, or that it is a lottery. However, the most frequent response was that people do not understand how the selection was made, and they want to know why. This uncertainty appears to instill frustration and a sense of insecurity.</th>
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<td>(5) Community perceptions of the accuracy and fairness of the beneficiary selection system: Community-level stakeholders (beneficiaries, non-beneficiaries, doctors, school directors) report that there is a large problem of poor people who should be included in the program and are not; and a smaller problem of non-poor people included who should not be. They do not understand how the list is determined and do not see the system as fair, either because of mistakes in the outcomes or their belief that everyone is poor and need the assistance. Beneficiaries and non-beneficiaries feel bad about this differentiation, and there are also reports of new social tensions.</td>
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<td>(6) Perceived or actual political influence on the selection process: Relatively few people say that local officials or other individuals determined the selection of beneficiaries. There are exceptions, where <em>promotoras</em> and school directors are blamed for excluding people. Some school directors believe that local officials influenced the process.</td>
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### Implications For Program Impact

| household census. These issues should be weighed into a cost-benefit analysis of different forms of targeting (geographical, household, and self-targeting), paying attention to social as well as economic costs and benefits. |
|Same as (5) below.|
|Again as above, where targeting is inaccurate, effectiveness at reaching those most in need of benefits is reduced. Also, where people perceive that the system is unfair due to lack of understanding of the process or outcomes, this may not have an impact on poverty reduction outcomes but can have secondary negative impacts on communities, which have been expressed as frustration, powerlessness, sadness, and increased social tensions. The ‘success’ of anti-poverty programs must also be judged by how its beneficiaries and others in poor communities evaluate it, and whether they like the program. While all local stakeholders have strong positive feelings about its health, education and nutrition dimensions, they have strong negative feelings about beneficiary selection. |
|A program where local officials or other individuals are not perceived as influencing selection can instill confidence in government social programs. This impact would be greater, however, if all stakeholders understood how the program worked and were thus aware of the controls on political influence. |

### Implications For Policy

| From the consistency of comments across local stakeholders, it appears that there are inaccuracy problems that should be given serious attention. However, this also points to the need for stronger systems of communication between PROGRESA and community members and local service providers so that they have a better understanding of the selection system. However, if equal treatment is more important to households than relative poverty distinctions, then more accurate assessments or better communications may not be sufficient. Although by economic criteria the targeting system may be performing well, the unmeasured social costs are high. The program should weigh these social costs in a reassessment of its targeting system, and give serious consideration to self-targeting or geographical targeting as an alternative to household targeting. If equity and leakage remain central concerns, self-targeting should be explored. |
|Same as (5) below.|

Controlling selection at the national level rather than at state or local level is a positive program feature in this regard. However, whereas the system is working in this sense, persistent misunderstandings indicate again the importance of more effective and systematic communication with local stakeholders.
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<tr>
<td>through directing enumerators and other ways. There may be truth to this in</td>
<td>A process of community review could help to improve the accuracy of the poverty targeting,</td>
<td>Given the potential for mistakes made in use of the census and low confidence in the</td>
</tr>
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<td>some cases, but comments also indicate a lack of understanding of how the</td>
<td>resulting in better allocation of scarce resources to the poor. If carried out well, it would</td>
<td>current system at local level, it is important that the program develop a systematic and</td>
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<td>program functions.</td>
<td>also increase confidence in the selection process and improve attitudes toward the program.</td>
<td>reliable mechanism for reviewing and revising results that involves community participation;</td>
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<td>(7) Community review of the selection process: PROGRESA originally envisioned</td>
<td>Lack of such review misses both opportunities. Community review is also likely to increase the</td>
<td>possibly: a public review process in a general assembly; a ‘social comptrollership’ as</td>
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<tr>
<td>community participation in reviewing the list of beneficiaries, in the interest</td>
<td>administrative burden on the program and the potential for the introduction of politics.</td>
<td>originally proposed by PROGRESA; the involvement of local key informants who know the</td>
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<tr>
<td>of transparency and to improve accuracy of the targeting. However, this</td>
<td>However, the potential gains appear to outweigh the potential costs.</td>
<td>communities well, or some combination of the above. Doctors and school directors propose</td>
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<td>community review is not taking place. Non-beneficiaries do not attend the</td>
<td>Good knowledge of how the program operates and their responsibilities is essential to</td>
<td>that their involvement would improve the process. Involvement of local key informants</td>
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<td>assembly where petitions for adding families were envisioned to be drawn up,</td>
<td>beneficiaries’ ability to participate in the program, fulfill their responsibilities and receive</td>
<td>should be approached carefully, however, in order to avoid the discretionality that the</td>
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<td>and there is no other system for participation. Some communities submit</td>
<td>their benefits. Such knowledge is also essential to their ability to take the fullest</td>
<td>program was designed to avoid. It would be beneficial to systematically invite non-</td>
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<td>petitions later, but the response does not appear to be systematic nor often</td>
<td>advantage of the health and education opportunities presented to them and their families by</td>
<td>beneficiaries to an assembly to inform them of the right to petition, and so that they</td>
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<td>positive. The main way in which new people have been included has been</td>
<td>the program. The increase between Good knowledge of how the program operates and their</td>
<td>understand the principles of the program and why they are excluded, helping to defuse</td>
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<tr>
<td>through the second round of general incorporation.</td>
<td>responsibilities is essential to beneficiaries’ ability to participate in the program, fulfill</td>
<td>reported tensions. The petition process does not seem to be systematic and reliable and a</td>
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<tr>
<td>(8) Program induction: receiving the booklet and explanation of the material:</td>
<td>their responsibilities and receive their benefits. Such knowledge is also essential to their</td>
<td>further research effort would be valuable in attempting to understand how this system is</td>
</tr>
<tr>
<td>This part of the induction process is performing quite well. There are few</td>
<td>ability to take the fullest advantage of the health and education opportunities presented to</td>
<td>working and how it can be improved.</td>
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<tr>
<td>problems in relation to beneficiaries’ receipt of the information booklet, and</td>
<td>them and their families by the program.</td>
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<td>the few are concentrated by locality. All beneficiaries report that the</td>
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<td>booklet was read or explained to them. Most beneficiaries report “adequate”</td>
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<td>knowledge of program requirements. However, the level of reported “excellent”</td>
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<td>knowledge is relatively low. Reading and explaining program requirements at</td>
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<td>induction, rather than just handing out the booklets, seems to have had a high</td>
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<td>return in terms of knowledge. The increase between Good knowledge of how the</td>
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<td>program operates and their responsibilities is essential to beneficiaries’</td>
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<tr>
<td>ability to participate in the program, fulfill their responsibilities and receive</td>
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<td>their benefits. Such knowledge is also essential to their ability to take the</td>
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<tr>
<td>fullest advantage of the health and education opportunities presented to them</td>
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<td>and their families by the program.</td>
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<td>The program is operating very well with regard to distribution of the</td>
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<td>booklet, with no apparent changes needed in this system. Those explaining the</td>
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<td>contents are doing a good job, but PROGRESA could look into ways to improve</td>
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<td>this process further, given the relatively low number of beneficiaries who</td>
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<tr>
<td>reported excellent knowledge. Reading or explaining the contents is necessary,</td>
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<td>not just handing over the booklet. However, the effects of instruction appears</td>
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<td>to be limited in the sense that the move from adequate to excellent knowledge</td>
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<td>appears in part to come from experience in the program.</td>
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<tr>
<td>Key Findings</td>
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<td>------------------------------------------------------------------------------</td>
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<tr>
<td>surveys in the households exhibiting excellent knowledge suggests the presence of some learning by doing and diffusion of information</td>
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## B. Education

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<thead>
<tr>
<th>Key Findings</th>
<th>Implications For Program Impact</th>
<th>Implications For Policy</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) <strong>Distribution of E1 forms:</strong> There is evidence that this is working well</td>
<td>Having forms is crucial to generating education and poverty alleviation impacts. It is important</td>
<td>Enrolment impacts are near maximum attainable given program design. Any further improvements must come through improved program design, e.g. increasing</td>
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<tr>
<td>time and improved over time.</td>
<td>to ensure that forms are distributed in an efficient and timely manner prior to annual September</td>
<td>grants and/or changing structure of grants.</td>
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<td></td>
<td>enrollment.</td>
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<tr>
<td>(2) <strong>Impact on enrollment:</strong> There is evidence that the program has a</td>
<td>It is important to understand the differential impact of the program on continuation and return</td>
<td>It seems desirable to keep the program rule that only those who are less than three years out of school are eligible for transfers. But it is important</td>
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<tr>
<td>substantial impact on enrolment and that this impact is achieved through</td>
<td>rates. The decrease in the latter suggests some children come back solely for the subsidy rather</td>
<td>to have a clearer picture of which children take-up the program and how the pattern of take-up evolves over time. This has implications both for the</td>
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<tr>
<td>both increased continuation rates and return rates, but that latter</td>
<td>than the perceived educational benefits or human capital formation. But such children will</td>
<td>education and poverty impacts of the program.</td>
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<td>decreases over time. It is probably difficult to keep children with good</td>
<td>presumably automatically drop-out of school and the program overtime.</td>
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<td>opportunities in the school system.</td>
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<tr>
<td>(3) <strong>Impact on attendance:</strong> There is evidence of a positive impact on</td>
<td>Attendance is crucial to the achievement of an educational impact. In measuring attendance, it is</td>
<td>It is important to consider the possibility of conditioning the grants on grades achieved with or without maintaining the attendance requirement. It</td>
</tr>
<tr>
<td>attendance, when measured by the percentage of children attending over 85%</td>
<td>important to distinguish between attendance levels (no of days attended) and achievement of a</td>
<td>also may be important to consider the implications of the seasonal nature of work opportunities for attendance, grant levels and school calendar.</td>
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<tr>
<td>of the time, but no substantial changes in the number of days attended is</td>
<td>threshold level (85% of the time).</td>
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<td>observed. Attendance does not seem to be a major problem, but it seems</td>
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<td>somewhat low in June, possibly reflecting seasonal factors (i.e. high</td>
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<td>income opportunities at harvest).</td>
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<td>(4) <strong>Distribution of E2 forms:</strong> There is evidence that the collecting,</td>
<td>Should build-up understanding of implications of resource-intensiveness of attendance monitoring</td>
<td>Efforts should continue to be made at looking for ways of simplifying the attendance monitoring process and to monitor this process itself. Also, as</td>
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<tr>
<td>filling out, and returning of forms can involve substantial time and money</td>
<td>for delays in distribution of grants.</td>
<td>indicated above, one should consider the possibility of conditioning grants on grade attainment with or without attendance monitoring.</td>
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<tr>
<td>costs often incurred personally by school directors. The decision to send</td>
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<td>the forms directly to schools has had a very beneficial impact in this</td>
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<td>regard. There is also evidence that the combination of teachers’</td>
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<td>commitment to the educational goals of the program plus external and</td>
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<td>internal monitoring (e.g., by school boards, parents and children) ensure</td>
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<td>consistent and truthful attendance monitoring. The fact that the forms</td>
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<td>have been simplified over time helps reduce the time intensiveness of</td>
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<td>reporting.</td>
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<tr>
<td>(5) <strong>Education grants:</strong> There is evidence that suggests that delays in</td>
<td>Non-receipt or delays in transfers may have an adverse effect on poverty alleviation and on</td>
<td>It is important to verify status of transfers and to identify operational factors that may be responsible for the delay.</td>
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<tr>
<td>receipt of transfers may be</td>
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<thead>
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<tbody>
<tr>
<td>occurring. This needs to be validated using the cash transfer data recently</td>
<td>consumption and nutrition impacts. This may also affect beneficiaries’ interest in the program and motivation to participate.</td>
<td>for the delays in order to improve the process.</td>
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<td>constructed by PROGRESA.</td>
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<tr>
<td>(6) <strong>Supply side:</strong> The evidence available is consistent with the view</td>
<td>For the program to have an impact on educational achievement and human capital formation, it is not enough that enrolment and attendance rates increase. The quality of education and the resources available to schools have to be adequate for these objectives to be met. It is therefore important to monitor the changes in the supply side and to ensure that they follow changes in demand.</td>
<td>It is important to remember the importance of the supply-side and to find ways to ensure that extra resources are matched to the increase in demand.</td>
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<td>that the supply side has at least not deteriorated, and has even improved to</td>
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<td>some extent in some areas, but from a low initial level. There is also</td>
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<td>evidence that the process of acquiring new resources is very time and resource</td>
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<td>intensive for school staff. This may discourage school directors from</td>
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<td>seeking improvements and additional resources. The school directors attribute</td>
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<td>the improvements in education performance to better attendance, student</td>
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<td>interest and nutrition, as opposed to improvements in the supply side.</td>
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<tr>
<td>(7) <strong>Attitudes To education:</strong> There is some evidence that the program has</td>
<td>It is hoped that the program will continue to be effective in enabling parents to continue to send their children to school and possibly in encouraging some of those who have dropped out to return. Private costs to households may not be as high as anticipated because other household members seem able to compensate for loss of child labor.</td>
<td>It is likely that the continuation of grants is necessary for generating a sustained increase in enrolments. Also, one expects that higher grants for girls may be necessary to encourage parents to facilitate their enrolment. But it should be recognized that some children travel long distances to school and this both discourages enrolment and affects the child’s ability to study at school and do their homework.</td>
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<tr>
<td>brought positive changes in the attitudes of parents and children towards</td>
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<td>education. It seems that the demand for education was always there but that</td>
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<td>households were economically constrained. Household members appear both</td>
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<td>willing and able to undertake tasks previously undertaken by those now</td>
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<td>going to school, but children still have to help with household chores and</td>
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<td>farm work at weekend. It is difficult, however, to stop children who dislike</td>
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<td>school or see opportunities to earn income from dropping out of secondary</td>
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<td>school. Travel distance is more of a constraint for keeping girls in school</td>
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<td>than for boys.</td>
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<td>(8) <strong>Teachers’ attitudes towards program:</strong> Teachers agree with the</td>
<td>The commitment of teachers and school directors is crucial to effective implementation of the program and to ensuring that the documented impacts are real.</td>
<td>The program should seek out views of teachers towards possible ways to improve program operation and enhance impact. It should also explore the desirability of linking grants to educational performance with or without attendance requirements.</td>
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<td>objectives of the program and the conditioning of transfers on attendance.</td>
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<td>They even suggest that grants could be conditioned on academic performance.</td>
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<td>The teachers and school directors expressed concerns about the supply-side</td>
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<td>constraints and they are also unhappy about not having been consulted about</td>
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<td>the selection of beneficiaries.</td>
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C. Health

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<tbody>
<tr>
<td>(1) Registration and forms: Registration of beneficiaries at health centers has improved considerably and was reaching up to 97% in 1999. Previous problems with the receipt of appointment booklets are largely solved, and doctors report little problems with filling out the S1 and S2 forms (the latter having been simplified over time).</td>
<td>Increases in registration rates at clinics have the potential to maximize the impact of the health component of PROGRESA on beneficiaries health outcomes. Thus it is important to ensure registration.</td>
<td>It is important for the program to maintain high registration rates and appropriate supply of forms and appointment booklets to the health centers.</td>
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<tr>
<td>(2) Compliance with scheduled clinic visits: Quantitative survey of beneficiaries indicates that possession of an appointment booklet is an important operational factor for beneficiaries’ compliance to scheduled visits. PROGRESA has a positive impact on attendance of young children to growth monitoring sessions (weighing and measuring), but not to immunization. Immunization rates were already high, probably due to effective immunization campaigns, so the fact that the program has not increased immunization rates is not a major concern. Pressure from beneficiaries to falsify compliance monitoring. Doctors report that this is not a major problem. However, they indicate that they need to be very flexible and they need to motivate people and remind them to attend their visits. Doctors report that promotoras are a great help in this regard. The main constraints to compliance are lack of time, transportation problems (especially among older people), and lack of health awareness about the benefits of preventive health care. Some operational problems have been reported whereas people do not receive their benefits on time, in spite of having complied with their visits,</td>
<td>The impact of the health component is likely to be greater if appointment booklets are made available, because the booklets help beneficiaries comply with their scheduled appointments. If growth monitoring is carried out appropriately in the clinics, PROGRESA is likely to have a positive impact on children’s growth because the objective of growth monitoring is the early detection of poor growth. Our findings suggest that the program has increased participation in growth monitoring, which in turn can have a positive effect on children’s growth. If the program does not achieve its goal of increasing beneficiaries’ attendance at their scheduled preventive health care visits, it is unlikely to have an impact on the health of the population, and especially in preventing diseases. It seems that, although achieving compliance may require a lot of effort from the health staff in some cases, compliance is quite high.</td>
<td>Same as above.</td>
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Attention should be given to finding ways to assist the health staff in motivating beneficiaries to attend their scheduled visits. It is important to also work on changing people’s attitude and perceptions about the importance of preventive health care, rather than forcing them to attend in order to receive their benefits. Promotoras should continue to receive training and supervision because they play a crucial role in motivating the population and maintaining good communication between communities and health centers.

Incongruence in program management can affect the morale and motivation of beneficiaries as well as their trust and interest to participate. It is
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<tr>
<td>(3) Impact of program on clinic attendance and on the demand for health services: There is no doubt that the coverage of health services has increased as a result of PROGRESA, particularly for preventive services. There is also a consensus among the health staff that this is mainly due to the program requirements that beneficiaries attend a predetermined number of preventive visits. Doctors do not complain about the resulting increase in work load, except with respect to administrative work.</td>
<td>Increased coverage of health services is likely to have a positive impact on the population’s health and well-being, assuming that the quality of health services and the resources available are adequate. These aspects need to be monitored closely in order to understand the health impacts of the program.</td>
<td>Important for the program to avoid delays and mistakes in the allocation of benefits.</td>
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<td>(4) The supply and quality of health services: There is some evidence that the quality of health services and the supply (of personnel in some cases) has improved to some extent with PROGRESA. The general opinion, however, is that the increases in resources and supplies have not paralleled the increase in the demand for health services.</td>
<td>The concern with the increased demand for health services is that it may result in over-crowding of health services, which in turn may affect the quality of care and the amount of resources available (staff, medicines, etc.) to attend each patient. Doctors expressed their concern about this, indicating that it may affect the quality of their work as well as limit the overall impact of the program on the health of the population.</td>
<td>It is important for PROGRESA to ensure that the supply side follows the rate of increase from the demand side. The program also has to ensure that the quality of care is maintained and improved where necessary in order to maximize the overall impact of the program on health conditions.</td>
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<td>(5) Pláticas: The pláticas were found to be widely available, effective and very popular among beneficiaries, promotoras and health professionals. The main problems identified were: a) promotoras are sometimes asked to give the pláticas and they feel uncomfortable and inadequately trained to do so; b) male doctors giving talks to women about family planning and the pap smear test seems culturally unacceptable in many areas; c) the participation of non-beneficiaries varies widely, but is often low; and d) men are generally reluctant to participate.</td>
<td>Health and nutrition education is a crucial part of preventive health care. The highly positive attitude of health personnel, beneficiaries and promotoras towards the pláticas is likely to result in positive changes in attitudes and empowerment of the population. This in turn has the potential to ensure not only a positive impact of the program, but also its sustainability over time. The program should make special efforts to promote the participation of non-beneficiaries in the pláticas. This would ensure that whole communities, as opposed to only specific individuals within communities, are empowered by the process. This is particularly important for issues related to general hygiene and sanitation, as well as it is important to continue to find ways to maintain the quality of the pláticas and to ensure that the information provided is accurate and culturally acceptable. Solutions to the problem of male doctors addressing sensitive issues with women have already been found in many communities (e.g. female staff members take charge). It is important, however, that when such solutions are adopted, the program be informed and that appropriate measured be taken (such as training) to maintain the quality of services. Although promotoras and other community members should not be responsible for giving the pláticas, it would be desirable to train them better so that they can assist families with questions about</td>
<td>It is important to continue to find ways to maintain the quality of the pláticas and to ensure that the information provided is accurate and culturally acceptable. Solutions to the problem of male doctors addressing sensitive issues with women have already been found in many communities (e.g. female staff members take charge). It is important, however, that when such solutions are adopted, the program be informed and that appropriate measured be taken (such as training) to maintain the quality of services. Although promotoras and other community members should not be responsible for giving the pláticas, it would be desirable to train them better so that they can assist families with questions about</td>
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<td>the spread of infectious diseases.</td>
<td>the topics covered.</td>
<td>Since the education is so well received it is worth continuing to provide useful material and creative ideas to help the staff carry out these activities more effectively.</td>
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<td>The lack of participation of men in pláticas may slow down progress and reduce impact on health.</td>
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<td>An effort should be made to improve attendance of non-beneficiaries and men to the pláticas.</td>
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<td>(6) Nutritional supplements: Both supplements (mother and child supplements) are very popular among beneficiaries, so product acceptability is not a problem. The main problem, however, seems to be that many of the targeted beneficiaries receive only a fraction of the daily ration (and hence nutrients) they are expected to receive from the program. This is due to 3 main factors: 1) families run out of supplement and do not replace it immediately; 2) there is significant leakage of the supplement to other household members; 3) the supplement is often diluted (with water) more than recommended on the package; and 4) the supplement is widely distributed to non-beneficiaries (irrespective of whether they are malnourished or not).</td>
<td>The formulation of the supplement was carefully designed to meet the daily nutritional needs of mothers and children, respectively. If the targeted groups do not receive the intended amount of supplement on a daily basis (most nutrients do not store and need to be ingested daily), the potential impact of the supplement on nutritional status is significantly reduced, to a point where it may have no impact at all. Similarly, the use of the supplement by other household members may have a positive impact on the nutrition of these other members, but should not be expected to benefit the targeted household members.</td>
<td>The problems identified with the use of the supplement are serious and require immediate attention because they can jeopardize the impact of the program on nutrition. Potential approaches to the problems identified include: 1) Make the supplements available for all children and possibly all family members; 2) Make the supplement available to non-beneficiaries in all health centers that attend PROGRESA beneficiaries; 3) Improve training of the health staff (and promotoras) in the use (preparation and dilution) of the supplement. Inappropriate dilution can result in over- or under-concentration of nutrients, both of which are undesirable and possibly harmful. It is obvious that all three approaches proposed have cost implications that need to be assessed by the program.</td>
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<td>(7) Suggestions for improvements of the health and nutrition component and other aspects of PROGRESA:</td>
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<td>The program should seriously consider addressing the adult illiteracy problem because, as indicated by doctors, it may limit the impact of all community development efforts.</td>
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<td>Program requirements: Doctors feel that current visit requirements are not excessive. They would like to add a “literacy” requirement, e.g., that illiterate beneficiaries be requested to attend literacy classes.</td>
<td>Doctors think that current poverty and illiteracy levels limit the impact of their efforts on improvements in the well-being of communities, households and individuals.</td>
<td>The program should continue to hold regular</td>
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<td>Promotoras: Doctors feel promotoras should</td>
<td>If promotoras are misinformed about the program,</td>
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**Key Findings**

receive additional training about the program because of their crucial role (see also Table ES1D).

*Money transfers:* Doctors think the money transfers should be replaced by in-kind transfers such as food baskets, or food-for-work activities.

*Beneficiary selection:* Doctors feel the process should be more transparent, and that current selection procedures have a negative effect on community dynamics.

**Implications For Program Impact**

they may confuse beneficiaries and this in turn, may negatively affect the impact of the program.

**Implications For Policy**

training and information sessions with the *promotoras* and ensure that they are well-informed about all aspects of the program (see also Table 6D).
## The Community Promotoras and Faenas

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<th>Promotoras</th>
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<td>(1) Role of the promotora: The overall findings of the research indicate that the promotoras are very useful and important, that they are meeting their main responsibilities, and that the promotora system is generally working well. Beneficiary attitudes toward promotoras present a strong picture of the promotora system fulfilling a crucial role and doing so effectively.</td>
<td>Since promotoras serve as conveyors of program information between beneficiaries and the program, problem solver, educator and facilitator, she is a vital link in the operations chain. If the promotora system works well it is likely that beneficiaries will be able to meet their obligations and benefit from the different aspects of the program.</td>
<td>Promotoras have built-up valuable knowledge and skills that enhance their effectiveness and therefore should not be rotated after short periods so as not to lose the capacity built.</td>
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<td>(2) Information conveyed by promotoras and monthly meetings: The main information conveyed by promotoras is the date of receiving benefits, followed by information on how the program works and program requirements. Fewer beneficiaries said they received information on composition of transfers. Almost all beneficiaries turn to the promotora with questions about the program with a small group saying they ask doctors (probably related to health issues). Almost all beneficiaries report knowing the promotora, and 75% report meeting with her at least once per month. A lower frequency of meetings is associated with meeting at the promotora’s place, so meetings held at community venues may be more conducive to greater contact. These meetings are mainly for transmission of program information. However, at some meetings women talk about broader issues and problems and give good feedback on this experience.</td>
<td>The promotora conveys basic program information necessary for beneficiaries to participate in all components of the program. More information provided on composition of transfers would make beneficiaries more satisfied with the program, as beneficiaries complain to promotoras when they do not understand deductions. These regular meetings with the promotoras are important to beneficiaries’ sustained participation in the program. Also, through providing information and answering questions, she can help to reinforce what beneficiaries have learned through participation in the program, e.g., health education. Broader discussions of issues and problems at monthly meetings can provide additional non-material benefits to women.</td>
<td>Promotoras are effective at conveying basic program information. Additional training for promotoras so that they could answer beneficiary questions regarding composition of transfers would add value to their role. Monthly meetings are occurring as intended, but their importance suggests that ongoing monitoring is important to assure this practice continues. Also, it may be useful advising promotoras to hold these meetings in public venues where possible, as this might increase their frequency. Promotoras could be encouraged to allow or facilitate the use of monthly meetings for discussing issues beyond program rights and responsibilities.</td>
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<td>(3) Promotoras role in the clinics: Doctors are very positive about the promotoras, who facilitate beneficiary participation in the health services and faenas, and keep doctors informed of the problems of beneficiary families. However, doctors think that promotoras should be better trained and better informed about the program.</td>
<td>Promotoras play an important role in encouraging beneficiaries to meet conditions, facilitate their uptake of the program’s health care benefits, and help doctors to be more responsive to beneficiary problems. Given the importance of their role, the quality of their training is critical to enabling beneficiaries to take the greatest advantage of what</td>
<td>PROGRESA may want to clarify with doctors the relationship between beneficiaries and faenas and how the promotora is used in this regard (see faenas section below). More promotora training is proposed in (7) below.</td>
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### Key Findings

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<th>(4) Promotoras role in the schools:</th>
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<td>School directors report far less contact with <em>promotoras</em>, though some say that <em>promotoras</em> help in answering their questions and also organize beneficiaries for <em>faenas</em>. Some tensions were reported where <em>promotoras</em> have attempted to monitor school attendance by children and teachers.</td>
<td><em>Promotoras</em> appear to have far less impact on the program via the schools than via the clinics. This may be fine as doctors say they need this assistance while school directors do not.</td>
<td>It is advisable to clarify to <em>promotoras</em>, teachers and school directors their respective roles and responsibilities with regard to beneficiary children’s attendance. There may be other ways that <em>promotoras</em> could assist teachers with regard to the program. The program should improve its guidance on this, as school directors interviewed currently see little useful role for <em>promotoras</em>. School directors also need clarification on the relationship between beneficiaries and <em>faenas</em>.</td>
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<th>(5) Contributions to <em>promotoras</em>:</th>
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<td>Just under 40% of beneficiaries report being asked by the <em>promotora</em> to contribute at meetings or to the <em>promotora’s</em> activities, with the most common being a monetary or in-kind entrance fee, but other payments and helping the <em>promotora</em> with tasks was also reported. There is some evidence that this is more likely to occur when meetings are held using community facilities. <em>Promotoras</em> say that these fees cover her transportation costs and other miscellaneous expenses incurred in carrying out PROGRESA-related business that is not covered by the program, such as trips to the municipality related to paperwork or delivering forms for the teacher. It is not clear to what extent they may be charging for trips that are covered by PROGRESA. <em>Promotoras</em> say that one of their main problems is expenses they incur in carrying out their job.</td>
<td>Charging beneficiaries reduces the value of the transfer, though by a small amount. However, the fees appear to be necessary to enabling her to do tasks that facilitate the functioning of the program. Burdening <em>promotoras</em> with additional responsibilities such as delivering forms may reduce her effectiveness is carrying out her formal responsibilities.</td>
<td>Since the program is supposed to cover <em>promotoras’</em> necessary transportation expenses, PROGRESA should investigate the claims of <em>promotoras</em> that they incur expenses that are not covered. Although efforts should be made to prevent <em>promotoras</em> from charging for transportation where that is already paid, if they are incurring costs for other necessary tasks, these should be covered by whatever institution is requesting the work. Policy should be clarified and communicated effectively regarding whether <em>promotoras</em> should or should not be asked to travel to assist with paperwork.</td>
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<th>(6) Pressures on <em>promotoras</em>:</th>
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<td><em>Promotoras</em> have to absorb the frustrations of people in their communities. They face pressure from beneficiaries when things do not go as expected, for example if transfers are late or are less than expected. They are also sometimes blamed for non-beneficiary exclusion from the program.</td>
<td>Pressure, criticism and social tensions between <em>promotoras</em> and beneficiaries or non-beneficiaries makes it more difficult for them to perform their work, which could have adverse effects on their performance and thus that of the program.</td>
<td><em>Promotoras</em> ask that PROGRESA help them by putting more effort into explaining to beneficiaries the reasons for these problems beneficiaries have and that <em>promotoras</em> are not responsible in these areas. This underscores the importance of clear communication with communities regarding how PROGRESA works and relative roles and responsibilities. This could occur through occasional visits by PROGRESA officials to <em>promotora</em> monthly meetings. PROGRESA should</td>
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<td>(7) Training for promotoras: Although promotoras are well trained enough to receive very good evaluations from beneficiaries and doctors in terms of how they perform their jobs, promotoras and doctors both say that promotoras need more training then they currently receive. Promotoras in some areas exhibit a lack of understanding of how the program works or do not have updated information. The two main areas for which promotoras and doctors suggest more promotora training is in health care and dealing with people. They are sometimes asked to carry out tasks for which they are not trained nor responsible, such as the health pláticas.</td>
<td>Given how crucial the role of the promotora is and the extent to which the program and beneficiaries depend on her for transferring good information and other assistance, insufficiently trained promotoras can have adverse effects on the beneficiaries’ ability to benefit from the program in terms of the cash transfers, health, nutrition and education.</td>
<td>The program should consider extending the period of training currently given to promotoras, and consider how to strengthen the training to respond to needs identified. The program should ensure that trainers use forms of pedagogy that encourage more participation and indicate whether promotoras have absorbed the material. It is also important that promotoras receive updated information in a timely manner, and that they are able to explain to beneficiaries the reasons for delayed or deducted payments. Additional health training for promotoras could be helpful in enabling them to answer questions of beneficiaries related to what they learn in the pláticas, but PROGRESA should clarify in communities that promotoras should not be giving health pláticas which are not their responsibility. The clinics should have sufficient staff to carry out these duties. In general, the program should ensure that promotoras are fulfilling only the roles for which they are qualified.</td>
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Faenas

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<td>(1) Most PROGRESA and poor non-PROGRESA communities have faenas, where men and/or women come together for communal work that benefits the community, and most people are said to participate. Faenas are not part of PROGRESA operations and are not formally associated with the program. Quantitative results suggest that PROGRESA has not increased the number of faenas or women-only (i.e., PROGRESA beneficiary) faenas. However, focus groups and interviews with doctors and teachers indicate ways in which faenas and the program are being associated, with doctors seeing them as a means of</td>
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<td>getting people to participate in needed communal work. Although this form of reciprocity was not intended by PROGRESA, the opinion of the doctors is that there are good reasons for requiring these obligations.</td>
<td>Doctors interviewed are strong advocates of <em>faenas</em>. They feel that one of the basic components of PROGRESA that has a major impact on health is hygiene, and where beneficiaries participate in <em>faenas</em> that improve the environment and sanitation, the <em>faenas</em> can enhance the health impact of the program. In increasing time and energy burdens on beneficiaries, they reduce the net impact of the program though probably by a small degree. However, if non-beneficiaries do not participate, this can have negative social impacts on the community.</td>
<td>The list of benefits that doctors believe are derived from beneficiary participation in <em>faenas</em> should be taken into consideration in PROGRESA’s decision to either try to discourage this practice, or allow it to continue at the discretion of the doctor, school director or <em>promotora</em>. However, the question of non-beneficiary participation should be solved if this practice continues. Linking participation in <em>faenas</em> to PROGRESA benefits may be a good way of introducing elements of self-targeting to the program, and for reinforcing the responsibilities of beneficiaries. These might be distinguished as PROGRESA activities, so as not to interfere with regular community <em>faenas</em> in which beneficiaries and non-beneficiaries participate together.</td>
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<td>(2) There are positive and negative dimensions to <em>faenas</em>. They produce important environmental, health, aesthetic, and social benefits for communities. However, they increase time and energy demands on beneficiaries. Also, in some communities non-beneficiaries do not want to participate in <em>faenas</em> because they do not get PROGRESA benefits. However, in other communities, non-beneficiaries do participate because the work is not associated with the program, they are convinced the work is important or because they hope that by participating they will get included in the program.</td>
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CHAPTER 1 — INTRODUCTION

The standard framework for the evaluation of programs (and projects) is the project cycle which views programs as going through a series of stages (i.e., identification, design, selection, implementation, monitoring, redesign, and completion). Although evaluation takes place at all these stages, the purpose of evaluation varies at each stage so that the relevant tools for evaluation can also vary. One should not view evaluation within the project cycle as a one-shot affair but as an information mechanism that applies lessons learned from the performance of past and existing programs to improving the identification, design and implementation of all programs. In this sense, evaluation is always prospective, the ultimate objective of evaluation being to improve the allocation of scarce resources and strengthen the ability of the program to meet its stated objectives.

Prior to the implementation of a program one is essentially evaluating a hypothetical or “paper program,” although the identification and design of the program will obviously be influenced by previous experience of actual programs. But even well conceived and well designed programs, in the sense of one having a good understanding of the underlying technical and behavioural relationships determining the transformation of inputs into outputs (or impacts), can fail due to poor implementation resulting in poor delivery of inputs. So, for example, although an ex-ante evaluation of a program at the selection stage may correctly have indicated a potentially high return, an ex-post evaluation of the actual program may find a much lower impact than anticipated reflecting the fact that actual inputs were not delivered as planned.

Both impact analysis and operations’ analysis are concerned with analysing variations in outcomes (e.g., school attendance or health visits), but whereas the former focuses on the difference in outcomes between beneficiaries and non-beneficiaries (or “control” and “treatment” groups), the latter focuses primarily on the difference in outcomes between groups of beneficiaries experiencing varying levels of operational efficiency. In this report we are concerned with this dimension of PROGRESA, i.e., with evaluating the process that delivers inputs to beneficiaries.1 The purpose of such an “operations’ evaluation” is to identify, early in the life of the program, any shortcomings in this process with the intention of informing corrective action. However, here we are also concerned with identifying the different channels

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1 This report draws heavily on a number of background reports; see Adato et al. (2000), Coady (1999a), and Coady and Djebbari (1999).
through which the program can have an impact, the range of impacts (intended or otherwise) on
the various program actors and stakeholders, as well as the various ways (anticipated or
otherwise) by which these actors and stakeholders can influence program operations and
outcomes. To do this we take a broad “systems approach”, which identifies a number of key
actors and stakeholders. Using a variety of information-collection mechanisms (i.e., both
quantitative surveys and qualitative interviews and focus groups), we identify and analyse their
experiences with the aim of identifying operational problems, as well as their causes and their
solutions.

The layout of this chapter is as follows. In Section 1.1 we place the operations’ evaluation of
PROGRESA within the context of the overall evaluation of programs and identify a number of
reasons why programs can fail to achieve their intended impacts. We develop the framework for
the evaluation of PROGRESA in Section 1.2. In Section 1.2.2 we outline the overall motivation
and objectives of the program, briefly discuss the objectives and design of the main program
components, identify specific intended program outputs and inputs, and list indicator variables
that will provide the basis for the quantitative analysis of the program. Then, in Section 1.2.2,
we describe the data used in the analysis and the methodologies employed. In Chapters 2-5 we
use this information to assess the operational performance of each component and highlight areas
that appear to require further attention. Chapter 6 provides an assessment of the general lessons
from the report for the impact analyses and program design.

1.1 The Role of Operations’ Analysis

For a program as large as PROGRESA, with a long gestation period and an intention to expand
coverage more widely over time, it is important to evaluate its operation at an early stage. It is
unlikely that those responsible for the implementation of the program anticipated all future
operational problems so that there can be a high return from such an evaluation. However,
before one can undertake an operations’ evaluation one needs to address a number of issues:

(a) What are the motivations underlying the program intervention?
(b) What assumptions lie behind the design of the program?
(c) What are the specific objectives of the program and how are these to be achieved?

In other words, before being able to evaluate a program one must first understand why it came
about, what are its objectives and how these are supposed to be achieved. Operations’ evaluation
addresses the last component in detail. It evaluates the operational performance of the program
in delivering crucial inputs. For example, it asks: Is the program functioning, or being
implemented, as planned? Are inputs (or resources) being delivered to the appropriate levels,
composition and quality? Are they being delivered at the right time and to the right individuals,
households or localities? If the delivery process is not adequate in any of the above respects,
why not? What actions can we take to improve delivery?

One can identify a number of reasons why programs can “fail” to deliver expected impacts:

(i) Design failure: resulting from a failure to explicitly specify (and justify) the motivations and
    objectives underlying the program intervention and their relationship to its design. The
design stage should also address the need for the various program actors (e.g., institutions and households) to have both the resources and incentives to generate the expected impacts.2

(ii) **Planning failure**: reflecting inadequate resources devoted to planning how inputs are to be delivered to program beneficiaries. This involves identifying or creating agents to deliver the inputs, informing agents of their responsibilities, as well as co-ordinating and monitoring their activities.

(iii) **Institutional failure**: resulting from the relevant institutions lacking the capacity or incentives to deliver inputs as planned. This involves recognizing the economic, political and social environments within which these institutions function. Stakeholders other than those responsible for delivering inputs also need to be considered since these have vested interests in influencing outcomes.

(iv) **Participation failure**: arising from intended beneficiaries not having adequate resources or incentives to participate and take-up the benefits, or to otherwise respond to and benefit from the program as intended in the course of participation. As with institutional failure, our understanding of the incentives and constraints facing beneficiaries must be placed within their economic, political, social and cultural environments.

But one should also recognise that some departure from the initial design may reflect ingenuity of program implementers (or other actors or stakeholders) in the face of obvious program deficiencies that are revealed as the program is being implemented (an example of learning by doing). All such improvements in design should be quickly diffused throughout the program. In addition, the program may have a range of unintended impacts that are more or less desirable. These may reinforce or adversely affect program performance in terms of explicit program objectives. Where they adversely affect performance, they can constitute acceptable or unacceptable trade-offs.

The above sequence reflects an underlying policy hierarchy, which may be iterative. For example, shortcomings in design identified at the planning stage can feed back into an improved program design prior to the actual implementation of the program. In general, one expects program design to be improved by the incorporation of important information provided from lower down the policy hierarchy. Also, the identified failures are inter-related. For example, beneficiaries may be willing and able to participate but this may not be facilitated by the relevant institutions; institutional failures in turn may reflect lack of co-ordination higher up the policy hierarchy; or participation failure may be the result of lack of understanding at the design stage of the incentives or constraints the intended participants face. So a complete evaluation of the program requires one to consider all the stages of the policy hierarchy. Operations’ evaluation addresses failures (ii)-(iv) in more detail. Its role is to identify the dimensions of program operations that are not performing well (i.e., the problems), from where in the operational

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2 Coady (1999b) provides an in-depth discussion of factors that should be taken into account at the design and impact evaluation stages.
"system" these problems arise (i.e., the sources), and how these problems can be avoided or minimized (i.e., the solutions).

It is clear from the above that in order to undertake an operations' evaluation (i.e., to identify operational problems, their sources and provide solutions) one needs to take a broad perspective of the operational environment, which includes all the policy actors as well as other actors and stakeholders who can influence the operational performance of the program or who are affected by the program. Examining the operational performance of the program from the perspective of a single (or narrow set of) actor(s) may help to identify specific operational problems, and the results may even be suggestive of their sources and solutions. However, a more complete analysis requires analysis in other areas of (or actors and stakeholders in) the operational system. Such a broader "systems approach" can be used to verify and interpret the problems identified by different actors and stakeholders (henceforth referred to as just “stakeholders”), and to identify the sources and solutions more precisely. The long-term sustainability of programs will also depend, in part, on whether the objectives and incentives of the various stakeholders reinforce or compete with each other.

However, another crucial ingredient to a successful operational analysis is participation by those responsible for implementing the program. No amount of quantitative or qualitative empirical analysis in isolation can provide a complete evaluation of the operational performance of a program. Operations personnel invariably have access to a more extensive knowledge base derived from their past experiences of similar or related interventions and have a richer understanding of the economic, social and political environments in which the program operates.³

Before turning to our operations analysis of PROGRESA it is useful to place our approach in the context of other approaches suggested in the existing literature on program evaluation. It seems conventional to distinguish between three approaches: operations research, systems analysis, and process evaluation (Blumenfeld 1988). Operations research is usually concerned with the selection and design of an operations mechanism for an intervention that is not yet in place. Its distinguishing features are usually taken to be its prospective nature (i.e., it is future oriented) and its systematic approach, which attempts to make explicit, and to assess, the assumptions underlying alternative operational designs. Systems analysis begins by placing an intervention within the context of the wider environment within which it has to operate (i.e., the “system”) and gradually focuses in on a narrower perception of the intervention but all the time being aware of the important interactions with different dimensions of the wider system. The term process (or formative) analysis usually applies to the evaluation of the operational performance

³ PROGRESA operations' team have been involved at all stages of the evaluation, especially with regard to identifying areas which need to be examined and collecting the relevant data. Throughout the program they have been responding to insights provided by their own and our on-going operations’ evaluations. Many of the issues addressed in this report were motivated by potential problems identified within PROGRESA through it’s own information channels. In this report we attempt to identify whether these problems exist and are important in magnitude, as well as identifying a range of other operational issues that need further attention and consideration.
of an intervention that is currently in progress to provide managers with an objective measure of how well the program is meeting existing operational targets. Arguably, most approaches can be incorporated under the heading “systems analysis” and viewed as analytical tools for the evaluation of different levels of the system.

Here we take a relatively broad perspective of operations’ evaluation that combines some elements of all these approaches. The motivations for doing so reflect our view that: (i) to be worthwhile, the eventual purpose of all analyses needs to be prospective in the sense of providing insights into how resources can be better allocated either within the program being analysed or in other policy areas. This is consistent with the application of the project cycle as described earlier; (ii) systematic or formal analysis, either prior to or early on in program design and implementation, can help to identify key features of the program which are crucial to its effectiveness and therefore need to be planned carefully; and (iii) the identification of sources of program failures, and of the appropriate corrective action to be taken, requires a "systems" view which recognises the roles played by a broad range of institutional actors and stakeholders and their inter-relations within economic, social and political environments. So, although there is always a certain amount of trial and error (or learning by doing) in most programs, and especially in large programs, the associated error can be minimized by systematic analysis of past experiences, careful planning, and allowing for feedback from the implementation and operational stages of the program.

As mentioned earlier, for a program as large and innovative as PROGRESA, with a long gestation period and an intention to expand coverage more widely over time, it is important to evaluate its operation at an early stage. Lack of experience with such programs means that it is unlikely that those responsible for the implementation of the program anticipated all future operational problems. So there may be a high return from such an evaluation. Just as careful attention at the planning stage can facilitate some fine-tuning at the design stage, systematic evaluation of operations at the early stages can facilitate some fine-tuning of program implementation.

We start by describing the program and identifying the various actors at different stages of the policy hierarchy. From the stakeholders identified, we select several key actors whom we think can provide important information regarding program operations. We then discuss the strengths of combining quantitative and qualitative research methods, and why we chose these combined methods for this evaluation. From there we discuss the data used in the empirical analysis and the methods employed to collect and interpret these data. This data is used as the basis for our operations evaluation of the various program components in later chapters.

1.2 Operations’ Evaluation of PROGRESA

1.2.1 Description of the Program

PROGRESA is the most important poverty-alleviation program run by the Federal government through the Ministry of Social Development and targets households in extreme poverty. Unlike previous poverty-alleviation programs, where operation was under State control, PROGRESA is designed and implemented by Federal-level institutions with branches at state and municipality
levels. The benefits from the program go directly from Federal budgets to beneficiary households.

The program was introduced in 1997 and the selection of beneficiaries was separated into three distinct stages. First, based on national census data, a "marginality index" was calculated for all localities. Eligibility for the program was based both on the degree of marginality and, consistent with the nature of the program, the requirement that localities have access to education and health facilities. Second, prior to implementation, a census of all households in eligible localities was undertaken with this information used to identify "poor" households. Third, after discussion with the localities, the eligibility of some households excluded in stage two (e.g., due to not being present at the time of the survey or because it was felt that they should be included) was reconsidered.4

Eligible households must satisfy certain “poverty criteria,” which are applied uniformly across all states and municipalities, and eligibility is to be re-assessed every three years. This process is expected to target the poverty-alleviation budget more effectively and to ensure a consistent poverty-alleviation strategy nationwide. This aspect of the program has been emphasised because previous programs were heavily criticised for being poorly targeted and being subject to political interference.5

Responsibility for the overall design, implementation and operation of the program is that of CONPROGRESA at the Federal level, which has operational arms at all lower levels. At the state level, the operation of the program is the responsibility of Unidad de Apollo Estatal PROGRESA (UAEPs), which also have access to a municipality liaison in each municipality who facilitates communication with his or her respective communities and provides other forms of assistance as needed. The size and composition of these bodies varies across states with, for example, the number of staff varying between nine (in the smallest states such as Yucatan) and fifty (in the largest states such as Veracruz). Their responsibilities include contacting eligible households, informing these households of the objectives and requirements of the program, and ensuring that they receive the appropriate cash transfers. Once CONPROGRESA identify eligible households, a list of such households is sent to the UAEPs, which then have to inform local authorities of the date for a general assembly at least ten days in advance. Both beneficiaries and non-beneficiaries are, in principle, welcome to attend this assembly. The detail of the assembly and the various program components is presented under the relevant sub-sections below.

4 This is the so-called "densification" process, which increased the proportion of households in marginal localities included in the program from around 52% to around 78%. This is analysed in more detail in Coady and Hernandez (2000).

5 For example, under PRONOSOL communities received benefits by submitting applications for project finance to state authorities thus potentially biasing the allocation of funds towards the more organized (as opposed to poorer) states. The lack of a consistent set of criteria also introduced the potential for political manipulation of the process. See Yaschine (1998) for a discussion of previous poverty-alleviation programs in Mexico.
The ultimate objective of PROGRESA is to improve the education, health and nutritional status of poor households, especially for women and children who are viewed as being among the most vulnerable groups in society (Table 1.1). Each of these components can be viewed as a form of human capital that enters directly into individual well-being (e.g., enabling one to contribute to, and participate as a valued member of, the society in which one lives) but also indirectly in determining an individual’s productivity and thus income-earning potential. The nature of the education-health-nutrition nexus is therefore seen as being at the root of the vicious circle of poverty, whereby children born into poor families disproportionately experience health and nutritional problems that diminish their potential for benefiting from whatever education they receive. Public action is, therefore, thought to be required to transform this vicious circle into a virtuous one.\(^6\)

In order to design and implement a program which contributes to the achievement of the ultimate objectives, and which can be evaluated, it is necessary to specify a set of derived objectives (or outputs) that help to make more explicit and to operationalize the overall objectives. These are listed in the first two columns of Table 1.1. Certain features of the design of the program are seen as being so crucial to its effectiveness that they can be viewed as secondary outputs. These essentially relate to households and communities participating in, and taking responsibility for, the success of the program, and are listed in Table 1.1 both separately, under an additional component category labelled “Other,” and within each of the three main components (in column 2).

Having identified outputs one then needs to specify indicators that facilitate an impact evaluation: these are listed in the third column of Table 1.1. Process evaluation, on the other hand, is concerned with specifying in detail the inputs (column 4) necessary for achieving these impacts and with evaluating the operational performance of the program in delivering in this regard (column 5).

The main purpose of Table 1, then, is to help to structure our analysis of the program by being explicit about program objectives, how the program impact in terms of these objectives can be captured, which inputs are meant to ensure that the impacts come about, and how we intend to measure whether such inputs are being adequately delivered. It also provides a starting point for identifying key program stakeholders as well as for determining the appropriate (mix of) approaches for soliciting information from these on program operations and impacts.

### 1.2.2 Methodology and Data

As indicated above, a complete evaluation of a program requires one to consider all the stages of the policy hierarchy. Programs can fail to deliver expected impacts because they are poorly conceived and designed or because they are poorly implemented. In this report we focus specifically on failures at the implementation stage. But identification of problems or failures is only the first step; once identified one must trace the source of the problems and where on the policy hierarchy corrective action needs to be undertaken.

\(^6\) For a detailed discussion of the motivation for public action, see Coady (1999b).
Our approach is to focus on, and collect information from, key program actors and stakeholders using a range of information-collection approaches. Using their experiences of program operations, we attempt to identify important operational problems (and successes). With this inclusive approach, we then follow the problems identified as far back through the policy hierarchy as is possible, with the intention of verifying their experiences, interpreting these experiences, and identifying the source of operational problems and possible corrective action.

From a policy perspective it is useful to think of three levels at which policy is formulated and implemented: national (federal), state and local. Given time and resource constraints we decided to focus exclusively on the lowest level, i.e., the local level. This decision is also consistent with the requirement that we first identify how well various operational aspects of the program are performing. The best and most direct way to gauge this is to focus on those stakeholders who experience at first hand the outcomes of program operations (e.g., the beneficiaries themselves) as well as those who are directly involved in delivering program inputs to the beneficiaries (e.g., school teachers and health clinic staff). By analysing the expressed experiences and views of these stakeholders we can expect to be able to identify operational shortcomings and their causes. Although the insights drawn from the analysis may often be suggestive of solutions, it is likely that the development of precise solutions will require going further back through the policy hierarchy (i.e., through the state and national levels). Therefore, the objective of our evaluation is solely to how the program is operating and why, but we purposefully refrain from prescribing solutions. We essentially identify crucial areas of program operations where corrective action needs to be taken and where further attention needs to be devoted. What corrective action is taken, and where in the policy hierarchy it takes place, is left to policy makers themselves. But we hope that the insights provided by our evaluation will contribute to this end.

1.2.3 Identification of Key Stakeholders

For the purposes of our evaluation we have identified four key stakeholders:

(i) Beneficiaries: These are the poor households in the most marginal communities in rural Mexico who benefit from the program but also must meet the conditions set by the program (e.g., ensure regular attendance at school and health clinics). The transfers are given to the mothers of children in the program, or to the female partner in childless households. It is not possible to adequately evaluate how well a program's operations are functioning without understanding how it is perceived through the eyes of the people served by it, and their own explanations of its performance.

(ii) Promotoras: These are beneficiaries who have been selected by their fellow beneficiaries to voluntarily serve as liaisons between themselves and PROGRESA’s personnel, providing beneficiaries with information on how the program works, when transfers will arrive, and identifying operational problems. In serving as government-community liaison, facilitator, educator and local problem solver, they are a key link in the operational process. Because they live in the beneficiary communities they are valuable key informants who have
intimate knowledge of the social and economic life of beneficiaries and how these factors may influence the operations and outcomes of the program.

(iii) School directors: These are responsible for ensuring that beneficiaries achieve the required level of attendance by providing information to PROGRESA on students’ attendance records. They can help to evaluate the education supply-side of the program, which is one of the program inputs that is outside the direct control of PROGRESA. They can also serve as key informants, providing insights into community life and how not only the education component, but also the other dimensions of the program, are evolving.

(iv) Health-clinic staff: These are responsible for ensuring that beneficiaries adhere to a scheduled list of visits to the health clinics for preventive check-up and health lectures. They also disperse the food supplement to mothers of infants and malnourished children. They must monitor and provide information on this attendance to PROGRESA and can help to evaluate how the supply-side of the program is being delivered. As with school directors, they can also serve as key informants, providing insights into community life and how not only the health component, but also the other dimensions of the program, are evolving.

Although we do not identify non-beneficiaries as one of the key stakeholders for the purpose of this evaluation, we do consider them important stakeholders as they are affected by the program, and also in turn affect program outcomes in ways that are illustrated in this report. Also, their welfare has importance. They were thus included in the focus group research, and the surveys and interviews with school directors and clinic staff include questions related to non-beneficiaries.

By collecting information from the above stakeholders in the program we hope to be able to build up a clear picture of program operations. To collect this information we decided to use a mix of both quantitative and qualitative data collection methodologies. Together it is expected that these information sources will complement each other and thus facilitate the construction of a more comprehensive and insightful evaluation aimed at identifying problems (and successes) and their causes, which also helps policy makers to decide what corrective action to take and where to take it. But we regard actions to reinforce successes to be of equal importance.

1.2.4 Combining Quantitative and Qualitative Research Methods

Our approach then involves combining research involving quantitative surveys and qualitative semi-structured interviews and focus groups. We chose to use all these methods in order to take advantage of the strengths of each method and the synergies of combining them, and the recognition that mixed method research, for the reasons outlined below, would provide the richest pool of data and analytical power that would not be available with any of these methods on their own. This section introduces our qualitative research methods and designs by reviewing the reasons for using these methods and for combining qualitative and quantitative research.
La rge - scale quantitative household and community - level surveys of the type carried out by PROGRESA in 1998 and 1999 enable the collection of data from a vast number of households and villages and thus provide information about program impact throughout the states where the data was collected. The breadth of coverage is thus large, giving a basis for comparability between regions, a controlled experimental design and statistical analysis to establish relationships between different variables.

There are, however, constraints on what this data can capture revolving around validity issues that stem from: the difficulty of communicating to respondents exactly what is meant to be asked (due to the necessary brevity of questions and the use of proxies); the inability of respondents to express exactly what they mean or explain their answers (due to the use of closed questions); the inability to follow up when more information or clarification is needed; the difficulty of developing rapport and trust in order to maximize truthfulness in the replies. Although some discussion can take place during a survey, the time and instrument is not conducive to developing depth in understanding.

The strength of qualitative research methods is that they are allow for all of the above. In addition, they are particularly well suited for enabling the understanding of the significance of local context to the phenomenon being studied, the complexity and multiplicity of explanatory factors, and latent, underlying or less obvious issues. By often focusing on peoples “lived experience” they enable a richer understanding of the meanings that people give to events, processes and structures in their lives. They provide “thick descriptions that are vivid, nested in a real context, and have a ring of truth that has strong impact on the reader” (Miles and Huberman 1994). In doing all this, however, they are time and resource intensive. There are thus significant limitations on the number of individuals and communities that can be included in any given study. This in turn constrains the ability to compare between different places or people, and the type of statistical or modeling techniques that can be used on the data.

The use of quantitative and qualitative methods together and in complementary ways is well established theoretically and empirically (Brewer and Hunter 1989; Creswell 1995; Tashakkori and Teddlie 1998). Triangulation, where several types of data are used in a single study, enables the weaknesses of one method to be offset by the strengths of another (Denzin 1978; Jick 1979). A study of 57 mixed method studies from the 1980s identified five purposes for mixing methods: 1) triangulation: seeking convergence of results; 2) complementarity: examining overlapping and different facets of a phenomenon; 3) initiation: discovering paradoxes, contradictions, fresh perspectives; 4) development: using the methods sequentially, such that results from the first method inform the use of the second method; and 5) expansion: adding breadth and scope to a project (Greene et al. 1989).

Aspects of all of these purposes are present in our use of mixed methods. Bearing in mind the advantages identified above, a qualitative component was designed for the PROGRESA evaluation specifically because:

- There were questions to be asked that were more suited to open-ended responses rather than closed categorical or continuous answer options.
• Respondents could answer in their own words and explain background to responses, enabling a more precise understanding of the meaning of their responses.
• People in PROGRESA communities, and service providers in those communities, could describe experiences and raise concerns that we had not anticipated.
• Responses could be probed and challenged, and contradictions explored or clarified.
• Congruence and differences in the four components, the beneficiary surveys, schools and clinics surveys, semi-structured interviews and focus groups could be explored and interpreted.
• Respondents were able to propose solutions as well as report problems.
• Responses could help to interpret survey results, and suggest new questions and response options for further survey work, as well as areas for additional qualitative research.

1.2.5 Methods and Data Sources

The quantitative and qualitative research methods and data sources we used are now described in more detail.

Quantitative Surveys of Beneficiaries

PROGRESA began implementation in August 1997. A preliminary operation's survey was carried out as early as October-November 1997 with the purpose of determining beneficiaries' overall perceptions of the objectives, design and operation of the program. A sample of 1000 women was chosen from all cash transfer points open at the time; one in every ten women in the queue was chosen. This survey was followed by a series of focus groups and in-depth interviews with beneficiaries in three communities in each of five states. The findings from both of these were used to fine-tune the October 1997 survey. The resulting survey was carried out in June 1998 visiting more or less the same sample of women as in October 1997, but this time in their communities.

The first large survey of beneficiaries relating to program operations was collected in October 1998 along with the ENCEL survey data (i.e., ENCEL98o) used for the analysis of program impacts. This involved a randomly selected sample of 506 localities in total, 320 of which were classified as “treatment” localities (i.e., as having received the program) and 126 as “control”

7 Where a certain mass did not exist in a locality the relevant households were replaced by others in one of the other localities. The preliminary analysis of the operational performance of PROGRESA (Coady 1999a) used the data from June 1998, combining it with the 1996 census data (ENCASEH96) covering the population of beneficiary municipalities in the first phase of PROGRESA (i.e., socio-economic data for beneficiary and non-beneficiary households in these municipalities). The main objectives of that analysis were twofold: (i) developing a useful framework for the operations’ evaluation (but also for the overall evaluation of the program), and (ii) facilitating a structured use of the survey data as well as identifying further improvements in the questionnaire. Although some preliminary conclusions were drawn from the analysis these were intended to be treated very cautiously given the small sample size (i.e., 959 households in five states).
localities (i.e., as not yet having received the program). The questions in the operations module of the survey were asked only of the 7237 beneficiary households in the seven states in which the sample localities were located. A similar survey was collected in June 1999. For the purposes of the present report we combine both these data sets. We confine ourselves to the 6579 households that can be matched across the data sets so as to get a clearer view regarding the evolution of operational performance across time. This means that we drop the 657 households that were in the October 1998 data set but not in the June 1999 data set, and also the 1359 households that were in June 1999 data set but not in October 1998 data set. The former presumably reflect migration while the latter may be the result of the “densification” process that increased the number of beneficiary households in the program within the communities selected to participate.

Since we are interested in evaluating operational performance, we need some criterion for what constitutes good or bad performance. As is to be expected there is always a certain degree of arbitrariness about identifying such a threshold and one expects it to be issue specific. We therefore proceed by focusing on what we see as key operational variables that are crucial to the ability of the program to deliver the expected impacts. We first evaluate the absolute level of performance by focusing on the average level of the variable and which implicitly involves comparing it to perfect operational performance. However, a “good” average can hide poor performance in some, especially small, regions. So, using regression analysis, we compare averages across states. This also gives us an indicator of relative performance where we view the state with the best performance as representing “best practice” operational procedures. This involves comparing the coefficients on state dummies.

Similarly, variation (or the lack of it) in averages across states may hide important variations at lower levels, such as variation across localities. For example, it may be that when some aspect of operational performance (such as receipt of a registration form) goes wrong in a locality that it goes wrong for a substantial block of households. In other words, imperfect operational performance may be highly concentrated in a few localities, i.e., problems may be locality specific. Knowledge of such patterns may be useful when interpreting the results and in identifying the sources of, and solutions to, operational problems. We therefore also analysed operational performance at the locality level by visually comparing the distribution of averages across localities. For example, on average, if 10% of households do not receive registration forms, it is useful to know whether this reflects a common level of operational performance across all localities or whether some localities account for most of this variation while others exhibit near perfect performance. Little variation in operational performance across localities may reflect problems inherent in the operational design that apply universally, while concentration of problems in a few localities may reflect locality-specific problems that need to be considered and addressed outside of the overall design of operations. In the present report for the most part we highlight the locality specific nature of problems only where it is relevant.

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Quantitative Surveys of Schools and Health Clinics

(i) School directors

The sample of localities that were selected for the impact evaluation (i.e., impact on school enrolment and attendance, impact on health visits, impact on consumption and nutrition etc.) of PROGRESA is 506, divided into 320 PROGRESA and 186 control localities. In 1997, a total of 620 schools (528 primary and 92 secondary) were identified in the sample of localities included in the evaluation, implying a ratio of about one primary school per locality and one secondary school for every 5-6 localities.

Table 1.2 presents the number of schools for which data are available in the 1997, 1998 and 1999 surveys. In 1997, the survey questionnaire was applied to a total of 427 schools from the overall pool of 620 (272 PROGRESA and 155 Control). In 1998, the questionnaire was applied to a total of 500 schools, but only 481 actually belong to either one of the three groups of interest: 1) PROGRESA; 2) Control; or 3) Outside of study area but where some PROGRESA beneficiaries go. In 1999, the total number of schools from these three community types is 439. Note that the sample size of secondary schools is rather small in all three surveys, especially among the control communities.

Attempts to merge the different data sets resulted in significant losses in the number of schools. Because the resulting samples were small and also because of the lack of direct comparability between the survey instruments from one year to the next, it was decided to analyze the data sets as three separate cross-sectional surveys. Thus, it is important to keep in mind in reading the report that comparisons between the data sets are only suggestive since they do not come from the exact same sample of schools. The 1997 survey can be seen as a baseline survey because it took place before the PROGRESA program was implemented in the selected communities of the evaluation. The 1998 survey was applied in the early stages of operations and the 1999 approximately one year later.

(ii) Health centers

A survey of 317 health centers (175 from the Servicios Estatales de Salud and 142 from IMSS Solidaridad) from the 7 states of the overall evaluation of PROGRESA was carried out in 1999. The main respondent was the doctor or other staff member in charge of the health center. The purpose of the survey was to collect information on the overall conditions of the health centers and the resources, supplies and equipment available. Information was also collected on the types of services offered, hours of operation, coverage and number of patients attended per day. The survey also included various questions about perceptions and opinions about the impact of PROGRESA on the demand for health services, both curative and preventive, about problems with the use of the forms and reporting system for PROGRESA, about the availability and distribution of the nutritional supplement, and about the health and education talks (pláticas).
Qualitative, Semi-Structured Interviews With School and Health-Clinic Directors

In order to get a more comprehensive picture of program operations we designed a series of qualitative, semi-structured interviews with school directors and health clinic directors, who are also doctors. The purpose was primarily to gain information on operations related specifically to the education and health components of the program. However, because school directors and doctors provide views on community life, they also serve as valuable key informants on other issues related to program impact on communities and visa-versa.

In selecting the sample for both sets of interviews, we chose to interview 16 school directors (18 were actually interviewed) and 16 doctors in four states: Hidalgo, Querétero, Puebla, and Veracruz. These states and the regions chosen were included in the beneficiary surveys and school and clinic surveys. In selecting communities, we stratified the sample using the criteria of poor and extremely poor; and mestizo and indigenous communities. The communities and persons interviewed are shown in Table 1.3.

The questions in the interview guides were developed based on research interests and new unanswered questions derived from other components of the operations evaluation — beneficiary surveys, school and clinic surveys, and the focus groups. The questions and structure of the school director and doctor guides paralleled each other but were tailored for their respective institutions. The same questions were asked of each school director and clinic staff interviewed. Each interview lasted between 1 and 2½ hours, depending on how loquacious the interviewee was.

Interviews were tape recorded and tapes transcribed, and transcribed material coded in a computerized qualitative data analysis program. Frequencies of responses were recorded for most codes. Data was coded in Spanish, with selected quotes translated into English for inclusion in this paper.

(i) School interviews

In total, we interviewed directors of 18 secondary schools and 4 primary schools, distributed according to the criteria described above. Because most of the impact of PROGRESA in the educational sphere occurs at the secondary level, we concentrated on secondary schools. We interviewed just one director of a primary school in each state to get a sense of their perspectives. With regard to secondary schools, 10 were located in mestizo communities and 8 in indigenous communities. With regard to primary schools, 1 was in a mestizo community and 3 were in indigenous communities.

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9 While we initially selected communities according to whether they were identified as mestizo or indigenous, the designation we report here was assessed by the school directors and doctors in that community. Note that this sometimes a primary designation, i.e., it is a mostly mestizo or indigenous community, not strictly.
The majority of the secondary schools visited were “concentration” schools. Concentration schools are those that do not educate exclusively children that live in the community where the school is located, but also take in students from other nearby places. Some “concentration schools” have lodging in which students from other communities stay during the week (these schools usually have dormitories for males, while girls stay with a local family). The concentration schools in our sample take in students from 35 different localities, but not all provide lodging.

In the sample of secondary schools, 6 were technical schools, where teachers are specialized in certain subjects. Twelve were telesecondary schools, where teachers are not specialized, and instruction is given via a television in the classrooms. In the latter, the directors have the double function of director and teacher. The schools rely on two or three staff members.

(ii) Clinic interviews

In total, we interviewed 16 doctors charged with managing clinics in communities chosen according to the criteria described above. Half of these communities were mestizo and half indigenous (see footnote 9 above). The clinics also included some of both the Ministry of Health and the Institute for Social Security.

In most cases, the clinics had two staff: the doctor and nurse. In some cases, there was a doctor’s assistant; in some cases there was a nurse’s assistant. The majority of doctors had between 7 months and one year of experience working in the communities, except in 3 cases in which some had more than 2 years of experience and another had spent 20 years in the community.

The clinics’ coverage is wide and varied. This is dependent on the location and size of the communities within the clinics’ sphere of responsibility, and their level of accessibility. The size of the communities ranged from 199 to 787 families. The coverage of families in PROGRESA ranges from 47% to 76%. The number of communities using the clinics’ services varied, from that of one base community and a neighboring one, to one base community with five neighboring ones. In general, the services and medicines offered by the health clinics are free, according to the doctors. Most clinics direct a call toward the community’s members for volunteer support for tasks such as the maintenance and cleaning of the site.

Focus Groups with Promotoras, Beneficiaries and Non-Beneficiaries

A second component of the operations evaluation qualitative fieldwork involved focus groups conducted with beneficiaries, non-beneficiaries and promotoras. This part of the research was
critical to understanding the interpretations, attitudes and lived experience of people in PROGRESA communities in relation to the program, and how these in turn affect program outcomes. This could be best accomplished by allowing beneficiaries, non-beneficiaries and promotoras explain, in-depth and in their own words, how they have experienced PROGRESA. Focus groups were chosen for this component of the evaluation rather than semi-structured interviews for the following reasons:

- Opinions are dynamic, and individuals’ comments can trigger recollections and opinions of other group participants.
- Responses may be more candid because in the group they are anonymous to the interviewer so there is less fear of being identified than when interviewed in their homes.12
- Focus groups are cost- and time-efficient, where more individuals can be interviewed at a lower cost and in less time than through individual interviews.

Focus groups also have certain disadvantages compared to individual semi-structured interviews that we bear in mind in our analysis. These are:

- Frequencies of responses reported are rough indications of the relative strength of a particular opinion, not a representation of the number of people who hold a particular opinion.13
- There is less time to probe responses because of the number of respondents and time pressure.
- It is not possible to get everyone to answer, so some opinions may be missed. In particular, people with minority viewpoints, or those less accustomed to speaking in groups, may be uncomfortable speaking and these views are not heard.

Research questions were developed through the following steps:

1. Previous quantitative and qualitative research reports were reviewed, which revealed partially answered questions in need of further investigation.

2. A series of meetings were held with PROGRESA stakeholders to reveal concerns and interests related directly and indirectly to program operations.

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12 Given people's current association between household surveys and their inclusion/exclusion in the PROGRESA, there is more reason to believe that they might bias their answers with the hope of being included or not dropped from the program.

13 In this paper, frequencies presented generally represent undercounts because often individuals note agreement with an opinion through nods and do not repeat the idea expressed by another. In the coding process used for this data, the undercount is further exacerbated by coding similar comments made by different individuals in immediate succession as one data 'chunk.'
3. A preliminary set of questions was drawn up and circulated to researchers and PROGRESA stakeholders for comments and additions.

4. These questions were tested in pilot focus groups and then adapted for the remaining groups, with some additional questions added or dropped based on findings in subsequent groups.

The focus groups were conducted in six states. In five of these states, beneficiary localities were selected nearby the treatment communities in the ENCEL surveys, but not in these communities in order to avoid overburdening them. The sixth state (Estado de México) was where the pilot groups were conducted, the data from which was analyzed along with the other groups. Promotoras participated from communities surrounding the towns near communities where the beneficiary/non-beneficiary groups were held. The one exception was Estado de México where no promotora group was held. Two of the eight communities were primarily indigenous, monolingual communities. Additional monolingual communities were represented by promotoras in these regions.

Twenty-three focus groups were conducted involving 230 participants: 80 beneficiaries, 80 non-beneficiaries and promotoras representing 70 communities from 7 regions. A group of beneficiaries and a separate group of non-beneficiaries were convened in each of 8 communities in 6 states. The locations are shown in Table 1.4.

Focus group facilitators used structured questionnaires so all groups were asked the same questions. Beneficiaries, non-beneficiaries and promotoras were asked parallel questions to collect views of each group on the same issues. Promotoras were asked to comment (as key informants) on the experience of women in their communities, as well as on their personal experience. Some questions were adapted, added or eliminated depending on their relevance to the respective group. Each focus group lasted between two and four hours, with the longer sessions those of promotoras who tended to speak more frequently and at greater length.

Focus groups were tape recorded and tapes transcribed, and transcribed material coded in a computerized qualitative data analysis program. Frequencies of responses were recorded for each group in each community. Data was coded in Spanish, with selected quotes translated into English for inclusion in this paper.

Coded responses are clustered into higher-order codes that are presented thematically in this paper. Response frequencies are given usually where they are particularly high, noting a large

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14 Throughout this paper, the states from which different responses emanate are identified for the information of the reader. However, the sample size in this research is not large enough to make meaningful comparisons across regions, i.e., to analyze responses based on their regional context. Instead, more emphasis is placed on findings that were common across regions.

15 Questions related specifically to gender issues made up approximately one-third of the interview guide, as this fieldwork was also part of other components of the program evaluation.
consensus on a particular viewpoint. Frequencies can also be viewed as rough indications of relative strength of different viewpoints, i.e., the number of comments made signifying one viewpoint can be compared to that of a contrasting viewpoint. Given the imprecision that focus group frequencies represent for the reasons stated above, these should not be evaluated as statistical comparisons. Note that frequencies reported here represent number of times a point was made, either by one individual or a group of individuals in discussion, in both cases given a count of only 1. To distinguish between them, individual quotes are presented as single paragraphs, while discussions are presented with each person's point on a different line, marked by a dash (—) to signify a new speaker. A key to identify the origins of the quotes (location and whether speaker is a beneficiary, non-beneficiary or promotora) is located in the references.
CHAPTER 2 — BENEFICIARY SELECTION AND INDUCTION

2.1 The Process of Beneficiary Selection

PROGRESA’s process of beneficiary selection is aimed at making the best use of scarce resources by targeting households living in extreme poverty. To this end, it uses a census to gather household level data. The purpose of this method is to determine which households most need assistance, and to avoid discretionary decision-making at the local, state or national level. Within selected localities, data is collected on socioeconomic characteristics of households, taking into account a wide range of data on individual household members, diverse economic activity, assets, dwelling characteristics, availability of basic services, and other criteria. A point system is used, which reflects the precariousness of the family with respect to a set of basic indicators. The points assigned to each family are compared with the value of a cutoff point that corresponds with the extreme poverty line. Those who fall below this line are considered the extreme poor and are selected as beneficiaries of PROGRESA.

People in PROGRESA communities, beneficiaries and non-beneficiaries, thus do not know the basis for selection, though they are told that it is for the poorest families, or sometimes that it is a lottery. While they are not intended to know how families are chosen, it is the intention of the program that they are satisfied with the outcomes. An early PROGRESA policy document states that:

The Program contains strict criteria and objectives to define priority regions and beneficiary families, while making sure in all cases that communities themselves are in agreement as to whom the recipients should be and approve some aspects of its operation. (PROGRESA 1997)

A number of questions were thus asked in the focus groups and semi-structured interviews around perceptions of this selection system in the view of beneficiaries, non-beneficiaries, promotoras, doctors and school directors. The beneficiary survey also included some questions on this issue. The purpose of these questions was to 1) learn how well the system was working in relation to program operation procedures and principles; 2) learn how effectively these procedures and principles were being communicated within communities; 3) learn about stakeholder perceptions of its fairness. The question of communication emerged in the research as we found gaps between community understandings of program principles and what is intended by the program. Effective communication of PROGRESA’s principles and operations is necessary to ensure that beneficiaries comply with its requirements, but also shapes attitudes toward the program among beneficiary and non-beneficiary households. Ineffective communications can lead to misunderstandings and discontent that affect a given community and spread to other communities through rumors. We also recognize, and explored through the research, the fact that people re-interpret meanings of program features in ways that make sense to them and are effected by social and cultural phenomena that are beyond the control of the program. This makes good and persistent communications with communities all the more crucial, in order to counteract misunderstandings.
Other reports have evaluated the targeting system from an economic perspective and found it fairly successful and efficient in terms of certain poverty measures.\textsuperscript{16} Within communities, however, the threshold of poverty that separates beneficiaries from non-beneficiaries is an imaginary one. Moreover, what appears as success in the aggregate does not always reflect local experience. The beneficiary selection process is one area in which we found a considerable gap between program objectives and aggregate statistics on the one hand, and the perceptions of beneficiaries, non-beneficiaries, doctors and school directors on the other hand. After learning through preliminary research in PROGRESA communities that people were unhappy with the outcomes, we wanted to learn what people knew about the selection process, how they understood, experienced and evaluated it. We found two sets of challenges PROGRESA faces: the first has to do with misunderstandings and rumors that suggest the need for more forceful communications; the second can be tied to operational problems that can be corrected more easily.

One issue examined was why people thought that they or others in their community had been included in or excluded from receiving PROGRESA. This emerged as important because: 1) many felt they had been excluded wrongly, and it was thus important to know whether this was due to operational problems or a lack of understanding of how the program operates; and 2) the issue of exclusion emerged as a significant source of discontent among beneficiaries, non-beneficiaries and \textit{promotoras} who felt that wrong distinctions of needy and not needy were being made between neighbors who they see as “equal.”

After these findings emerged in the focus groups we wanted to gain an outside perspective on these issues, so we asked doctors and school directors for their opinions of the selection process. These opinions are also presented in the sections that follow.

\subsection*{2.1.1 Local Understandings of Why People are Included in or Excluded from PROGRESA: Relative Poverty, Problems with the Census, and other Explanations}

Focus Groups with \textit{Promotoras}, Beneficiaries and Non-Beneficiaries, and Interviews with Doctors and School Directors\textsuperscript{17}

\textit{(i) Relative poverty}

When asked in the focus groups why people are included in PROGRESA, the largest group of responses indicated that most people do have a generally correct understanding that 1) a census is used; and 2) people are supposed to be included only if they are poor. Note two examples from a beneficiary in Michoacán and a \textit{promotora} in Hidalgo:

\begin{quote}
There’s a guy who goes and makes the census but it depends on how he finds the person. If the person is very poor...or he finds someone who is more or less fine. (BM1-2)
\end{quote}

\textsuperscript{16} This came with some qualifications, however. See Skoufias \textit{et al.} (1999)

\textsuperscript{17} In some sections in this report, the discussion goes back and forth between two data sources. This is usually where only a small quantity of data is available from one of the sources, but also enables us to more directly compare responses from the two sources on certain issues.
I speak with my mother in law then she says ‘you receive PROGRESA because you need it more. Thank God, I have. But I think its o.k. that PROGRESA goes to those who really need it.’ (PH-2)

(ii) **Problems with the census**

People’s understanding of why some are *not* included in the program can be grouped into 9 different reasons. Most of these fall under the theme of the census. An exceedingly large number of comments or discussions (120 in total, spread across all the focus groups) raised problems with the administration of the census. It is also significant that the interview guide did not mention the census; rather, in each of the focus groups it was raised by participants. Problems with the census can be divided into two categories that indicate 1) administrative problems; 2) social and cultural barriers to effective use of a census for determining inclusion or exclusion from an anti-poverty program.

**Administrative problems**

Approximately 40% of the comments made about the census had to do with people being left out because they were not home. These responses were made roughly evenly between beneficiaries, non-beneficiaries and *promotoras*, and this was raised in groups in every state. The concern raised in all these communities is that if someone has the bad luck to not be home on the day the enumerator comes by, they lose their chance of getting PROGRESA benefits. Below are comments from a non-beneficiary in Guerrero and a *promotora* in Michoacán:

> When the enumerator came, I wasn't there. I went to Sinaloa in September, specifically because my children need money, and I had to go to work in the fields. They came, and the woman told me, but she also wasn't at home, she was working in the field, so when the boys passed no one saw them. And when she came, the boys had pasted the paper on the door. (NBG-3).

> In my community, the majority that didn't get onto the list were not at home so they didn't give their data. So it's impossible that they would get it. But they are conscious about that, that they were not at home. So they say its bad luck that they were not at home that day. (PM1-3)

In interviews with doctors, the same explanation emerged, for example:

> There are many families who are interested in the program and yes they are poor, they were probably absent from their house when the census was done – that is what I think – and for this reason they were left outside of the program. Yes, they did want to receive the benefits and we have seen very often their sadness.

Although the enumerator is supposed to return to the household, the frequency with which people said they were excluded for not being home raises the question as to whether enumerators are returning at a later time. One can imagine disincentives for returning a second time, particular to remote villages and homes. Given that such ‘bad luck’ is of considerable consequence to the family, these findings suggest that attention should be given to improving
training and supervision of enumerators so that they return to households where people are not home on previous visits. Communities where people feel they have been wrongly excluded for this or other reasons are also permitted to submit these names in a petition. We did not find examples of success using this channel in the communities we visited, however. This issue is taken up later in this chapter.

Another problem raised in the interviews with school directors is that enumerators do not go to outlying areas of villages, and thus groups of very poor families in remote areas are excluded. School directors said that one of the main problems was that those who came to do the census did not know the communities. They recommend that local expertise is used, while cautioning that allowing local officials to advise can introduce political influence. In addition to not being properly advised, one could also imagine that enumerators might sometimes choose not to go to certain outlying areas. This issue of excluding outlying areas was not raised in the focus groups, although some people did say that the enumerator never came to their house.

Two other reasons were given to explain why people were excluded based on the census. One relates to language. Note the following comment from a promotora in Hidalgo:

People don’t know how to speak Spanish. They speak Nahuatl. And when the enumerator comes, and speaks to them in Spanish, they don’t understand him. (PH-3)

The second had to do with whether the person who gives the information to the enumerator is knowledgeable regarding household resources:

When they came to one house they found only a young boy. His mother was not at home. They asked him, “can you give us the information?” But the boy was so young... They asked him, “where is your mom?” And he said, “taking care of the cows.” So they asked him, “how many cows has your mother?” So he told them, “50.” Then they took this data, that the family has 50 cows. But they were not her cows, she was taking care of someone else's cows, someone she worked for (el patron). (PQ-3).

The examples of language and children answering were few, but flag issues that should be given attention to in the process of selecting and training enumerators.

Social and cultural issues encountered in use of a survey

Approximately 50% of the focus group comments regarding the census had to do with problems people had in answering it: either they did not want to answer or they gave wrong information. On the one hand this could be viewed as the ‘fault’ of the non-respondent, i.e., if people do not want to answer or do not answer truthfully then that is their responsibility. However, the fact that peoples’ experience and beliefs lead them to fear or reject answering the questions should be

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18 In preliminary research in the state of Durango, a doctor interviewed also made these points: that enumerators do not know the communities; that they thus miss some outlying places and this has the effect of missing some of the poorest people; and that local people who know the communities (such as doctors) should be consulted.
understood in its social context and consideration given to the problems associated with using of this type of instrument for determining inclusion in a poverty program.

Of these responses, about half explained that people did not want to answer the census, either because they were distrustful, afraid or fed-up with being asked survey questions. These explanations were given in groups in every state except Hidalgo. The other half of the explanations, again raised in groups in every state, stated that people gave wrong information on the census. The reasons, explained in more detail below, include shame over revealing their poverty, language problems and an unknowledgeable person answering the census.

Regarding those who were afraid to answer the census, for some it is because they did not know for what the information was being requested. According to a Michoacán promoter, "One of my relatives told me that my sister doesn't receive [PROGRESA] because she hid. She didn't want to get out to speak with the enumerator, because she didn't know what it was for." (PM2-3)

Responses to the census also are affected by beliefs about government surveys that have developed and then spread across regions. In Veracruz, Michoacán, and Guerrero, beliefs circulate that the government will take things away from people if they give information to the census: they will lose their land, their children, they will be sent away to war. Note the following comments from promotoras in two different regions of Veracruz:

- In my community, people hid themselves when the enumerator came. They were saying, what will they do to us? Maybe they want to make a census to take something from us, maybe our land. (PV2-3)

  The census was the problem, because there were families that were not at home or families that gave wrong information. they didn't want to say the truth. Some changed their names, or some hid. [Q: why?] Because they heard the whisperings that someone will take away their land. Or that someone will take away their children. (PV1-3)

In Michoacán an emblem used by the municipality in documents related to PROGRESA led people to believe that there was a connection between the program and the anti-Christ. This rumor spread to communities throughout the state (it was raised by beneficiaries from both villages interviewed and promotoras in both groups representing different communities throughout the region). This was said to affect both cooperation with the census and take-up of the benefits among some beneficiaries. Below are examples from the two groups of promotoras:

- Many people comment they didn't want the help because it came from the Antichrist. And I said to them, “how can you believe that?” Someone said, “don't spend the money because they will soon take your children. Don't receive this money.” (PM2-3)

  [Q: how do you understand the antichrist?]
- It’s like the devil who is buying their children. Taking away the kids and they said, don't receive this money, they will take your children.

  [Q: there are still people who think this way?]
- Yes, there are quite a few. They are afraid. (PM2-3)

They will steal our children. A lot of people thought this. (PM1-3)
This is a rumor that is of limited geographical concern. What it does say, however, is that rumors can spread far and do affect participation in those areas. This rumor is limited to parts of Michoacán, but other local beliefs arise in other areas. In Guerrero, it was the following:

One old woman who was supposed to be a beneficiary said why should I receive this money, and later they take me to some other place and charge me? (PG-3)

Another old lady, she also was on the beneficiary list, and one day she came to see me and said, “I’m bringing you these papers because I was just frightened by one woman who told me that they will come and put an iron on my forehead like an animal. So I don’t want this money. Take the paper.” I said “no, you do need it.” And you won’t believe but she told me, “why don’t you take the money.” She threw away the papers. People that never leave their houses, they are always at home, they don’t go out so they don’t know. And later when the day of payment came, the old lady came and asked me did you save my papers, I told her “yes, here they are” and she said, “I will take my money because now I don’t have corn.” (PG-3)

In Hidalgo, misinformation appears to have been spread by a political party. A promotora told a story about a woman who had given a wrong name:

I asked her why did she not give her right name? And she said that the organization which she is a member of told her that when someone comes and asks for their name, that they are told don’t give them the right name. So we asked is it a religious organization and the person responded, no it was a political party. (PH-3)

Another case in Michoacán gives some different insight into why some people do not take their benefits:

One elderly couple didn’t wish to receive PROGRESA. When the list came out the woman didn’t present herself. The promotora spoke to the couple and she came to their house but the man said to her, answered very badly, said I have nothing to speak about with you. A man who likes to drink and doesn’t allow his wife to leave the house. So I told him but you really need this resource because you are old people. And then when they did wish they were no longer on the list. (PM1-3)

Another reason people do not answer the census is that they do not understand why the government wants to know the answers to the questions asked. Note the following from promotoras from Guerrero:

People were wondering why they asked so much, why they want to know what do I eat, how much do we earn? (PG-3)

We were asked what do we eat, do we eat meat every day or every three days. How many times a week? That’s what happened with my mother in law. The enumerator found her alone at home, and she told me that he asked her and she answered, ‘why are you so interested in how much and how I eat?’ She didn’t answer the question, and that’s why she didn’t get selected. (PG-3)
Related to this is a sense of being tired of surveys and disappointed expectations that something will come of them. The following is an example from promotoras in Veracruz and beneficiaries in Guerrero and Estado de México:

People mistrust the authorities because they were deceived; because the government promised us this and promised us that and never since I can think, we never did receive any help. That's because when they campaign for office, they go to the community and offer so many things but they never fulfill. And that's why many people, even I, distrust those persons that came to survey. (PV2-3)

Some people left in September so they were not in the village. But the others were not surveyed because they didn't want to, I don't know why... Some were afraid, the others because there were too many questions. For what does all this serve? So they don't want. But now that the help is arriving, now they are asking why don't they get PROGRESA? (BG-3)

[They say] “because we already gave the information last year. We were surveyed 2, 3 times, and we never saw anything. So why do they want more information?” (BM-3)

As seen in some of the above quotes, some comments explaining why people did not answer the census were followed by stories of how they later regretted not giving the information when others started to receive PROGRESA benefits. Now that communities are aware of the connection between PROGRESA and the census there is less of a chance that people will not answer, if news spreads to regions that are being newly incorporated. In preliminary research in Durango as the census was being taken, we observed people from another community who had traveled to this community, asking to be surveyed.

Wrong information given to the enumerator was another frequently given reason for why people were excluded. The main reason why people give wrong information was said to be shame over revealing their poverty. Responding to a question from the facilitator as to why people who are very poor would be left out of the program, a Michoacán promotora explained that

It depends on the information you give. Because if I am poor but very proud, and don’t want anyone to know it, it depends on that. (PM1-3)

A promotora in Hidalgo said that some people in her village were left off the list because:

the day when the census came they said they eat meat, and that’s why they don’t receive. People that do receive PROGRESA told the truth about what they eat. They said that they eat only chilies. (PH-3)

In Querétero and Veracruz, respectively, promotoras reported similar problems:

When they were asked how much money do their husbands earn, or how much income supports the house, some of them reported a very high wage, to give a good impression. That’s why they don’t receive PROGRESA. (PQ-3).

When they started the census, noone knew what it was for. We thought it was the political campaign. Because the government makes census when someone is launching
their campaign. That’s what we thought. We were asked to tell everything like it was and not to lie. They asked us what did we eat, how much money our husbands earn, if our sons work. Then many people felt shame. Well you see the poor families can’t eat like other persons. So because of shame they were telling that they did eat. The shame of eating beans, enchiladas, and that sometimes the families don’t eat because they don’t have food. So that’s why many felt shame and didn’t answer nothing or they thought it better to hide themselves so not to answer. And that’s why many families that really do need, many poor families stay without PROGRESA. (PV1-3)

The more poor they are, they report higher income. (PV1 -3)

The extensive discussions we observed over inclusion vs. exclusion, and the role of the census in determining entrance to the program, suggests the possibility that in the future the program may encounter the opposite problem: Now that people know that the census and relative poverty determines inclusion or exclusion, and given the desire of non-beneficiaries to enter the program, it is conceivable that people may underreport their resources.

One issue that arises from these discussions is how much information should be given to people about the purpose of the census, and what the enumerator is told to say. One promotora said that people asked the enumerator and “he said he didn’t know but maybe some support would come to the family.” (PQ-3) A promotora in Veracruz said that at first she was hesitant to answer the census but then the boy explained, “now you will receive the help named PROGRESA.” (PV2-3) A non-beneficiary from Queréterro also said that “I think somebody did mention something about help but we didn't believe, because there are so many census, so how can we know what it is for?” (NBQ-3). If the enumerator is not supposed to indicate any connection between the survey and government benefits, then this should be more clearly conveyed to enumerators. On the other hand, giving no information whatsoever also leads to problems as cited above, where people close the door on the enumerator for a variety of reasons. The balance between giving too much information and not enough is a delicate one and, given the problems identified above, is an issue that should be revisited.

The reasons explained here for why potentially eligible people did not receive benefits: that they were not home, that they did not want to answer the census for various reasons or answered it wrongly, suggest that there are problems in using a survey method for targeting in rural communities. These should be weighed into a reconsideration of geographical vs. household-level targeting.

(iii) Other explanations

The comments made regarding problems with the census reflect an understanding among respondents that the information given on the census is used in some way to make this decision. However, other beliefs as to the basis for inclusion or exclusion also emerged. One is that the promotora chooses beneficiaries, as reported by these promotoras from Queréterro and Michoacán, respectively:

My sister in law has PROGRESA and people from the village gossip that it was because of my influence. (PQ-3)
In my community people say the *promotora* chooses the beneficiaries. She gives PROGRESA to those she wants to. (PM1-3)

However, the low number of times this was said indicates that this is not a widespread belief. Most of these comments were made by *promotoras* themselves, however, for whom it is a concern.

More frequently suggested was the role of luck, where people said either that a lottery was used, or simply that individuals had good or bad luck. For example, this non-beneficiary in Michoacán said:

> I think it's a question of luck, because more than one person gave the information but not all of them were chosen, and in this region we don't all have...Many people who are poor, did not come out on the list. (NBM2-2)

Other examples include a comment from a beneficiary in Querétero that “only God knows why” and a *promotora* in Michoacán who said:

> In my community, let me tell you that the persons that were not chosen tell me that they are never lucky for anything, that people who were chosen were people who really have good luck. And I told them it wasn't true. (PM2-3).

Although having *promotoras* encourage the belief that it was luck (which we were told happens in some *promotora* training) may help people to accept it and not place blame anywhere, beneficiaries and non-beneficiaries expressed a great deal of sadness about this bad luck. It may be better to instead encourage *promotoras* to explain that the program is trying to be fair by targeting those who most need it.

Most of the comments made regarding problems with the census were made by *promotoras*, which may be because they are more aware of the role of census information than beneficiaries and non-beneficiaries. However, even where people knew that the census was used, in some cases they still saw the decision as a matter of luck, because in their view everyone is poor and should have been on the list. We were struck by the fact that several *promotoras* (from four states, with most of the comments from Michoacán and Veracruz) told us that beneficiaries were chosen by a lottery. The use of a lottery is mentioned in conjunction with the expectations of further inclusion, where people hope that the new lottery will include them the next time. Note these examples from *promotoras* in two different regions in Veracruz:

> We were told that it was a lottery. That the beneficiaries were chosen by lottery and that they will do it again, but they only say that. The government promises but they don't believe it is coming. (PV2-3)

> We were told that everybody, we all can understand things our way. What I understand is, when people ask me why they were not on the list, even though they were surveyed, I tell them I don't know precisely how it was, but probably it was a lottery, and because it was a lottery the lottery can't know who needs it more. Maybe this is how it was, we don't really know how it was. So because we were told that the program was going to be expanded, so in the first phase PROGRESA came to so many persons, in the second one
PROGRESA came to others, so I tell them in my community that probably in the future will come another phase and the people that don't have PROGRESA will enter. (PV1-3)

Finally, we found it interesting that the second most frequent response (spread among groups in every state) of focus group participants to the question, “why are some families included in PROGRESA and others not?” was that they do not know. Sometimes people did not know that there is a poverty criterion, but more often the comments referred to not understanding why some people are considered poor enough and others not. Some people put the question back to us. For example, in Guerrero non-beneficiaries said: “that is what we don’t understand. We don’t understand why. We would like to know why.” (NBG-3). Beneficiaries in the same community made a similar point: “So we would like to know why did the government give us PROGRESA; explain to us, and the others do not have, that's what we'd like to know.” (BG-3) It is perhaps most noteworthy that a number of these responses came from *promotoras*, whom one would expect to know. This response mainly related to their feeling that people should have been included that were not. A *promotora* from Michoacán said:

I don't understand why. For example in my community a lot of people applied, many people were surveyed, but now that the list came a lot of them didn't appear, so we don't understand, at least I don't understand why. (PM1-3)

We got the distinct impression that the lack of knowledge in communities as to the basis of selection left people with a sense of frustration over this bad luck or poor judgment as to who needs it and a sense of insecurity. If people do not know why they receive PROGRESA, then they also do not know why they might lose it.\(^{19}\)

A few other explanations were given as to why people did not want PROGRESA. These comments were infrequent, but worth noting on the possibility that they can give some additional insight into why some people do not take up benefits. These are: people preferred to migrate for work rather than receive the benefits, people do not want help from the government and prefer to support themselves, and people do not want to go to *platicas* or to the doctor.

**Summary**

PROGRESA’s process of beneficiary selection is aimed at making the best use of scarce resources by targeting households living in extreme poverty. To this end, it uses a census to gather household level data. The purpose of this method is to determine which households most need assistance, and to avoid discretionary decision-making at the local, state or national level. While people in PROGRESA communities are not intended to know how families are chosen, it is the intention of the program that they are satisfied with the outcomes. The issue of beneficiary selection emerged as a critical one in our research in PROGRESA communities. Most people know that selection involves a survey, and that PROGRESA is for poor people. However, they do not understand or agree with much of the outcome. This issue emerged as a significant source of discontent and perhaps the strongest criticism of the program from beneficiaries, non-beneficiaries, *promotoras*, doctors and school directors. The main criticism is that poor people

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\(^{19}\) This was apparent at various points in the focus groups where beneficiaries were concerned about how their answers might affect their participation in the program.
are wrongly excluded because of operational failures of the census, or wrong determinations of who needs assistance and who does not.

Problems identified by the above stakeholders related to use of the census related to 1) inadequate implementation and 2) social and cultural barriers. In the first category the problems were that: people were not home when the enumerators came by and enumerators did not return (the main problem); enumerators did not go to remote areas where poor people live due to advice from people who did not know the area or who may have a political agenda; the person who answered did not know the household’s conditions; the enumerator could not speak the local language well enough. In the second category, the problems were that: people did not want to answer the census because they were distrustful, afraid (rumors spread about what will happen) or tired of government surveys of questionable benefit; people over-reported their resources due to shame over admitting their poverty. A better balance needs to be struck between giving sufficient information to reduce distrust, and not giving out so much information that incentives are created to overstate poverty. A better job at establishing more basis for trust might be done before entering the community using local contacts. However, taken together with administrative problems raised above, these problems that reflect local historical, social and cultural conditions may mitigate against the use of poverty targeting via a census. These issues should be weighed into a cost-benefit analysis of different forms of targeting (geographical, household, and self-targeting), paying attention to social as well as economic costs and benefits.

Other ways in which beneficiaries and non-beneficiaries explain inclusion and exclusion is that it is luck: those who were excluded had bad luck and hope they will be luckier next time. Some are told by promotoras or others that it is a lottery. Many are waiting in the hope that PROGRESA will come back and include them. In trying to understand the basis for exclusion or inclusion in PROGRESA, the most frequent response was that people do not understand how the decisions were made, and they want to know why. This uncertainty appears to instill frustration and a sense of insecurity. This, and the problems cited above with the census, highlights the importance of good communication between the program and communities. Effective communication of PROGRESA’s principles and operations are essential for ensuring that beneficiaries comply with its requirements, but also shapes local attitudes toward the program. Ineffective communications can lead to misunderstandings and discontent that spreads to other communities through rumors. People re-interpret meanings of program features in ways that make sense to them and are affected by social and cultural phenomena that are beyond the control of the program. This makes good and persistent communications with communities all the more crucial.
2.1.2 Local Perceptions of the Fairness of the Selection Process

Quantitative Survey with Beneficiaries

In the June 1999 survey, 86% of beneficiaries said that the benefits are received by families who most need them. However, 45% also said that many families who need the benefits do not receive them. Note that these responses were only from beneficiaries, not non-beneficiaries who if added might be expected to raise this percentage. Sixteen percent of beneficiaries said that benefits are received by families who don’t need them. It appears from these responses that beneficiaries feel that there is a small problem with people getting benefits who do not need them, and a bigger problem with people needing benefits who do not get them. Results were roughly similar in the November 1999 survey, except that the number of beneficiaries who said that there were many families who need the benefits and do not receive them fell to 36%. This may be a reflection of the “densification” process that increased total coverage of those the government designates as “poor” from 52% to 78%.

Focus Groups with Promotoras, Beneficiaries and Non-Beneficiaries

In the focus groups, we asked participants their opinions about the selection system, whether they felt it was working properly and fairly, and why. The question consistently generated a barrage of responses, with a total of 111 comments or dialogues responding directly. Of these, just 12 said they thought the process was fair. The 99 comments or dialogues explaining why the selection was not fair was spread across all six states and were made in all groups of beneficiaries and promotoras. Interestingly, of these comments that the system was not fair, only about one-quarter were made by non-beneficiaries, with the remaining comments made approximately equally by beneficiaries and promotoras. This is consistent with the findings in the PROGRESA community study (Adato 2000), where beneficiaries and promotoras talked more freely about feeling bad that their friends, family and neighbors were excluded, and about the non-beneficiaries bad feelings, with non-beneficiaries speaking less on this issue, but alternating between complaining and displaying an acceptance of the cards they were dealt.

Among the assessments that the system was not fair, the responses can be divided into two main types: about 65% expressed that families in need of PROGRESA do not get it, while 35% said that families who get it do not need it. This can be seen in a very rough sense as consistent with the survey results. These comments of both types emerged in groups in every state, with the exception of Guerrero where no one mentioned that there were people who got benefits that did not need them. About half among the first type of comments make the point that everyone in their village is poor and thus everyone needs PROGRESA. The following are typical comments

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20 This question may have been interpreted as whether it is the ‘very needy’ receiving benefits, rather than as a request for a comparative judgment, in light of the answers to the next question that might otherwise appear as contradicting the first.

21 It is not certain, however, that those who answered differently are in communities where densification occurred.
from beneficiary, non-beneficiary and *promotora* groups in five states, Estado de México, Hidalgo, Veracruz, Guerrero, and Querétaro, respectively:

Well there is no rich here. Maybe less poor but we all need. (NBM-5)

Here we are all poor. We all have nothing. (NBH-5)

We should all receive because we are all poor but there are some people that do not receive. [Q: Are some poorer than others?] We are almost all the same; there is no one that has more here. We are all the same. (BV1-5)

Here everyone needs because we are rural people. Here everyone lacks. All of us are poor. (PG-9)

In this community there are no people who have too much. (BQ-9)

Many of the comments simply state that there are people who are very poor and not receiving benefits. Although it is hard to make this distinction clearly, some comments suggest that a selection system based on relative poverty is irrelevant where everyone is poor, while others imply that a selection process based on need is fine but that those who need the benefits have been excluded, i.e., they do not agree with its implementation. The following comment is from a non-beneficiary in Michoacán:

We noticed that there are people who have shops, who have a business, they have somewhere to get money and they receive, and one that has nothing doesn’t receive. (NBM1-5)

Among the comments indicating that families who do not need PROGRESA receive it, there was a focus on professionals and teachers, who also were mentioned when the groups were asked who should *not* receive PROGRESA. For example, a Veracruz *promotora*, and non-beneficiary from Michoacán, respectively, said:

In some communities there are people that get and do not need. For example, some professionals, and because this program takes everyone into account, so they also gathered wrong information. For example, there are teachers that had their car parked in front of the door of their house and they said this car was there just because they were taking care of it. And these people receive PROGRESA, so I think it is not just, because these people really do have. (PV1-5)

There are people that receive PROGRESA who have cars, who have vegetable gardens, so many things. They have so many things and one has to work to eat because if one does not work one does not eat. (NBM2-5)

When asked who *should* get PROGRESA, most respondents said it should be everyone because they saw themselves as equal and all poor. The main reason given is that ‘everyone is poor,’ as the examples above illustrate. However, the other reason given is that both beneficiaries and non-beneficiaries feel bad when some are elevated and others are left behind:
I think that even though it is little but let us be equal. In order that the other don’t feel [bad], because now as we say the others are satisfied, we that receive are satisfied, but the other that don’t receive are upset. (BM1-9)

Finally, a major problem related to the targeting system has to do with tensions and divisions introduced in communities by the programs’ designation of beneficiaries and non-beneficiaries. Beneficiaries, non-beneficiaries and *promotoras* all report a breakdown in social capital that manifests itself in various ways. It takes the form of resentment and gossip, and non-beneficiaries’ reluctance to participate in health *pláticas* because they are ‘for PROGRESA’s people,’ or communal activities such as *faenas* because they are ‘not being paid.’ This increased social conflict is among the strongest argument for using geographic or self-targeting rather than household targeting. This issue is the subject of a separate report on effects of PROGRESA on community social relationships (Adato 2000).

It is encouraging that few comments suggested that people think an individual influenced the list, e.g., the *promotora* or municipal official. This means that people generally do not have the impression that the process is corrupt or favoritism being granted. However, some *promotoras* said that non-beneficiaries hold them responsible. As noted below, a few school directors said that non-beneficiaries believe that the school is responsible for selection.

A number of people commented that they hoped that they would be added in the 'next phase.' In most cases, non-beneficiaries had been told that they would be included next time. In Hidalgo, the entire group of non-beneficiaries said they had been promised that they would be included in the next group. In Veracruz as well, non-beneficiaries expressed the same: "We were told if we wait, it will come." *Promotoras* tell this to beneficiaries because they were told there would be a new round of incorporation, and it also appears to be a means of placation: "the point is you have to be patient, and it will come...have some patience, it will come with calm." (PM1-8) In some communities there had been a second round of incorporation.

**Interviews with Doctors and School Directors**

Doctors also were critical of the selection process, repeatedly referring to people in their communities who needed PROGRESA but were not beneficiaries, and others who did not need it who received it. They questioned the validity of the selection methods being used, saying that they do not understand the process and the results are not fair:

> The allocation of benefits seems unfair to me because we work with 100% of the people and we know their living conditions. I have one community where there are even teachers who receive the benefits, and in the same community, you have people without shoes, who really need the support, but unfortunately, those who receive it have a higher education level and abuse the support they receive, using it for other purposes (doctor, Puebla)

All the doctors were able to cite approximately how many people or what percentage were not receiving PROGRESA who need it. This lends weight to the suggestion that key informants who know their communities well be asked to review the list to flag areas or individuals excluded in error or people erroneously included. Involving local people in beneficiary selection runs the
risk of reproducing political influence that has plagued past anti-poverty programs, reintroducing the discretionality that PROGRESA was designed to avoid. However, involving professionals such as doctors, or a process of community review that is conducted publicly, could avoid some of the political problems that would be encountered using local government officials. Given the extent to which selection mistakes are made and the tensions caused by this, some system of local level review should be devised. Such a review was originally intended to be part of the program. This issue is taken up again later in this chapter.

School directors also add their voice to this chorus of criticism of the beneficiary selection process. Specifically, they say that the people who did the surveys were not properly trained, they did not know the communities, and they did not try to reach the most remote areas where the need is greatest. In fact, over half of the school directors interviewed made the point that the selection of the beneficiaries was done by people who were not competent to do so, were foreign to the community, and did not know the living conditions of the population.

According to the school directors, one consequence of lack of knowledge about the community is that those doing the survey tended to go to where the municipal government suggested. While in principle this could be useful advice, it has the potential to invite political influence. The director of a secondary school in Hidalgo said:

If it were in my hands, I would do a real survey. To do this, I would focus on my neighbors and not on the influences. It would be more fair, even if this would imply traveling to the remote villages. I know it would do good for those that need it and not only because the delegate decided to whom to grant the scholarship or not, for compadrismo’s sake. I’m not saying it is badly distributed, but there are more people in need that deserve to receive it.

School directors raised the problem of political influence a number of times. Some said that political parties took advantage of the program during campaigns and that municipalities influenced the selection of beneficiaries. They raise a potentially valid caution that political influence can enter the process through local officials influencing where the survey takes place. However, the extent to which the school directors believe that the municipal government influences beneficiary selection appears to be more of an indication of a broader problem that emerged in the interviews with school directors, that they had received little explanation of the operations of PROGRESA.

School directors were critical of the outcome of the selection process. Like the doctors, they feel they know their communities and can see where the list is wrong. A doctor in Querétero said:

Well frankly I don’t know how the data was taken for PROGRESA because there are families here in this community that are poor, poor, poor- large families, who do not get the support of PROGRESA and we have proven this; I have been here 8 years and know the whole community, inside and out, all the communities where my students come from, because I am always careful to visit them over there to see how each of them lives, and we have found that there are many poor people who do not have PROGRESA and we don’t know why they have been left out of the program.
Almost all the school directors felt that they should have been asked to review the list for fairness. They said that if they were involved, they would make the selection more fair and equitable. Speaking on behalf his colleagues, the director of a telesecundaria in Hidalgo said:

In the principals’ meeting, we have commented that…we who are here or in the communities every day, we know…not all, but most of the people. Well, we should have been asked before beginning this program to see if indeed they needed it…so that if someone who had a better economic situation received it, well, too late, right? But unfortunately is was not like that; it was 2 or 3 years ago when we were just being informed about the management of the program and what its goals were…They should conduct a new survey so that those who really need PROGRESA are the ones to whom it is given--because for example, in some communities, I know that there are some teachers whose children are receiving these benefits and I feel that--well, no!…I tell you, we know neither where nor when this survey was conducted.

Doctors and school directors also refer to tensions and divisions among beneficiaries and non-beneficiaries that have been introduced by the program. For example, a doctor from Veracruz said that beneficiaries and non-beneficiaries:

…bad-mouth each other, they even stop talking to each other; from buddies that they used to be, they stop talking… The fact that some people receive the benefit and other do not has caused a lot of problems and people wonder why do they give to me and not to you.

Finally, as mentioned above, school directors provide some additional insight into local perceptions of fairness in reporting that in some communities beneficiaries and non-beneficiaries attack the teachers, believing that they are responsible for selection. They ask the teachers to explain the reasons for their children being excluded while the children of others are included (some of who, in their opinion, need the money less).

Summary

In the June 1999 survey, 45% of beneficiaries said that many families who need the benefits do not receive them, falling to 36% in November 1999, possibly as a result of “densification.” Approximately 16% said that benefits are received by families who do not need them. In the focus groups, when participants were asked whether they thought the beneficiary selection process was fair, the question generated a great deal of response across all the groups, about 10% of which said that they thought the process was fair. Beneficiaries and promotoras raised the issue of lack of fairness far more frequently than non-beneficiaries, indicating they are affected by this exclusion too. The surveys, focus groups, and interviews with doctors and school directors were consistent in their primary concern that there were many poor people who needed PROGRESA and had been wrongly excluded, and the secondary concern that there were people who received PROGRESA but did not need it. With regard to the latter concern, the focus was on professionals such as teachers, or people with cars or shops. With regard to people who need the benefits and do not get them, in addition to the problems raised with the census, the main reason that beneficiaries, non-beneficiaries, and promotoras feel that the selection is unfair is that they perceive everyone to be poor, “equal,” and in need of the benefits. Beneficiaries and non-beneficiaries feel bad when some are elevated and others are left behind.
Doctors and school directors do not think that everyone is equal but instead think that the selection is done poorly and the results are wrong. In addition, beneficiaries, non-beneficiaries, promotoras, school directors and doctors all raise the issue of tensions and divisions created in communities between beneficiaries and non-beneficiaries as a result of the program’s including some and excluding others. The ‘success’ of anti-poverty programs must also be judged by how its beneficiaries and others in poor communities evaluate it, and like the program. While all local stakeholders have strong positive feelings about its health, education and nutrition dimensions, they have strong negative feelings about beneficiary selection.

This again points to the need for a better system of communication between PROGRESA and community members and local service providers (doctors and school directors) so that people at the local level better understand the methods for selecting beneficiaries. However, if equal treatment is more important to households than relative poverty distinctions, then better communications or more accurate assessments may not sufficient. Although by economic criteria the targeting system may be performing well, the unmeasured social costs are high. Once again, the program should weigh these social costs in a reassessment of its targeting system.

Regarding the issue of political influence, very few comments in the focus groups indicated that people believe the selection is influenced by a local individual such as a local official. However, some promotoras expressed concern that they were blamed, and a number of school directors said that beneficiaries and non-beneficiaries attacked the teachers, holding them responsible for the selection. Doctors and school directors made the point that the selection should be made or reviewed by local people who knew the communities well and could make sure that the enumerators did not miss areas and that the final list was fair. However, this kind of guidance would have to be approached carefully so as to avoid political influence. Some school directors said that municipal officials influence the process for political ends by guiding where the enumerators go and through other means. This may be a real concern in some areas, but the extent of their concern about municipal influence indicated a lack of information on the part of school directors about how the selection process works.

2.2 Program Induction: Community Participation and Provision of Information

After the census is taken, the data analysed according to program criteria and the list of beneficiaries generated at PROGRESA headquarters, the induction process introduces communities to the program and enrols beneficiaries. The design of the program mirrors the belief that its effectiveness at alleviating poverty in the long-term depends crucially on beneficiary households and communities accepting joint responsibility for the successful operation of the program. This is reflected, for example, in monetary transfers being conditional on household behaviour.\footnote{Subject to meeting these conditions, beneficiaries are allowed to stay in the program for three years after which they can apply for re-admission.} It is therefore essential that beneficiaries understand the objectives and design of the program (and its sub-components), and their responsibilities in terms of what is required of them in order to be eligible to claim the monetary transfers. Two aspects of the
program’s design address this issue, the program induction process and the community *promotora* (the *promotora* is taken up later in this report).

### 2.2.1 Program Induction

Once beneficiaries are identified, a community general assembly is arranged which provides information on the design of the program (i.e., assistance, obligations, operation etc.). Eligible households are identified and are asked to sign an “Acuse de Recibo” to certify that they agree to participate in the program and that they have received all the necessary documentation and information regarding program operation and their commitments. They should receive:

- A temporary identification card which will be replaced at the time of their first payment by a permanent identification card (“Cedula de Identificación”) and a hologram card consisting of six hologram stamps, one for each bi-monthly payment of the year.
- An E1 form for each family with at least one child eligible to participate in the education component of the program. This form contains a list of eligible children in the household and is required for the registration of children at school.
- A health form with two sections; S1 for registration at the health clinic, and another (“formata CRUS”) that must be presented at the time of the first payment as proof of registration.

An information booklet (“Guía para la titular de la familia beneficiaria”) contains various materials with information on each of the components, their operating mechanisms, and on the schedules and procedures for receiving the different supports. A bi-monthly bulletin containing information on program operation and on related issues (e.g., channels through which the program is meant to have an impact) is also available. Posters with similar information are placed in schools and clinics and are meant to be easy to read and understand. The program also uses the network of Indian radio stations from the National Institute of Indigenous Peoples to air messages in 28 indigenous languages.\(^{23}\)

### 2.2.2 Community Participation

PROGRESA policy intends for communities to have a role in reviewing the list of beneficiaries. Early policy proposed community participation in the control, supervision verification and evaluation of the program, through the establishment of a system of “social comptrollership.” One of its main tasks was to be “an analysis of the list of the Program’s beneficiaries in the locality, to help verify the accuracy and quality of the procedure followed in identifying

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\(^{23}\) Beneficiaries absent during the assembly are incorporated at the time of the first payment. Also, two minor changes were made since the beginning of the program. First, CONPROGRESA previously produced all the documents and sent them to the UAEPs, but now production is done by the latter. Second, the S1 forms were previously sent directly to the health centers by CONPROGRESA (i.e., to the center nearest to the household) but not it is given to the beneficiary who chooses which clinic to attend. This registration information is passed on to the state health authorities.
households in extreme poverty, that is to say, that the assistance is in fact reaching those who most need it” (PROGRESA 1997).

This role for the community has been scaled back since earlier program visions. According to personal communication with program staff, current policy envisions that beneficiaries are actively informed of the general assembly while the non-attendance of beneficiaries is not discouraged. During the assembly claims are to be registered concerning both households that should have been selected to participate but were not, and those that were selected but should not have been. This information is to be sent to CONPROGRESA for assessment. For households that were not selected because they were absent on the day of the locality census, their relevant socio-economic characteristics are to be subsequently collected and the same selection methodology applied. For those who were present, the analysis is to be conducted again and, if they were just close to the poverty line, their case may be reviewed. How exactly this process has worked in practice was not thoroughly investigated in this report. The beneficiary survey does not address it, though the focus groups do address the question of appeals. Further investigation is needed given the emphasis put on the need for consistent application of the criteria, and the degree of discontent at community level that emerged in the focus groups and doctor and school director interviews. From the survey data, however, it appears that the changes have been in terms of adding households rather than dropping them. It is not clear to what extent this reflects response to petitions or the systematic application of new criteria.

Focus Groups with Promotoras, Beneficiaries and Non-Beneficiaries

Given the degree of concern expressed about inclusion and exclusion, the focus groups explored whether communities were getting a chance to appeal mistakes they find in the selection, and whether the assemblies were being used for this purpose. In none of the groups did anyone say that this had occurred at the assembly. The main explanation was that non-beneficiaries were not invited to the assembly. Only those ‘on the list’ had been invited because people see the purpose of the assembly to be for explaining the program to beneficiaries and thus not relevant for those who were not selected:

All beneficiaries were invited, the beneficiaries who were on the list, so they only explained to us what is going to be our duties, if we accept PROGRESA. Then we chose promotora and that's all. (PQ-8).

Non-beneficiaries said they would not go because they were not invited:

No I didn't go because I heard that only those that came on the list will go so because I wasn't on the list, how could I go? (NBV1-8)

When the list came out, the lady with the loudspeaker mentioned the names and why should one go if one is not invited? If ones name does not get out? (NBM1-8)

A Michoacán promotora explained that she did not invite non-beneficiaries because there was no point in putting them to the trouble, and stirring up their resentment:
My community only invited people who were on the list. Because they had to come to receive their notification. Because if I invite the rest of the people they will only waste their time and after that they will blame me, they will talk about me behind my back and they will say, “why did you invite me?” (PM1-8)

In a few cases people asked for explanations of the purpose of the meeting but municipal authorities did not offer them. Municipal authorities could play a more useful communication role than they appear to in these comments made by a Guerrero promotora and Querétero non-beneficiary:

Somebody came and gave us this notification, ‘tomorrow you have to go with the women to another place to Chilapa.’ [Q: what happened with women not on the list?] They only came to ask what it is about. [Q: Did they ask to go to Chilapa?] No, they came to ask here in the community, because the women from the village don't leave the village, they don't speak Spanish so they just came to ask the promotora, "why were we not on the list? Why don't we receive help? Why did you only choose some of us?" and I said, it wasn't me who chose. The list came here, I don't know where from. Then we went to ask the Presidente Municipal and he told us, I don't know anything about it. (PG-8)

He said that the persons who were there should go to the meeting. I thought it was for the people of the ejido or something like that, only between them. So we that were not named, why should we go if it is in Ixquiapan? [Q: But there were no meetings in the community where it was explained?] No not at all, because actually when the subdelegate told us that named persons have to come there, even he didn't know what for. He just told us that [the beneficiaries] have to present there (NBQ-8)

A number of comments said that it is not possible to influence the list. All but one of these comments were made by promotoras. Below are illustrations from Guerrero and Michoacán:

The names already came, and well if the names came, there is nothing we can do. Lets suppose if they already are in the program and I'm not, well there is nothing I can do because as much as I tell you, the solicitations are already made...(PG-8)

The community had a meeting principally for knowing who was chosen. But the community can't say if someone should receive or 'give it to me because I need it.' (PM1-8)

In about one-quarter of the comments, respondents said that non-beneficiaries either attended or were at least invited to the assembly. Among these none said that a process took place where the community discussed whether people who were left off should be added. As in these examples from Michoacán, non-beneficiaries explained that they went to the assembly but then felt that since they were not involved they should not stay:

Yes people came and they invited us. I came to the assembly and I asked and the man asked me the names of my children. Then he told me no, you were not selected, so they separated us, beneficiaries from non-beneficiaries. Then I didn't want to stay, so I left. (NBM1-8)
I did come to the assembly and I was told to bring my identification. And there you have me running and running and I was told no, you are not here on the list, so you can go. (NBM1-8)

If communities are to play a collective role as a final check on the accuracy of the list, and the assembly is one place where this is to occur, we found no one who was aware of this. In fact, people generally did not understand why non-beneficiaries would attend the assembly, which was for beneficiaries. It seems less likely that the assembly would be used for seeking changes to the list if non-beneficiaries do not attend and if it is not known that this is one of the functions of the assembly. We did find cases where communities had since submitted petitions to include new families on the list, but no examples where new names had been added as a result of a petition. For example, a *promotora* in Guerrero said that “I made two applications, but I haven’t known any results.” (PG13) In general, *promotoras* who addressed this issue expressed the belief that it was not possible to change the list. This does not mean it never happens; of course it has. Rather, it means that it does not happen as often as it should (i.e., in these communities visited where people say the list is wrong). Where households have been subsequently added it appears to have been part of a new round of incorporation.

The value and trade-offs involved with giving communities systematic opportunity to review the list is a policy choice to be made by PROGRESA. Early policy envisioned such participation, but current practice does not appear to. Encouraging communities to submit petitions during the induction process creates administrative and potentially political complications. However, since currently the right to petition and participate does exist, the practice should be squared with the policy. PROGRESA should thus reintroduce this function of the assembly, if this is the best place available for communities to comment on the list and organize a petition. Given the problems identified in this report regarding the potential for mistakes to be made through use of a census, some type of mechanism for reviewing and revising results is needed, one that is systematic and reliable. As noted above, doctors and school directors interviewed suggested using professionals or others in the community with greater local knowledge to have input in the process and help to correct mistakes. However, the original idea of using the assembly for this purpose would keep the process more transparent (such professionals could participate there). Another reason to invite non-beneficiaries to the assembly is so that they understand the principles of the program and why they are not included. This might help to defuse some of the reported tensions.

**Summary**

Early PROGRESA policy envisioned community participation in reviewing the beneficiary list for fairness through the establishment of a system of social comptrollership. The induction assembly was to be an opportunity for claims to be registered concerning both households who it is thought should have been selected to participate but were not, and those who were but should not have been. These claims are to be investigated by PROGRESA and a decision made to add or drop families. From the focus groups and key informant interviews (school directors and doctors), we found no examples of assemblies were being used for this purpose. Non-beneficiaries did not attend, making it less likely that the assemblies would be used for seeking changes to the list, particularly since beneficiaries and non-beneficiaries do not know that this is supposed to be one of the functions of the assembly. Another reason to invite non-beneficiaries
to the assembly is so that they understand the principles of the program and why they are not included, which might help to defuse some of the reported tensions.

The rights of communities to review and challenge the selection of beneficiaries is stated by PROGRESA, so practice should be squared with policy. PROGRESA should thus reintroduce this function of the assembly, if this is the best place available for communities to comment on the list and organize a petition. Given the problems identified in this report regarding the potential for mistakes to be made through use of a census, some type of systematic and reliable mechanism for reviewing and revising results is needed. We did find cases where communities had submitted petitions, either without success or they were awaiting an answer. Promotoras who addressed this issue said it was not possible to change the list. A further research effort should attempt to determine the extent to which petitions are being submitted in communities with complaints, and the outcomes. Given the extent of the belief among stakeholders at the local level (beneficiaries, non-beneficiaries, promotoras, doctors and school directors) that there are mistakes and fairness problems, it would be important to 1) revisit ideas for effective community participation; 2) consider geographic or self-targeting rather than household level targeting.

2.2.3 Program Induction and Information Provision

In spite of the emphasis placed on informing beneficiaries about the objectives, design and requirements of the program, concerns have been expressed by those involved in induction at the locality level regarding the effectiveness of the information-provision process. In particular, some observers have suggested that the difficulties of organizing the general assembly for a 2-3 hour period (e.g., problems with retaining peoples’ attention over this length of time) have adverse consequences for beneficiaries’ understanding of the program. However, beneficiaries also receive an information booklet that can compensate for poor induction.

Quantitative Survey with Beneficiaries

In the June 1999 survey, households were asked if they still have the booklet that they were supposed to receive during induction. Just over 85% still had the booklet, with 11% having received it but no longer having it and 1.4% never receiving the booklet. The percentage never having received the booklet shows very little variation across states, with the lowest being 2.1% in Michoacán (Table 2.1). Overall, 84% of localities, accounting for 73% of households, report all households receiving the booklet. So those not receiving the booklet are concentrated in around 15% of the localities, with all states having their share of such localities.

Out of those who still had the booklet, over 97% said that they read it, had it read to them, or had the material explained to them. Again there was very little variation across states with the

24 Unfortunately, those who received the booklet but no longer had it were not asked whether or not they read it or had it explained to them. For example, they could have read it or had it explained but have thrown away the booklet. In the October 1998 survey these codes were combined, with 96% answering that their commitments were “explained” when they entered the program, the lowest percentage being 90% in Querétero (See Coady and Djebbari 1999, p20-21).
lowest being 92% in Guerrero. Only 26% of localities, accounting for 14% of households, reported everyone having been read the booklet and/or having had it explained to them. But overall, this aspect of the program appears to be actually working well, at least in terms of these outcomes.

In the June and October 1998 surveys, households were asked if the explanations were clear. Out of those in June 1998 who had their commitments explained to them, 87% thought that the explanation was either clear or very clear, this number rising to over 90% in October 1998. Focusing on the data in the October 1998 survey we find little variation across states with Guerrero and Querétero (the smallest states) having the lowest percentage, with 75-80% finding the explanations clear or very clear.

We can get some idea of the effectiveness of the booklet and the explanations of its contents in terms of beneficiary understanding of the program by analyzing the questions where beneficiaries were asked to identify program requirements with the following independent options: (a) to visit the health center, (b) to attend health center lectures, (c) to send children to school, and (d) to use the transfer to buy food. In each case, beneficiaries are registered as having answered correctly and spontaneously (1), having answered correctly when prompted (2), or not being able to answer. Since in the June 1999 survey (October 1998), for all of these questions, over 95% (97%) were registered in the first two categories (“adequate” knowledge), we focus mainly on the first as capturing “excellent” knowledge. Over all questions, in June 1999 between 54% and 69% were registered in this category; an increase from the 27-37% in October 1998. In June 1999 we construct a single dummy variable that takes the value unity if the beneficiary answered spontaneously to at least three of (a)-(d). Overall, nearly 54% met this standard, with the lowest levels in Guerrero (41%), San Luis (37%) and Querétero (43%). This pattern is consistent with those observed in the October 1998 survey where nearly 60% met this standard. It is interesting to note that excellent knowledge of requirements was also significantly positively correlated with the years of education of the head of household.

When we include the operational variables discussed above we find a strong relationship, with those who never received the booklet exhibiting a 19% points lower probability of having excellent knowledge. This decreases to 12% when locality dummies were included in place of state dummies. Disaggregating this operational variable, we find a positive relationship between having had the booklet read and explained and the probability of having excellent knowledge, this probability decreasing if one had it explained only (a 7.4% point reduction), if one neither had it explained nor read (-18.2), if one never kept the booklet (-17.1), if one never received the booklet (-24.1), or if one is coded as not responding to the question (-28.5). These relationships were robust to the inclusion of locality dummies and similar results were produced when we analysed each of (a)-(d) separately using ordered probit estimation techniques.25

25 Similarly, in October 1998, when we introduced a dummy for whether or not the commitments were explained as an extra explanatory variable, it proved highly significant and indicated that knowledge was positively associated with receipt of such an explanation.
Summary

It appears the aspects of program induction covered by the quantitative survey, specifically receiving the booklet and explanation of its contents, is performing quite well in spite of concerns regarding its effectiveness. There are very few problems in relation to receipt of the induction booklet which contains information on the operation of the program and beneficiaries’ responsibilities, and the few that exist seem to be highly concentrated by locality. Similarly, virtually all beneficiaries report having had the booklet either read or explained to them, or both. Those households that do not seem to be spread relatively evenly across localities and states. This pattern manifests itself through most beneficiaries having “adequate” knowledge of the program requirements with no evidence of any outlying states in this regard. However, the fact that the level of “excellent” knowledge is relatively low suggests room for improvement. In this regard, reading and explaining program requirements at induction seems to have had a high return in terms of knowledge. Just handing out the information booklets is not enough. Also, the increase between the surveys in the percentage of households exhibiting excellent knowledge for each component surveys suggests the presence of some learning by doing and diffusion of information. The structure of the program induction thus seems to be important in ensuring beneficiaries know what is required from them to be eligible for receipt of benefits.
CHAPTER 3 — EDUCATION COMPONENT

Education is seen as a pivotal component of PROGRESA reflecting the strong empirical link between human capital, productivity and growth, but especially because it is seen as a strategic factor in breaking the vicious circle of poverty. Investments in education are therefore seen as a way of facilitating growth while simultaneously reducing inequality and poverty.

The stated objectives of the program are to improve school enrolment, attendance and educational performance. This is intended to be achieved through four channels:

(i) A system of educational grants;
(ii) Monetary support for the acquisition of school material;
(iii) Strengthening the supply and quality of education services; and
(iv) Cultivation of parental responsibility for, and appreciation of the advantages stemming from, their children's education.

These are obviously inter-related in that each is thought to enhance the effectiveness of the others in improving attendance and performance.

The system of educational grants is intended to encourage regular and continuous attendance, especially for females. This is reflected in two crucial design features (Table 3.1). Firstly, the size of the grant increases through grades. Secondly, at the secondary level, grants are higher for females. The latter is meant to address the cultural gender bias against female social participation as well as being an attempt to internalise education externalities that accrue to other families after the marriage of females. The level of the grants were set with the aim of compensating for the opportunity cost of children’s school attendance but also include an additional increment directed at the alleviation of current poverty, on average equal to approximately 15% of income earned by children and youths.26

The program design has also tried to incorporate the need to avoid adverse incentives. In order to avoid diluting a household's incentive for self-help, the total monthly monetary transfer (i.e., from education grants and food support) a family can receive was initially capped at 550 pesos (including 90 pesos for food). This may possibly impact on family education decisions, e.g., how many and which eligible children to enrol. In order to avoid adverse fertility incentives, only children over the age of seven years (the standard age of 3rd year primary students) are

26 In the rural context, where there is greater involvement of children in productive tasks at an early age, it was estimated by PROGRESA that what they earned prior to the program accounted, on average, for between 5-9% of the total income of families in extreme poverty (i.e., the target population). This was one of the factors used to set grant levels, together with the proportion of children and youths contributing income to households at different ages. Average monthly monetary household income of poor households was calculated at 685 pesos. On average these households should receive monthly education grants of 206 pesos, approximately 30% of household income. The numbers stated here and in the text refer to the situation at the start of the program (i.e., June 1997).
eligible for education grants.\textsuperscript{27} This may affect households' decisions on whether or when to send younger children to school. In principle, it also may have implications for targeting effectiveness, e.g. the children of the poorest of the poor may never reach the third grade of primary school (especially without assistance). However, the evidence suggests that enrollment rates are much higher over the early years of primary education, presumably reflecting varying household opportunity costs and benefits across children of different ages and suggesting that public intervention geared towards increasing enrollment (as opposed to addressing current poverty levels) should be concentrated on older age-groups as is the case in PROGRESA.

The grants are awarded to mothers every two months during the school calendar and all children over the age of 7 years and under the age of 18 years are deemed eligible. To receive the grant parents must enrol their children in school and ensure regular attendance (i.e., students must have a minimum attendance rate of 85%, both monthly and annually). Failure to fulfill this responsibility will lead to the loss of the benefit, at first temporarily, but eventually permanently.

There are two forms that contain registration and attendance information. Beneficiaries are provided with a form (E1) at the general assembly that contains a list of the names of eligible children. This has to be taken to the specific school where each child is to be registered and must be signed by a school teacher/director to certify enrollment. This form is then returned to, and retained by, the UAEPs when the first payment is collected. The second form (E2), for maintenance of detailed attendance records, is sent directly to the schools: one form per school with names of registered children taken from the E1 forms returned by beneficiaries. Also, valid justification for absences (e.g., sickness) are to be maintained by the school authorities with the cooperation of parents' associations.\textsuperscript{28}

The amounts for the support of school materials differ according to educational level. For primary school students from beneficiary families, the support consists of 120 pesos per school year. This amount will be provided in two disbursements; the first, of 80 pesos, at the beginning of the school year, given children's enrollment in school; the second, of 40 pesos, half-way through the school year, for the replacement of materials, as long as children continue to attend school. For secondary school students, this support rises to 240 pesos and will be delivered in a single payment, at the beginning of the school year, once pupils have enrolled. Children attending primary schools that are supplied by the state-run CONAFE suppliers (under the Ministry of Education), i.e., essentially all schools except those located in very marginal communities, receive school materials directly from their schools rather than a cash transfer. These are delivered at the beginning of the school year and CONAFE informs PROGRESA which schools received the school materials and how much they received.

In line with improving the supply and quality of educational services in the face of increasing demand, the program (with the participation of Federal and State authorities) will attempt to ensure adequate supply of quality schools, supporting infrastructure and school equipment. In addition, a program of training and updating of teaching and supervisory skills is to be

\textsuperscript{27} Exactly how this incentive works is unclear and deserves further attention.

\textsuperscript{28} Recent changes now mean that schools will only return details for those who do not meet attendance requirements.
implemented. These investments are not directly under the control of PROGRESA but are determined at the state level through the Ministry of Education.

Below we address a range of operational issues from the perspective of different actors. Using information from the range of data sets described earlier, we try to build up a consistent picture of how effective the operation of the program is as well as to identify the range of channels through which it is having an impact. At the end of each section we provide a summary of the insights from the various data sets.

3.1 Registration, Enrollment, and Forms

In this section we examine how the program is operating with regard to the registration and enrolment process. We examine how well the distribution of registration forms to households has been performed, whether these have been brought by households to school as well as returned to the appropriate authorities, and any problems that arise for the various parties involved in this process.

Quantitative Survey of Beneficiaries

Of the 6579 beneficiary households common to the 1998 and 1999 surveys, around 80% report that they have at least one child in the age group 6-16 years (17 years in 1999) and are therefore potentially eligible to receive resources from this component.29 Out of these, the percentages receiving registration forms were 93.8% and 96.3% respectively (Table 3.2), suggesting an improvement over time.30

Problems with non-receipt of forms appear to vary spatially with the smallest states in the sample reporting the highest rates. In 1998 non-receipt was highest in Queretéro (17%), followed by Guerrero (8%) and Michoacán (5%). All states show an improvement in 1999, with the highest incidence of non-receipt also being in Guerrero at 7.5%, followed by Queretéro at 6.4%. Non-receipt also appears to be concentrated in a few localities with all non-receipt occurring in 38% of localities, which account for about 50% of households.

Having received the form, households need to take it to school to register on the program. The percentage of those who received forms that report taking them to school to register as PROGRESA students varied little across the surveys at between 78% and 81%. Queretéro,

29 Since eligibility relates to grade and not age, we may be slightly biasing the analysis against good operational performance since many 6-7 year-old children may not be eligible if they are in lower grades.

30 These numbers are based on the 5056 households with school-age children common to both data sets. The figure for 1998 is based on the question regarding receipt of form asked separately for primary and secondary school children. The raw variable in 1999 suggested that over 22% did not receive the form. However, categorizing those who later in the survey said that they had returned the form, or who in 1998 indicated that they had received the form, as having received the form, this falls to 3.7%.
which reported only 61% registering in 1998, increased to 82% in 1999 with otherwise little variation across states. This suggests that the earlier problems in Querétaro have been overcome. The non-registration that remains does not appear to be locality specific since 87% of localities have households reporting non-registration.

Households were asked if they were charged when registering or if they encountered any other problems when registering. The percentage of those registering who report being charged, at 5%, was low in both surveys with little variation across states. In 1999 only 1.4% of beneficiaries report problems when registering, again with very little variation across states. The most common problems were with regard to the school either not knowing about PROGRESA or about the need to register using the forms.31 The few problems that occur also appear to be locality specific and not universal: only 16% of localities, accounting for 25% of households, have households reporting registration problems.

In 1999 households were asked to whom they returned the certified forms: in principle, these were to be returned to the MAP at the time of the first payment. Returning to other persons or locations may be suggestive of political (or other) bodies attempting to take credit for the program and give an erroneous impression of political patronage. Surprisingly, only 30% report returning the form to the MAP, with 60% returning it to the promotora. But exactly what this means for operations is unclear since the promotora may just be acting as a collection agent; one who very often travels to pick up the transfer together with the beneficiaries. Just under 4% report returning the form to the local mayor, with 5% saying that they didn't return the form to anybody, neither of these exhibiting much variation across states.

In order to analyse the implications of operations for program enrolment impacts we combined each of the 1998 and 1999 data separately with individual data for children aged 6-17 years. The patterns of enrolment across surveys, states and age groups are presented in Tables 3.3-3.6.32 Households were asked if each child was enrolled in school. In 1998 we can see that enrolment is very high (i.e., near to 100%) over primary-age groups (i.e., ages 6-12 years), but falls rapidly thereafter to 38% by age 16 years. Secondary school enrolment rates (i.e., ages 13-16 years) also appear substantially lower in Querétaro. A similar pattern is seen in 1999.

To identify the impact of not having an E1 form on enrolment outcomes, we run a probit regression on a dummy variable which takes the value one if the individual is enrolled, zero otherwise, and include as an extra explanatory variable (e.g., along with individual age and gender variables) a dummy variable which takes the value one if the individual resides in a household which did not receive a form and zero otherwise. The coefficient on this dummy can

31 Most of those answering gave "other problems" as a response. Lack of information by teachers regarding how the program operates and its motivations is a theme that we return to later.

32 See Schultz (2000) for a more detailed statistical analysis of the enrolment impact of the program.
be interpreted as the *potential* impact of the program when all households receive the forms.\footnote{33}{Strictly speaking, this interpretation is only valid if receipt of the form is exogenous (i.e., not determined by household behaviour and uncorrelated with unobserved household characteristics which also affect enrolment).} These impacts are reported in Table 3.7.

Over the full sample of children (i.e., aged 6 to 16 years) we find in 1998 that those not having the form have an average enrolment rate which is 6.4 percentage points below that of households receiving the form, this difference increasing to 15.4 percentage points in 1999. But this average impact hides substantial variation across age groups. Splitting the samples into primary-school children (i.e., ages 6 to 12 years) and secondary-school children (i.e., ages 13 to 16 years), we find no impact on the former in 1998 but a 7.1 percentage point difference in 1999. The corresponding differences for secondary-school children were 26.8 and 34.1 percentage points respectively. We also find that this pattern is robust to the replacement of state dummies with locality dummies, as well as to the inclusion of household-level variables.\footnote{34}{When locality dummies were included the probit regression is automatically run only on the sample of localities that have less than 100% enrollment rates. This is obviously more relevant to primary-school children; the impact then relates to those communities with less than 100% enrolment.} Since, over the surveys, respectively 6.2% and 3.6% of households do not receive the forms this suggests that ensuring that all households received forms could increase the average program impact on, say, secondary-school children by 1.2-1.7 percentage points. In other words, although receipt of forms is potentially very important, in practice the fact that a very high proportion of households receive the forms ensures that the enrolment losses due to operational failure in the context of E1 forms is not very substantial. But ensuring operational efficiency in distributing forms each year is crucial to generating enrolment impacts, especially since this occurs annually prior to September enrolment.

As well as potentially affecting enrolment, the non-receipt of forms can have an additional adverse impact since these forms are in principle required to register as a PROGRESA beneficiary of cash transfers. Therefore, non-receipt of a form could (and presumably should) lead to non-receipt of benefits. Given that the consequences may be severe for some families (i.e., no benefits), these numbers appear high. In 1999, households were asked if they had received their scholarships and, if not, why. Just over 26% of beneficiaries report not receiving any scholarship money (Table 3.2), with 4% of these answering that they just did not want it, 6% that the children were not attending regularly, 60% that it was not given to them, 20% that they had not received an E1 form, and 10% that their child had quit school. Non-receipt of scholarships was noticeably highest in Guerrero at 39%. Only 9% of localities, accounting for 3.3% of households, have all households receiving the scholarship. Out of those receiving scholarships, 50% report receiving it every two months (as intended), 20% every four months, and 30% more “irregularly.” As expected, there is a very strong relationship between non-receipt of scholarship and non-receipt of E1 forms, with the latter leading to a 65 percentage point lower probability of receiving scholarships. This similarly applies to those who did not wish to participate, these having a 59 percentage point lower probability of receiving grants.
Also, those who did not take the form to school to register also had a 29 percentage point lower probability of receiving grants. These results were robust to the inclusion of locality (instead of state) dummies. Although the above does not indicate any major problems regarding receipt of scholarship payments (conditional on enrolling children and achieving adequate attendance), there is some evidence that these may are received with a substantial delay.

With regard to the receipt of school supplies, in 1999 60% report receiving school supplies or their monetary equivalent (Table 3.2). This number was lowest in Puebla (48%) and Guerrero (51%), but nearly all localities have some households reporting non-receipt. Non-receipt of an E1 form leads to a 34 percentage point reduction in the probability of receiving the school supplies, this being robust to the inclusion of locality dummies. Disaggregating this operational variable we find a similar effect with a 43 percentage point reduction in the probability of receipt due to not having an E1 form, and with not wanting the form and not taking the form to school associated with a 36 percentage point and a 12 percentage point reduction respectively. All these results were robust to the inclusion of locality dummies. So, even accounting for non-eligibility (e.g., due to not meeting conditions or not receiving an E1 form), the numbers above suggest that the distribution of school supplies may be encountering problems and so requires further attention.

Quantitative Survey of School Directors

We now turn to the analysis of the survey of school directors. These surveys (for 1997, 1998 and 1999) do not have any information related to the E1 and E2 forms or on the processes related to students’ enrollment. We analyze primary and secondary schools separately, the latter expected to have experienced larger enrollment (or demand) increases.

(i) Primary schools

Table 3.8 shows the results from the three surveys about changes in enrollment levels in these years. The percentage of schools that report having experienced increased enrollment over the previous year has remained relatively steady between 1997 and 1999, at roughly 40%. A similar percentage of schools report having experienced decreased enrollment over the same time periods. The remaining schools showed no change. The results were no different by community type, i.e. whether the schools were located in PROGRESA communities, control communities, or outside communities with PROGRESA beneficiaries. This is as expected since primary enrollment rates were very high everywhere.

Among the schools with reported increased enrollment, the percentage increase in the student body was 14.6% on average in 1998. The increase was greater among schools in PROGRESA communities and outside communities (16.2% and 19.1%, respectively), compared to the control communities (6.2%). In 1999, the increase in enrollment rates was 12% for PROGRESA and control communities, but was lower (only 4%) among outside communities. The factors reported by school directors in both 1998 and 1999 as mostly responsible for the increased enrollment rates were the PROGRESA program, followed by population growth, re-incorporation of children who had dropped out of school, and improved quality of teaching (in decreasing order; see Table 3.8). More than 50% of the school directors expressed concerns about the following
problems if enrolment continues to rise: lack of teachers, lack of furniture and lack of classrooms. The responses were consistent in 1998 and 1999.

Among the schools that reported decreased enrollment (approximately 40%), the average decrease in enrollment rates was 12%, without any differences between the three types of communities. The main reasons reported for the decreases in enrollment rates were: (i) that there was a decrease in the population or that families had left the communities (75% in PROGRESA and control communities); (ii) that economic conditions had deteriorated (approximately 42% gave this reason); or (iii) that children go to schools in other communities (this response was more common among the schools from outside communities). Other pre-coded answers such as changes in teachers or lack of adequate installations were rarely given.

The PROGRESA program is supposed to assist students with school supplies. According to the school director surveys, large proportions of children have received all textbooks (93% and greater) since 1997, as well as school supplies (80% and greater). Although there is a slight drop between 1998 and 1999 in the percentage of schools reporting that children received school supplies, from 88% to 80%, the percentage receiving school supplies overall remains high. There were no differences between community types in the percentage of schools receiving school supplies or textbooks. It is unclear, however, how these school supplies relate to those supplied through the program. But it is clear that the situation described is at odds with that described in our analysis of the beneficiary survey.

(ii) Secondary schools

From Table 3.9 we can see that secondary schools experienced marked increases in school enrollment in 1997 and 1998 (Adato et al. 1999), consistent with the introduction of the program in 1997/8 and the statistical analysis of Schultz (2000). In 1999, however, a small drop in the percentage of secondary schools reporting increased enrollment was observed, from a high overall 83% in 1998 to 65% in 1999. The percentage increase in the number of students enrolled among schools with increased enrollment rates in 1999 was slightly higher for schools from the PROGRESA and control communities, compared to the outside schools (21%, 24%, and 14%, respectively). More than three quarters of the school directors reported being concerned about continued increases in enrollment rates as schools have insufficient space, teachers, furniture and supplies.

Conversely, there was also a greater percentage of schools in 1999 reporting a decrease in enrollment compared to previous years (23%, compared to 15% and 10% in 1997 and 1998, respectively). More schools from the outside communities reported a decrease in enrollment rates compared to PROGRESA and control communities, and among those who documented a decrease in enrollment, the outside schools also experienced the greatest percentage decrease in enrolment rates (27% compared to approximately 11% for other types of communities).35

35 Note that because of the very small sample size for control communities (n=9), the statistical significance of differences is not reported here.
Surprisingly, in 1999 only approximately 14% of the secondary school directors indicated that students had received school supplies. A similar pattern existed in 1997 and 1998 (i.e., 2.4 and 6.2%, respectively). However, as above, it is not clear that these supplies are at all related to those coming through the program, especially since PROGRESA secondary students receive monetary transfers to finance the purchase of school materials.

**Qualitative Interviews with School Directors**

The interviews with school directors began with a very general question about the changes that PROGRESA had brought to each school. The most frequent answer to this question was that due to PROGRESA there were more children in school; more specifically, this was expressed by 12 (out of the 18) secondary-school directors, with percentage increases varying from 10-50%. Some noticed a decrease in dropout rates. For example, the director of a telesecondary in Querétaro stated that before PROGRESA his school had a dropout rate of 20 students a year, while now, with PROGRESA, there was a dropout rate of about 8 students on average. The director of a technical school in Veracruz said that before PROGRESA about 6-10 students a year would drop out because:

> they could not pay their expenses, but now they have something for their food, for their notebooks, the supplies they use, so yes, it has brought us benefits because yes, it has helped the children.

However, the fact that since PROGRESA more children are attending secondary school seems mainly due to the increase of new entry registrations (i.e., higher continuation rates) and less to the decrease in dropouts. The director of a telesecondary in Puebla commented that since PROGRESA’s arrival 98% of the children finishing primary school enroll in secondary school, which was not the case before.

Since the condition for maintaining a school is that it have a certain number of students, PROGRESA has in a way contributed to the survival of some of them, as expressed by the director of a technical secondary school in an indigenous community in Hidalgo:

> Well, I feel that the impact has been considerably positive. Before, the number of students was very small and yet from the moment PROGRESA was implemented, well, there was a considerable increase of students and it has benefited us because at a given moment, without PROGRESA, the school probably would have disappeared.

There is often much pressure on parents in smaller localities to ensure that their children do not dropout after primary school in order to prevent the loss of their school due to insufficient demand. In some of these circumstances, the introduction of PROGRESA does not necessarily increase enrolments where sufficient incentives existed previously, though presumably adds additional support for this objective. For example, in an indigenous telesecondary in Hidalgo, by community accord all children who are of age to be enrolled in secondary school have been in school since its creation. In some cases school staff have worked to influence families’ attitudes towards education and increase enrolments this way. The director of a telesecondary in Queretéro explained the increase in enrollment in the following way:
I began working here in 1992 when we had a total enrollment of 45 pupils in the three grades. We tasked ourselves to make invitations directly to the communities; we would make house by house visits and show them the need for secondary education, and in speaking to the parents we created an awareness and to this date we no longer have to create this awareness, they themselves come on their own to enroll.

It is worth noting that in two schools, the increase in the number of students was perceived as a problem since it put extra pressure on already constrained resources (we will return to supply issues later). This is illustrated by the following dialogue with the director of a telesecondary in Queretéro:

Look, to begin with, we worked last year with 59 students in first grade, due to PROGRESA. Due to the administration’s not authorizing another teacher, it was very difficult for us to work with 59 students and one teacher, when the regulations state that there should be two teachers for 50 plus 1 students. The authorities argued that we did not have enough space (for a second teacher). That is, with the advent of PROGRESA came benefits but also a problem of space, so with the help of parents and the state government we built another classroom. But for the coming year, we are going to need another classroom because with PROGRESA, I told you that we had about a 30% increase in students; if 60 students come out of the primary schools and between 50 and 55 go on into secondary school, then this is little.

[Q: How did you manage when you did not have another teacher?] When we did not have a second teacher, the sole teacher, thank God, fulfilled his duty, which was very difficult working with 59 pupils. But then the homework wouldn’t be graded, and the education content was more general than that of a telesecondary. A telesecondary should be more direct with the student, with greater understanding, but in those situations it just couldn’t be done, it was impossible; the teacher couldn’t even walk between the desks.

That being said, three directors said that the increase in the number of students took place in the first years, at the beginning of PROGRESA, but that dropouts are once again taking place. A director of a telesecondary school in Hidalgo, for example, attributed the increase in dropouts to the general economic condition of the country. Another director of a telesecondary in Hidalgo gave a similar opinion but also emphasized that, in his opinion, students were initially forced to go to school but eventually lost interest, especially if the scholarships were delayed:

Some would come only to fulfill the requirements of the scholarship, and they really didn't take advantage of this benefit, and besides, if they are a bit behind, if they had not gone to school for one or two years, suddenly they face serious problems, because they don't reach their learning level and they forget some basic things. So it takes a toll on them and so there was a decrease in the number of beneficiaries.

Another reason given for the recent fall in enrollments in some schools was the opening of new schools. For example, the director of a telesecondary in an indigenous area of Queretéro attributed the decrease in enrollment in his school to the fact that several telesecondaries opened up near his school and took in a portion of the students who previously would go to his school.

Another issue addressed was whether the PROGRESA scholarships result in some students switching from telesecondaries to the technical schools in search of better learning conditions.
The majority of telesecondaries do not seem to have had this problem mainly because surrounding schools were of a similar kind and travel costs were usually prohibitive and not adequately covered by the scholarships.

With regard to children who were eligible but failed to ever take up the scholarship, the general view was that this was due to lack of interest in schooling for some parents and older children, especially when they could earn relatively high incomes by working. For some, it was suggested, forgone earnings plus the additional expenses of schooling (although thought small) make extra schooling less attractive. For example, in two schools in Queretéro the children who have the chance to migrate to the United States prefer to do this rather than stay and study, despite having received the PROGRESA scholarship. This appears to occur on a wider scale. According to one of the director from these schools:

> There is much influence from the families that are in the U.S. and they are lured by the money. We can count on the support of the primary school, which has some 30 or 50 students in each level, but at the secondary level, this decreases by about a half, which means that there has been a very strong migration of secondary students who stopped halfway.

Summary

From the quantitative surveys of beneficiaries, we find that the distribution of the E1 forms required by the household to register as a PROGRESA beneficiary has worked well. As one would expect, the percentage of households reporting that they did not receive the E1 form has decreased over time from 6.2% to 3.6%. This mainly reflects a relatively big improvement in Queretéro where the percentage not receiving the form decreased from 17% to 6.4%. All states exhibited an improvement over time, an important trend since non-receipt may have important consequences for the observed impact of the program, e.g. both in terms of schooling outcomes or receipt of cash transfers. Few report problems when registering and these also appear to be concentrated in a few localities in each state.

The non-receipt of the registration form is associated with a lower average enrollment rate of nearly 6.4 percentage points. But this average hides substantial variation across age groups. Non-receipt of the form does not appear to be associated with lower enrolment rates for primary school children in 1998, but is associated with a lower enrolment of 7.1 percentage points in 1999. Over both surveys, non-receipt of the form is associated with substantially lower enrolments, at between 27-34 percentage points, for secondary school children. However, given the low proportion of households not receiving the form, one can conclude that the resulting operational failure is relatively small: ensuring everyone receives the form would increase the average enrolment rate by no more than 1.7 percentage points.

So the program appears to have had a substantial impact on enrolment rates, especially in secondary schools. The results from the quantitative survey of school directors also verify that enrolment impacts have been especially large in secondary schools, sufficiently so that teachers are now even more concerned about space and resource constraints and education quality. Directors identified the introduction of PROGRESA as the main reason for this increase. The results from the qualitative survey of directors attribute the large increase in enrolment more to
increased continuation rates and less to the decrease in dropout rates. In some cases this increase has enabled some schools to survive where previously they may have closed due to inadequate demand. There is some evidence that the initial decrease in dropout rates later reversed as students primarily motivated by the transfers (as opposed to the benefits of further education) failed to keep up and thus decided to discontinue in spite of losing the transfers, or because the benefits of working, particularly involving migration, were perceived to be greater than staying in school, despite the transfer. This was probably more true of older children.

As expected, we also find (in 1999) that those not registering their children at school have a very low probability of receiving the scholarship. In all, 26% of the beneficiaries report not receiving the scholarship, either because they were ineligible or it was never delivered. This has obvious implications for the actual impact of the program on poverty alleviation and on consumption and nutrition impacts. Non-receipt was noticeably higher in one of the states at 39%. It is important to get a deeper understanding of this phenomenon and it is hoped that in a later report we can to analyse the cash transfer data recently made available by PROGRESA to shed light on these findings. Also, only 60% report receiving school supplies, this being 34 percentage points lower for those not receiving the registration form. Those not wanting the form or not taking it to school also have a 36% and 12 percentage point lower probability of receiving these supplies.

3.2 Attendance

In this section we examine the implication of the program for school attendance and how well the monitoring of attendance is being implemented. In order to generate higher human capital, it is important that children attend school regularly and participate, and not just sign up in order to collect benefits. Ensuring adequate attendance is crucial in this regard.

Quantitative Survey of Beneficiaries

As with enrolment, we can also use information at the individual level on attendance levels (conditional on enrollment) to identify any operational impacts. Examining attendance rates we find variation both across states and over time. We first examined the number of reported days missed from a 20-day month (Table 3.10-3.11) and found that the average across all age groups is substantially higher in Queretaro (1.61 days) in 1998 and in Guerrero (9.47 days) and Michoacan (5.11 days) in 1999. We also find that the average increases from 0.76 days to 2.14 days over the surveys, possibly reflecting seasonal factors. However, using regression analysis, we do not find any significant difference between those who received the E1 form and those who did not.

To continue receiving benefits, children must also have “adequate” attendance records, which means attending at least 85% of school days per month. We therefore analysed, using reported days missed, if having the form affected attainment of “adequate attendance” by using as the dependent variable a dummy which takes the value one if the child misses no more than three days out of twenty. The proportion of children meeting adequate attendance requirements (conditional on enrolment) was very high at 97% in 1998 and 89% in 1999, with very little variation across states in 1998 but with Guerrero (45%) and Michoacan (72%) being clear outliers in 1999 (Table 3.8). The results of our regression analysis show that having the E1 form
increased the probability of reaching adequate attendance by 3.4 percentage points for primary-school children and 7.4 percentage points for secondary-school children in 1998. Although the corresponding coefficients on the form dummy were positive (but lower) in 1999 they were not statistically significant. The substantially higher impacts observed when we use locality dummies reflect the difference in the underlying samples since a lot of localities have 100% attendance and these are dropped from the regression. One way of interpreting this is that the program can have a substantial effect on adequate attendance in localities that do not normally attain high levels, but these are a small proportion in aggregate. It is interesting though that the impacts seem to be much smaller in 1999 in spite of its lower average attendance levels. This again suggests some seasonal factors may be at work.

Quantitative Survey of School Directors

(i) Primary

Consistent with the above, the school director surveys provide no evidence that students’ attendance is a problem. In approximately 97% of the cases, school directors reported that less than one quarter of the students missed school 4 days or more per month. When the question was asked in 1999 about changes in attendance rates since the previous year, improvements in attendance were reported in more than 50% of the schools. No differences in reported attendance rates were found between PROGRESA, control and outside communities.

(ii) Secondary

As with primary schools, reported attendance rates among secondary school children are very high, and up to 51% of the school directors noted that absenteeism had decreased during the 1998-1999 school year.

Qualitative Interviews with School Directors

In answer to a general question regarding the changes PROGRESA has brought to schools, the decrease in absenteeism was reported in half of the interviews that took place in secondary schools. Directors attributed this to the conditioning of scholarships on attendance and the strict monitoring of absences. This is illustrated by the words of the director of a telesecondary in Hidalgo:

There was a big change in attendance, right? Or absences, however you want to see it. They have gone down to zero, I could say. Since we are a small community, well we can also detect perfectly those who would often not come to school. Curiously enough, before, when one of the students would get sick, one or two of his closest friends would also not show up to school. When PROGRESA began to pay, well, one way or another they were given warning that absences will not be as they want, either looked over or unnoticed, right? But rather that there is a risk that they can lose their monthly scholarship, possibly for good, so this immediately causes an improvement.

With regard to the filling out of E1 and E2 forms, the latter presumably involving more resources since it relates to attendance and is filled out bi-monthly (as opposed to the E1 form which just
registers enrolment at the beginning of the school year), the general feeling was that this put substantial pressure on both their finances and time. One primary school and eleven secondary school directors (60% of the latter group) considered that the form was not complicated and thus easy to fill out, especially because PROGRESA put effort into simplifying them. It is worth noting that regarding the filling out of the form, in passing they said that no one ever had explained to them how to fill them out and that they learned on their own how to fill them out, by trial and error (and by those that were returned to them), and by consulting with physicians, *promotoras* and their supervisors who also were not very clear as to how to fill out the forms. Nonetheless, the main complaints of the teachers in relation to the forms referred to the fact that they increased their workload, that filling them out and returning them was time-consuming and required a series of additional trips at their own expense.

It was also pointed out that the forms do not arrive sufficiently far in advance so that they are filled out in a hurried manner. Often, the authorities want them filled out unacceptably quickly or “yesterday” as the director of a secondary school in Queretaro put it. This puts staff under substantial extra pressure. The director of a telesecondary in Queretaro expressed that “there comes a time when one feels imprisoned by the quickness.” A director of a telesecondary in Puebla made a similar comment, saying that the delay of the forms’ arrival and the demand that they be returned immediately made them “run all over,” adding that:

> The thing is that sometimes they send them to us and we have to return them immediately, that is, they tell us ‘here are the forms, they are to be sent tomorrow’ and then I scurry about to take these documents so that the president of the parents’ committee can sign them and this causes a work bottleneck.

He also complained that he had to travel outside the community to turn in the forms and even tried to delegate this task to the parents and the *promotora*, but apparently without success:

> It is time-consuming because we have to take them and many times all the way to Huachinango. In principle, I would tell the parents to form a committee or for the promotora herself to take these documents. The problem is that the promotora would say that she doesn’t have the money for the trip, an economic problem, so then I say to the parents ‘you should be aware that you must turn in these documents and you should contribute toward the promotora’s trip.’

In a telesecondary in Hidalgo it was more the fellow teachers who wanted to liberate themselves of the task of filling out the forms and delegate them to their director, who already feels has had an increase in his workload:

> My workload has increased because in this case I am in charge of the administration, I have my group of students, then I have a lot of documentation, and then more and more forms, the truth is that our workload has increased.

When asked how long it takes to fill out the forms he replied:

> We fill them out every two months, and they take, oh, I don’t know, about an hour, half hour, and since you have to do them after class because sometimes you can’t during class hours because you are super busy, so then you do it a little later and then there are times
that the teachers are bothered and they tell me that I fill them out because I’m here all afternoon, so they become shamelessly abusive.

When asked further if the filling out of forms has affected him and his staff he replied:

Yes. Because I don’t have the staff I need to handle it. We have a student population of 408, and I have but one secretary, so this has come to upset everything administratively.

Finally, the director of a telesecondary in Queretéro talked about the loss of time and money that are related to travel and to filling out the PROGRESA forms:

Our school has few economic resources and the problem is that I just finished going to USEBEC [the state education department] and they give me this document and tell me that I have to bring it tomorrow or the day after tomorrow and I have to take it because if I don’t, then they will call my attention and so by taking this document I spend 300 or 400 pesos and this I have to pay out of my own pocket. The school doesn’t pay for it because it can’t, it doesn’t have the wherewithal, and so every two months, one, two or three times I have to go. Then the problem is that we do not have the wherewithal to be doing this transaction. It is a terribly heavy expense.

Similar problems were expressed by other directors. For example, a director of a telesecondary in Hidalgo says:

At first, I did have a huge problem, because my forms were all the way up in Ozochitla and this business of going to look for them up there, because if I didn’t go, the time to turn them in over here to the appropriate offices would pass by, so it was somewhat difficult for me but now, I believe, now they send them to me here.

So the decision by PROGRESA to send forms to schools seems to have been important in reducing the private costs incurred by schools and their directors. The following dialogue with this same director reinforces the importance of this point:

[Q: So before, you had to go look for the forms, or what?]
- Yes, I had to go track them down over there, to see where they were because then, not even the regional supervisor knew where they were.
[Q: But how did you know you had go get them?]
- Because the supervisor would tell us: “Do you know what? This PROGRESA thing is urgent so go see because it is for the benefit of your students, you have to go get it, see what way you can get it so that you don’t lose out. So that the students wouldn’t miss out, here I’d go running behind the supervisor so that he’d give us the forms, and then I have to turn them in, and to this day, I have to go to turn them in all the way to the offices in Meztitlan.

One of our concerns about the program design was the willingness of teachers to monitor attendance truthfully and consistently due to social pressures and an understandable concern for the consequences for very poor households. However, our concerns have been somewhat allayed by the responses of the teachers, although we should emphasize that this issue requires continued and further analysis. Not one teacher complained about the level of absences or the need to monitor absences and enforce attendance rules. The teachers said that, in general,
students missed few classes and that this was the case for both the PROGRESA beneficiaries and non-beneficiaries. Regarding the principle motives for absences, a large majority of the directors mentioned that the first and almost only reason was illness and “excused absences” followed by the taking care of siblings, home affairs and work.

Regarding the monitoring of absences, the large majority of those interviewed concurred that the monitoring is strict (15 secondary school and 4 primary school directors, i.e., almost all those interviewed), and that they excuse only the absences that merit being excused. Among the reasons are illness, family problems or "very personal" problems, or when for any reason they had to leave the community. Almost three-quarters of the directors said that they have no difficulty marking as absent the child of a friend or an acquaintance. How convincing such proclamations were can be gauged from the following:

[Q: Do you strictly follow roll-call, or are there suddenly exceptions allowed?]
No, no way, because we would fall into paternalism. Others would notice and the goals or objectives of the program would be lost. There are exceptions such as when a student is sick or his family has a problem so that the student had to miss school, so in these instances we try to help out. (Director of a technical secondary school in Hidalgo)

Look, what we are now doing is most drastic, that is, when there is an absence, we report it. I have asked the teachers to be as transparent as possible regarding this, and I'll have none of this 'well, I like this kid' or this or that, no….I am very sorry, but this must be so that they take a greater interest, so that they realize that if they fail to attend their money will be suspended and in such cases there are times they resent it. (Director of a telesecondary in Hidalgo)

As far as I can recall, no absent student is the teacher's favorite. Normally, the favored ones are the best ones. If we would cover up for one absentee, the parents would notice and obviously this would bring about problems, not as much between the parents and children but more so between the parents and ourselves. (Director of a telesecondary in Hidalgo)

One must adhere to all these norms and regulations, for the same reason that persons are checking up on us. It seems that they are the ones carrying the roster (and say): 'he didn't come, why did you say he came?' so the students themselves are looking, even when I am counting that so-and-so has 'x' absences and the students tell me 'no, he has more’. They sometimes know more than I do, so therefore I can't get away with it. (Director of a telesecondary in Puebla)

These quotes strongly suggest that both the commitment of teachers to education and their generally positive attitude towards PROGRESA, combined with monitoring by parents, students and local authorities, all play a crucial role in ensuring generally consistent and truthful monitoring of attendance and application of the conditions of PROGRESA. However, three directors admitted to relaxing the strict rules of PROGRESA regarding attendance when they deemed it warranted. This assessment is, in our minds, fairly convincingly reinforced by the following range of quotes:

Exceptions are allowed. We feel we are human beings and as part of the environment where we live and, well, in some ways we are sometimes a bit tolerant. But if the father
of the family or the student exceeds the agreements, well, I'm sorry, we can't be more tolerant. (Director of a telesecondary in Puebla)

They supposedly come to study for their own good. I have told them 'we aren't anyone to take away your scholarship from you; on the contrary, I can neither give it or take it away. You yourselves are the ones who take it away.' And they don't do as they please. Their parents are the ones who say 'ask the teacher's permission so that you can go work' so they come ask me permission and it seems bad for me to tell them 'no'. I tell them "sure, go on, but you have your excused absence. (Director of a telesecondary in Puebla)

We take roll but sometimes we are a bit flexible because there are students who have to help their parents on some days and in this respect we give them permission, even if it says here that they have to present a medical slip to excuse their absence but in this case we are flexible, we aren't that rigid. (Director of a telesecondary in Hidalgo)

When asked "When the children need to help their parents, do the parents themselves come to ask permission or how do they do it?", one replied:

Yes, they come, or they come late in the afternoon. There is a colleague here in the afternoons and they notify her and she then notifies us and since we have already spoken with them that they have one day a month, for example...(Director of a telesecondary in Hidalgo)

Although these teachers admitted that they are sometimes flexible regarding absences, they insisted that the reason for their being flexible is because they recognize the economic needs of the families involved and that it was not out of friendship:

I tell them many times: there is friendship, and there is work. I have no preference or none that would make me not report (absences). (Director of a secondary School in Hidalgo)."

I believe that we are mature enough and understand that friendship is one thing and obligations are another; the obligations they have as parents, the obligations they have as students, and the obligation we have as educators. (Director of a secondary school in Hidalgo).

Finally, the teachers underscored that they are ethical and that even if they help people in need from time-to-time, they do not allow nor do they cover up any abuse:

I feel that the teacher acts ethically, with professional ethics, but what happens is that sometimes the same gentlemen would want these children to receive the scholarship, even if they don't go to school, but they only go this far. I believe that all my colleagues act honestly. (Director of a technical secondary school in Hidalgo)

Last year we had two brothers who were constantly absent, but when they learned it was pay day, they came so that we would stamp (their papers), but then we called the parents and told them "what were we going to tell PROGRESA because they only come to get their papers stamped", and so they dismissed themselves. (Director of a technical secondary in Hidalgo)
However, when asked how they would change the program to reduce absences no useful pattern could be discerned from their answers. In principle, most of the directors think it is fair that the family whose child misses more than the allowed number of absences should lose his or her benefits, especially if it encourages parents to show a little more interest in their children’s education, and if they acquire the habit of going to school to find out about their children's progress. The following reasons were given as to why they thought it justified that benefits be made conditional on attendance:

- because you have to teach the Mexican how to be responsible
- because they consider that PROGRESA pays them so that they study and not go to work
- because if the federal government destines certain monies to humble people, well poor people have to respond, because imagine if the government didn't do anything but send resources and they did nothing but receive them without doing anything
- because they consider that there should be a commitment from the teachers themselves to provide a service, a commitment from PROGRESA, who grants the support, and from the families' parents to send their children to school as part of their obligation
- because it is one way of pressuring the student not to miss school

This is an interesting point we will take up later on when we will discuss the attitudes of the parents regarding education. The directors consider that the parent interested in their children’s education should not only send them to school but also track their progress, be interested in them and go every now and then to speak to the teachers.

Summary

We do not find any strong evidence of an adverse impact of non-receipt of the relevant forms by beneficiaries on attendance levels (conditional on enrolment), but these levels increase over the surveys from an average of 0.76 days per month in 1998 to 2.14 days in 1999, possibly reflecting seasonal differences since the 1999 survey was in June and the 1998 one was in November. We do find, however, some evidence in 1998 that those not receiving the form have 3.4% and 7.4 percentage points lower probabilities of reaching “adequate attendance levels” for primary and secondary school children respectively. No impact was found in 1999, but it was noticeable that attainment of adequate attendance seems exceptionally low in some states, particularly Guerrero where only 45% reached the required attendance levels. This problem thus seems to have its origin in a design failure rather than an operational failure, i.e. income opportunities for children may be much higher in certain seasons so that larger grants would be required to persuade parents to keep their children in school. Attainment of adequate attendance was much higher in the earlier survey, possibly reflecting such seasonal patterns. The small impact on attendance relative to enrolment may reflect the initial high attendance levels: essentially students who decide to enrol generally attain adequate attendance levels. Consistent with this, the program seems to have had a greater impact on attendance levels in localities where initial levels were relatively low.

Alternatively, one might argue that the school calendar should be sensitive to the economic needs of poor households.
The quantitative survey of school directors supports the above view regarding high initial attendance levels with some program impact in reducing absenteeism. The qualitative interviews with school directors attributes the decreased absenteeism to the conditioning of transfers and the strict monitoring of absences. They also highlight the fact that the requirement to regularly fill out attendance forms puts pressure on finances and time resources since, at least initially, directors seem to have had to travel long distances to pick up the forms at their own expense. The decision to send the forms directly to schools may have helped in this regard, but some directors still see it as a problem. This is not helped by the perceived tightness of the deadlines for filling out forms, especially as they seem to arrive insufficiently in advance. But the forms themselves are easy to fill out and have been simplified with this in mind over time, e.g. teachers now only have to report the absences of students not achieving the necessary attendance levels rather than the attendance of all students. However, school directors complained that they were not informed properly about the operational details of, and motivations for, the program so that much had to be learned by a costly process of trial and error.

Our concerns about the willingness of teachers to monitor and report absences truthfully and consistently (e.g., due to social pressures or to understandable concerns for the consequences for very poor households) have been somewhat allayed by the responses of teachers, although we must emphasise that this issue requires continued and further analysis. It appears that a combination of the commitment of teachers to the educational goals of the program, the monitoring of the process by children and parents who actually meet the attendance conditions, and external monitoring by education departments, may be sufficient to ensure truthful and consistent monitoring. The exact (or potential) role of parent committees is unclear, but this could be a useful avenue through which to reinforce this monitoring process (e.g., by requiring the parents committee to validate attendances and absences). Any deviations from the strict application of the conditions that occur seem to reflect a recognition of the severe economic plight of some families, but it also seems that efforts are made to keep such departures to a minimum.

3.3 Supply Side and Education Quality

Above we have focused on the demand side of the program (i.e., enrolment and attendance). While greater demand is important in generating greater human capital, in itself it is probably not sufficient. Increased demand should be matched with extra supply side resources. In principle, in coordination with PROGRESA, schools were to receive additional resources (i.e., teachers, classrooms, didactic materials, etc.) to match the increased demand from the relevant bodies through the Ministry of Education. The Ministry of Education (at the state level) is responsible for supplying teachers and classrooms, but other requirements (e.g., maintenance or school supplies) are, for the most part, financed through parental contributions and applications to other municipality bodies for additional funding. This, of course, adds to the private cost of education facing households.

Quantitative Survey of Beneficiaries

In an attempt to meet the expected increase in demand for education, schools are supposed to receive increased resources and technical assistance-cum-training. In 1999, beneficiaries were
asked whether the supply side had improved in a number of respects since the program was implemented. For the most part, households' answers were divided between "has improved" or "no change," with only a few households reporting a deterioration. The percentages replying that they had improved were, by question: (1) school registration services, 66%; (2) teachers attendance, 62%; (3) quality of school services, 62%; (4) school facilities, 51%; (5) school resources, 49%; (6) class size, 57%; (7) school management, 52%; and (8) child care, 60%. In virtually all cases, the proportion indicating an improvement was highest in Hidalgo and Puebla, while being lowest in Guerrero and Michoacán (Table 3.12). It is noticeable that households with only secondary school children, and presumably thus referring only to secondary schools, are invariably less likely to indicate an improvement than those with only primary school children.

Quantitative Survey of School Directors

(i) Primary

We have documented previously (Adato et al. 1999) that schools included in the 1997 and 1998 samples generally had limited resources. Many schools did not have even basic facilities such as running water, electricity or sanitary facilities. The availability of libraries, laboratories and basic didactic material was also very limited. In both 1998 and 1999, the school directors were asked to qualify the schools relative to their general conditions. Approximately 22% in both surveys reported that the schools were in good conditions, 73% in 1998 and 64% in 1999 reported regular conditions, and 5% and 10% in 1998 and 1999 respectively qualified the schools as being in bad conditions (Table 3.13a). However, such assessments are presumably relative as opposed to absolute, e.g., regular conditions relative to other schools.

In 1999, a specific question was asked to the school directors to verify whether any repairs had been made in the previous year. Up to 75% of the schools reported having some improvements or repairs done during the year. The most common type of improvement was painting (62%), some construction (30%), installation of new services such as water, electricity or sanitary facilities (25%), and furniture and equipment repairs (22%) (Table 3.13b). Some variability was found between types of communities, but no specific pattern indicating preferential treatment of schools from different community types was observed. Only furniture and equipment repairs were significantly more common among the outside communities with PROGRESA beneficiaries.

The 1998 survey also revealed that the schools were generally poorly equipped (Adato et al. 1999). The 1999 survey included a question about the specific material and equipment acquired during the previous year (Table 3.13c), which shows that relatively few schools acquired any material other than geometry sets and maps. The schools located outside PROGRESA communities and attending PROGRESA beneficiaries, tended to report more acquisitions than the schools in PROGRESA and control communities, and differences were statistically significant for blackboards, videotape recorders and computers. Up to 25% of the schools outside of PROGRESA communities acquired computers in the previous year, compared to less than 2.5% among control and PROGRESA communities.
The school directors were also asked whether they thought that the school conditions, and life in general at school, had improved since PROGRESA started. More than half of the school directors responded affirmatively. A slightly higher percentage from the control communities (64%) thought that the conditions of their school had improved, compared to 55% from the PROGRESA communities and 50% from outside communities. Less than 2% reported deterioration. Table 3.13d lists the types of improvements reported by the school directors, by community type. The most commonly reported improvement was the acquisition of didactic material, followed by improvements in infrastructure (building of latrines, installation of electricity, improvements of the floor, walls or roof), and improvements in the level of stimulus offered to the teachers (reported by approximately one third of the school directors from PROGRESA and control communities). Differences between community types also indicated a tendency for schools from outside communities to have been favored in terms of improvements in infrastructure and equipment (none of the differences between groups are statistically significant, however).

(ii) Secondary

More secondary schools are reported to be in good condition in 1999 (31%) compared to 1998 (24%), suggesting some level of improvement (Table 3.14a). Up to 71% of the school directors confirmed that improvements to the school had been made during the 1998-1999 school year (Table 3.14b). The most common improvements were painting (57%), installation of new water or sanitation services (30%), construction and repairs (28%), or acquisition of new furniture and equipment (both 19%). These are similar to the reported improvements for the primary schools.

Based on the 1997 and 1998 surveys, the secondary schools have been described as poorly equipped in terms of material supplies and equipment. Still, only a small percentage of schools reported acquiring new items during the 1998-1999 school year (Table 3.14c). One exception is televisions, which 42% of schools from PROGRESA communities and 50% of schools from the control communities reported acquiring during the previous year. These televisions were probably replacements of older ones because in 1998, already 90% of schools had a television (most of the secondary schools are telesecondary, and thus require a functioning television; there was no question in the survey about whether or not the television was in working order). Simple equipment such as maps, blackboards and geometry sets were also acquired during the 1998-1999 year, as well as laboratory equipment. The schools from control communities (only 90 in total) appear to have received nothing else other than televisions.

A little over one half of the school directors indicated that the overall conditions at their school had improved since PROGRESA was introduced (Table 3.14d). A slightly higher percentage of school directors from PROGRESA communities reported improvements (67%), compared to 44% and 51% among control and outside communities. The most frequently reported improvements were related to aspects such as infrastructure, services, and furniture and equipment. Increases in the number of teachers were also reported in approximately 28% of the schools from the PROGRESA and the outside communities. The few control communities surveyed report improvements only in the number of classrooms and in the acquisition of furniture and equipment (consistent with the supply of televisions reported above). This is consistent with the control communities receiving investments in advance of the introduction of
the program and presumably more teachers will be allocated once the program is begins. In any case, since many of the control and treatment communities may attend the same school, investments are to a certain degree shared.

Qualitative Interviews with School Directors

In approximately half of the schools visited there was an increase in enrolment due to PROGRESA. However, the general view in the survey is that the expected increase in resources available to schools has not happened and, consistent with the above, that the initial conditions were in any case very poor. Fifteen (out of 18) school directors said that they had not received additional resources over the last few years, not even since PROGRESA’s arrival. It is significant that in this group there are seven of the schools that reported an increase in the number of students. Only three secondary schools and one primary school reinforced its teaching staff over the last few years with new teachers, while in four primary schools and two secondary schools additional support was received in the form of didactic material and tools. It is interesting to note that only three of the schools that reported an increase in enrollment produced by PROGRESA received additional resources.

It is also widely reported that the process of acquiring extra resources is very time and resource intensive with adverse consequences for education quality (e.g., teachers having to devote time away from class to pressure for extra resources and low or even deteriorating teacher-student ratios). The increase in resources in response to higher enrolment is not automatic and requires the director to submit an application, a process which appears to be very resource intensive. This is well illustrated by the following response of the director of a telesecondary in Queretéro when asked if applications for extra resources were generally met favorably:

The response we got last year from the state’s Services Unit for Basic Education (USEBEC), was that they came to conduct a feasibility study, they came to see if we really had the number of students required to have an additional teacher assigned to us. They came to the conclusion that we did have a sufficient number of students; that is, that we had the right to an additional teacher, but the problem was that according to them, we did not have enough space. Then they told me ‘if you build for us an educational space, maestro, then we will authorize another staff member.’ So then we went to see the president of the municipality and he committed himself to give us sheet metal and alfardas to build a provisional classroom. The parents took charge to raise funds and collected about 8,000 pesos to build a little wall with a ‘bloc’ for a little roof, but in October the governor came and saw what we were doing so then he told us that he was going to support us with a budget to finish the job, and sent engineers and they structured the project, and gave the classroom its shape. Then, since we had received no support from the presidency, the governor authorized 46,000 pesos to finish the project, and the parents and members of the community donated their manual labor. We were lucky, but for this year the problem is difficult because of the situation of the other classroom, we don’t have educational space and we are going to have the same problem. I already mentioned this to the president of the municipality because he had told me that the state government did not authorize another classroom and that it would not be built. This is a serious problem that we have for next year.
So the process of requiring extra resources is generally perceived to be tedious, wearing, frustrating, and expensive. When asked if applications were dealt with swiftly and usefully, the director of a telesecondary in Hidalgo (which requested a television, an indispensable item for a telesecondary) replied:

No, well we see it as we see the didactic material we requested, the television set, and the truth is, man, there is no bureaucracy that wastes more time that...it would be better to save all these expenses and buy your own television set. I don’t know what goes on with the budget that the state government allocates to the state SEP, because it doesn’t trickle down to us.

In response to the same question the director of another telesecondary in Hidalgo (also requesting a television) replied:

[The requests] can be accepted positively at first, but then they don’t give you a date, you have to be insisting, coming and going. They tell you: “Hey c’mon down for a visit!” That I go down to visit them? Fine. I ask them: “Do you know more or less when?” “Well no, in about a week or two.” Then I go back and I ask: “What happened?” They answer me: “I’m looking out for you, come on down.” That is, “come on down” as if we were working half a block from their offices, being that we have to go to the state capital and we have to pay our own way, and well, this disturbs me very much.

With these precedents, it is not surprising that there is a long list of expressed needs by the directors we interviewed; needs such as didactic material (7 cases), furniture (7), classrooms (5), teachers (4), television sets (3 telesecondaries), budgets, even bathrooms, libraries, sports fields, buildings, laboratories, directors, secretaries and social workers. In general, some of the schools need more than one thing, but there were 4 directors who said that they needed everything. Lack of resources and the laborious process of trying to acquire them can be expected to affect the quality of education, especially if this involves crucial resources such as televisions. This was the case in a telesecondary in Puebla where the director said:

Well, in this sense, the didactic material, that is, the television set, well, in a certain way it sets us back, right? Because this material is of vital importance for teaching, for the students to learn, right? Also, we don’t have the laboratory items that all of the telesecondaries would like to have, right? Not only that, we don’t have certain items, like a typewriter to type documents. We have to go looking around, and there are many, many things we lack.

When a teacher has to attend to two groups, or a director has to attend to up to two groups plus management, the workload gets heavy for them and they admit that this situation probably has repercussions in their ability to carry out all their duties, and consequently is harmful to the students. But schools generally attempt to make do as best they can with their limited resources. When asked if the school had received extra resources in response to higher enrolment stemming from PROGRESA, the director of a Puebla telesecondary said:

Unfortunately, we have not received them. (W)e have been requesting and we have proof of having asked for staff, we have gone to Puebla, we have tried to manage and to fight to receive these resources, mainly us with respect to the respective administration. I have
the administrative responsibilities and in addition, my group, or rather, my two groups, so just imagine this line of work. Of course, we don’t complain because this is our duty, this is why we chose this profession, but it is really hard.

With regard to the impact on education quality, the director of a telesecondary in Hidalgo that needed benches for the students, replied:

The truth? This school needs many many things: furniture, for example, we almost don’t have any furniture. When we had a lot of students, we would seat some of them in little chairs, just plain and ordinary ones, with a box in front for their books.

In spite of all these resource constraints, most teachers believe that education has improved since the introduction of PROGRESA. The main reason for this is that regular attendance is seen as the most crucial factor in improving education outcomes as is improved nutrition. These issues are taken up in the next section.

Summary

Analysis of the beneficiary surveys suggests that, on the supply side, the increased demands generated by the program has at least not led to a degeneration in the quality of education services suggesting that resources have been increased. In many cases, there seems to have been an improvement. This view is also consistent with evidence from the quantitative survey of directors, with most schools reporting some improvements in infrastructure and other resources, albeit from a poor initial position. It is clear from the qualitative interviews that the process of acquiring extra resources is time and resource intensive for teachers and school directors. But some teachers still complain that they lack such basic resources as televisions for telesecondaries. It will be interesting to compare this picture of the supply side with other data sources. Although most directors in the qualitative interviews report improvements in education outcomes, they attribute most of this to improved attendance, student interest and nutrition, rather than improvements in the supply side.

3.4 Attitudes Towards PROGRESA and Education

It is useful to identify two separate, although not mutually exclusive (or exhaustive), avenues through which the program hopes to encourage households to increase their investment in their children’s education. Firstly, the program provides a subsidy to such investment (i.e. the scholarship) thus decreasing the cost of education to beneficiaries. This essentially assumes that the demand is there but that the price of education is too high for some households (e.g. due to forgone earnings of children or the private time and financial costs of traveling long distances to school, especially for secondary-school children). Secondly, it is hoped that the program will enhance parents’ and children’s appreciation for the benefits that education provides. It is this channel of influence that would generate a sustained increase in education even were the subsidy to be withdrawn. In this section we attempt to identify the relative importance of each of these channels, essentially by using information on parents’ and children’s attitudes and behavior with regards to education and how these have been affected by the presence of the program. We start by discussing beneficiaries’ attitudes towards schoolwork and housework using information from the various data sets. We then examine the various reasons given by beneficiaries regarding why
some students fail to continue in secondary school. We finish by examining the attitudes of teachers towards the program.

### 3.4.1 Managing Schoolwork and Housework

Focus Groups with Promotoras, Beneficiaries and Non-Beneficiaries

An issue that generated a great deal of discussion in the focus groups (162 comments in total) was how families managed the need for children to both study and work in the home and fields. By far the most common attitude expressed was that the women valued the children’s schoolwork. In not a single case did women say that housework was more important than schoolwork, and in only a few they said it was of equal value. In all the focus groups, women (in 54 comments) said that it is more important for their children to study than to work at home.

Below are comments from promotoras from indigenous communities in Veracruz, and a beneficiary from Michoacán:

— It's more important to study... well, in my case my mother has her rules: they come from school and she gives them food, and they do their homework, and in the afternoon they take care of my mother's animals. But only if they do their homework first. Yes, first she makes them study

— It's more important that they do their homework [than help the mother] because there should be a rule at every home: get home, eat, rest for a while. For me it's more important to tell them to do their homework and after they finish that: "did you finish?", well then help me", but only then. (PV1-29)

Some times they [my children] tell me "now they gave me too much homework" and then I tell them "you better hurry up [in the sense of “better devote your time to studying”]" because if I ask you for something maybe you are not going to finish, and it's not good that you don't finish your homework. (BM-29)

Enough non-beneficiaries made similar comments to suggest that these attitudes are not necessarily related to the impact of PROGRESA, although the comments were twice as frequent coming from beneficiaries. It is possible that these attitudes may have always existed in communities, even when families could not afford to keep their children in school, or that non-beneficiaries in PROGRESA communities are influenced by ideas introduced by PROGRESA. Finally, one must also bear in mind that non-beneficiaries are mostly anxious to be admitted to the program and their responses may be influenced by the desire to be seen as behaving in accordance with program requirements. This could also explain why no non-beneficiaries said their children did not have enough time to study, while some beneficiaries and promotoras did.

Some women said that their children have an allotted time reserved exclusively to study. A promotora from Hidalgo explained how they manage the time:

I give my daughters time to study, three hours, and after that they help me, and they do it: the only thing they do is to wash their dishes and I have make them learn to help me at least a little bit in the kitchen. I tell them "look, I would make you sit all day with your books to do your homework, —and when they have homework they do it—, but you shouldn't abandon the kitchen because we don't know if you are going to stay at school".
Because [if not] later they meet a young man and they go [with him] and they don't know anything about the kitchen. (PH-29)

As this comment indicates, there is still the necessity for children to help at home or in the fields (this point was made specifically in 41 cases). This is necessary to help the family but also is part of their learning process to prepare children for life. But it requires time management and means the children work hard. Here are some examples given by beneficiaries from two communities in Michoacán:

[Q: For example, the boy that used to help at home, and now goes to school, What happens with his work?]
—He keeps helping
—After he comes back from school
—Everybody does their little part.(BM2-29)

—For example [my children] have their animals that they have to feed, they have to move the chicken, the turkeys; they have to gather firewood, they have to build a fence or something. Because we are poor maybe we ask them too much to do. At least I do, let me tell you, because I don't let them to only study and play. They have to learn to have responsibilities, they are not only going to study. (BM1-29)

Previous research on PROGRESA’s impact on the household found evidence that children’s attendance in school, particularly secondary, was increasing the work of other members of the household, especially mothers and other children (CIESAS 1998). In investigating this statement, we heard some comments indicating that the mother carries out part of the student’s chores, and fewer stating that another child or the father assumes these responsibilities. It appears as though all the household members coordinate to replace those missing. Note a discussion among promotoras in Guerrero:

—We. The parents have to do it
—Yes
—The parents and the other children
—Yes. After one comes back from school, they switch: the one that was helping comes home, and the one that comes home goes [to help]. It’s just a matter or organizing our selves with the work.
[Q: Is it more work for you?]
—Sometimes it is, and more in the morning. They go to classes and one stays alone until they come back to do the work they have to do. And if not, we do the work Saturdays and Sundays (PG-29).

Although women talked about how it increased their work, all said that they did not mind working more if their children have the opportunity to study. Below are comments made by women from indigenous communities in Veracruz (non-beneficiaries) and Hidalgo (promotoras):

—…they can help us at home. They can, and if they can't, then it is better that they study and one [me] has to do her [my] chores, one has to do it.
[Q: Even if you get more tired?]
—One does it so he [my son] can advance [at school] more
[Q: And your husband also gets more tired because of that?]
— No because if two of us do it, the work is less (NBV1-29).

[Q: But if she [your daughter] can't help you because she is studying, do you get more tired?
— Well yes, but even if I get tired...I have to do it, because it's my job, I have to do everything.
— I rather my daughter to study, so she can keep going (PH-29)

Quantitative Survey of School Directors

The majority of primary school directors reported mainly positive effects of PROGRESA on beneficiary students and their families towards their education (Table 3.15). Up to 70% reported that beneficiary families were generally better organized, 80% reported that they were more interested in the education of their children and 76% reported greater participation of beneficiary families in school activities than before. On the other hand, almost one third of the school directors reported some negative effects such as families being more divided or having increased problems as a result of PROGRESA.

With regards to the impact of PROGRESA on the primary-school students themselves, the opinion of school directors was also largely positive. For instance, more than 70% of the school directors reported that beneficiary students are more serious about their homework than previously, that they have improved their performance and that they are more interested in school than before. Up to 96% of the school directors also reported regular attendance at school of beneficiary children. In spite of the fact that the school directors feel that beneficiary children have improved their performance compared to previously, still three quarters of them report that the performance of PROGRESA children is similar to that of their non-beneficiary peers. This suggests that the PROGRESA beneficiaries might have been performing more poorly than the non-beneficiary group before PROGRESA was introduced. The data, however, do not provide sufficient details to answer this question.

As above, the secondary school directors appear very positive about the impact of the PROGRESA program on beneficiary students and their families (Table 3.16). Up to 86% of them feel that parents of beneficiary students are more interested in the education of their children, a main objective of the program, and also participate more in school activities (77%), and are better organized (64%) and better united (55%) as a result of PROGRESA. Only approximately 20% think that PROGRESA has caused problems among families. According to the school directors, the program also had a positive effect on the performance of beneficiary students at school and on their interest and attitude towards their homework and school in general.

Qualitative Interviews with School Directors

The above is consistent with the fact that 14 directors from the 18 secondary schools said that, with or without PROGRESA, their students need to work and help their parents. Going to school does not free these children either from paid work one or two days a week, or from working on the weekends or seasonally, or from their unpaid household chores. A teacher in a telesecondary in Hidalgo says:
I know that they go to work in the fields on the weekends, they spend the entire day with their dad. I don't think this has decreased; on the contrary, PROGRESA is like a bonus but they don't stop doing what they're doing, everything goes on as before. They don't work during the week, this is true or at least in school it is forbidden for them to work, it is not justified.

If children continue to help at home and on-farm then this may have an adverse impact on their studies and educational performance. In the interviews, 12 secondary school directors believed that the children had enough time to work, study and have fun. Those who did not study did not do so previously either due to lack of motivation on their parents or their own part. According to a teacher in Puebla:

I believe that young people have time for everything. I have seen them doing their homework in the afternoon and at night. Their only distraction is playing on the basketball court--they come and play for a little while and then return to their activities at home.

But some directors believe that because of work requirements at home some children do not have enough time either for studying or for entertainment. Regarding their chores, the same director says:

Some students definitely work a lot after class at chores; gathering wood is essential so that they have fire, they bring water so that they can bathe, and their days are not short. That is, they don't just get firewood from around the corner. They have to go way into the mountains and valleys, and this takes a while. The rivers are dry, so to bring some clean water, they have to go a little further. This makes them lose a lot of time in the afternoons (evenings).

With regard to traveling to and from school, it is not unusual for children to take up to three or four hours daily in their walks. Those that live very far away from school leave their homes around five in the morning, tired, and many times hungry. According to the teachers, this is because they go to school without eating breakfast. This pressure to work and these living conditions affect the students’ academic performance. According to eight of the interviewed school directors, their academic performance is sometimes low, which they say should not be surprising because when they arrive at school, you notice their fatigue, they nod off in class, they don't take their homework or they excuse themselves from class because they didn't have time to study. According to a director in Hidalgo:

Their performance is low, I have some students who are nodding off in class because they no longer have a father or a mother, and they are the faeneros (farm hands), those that are in charge to bring home the faena (“bacon”) as if they were adults.

But the general view is that most of the children have enough time if they are motivated to study. With regard to the role of PROGRESA in increasing the motivation of students (and their parents) to spend time at their studies, some directors believe that having or not having PROGRESA in and of itself does not determine whether one is a good or poor student. Performance is seen as being more determined by the students own interest, that of their parents,
and the quality of teaching. Regarding a family's motivation, the teachers distinguished between those parents who send their children to school and believe that by doing so they have done all they could, and those who were concerned about their homework, gave them enough time to complete them, and go every now and then to school to be briefed on their children's progress.

According to some directors (10), the attitude of parents has changed for the better. With regard to parent-teacher meetings, a director in Veracruz says:

If I make an appointment with them, they come. Of course, we do not have 100% of the parents meet with us but we will never have this, but I consider that things are fine since only 10% don't make it in, but sooner or later the others come.

According to a director in Hidalgo, parents realize the advantages of having a secondary school graduate in the home:

Yes, I notice a change in that if they see that their children are better prepared, they can help out as a support when they have problems. They say ‘when we had a secondary school student at home, it is as if we feel he can guide us either in mortgage or deed problems, problems with the municipality…..they give my son a better paying job than the one I have, they no longer go as simple peons, but they now go into other jobs,’ so then they value this, they value it because a certificate for them is more useful.

We asked directors: "Do you believe that if PROGRESA were to disappear, the number of children in school would decrease?’ The majority of them responded affirmatively. A director in Hidalgo went on to say:

- Well, the persons who really are in need and come because of PROGRESA, they would decrease.

[Q: They wouldn't come any more?]
- They wouldn't come any more because where is the father going to get the resources to send his children to school?

[Q: So you're saying that they aren't sufficiently motivated to say 'oh well, no big deal, there is no more PROGRESA, but I'll keep on sending my daughter,’ right?]  
- No, some yes, but others, no.

[Q: Why would they stop coming?]  
- Because some people really don't have adequate economic resources and they have plenty of kids and they require some extra money.

### 3.4.2 Reasons Children Drop Out of Secondary School

During the research design and stakeholder consultation phase, PROGRESA staff requested more information on why children leave secondary school, in order to understand better whether PROGRESA’s economic incentives were likely to be effective and whether there were other
reasons aside from economic constraints that cause children to leave school. Our analysis in this section draws exclusively on the focus groups with *promotoras*, beneficiaries and non-beneficiaries.

The most frequent answers related to the family’s lack of economic resources. Informants stated that families withdraw or do not enroll their children in secondary when they cannot keep up with the expenses or when they need additional income and the child has to work. Beneficiaries and non-beneficiaries gave similar responses. Expenses are said to be especially high when there is no secondary school in or near their locality, which requires an investment in transportation or rent. Below is a discussion among a group of non-beneficiaries in Guerrero:

— We don't all live the same circumstances, and some can afford [to send their children to secondary school] and some can't. Too bad. There are many parents that want to sacrifice themselves for their children and there are many who don't...They don't live in the same conditions.
— Some work and they have money, others don't, others don't have enough money to buy a [bag] of beans
[Q: Is that why they don't send their children to school?]
— They can't afford it, imagine the telesecondary if they don't have any place to stay, to pay a rent, all that.
[Q: How far is the telesecondary from here?]  
— In Chilapa; it's very far and to go and to come back that far is not worth it.
[Q: Do you think the same way?]  
— Yes, because if they don't go everyday they need money to rent a house for them to sleep, to stay, and that is another expenditure and... one has to borrow money even if one doesn't have it to give it to one's child. That is why many people that do not live in the same conditions do not send them. 
— …if there was money, it would be nice and I would be happy for them to finish their telesecondary. They don't send them to school because the father doesn't have money, and how? He doesn't send them to study. Because if he can afford it, he sends him. If he has or he doesn't have he has to go see his daughter to see how she studies, he worries about them [his children] (NBG-30).

Note that the last statement implies that transportation expenses are also incurred by parents who visit their children away at school.

In addition to costs for transportation, books, school supplies and uniforms are said to be too expensive, as indicated in these discussions among Guerrero beneficiaries and *promotoras*:

— As we said here, we don’t send our children to secondary school because we don’t have money
— They [the school] ask for books, and there’s no money. That’s why we can’t send them
— They ask for books, clothing, notebooks
— They think everything they ask for is going to be bought but there’s no money here, so what are we going to buy? (BG-30)
— There's not enough [money] to send them to school. I mean the expenses to send one child to school, the expenses of a pencil, of a notebook.
—I think it's because we can't afford it, like I told you of all my children three studied, and we could only send them to secondary school and now that they go to secondary school I didn't sign them all up, because there's no money. Only the oldest one stayed (PG-30).

A related argument is made that in families with many children and low income, not all children can finish secondary school. Some children have to drop out of school before others, and they help their parents support the ones who just started school or are still studying. Below is a discussion among Queretéro non-beneficiaries:

—For example I had two who were ready for the telesecondary but the truth was that I could only afford to send one, because I have five here, and now only one goes to telesecondary. I couldn't afford the other one. He wanted to keep studying but I couldn't send him any more... I couldn't afford to help the two of them

[Q: And which one of them did you choose?]
—The younger one

[Q: Why the younger one?]
—Because I couldn't afford the other one, and he also realized that, and he went to look for a job. He is better off working.

Economic constraints were not the only reason for leaving school, however. After high costs and general poverty, the third most frequently cited reason for children leaving secondary school is that they do not want to study. Some informants emphasized that it is not just that parents withdraw their children from school. They want them to study, but they cannot force them. The reasons children choose not to study include the following: (i) laziness; (ii) boredom with school and preference for work; (iii) girls would rather be with their boyfriend than in school; (iv) teachers treat them badly; (v) children who are older than the average age of their classmates fear being laughed at; (vi) children want their own incomes rather than study; (vii) they can earn more money working than their family earns from PROGRESA; (viii) they can help their families more by leaving school and going to work. Below are discussions among beneficiaries, promotoras and non-beneficiaries from Michoacán, Querétaro, and Estado de México:

—We make them see that [they should] keep their studies, but when they don't want to, they won't. Because we can't force them, because they don't learn like that.

—If the daughter doesn't want to go to school. Because some daughters that finish primary school say they don't want to study anymore. Even when one tells them to, but it they don't want... (BM-30)

—One of my sons was in a (Veracruz) secondary school. I just tell him: "Study is for your benefit, because I didn't study". But he didn't want, didn't want. Then we put him to work. After that, when the telesecondary got here the teachers invited him, and I told him to study but he said he couldn't and he didn't like it....

—Well, I think that in my house, my father has been responsible for the expenses and all that. Maybe he left with that image, because he went to the US, maybe he thought about helping my family or my mother or something. I think some [children] have left [school] because they have seen the necessity in their homes and have wanted to progress. (BQ-30)
— One of the beneficiaries also sent a boy, he went to the telesecondary and he left in January, because he didn't want to go. And now he got PROGRESA and [we told him] "you have to keep studying." We went to talk to him and his grandmother, (because he was with his grandmother) told us that he was definitely not going to go to school even if [PROGRESA] took [the scholarship] away.

[Q: What is his reason to not go?]
— He wants to work. To earn more money (PM2-30)

— We don't take them out [telesecondary] they leave [LAUGHTER].
— Yes, because they want to go work, for example when there are no classes they go to work and they earn their little money, and from there they start to get used to it. And at school sometimes we can't give them one little peso, and they want to spend in the lunchtime, and they get ideas, they say "I better work" and they leave. We would like them to finish but if they don't want anymore..."(NBQ-30)

— My brother was in secondary and he is from PROGRESA and he didn't want to keep studying. He preferred to work, because in his vacation time he worked and he saw he earned more or less, and then he said: "I prefer to work than to study." And my father didn't want to send him anymore, because it is worse when you send them and they don't learn anyway, it's more expensive." (BM1)

— I knew about a girl that was in sixth grade and left to work to Mexico, and she had a scholarship
— Yes, she is studying in Mexico because she sees that her parents are old fashioned and poor, and the poor girl realized that they couldn't afford it. Because everybody was working in the field, and that's why she is not studying, she went to Mexico because she decided to progress. (BM-30)

Finally, in some places girls do not stay in secondary school because there is no secondary school in their community and it is considered dangerous for them to travel alone in the roads. When asked why they would choose to send boys to school over girls, non-beneficiaries from Hidalgo and beneficiaries from Veracruz, both indigenous groups talked about safety:

— [Why the boy and not the girl?]
— Because it is more dangerous for the girl by herself
[Q: How?]
— Because sometimes she shouldn't be alone
[Q: Is it dangerous?]
— Yes
[Q: Does it mean that is better that she doesn't go [to school]??]
— It's good for her to go, but only to primary that is near here. (NBH-30)

— [Translator:] The lady says she won't send her daughter to secondary because she is a girl. And this other woman also [says the same]
[Q: Why]
— Because she just told me something could happen to her on the road. (BV2-30)

There are no necessary contradictions between parents’ statements about the value of education, and the many admissions that their children may not all continue studying. The contrast is striking, however, between the value women place on education for their children, and the range
of obstacles to educating them. Even the many comments made about children who do not want to study give the impression that life’s circumstances and financial pressures make leaving school an attractive option. All of this indicates that PROGRESA’s educational incentives are on target, although they may not be sufficient to address the range of constraints that parents face to keeping their children in school.

**Summary**

Both the quantitative analysis of the school directors’ survey and the qualitative analysis of the focus group interviews support the general perception that PROGRESA has led to improvements in the attitude of beneficiary students and their families towards education. The program is viewed as allowing those parents and children who were always motivated to acquire education, but who faced severe economic hardship thus being unable to incur travel and other educational expenses and needing any income that children could contribute, to continue to send their children to school. The fact that lack of resources (or poverty) seems to be a major factor in explaining non-attendance at school, especially for older children, is consistent with the program design and initial estimates of program impact (Schultz 2000) since the education subsidy (or scholarship) seems to have been effective in increasing demand. New evidence (Coady, Parker, and Hernandez 2000) also suggests that the medium- to long-term impact of the program on human capital is in terms of increasing continuation rates (i.e. decreasing drop-out rates) as opposed to increasing return rates for those who had already dropped out.

Particularly from the focus-group analysis, there is evidence that families place a strong emphasis on school attendance and homework and that, where possible, parents attempt to adjust to these demands if children attend school. This was seen to be an acceptable trade-off, with others in the family willingly substituting for school-going children’s time especially during the week. But children, in general, appear to have to continue to contribute to household chores, especially at the weekend and during the peak agricultural season. For some children, possibly those from the poorest families or those who have long distances to travel to secondary school, the balancing of the demands of school and work are very demanding.

But children’s lack of interest in school is also an important factor in explaining non-attendance at school, especially for older children, although this appears to be at least in part indirectly motivated by poverty and the desire of older children to contribute to the family, and the lure of migration which is seen as “progress.”. In the case of older female children, concern for their safety when they have to travel long distances is also an issue.

### 3.4.3 School Directors Views of PROGRESA

School directors provide a potentially very important source of information on how relevant and effective the design of the program is and as a source of ideas for further changes. We therefore decided to ask them for their views and to identify changes that would make the program more effective. This was done as part of the qualitative interviews with school directors.

One of the most common complaints from school directors was that they were never consulted about the program and that it was never properly explained to them. They also felt aggrieved
that neither were they consulted about the selection of beneficiaries; they cannot understand why some children who wish to continue in school but face economic difficulties are not eligible for scholarships. While the former is an important point, the latter is less worrying since poverty and not education was the main criterion for selection. But this should be explained clearly to teachers and other members of the community. However, in some cases the school directors also did not understand or agree with the designation of who was poor enough to receive benefits, believing it to be inaccurate or misinformed (see chapter 2).

The director of a secondary school in Hidalgo expressed his unfamiliarity with PROGRESA in a very illustrative manner:

Since we have little information about PROGRESA, we don't know how it functions. Not only that, as soon as PROGRESA arrived, they tell us that we have to fill out forms to take attendance, tally the number of absences for each student, sign, seal; that's all and nothing more. But basic information? None. I mean they give scholarships to the kids, but whether they can, if they can, contribute anything to the schools, whether they have any obligation towards the schools, well, we don't know. Not a thing--they haven't informed us about anything. I tell you, once the forms arrived, we even asked our supervisor why we received these forms, and if he says anything, he says: ‘You know you've got to fill them out.’ So I say to you that I don't know some of those on the list, and some I do know, and I ask the supervisor upon what basis did they make this selection, because there are people that want to continue to study and that have an interest in school, but they're not on the list. Then I ask him what the selection criteria was or who had selected these students, but he also did not know how these scholarships were distributed. We are at point zero on this issue, we don't know. I tell you we don't know what organisms are those that founded PROGRESA, or on what it was based.

A number of collateral problems that PROGRESA brought to the schoolteachers were identified. The most frequently reported problem was that both the parents of the PROGRESA beneficiaries and the non-beneficiaries would attack the teachers and blame them for problems that are part of PROGRESA. The parents of the non-recipients believed that the school is the responsible party for the selection of the recipients and they want teachers to explain to them the reasons for their children being excluded while others' kids are included who, in their opinion, don't deserve the money. For their part, the beneficiaries complain every time that a payment is suspended, decreased or delayed; they believe this is unjust and they ask the director the motives for having falsely reported their children’s absences (because supposedly, this is a reason for payment being suspended). Sometimes when a payment is delayed for one reason or another, the fathers arrive at school along with their wives, simply because someone designated the director as the party responsible for the delay. The teachers also stated that some women who receive money become aware of the amounts received by other women, so they then go and demand an explanation from the teachers for these differences.

Another collateral problem that teachers faced was related to the “fees” that parents were asked to contribute. They say that the beneficiaries complied more readily than non-beneficiaries and that non-beneficiaries each time would ask that those who receive PROGRESA money be relied on more.
The teachers also observed that due to PROGRESA, they have to struggle with low-performing students who come from different areas and who received a level of education that was deficient. This requires greater effort on behalf of the teachers, in addition to working with larger groups. The other problem they mentioned was the scarcity of didactic materials for the students without PROGRESA, whose parents allege they cannot afford them and the same demands should not be imposed on them as those who receive the scholarships.

But on the whole, the teachers considered the program to be beneficial to the communities. None of those interviewed suggested that the program be abolished. On the contrary, most believed that it would be better to widen its participation. In principle, they considered that the objectives, incentives and program requirements were desirable, although as far as the incentives go, they mentioned a few suggestions for eventual modification:

(i) Fourteen (of the 18) secondary schools and three (of the 4) primary school directors agreed with the program's objectives.

(ii) Nine secondary school directors37 and three primary school directors said that the requirements are fine just as they are. However, one primary school and 10 secondary school directors proposed that the scholarships be conditioned not only on regular attendance but also on a certain grade point average, as is the case with the scholarships offered by other institutions. The teachers weren't too ambitious in their proposal, thinking that of 8 as a minimum. As the director of a telessecondary in Puebla put it:

I feel that a scholarship, for example, shouldn't just be given away just like that; but if a student has good grades, does all his homework, this one can get a scholarship. But if at any given moment his grades fall, you withdraw the scholarship. This is how other institutions handle this, so I feel this would be good; we aren't asking for a 10, but an 8.

Similarly, a director of a technical secondary school in Queretéro said:

I would like for [the benefit] to be greater, I feel it is meager, but I wouldn't like for it to be disbursed without a commitment from them to be better students. I mean, instead of saying in first grade ‘I will give you 100’ and in second grade ‘I will give you 150’, you should say ‘I will give you 100 if you get a 6 or 7 (grades), I'll give you 200 if you get a 7 or 8, and I'll give you 300 if you get a 9 or 10’.

(iii) Regarding the incentives, 11 secondary school directors and one primary school director said that it is good for the families to receive money, since their incomes were extremely low and the assistance from PROGRESA was substantial. The director of a telessecondary in Hidalgo expressed it in the following words:

37 Note that as throughout the reporting on the school director interviews, these numbers do not indicate that the other (in this example, 9) school directors disagreed with these ideas, as the issues may not have come up. The numbers represent how many interviewees raised these issues unprompted.
What if the incentive wasn't monetary, you ask? I believe that the most powerful inducement for the parents and students is to see the money.

(iv) In addition, 5 secondary school and 4 primary school directors said that it would be good to increase the amount of money disbursed. The director of a telesecondary in Hidalgo said:

If you gave a little more assistance to the students in this program, we also think we would benefit because we would have greater support from the families and greater conviction from the students.

(v) Four secondary school and 2 primary school teachers said that it would be good to increase the incentives and give not only money but also supplies and didactic materials.

(vi) Finally, five directors, all of them from secondary school, said that it would be better to think of other types of benefits other than money, such as in kind benefits, with the goal to ensure that it is the student who receives them.

Nine directors think that students have also benefited from PROGRESA in the sense that they have been able to buy some things that haven't been primary necessities, because it motivates both them and their parents to send them to school, and because it requires them to attend class regularly, which leads to better grades and greater continuity of the prescribed programs.

While school directors see the parents of PROGRESA as having benefited most, the majority also believe that schools have benefited in some ways. According to them, PROGRESA has benefited the schools because it has ‘recovered’ students without which some would have already closed in addition to decreasing the number of absences and dropouts. Half of them mentioned that they also benefit indirectly in the sense that parents pay more attention to their children and consequently then have more rapport with the teachers. Also, the teachers say that they no longer have to quarrel with students to bring their notebooks to school. The director of a primary school in Queretéro summed it up as follows:

It has helped us, the teachers, to exert some pressure, and it has been useful for when we ask for supplies, notebooks and uniforms for the children; they comply with this and this in some way permits us to maintain a semblance of order in the school. Satisfaction, nothing more.

But directors continued to emphasize the need for greater school resources.

Regarding the relationship between schools and promotoras, in some cases the promotoras were viewed as an asset to the school, in others there seemed to be some friction because of her perceived “interference” in educational matters. The views of the school directors on promotoras is detailed in chapter 6.

Summary

One of the common complaints in the qualitative interviews with school directors was that teachers were never consulted about the objectives and design of the program nor informed how
it would function. In particular, many could not understand why some “deserving” students were excluded, why some who need it do not receive it, and why they could not have had a role in the selection of beneficiaries. Also, parents often blame teachers for their children not being included, for delays in transfers or for their child not receiving transfers due to poor attendance. Non-beneficiaries in some communities are reluctant to contribute towards school resources arguing that beneficiary families should be relied upon more. They also argue that the demands on them for school supplies should be less than for non-beneficiaries. Finally in some cases the school directors point out that the increase in demand has brought in some students from remote areas who were given poor quality education and thus require more input from teachers.

In the qualitative interviews with teachers we asked them for their overall view of the program. Their answers suggested that, on the whole, teachers saw the program as being beneficial for the communities and were in favour of greater participation. They invariably agreed with the objectives of the program as well as the conditioning of transfers. Some even suggested attaching extra conditions such as linking scholarships to academic performance. Most were in favour of money transfers, although concern for how households spent their money were behind some suggestions that food or education coupons be introduced. The general perception was that the supply side was not sufficient to deal with the increase in demand, although better attendance and attitudes to schooling made teaching easier and more rewarding. Also some schools that would have shut down due to insufficient demand could now remain open. While in some cases the promotoras were viewed as an asset to the school, in others there seemed to be some friction possibly because of her perceived “interference” in educational matters.
CHAPTER 4 — HEALTH AND NUTRITION

4.1 Description of the Health and Nutrition Component

The multi-component approach of PROGRESA reflects a broad notion of the concept of human capital that includes the health and nutritional status of individuals together with the more conventional idea of educational achievements. The integrated nature of the program reflects a belief that addressing all dimensions of human capital simultaneously has greater social returns than their implementation in isolation. Improved health and nutritional status are not only desirable in themselves, but have an indirect impact through enhancing the effectiveness of education programs since, for example, school attendance and performance is often adversely affected by poor health and nutrition. Poor health is therefore both a cause as well as a consequence of poverty.

The health and nutrition component can be seen as a collection of a number of inter-related sub-components, namely:

(i) A basic package of primary health care services;
(ii) Nutrition and health education and training for families and communities;
(iii) Improved supply of health services (including annual refresher courses for doctors and nurses);
(iv) Nutrition supplements for mothers and young children.

While the general focus is on improving the health and nutritional status of all household members, special emphasis is placed on the welfare of mothers and children. Some components are more important than others in this regard.

4.1.1 Primary Health Care Services

The basic approach of PROGRESA is that of preventative health care which enables households to anticipate both the causes and presence of illnesses, with the objective of decreasing the incidence and duration of these illnesses. This is reflected in the nature of the package of health services provided (Table 4.1). The most important actions are related to maternal and child health (e.g., pre- and post-natal health care) and family planning services. A crucial ingredient in the program is the emphasis put on regular visits to health centers and the setting up and monitoring of a schedule of appointments. This includes the setting of appropriate health-center timetables that minimize the inconvenience associated with the making and keeping of appointments. To facilitate this, upon registration at a health clinic beneficiaries are given an appointments booklet (“Cartilla familiar”) containing a specified schedule of appointments for each household member, with particular attention placed on visits by vulnerable members, according to Table 4.2. This information is entered on the S1 form brought to the clinic by the beneficiary, ensuring that a record of attendance by household members is kept at the clinic. The other part of the form (“formato CRUS”) is returned to the beneficiary who uses it as proof of registration in order to receive cash grants for food. Beneficiaries are also asked to attend health and nutrition talks (referred to as “pláticas”) at the clinic.
Each clinic receives an S2 form from the UAEP every two months that contains the names of beneficiaries as compiled from the CRUS form. The S2 form, which contains only the beneficiary's name with two columns (one for health center visits, another for attendance at pláticas) for registering compliance or non-compliance by the household, must be filled out by a nurse or doctor at the health unit every two months, certifying whether family members visited the health units as recommended (and presumably scheduled). This form is then submitted to the UAEPs, via the state health authorities ("Juridicion Sanitaria"), in order to trigger the receipt of the bi-monthly food support. In principle, if at least one member did not comply with scheduled visits then the household is considered not to have complied and thus will not receive food support. However, since adults are only asked to comply with one visit per year, if the appointment date is changed in advance, the health center will focus only on the compliance of women and children. Very often, though, adult members complete their required visit at the time of registration. Also, since a household may visit a clinic other than the one at which it is registered, the UAEPs require information from more than one clinic in order to register compliance correctly. This information is entered onto a computer and a computerized file sent to CONPROGRESA.

4.1.2 Nutrition and Health Education

An underlying assumption in PROGRESA is that effective health care requires active community participation and a culture of preventive care. In order to empower individuals and communities to take control over their own health, beneficiaries are required to attend nutrition and health education lectures (‘pláticas’). Up to 25 themes are discussed in the lectures, including nutrition, hygiene, infectious diseases, immunization, family planning, and chronic diseases detection and prevention. Because mothers are the primary care takers, the pláticas are mainly directed to them, but other members of beneficiary families as well as non-beneficiaries are invited to attend. Participants are trained in various aspects of health and nutrition, with a special emphasis on preventive health care, more specifically they are taught about: (a) ways to prevent and reduce health risks (e.g., prenatal care, early detection of malnutrition, childhood immunizations, safe food and water treatment), (b) how to recognize signs or symptoms of sickness, and (c) how to follow appropriate primary-care procedures (e.g., such as treatment of diarrhea by means of oral rehydration). Participants are also trained in the use of the nutritional supplement provided by the program, as well as in optimal breastfeeding and complementary feeding of young children. Efforts are also made to broaden the information for adolescents and young people, particularly women, to favor the adoption of appropriate behaviors to protect their health from an early age.

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38 Regarding mobile clinics ("Unidad Mobiles") which already existed in some localities, PROGRESA reached agreement with another program ("Programs de Ampliacion de Cobertura") on a new frequency of visits to beneficiary localities in order to facilitate the expected increase in demand.
4.1.3 Supply of Health Services

All public-sector health institutions are to provide the package of basic health-care services. To facilitate this, especially in the face of anticipated increased demand, resources will be devoted to strengthening the supply of health services as follows:

(i) Ensuring adequate supply of equipment to units;
(ii) Encouraging staff working in remote rural areas to remain there on a long-term basis;
(iii) Ensuring that health-care units have the necessary medicines and materials (including educational health materials to distribute to families);
(iv) Providing extra training to improve both the quality of the medical attention and the operational dimensions of the service.

These resources are deemed necessary if the public health sector is to meet the additional demands placed on it by the program and provide an efficient and high quality service. Although the greatest efforts made by the institutions involved will concentrate on primary care, mechanisms will also be established for the timely detection and referral (free of charge) of the beneficiaries who need attention in units at the second and third levels of health care.

4.1.4 Nutritional Supplement

Special attention is given to the prevention of malnutrition in infants and small children, which is a crucial determinant of their future development. Therefore, an additional component of the program is the provision of food (nutritional) supplements to pregnant and lactating women and to children between the ages of four months and two years. These supplements will also be given to children between two and five years if any signs of malnutrition are detected or to non-PROGRESA households under similar circumstances.

Two different supplements were formulated specifically for the program: one for pregnant or lactating women and the other one for young children. Both supplements contain whole dry milk, sugar, maltodextrin, vitamins, minerals, and artificial flavours and colours, but their specific macro and micronutrient content is adapted to meet the specific nutritional needs of mothers and children, respectively. The supplements are distributed in 240 grams packages and are ready to eat after they are hydrated. The child supplement produces a type of pap and is available in banana, vanilla, and chocolate flavours. A 40 g daily ration (of dry product) supplies 194 kilocalories, 5.8 grams of protein and approximately one recommended daily allowance (RDA) of selected micronutrients (see Table 4.3). The supplement for women is intended to be consumed as a beverage after rehydration, and is available in banana, vanilla or natural flavour. The daily ration is 52 grams and provides 250 kilocalories of energy, 12-15 grams of protein and selected vitamins and minerals.39

39 A complete description of the design, formulation, and composition of the supplement is available in the following two publications: Rosado et al. 2000 and Rivera et al. 2000.
The supplements are prepared at one production plant devoted solely to this task and then distributed to health centers through DICONSA, which is an operational arm of the Ministry of Social Development (SEDESOL) and also the largest distributor of food in rural areas. There are about 18,000 DICONSA stores in rural areas. The supplements have a long shelf life of about one year.

Mothers visit the clinic at least once a month (more if they are pregnant or have small children) and are expected to pick up a one-month supply of the supplement for each targeted household member. Appropriate use of the supplements and other concepts of optimal child feeding and feeding during pregnancy and lactation are reinforced during the nutrition and health pláticas provided in the clinics.

4.2 Research Results: Registration, Forms and Compliance with Scheduled Clinic Visits

4.2.1 Registration and Forms

Survey of Beneficiaries

The percentage of women reporting that they have registered at a clinic increases from 89% in October 1998 to 97% in June 1999. The former is a low registration rate given that this officially precludes receipt of the money transfer for food support. Of those in 1990 who are registered, 61% are registered at a health clinic, 29% at a IMSS-Solidaridad clinic, and 10% at a mobile health unit (MHU). However, a (possibly) surprising pattern is that, although 46% report that their locality is visited by a MHU, only 10% are registered at these units. This could reflect a registration process or just the beneficiaries' perceptions, but may reflect a lower quality service from these units. Out of those having access to a MHU, 59% register at a health clinic, 20% at an IMSS clinic and 20% at the MHU. It is difficult to interpret this pattern since around 70% say they register elsewhere because it is closest, they were told they had to, or they had no other option, the first being the most prominent answer (65-70%). Much fewer indicated that it was due to differences in the quality of services.

There was little variation across states in the decision to register, the lowest being 94% in both Queretaro and Guerrero, and the best being 99% in Puebla (Table 4.4). The big improvement seems to be in the first two states, which in October 1998 had 66% and 80% registration rates respectively. Probability of registration was found to increase with education level of the head of household. Since we only have distance travelled to place of registration and not to nearest health center, we cannot determine whether those who had access to a MHU were more likely to register there if this distance was large. However, we include as a possible determinant of registration whether one had a health center in their locality, had a MHU visiting, or neither. As expected, we find a statistically significant difference between these groups with registration highest where one had a health center in the locality, and lowest where one neither had a health center nor a MHU in the locality.

Although the 1999 survey does not ask whether or not households received their registration forms, answers to the question regarding why they did not register may provide some insights.
The main reasons given for not registering was that they did not know that they had to register (40%) and that it was too far (10%) - 10% were coded as "other" as their reply, with 29% not replying. Unfortunately not having the form was not a coded option. In the June 1998 survey the main reasons given for not having registered are (in order of importance): no registration form, no time, and not told. This question was not asked in the October 1998 survey. Since registration was also fairly high at 92% in June 1998, it may be then that the same problems apply in 1999, i.e., non-receipt of forms explains a lot of the failure to register. Alternatively, it may be that improvements in distribution of forms explain the increase between the surveys and that the non-registration that is left is mainly due to distance.

In 1999, beneficiaries were asked if they were charged for a range of health services. Nearly 10% said that they were charged for medical consultation, 2% for children's height and weight measurements, 6% for medicines, 2% for medical treatment, 2% for registration (4.5% in October 1998), and 2% for nutritional supplements. Looking at charges for medical consultation and for medicines, there is evidence (especially for the former) that the probability of being charged is lower if one is registered at an IMS SOLIDRIDAD (IMSS) clinic or a mobile clinic and higher if one is not registered. With regard to charges for medical consultation, the level is highest in Puebla (17.4%) followed by Guerrero (17.0%), followed by San Luis (12% points higher). With regard to charges for medicines, 41% report being charged in Queretéro, 21% in Puebla and 19% in Guerrero. Otherwise few report being charged and in any case, it is not clear that beneficiaries would know what they were being charged for, e.g., medicines or weighing of children.

In the October 1998 survey, households were also asked whether they encountered any other registration problems but only 1.2% of those who registered reported any. This suggests that registration problems may not be the root cause of the lower registration levels in that sample, although it is important to note that this question was only asked of those who actually (rather than, say, tried to) register.

In this same survey a substantial proportion of women (22%) reported that they were not given an appointment book upon registration. A clear outlier in this respect was Querétero, with 67% not receiving a booklet, this being robust to the inclusion of household characteristics. Otherwise there is not much variation across states. This number has decreased substantially in the June 1999 survey, with only 3.2% reporting that they were not given the booklet, this being highest at 11% in Querétero. So it seems that the magnitude of this problem has reduced substantially, possibly due to initial problems in getting the appointments booklets to health centers. But there is still room for improvement in Querétero. In June 1999, although the probability of receiving the booklet was higher for those registered in IMSS clinics, the magnitude of the difference was quite small at 2% points.

All those who registered were asked if they were seen on the appointed day with 95% answering that they were in October 1998 and nearly 97% in June 1999. Again, in both surveys there seems to be very little variation across states. In October 1998, Querétero was an outlier here

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40 Although some households who say they are not registered report receiving a booklet, we work on the assumption that its receipt is conditional on registration.
with only 79% answering yes. When we controlled for whether or not the household received an appointment book, Querétero still exhibited the lowest level. Possession of an appointment book increases the probability of being seen on the appointed day by 16.8% on average. In 1999 we also find that those registered at a MHU have a 2% point higher probability of being seen on the appointment day.\textsuperscript{41}

Only about 4% in June 1999 (5% in October 1998) report not being available on the appointed days. In October 1998, Querétero again has the highest level with 13% saying they were not available. Including household characteristics, the relative performance of Querétero improves substantially. But receipt of an appointments booklet is significantly positive, increasing the probability of availability by 12.7% on average, indicating that this may be one of the root causes of Querétero's poorer performance. By June 1999, however, the performance of Querétero has improved substantially, and those registered at a MHU have a 1.6% point higher probability of being available for the appointment.

In the October 1998 survey, nearly 7.5% said that the standard opening hours for consultation were not convenient with little variation across states. Possession of an appointment book decreases this probability by 10.6% on average.

In 1999 just over 94% indicated that the time of the appointment was convenient, again with very little variation across states. But the probability of finding the time convenient was nearly 5% points higher for those with an appointment book — virtually all with the appointment book found the time convenient. Place of registration was not very important but those not registered were more likely to find their appointment times inconvenient.

\textbf{Survey of Health Centers}

Information on the efficiency of the registration procedures and the convenience of appointments is not available in the other three sources of data available for this analysis. A few questions about the forms and appointment booklets were asked to doctors in the survey and interviews and their answers are summarized below.

From the point of view of the doctors, there seemed to be no major problems with the S1 and S2 forms. Up to 88% of the doctors reported having S1 forms, which they use to register the schedule of appointments of beneficiaries (85.1%), to annotate the compliance of beneficiaries (84.7%) and to schedule the nutrition and health education sessions (88%). More than 95% of the doctors reported having no problems filling out the S1 forms. The same was true for the S2 forms. Close to 85% of the doctors reported that they have no problems filling out and that they try them regularly at the health centers. The few problems reported included problems receiving the forms (n=11), irregularity of receipt (n=32), insufficient amounts (n=4) and difficulties because some of the population is not registered (n=2).

Regarding the appointment booklets, 78.1% of the clinics had a sufficient supply for the number of PROGRESA families they were attending. This implies that almost one quarter of the health

\textsuperscript{41} Only those who have an appointment book answer this question.
centers had a shortage of appointment booklets. This confirms the responses of beneficiaries reported above.

**Interviews with Doctors**

The qualitative study also indicates that, although in the past there used to be problems with receiving the S1 and S2 forms on time, this problem is largely resolved now that PROGRESA sends a supply for a whole year at a time. The forms are considered time-consuming to fill out, but not difficult. The time involved filling them out ranges from 3 hours to one full day, depending on the number of beneficiaries attended at a particular health center. The doctors felt that the recent changes made to the S2 forms, which involves reporting only on families that do not attend their visits, saves time and simplifies the process.

**Summary**

The quantitative survey of beneficiaries indicates that there has generally been an increase in registration rates over time, from 89% to 97%, reflecting mainly an increase in states with previously low rates, namely Querétero (66% to 93%) and Guerrero (80% to 94%). Surprisingly, although 47% report that their locality is visited by a mobile health unit (MHU), only 10% report being registered at such a facility. It is not clear whether this reflects a registration process or a perception of low quality or unreliability of mobile units. Access to a MHU is associated with 4.6% points higher registration rates, suggesting that distance may explain a lot of the non-registration that remains. Earlier problems regarding receipt of appointment booklets (especially in Querétero) seem to have become much less acute, although the problem still exists in some places. Appointment booklets appear to be very important in ensuring convenient and regular appointment times.

The survey of health centers and interviews with doctors, the quantitative and qualitative research, confirm that doctors do not see major problems with receiving and filling out the forms for the registration and reporting of PROGRESA beneficiaries (S1 and S2) and the appointment booklets. Doctors did indicate, however, that there used to be problems with the S2 forms in the past, but that they have been largely resolved now that PROGRESA sends a supply for one year and that the forms have been simplified.

**4.2.2 Compliance of Beneficiaries with Scheduled Visits**

**Survey of Beneficiaries**

Data from the beneficiary survey were used to examine the association between some operational aspects such as availability and use of the forms and appointment booklets, and beneficiary’s compliance with the requirements of the program. For instance, mothers are required to take their under-five children to the clinic for measuring and weighing in order to detect early signs of malnutrition. In both surveys, around 93% of households report that they took their child at least once in the last six months to a clinic. Reasons given for not attending were, in order of importance, that it was not thought necessary to do so, it is too far, not attended to when visited, no time, treated badly, and no money. In the October 1998 survey, out of those
who brought the baby to the clinic in the last 6 months, 73% had not been to a clinic with the child for these purposes prior to this period. This constitutes nearly 80% of those who had not previously taken the child and is suggestive of a big impact by the program in this respect.

There were very small variations across states in the probability of mothers taking their baby to the clinic, with the probability in the 1999 survey being lowest at 82% in Guerrero and 89% in both Querétaro and Michoacán (Table 4.5). In both surveys, those not registered anywhere are less likely to have visited. This likelihood also decreases with the age of the child with weak evidence that it is higher for males. Among those who are registered, it is higher for those having an appointment booklet.

In June 1999, only 50% of children were brought to a clinic five times or more in the last six months. This percentage is substantially lower at 32% in Querétaro and 41% in Guerrero (Table 4.5). It also appears to be slightly lower at IMSS clinics, but with no difference among those who are registered or according to whether or not they had an appointments booklet. The percentage of children having met their number of required visits to the clinics is lower for older children, although there does not seem to be a gender effect, but it increases with the number of children in this age group in a particular family.

Mothers were also asked how many trips they made to the clinic in the last month. In the June 1999 survey, 28% of children have been taken at least six times and 20% at least three times. We find little variation across states, and (surprisingly) no age or gender effects (Table 4.5). But it is substantially lower for those registered at IMSS clinics, and especially for those not registered. The number of trips is also positively correlated with possession of an appointments booklet for those who are registered.

In October 1998 (see Coady and Djebbari 1999) nearly 82% report making at least one trip in the last month. The average number of trips was 1.5, with households in Querétaro (1.13) and San Luis (1.27) having the lowest frequency of trips. Possession of an appointment booklet increases the number of trips by 0.43 on average, a substantial impact in comparison to the variation across state averages. The low average frequency in Querétaro reflects in a large part the high percentage of households never visiting the clinic, i.e., 39% compared to an overall average of 18%. Possession of an appointment book increases the probability of making a visit, and the frequency of visits increases with the number of children between 3-5 years, and decreases with the cost of travel.

In the June 1999 survey, households are also asked if, over the last six months, they brought their child 2 years or younger to a clinic for immunisations, including tuberculosis, tetanus, polio, and measles (Table 4.5). Vaccination rates were 92% for tuberculosis, 71% for tetanus, 62% for polio, and 70% for measles. With tuberculosis we find very little spatial variation, no gender or age effect, a slightly lower rate for those registered at MHUs, a lower rate for those not registered, a substantially higher rate for those with a vaccination card, but no appointments booklet effect. These results were robust to the inclusion of locality dummies, except that now there was some evidence that rates were lower for older infants and also for female children. With tetanus we find little spatial variation, rates higher at MHUs, no age or gender effects, no appointments booklet or vaccination card effects. These results were robust to controlling for
household fixed effects. With polio we find rates substantially lower in Querétero (51%), no age or gender effects, lower rates at IMSS clinics, and no appointments booklet or vaccination card effects. These results were robust to the inclusion of locality dummies, except that now IMSS rates were not statistically lower. With measles we find little spatial variation, very strong (positive) age effects, no gender effect, no difference according to place of registration or even whether registered or not, no booklet effect, but a large positive effect for those with vaccination cards. These patterns were robust to the inclusion of locality dummies.

Interviews with Doctors

As was the case for school attendance (see Chapter 3), one question of importance for the analysis of operations is how doctors deal with the control of beneficiary compliance with their required clinic visits. This is an important, but possibly delicate issue to discuss with them, considering that compliance is a pre-requisite to continuing to receive benefits, just as school attendance is a prerequisite for beneficiary pupils. This may put a lot of pressure on health clinic staff (as with teachers and school directors), because their reporting determines whether beneficiaries remain in the program or not. There were several issues explored in the interviews with doctors; whether there were problems with non-compliance and why; how doctors handled these problems; and their views on reporting non-compliance.

Some doctors say that there are discrepancies between the rules of the program and what happens in practice with the control of beneficiary compliance with their scheduled visits. For instance, some doctors say that even though they fill out the forms and report that some families do not attend, the families still receive their benefits. This has happened in two communities in Puebla. One doctor recalls:

We had problems because there were persons who complied with their appointments, everything was in order and they don’t get the help. On the other hand there are others who did not attend the pláticas, were not doing anything for their health and they receive all the benefits; so those who comply are unhappy.

Apparently, it is very unusual that doctors receive complaints from families that their benefits were cut because of lack of compliance. It is more frequent that they receive complaints that they did not receive their benefits in spite of the fact that they complied with their appointments. There are also various reports of families who pull themselves out of the program because they cannot comply. They know they could lose their benefits if they do not comply, so they decide to quit rather than have the doctors report them as having missed their appointments. The doctors note that participation and compliance with the health requirements of PROGRESA happens largely because people are afraid of losing their benefits, and those who cannot comply tend to request not to be included or they pull themselves out.

According to the doctors, beneficiaries usually attend their programmed visits and rarely miss them. However there are situations where non-attendance is due to temporary migration to other areas, like in a community in Veracruz, for example, where the population migrates for some time of the year to work on coffee plantations.
A compliance problem reported in an indigenous community of Puebla revealed two different explanations for why people do not come to the clinics, related to distance and cultural factors. This led to the exclusion of all beneficiaries from this community. The doctor described the situation as follows:

People speak Totonaco, nobody speaks Spanish and it is a little difficult to get to this community because the population is very disperse. The thing that makes our work with them difficult is that we cannot communicate with them and they are very far, sometimes up to 2 hours walking; the elderly and the pregnant women, those who have young children, it is very difficult for them to come to the houses where we provide health services. Another problem that we have in these communities is that, for cultural reasons, the husbands tell their wives not to go, so the wives do not come. The community had to be dropped.

Doctors appear to really do their part to help people comply with their visits and attend the education sessions. Doctors report having implemented systems to remind families of their appointments, usually through the promotoras. They coordinate with them, send messages to the families, and the promotoras establish the link with the communities.

In Papaloctipan the doctor explained that “each promotora has a specific number of families, this promotora is in charge of seeing that these families come to see her if they have a problem, that they link up with her so that at the same time the promotora can inform the health center so that we can keep a better control.”

In some cases doctors even go to peoples’ homes to get them to come to the clinics. According to one doctor:

In fact, for patients who have to come frequently like diabetics, malnourished (children) and pregnant women, because they are a priority, if they do not come, we have the obligation to look for them at their home and invite them to attend their appointments and try to make them participate.

Doctors see a great deal of difference in peoples’ motivation. Some say that people come only because they are receiving PROGRESA benefits. These doctors believe that if they were to stop receiving the benefits, they would stop coming to the clinic. Another doctor from Veracruz mentioned that attendance at the education sessions is not a problem or a reason for people to lose their benefits, but he says that people come to the sessions to sleep and that they do not pay attention: “They all do attend, but they come here to sleep.”

One doctor in Puebla summarized the opinion of some of his colleagues as follows:

I think here in Mexico, there are still gaps in people’s education, I think it would not be the most adequate to force people, but up to a certain point we do force them, we force them to come to the nutrition and health education sessions and to the regular check ups. People perceive benefits when they receive something.

Other doctors indicate that they really have to insist a great deal, and they have to convince the population of the importance of attending their visits. They feel that progress is being achieved, albeit very slowly, and that the medical staff has to continue to persevere.
Relative to the requirements imposed on the beneficiaries, most doctors feel that there should be exceptions made in specific cases. They actually have a system by which they allow changes in appointments and they accept valid excuses for those who cannot attend on the day of their appointment.

We allow exceptions once in a while, depending, we need to take into account the distance from the community, the availability of people. Sometimes, they have to go out to work, or it’s a day of celebrations in their community. In these circumstances, we postpone by one day. One other exception is older people, for whom it is difficult to travel to the health center.

In general doctors try to apply the rules, but when necessary, they have someone remind the family. If after a while the families do not come, they then do record their absence.

Doctors agree that they need to be flexible, considering the type of population they are dealing with. The majority of doctors say that they have not come across a problem with beneficiaries’ attendances, that would have forced them to exclude them from the program. However, doctors made it clear that if they had to they would, no matter who the beneficiary is (mother, friend, brother, other relative, etc.). One doctor said: “I act according to the rules, whether it is my friend or my relative, if the norm says that if the PROGRESA family missed 3 times I have to eliminate this family from the program, then I do it.”

However, when asked whether they thought it was fair to exclude families from PROGRESA for lack of compliance with the requirements, they almost unanimously expressed a view that is summed up in this doctor’s response: “if the family appears to have made the effort, then there is a need to inquire why they failed to attend and to try to motivate them to come,” rather than just withdraw a benefit that they really need. However, if the families do not participate and are not interested, then the doctors feel that it is only fair to withdraw the benefits, because this has a demoralizing effect on the families that make the effort to participate.

**Summary**

The findings of the quantitative survey of beneficiaries confirm that possession of an appointment booklet is an important operational factor for beneficiaries’ compliance to their scheduled appointments. Beneficiaries without the booklet are substantially more likely to report not being seen at an appointed day, not being available on the appointed day, not finding the appointment convenient, and more likely not to make their required monthly trip to the health clinic. The improved availability of booklets is thus expected to have led to improvements in all these aspects. The program also appears to have had an important impact in terms of getting those who previously did not bring their infants for measuring and weighing (growth monitoring) to the clinic to do so. Being registered at the clinic is also associated with greater probability of attending the growth monitoring sessions. In contrast to the above, possession of an appointment booklet is not in general associated with higher vaccination rates, but these are generally high to start with and vary very little by place of registration. In fact, only for tuberculosis do those not registered have lower vaccination rates. This may reflect the effectiveness of vaccination
campaigns, which are often well advertised and involve fewer visits than participation in growth monitoring.

The interviews with doctors indicate some problems with the control of beneficiary compliance with the required visits. One problem relates to discrepancies between the actual compliance of families and the receipt of their benefits. Doctors report situations where beneficiaries attend all their visits and do not receive their benefits, as well as instances where beneficiaries do not comply and do not have their benefits cut. In general, however, the majority of doctors say that they have not come across problems with beneficiaries’ compliance that would have forced them to exclude them from the program. They do mention that they have to be flexible though, changing appointments when necessary and having a system in place to remind beneficiaries of their appointments and of the importance of complying with PROGRESA requirements. Promotoras are an important help in this respect. Doctors are also unanimous in saying that it is fair to exclude families who do not comply with the rules out of disinterest and they would do it if necessary, irrespective of whether the family is a relative or a friend. However, if families have problems with compliance, but show interest and are making the effort to attend, they consider that they have to be flexible because of the poor conditions in which people in their communities live.

4.3 Impact of PROGRESA on Clinic Attendance and the Demand for Health Services

This section reviews the changes in clinic attendance and in the demand for health services that have occurred since PROGRESA was implemented. Only information from the two research modules with doctors (the quantitative and the qualitative interviews) is available to examine these issues.

Interviews with Doctors

There is a general consensus among the doctors interviewed that PROGRESA caused an increase in coverage of medical services and an increase in the number of patients attending the clinics, including PROGRESA beneficiaries and non-beneficiaries. There is, however, a lot of variability between communities and health centers as described below.

One doctor says that attendance increased due to PROGRESA, because of the requirements to attend for preventive services. The doctor indicated that in his clinic, PROGRESA beneficiaries do comply with the required visits according to their appointment booklet. Another doctor says that some of the increased attendance is due to migration from large cities back to rural areas because of the high levels of contamination in the cities.

Many doctors talk about the changes in peoples’ thinking and attitudes brought about by PROGRESA in relation to curative and preventive health care. The doctors point out that the culture in Mexico is largely one of curative medicine. However, PROGRESA has changed this among beneficiaries, for whom it has encouraged use of preventive medical services. Through this process, the health staff now feels that they can request that people attend the clinics:

Those who are not PROGRESA do not come to the health clinics (or regular check ups);
the ones who come more are the women with children less than 5 years of age who come
for weighing and measuring them, because those who are not PROGRESA come more for curative purposes than for check ups.

This difference between beneficiaries and non-beneficiaries is also emphasized by a doctor from another community:

Regular beneficiaries, for the mere commitment that they have with the program, do come to the health center, but those who do not receive the benefits are, let’s say, separated even though we do try to unify them, there is a split between the beneficiaries and the non-beneficiaries who come to a minimum; in fact the beneficiaries are the ones who request the most from us.

Doctors observe that beneficiaries attend because they are required to do so. Nevertheless, the program appears to have a positive impact on the non-beneficiaries as well. Some of the doctors have noticed a slight increase in the presence of non-beneficiaries as a result of the program.

The doctors admit that preventive health care was not invented by PROGRESA, rather it has been promoted by their own health institutions for a long time. They feel, however, that PROGRESA has helped to reinforce the notion of the importance of preventive health care. One doctor also mentions that the health personnel in his clinic:

is oriented towards preventive health and does not distinguish between PROGRESA and non-PROGRESA individuals; they all receive the same services and attention. With PROGRESA, however,… it is different because people have to follow the schedule of preventive visits in order to receive their benefits, and therefore they do come.

Regarding the increase in numbers of visits, one doctor notes that “the general number of visits has been maintained constant, but what has increased are the ‘obligatory visits’ of the PROGRESA patients.” Another doctor similarly emphasized the role of PROGRESA in increasing the rate of visits:

With PROGRESA a new clinic was set up here and the PROGRESA people come to their visits at a rate of 100%, whereas the non-PROGRESA also come, but at a rate of about 70-80%. So, this is a new service, which is popular, and which was created as a result of PROGRESA.

PROGRESA is also credited with increasing the number of health staff attending the needs of the community. One community in Puebla, where before they had only a small clinic with only one assistant working two hours a day. Since PROGRESA, a doctor, nurse, and promotora all work in the community. Among other things, they mention that this increase enables them to detect malnourished children and to give them the nutritional supplement. Another positive aspect that the doctor mentions is the increase in coverage of pregnant women. He sees a big difference now in the coverage of pregnant women, many of whom, he recalls, were never seen at the clinic before. He also emphasizes that, because now people have to come to the clinic for PROGRESA, there is a big increase in the number of patients coming on a daily basis.

Overall the majority of doctors estimate that visits have increased by approximately 30% for curative services and by 70% for preventive services. According to these doctors, the main factor
causing the increase is the monthly visits required by the PROGRESA program. Some doctors also say that people have started to come more often because they know the staff better, and there is better communication and bonding between the health center and the community. They mention that at the beginning people were coming because they had to, but gradually they have started to come because their attitudes are changing and they are becoming convinced of the utility of attending. Some report that non-beneficiaries also attend the clinics more, possibly as an indirect effect of the program, whether they are imitating the beneficiaries, or because they are also becoming more convinced of its usefulness. Since some non-beneficiaries attend pláticas this also may convince them to go to the clinics more often.

One problem doctors raise, however, is that they think if the program went away, the preventive health services would be difficult to maintain. They raise the question of sustainability.

Overall, the general perception among the doctors is that PROGRESA has a positive impact on the communities where it has been implemented. This is because it has changed peoples’ attitudes and made them more interested in their own health, and because the clinic staff has become more committed and more motivated to provide high quality services.

To illustrate the doctor from Hidalgo says:

PROGRESA has changed people’s attitude. Especially because it helps people who are very needy. Yes, the fact of participating in the program that gives them support motivates them, and commits them to take care of their own health, and my experience is that it used to be really difficult for me to go immunize children because people did not have much interest and many did not participate. With PROGRESA, however, they feel more committed and they have improved.

The same positive changes in attitude and increased health awareness of people is confirmed by two more communities in Hidalgo. The doctors also emphasized that at the outset PROGRESA insisted a great deal on the importance of improving the quality of health care.

As a result of this increase in attendance, most doctors feel that their work load has increased since PROGRESA was implemented. Doctors indicate that they have much additional work as a result of the greater number of visits and patients they need to attend every day. They do not express any major concern about having to take care of more patients, but they complain about the additional administrative responsibilities, which have also increased as a result of PROGRESA. Doctors comment that they would like to receive additional help to assist them with the increased administrative tasks.

Survey of Health Centers

The doctor survey confirms the views expressed above that the demand for health services has increased in the previous year, with 82.6% saying that it has increased, 15.2% saying that it has remained the same, and only 2.2% saying that it has decreased. The reasons reported most frequently for the increase in attendance and the problems this increase has caused are listed in Tables 4.6 and 4.7. The reasons reported most frequently for the increase in attendance are related to PROGRESA: 57.3% of the doctors mention that it is because of the requirements of
attendance set by PROGRESA, and 36.4% indicate that it is because PROGRESA caused increased awareness among the population. Regarding the problems that this increase in demand has caused, half of the doctors report a shortage of medicines, 36.7% report an increased work load, 33% report that the clientele is very demanding and to a lesser extent they mention a concern about shortage of staff and equipment.

Summary

In conclusion, there is no doubt that the objective of PROGRESA of increasing the coverage of health services, particularly preventive services, has been met. There is also a general consensus that this is largely due to the requirements of PROGRESA that beneficiaries attend a predetermined number of visits in order to maintain their eligibility in the program. Doctors appear satisfied by this increase, especially with respect to the increased use of preventive health services. They are also optimistic about the apparent positive changes brought about by PROGRESA in the population’s general attitude and awareness towards preventive health care. Doctors do not generally complain about the resulting increase in work load, except for the increase in administrative work. There is, however, a certain concern that the increase in demand stretches the already scarce resources, especially relative to medicines and personnel.

4.4 Nutrition and Health Education

The main mechanism for providing education and training is through lectures ("pláticas") held at health clinics. These are supposed to be given monthly and attendance of PROGRESA beneficiaries is required as a condition of receiving PROGRESA benefits. The pláticas are supposed to be open to other beneficiary family members and to non-beneficiaries. Availability, attendance, perceived benefits and value of the health and nutrition education, as well as problems with this activity are discussed in this section.

4.4.1 Availability and Attendance

Survey of Beneficiaries

In both the October 1998 and the June 1999 surveys, only 3% of households report that pláticas were not given in the local clinic, in both cases with little variation across states (Table 4.8). Neither, in 1999, was the correlation with place of registration statistically significant, but those with an appointment book had a 4% point higher probability of reporting the unavailability of lectures.

Out of those who had access to such lectures, 97% (June 1999) and 95% (October 1998) reported having attended them. While in the October 1998 survey there was little variation across states, in the 1999 survey attendance was lowest at 93% in Querétaro and 94% in Guerrero. Again, there was little variation according to place of registration and, as expected, those not registered had significantly lower attendance levels. Those with an appointment book had nearly a 3% point higher level of attendance.
In the October 1998 survey, supporting questions were also asked regarding expectations of future benefits from the program with 97% expecting the program to lead to improvements in family preventative health, 86% expecting it to lead to improvements in their family's nutrition, 59% expecting it to lead to better care for those who fall ill, and only 0.7% not expecting it to lead to any improvements. The high percentage of beneficiaries that expect an improvement in family preventive health is quite noticeable.

Thus, the availability of, and attendance at, health lectures appears to be very high. Those with an appointments booklet have a 3% point higher probability of attending; a very high marginal effect given 97% attendance levels.

**Survey of Health Centers**

The clinic survey (n=317) also confirms that all but one health center reported giving some education sessions every month. The number of sessions varies widely, as well as who gives them. In many cases various staff members give the pláticas during the month, as shown in Table 4.9. It is of concern that people such as nurse assistants, primary health care technicians and community workers, who may not have received any prior training in the specific themes being discussed, seem to be quite involved in giving the pláticas.

A very large number of themes is also said to be covered in most health centers. Beneficiary mothers are said to attend the education sessions in 97.1% of the health centers, and other family members (from beneficiary families) in 46.6% of the health centers. Non-beneficiary mothers are also said to attend the pláticas in 61.7% of the health centers, as well as a large number of other non-beneficiary family members (in 46.6% of the health centers).

Attendance at the pláticas is monitored in 99% of the health centers, and up to 91.6% of the interviewees indicated having received didactic material to carry out the education sessions.

### 4.4.2 Perceived Value of the Pláticas

**Focus Groups**

According to the focus groups with beneficiaries, non-beneficiaries and promotoras, the monthly health pláticas, are very popular, and appear to be influencing health-related habits among beneficiaries, and to some extent non-beneficiaries as well. In response to questions about pláticas, 70 comments were made (or discussions took place) stating they were useful. No comments were made that the pláticas were not useful or worthwhile.

Among these comments, the two largest groups of comments were made about 1) family planning; and 2) prevention of illness, primarily hygienic practices and illness detection. Of the positive comments made about family planning, none were made by women in the groups from
indigenous communities, with the exception of one *promotora* from Hidalgo.\textsuperscript{42} The next largest group of comments was about how to take care of children. Additional comments were made about cancer detection. The full list of issues covered in *pláticas* that women felt were useful include: food preparation, feeding children with liquid salt solutions, vaccinations, pregnancy checks, mosquito protection (to throw away or bury dirty dishes), boiling water, boiling vegetables, washing vegetables and fruits well, using disinfectants/chlorine, cooking foods well, keeping food covered from dust or flies, wash hands, pneumonia, digging holes to bury or burn garbage, AIDS protection, birth control, family planning, medicines to take for different illnesses, cancer detection, not to use baby bottles, clean the roads, use latrines, clean latrines well, make baby food and juice, consuming nutritious foods, weighing the children in relation to their age, growing their own vegetables, selecting between organic and inorganic garbage.

Below are examples of topics that beneficiaries said they learned about in the *pláticas*:

It is to make our family better, in the cleaning, in the nourishment. The doctor explains to us how to prepare food, how to feed the child when he is sick with diarrhea, to give them liquid salt solutions so they won’t get dehydrated, and to vaccinate them to prevent them from dying. (BM2-33)

Hands have to be washed in order to prepare food. One has to be showered, clean because that counts very much. And the hygiene of food and everything, not a dirty tomato for the soup, no no no. (BM-33)

Women spoke about what they were doing now that they did not do before PROGRESA introduced the health *pláticas*. Below are some examples in the area of hygiene from Guerrero, Michoacán, and Hidalgo:

—Before there were people who didn’t burn their garbage and didn’t boil their water, and now they do. There’s more and more cleanliness....
—Food has to be covered.
(PG-33)

In the past we used to throw and pile garbage anywhere, and now we have to make a hole and we have to burn it there. And for example in the rainy season we have to throw some soil over it to prevent it from flies that after that go to our food. (PM2-33)

[Local translator] They say it has changed very much, because they say that people who get PROGRESA, they clean everything in the community, they burn garbage, they drink boiled water, they do everything for the community, and the community doesn’t have any garbage in the river. (BH-33)

Below are examples of comments about health care and disease prevention:

\textsuperscript{42} As noted earlier, most, though not all, *promotoras* from Hidalgo were from indigenous communities. However, these areas were on the whole less remote than the indigenous region visited in Veracruz.
— There are not very ill children anymore. Before PROGRESA most [women] didn't vaccinate them, they didn't take them to the health center, and if they got sick they only gave them some herb from the community, and the doctor didn't see them. And some children did die from some disease. And now they take their children to vaccinate so the disease they get doesn't last or doesn't kill them. (PG-33)

[What have doctors taught you and your communities, that you now do?]
— To make salt solution: you boil the water and when it's cold, you wash your hands with water and soap, and after that you prepare it and you give it to the sick child with little spoons. Because we didn't know this before, at least I didn't know, and you see that I have little daughters, I didn't know how to prepare it and now I know. (BG-33)

— They teach us how to prevent sickness, for example if we feel a symptom and we went to the talk about which sickness starts like this, I better go [to the clinic].
— We know the alarm signs.
— If our children have any symptoms of a disease, as stomach ache...
— How to feed one who has diarrhea.
— How to nourish them.
— Now we know more than we knew before.
— Because before we didn't have those talks. (BQ-33)

In these comments made in a discussion by beneficiaries in Querétero, women indicate that the lectures on family planning and the cervical cancer test have had an impact:

— It is up to us if we feel that we can't afford to have more [children].
— I have many children, I say that if we had [family planning] before I wouldn't have had all that family. (BQ-33)

[Q: Is there something that the doctor has taught you that you do it now?]
Like to have the papanicolaou examination.
— …before we didn't [have the test].
— Some did, some didn't
— We were embarrassed.
— And now the doctor tells us that we shouldn't be embarrassed because we can get cancer for being embarrassed…
— Now with PROGRESA, some people who didn't do it before, do it now.
— Older women used to not do it, and now they do it.
[Q: And what happens with the women who don't receive PROGRESA?]
— They do it also.
— They also told them about it. (BQ-33)

Note that non-beneficiaries are said to also have the test done. However, only a handful of comments regarding the health pláticas were made by non-beneficiaries, which may indicate that fewer attend the pláticas. This topic is taken up in the next section. However, some comments by non-beneficiaries are worth noting because they imply that at least in some places, non-beneficiaries are either attending the talks or that beneficiaries and promotoras who attend
communicate what they learn to non-beneficiaries in their community. Below are discussions among non-beneficiaries in Veracruz, Hidalgo, and Guerrero:

[Q: Do you do the same as women who go to the talks?]
—Yes.
[Q: Like what? Do you boil water?]
—We boil water, and we put disinfectant in it...
[Local translator] she says she buries [her pots].
[Q: Who told you to bury them?]
—The doctor did.
[Q: But didn't you say that you don't come to the talks?]
—Well, we hear them talking.
—That's what the promotora, and all say. Even if we don't have PROGRESA, we find about it. If we have bottles or anything, we bury them.
(NBV2-33)

[Q: But do you really do at your homes what they tell you in the talks...Like what?]
—To vaccinate our children.
—To drink boiled water.
—To use latrines.
—To wash them well.
—To clean our houses.
—We sweep all the community.
(NBH-33)

[Q: Are the talks useful for you?]
—I think so.
[Q: Why?]
—Because we are less embarrassed, because many people in here are very shy, and the doctor tells them “you have your appointment for your papanicolau.”
(NBG-36)

4.4.3 Non-Beneficiary Participation in Pláticas

Only the focus groups with beneficiaries, non-beneficiaries and promotoras provide information on this topic.

Probably because the pláticas are valued by the people in these communities, the issue of who attends and who does not generated an unanticipated amount of discussion. Because we were interested in the impacts of PROGRESA on non-beneficiaries and the community as well as on beneficiaries, we asked about whether non-beneficiaries attended pláticas. This issue sometimes was raised first by the informants, in the context of discussing the issue of differentiation within the community between beneficiaries and non-beneficiaries. In total, 87 comments were made about non-beneficiaries attendance or lack of attendance at pláticas. The comments were almost evenly split between those who talked about non-beneficiaries not attending (38) and those who talked about non-beneficiaries attending (49), implying that there is considerable variation between villages (30 of these comments, evenly split between the two categories, were made by promotoras, implying information from about that many different communities). There was also
variation within each state, again with roughly the same numbers of comments indicating attendance and non-attendance.

Given the value of the *pláticas*, and problems associated with excluding some people in the community not only from economic benefits of PROGRESA but educational benefits as well, the degree of non-beneficiary participation and non-participation should be investigated through the survey. Based on these concerns, the reasons why non-beneficiaries do or do not attend are important. A discussion among *promotoras* in Veracruz offers some explanations:

[Q: O.K., almost the half of you told us that non-beneficiaries attend *pláticas* (and community activities (faenas)) and the other half told us they don’t. In the communities where non-beneficiaries do attend *pláticas* (and community activities (faenas)), we would like to know why they do.]
—Because they too have kids in the school.
—Well, in my community, as *promotora* I explain to them, I tell them ‘look, I call you all even though you are not beneficiaries, I want you to understand that because we all live in the community we all have a right to participate, above all in *pláticas* because it’s very important for you, for all of you, beneficiaries and non-beneficiaries, to learn about a lot of issues, right? So, a great many of them understand and they go even though they are not beneficiaries.

Other comments suggest that non-beneficiaries go because they want to learn:

[Q: Why do you go to *pláticas*?]
—Because if sometimes we are offered *pláticas* one has to go, right, because there are diseases that we don’t recognize and the doctors explain what it is about, like that one, right, that gives fever and makes the eyes get red, but one doesn’t know what disease is that, conjunctivitis, and there is a lot of persons there [in the community] that have it, a lot of persons don’t, but who knows why this is (NBV-35).

One Veracruz *promotora* implies that non-beneficiaries are more appreciative, perhaps because they do not take the *pláticas* for granted (this is an isolated comment but is included because it makes an interesting point):

[Q: Do you invite all the women [to *pláticas*, regardless of being a beneficiary or not]?]
—Yes, equally.
[Q: And all the beneficiaries go? [to *pláticas*]
—Yes, well, there are some that don’t want to attend because they say they don’t have enough time...
[Q: And non beneficiaries, do they go?]
—Sometimes we have more non beneficiaries than beneficiaries at *pláticas*, and they are who complain less, I mean, they don’t say that they are losing their time.
(PV-35)

Three main reasons were given to explain why non-beneficiaries do not participate. The first two are that non-beneficiaries are either not invited or do not feel welcome:

—My daughter-in-law is a beneficiary and they only call her, so why would I go? (NBM-35)
—Only those that have PROGRESA [are invited]. (NBV-35)

Note the different perspectives offered by beneficiaries and non-beneficiaries from the same community:

—Only those that are on the list get in. (NB-M1-35)
—And those that have PROGRESA, if one goes there, they just scowl at you. (NB-M1-35)
—The non-beneficiaries were invited to participate because it’s for their good too, but they don’t participate. (BM1-35)

The third and most frequently mentioned reason that non-beneficiaries do not want to participate is that they do not get PROGRESA benefits and thus do not want to participate in PROGRESA obligations. Below are discussions among beneficiaries and promotoras from different regions of Veracruz:

—Because they don’t receive PROGRESA, they don’t want to go to pláticas.
—They don’t participate, they are not willing.
—They don’t want to come because they don’t receive PROGRESA and they waste their time here. (BV2-35)

[Q: Why don’t non-beneficiaries come [to pláticas]?]
—They are reluctant, they are not interested in knowing about what we learn there.
—No, they don’t go, from the beginning they decided that only PROGRESA women have to participate. (PV1-35)

4.4.4 Problems with Pláticas

Problems with the pláticas were investigated in both the focus groups with beneficiaries, non-beneficiaries and promotoras and in the interviews with doctors. A summary of findings is presented below.

Focus Groups

Participants reported few problems that they have with pláticas. Regarding the potential problem that the material might not be presented in a way that is understood, most of the women said they understood the content of the pláticas. Some said that if they do not understand, they ask for clarification. Below is a discussion among promotoras in Michoacán:

—If we don’t understand, we ask
—Because the doctor says ‘do you have any questions? And they make us participate in the discussion, and ask us what do we know about the subject is being talked about, and whoever knows answers it.
—And the ones who don’t [know the answer] we start to learn. (PM-34)
There were examples given, however, of where promotoras or beneficiaries had trouble understanding what was being taught. The following discussions among promotoras, in Veracruz and Hidalgo indicate the nature of some of these problems:

[Q: Is there something that doctors or nurses taught you that you can’t do?]
—What they teach us about weighing children, no.
—To fill that... how is it called? that thing to fill with cards [fichas], I don’t know what that is.
—Is a piece of paper they gave us to write down the children’s weigh, it’s a graphic
[Q: But why can’t you do that?]
—I don’t understand why —because I don’t understand it
[Q: Well, you haven’t understand that graphic.]
—I do, I understand it now.
[Q: Do you understand it now too?]
—Yes, I had understood it before, some sort of helper from PROGRESA, as you are, told me about it.
[Q: Then not everybody has understood such a graphic?]
—No. (PV1-34)

—In my case, we had made some teams with the doctor to do the cleaning, and he was going to explain many things to the first team, I never knew which things, but they were about illness, and about medicine. But the doctor said it was a total failure because women didn’t learn anything, and he didn’t teach us anymore.
[Were they from PROGRESA?]
—Yes they were. And they were going to teach the rest of us, they were going to explain us but they didn’t. First they didn’t go the day he made the appointment, and second the ones that he taught didn’t learn anything because they were embarrassed.
[Q: But besides that, is there something that he taught you and you did understand, but you won’t do it anyway?] (PQ-34)

We asked whether there were things that women were instructed to do in the pláticas that they could not or did not want to do, to get a sense of whether there were disjunctures between the platica content and the beneficiaries’ life situations. There were not many examples, but those that were offered were informative. Some examples included boiling or chlorinating water, building latrines, and getting health examinations, particularly the cervical cancer test (pap smear), and especially with male doctors. The following example from a discussion among promotoras in Veracruz, illustrates both the difficulties of bringing about change, and the important health practices that are being introduced in communities by the program and encouraged by promotoras:

There are some who don’t do some things, like not boiling the water or to put chlorine in it, because they say it has a bad taste, that it doesn’t taste the same as raw water. Of course it doesn’t taste the same —we tell them—but it has to be natural in order to have less illness, less viruses, less parasites.
[Q: Which other things you haven’t wanted to do?]
—Latrines because they say they don’t want to bury excrement.
—Because each one thinks a different way, right?
—[They say] that they are old and that they are going to die soon…
—In my community some women told me that even if she wanted to have her house clean, they have never had a latrine, and her husband says that since he was a child his parents never had a latrine, and they haven’t died so why does he have to have one? And I try to make them understand that we have to get better, that’s what it is about, and the program is asking for our support.
—…In my community everybody has to convince people.
—We have improved, because now in my community almost everybody is making their latrines. (PV1-34)

An issue that was raised often enough to merit attention is that of male doctors and shy female patients, both in the context of the *pláticas* and the health exams. Regarding the *pláticas*, some health issues are fine to be presented by a male doctor, but others are seen as too personal, as indicated in the following discussions among *promotoras* in Hidalgo and beneficiaries in Veracruz:

Well, once the nurse asked me to give *plática* about family planning, pregnancy, and all that, and because I did know something about that, because I took a course about that in the hospital, I told her O.K., I will help you, I will give *plática*. But now we have a rural assistant, but because he is a man, women hardly pay attention to him.

[Q: Why?]
—Well, maybe they feel shame to tell him about their issues.
[Q: So, he doesn’t help?]
—No, because the women don’t ask him about women’s issues, I mean, I would like to tell him about my problems, but I can’t because he is a man.
[Q: You feel shame?]  
—Yes, and because they [women] already know me, they ask me.

(PHidalgo-35)

—She said the doctors are fine, it’s fine and they understand well, but it would be better, if possible, that the [female] doctor came, but if not it’s o.k.

[Q: Asks the group? Everybody?]  
—Yes [Entire groups nods agreement] (BV2-34)

The issue of *promotoras* giving *pláticas* is another operational concern. Although in the example above it was not a problem, some *promotoras* said that they do not feel qualified to give them. This raises questions about the quality of the health education in these cases. While only a few *promotoras* raised this issue, the survey should inquire as to who gives the health *pláticas*.

**Interviews with Doctors**

The doctors interviewed expressed that they thought the education was very important. However, some indicate that people are not always motivated, and that they sometimes come, but they do not pay attention. In spite of this, the doctors think that the people who attend the *pláticas* do learn something in the end.

The doctors mentioned various problems with the *pláticas*. One is a problem of language. In some indigenous communities, the education sessions have to be carried out with a translator. In other communities, the doctors mentioned that illiteracy of the population was a problem sometimes. The doctors indicate that they have to repeat the same things many times and they try
to use creative ways of teaching that illiterate people can understand. In general, the doctors mention using a variety of visual and communication aids (theater, drawing, pamphlets, posters, etc.)

One of the most frequently reported problems is the discussions about the pap smear test and the subject of family planning. Doctors feel that there is a real need to talk about family planning, especially with young adolescents (pregnant 11 or 12 year old girls are seen at the clinics). There is also a need to talk with them about sexually transmitted diseases. However, they note that this topic is very difficult to address, especially for a male doctor.

Another commonly reported problem is that men usually do not come to the education sessions. Apparently men consider that they have to work, and also they are not the direct beneficiaries of the program, and therefore they do not have to come. Doctors see this as a real problem, as conveyed in the following examples:

   It would be good for men to attend so that they would see all what women have to suffer, and so that women could share their experiences with them and that men would be more understanding and could help their wives. It would be important that they participate. if both received the education, they would both be involved in improving their health.

Another reason why doctors feel that men should attend the pláticas is because they would like to discuss the subject of alcoholism with them. Young people also would benefit from education on this subject. Some doctors have given lectures to men, but they see a problem of machismo and a very strong reluctance of men to change. According to the doctors, if they could get the young people to participate and to start receiving education from early on, maybe they would be more receptive to the new ideas proposed and it may be easier to achieve behavior changes now and in the future.

Another group who appears to be difficult to involve is the elderly both because they often feel that they have experience, do not need the education and are not interested, or because in some cases they have difficulties coming to the health center.

Regarding non-beneficiaries, the doctors report that their participation varies from one place to the other. Doctors put much effort into motivating the whole community to participate and trying to eliminate the barrier between beneficiaries and non-beneficiaries, but they do not always succeed. They note that much of it also depends on the attitude of the beneficiaries towards the non-beneficiaries.

Overall, the doctors agree in their view the pláticas have a positive effect on the population. One said that:

   People now have a little bit more knowledge and awareness, and this has helped reduce mortality; people now know more about preventive health care; people with diabetes and hypertension come to the health center more frequently now, and this way we have had less cases of patients coming with severe hypertension or suffering from hypoglycemia than we used to have.
Summary

It is very interesting to see that all four research methods used in our study concur in showing that the health education is both widely available and very popular among beneficiaries, promotoras and health professionals. The different research methods also bring up many of the same issues, positive or negative. For example, the focus groups with promotoras, beneficiaries and non-beneficiaries identified a potential problem with promotoras being asked to give the pláticas, and feeling that they were not necessarily qualified to do so. The health centers survey confirms that the pláticas are given by a wide variety of people, including people with minimal training and even possibly limited formal education such as the primary health care technicians (14% of the clinics) and community workers or assistants (20% of the clinics). Another point raised in both qualitative studies (interviews with doctors and focus groups with promotoras, beneficiaries and non-beneficiaries) is the problem with male doctors giving lectures on the pap smear test or on family planning. This seems to be a well-understood issue at the level of the health staff and some clinics have already taken measures to have these themes discussed by female staff members. In some cases, however, it appears to fall on the promotoras, who do not feel qualified (and are not) for this assignment. There is also some consistency in the point about the non-participation of non-beneficiaries, which is said to vary significantly between communities. The focus groups reveal a highly positive attitude from the population towards the pláticas, in spite of the fact that it may be time consuming for mothers and other family members to attend. As indicated by the quotes, mothers and promotoras also seem to have learned a lot of information from the pláticas, especially in the much needed areas of hygiene, disease prevention, and early detection and treatment of illnesses. Finally, the focus group participants and doctors strongly agree on the importance of health education for men, which would help men in a variety of ways but also make women’s lives easier and enable women to put into practice what they learn through the platicas (e.g., family planning, the importance of health care for the entire family).

4.5 The Supply and Quality of Health Services

Survey of Beneficiaries

In the October 1998 survey an attempt to get information on the supply side, beneficiaries were asked if there were enough medicines at the clinic. Over 53% reported a shortage, with Querétero again appearing as an outlier with nearly 74% reporting a shortage of drugs (Table 4.8). However, although the results indicate that a shortage of medicines is a major problem in many areas, they do not throw much light on whether the situation had worsened because of the extra demand generated by the program.

In this survey, households were also asked if they felt that health-center services had improved since the inception of PROGRESA, with 75% reporting that they had. Only 47% and 63% of those in Querétero and Guerrero respectively perceived an improvement.

To validate some of these results, in the June 1999 survey beneficiaries were asked if the following had improved since PROGRESA started (% reporting improvement, followed by lowest and highest, in brackets):


(i) The disposition of doctors and nurses (70%; 61%, Veracruz; 79%, Puebla);
(ii) The treatment by doctors and nurses (69%; 63%, Veracruz; 75%, Puebla);
(iii) The availability of medicines (60%; 46%, Veracruz; 70%, Querétero);
(iv) The time spent in consultations (56%; 51%, Veracruz; 63%, Guerrero);
(v) The waiting time for consultations (51%; 46%, Veracruz; 62%, Querétero);
(vi) The cost of consultations (50%; 45%, San Luis; 64%, Guerrero);
(vii) The cost of medicines (50%; 44%, Querétero; 62%, Guerrero).

In virtually all cases, approximately 98% replied that at least the conditions had not deteriorated. A common pattern was that of the families registered in MHUs, were more likely to report an improvement whereas those not registered has a substantially lower probability of reporting an improvement.

Given the remoteness of some of the beneficiary communities, the introduction of and improvement in access to MHUs is seen as a crucial dimension of the program. Nearly 47% of beneficiaries report that a MHU visits their community, most commonly every month or even every two weeks. Over 37% of these households report an increase in the frequency of visits. Guerrero (55%), Puebla (46%) and Querétero (44%) had the greatest proportion reporting an improvement, with Michoacán (31%) having the smallest.

When asked whether the time spent by MHUs in the community had changed, 42% said it had increased with 48% reporting no change. The proportion indicating an increase was highest in Guerrero (60%) and Querétero (54%), the lowest being in Veracruz (38%).

In summary, the earlier survey found that many (75%) perceived improvements in health-center services, but much less so at 47% in Querétero and 63% in Guerrero. A more detailed question found that in a large number of dimensions nearly everyone reported that services had at least not deteriorated. In all of these dimensions, over 44% of households in each state report an improvement, and perceptions of improvement appear to be more prominent in Guerrero and Querétero. These states have a higher percentage of households reporting a greater frequency of visits by MHUs and that these stay longer in the community.

Survey of Health Centers

Of the 317 health centers surveyed, 175 are from the “Servicios Estatales de Salud (SSA)” and 142 from IMSS Solidaridad. Most of the centers reported having electricity (86.8%), water (72.9%) and sanitary facilities (84.8%). In terms of staff, the percentage of health centers with different categories of personnel is presented in Table 4.10. Note that only 70% have a doctor and 66% have a nurse.

Services offered: More than 99% of the clinics offer the complete package of primary health care services: hygiene, family planning, prenatal care, delivery, pap smears, child growth monitoring, immunization, management and treatment of diarrhea, acute respiratory infections, deworming, tuberculosis prevention and control, hypertension and diabetes prevention and
control, accident prevention, first aid, community health education and training. Up to 82% also offer hospitalization services.

**Supplies:** A series of questions were asked to the doctors to verify whether various types of supplies were available in sufficient quantities at the health center at the time of the survey. The findings are presented in Table 4.11, which shows that many report a shortage of supplies and equipment.

*Training in use of PROGRESA forms and in providing services as required:* All doctors interviewed report having received some training from PROGRESA. Training was said to be very good in 9.7% of the cases, good in approximately half (49.8%), regular in 36.4%, poor in 3.7% and very poor in 0.4%.

Almost all of them report having received PROGRESA manuals (92.7%) and a guide on how to fill out forms (88.2%). Half of the health centers report using the manuals and guidelines once a month (49.5%), whereas 29.6% report using them once a week.

Thus, although this survey provides a general picture of the conditions of health centers and the availability of services and supplies, it does not inform us about whether or not the supply side in the health sector has improved since PROGRESA was implemented.

**Interviews with Doctors**

According to the interviews with doctors, there seems to be a general consensus that PROGRESA has brought about additional training for the staff, especially relative to the use of the forms for PROGRESA reporting purposes. The frequency and duration of training varied widely, however, according to the interviewees. There was only one clinic (Querétero state) where the doctor indicated that no training had been received from PROGRESA.

One doctor from Hidalgo indicated that since he was hired, he had been motivated to provide better quality of services, but he considers that the quality improved because the process of medical attention is now seen from an integral point of view — i.e., more resources, better training and motivation.

**Personnel:** The majority of doctors indicate that there was no increase in staff as a result of PROGRESA. Exceptions, however, are found in one community of Hidalgo, where the staff did increase considerably. The clinic acquired a doctor, a dentist, nurses and health *promotoras*. The doctor, however, does not believe that this is due to PROGRESA, but rather to the Ministry of Health. Similarly, in Tlatzonco, a significant increase in personnel occurred, the center acquired a doctor, a dentist, nurse, and health *promotoras*. Also in a very poor, indigenous community of Puebla, with previously only a health *promotora*, a significant increase in staff has occurred. This community went from only one health *promotora* to now having a doctor living in the community and available 24 hours a day, plus a nurse and a *promotora*. A similar case occurred in another community of Puebla, where the process of opening a new clinic was accelerated by PROGRESA.
In one health center in Querétero, however, a shortage of staff, especially for administrative work is reported.

In another community of Querétero, there is a clinic of 2nd level care, which in theory should provide specialized care. The doctor says, however, that the specialists are not available every day, but rather they come one day per week. In relation to this problem, the doctor says that: “the type of attention provided here does not correspond to the institutional classification assigned to it, that is, an institution that should have a specialist working full time.”

Equipment and supplies: Some doctors indicate having received some additional resources: equipment, various instruments (stethoscopes, furniture, scales and portable equipment to work in far away communities). Again, the staff believes that this equipment was provided by the Ministry of Health, not by PROGRESA.

In terms of drugs and first aid supplies, only one community (Veracruz state) reports having received material, supplies and drugs from PROGRESA on one occasion.

Some doctors indicate that they did not receive any additional resources since PROGRESA started, even though the demand for services has increased. Some complain that space is insufficient and inadequate, which affects the quality of the services they can provide. They also mention the lack of more sophisticated equipment such as ultrasounds for example, which would help them screen and treat their patients better. There is a shortage of medicines and doctors mention that people complain because they have to buy medicines themselves.

Others are of the opinion that the only benefit of PROGRESA is the nutritional supplement for malnourished children and pregnant and lactating women, and therefore only beneficiaries receive something from the program. The same comment was made by the doctor in a community in Puebla when asked whether the health center had benefited from the program. Note that this is the same doctor who previously explained how with PROGRESA they had been allocated one doctor, a nurse and a promotor.

In summary, 40% of the doctors interviewed think that the demand for services has increased as well as the resources to attend them. On the other hand, 60% believe that the demand is greater than the additional resources obtained, and that this causes a problem among the population.

There also seems to be a certain confusion about where the help comes from (the Ministry of Health, IMSS-Solidaridad or PROGRESA), and the doctors do not seem to see the potential interactions between these different institutions, or the fact that PROGRESA may have had a direct impact on their own institution. However, the doctors agree that the quality of health care has improved since PROGRESA started, because of the increased support, monitoring and supervision they receive.
Focus Groups

In all the communities visited, beneficiaries talked about the value of the health care they were receiving through PROGRESA. However, when asked about problems they experienced in the clinics, they were also very vocal. In total 92 comments were made describing specific problems encountered. Almost half of these comments were from beneficiaries, the next largest group from promotoras, and about one-quarter of comments were from non-beneficiaries. Thirty percent of the comments came from one community in Michoacán, so there appears to be a particular problem in that community.

Rather than finding a small group of problems raised many times across all communities and states, we found a long list of problems each raised in a few discussions. Because we do not know whether the small numbers indicate isolated experiences of the speakers or non-verbally expressed agreement by other participants, the problems mentioned and descriptive explanations in the quotes should be viewed for what they tell us about the nature of the problems where they are experienced, rather than an indication of the prevalence of a particular problem. The types of problems identified are listed below, followed later with illustrations of selected issues. The problems marked with (*) below indicate the problems cited most frequently.

Problems related to supplies and services:
- Doctor gives more attention to beneficiaries*
- Doctor gives more attention to non-beneficiaries
- Doctor does not show up in community when he should
- Not enough doctors*
- More illnesses should be covered
- Not enough medicines*
- Clinic charges
- No dentists
- Prefer private doctors to PROGRESA doctors

Problems related to convenience:
- Beneficiaries do not get sick according to their PROGRESA schedule
- Clinics are too far away
- Clinic hours inconvenient

Cultural obstacles:
- Women not comfortable with male doctor*
- Men do not want male doctors to look at women
- Doctor requires family planning

Other:
- Non-beneficiaries do not go to the clinic

One question of concern to PROGRESA is whether beneficiaries are receiving more attention than non-beneficiaries in the clinics, because of the requirements that clinics face with regard to PROGRESA paperwork. This question was asked in the survey and focus groups. In the focus
groups this did not emerge as a major problem, though non-beneficiaries in four of the states visited reported that beneficiaries received more or faster attention. Below are examples from Michoacán and Guerrero:

—We go to the health center, the first thing they ask us is if we have PROGRESA. Now they almost only tend PROGRESA's people, and not us. (NBM1-36)

—I went there because I am not from PROGRESA, and they humiliated me: "in here PROGRESA's people is going to enter, and the rest of you leave", and they didn't want to give me milk for my children… (NBG-36)

[Q: Do you feel they treat you the same or they treat PROGRESA's people better?]
—I don't know because they treated me the same
—They didn't tend to me, I was sick and I was asking for a pill and to be tended and he didn't wanted to tend to me, and I had to wait longer and I told him "are you going to tend to me or not", "I won't, now I am going to treat PROGRESA's people", and that was it. I came back and next morning I went to Santa Catarina and there they tended to me and they gave me a prescription and milk for my child. (NBG?-36)

4.5.1 Problems Related to Supplies and Services

One set of problems reported has to do with shortages of services and supplies in the clinics. The largest number of complaints has to do with insufficient medicines in the clinics (half of which came from one community in Michoacán). Below are illustrations from discussions among promotoras from two regions in Veracruz and a beneficiary from Estado de México:

—My problem is that my people go to the doctor and they prescribe for them but they don't give them medicine, and like this I don't go because I won't get cured with a piece of paper.
—The doctor sees us and there's no medicine, and it is true that they tend to us normally, but the problem is that we go and there's no medicine. What good does it do for a sick person to go if there's no medicine in here?
(PV2-36)
—They give consultation to the beneficiaries, to the local families, but there's no medicine, and then as you say, with the money they earn they eat poorly, and families don't have money to buy medicine. And what happens is that the doctor prescribes for them and he knows we don't have any medicine and we are going to have to buy it.
—And then people stay like this, and they can stay sick because there's no medicine.

—But there are times in which there is no medicine, and they say that PROGRESA hasn't sent any medicine.
—And I don't think my community is the only one, but all of them because they say at the hospital that they don't have any medicine.
—I also had to buy my medications.
—…they gave us some notebooks to fill out, they told us they were questions and I wrote there that health and medicines are the most important things, and I think for most people it would be. As they say, even if we got less money, because if our child gets sick we could have medicines at least, because that is the most expensive over there.
(PV1-36)
— The other time they said there wasn't any medicine, when there were very few people.
And now they say that only if they are almost dying: “We have medicine but very little,”
you said, because that day there were a lot of people. (BM-36)

Another problem is too few doctors to be able to cover communities on enough days:

— That's what we have been asking, all the beneficiaries, whether it would be possible to
have a full time doctor.
— [the doctors] say no, because they can't tend to all the communities, and they agree with
us: "because we only have one day for each community and then it's not enough" they say.
And then we don't have any option…(BV2-36)

Or sometimes the doctor does not show up:

[Q: Do the doctors always go?]  
— No, the doctor is absent very often.
— I don't, because the doctor couldn't see me. He is very far, in San Antonio Tercero, and
that's the problem...let's say that he is going to come tomorrow and we are waiting for him
and he doesn't come all day, and people are waiting there and he doesn't come. And
sometimes he suddenly arrives without us knowing he is coming and we are not there.
(PV2-36)

There is also dissatisfaction that health care for certain conditions is not free:

— In the hospital they charge on weekends even if we have PROGRESA.
— If we could change to other illness, so we can get a support for those.
— Yes, because we work, we have heavy work and sometimes we have back or lung
problems and there is no support for that.
— Or they don't give us support for the head
(BQ-36)

Finally, clinics in some communities are charging beneficiaries for services that are supposed to
be free and during the times of their PROGRESA-scheduled visits. Below are discussions
among promotoras in Querétero and Guerrero:

— One woman from my community had her 5 consultations and she had a delivery and
they charged her…
— She had to come immediately and make a complaint because in my community there
was also a similar case, but I went here and there and I fixed it and the woman didn't have
to pay.
— …many communities have the same problem. (PQ-36)

— …when they brought us our documents they told us that we weren’t going to pay
consultations, that we weren't going to pay medicine, and if we were beneficiaries we
wouldn't have to pay for [baby] deliveries. How can I tell you? We have to pay the
medicine but not the tending.
[Q: And then, why are you paying?]  
— Because the doctor tells us to pay him the tending.
—In my community the doctor charges us. But only for the electricity, he says, and for some little expenses. One peso, two pesos, no more.

[Q: Does he charge you for the electricity… and little expenses?]

—Yes.

—Like whatever he needs in there. Or when he goes to Chilapa to bring something he asks us for 2 pesos or 1 peso.

—He has a little can, and whenever we go for a check up and he looks at our credentials we have to put money in his little can.

(PG-36)

4.5.2 Problems Related to Convenience

Another set of comments reflects inconvenience related to timing and location. Some complaints are that the clinics are too far away. Below are discussions among promotoras in Veracruz, and non-beneficiaries in Michoácán:

—…the doctor is too far for me, and when some child is sick where are we going to take him? We have to take him to San Antonio Tercero, because if we come here to the hospital they don't tend to us.

—They don't want to tend us, they say, "take him/her to San Antonio", which is 6 hours walking distance.

—One hour, we have to walk one hour.

[Q: Do you have to walk 6 hours to have your children tended by a doctor?]  

—Yes, 6 hours, and when we have an emergency, because it happened one time with a woman who was dying, and we brought her here to the hospital, and…they didn't tend her, because her husband doesn't have any money the doctor said "go, take her to San Antonio Tercero, because you are assigned there. One time I made a petition to Xalapa to change us to Tenayuca because it is closer from here. And the answer came and now they have been tending to us for one month, and when we are sick they tend to us quickly. And then again they denied it to us: "you don't have it anymore at San Antonio Tercero" they told us, and people are very sad: "how are we going to make it if we have PROGRESA but we don't have a doctor to tend to people a little, and there isn't any medicine.

(PV2-36)

[Q: Do you go to the public clinic?]  

—It takes an hour walking.

[Q: One hour?]  

—I don't go because sometimes there are too many people and sometimes they don't tend to us and they say "come back tomorrow." And now that it's raining I don't go because it's like getting all soaked there.

(NBM2-36)

Another complaint is the restricted schedule of the visits, since beneficiaries cannot time their illnesses. They end up paying for services when they 'get sick at the wrong time':

—I don't know why, but I have heard that in some meetings they have said that the doctor doesn't tend them, or that they charge for the consultation in all communities.

—It's because each community has a schedule. For people of PROGRESA there's a schedule. But sometimes, as I tell them some are very sick and they come for an emergency.
— ...We don't get sick from 8 to 10, but we can get a pain at 11, and then I am going to have to pay even if I have PROGRESA. (PQ-36)

4.5.3 Cultural Issues

Another set of problems identified are not related to supply, rules and logistical issues, but rather to cultural characteristics of beneficiaries and their families. As with the pláticas, one issue raised with relative frequency is that women are not comfortable with male doctors. This is especially problematic with regard to the cervical cancer test. Men’s attitudes towards women’s visits to the clinics are also a problem. Although increase in the numbers of women taking the test throughout the country indicates that many women do go, the comments of women about their discomfort or their husbands’ attitudes helps to explain why women in some areas do not go. Below are illustrations from discussions among promotoras in Guerrero, Veracruz and Michoacán, and beneficiaries in Michoacán. Two suggestions come out of these discussions: that more female doctors are sent to perform these tests, and that men attend health pláticas so they understand that it is important that their wives get this test:

—Because nobody sees them, they are embarrassed about the doctor seeing them. That’s why they don't want to come to have their papanicolau test.
—They are embarrassed about the doctor seeing them, and even more if they know their husbands know what the doctor is going to do to them, because their husbands don't know about it. I even have a meeting with her: "...you don't have any reason to tell your husband, this is a women's matter, not men's", and that's how women started doing [the test]. (PG-36)

— Men don’t let them be checked by the doctor for the papanicolau test, and she has to go to the hospital.
—And there is one woman who is going to get out from PROGRESA because if they are going to check her out [through the test], it is better she leaves.
[Q: And if men went to the pláticas, would they understand better?]
—If they understood better they would have more... they could convince their wives to have the papanicolau test.
[Q: Are there many women who are not allowed to have the papanicolau test?]
—The [women] don’t want to.
—They don’t want to themselves. (PV2-34)

—...when they told us to have the papanicolau test some people said they wouldn’t do it even if they take PROGRESA away from them. And I told them..., it’s not necessary that they take it away, if you don’t want to do it, they are not going to force you to. I mean, there are some people who ignore it. But that is very important for women, and they are very resistant, because they don’t want. (PM2-34)

—Like papanicolau test. I don't do it.
—Many women haven't done it because they are embarrassed where they send us because they always have a male doctor, and we told them one time "why don't you send a female doctor?" (BM1-36)
The other problem discussed in the focus groups relates to the issue of family planning, whether it is offered, recommended or required. A few comments from *promotoras* in Guerrero, Michoacán and Veracruz stated that birth control had been presented as a requirement. However, comments from four times as many communities said that family planning had been offered or recommended but not required:

— [in my community] the doctor used to ask them to do it, to have planning and to take children to be vaccinated, otherwise they wouldn't have PROGRESA.

[Q: Did he threaten to take PROGRESA away?]

—Yes.

[Q: They had to have birth control?]

—Yes, but he did it for the children's benefit. Because the family grows and she shows them how it is bad, right? Because we can't give them everything.

[Q: Has anybody else heard about what happened in [that community]?]

—We also knew that was happening [there]

—The *promotoras* disagreed with it.

(PM2 - 36)

—It's because all women who have come to the health center the doctor has told them to have family planning, but some of them say "I am not going to do it, why should I?"

—In the health center the doctor told them to have birth control and if not, we will write it down in their credential [*carnet*]. And two women have been told that... I came to ask the doctor— is it obligatory? …He said no, not PROGRESA. If they don't want to use birth control, they can't force them. (PG-36)

[Q: Have they told you that you shouldn't have any more children and if you do they'll take PROGRESA away from you?]

—No, they haven't.

—No, they have only told us to have more birth control for our children's benefit, to not have any more [children] because if not we won't be able to bring them all up. It's for our own benefit. I understand it is for my own benefit because the less family you have the better you feel, and if you have too many children you can't, because the economic situation is not enough. That's why we say we are going to have birth control. (BM2-36).

*Summary*

There is some evidence from the various data sources that the quality of health services and the supply (of personnel in some cases) has improved, at least to some extent as a result of PROGRESA. The focus groups with beneficiaries, non-beneficiaries and *promotoras*, however, reveal that there are still many unresolved problems with the quality of the attention provided by the health staff in some clinics, as well as with the cost of the services and availability and cost of medicines and with the convenience of the services. Some delicate cultural issues also still need to be addressed with more caution, especially the detection of cervical cancer with the pap smear test and the family planning discussions. The quantitative survey of beneficiaries also suggests that more than 50% of the beneficiaries report improvements since PROGRESA started in various aspects of the health services, such as the disposition and attention of the staff, the availability and cost of medicines, the waiting time and the cost of services. To remain on
the positive side, up to 98% of the beneficiaries reported no deterioration in any of these aspects since PROGRESA started.

From the point of view of doctors, resources and supplies have not paralleled the increases in demand for health services. Although some significant increases in staff were observed in some communities, they seem to be more the exception than the rule and doctors feel that more resources are needed to meet the growing demand for health services.

4.6 Nutritional Supplements

Survey of Beneficiaries

Field operators and health institutions have raised concerns regarding the lack of availability of food supplements at clinics because of distribution problems. In the June 1999 (October 1998) surveys, 34% (39%) of families report that they have children under two years of age. Out of these, 88% (67%) have reported receiving the nutritional supplement, which is most commonly picked up at the health center.43 There seems to have been a substantial increase in the percentage of households receiving the supplement, although 13% still report never having received the supplement. In 1999, of those not receiving the supplement, the reasons given for non-receipt were that it was not available (28%), problems getting it (14%), didn't want it (11%), and not knowing about the supplement (31%). Of the 11% that didn't want it, the main reasons were that the child didn't like it or that it did not sit well in the child's stomach. But much of non-receipt is in a sense involuntary in that the household appears to want to receive it. Also, as well as there being households that never received the supplement, there may be those that have received less that they should have. We address this issue later on.

The percentage of households reporting never having received the supplement in SEGÚIM4 was highest at 13% in both Guerrero and Puebla (Table 4.12). This compares favourably to SEGÚIM3 where the percentage not receiving the supplement was 55% in Puebla and 45% in Veracruz. It did not vary according to place of registration, and it was 30% points higher for those who were not registered. Among those who were registered, non-receipt was 13% points lower for those who had an appointment book.

In the 1999 survey, households are asked when (month, day) they last received the supplement, the number of packages they receive per child, the frequency with which they give it to their infant, and how long it lasts. Most households receive 6 (37%) or 12 (12%) packages, consistent with receipt every one or two months — this pattern is similar to that found in October 1998. Just over 86% received at least 12 packages. However, the responses to the question regarding the last time the supplement was received suggests that some households may not be receiving the supplement as regularly as intended. For example, only around 65% received the supplement within the last month and nearly 80% within the last two months. Of course, this may not be a

43 In June 1999, 66% say they pick it up from the health clinic with 20% saying they pick it up from the promotora. It may be, of course, that she in turn picks it up from the clinic or that it is left with her by the mobile clinic when the beneficiary does not turn up.
problem if sufficient packages were previously given to those who have not received the supplement recently. To examine this issue further, we calculate the shortfall as follows: we take the number of days since they received the supplement, divide by five to get the number of packages required to cover this period, and subtract from this the number of packages received. Households in surplus are then given a value of zero, so that the variable then captures the extent of deficit across households.

Just over 65% do not have any shortfall, and the largest average shortfall is 30 days in Michoacán and 28 days in Hidalgo, the lowest being 12 days in Querétaro and 15 days in San Luis. Since these averages include those households without any deficit (i.e., the zeros), they appear sizeable. We do not observe any systematic pattern according to where the household is registered, or indeed whether it is registered or not, or whether it received an appointments booklet. But those who said that they were not told when to return to collect the next instalment of the supplement (or did not know when to return) have on average nearly a 15 day larger deficit. It appears from the above then, that there is a shortage of supplements and that some of this is highly correlated with not knowing when to return to the clinic for additional supplies. This is also worrying since mothers with infants are supposed to have regular visits to the clinic.

We also analyzed the pattern of incidence of not knowing when to return to collect more of the supplement. On average, 57% report not knowing when to return. This was highest at 75% in Veracruz, followed by 61% in Guerrero. Those who are not registered have a 28% point higher probability of not knowing, with no difference observed between those with or without an appointments booklet. So Michoacán and Hidalgo have the largest deficit despite having a relatively good performance in terms of households knowing when to return for the supplement. Households located in these states who do not know when to return to collect their supplement have, on average, 35 days deficit.

Households were also asked how long (in days) the supplement lasted. One expects it to last longer if they are given bigger amounts to cover longer intervals, if they feed it to the child less often, and if there is no leakage to other family members. We regressed the number of days the supplement lasted on state dummies, the day-worth of the supplement received (i.e. number of packs times five), whether or not the supplement sat well in the baby's stomach, the number of times per day the child was fed, the number of others in the family who ate the supplement, and other household characteristics (Table 4.12).

We first regress the number of days it lasted on the number of days worth of the supplement received. A coefficient of one implies one days worth lasted one day, suggesting appropriate feeding behaviour. A coefficient less than one indicates that either it is being consumed too quickly by the child or others are consuming. We find a coefficient of 0.16 suggesting that the supplement is being consumed much more quickly that intended. When we introduced a squared term in the regression to allow this to vary according to the number of packages given at any one time, we find that one days worth seems to last only 0.25 days when the household receives one months supply (i.e., 6 packs), 0.23 days when it receives two months supply, and 0.16 when it receives six months supply. Therefore, households receiving the supplement in bulk does not encourage their timely use. There appears to be very little spatial variation. The supplement lasts on average 2 days longer for those registered at an IMSS clinic.
An extra person, other than the infant, consuming the supplement reduces the time by 0.42 days (i.e., as if it was shared equally!), and the frequency with which the child is fed the supplement also reduces the length of time it lasts. Among those who are registered, we find only a weak link with the possession of an appointment book. We also find that the length of time the supplement lasts is negatively correlated with the number of children aged 3-5 years in the household, and this effect was not sensitive to the inclusion of a dummy for any such children also receiving a supplement — nearly 35% of households report having children aged 2-4 years who also receive a supplement. The number of others consuming the infant’s supplement is positively correlated with the number of children in the household. Dropping it from the regression, we therefore find a stronger relationship between the number of children in the household over two-years of age and how long the supplement lasts, with the magnitude being much larger for children aged 3-5 years. These results suggest that there may be substantial leakage to other household members and that the feeding pattern does not seem to follow that intended. These issues presumably can have important consequences for the impact of the supplement as measured by the anthropometric measurements of infants or their micronutrient status (as opposed to other household members’). In particular, some of the intended benefit may have been redirected by the household to children aged 3-5 years.

In the October 1998 survey we similarly found that the length of time the supplemented lasted was positively correlated with the number of packs received, and negatively correlated with the frequency with which the child was fed the supplement and whether or not others in the household ate the supplement. Whether or not someone else eats the supplement is positively correlated with the number of children aged 3-5 years and 6-12 years and negatively correlated with years of education of head of household.

In summary, there appears to have been a substantial decrease in the percentage of households reporting never having received the supplement, decreasing from 37% to 13% over the surveys, especially in the states performing badly during the first survey. Non-receipt is 30% points higher for those who are not registered and 11% points higher for those without an appointment book. In addition to the problem of families never having received the supplement, there are others who have not received the intended amounts. Over the whole sample, the average deficit varies from 28 days in Michoacán to 10 days in Querétero, this average including the 65% of households that are not in deficit. Deficits are therefore sizeable and appear to be highly correlated with not knowing when to return to the clinic for extra supplies. This is all the more worrying since mothers and infants are supposed to have regular visits to the clinic. Those who are not registered are more likely not to know when to return (a 25% point higher probability). As a result, those in Michoacán who do not know when to return have an average deficit of 35 days. Combined with this deficit, it appears that some households consume the supplement much more rapidly than is intended, partly due to a leakage to other children in the household especially those aged 3-5 years. Such behaviour will presumably have substantial adverse implications for the magnitude of the program impact, at least as measured by the impact on the target group of children (as opposed the others consuming the supplement).
Survey of Health Centers

All 317 health centers surveyed reported receiving the nutritional supplements on a regular basis. In 80.1% of the cases the supplement is delivered to the clinic, whereas in 14.9% of health centers the staff needs to pick it up, and in other cases it varies from time to time.

Doctors felt that the amount of supplement received was sufficient in 75.9% of the health centers, insufficient in 18.4% and has exceeded that needed in 5.1% of the health centers.

The question of who the supplement is distributed to shows that a lot of non-beneficiaries and non-targeted individuals and families receive the supplement. This is consistent with the findings reported for beneficiaries above. The percentage of health centers who reported giving the supplement to different groups of the population is presented in Table 4.13. Clearly the supplement is widely distributed to preschool children, pregnant and lactating women, but is not restricted to PROGRESA beneficiaries and malnourished children, as intended by the program.

Interviews with Doctors

All doctors interviewed said that the population loves the supplement. They are very happy to receive it, even young children come and ask for it, and if it is not available they get sad.

One doctor from Puebla, however, indicates that although children like the supplement, sometimes it gives them gastrointestinal problems because it is a concentrated product. Therefore, the doctor recommends that families dilute it more, or that they use it in recipes so that it makes it easier to digest:

Yes, they do like it; the thing is that it is a concentrated formula and in some cases it gives them stomach or digestive problems and for this reason we recommend that people dilute it more or we give them some recipes that have been given to us so that people can tolerate it better, because if we give the supplement the way it comes, sometimes it gives them diarrhea or intolerance; but whether people like it, they sure do, you can tell them, here I have a box of supplement and both PROGRESA and non-beneficiaries come and they fight for the supplement.

Only one doctor reported that people in his community (Veracruz state) did not like the supplement very much because they are not used to sweet flavors, and therefore it is hard for them to consume large amounts of sweet foods.

A popular use of the supplement is to mix it with water and milk to make an Atole type of drink, which is part of the culture in Mexico. Other types of preparations include mixing it with maicena (corn flour), also to prepare an Atole. People sometimes add fruits or cereals, they add bananas, or they make juices.

The doctors say that the good thing is that people do use the supplement. They are not worried about the way they prepare it, as long as they use it. They indicate that they do not require that
people use the supplement according to the instructions on the package. They prefer to let people use it the way they like.

Sharing of the supplement within the family is customary, according to the doctors. One doctor from Hidalgo summarizes the reason:

> A lot of people have very few economic resources and when the problems become more severe, well if they make an Atole, it is for everybody. It is very difficult to imagine that it would be used for only one member of the family. This would be against the basic principals of sharing that are common among rural and indigenous communities.

Sharing occurs with both the children’s and women’s supplement. Again, they indicate that: “pregnant women who are taking the supplement ask for more packages because they says they do not have enough because they share with the rest of the family.” Mothers think it would be unfair to prepare a glass of milk for themselves and not share it with their children.

To illustrate how strongly entrenched the practice of sharing is in this culture, a doctor from a community in Veracruz says that even when he does home visits, families offer him some supplement. People are not inhibited to share the supplement even with clinic staff, who potentially, could scold them for using the program benefits improperly.

In spite of the high demand for the supplement, the doctors feel that they have enough supplement for the PROGRESA families. If quantities exceed the needs, then they give it to non-beneficiaries. They try to follow this rule, but sometimes they find cases of severely malnourished children and they make exceptions, but of course only if there is enough for the beneficiaries.

The doctors say that they give the supplement to: pregnant or lactating women, children <2 years and those <5 with malnutrition, as required by the program norms. They distribute the supplement regularly (no mention of how frequently).

Only 3 communities reported problems with the distribution of the supplement. In one community (Puebla state), originally the distribution was irregular and insufficient, but this situation has improved now. In a community from Querétaro, they received it only once. Finally in one community from Veracruz the doctor mentioned that the amount received was insufficient and did not arrive on time.

**Summary**

From the evidence provided by the quantitative beneficiary survey, it seems that the distribution and intake of nutritional supplement by the targeted group might be the most serious operational problem of the health component of PROGRESA. Although the type of data provided in this survey generate only indirect estimates of the potential deficits in supplement intake of the targeted groups, they do strongly suggest that the targeted infants and young children probably receive only a fraction of the nutrients that the program intends to provide them on a daily basis. This is due to a combination of two main problems. First, that many mothers appear to run out of supplement and fail to refill immediately. The reason for this is not entirely clear. A probably
even more serious problem is the widely admitted sharing of the supplement within the household. This should not come as a surprise because food sharing is strongly entrenched in the Mexican culture and is basic to their hospitality principles. As noted by one doctor, families do not hesitate to offer him a glass of supplement when he visits, showing that they have no sense of guilt for non-compliance with the program rules when they share the supplement. Thus, the program should seriously consider what would be an adequate approach to make the supplement available to other household members (all preschool children in particular), so that the targeted child could still receive the amount of extra daily nutrients he/she needs from the supplement to ensure adequate growth and health.

Another problem that was revealed mainly in the interviews with doctors is the fact that families do not prepare the supplement according to the recommended recipe. One doctor even recommends diluting the supplement more than recommended in order to avoid gastrointestinal problems. The formulation of the supplement was carefully designed by a group of health professionals from Mexico, who have extensive knowledge of the nutrient requirements of young children, of the appropriate mix of nutrients they can tolerate, and of the optimal dilution of the product (Rosado et al. 2000; and Rivera et al. 2000). By increasing the amount of water, the nutrient density of the product is reduced thereby also reducing the child’s total nutrient intake. This in turn is likely to reduce the potential benefits of the supplement and its measurable impact on children’s health and nutrition.

4.7 Problems with the Nutrition and Health Component of PROGRESA

This section summarizes the doctors’ responses to the question about their perceived problems with PROGRESA and PROGRESA’s beneficiaries. Information from both the quantitative survey and the interviews is included.

**Survey of Health Centers**

The question asked in the quantitative survey was which specific problems had the clinic staff had with PROGRESA beneficiaries? The answers are summarized in Table 4.14. The most commonly reported problem is that of the complaints of beneficiaries about the unavailability of medicines (36% of the clinics), followed by their request to be falsely registered as having attended all their clinic visits when they in fact have not fully complied (33%). The doctors also report a problem with compliance of beneficiaries in more than one quarter of the clinics and 20% report that beneficiaries do not attend the pláticas.

**Interviews with Doctors**

When asked about which types of problems PROGRESA had caused in the health centers and communities, doctors mentioned a variety of problems, which are summarized below.

Supply side: Some doctors mention the increase in attendance at the clinics, but they do not see it as a downside, but rather a positive impact of PROGRESA on the population. On the other hand, they mention the problem of limited supplies and resources and the fact that in many cases additional resources (if received) were not sufficient to meet the increase in demand. In terms of
personnel, the only problem mentioned is the increase in administrative tasks as a consequence of PROGRESA and the need to receive additional help to relieve some of this burden. Some doctors mention the scarcity of supplies and medicines, the lack of forms and nutritional supplement, the lack of space, and the generally poor conditions of communities and health centers as factors that affect the success of their work in the health clinics. Similarly some mention the lack of transport as limiting their ability to carry out community and home visits. A doctor in Veracruz says that he feels that the program has good objectives but that there are situations such as extreme poverty and illiteracy, which limit the potential success of the program.

Non-beneficiaries: Also in Veracruz, a doctor reports that the program has had a negative effect on non-beneficiaries because they tend to stay away from the health centers. There are some differences between the community members who receive and those who do not receive the program. Other similar problems are mentioned in other communities where non-beneficiaries are said to be reluctant to participate in community activities (faenas and others) because they do not receive any benefits from the program. In a community in Puebla, there are some activities where more beneficiaries are found participating than non-beneficiaries. In Hidalgo state, the beneficiaries from one community come to their visits and organize among themselves who is going to stay that day to help out in the clinic. In another location, (Veracruz state), a community has been divided in two groups for political reasons for a long time. However, both groups comply with their responsibility, although they do it separately. In other examples, however, the doctors indicate that there is no split between beneficiaries and non-beneficiaries in their community relative to the community chores and that most community members do get involved.

Beneficiaries: The topic of PROGRESA beneficiaries being very demanding was raised by some doctors when asked about the problems they see with the program.

Men’s attitude and participation: The majority of doctors indicate that men are very reluctant to participate in the program, and that they use the excuse of not being the targeted beneficiary to justify their lack of interest in participating. Although not frequently reported, there has been some cases where doctors have indicated that the program has caused conflicts within households, because men have taken the money away from their wife to use to buy alcohol. Some doctors also report that men have even been reluctant not only to attend their preventive visits and the education sessions, but also to build latrines in some cases. According to doctors, men come only when they are ill. Women have to insist and argue with their spouse that if he does not comply with the program’s requirements, they (the women) will lose their benefits.

Alcoholism and domestic violence: Doctors indicate that domestic violence has increased due to the increase in alcoholism. They do not associate this directly with PROGRESA. However, they indicate that some husbands take the money away from the women and use it to buy alcohol. Some women say it to the doctors but others do not, but the doctors say they can tell. The majority of doctors think that alcoholism is one of the most severe problems in their communities. They note that alcoholism exists also among women and youngsters. In one community (Veracruz state), the doctor says that 99% of the household heads are alcoholic and smoke and that up to 60% of women are also alcoholic in this community.
Problems with the pláticas: The problems with the pláticas have been described extensively in a previous section (see Section 5.4.4), but they were mentioned by doctors when asked to talk about problems with the program.

Problems with compliance with requirements of program: The majority of doctors agree that the most difficult requirement for beneficiaries to comply with is the pap smear test to detect cervical cancer. As discussed in previous sections, many men oppose their wives having the test done, especially if the doctor is a male. Apparently the gender of the person doing the test influences the decision to have it done or not, even among the women themselves. In the community of Acececa, the doctor, who is a female, mentions that it is easier to convince younger women to have the test done. Older women are more reluctant, in spite of the fact that in this clinic she, the female doctor, carries out the test. In many clinics where the doctor is a man, a system has been put in place to ensure that nurses (women) would do the test.

Other problems of compliance occur, as indicated in previous sections, with the regular check ups for men, who tend to be reluctant to attend any activity related to the health clinics, and with the elderly.

Summary

Doctors in qualitative interviews were asked to comment on their overall perception of the problems with the health and nutrition component of PROGRESA. In the quantitative health clinics survey, doctors were also asked a few specific questions about the problems they had experienced with PROGRESA beneficiaries.

The types of problems doctors reported with PROGRESA beneficiaries include the complaints about the unavailability of medicines (reported by more than one third of the doctors) and problems with beneficiaries being charged for some medicines and other services. Surprisingly, most other problems reported were related to compliance of the beneficiaries with their visits, or with the attendance at pláticas. Up to one third of the doctors actually reported the problem of beneficiaries requesting to be falsely registered as having attended all their visits when they in fact had not fully complied. This result was somewhat surprising because, as described in a previous section of the report (4.2.2), the qualitative interviews with doctors suggested that attendance and request for falsification of records was not really a problem. This discrepancy may be related to the selection of clinics for the qualitative interviews (only 16 clinics from 4 states were included in this data collection), and the fact that this was truly not a problem in these communities. It may, however, indicate that doctors did not feel comfortable about elaborating on this issue in the more in-depth interview.

Other problems that were mentioned by doctors in the qualitative interviews include the scarcity of supplies and equipment, which they feel in some cases may limit the quality of the services they offer and their impact. The problems with non-beneficiaries feeling left out of the program and refusing to participate in some communities was mentioned by some. The difficulties they have with men’s reluctance to participate in the activities of the health clinics was deplored by many doctors who feel that, not only would it be good for men to attend their check ups and the
pláticas, but they would also like to take the opportunity to touch on other delicate subjects such as alcoholism and domestic violence with them. Finally, as mentioned in other sections as well, the problem of male doctors discussing issues of family planning and the preventive pap smear test to detect cervical cancer with women was reiterated.

4.8 Suggestions for Improvements of the Health and Nutrition Component and other Aspects of PROGRESA

This section reports only from the qualitative interviews with doctors, who were asked their opinion about how the program could be improved. Doctors volunteered opinions about the health component as well as about other aspects of the program.

Program requirements: The doctors did not have any suggestions regarding eliminating any of the requirements for clinic visits or attendance at the pláticas for the beneficiaries. They thought that the requirements conform with the basic minimum essential health care package. For instance, they said, “these requirements are not exaggerated, they are fundamental, for example the requirement for a pregnant woman is 5 visits, when in fact it should be one per month.” Doctors consider that the requirements for pregnant women, children, adolescents and malnourished children are important. They also consider that the food supplement is essential.

Some doctors even suggested that some requirements should be added. For example, one doctor (from Veracruz state) suggested that all illiterate adults should be required to register at a literacy course. Half of the doctors interviewed consider that formal education is an essential requirement to improve communities and that formal education would help maximize the impact of their actions on the health and development of the communities they are working with. The doctors consider that the health and nutrition education they provide is gradually having an impact on the population, but that it would be even greater if populations had more basic, formal education.

Regarding the health and nutrition education, one doctor also said, “there is no way we can impose or force families to put into practice what they learn through the pláticas. Because we don’t have any way of pressuring or force people to comply, we may be diluting our efforts.”

Doctors think that they should receive a little more judiciary help to force the population to comply with some of the requirements, especially those related to constructing latrines. One doctor said, “Some people say, we will not make latrines because we do not want any, and they throw us out of their house.”

Objectives of PROGRESA: The majority of doctors feel that the objectives are very good and adequate. One doctor indicated that he feels that the population is not taking as full advantage of the program as they should. He has a problem with the way the benefit is distributed. He feels that it is alright to give benefits and health services, but people have to be made more responsible for what they receive.

Administrative issues: The majority of doctors agree that most administrative matters are fine, but that certain problems could be resolved. The more frequently mentioned problem is the
management of information and the control and monitoring related to the reports they prepare on the beneficiaries’ compliance. One problem is that the forms get to the doctors late and they are the ones who are supposed to report on attendance. Additionally they think that the forms could be simplified.

Another problem is that errors are made, which result in beneficiaries going to pick up their monetary transfer and not receiving them. Doctors believe that it may be because some of the beneficiaries lose or do not bring their forms, but there are also some administrative errors that impact negatively on the beneficiaries. In addition, there are often delays in receiving the money and this causes problems for doctors in their relationship with the community because they are the ones who receive the complaints. Obviously, the doctors are not responsible for the logistical problems related to the money transfers, but the population comes to them for help and to express their dissatisfaction with the program.

Money transfers: Some doctors say that the program should stop giving money, while still finding a way to help poor families. One doctor says:

I think it would be better to eliminate the money transfers, money is bad for people because sometimes women get used to it and become lazy when it comes to work, whereas now, they are just waiting for the money to arrive. I would change this approach in the first place, but I would not modify the nutritional supplement, and may be they could receive a food basket, but without any money at all. Money is bad even for us sometimes.

This opinion was shared by various doctors in slightly different ways, but all of them agreed that money is a bad idea. They suggested to make people work for the money, that is, make people do community work, because what is given is often not appreciated. They also think that there should be no money for school either, but rather, the kids should receive all their uniforms, books and supplies, but not money. This coincides with a suggestion made in chapter 5, that PROGRESA considered linking benefits to faenas, as part of a self-targeting strategy to reach the poorest of the poor.

One of the reasons for suggesting to drop the money is that mothers sometimes complain that the husbands take the money from them. Also, money is always a temptation, whereas goods are what they are. The doctor from a community in Hidalgo, talks about the problem that money creates a relation of dependence. “What people need is to be motivated to work, for instance that people would say: ‘I am motivated to do this work for PROGRESA,’ instead of making people not feel the need to work.”

They also comment that no matter what, people complain that the money is too little anyway. Some doctors mention, however, that giving money to older people may be a good way to help them because often they are unable to work. In all other cases, however, they feel that it would be better to generate employment, because lots of the youngsters have to migrate away because of lack of local employment.

A doctor from Veracruz state mentions that people need help to improve the productivity of their land, they need resources for their land, for food, or even technical assistance in farming.
The promotoras: The relationship that doctors have established with the promotoras in general seem adequate. The majority feel that they receive help and support to realize different activities that they program. The details of this relationship is reported in Chapter 2.

Beneficiary selection: Various doctors disagree with the process of beneficiary selection. They mention frequently that they do not understand the process and that it is unfair. Doctors also report problems of bad feelings between beneficiary and non-beneficiary families as a result of the program. For example, a doctor from Veracruz said:

Yes, this is it, they bad mouth each other, they even stop talking to each other; from buddies that they used to be, they stop talking… The fact that some people receive the benefit and other do not has caused a lot of problems and people wonder why do they give to me and not to you.

These issues are discussed further in chapter 2 and in a separate report on the impact of the program on community social relationships (Adato 2000).

Summary

Relative to the requirements of the program, doctors made no suggestions to reduce the number of visits or any of the other requirements related to attendance at health clinics. On the contrary, they believe that the requirements simply conform with the basic package of primary health care that all the population should receive. They even go as far as saying that they would like to receive some judiciary help to force the population to comply with some of the requirements to improve sanitation in the communities, such as building latrines. They also recommend that beneficiaries of PROGRESA should be obliged to attend literacy classes if they are illiterate. Doctors really appreciate the work of the promotoras, but they suggest that it would be useful if they were better trained and received more accurate and timely information about the program. Doctors also had some suggestions about how to improve the control of attendance, and the importance of trying to avoid errors in the forms so that beneficiaries do not lose their benefits when they have complied, because this tends to demoralize them.

Two other aspects of the program were discussed by the doctors: 1) the money transfers and 2) the beneficiary selection. Various doctors expressed that providing cash transfers to the population is a bad idea. They strongly recommend that food baskets be provided to avoid beneficiaries making inappropriate use of the money that they receive or to reduce the possibility of problems with the husbands who use the money for alcohol. Finally, the beneficiary selection process is criticized by many of the doctors who feel that in a lot of their communities there are many families who receive the benefits and do not need them, whereas other extremely poor families have been excluded from the program for unclear reasons. Doctors also consider that the process of selection has a negative effect on the interaction between families within communities.
CHAPTER 5 — OTHER ISSUES

5.1 The Community Promotora

Every PROGRESA community has a community outreach worker called the promotora, a beneficiary chosen by other beneficiary families to work on a voluntary basis as the liaison between beneficiaries and PROGRESA. At the start of program operations in her community, she is to receive training and materials to support her work. Her main responsibilities are to collaborate in giving information and training to beneficiaries related to their PROGRESA rights and responsibilities, to answer questions and respond to problems of beneficiaries. They communicate issues that arise in their communities with PROGRESA offices.

Promotoras are one of PROGRESA’s key delivery institutions. While they participate in the program as beneficiaries, in serving as government-community liaison, facilitator, educator and problem solver, they are a key link in the operational process. Promotoras take on considerable responsibility and time commitments on a volunteer basis, and they are effectively the face of PROGRESA at the community level. All of this places burdens on them of various types. The rewards they get revolve around the training they receive from PROGRESA, the education they receive from experience on the job, increased local status and power, and satisfaction in helping their communities.

The overall findings of the research with beneficiaries, doctors and teachers indicate that the promotoras are very useful and important, that they are meeting their main responsibilities, and that the promotora system is generally working well, with some locale-specific exceptions. The sections that follow examine promotoras’ contact with beneficiaries and the frequency of their meetings; the functions of the promotora, and the extent to which they charge beneficiaries. This leads into a discussion of the areas that promotoras identify as making their jobs more difficult and things they would like to change: the costs they endure in traveling to carry out various responsibilities; the blame that beneficiaries put on them if they do not receive their payments; the blame they receive from non-beneficiaries for not getting them on the list; and the need for better information and more training.

5.1.1 Contact with Beneficiaries and Frequency of Meetings

Quantitative Survey with Beneficiaries

The promotora plays a crucial role in ensuring beneficiaries have a clear view of the project objectives and requirements, and generally in facilitating the effective operation of the program. It is therefore important that beneficiaries find her easily accessible. When asked if they knew the promotora, approximately 98% in both surveys replied that they did with very little variation across states (Table 5.1). In the June 1999 survey, just over 75% of all localities (accounting for 60% of all households) have all beneficiaries reporting that they know the promotora.

Over 70% in the June 1998 survey said they meet the promotora at least once every two weeks, this number being higher, at 78%, in June 1999 (Table 5.1). The most common place of meeting
was at a neutral community venue. We tested for spatial variation in the frequency of meetings with the promotora using an ordered probit regression technique. In June and October 1998 the dependent variable takes the value 5 if they met every day, 4 if they met once a week, 3 if they met once a fortnight, 2 if they met once a month, 1 if they met only when they receive support (which is officially every two months), and 0 if they never met. As well as including dummy variables for location (i.e., state dummies), we also control for place of meeting, i.e., at promotora's place, at a community venue, where they receive help, and elsewhere. Of these, using June 1998, only “where they receive help” was significant; the associated lower frequency reflecting the fact that we assume help is received bi-monthly. Using October 1998, we in addition find a lower frequency being associated with those meeting at the promotora's place. So meetings held at community venues may be more conducive to greater contact. We also observe variation in frequency across states, it being lowest in the smaller states with the lowest frequency being in Guerrero and San Luis in both October 1998 and June 1999. When, in June 1999, we focus on the program requirement that promotoras hold monthly meetings, we find the same spatial pattern. We also found some evidence that the lack of regular meetings is highly locality specific, i.e., only a few localities have beneficiaries reporting not having regular meetings.

Summary

Almost all beneficiaries reported that they knew the promotora. In all three surveys, over 75 % of beneficiaries said they met the promotora at least once a month, indicating that this feature of the program is working as intended. We found the lower frequency of meetings being associated with meeting at the promotora’s place, so meetings held at community venues may be more conducive to greater contact. There is variation in frequency of meeting across states with room for improvement in Guerrero and San Luis.

5.1.2 Functions of the Promotora

Quantitative Survey with Beneficiaries

The most common type of information received from the promotora concerned the date one can receive benefits at 74% (80%) in the June 1999 (October 1998) survey, followed by information on how the program works, at 56% (63% in October 1998), and on program requirements (48% in October 1998). Also, 30% of those in June 1999 cited information on composition of transfers as important. Questions regarding attitudes towards the promotora (in June 1999) also present a clear picture of the promotora system fulfilling a crucial role and doing so effectively.

In June 1999 (October 1998) beneficiaries were also asked to whom they turn when they have questions about the program. Over 92% (85%) answered that they would go to the promotora if they had doubts about what the program requires them to do. But the promotora may not be the obvious person to ask and 5.1% (8.3%) said that they would go to doctors at their health center. The latter seems sensible when questions relate to the health component and beneficiaries have regular meetings at the clinic.
Interviews with Doctors and School Directors

Interviews with doctors paint a mostly positive picture of the promotoras system. The majority of doctors feel that they receive help and support from promotoras in realizing the different PROGRESA activities that are planned. Promotoras organize beneficiaries for the health platicas, help in carrying out the census, coordinate faenas, make home visits, promote basic hygiene, and keep the doctors informed of problems the families encounter. They also remind families of their appointments and motivate them to come to the health centers. The only criticism that they have about promotoras is that they need to be better trained (see section below).

Regarding the relationship between school directors and promotoras, several school directors said that they had no contact with promotoras, while others indicated that there is mutual support. The promotoras help out when the teachers have doubts, and they organize the mothers to clean or paint the school building, or pick up the trash, when necessary. It appears that where there was less contact or relationship between the school and the promotora, there was more tension. From what we have been able to ascertain, it appears that some school directors consider that the promotoras get too involved in their affairs, as in the case where they ask them for a report on children’s absences, or worse, a report of the teachers’ absences. The teachers resent being supervised. The director of a telesecundaria in Hidalgo commented on this directly, whereas in another Hidalgo community we explored this issue informally. There, the school director said that he did not know who the promotoras were—that he would seek them out and ask for them but that they never came to the school. In an informal conversation we had with the promotoras about their experiences and problems on the job, what came to light was that the principal became annoyed when the promotoras would come to ask for a report on staff absences and since that time, they had never returned. This reflects a lack of clarity on the part of school directors, teachers and promotoras as to respective roles and responsibilities with regard to beneficiary children’s attendance.

Focus Groups with Promotoras, Beneficiaries and Non-Beneficiaries

As indicated in the quantitative work, the promotora communicates information on dates of payments, program functioning and program requirements. This information is most often transmitted at the meetings convened by the promotora. Of additional interest were comments in the focus groups about other ways in which the promotora meetings are used. Some promotoras and beneficiaries said that at these meetings, beneficiaries begin to talk to each other, open up more and learn to speak more, share problems and offer each other solutions. November 1999 survey data suggest that among beneficiaries who attend promotora meetings, at most 26% may attend meetings where problems are discussed, either related to PROGRESA or other issues. Given very good feedback from women where such broader discussions take place, promotoras could be encouraged in their training to facilitate the use of monthly meetings in this way.44

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44 See Adato and Mindek (2000) for examples of these comments in the focus groups, and for a detailed discussion of this issue in the context of women’s empowerment.
Summary

The most common type of information received from the *promotora* concerned the date of receiving benefits followed by information on how the program works and program requirements. A number of beneficiaries said they received information on composition of transfers. Almost all beneficiaries turn to the *promotora* with questions about the program with a small group saying they ask doctors (probably related to health issues).

They could be more helpful to beneficiaries if they were able to provide additional types of information, for example, on the composition of their transfers. Increasing the types of issues they could assist with would involve additional training. Also, given good feedback where this has happened, *promotoras* could be encouraged to allow monthly meetings to be used for discussing issues and problems beyond program rights and responsibilities.

Beneficiary attitudes toward *promotoras* present an overwhelming picture of the *promotoras* system fulfilling a crucial role and doing so effectively. This does, however, raise potential concerns about the impact of the initial intention to rotate *promotoras* and the consequent loss in terms of capacity building. This issue has not been ignored by program officials, since it appears that the term of office of *promotoras* is to be extended.

Doctors are also very positive about the *promotoras*, who facilitate beneficiary participation in the health services and *faenas*, and keep doctors informed of the problems of beneficiary families. School directors report less contact with *promotoras*, though some say that *promotoras* help in answering their questions and also organize beneficiaries for *faenas*. Some tensions were reported where *promotoras* have attempted to monitor school attendance by children and, in some cases, teachers. This suggests the need for clarifying to *promotoras*, teachers and school directors their respective roles and responsibilities with regard to beneficiary children’s attendance.

In addition to providing information related to the program, women in the focus groups said that *promotora* meetings are sometimes used as a forum for women to talk to each other, where they learn to speak more, share problems and offer each other solutions. Although only about a quarter of beneficiaries surveyed report meetings being used in this way, very good feedback from women where this does take place suggests that *promotoras* could be encouraged in their training to facilitate the use of monthly meetings in this way.

5.1.3 Contributions to Promotoras

Quantitative Survey with Beneficiaries

Nearly 37% (40%) of beneficiaries in the June 1999 (October 1998) surveys report being asked to contribute at meetings or to the *promotora*’s activities, this being highest in San Luis and Guerrero, both at around 46%. It is not clear whether this is good or bad: presumably whether the contribution is voluntary or not, or in payment for expenses incurred, is important. The most common contribution was the payment of either a monetary or in-kind entrance fee, but other payments to the *promotora* and helping the *promotora* with tasks was also important. We might
expect this to vary according to the meeting venue. In October 1998, including controls for the latter, we find that those meeting at a community venue were more likely to be asked to contribute suggesting that these contributions may be necessary to cover charges incurred by the *promotora*. Of course, the magnitude of these charges is also important.

When asked in June 1999 whether they were forced to pay, less than 14% of those contributing said that they were forced. Regressing a dummy taking the value one if the household reports being forced to contribute, we find that it is highest in Guerrero at 14%, other states being below 5%. Just over 61% of localities, accounting for 45% of households, have no one reporting being forced to contribute.

“Force” is a difficult term to interpret, however. While there may be no overt “force,” there are many ways in which people can feel compelled to contribute even if they would rather not. Some of these forms of more subtle pressure, as well as reasons why *promotoras* charge beneficiaries, are explored in the qualitative work below.

**Focus Groups with Promotoras, Beneficiaries and Non-Beneficiaries**

The focus groups explored the issue of contributions with beneficiaries to see their perspective on these requests, and with *promotoras* to understand their reasons for charging. *Promotoras* said that the main problem with their role as *promotora* was financial, that they pay for transportation in fulfilling demands from PROGRESA and from the municipal liaison who make various requests of them. *Promotoras* travel to the capital to bring various documentation and forms, and then return later to follow up on the cases. When the payments are delayed, they travel to ask the municipal liaison if they know when the payment is arriving. There are also other expenses, such as photocopying. They thus see it necessary to ask beneficiaries for small contributions.

*Promotoras* seemed to be largely unaware that they are not supposed to charge beneficiaries. Below are discussion among *promotoras* in Guerrero and Veracruz, and beneficiaries in Querétero, indicating amounts charged and some reasons:

— They give me 5 [pesos].
— In my community they all made an agreement a year ago about giving me 5 pesos.
— I get $1.50.
— But only when [beneficiaries] get paid.
— I don't get anything.
— Well, in my community they are cooperating with 3 pesos.
— Some give me 1 peso, others 3.
— I do get 3 pesos. (PG-40)

— I do ask them [for money].
— To make the photocopies.
— For the photocopies and sometimes for the bus tickets, when we get charged. [Q: How much do you ask them to give you?]
— One peso.
— I ask for 3 pesos.
— Yes, but it also depends on people.
—I ask my people 3 pesos to help me but sometimes I spend all in the meetings. (PV2-40)

[Q: Does the promotora ask you for money?]
—Only when she has to leave for the platicas, we give her.
—Only for her gas, one or two pesos.
—Yes, and we are around 50 [women].
—And between many we don't have to give her much.
—Because there is no transportation, the truck charges 200 [pesos]. (BQ-40)

PROGRESA officially gives promotoras money for traveling to PROGRESA meetings, so there is need for an examination of what additional travel expenses are not covered, as well as other expenses incurred. Clearly though, promotoras are charging beneficiaries money when they are not authorized to do so. However, many comments from promotoras stated that beneficiaries are conscious about the promotoras' expenses and do not mind supporting them:

—Sometimes women are aware and they tell me "we know you have expenses." But it is because they are conscious, not because I tell them “now you have to give me this much,” but because they are conscious that there are expenses and they support me. (PQ-40)

Promotoras say that they often have to travel on short notice, which does not give them enough time to ask for money. They thus propose that PROGRESA gives them additional money, which would save them from having to ask beneficiaries, or pay out of their own pockets. Below are discussions among promotoras in Hidalgo, Veracruz and Querétero:

—Well…we are, as you said, voluntary promotoras, but I think if [PROGRESA] sent us some more help, we would do even more, I mean we would endeavor even more.
—In June they called us to give us the list of the women that will not receive PROGRESA this month, the payment corresponding to March-April, it was a day when we came to receive the list…
—Yes, about a month ago. And then again, about 15 days after that they called me again because it seemed like the list of new beneficiaries came, but they were not from my community…
—Or we have to go and ask when will the notebooks, or the money, come.
—Yes, because in the community people ask you "why didn’t our money come," they expect you to know, so you have to go...you have to go and ask.
—…”if I receive more [from PROGRESA], I wouldn't ask [beneficiaries] to give me. They themselves asked me "why don't they give you little bit more"? (PH-40)

—I feel the main problem is the economic one, right?, Because sometimes we don't have [money] for travel but nevertheless they call us and we have to go and sometimes we don't even have a chance to ask the beneficiaries for their contribution, because they call us from one day to another, at the last moment, with no anticipation, and I think this is also a problem. (PV1-40)

—Some beneficiaries give once a month and some don't.
—At least to me, they don't give me anything.
—You know, sometimes I have to go to the presidencia municipal 3 or 4 times because of some paper, sometimes the bus leaves me and I have to run to reach [the local
authority], but no one tells me "I'll give you for your travel expenses" or "we should contribute for the travel," no one gives me and I have to spend my money...
—That's why it is hard for us, lets say, we receive for food $230 and if we have to come 5 times a month to leave some papers, this or that, it means 10 times in two months, so, how much money of 230 [pesos] is left? Nothing. The truth is that [beneficiaries] did understand and they did give me.
—For example, those of us that submitted petitions for support [to include others in PROGRESA] have to go and ask, around and around, and who helps us for doing that? On the contrary, some say no, promotoras are paid, but who pays us? (PQ-40)

In most cases beneficiaries seem to contribute when asked, but they may or may not mind. In some cases beneficiaries will object, as individuals or a group:

I was asking them for one peso for my expenses and they told me "we all agree in helping you, because you are the promotora, you are going to bring the decisions, go, go", but there were three women that got into their heads that it was too much money, and "what was I going to do with all that money?" And then I got very upset and I didn't want to do anything about it. But there were only three women who were putting ideas in the others, but the rest of them agreed with me. (PV1-40)

But we are not asking for money, it is voluntary for the buses, because at least we get for our bus ticket, because not all of them cooperate, very few people help me. But if they were aware about our expenses. But there is one person who spoils it, she is the only one, a woman who is very problematic. (PQ-40)

Now that I came to receive papilla for the community, some gave me [a fuerza; "without their desire to do it"], all of us had to give 2 pesos for the truck that brought the food, but some women didn't have the money with them when they went to receive the food so they told me "I'll give it to you later", but they won't give me anything, and I told them "we must pay the truck" and I won't pay it from my money, I tell them, "if this food is for your benefit, well then, it was not for me." Now they will say "why should I give her, she'll keep the money for herself", and I tell them, we have expenses, sometimes we have to go here and there for some issue, the whole week. (PQ-40)

Promotoras have some concern that beneficiaries think that they are being paid a salary by PROGRESA. The impression may be created when promotoras receive their travel allowances. One of the requests made by promotoras is for PROGRESA to explain to beneficiaries that promotoras do not receive a salary, as expressed by these promotoras from Guerrero and Hidalgo:

[Explain] that we as promotoras don't receive any salary. There in Tepozonalco one women kept her eye on [me] the day of the payment, because one man from there told her..."you, how much money do you give to promotora for dealing with the documents or forms regarding your school children? Don't give her any contribution, because she receives extra money from PROGRESA"...
—...sometimes they say we have a salary, that they are paying us extra money from PROGRESA.
—Let PROGRESA people explain to [beneficiaries] on the day of receiving the help...when they all come here to Chilapa. (PG-40)
And some of them get upset at me, some of them don't even want to talk to me, because they think I earn very much money, and that I get paid every 15 days. And I tell them that I am not getting paid for it, the only money I get is the help from PROGRESA. (PH-41)

Interviews with School Directors

A school director in Puebla lent support to the promotoras’ claims of extra travel expenses, explaining that he had asked the promotora to deliver forms to the officials in town but

the problem is that the promotora would say that she doesn’t have the money for the trip, an economic problem, so then I say to the parents 'you should be aware that you must turn in these documents and you should contribute to the promotora’s trip.'

It is important to note that returning forms for school directors is not one of her duties, thus PROGRESA has probably not given her money for such trips.

Summary

Nearly 37% (40%) of beneficiaries in the June 1999 (October 1998) survey report being asked to contribute at meetings or to the promotora's activities, this being highest in San Luis and Guerrero. It is not clear whether this is good or bad: presumably whether the contribution is voluntary or not, or in payment for expenses incurred, is important. The most common contribution was the payment of either a monetary or in-kind entrance fee, but other payments to the promotora and helping the promotora with tasks was also important. There is some evidence that this is more likely to occur when meetings are held using community facilities. In the June 1999 survey some beneficiaries said they are being forced to pay. There are, however, indirect ways in which beneficiaries are compelled to pay where they may or may not want to, as seen in the qualitative research. Some beneficiaries say they do not mind contributing to the promotoras expenses. In the focus groups and interviews with school directors, the main reason promotoras charge appears to be that they have transportation and other expenses that are not covered by PROGRESA, probably because these are not part of their regular expected responsibilities; for example, trips to the municipality related to miscellaneous paperwork or delivering forms for the teacher. They usually charge a few pesos per beneficiary. It is not clear to what extent they may be charging for trips that are covered by PROGRESA. Since the program is supposed to cover promotoras’ necessary transportation expenses, PROGRESA operations should investigate the claims of promotoras that they incur expenses that are not covered. Although efforts should be made to prevent promotoras from charging for transportation where that is already paid, they may have other expenses that need to be covered.

5.1.4 Pressure from the Community

Focus Groups with Promotoras, Beneficiaries and Non-Beneficiaries

Another problem that promotoras report is that beneficiaries blame them when the transfers come late or when beneficiaries receive less than expected. Sometimes beneficiaries are suspicious that the promotora has not filled out forms correctly or not delivered them. In this regard, promotora requested that PROGRESA explain to beneficiaries that promotoras are not
Promotoras try to explain this themselves, and to explain to beneficiaries possible reasons why their money has not arrived, but beneficiaries do not always believe them. Below are discussions among promotoras in Veracruz, Querétero and Guerrero:

—I was blamed. Last year some forms concerning scholarships were returned to us because the grades of the students were not properly marked on them so in December, when the money came, there were five or six women that didn't receive their children's scholarship, they only received the money for the food and they said that I kept the missing money, that I hid the forms and also that the municipal president's wife didn't deliver the forms, that because we left the forms with her…

[Q: And how was this question resolved?]
—Well, I explained them that it was not for that reason or because we wished it this way that the money didn't come, but because the documents were returned. Well, some of them [believed us] and some did not."(PV1-39)

—They think it's our fault, but what are we supposed to do? On the contrary, it's their fault because they don't attend the clinic or school, that's why they don't receive their payment, because they don't send their kids to school. (PQ-39)

[Q: What would you change, if you would be able to change something of PROGRESA in order to improve your work as promotoras?]
—We would like you to send one message to all beneficiaries in order to make them understand that it's not our fault.
[Q: What fault?]
—Well, that their children's scholarships don't come. (PG-39)

Some promotoras reported the opposite, however: that beneficiaries understand that it is not the promotora’s fault when the money is not complete or it is delayed.

Promotoras also raised the concern that non-beneficiaries consider the promotora responsible for their exclusion from the beneficiary list. Some non-beneficiaries complain to promotoras directly that they are not making enough effort to include them in the list, while others gossip or criticize them behind their backs, stop talking to them or refuse to participate in community faenas:

—At the beginning I used to see that women were very dubious, because nobody knew what was it about, and some women were saying 'why my name wasn't in the list?… But as time passed by and they explained it to us in the meetings, women that were left out from the program stopped getting upset at me, and they participate [in faenas]. We all, with or without PROGRESA, participate. [Q: And do they understand?]
—Yes.
[Q: Because they hope they are going to get the benefit?]
—Well, I tell them in each meeting. Before they used to ask me why didn't I support them, and I showed them the list so they won't say I don't want to get them in. (PH-41)

—In my community women who didn't get PROGRESA get upset, but they still ask me the favor to ask the teacher, or myself, to write down the application and to sent it to Pachuca or to México City to ask for the people who didn't get this program…And some of them get upset at me, some of them don't even want to talk to me, because they think I earn very much money, and that I get paid every 15 days. (PH-41)
Summary

As members of communities and the representatives of a program that brings benefits and problems, promotoras are vulnerable to social pressure and have to absorb the frustrations of people in their communities. As the link between PROGRESA and beneficiaries, promotoras face pressure from beneficiaries when things do not go as expected, for example if transfers are late or are less than expected. They are also sometimes held responsible for non-beneficiary exclusion from the program. Promotoras thus ask that PROGRESA put more effort into explaining to beneficiaries the reasons for these problems and that promotoras are not responsible in these areas. From an operational standpoint, this underscores the importance of clear communication with beneficiaries regarding how PROGRESA works and relative roles and responsibilities.

5.1.5 Promotora Training

Focus Groups with Promotoras, Beneficiaries and Non-Beneficiaries, and Interviews with Doctors and School Directors

Although promotoras are well trained enough to receive good evaluations from beneficiaries and doctors in terms of how they perform their jobs, promotoras and doctors both say that promotoras need more training then they currently receive. PROGRESA is demanding in terms of the complexities of beneficiary rights and responsibilities, as well as the human and social issues confronted in the course of doing community work. Promotoras in some areas exhibit a lack of understanding of how the program works. For example, the promotoras' guide suggests that they talk with beneficiaries about the reasons that girls receive slightly higher scholarships than boys. However, in interviewing the promotoras, we found that most of them did not know why, attributing the higher scholarships to higher expenses of girls, based on physiology and appearance. (Adato and Mindek 2000). Promotoras have a limited understanding of how beneficiaries are selected and are thus ill-equipped to deal with questions and problems that arise in the community in relation to this. They also have difficulty explaining to beneficiaries the reasons for delayed or deducted payments. Promotoras cannot be effective at explaining aspects of the program to beneficiaries if they do not have sufficient information themselves.

Almost all doctors interviewed said that the promotoras need to receive more training in relation to the objectives and guidelines of PROGRESA. They also said they should be informed of any changes in a timely manner to avoid misunderstandings. The doctors imply that the promotoras often do not have sufficient information.

Regarding additional skills training, two areas that both promotoras and doctors identified were health issues, and how to deal with people. Such additional training would help promotoras more effectively handle anticipated and unanticipated challenges. However, while it would be useful for promotoras to have additional health training to enable them to answer questions of beneficiaries related to what they learn in the pláticas, giving pláticas is not their responsibility. In Querétero, a few promotoras said they need better training in order to give the health pláticas.
However, some rightly did not want to be in charge of the pláticas, preferring that someone with more health training be responsible for this. Note these comments:

—Well, I would like to have more training.
—Above all health training because now it's our responsibility to give health pláticas and it's always a little bit hard. Last Monday I didn't attend one plática because it was raining a lot and I have to go there walking and I was told that the doctors were upset, they are getting very strict and they want us to learn everything. That's impossible. One is not able to learn everything. (PQ - 39)

—Regarding platicas they should give us more health training because, to tell the truth, we don't have sufficient knowledge. (PQ-39)

Currently, promotoras are supposed to receive training at the outset of the program. Sometimes this occurs before they assume their responsibilities but in other cases, training takes place later. Although this training normally takes place, the time does not appear to be sufficient and the quality varies. In one training session we observed during preliminary research, there was little two-way communication between the trainer and promotoras so there was no indication whether the promotoras were absorbing the material. It is important that trainers test the comprehension of the promotoras to be sure that they understand the material and are able to communicate it effectively to beneficiaries. Finally, there appears to be variations in what promotoras are trained to say with regard to certain issues such as beneficiary selection.

Summary

Although promotoras are well trained enough to receive very good evaluations from beneficiaries and doctors in terms of how they perform their jobs, promotoras and doctors both say that promotoras need more training than they currently receive. PROGRESA is demanding in terms of the complexities of beneficiary rights and responsibilities, as well as the human and social issues confronted in the course of doing community work. Promotoras in some areas exhibit a lack of understanding of how the program works, and are unable to explain some things to beneficiaries, such as reasons for delayed or deducted payments, or why non-beneficiaries are not in the program. Doctors imply that promotoras do not have sufficient information about the program, and stress that it is important that they receive updated information in a timely manner. Promotoras and doctors propose that promotoras receive more health training, and skills training to help them to deal better with people. Additional health training could be helpful in enabling promotoras to answer questions that beneficiaries have related to what they learn in the pláticas, but they should not be giving pláticas, as this is not their responsibility. The short period of training currently given to promotoras appears to be insufficient. Finally, trainers need to use forms of pedagogy that encourages more participation and ensures that promotoras have absorbed the material.

5.2 Faenas

Faenas, a longstanding feature of rural communities, are communal work activities in which men and/or women come together to perform volunteer labor to benefit the community. Faenas are not part of PROGRESA operations and are not formally associated with the program in any
way. In practice, however, in many communities *faenas* are being informally linked to PROGRESA by doctors, teachers or *promotoras*; in particular, doctors see the program as an opportunity to get people to do important community work that they otherwise would not do. The type of activities mentioned were cleaning and painting the schools, cleaning the clinics or streets, building fences and gardens, cutting grass and tending community orchards. *Faenas* serve several purposes, providing environmental, health and social benefits. They also have costs in terms of participants’ time and energy. This section describes the prevalence and use of *faenas* in PROGRESA communities, and their benefits and costs.

### 5.2.1 Prevalence of Faenas in PROGRESA and Control Communities

**Quantitative Survey with Beneficiaries**

In a community survey in 1998, 89% of PROGRESA and poor non-PROGRESA (control) communities were said to have *faenas*. The median number was about 10 *faenas* in the year preceding the survey. These numbers stayed roughly the same in 1999. Roughly 75% of PROGRESA and control communities report that either all or most people participate in the *faenas*. In approximately 85% of both communities, the participants were said to be either men only or men and women together, with only between 2 and 3% said to be women only. This was roughly the same from 1998 to 1999. All of the focus groups discussed some aspect of *faenas* in their communities. Although the survey data suggest that PROGRESA has not increased the number of *faenas* or women-only (i.e., PROGRESA beneficiary) *faenas*, many of the focus groups and interviews with doctors and teachers indicate ways in which *faenas* and the program are being associated.

### 5.2.2 Beneficiaries’ and Doctors’ Views of Faenas

**Focus Groups with Promotoras, Beneficiaries and Non-Beneficiaries**

Focus group comments were roughly evenly divided between those saying that beneficiaries like *faenas* for various reasons, and those that implied that they did not. Those that liked them talked about them being fun, that they unite people, and that they get people to do needed community work that they were not doing before. The reasons that beneficiaries like *faenas* are illustrated by comments from *promotoras* in Michoacán and Hidalgo, and beneficiaries in Michoacán:

—The nice part of it is that we are all united.

—In my community we all work very well, in less than an hour or in an hour we finish doing all the work. And we go home very happy to make breakfast. All of us. (PM1-42)

—Before we had PROGRESA, women wouldn't do anything, and now that they are getting PROGRESA, they do any work, they do *faenas*. We organize ourselves to do any work, and the rest of them don't get upset, they don't say anything to us. I just tell them, let’s do this work and sometimes some of them can't go, but they apologize “do you know what?, I can't help today, but I'll do it next time.” (PH-42)

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45 The reference to “work” in these quotes refer to *faenas*. 
— It's good to distract ourselves.
— Yes because when we go, we spend time together, because all of us participate in the faenas. (BM1-42)

Those who do not like them are said to just not like to work, or do not have the time. In the comments below, promotoras from Veracruz and Querétero indicate that they sometimes have to persuade beneficiaries to participate:

— They get upset, they don't want us to ask them to share a moment, one hour in the faenas in order to have our community cleaner.
   [Q: Women don't go?]
— No, because they say that they don't have any time, but I tell them that we have to make a little time, because at least I am always going from here to there, I tell them…
— Because she says that she doesn't have to go to any faenas, but I tell her that it is for having our community clean, for having the classrooms clean, where our children go, cleaner. (PV-42)

— If they don't go I have to find them, but nobody ever does that, they never fail to go. I haven't counted how many of them go.
— Is the same with me, they always go.
— With me there are 123, but not everybody participates in the faenas.
   [Q: Why don't they? What do they tell you?]
— Some say they don't have time. Others because they work, but sometimes they get paid and sometimes they don't. But definitely some of them never participate. (PQ-42)

In a few communities, it emerged that faenas were obligatory, i.e., beneficiaries were told that they would lose some of their benefits if they do not participate in the faenas. More comments, however, indicated that faenas were not usually treated as obligatory, but more often that beneficiaries felt a certain sense of obligation.

Interviews with Doctors and School Directors, and Quantitative Survey with Beneficiaries

Doctors interviewed are strong advocates of faenas. They feel that one of the basic components of PROGRESA that has a major impact on health is hygiene, such as cleaning the surroundings, cutting grass, picking up garbage and other activities. Doctors make home visits to verify compliance with these actions to maintain a clean environment. An interesting explanation as to why faenas are made obligatory was given by a doctor in Querétero.46 He said that faenas were extremely important to the community, a way of accomplishing activities that will improve the community, and PROGRESA gives him a way to make these happen:

If we couldn’t count on PROGRESA we will have to look for other resources. For example, here 50 families have PROGRESA, so I obligate those 50 families to do those things. It is more than half of the community. If PROGRESA didn’t exist, I will have to get organized with a committee that will help me organize all the people for the fulfillment of these actions. But this program allowed me the facilitation to carry out all the activities, I can obligate them to help me out.

46 This doctor was interviewed during the focus group research in July 1999, rather than with the other doctors in January 2000.
[Q: What is the mechanism by which you get people to participate?]
I get the people together every Tuesday and I tell them we will have to do cleaning in the health center, for the community we have to do it. How many people want to participate? I tell those who don’t want to participate that I’m aware of the situation and that it is part of PROGRESA, part of the support PROGRESA gives them, because it is not a salary, it is a support. If they don’t want to participate I can see the way they don’t get that support. I don’t tell them I will take away the support, just that they will have problems if they don’t work. I will not sign, or I will not fill out a month or something like that, but it hasn’t been necessary, since they all participate. All the ones in PROGRESA participate, either because they are convinced and think it is good for their community, or because they feel obliged to do it since they are receiving the help. I don’t have to threaten them any more, at the beginning I had to.

In the June and November 1999 household surveys, 9% of people said they had been asked to participate in faenas in return for their visits to the clinic. The question does not refer to PROGRESA benefits more broadly, which could increase or decrease this figure. This percentage was roughly the same for PROGRESA and control communities, indicating that the practice of requiring participation in faenas in exchange for government benefits, while not widespread, is not new for doctors. What is specific to PROGRESA communities, as explained by the above doctor in Querétaro, is that this program facilitates this arrangement by giving doctors a ready-made group of women who will respond. Both doctors and school directors also mentioned that promotoras are helpful in organizing beneficiary participation in faenas.

Although the form of reciprocity described by the Querétaro doctor is contrary to PROGRESA policy, the opinion of some doctors is that there are good reasons for requiring these obligations. The list of environmental, aesthetic, social, health and potentially even economic benefits that doctors believe are derived from faenas should be taken into consideration in PROGRESA’s decision to either try to discourage this practice, or allow it to continue at the discretion of the doctor, school director or promotora. If the policy remains that PROGRESA should not be associated with these activities in any way, this needs to be restated and explained at the community level.

Linking participation in faenas to PROGRESA benefits, i.e., increasing the private costs of taking up the benefits, may also be a good way of introducing elements of self-targeting to the program, and for reinforcing the responsibilities of beneficiaries. In a self-targeted program the costs (in particular the time costs) of participation in relation to the level of benefits is high enough to cause people who need the benefits less to select themselves out of the program, and those whose time costs are lowest to select themselves in. This has potential advantages over household-level targeting in for reasons explored in chapter 2, among others. However, formal association of faenas with the program also runs the risk of exacerbating the problem whereby non-beneficiaries cease to participate in communal activities with beneficiaries. This issue is taken up in the next section.
5.2.3 Non-Beneficiary Participation in Faenas

Focus Groups with Promotoras, Beneficiaries and Non-Beneficiaries, and Interviews with Doctors

Faenas are volunteer activities and they are not supposed to be an obligation. They are not supposed to have any specific connection to PROGRESA. However, the fact that beneficiaries receive cash transfers from the program, and that faenas are being directly or indirectly associated with the program, has led non-beneficiaries in some communities to see faenas as work for which beneficiaries ‘get paid.’ While beneficiaries report some increased social interaction as a result of this participation, it can have a negative effect on communities where non-beneficiaries either do not want to participate or are not invited to faenas⁴⁷ (either because promotoras do not think they should be invited or think that they do not want to come). Note the comment of a non-beneficiary in Estado de México:

—No, they say only the ones in the list, the ones in PROGRESA are the ones who are going to go [to the faena], but the ones who are not in the list, they don't tell us about it. (NBM-42)

The problem of non-beneficiaries not attending faenas because they are not getting benefits was raised in half of the focus groups and in all six states, and by some doctors in their interviews. Below are examples from promotoras in Querétero and Guerrero:

[Q: Why don’t non-beneficiaries go?]
—As we told you before, they say that they don't have any help, and they say "why should I work, they say, if the government is not supporting me? The government is not helping me, they don't recognize me" they say. (PQ-42)
—We had a talk with the doctor and he told us that whenever we had time we should do a little bit of work, for example go to the cemetery, and water the plants, to bring water, or to throw away garbage from the cemetery, and he was going to check assistance in all that.
—And then, all the roads, to pick up garbage and to burn it.
[Q: That is done only by PROGRESA's people?]  
—Yes, only women from PROGRESA do that.
[Q: And you told me that non beneficiaries don't want to do it]  
—The non-beneficiaries don't do it.
[Q: And do you invite them to go?] 
—Yes, I invite them, but they tell me that they won't do it because they are not getting paid. (PG-42)

Many doctors in the interviews confirmed that non-beneficiaries do not want to participate in faenas, which they perceive as a problem. Doctors and promotoras try to convince them to join, arguing that the community is for everyone. Note the following explanation by the same Querétero doctor:

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⁴⁷ This issue is taken up further in Adato (2000).
The non-beneficiaries don’t want to work because they think that the program PROGRESA is only for the beneficiaries, or that I only come to work for them. To faenas, I refer to the cleaning of the streets, of the school, the kindergarten and the clinic. We work with family orchards and as they think it is only for PROGRESA, we have problems there. I have to take other measures to assure their presence, telling them that the talks are for everybody, that the community is of everybody, so it has to be clean. So we start to work.

However, non-beneficiaries were said to participate in faenas in half of the focus groups (mentioned in all states except Estado de México48). The explanations given for this are of two types. The first is that non-beneficiaries care about their communities and participate with or without PROGRESA:

—But then that's when we bring up our ethics, convincing words: "look to clean is general because hopefully God won't let it happen but if we get an epidemic, it's not only going to attack beneficiaries from PROGRESA, it is going to affect all of you, all of us". And that's how I unite people, whether they have or don't have [PROGRESA], because they are conscious. (PM2-42)

—No, we do it gladly, knowing we have the commitment, and we can't say anything, we have the commitment, and we have to go clean. [Q: Do non-beneficiaries also participate in faenas?]
—Yes, yes, because they also have their children in school, and they also work in the faenas. (BV-42)

The second explanation is that non-beneficiaries participate because they hope that they will get added to the beneficiary list. In the following examples from Hidalgo, a beneficiary and non-beneficiary described how non-beneficiaries are disappointed when beneficiaries later get their money and non-beneficiaries do not:

LOCAL TRANSLATION: They say that some of them get upset, because they don't have PROGRESA, and when they have to go clean everybody participates and they don't get any help, and they get upset. (BH-42)

[Q: Do you hope to receive in the future?]
—Yes, I do.
LOCAL TRANSLATION: She says she participates in everything [community work] every time they ask her to.
LOCAL TRANSLATION: When they [beneficiaries] go get their money, they get very sad. (NBH-42)

Summary

The vast majority of PROGRESA and poor non-PROGRESA communities have faenas and most people in the community are said to participate. Faenas are not part of PROGRESA operations and are not formally associated with the program. Although the survey data suggest that

48 This is the one state where there was no promotora focus group conducted, hence the answers represent only one community.
PROGRESA has not increased the number of faenas or women-only (i.e., PROGRESA beneficiary) faenas, many of the focus groups and interviews with doctors indicate ways in which faenas and the program are being associated, as a means of getting people to participate in communal work. Doctors and teachers both mention that promotoras are helpful in organizing participation in the faenas. In the June 1999 survey, beneficiaries and people in non-PROGRESA communities said that they are asked to participate in faenas in return for their clinic visits. Although this form of reciprocity was not intended by PROGRESA, the opinion of the doctors is that there are good reasons for requiring these obligations.

There are positive and negative dimensions to faenas, as well as to their association with PROGRESA. Faenas produce important physical and social benefits in communities. Doctors are particularly strong advocates of faenas because of the role they play in promoting hygiene and other dimensions of well-being. However, they also increase time and energy demands on people. Also, in excluding non-beneficiaries they produce social divisions, where non-beneficiaries will not participate because they do not get PROGRESA benefits. In some communities, non-beneficiaries do participate either because the work is not associated with PROGRESA, they are convinced that they should work anyway, or because they hope that by participating they will get included in the program.

The list of environmental, health, aesthetic, and social benefits that doctors believe are derived from faenas should be taken into consideration along with the drawbacks, in PROGRESA’s decision to either try to discourage this practice or allow it to continue at the discretion of the doctor, school director or promotora. If the policy remains that PROGRESA should not be associated with these activities in any way, this needs to be restated and explained at the community level. Linking participation in faenas to PROGRESA benefits may also be a good way of introducing elements of self-targeting to the program, and for reinforcing the responsibilities of beneficiaries.
CHAPTER 6 — SUMMARY OF FINDINGS AND IMPLICATIONS FOR PROGRAM IMPACT AND POLICY

As indicated in the introduction, the goal of this operations evaluation of PROGRESA was to explore, through quantitative and qualitative research methods, how various operational aspects of the program were performing, and to identify key areas where the program appears to be experiencing operational problems. The evaluation focused on two of the three main components of the program, i.e., the education and the health packages, and included other key aspects of the program such as beneficiary selection and induction processes, and the community promotoras. The operational aspects of the cash transfers component were not addressed in any detail in this evaluation — but it is important that this aspect of the program be evaluated and a data set to facilitate such an evaluation has recently just been constructed by PROGRESA.

The data used in our report provides information about the program as seen through the eyes of four different stakeholders at the local level: the beneficiaries (and some non-beneficiaries), the school directors, the health clinic staff, and the community promotoras. These provide potentially valuable information on both the operational and impact performance of the program. The different research methodologies used allowed us to capture their perspectives on the various aspects of this complex program. Preliminary research and series of meetings with stakeholders at the state and national levels of PROGRESA guided us in shaping our research questions and data analysis, and their concerns are reflected in this way. However, national and state level stakeholders in other institutions (e.g., health and education) had to be left out of the evaluation due to time and resource constraints, but it is hoped that the program will be able to follow up and amplify the evaluation to include these other levels and to get a more global view of the program’s overall operational system. Interactions between these different levels may exert key constraints on operations that our study was unable to address.

Also as mentioned in the introduction it is important to remember that the main focus of the evaluation was to provide the necessary information for program and policy makers to better understand where improvements to the program could be made (and would be desirable), so that they can assess the situation and prioritize areas of action. We do not attempt to provide specific recommendations about which corrective actions need to be taken to improve the program. Rather, it is hoped that the insights available in the report provide a starting point for such a process. More specifically our data provide information on which problems exist, how widespread and serious they appear to be and how they are perceived by different stakeholders. The key findings about successes and problems with operations of the program are summarized in Table 6.1 (left column). The matrix also includes two additional columns. The middle column entitled “Implications for Program Impact” describes how failure to address the issues or problems listed on the left column could affect the expected program impact on different outcomes. It is important that the existing level of operational performance be taken into account when interpreting the magnitude of the program impact as identified in, for example, the education and health impact evaluations. Obviously, where potential for improving program operations exists, current levels of impact can also be improved upon. The right column entitled “Implications for Policy” proposes some potential solutions to existing problems, highlights issues or recommendations that have been raised by the various stakeholders themselves on how
the program could be improved, and suggests ways to ensure that effective operations in specific areas can be maintained through the strengthening of already existing effective processes. We hope that the insights provided by our evaluation will contribute to strengthening the program both relative to its cost-effectiveness and its impact on poverty alleviation in Mexico.
Table 6.1 — Summary of Key Findings and Implications for Program Impact and Policy

A. Program Induction and Beneficiary Selection

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<td>(1) Local understandings and assessments of the selection process: The issue of beneficiary selection emerged as a significant source of dissatisfaction and perhaps the strongest criticism of the program from beneficiaries, non-beneficiaries, promotoras, doctors and school directors. The main problem raised is that poor people are wrongly excluded because of operational failures of the census, or wrong determinations of who needs assistance and who does not.</td>
<td>Same as (2-5) below.</td>
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<td>(2) Administrative problems with the census: (a) people were absent from their homes at time of census and enumerators not returning; (b) enumerators were not advised to go to remote areas where clusters of extreme poor live, due to advice from people who do not know the area well or who may have a political agenda; (c) enumerators survey a person who does not know the household's conditions; and (d) enumerators cannot communicate well enough in the local language</td>
<td>Extreme poor and poor who should be included in the program may be missed, reducing the program’s targeting effectiveness and poverty reduction impacts.</td>
<td>It is important that the program ensures sufficient training, monitoring and control of enumerators and enumeration process, so that they make the required number of return visits; do not allow people who do not know household conditions to answer the survey; and can communicate well in the appropriate language. It may be possible to develop a more effective system of return visits. It is also important to disseminate a more systematic approach to obtaining good local advisors to map out area to be enumerated, while avoiding political influence.</td>
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| (3) Socio-cultural issues in use of the census: Some people do not answer the census or give incorrect information due to: (a) distrust of unknown intent of the survey; (b) rumors spread about consequences of giving information; (c) fatigue from surveys of questionable benefit; and (d) shame to admit their poverty. | Same as (2) above.              | It would be beneficial to clarify policy as to what information the enumerator can reveal to family about the intention of the survey. A better balance could be struck between giving sufficient information to reduce distrust, and not giving out so much information that incentives are created to overstate poverty. A better job at establishing more basis for trust might also be done before entering the community using local contacts, e.g., community leaders. However, taken together with administrative problems raised above, these problems that reflect local historical, social and cultural conditions may mitigate against the use of poverty targeting via a
## Key Findings

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| (4) Other local explanations of selection:  
Other ways in which selection is understood is that those excluded had bad luck, or that it is a lottery. However, the most frequent response was that people do not understand how the selection was made, and they want to know why. This uncertainty appears to instill frustration and a sense of insecurity. | Same as (5) below. | Same as (5) below. |
| (5) Community perceptions of the accuracy and fairness of the beneficiary selection system:  
Community-level stakeholders (beneficiaries, non-beneficiaries, doctors, school directors) report that there is a large problem of poor people who should be included in the program and are not; and a smaller problem of non-poor people included who should not be. They do not understand how the list is determined and do not see the system as fair, either because of mistakes in the outcomes or their belief that everyone is poor and need the assistance. Beneficiaries and non-beneficiaries feel bad about this differentiation, and there are also reports of new social tensions. | Again as above, where targeting is inaccurate, effectiveness at reaching those most in need of benefits is reduced. Also, where people perceive that the system is unfair due to lack of understanding of the process or outcomes, this may not have an impact on poverty reduction outcomes but can have secondary negative impacts on communities, which have been expressed as frustration, powerlessness, sadness, and increased social tensions. The ‘success’ of anti-poverty programs must also be judged by how its beneficiaries and others in poor communities evaluate it, and whether they like the program. While all local stakeholders have strong positive feelings about its health, education and nutrition dimensions, they have strong negative feelings about beneficiary selection. | From the consistency of comments across local stakeholders, it appears that there are inaccuracy problems that should be given serious attention. However, this also points to the need for stronger systems of communication between PROGRESA and community members and local service providers so that they have a better understanding of the selection system. However, if equal treatment is more important to households than relative poverty distinctions, then more accurate assessments or better communications may not be sufficient. Although by economic criteria the targeting system may be performing well, the unmeasured social costs are high. The program should weigh these social costs in a reassessment of its targeting system, and give serious consideration to self-targeting or geographical targeting as an alternative to household targeting. If equity and leakage remain central concerns, self-targeting should be explored. |
| (6) Perceived or actual political influence on the selection process:  
Relatively few people say that local officials or other individuals determined the selection of beneficiaries. There are exceptions, where *promotoras* and school directors are blamed for excluding people. Some school directors believe that local officials influenced the process. | A program where local officials or other individuals are not perceived as influencing selection can instill confidence in government social programs. This impact would be greater, however, if all stakeholders understood how the program worked and were thus aware of the controls on political influence. | Controlling selection at the national level rather than at state or local level is a positive program feature in this regard. However, whereas the system is working in this sense, persistent misunderstandings indicate again the importance of more effective and systematic communication with local stakeholders. |
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<td>through directing enumerators and other ways. There may be truth to this in some cases, but comments also indicate a lack of understanding of how the program functions.</td>
<td>A process of community review could help to improve the accuracy of the poverty targeting, resulting in better allocation of scarce resources to the poor. If carried out well, it would also increase confidence in the selection process and improve attitudes toward the program. Lack of such review misses both opportunities. Community review is also likely to increase the administrative burden on the program and the potential for the introduction of politics. However, the potential gains appear to outweigh the potential costs.</td>
<td>Given the potential for mistakes made in use of the census and low confidence in the current system at local level, it is important that the program develop a systematic and reliable mechanism for reviewing and revising results that involves community participation; possibly: a public review process in a general assembly; a ‘social comptrollership’ as originally proposed by PROGRESA; the involvement of local key informants who know the communities well, or some combination of the above. Doctors and school directors propose that their involvement would improve the process. Involvement of local key informants should be approached carefully, however, in order to avoid the discretionality that the program was designed to avoid. It would be beneficial to systematically invite non-beneficiaries to an assembly to inform them of the right to petition, and so that they understand the principles of the program and why they are excluded, helping to defuse reported tensions. The petition process does not seem to be systematic and reliable and a further research effort would be valuable in attempting to understand how this system is working and how it can be improved.</td>
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<td>(7) Community review of the selection process: PROGRESA originally envisioned community participation in reviewing the list of beneficiaries, in the interest of transparency and to improve accuracy of the targeting. However, this community review is not taking place. Non-beneficiaries do not attend the assembly where petitions for adding families were envisioned to be drawn up, and there is no other system for participation. Some communities submit petitions later, but the response does not appear to be systematic nor often positive. The main way in which new people have been included has been through the second round of general incorporation.</td>
<td>Good knowledge of how the program operates and their responsibilities is essential to beneficiaries’ ability to participate in the program, fulfill their responsibilities and receive their benefits. Such knowledge is also essential to their ability to take the fullest advantage of the health and education opportunities presented to them and their families by the program.</td>
<td>The program is operating very well with regard to distribution of the booklet, with no apparent changes needed in this system. Those explaining the contents are doing a good job, but PROGRESA could look into ways to improve this process further, given the relatively low number of beneficiaries who reported excellent knowledge. Reading or explaining the contents is necessary, not just handing over the booklet. However, the effects of instruction appears to be limited in the sense that the move from adequate to excellent knowledge appears in part to come from experience in the program.</td>
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<td>(8) Program induction: receiving the booklet and explanation of the material: This part of the induction process is performing quite well. There are few problems in relation to beneficiaries’ receipt of the information booklet, and the few are concentrated by locality. All beneficiaries report that the booklet was read or explained to them. Most beneficiaries report “adequate” knowledge of program requirements. However, the level of reported “excellent” knowledge is relatively low. Reading and explaining program requirements at induction, rather than just handing out the booklets, seems to have had a high return in terms of knowledge. The increase between</td>
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<td>surveys in the households exhibiting excellent knowledge suggests the presence of some learning by doing and diffusion of information</td>
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B. Education

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<td>(1) Distribution of E1 forms: There is evidence that this is working well and improved over time.</td>
<td>Having forms is crucial to generating education and poverty alleviation impacts. It is important to ensure that forms are distributed in an efficient and timely manner prior to annual September enrollment.</td>
<td>Enrolment impacts are near maximum attainable given program design. Any further improvements must come through improved program design, e.g., increasing grants and/or changing structure of grants.</td>
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<td>(2) Impact on enrollment: There is evidence that the program has a substantial impact on enrollment and that this impact is achieved through both increased continuation rates and return rates, but that latter decreases over time. It is probably difficult to keep children with good opportunities in the school system.</td>
<td>It is important to understand the differential impact of the program on continuation and return rates. The decrease in the latter suggests some children come back solely for the subsidy rather than the perceived educational benefits or human capital formation. But such children will presumably automatically drop-out of school and the program overtime.</td>
<td>It seems desirable to keep the program rule that only those who are less than three years out of school are eligible for transfers. But it is important to have a clearer picture of which children take-up the program and how the pattern of take-up evolves over time. This has implications both for the education and poverty impacts of the program.</td>
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<td>(3) Impact on attendance: There is evidence of a positive impact on attendance, when measured by the percentage of children attending over 85% of the time, but no substantial changes in the number of days attended is observed. Attendance does not seem to be a major problem, but it seems somewhat low in June, possibly reflecting seasonal factors (i.e., high income opportunities at harvest).</td>
<td>Attendance is crucial to the achievement of an educational impact. In measuring attendance, it is important to distinguish between attendance levels (no of days attended) and achievement of a threshold level (85% of the time).</td>
<td>It is important to consider the possibility of conditioning the grants on grades achieved with or without maintaining the attendance requirement. It also may be important to consider the implications of the seasonal nature of work opportunities for attendance, grant levels and school calendar.</td>
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<td>(4) Distribution of E2 forms: There is evidence that the collecting, filling out, and returning of forms can involve substantial time and money costs often incurred personally by school directors. The decision to send the forms directly to schools has had a very beneficial impact in this regard. There is also evidence that the combination of teachers’ commitment to the educational goals of the program plus external and internal monitoring (e.g., by school boards, parents and children) ensure consistent and truthful attendance monitoring. The fact that the forms have been simplified over time helps reduce the time intensiveness of reporting.</td>
<td>Should build-up understanding of implications of resource-intensiveness of attendance monitoring for delays in distribution of grants.</td>
<td>Efforts should continue to be made at looking for ways of simplifying the attendance monitoring process and to monitor this process itself. Also, as indicated above, one should consider the possibility of conditioning grants on grade attainment with or without attendance monitoring.</td>
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<td>(5) Education grants: There is evidence that suggests that delays in receipt of transfers may be</td>
<td>Non-receipt or delays in transfers may have an adverse effect on poverty alleviation and on</td>
<td>It is important to verify status of transfers and to identify operational factors that may be responsible</td>
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<td>occurring. This needs to be validated using the cash transfer data recently constructed by PROGRESA.</td>
<td>consumption and nutrition impacts. This may also affect beneficiaries’ interest in the program and motivation to participate.</td>
<td>for the delays in order to improve the process.</td>
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<td>(6) Supply side: The evidence available is consistent with the view that the supply side has at least not deteriorated, and has even improved to some extent in some areas, but from a low initial level. There is also evidence that the process of acquiring new resources is very time and resource intensive for school staff. This may discourage school directors from seeking improvements and additional resources. The school directors attribute the improvements in education performance to better attendance, student interest and nutrition, as opposed to improvements in the supply side.</td>
<td>For the program to have an impact on educational achievement and human capital formation, it is not enough that enrolment and attendance rates increase. The quality of education and the resources available to schools have to be adequate for these objectives to be met. It is therefore important to monitor the changes in the supply side and to ensure that they follow changes in demand.</td>
<td>It is important to remember the importance of the supply-side and to find ways to ensure that extra resources are matched to the increase in demand.</td>
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<td>(7) Attitudes to education: There is some evidence that the program has brought positive changes in the attitudes of parents and children towards education. It seems that the demand for education was always there but that households were economically constrained. Household members appear both willing and able to undertake tasks previously undertaken by those now going to school, but children still have to help with household chores and farm work at weekend. It is difficult, however, to stop children who dislike school or see opportunities to earn income from dropping out of secondary school. Travel distance is more of a constraint for keeping girls in school than for boys.</td>
<td>It is hoped that the program will continue to be effective in enabling parents to continue to send their children to school and possibly in encouraging some of those who have dropped out to return. Private costs to households may not be as high as anticipated because other household members seem able to compensate for loss of child labor.</td>
<td>It is likely that the continuation of grants is necessary for generating a sustained increase in enrolments. Also, one expects that higher grants for girls may be necessary to encourage parents to facilitate their enrolment. But it should be recognized that some children travel long distances to school and this both discourages enrolment and affects the child’s ability to study at school and do their homework.</td>
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<td>(8) Teachers’ attitudes towards program: Teachers agree with the objectives of the program and the conditioning of transfers on attendance. They even suggest that grants could be conditioned on academic performance. The teachers and school directors expressed concerns about the supply-side constraints and they are also unhappy about not having been consulted about the selection of beneficiaries.</td>
<td>The commitment of teachers and school directors is crucial to effective implementation of the program and to ensuring that the documented impacts are real.</td>
<td>The program should seek out views of teachers towards possible ways to improve program operation and enhance impact. It should also explore the desirability of linking grants to educational performance with or without attendance requirements.</td>
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## Health

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<td><strong>(1) Registration and forms:</strong> Registration of beneficiaries at health centers has improved considerably and was reaching up to 97% in 1999. Previous problems with the receipt of appointment booklets are largely solved, and doctors report little problems with filling out the S1 and S2 forms (the latter having been simplified over time).</td>
<td>Increases in registration rates at clinics have the potential to maximize the impact of the health component of PROGRESA on beneficiaries health outcomes. Thus it is important to ensure registration.</td>
<td>It is important for the program to maintain high registration rates and appropriate supply of forms and appointment booklets to the health centers.</td>
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<td><strong>(2) Compliance with scheduled clinic visits:</strong> Quantitative survey of beneficiaries indicates that possession of an appointment booklet is an important operational factor for beneficiaries' compliance to scheduled visits. PROGRESA has a positive impact on attendance of young children to growth monitoring sessions (weighing and measuring), but not to immunization. Immunization rates were already high, probably due to effective immunization campaigns, so the fact that the program has not increased immunization rates is not a major concern. Pressure from beneficiaries to falsify compliance monitoring. Doctors report that this is not a major problem. However, they indicate that they need to be very flexible and they need to motivate people and remind them to attend their visits. Doctors report that promotoras are a great help in this regard. The main constraints to compliance are lack of time, transportation problems (especially among older people), and lack of health awareness about the benefits of preventive health care. Some operational problems have been reported whereas people do not receive their benefits on time, in spite of having complied with their visits.</td>
<td>The impact of the health component is likely to be greater if appointment booklets are made available, because the booklets help beneficiaries comply with their scheduled appointments. If growth monitoring is carried out appropriately in the clinics, PROGRESA is likely to have a positive impact on children’s growth because the objective of growth monitoring is the early detection of poor growth. Our findings suggest that the program has increased participation in growth monitoring, which in turn can have a positive effect on children’s growth. If the program does not achieve its goal of increasing beneficiaries' attendance at their scheduled preventive health care visits, it is unlikely to have an impact on the health of the population, and especially in preventing diseases. It seems that, although achieving compliance may require a lot of effort from the health staff in some cases, compliance is quite high.</td>
<td>Same as above. Attention should be given to finding ways to assist the health staff in motivating beneficiaries to attend their scheduled visits. It is important to also work on changing people’s attitude and perceptions about the importance of preventive health care, rather than forcing them to attend in order to receive their benefits. Promotoras should continue to receive training and supervision because they play a crucial role in motivating the population and maintaining good communication between communities and health centers. Incongruence in program management can affect the morale and motivation of beneficiaries as well as their trust and interest to participate. It is...</td>
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<td>or the reverse, beneficiaries who have not fully complied sometimes still receive their benefits.</td>
<td>Increased coverage of health services is likely to have a positive impact on the population’s health and well-being, assuming that the quality of health services and the resources available are adequate. These aspects need to be monitored closely in order to understand the health impacts of the program.</td>
<td>important for the program to avoid delays and mistakes in the allocation of benefits.</td>
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<td>(3) Impact of program on clinic attendance and on the demand for health services: There is no doubt that the coverage of health services has increased as a result of PROGRESA, particularly for preventive services. There is also a consensus among the health staff that this is mainly due to the program requirements that beneficiaries attend a predetermined number of preventive visits. Doctors do not complain about the resulting increase in work load, except with respect to administrative work.</td>
<td>The concern with the increased demand for health services is that it may result in over-crowding of health services, which in turn may affect the quality of care and the amount of resources available (staff, medicines, etc.) to attend each patient. Doctors expressed their concern about this, indicating that it may affect the quality of their work as well as limit the overall impact of the program on the health of the population.</td>
<td>Increased coverage of health services may put an additional burden on already scarce resources. It is important that the increased demand be accompanied by a corresponding increase in supply, especially staff, equipment, supplies and medicines.</td>
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<td>(4) The supply and quality of health services: There is some evidence that the quality of health services and the supply (of personnel in some cases) has improved to some extent with PROGRESA. The general opinion, however, is that the increases in resources and supplies have not paralleled the increase in the demand for health services.</td>
<td>Health and nutrition education is a crucial part of preventive health care. The highly positive attitude of health personnel, beneficiaries and promotoras towards the pláticas is likely to result in positive changes in attitudes and empowerment of the population. This in turn has the potential to ensure not only a positive impact of the program, but also its sustainability over time. The program should make special efforts to promote the participation of non-beneficiaries in the pláticas. This would ensure that whole communities, as opposed to only specific individuals within communities, are empowered by the process. This is particularly important for issues related to general hygiene and sanitation, as well as although promotoras and other community members should not be responsible for giving the pláticas, it would be desirable to train them better so that they can assist families with questions about</td>
<td>It is important for PROGRESA to ensure that the supply side follows the rate of increase from the demand side. The program also has to ensure that the quality of care is maintained and improved where necessary in order to maximize the overall impact of the program on health conditions.</td>
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<td>(5) Pláticas: The pláticas were found to be widely available, effective and very popular among beneficiaries, promotoras and health professionals. The main problems identified were: a) promotoras are sometimes asked to give the pláticas and they feel uncomfortable and inadequately trained to do so; b) male doctors giving talks to women about family planning and the pap smear test seems culturally unacceptable in many areas; c) the participation of non-beneficiaries varies widely, but is often low; and d) men are generally reluctant to participate.</td>
<td>It is important to continue to find ways to maintain the quality of the pláticas and to ensure that the information provided is accurate and culturally acceptable. Solutions to the problem of male doctors addressing sensitive issues with women have already been found in many communities (e.g., female staff members take charge). It is important, however, that when such solutions are adopted, the program be informed and that appropriate measured be taken (such as training) to maintain the quality of services.</td>
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<td>the spread of infectious diseases. The lack of participation of men in <em>pláticas</em> may slow down progress and reduce impact on health.</td>
<td>Since the education is so well received it is worth continuing to provide useful material and creative ideas to help the staff carry out these activities more effectively. An effort should be made to improve attendance of non-beneficiaries and men to the <em>pláticas</em>.</td>
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<td>(6) <strong>Nutritional supplements</strong>: Both supplements (mother and child supplements) are very popular among beneficiaries, so product acceptability is not a problem. The main problem, however, seems to be that many of the targeted beneficiaries receive only a fraction of the daily ration (and hence nutrients) they are expected to receive from the program. This is due to 3 main factors: 1) families run out of supplement and do not replace it immediately; 2) there is significant leakage of the supplement to other household members; 3) the supplement is often diluted (with water) more than recommended on the package; and 4) the supplement is widely distributed to non-beneficiaries (irrespective of whether they are malnourished or not).</td>
<td>The formulation of the supplement was carefully designed to meet the daily nutritional needs of mothers and children, respectively. If the targeted groups do not receive the intended amount of supplement on a daily basis (most nutrients do not store and need to be ingested daily), the potential impact of the supplement on nutritional status is significantly reduced, to a point where it may have no impact at all. Similarly, the use of the supplement by other household members may have a positive impact on the nutrition of these other members, but should not be expected to benefit the targeted household members. The problems identified with the use of the supplement are serious and require immediate attention because they can jeopardize the impact of the program on nutrition. Potential approaches to the problems identified include: 4) Make the supplements available for all children and possibly all family members; 5) Make the supplement available to non-beneficiaries in all health centers that attend PROGRESA beneficiaries; 6) Improve training of the health staff (and <em>promotoras</em>) in the use (preparation and dilution) of the supplement. Inappropriate dilution can result in over- or under-concentration of nutrients, both of which are undesirable and possibly harmful. It is obvious that all three approaches proposed have cost implications that need to be assessed by the program.</td>
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<td>(7) <strong>Suggestions for improvements of the health and nutrition component and other aspects of PROGRESA:</strong></td>
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<td><em>Program requirements</em>: Doctors feel that current visit requirements are not excessive. They would like to add a “literacy” requirement, e.g., that illiterate beneficiaries be requested to attend literacy classes.</td>
<td>Doctors think that current poverty and illiteracy levels limit the impact of their efforts on improvements in the well-being of communities, households and individuals. The program should seriously consider addressing the adult illiteracy problem because, as indicated by doctors, it may limit the impact of all community development efforts.</td>
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<td><em>Promotoras</em>: Doctors feel <em>promotoras</em> should</td>
<td>If <em>promotoras</em> are misinformed about the program, The program should continue to hold regular...</td>
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<td>Key Findings</td>
<td>Implications For Program Impact</td>
<td>Implications For Policy</td>
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<td>receive additional training about the program because of their crucial role (see also Table 6 D).</td>
<td>they may confuse beneficiaries and this in turn, may negatively affect the impact of the program.</td>
<td>training and information sessions with the promotoras and ensure that they are well-informed about all aspects of the program (see also Table 6D).</td>
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<td><strong>Money transfers:</strong> Doctors think the money transfers should be replaced by in-kind transfers such as food baskets, or food-for-work activities.</td>
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<td><strong>Beneficiary selection:</strong> Doctors feel the process should be more transparent, and that current selection procedures have a negative effect on community dynamics.</td>
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</table>
### D. The Community *Promotoras* and *Faenas*

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<th>Key Findings</th>
<th>Implications For Program Impact</th>
<th>Implications For Policy</th>
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<tbody>
<tr>
<td><strong>Promotoras</strong></td>
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<td>(1) <em>Role of the promotora</em>: The overall findings of</td>
<td>Since <em>promotoras</em> serve as conveyors of program</td>
<td><em>Promotoras</em> have built-up valuable knowledge and skills that</td>
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<td>the research indicate that the <em>promotoras</em> are very</td>
<td>information between beneficiaries and the program, problem</td>
<td>enhance their effectiveness and therefore should not be</td>
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<td>useful and important, that they are meeting their</td>
<td>solver, educator and facilitator, she is a vital link in the</td>
<td>rotated after short periods so as not to lose the capacity</td>
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<td>main responsibilities, and that the <em>promotora</em></td>
<td>operations chain. If the <em>promotora</em> system works well it is</td>
<td>built.</td>
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<td>system is generally working well. Beneficiary</td>
<td>likely that beneficiaries will be able to meet their obligations</td>
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<td>attitudes toward <em>promotoras</em> present a strong picture</td>
<td>and benefit from the different aspects of the program.</td>
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<td>of the <em>promotora</em> system fulfilling a crucial role</td>
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<td>and doing so effectively.</td>
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<td>(2) <em>Information conveyed by promotora</em> and monthly</td>
<td>The promotora conveys basic program information necessary for</td>
<td><em>Promotoras</em> are effective at conveying basic program</td>
</tr>
<tr>
<td>meetings*: The main information conveyed by <em>promotoras</em> is the date of receiving benefits, followed by information on how the program works and program requirements. Fewer beneficiaries said they received information on composition of transfers. Almost all beneficiaries turn to the <em>promotora</em> with questions about the program with a small group saying they ask doctors (probably related to health issues). Almost all beneficiaries report knowing the <em>promotora</em>, and 75% report meeting with her at least once per month. A lower frequency of meetings is associated with meeting at the <em>promotora</em>’s place, so meetings held at community venues may be more conducive to greater contact. These meetings are mainly for transmission of program information. However, at some meetings women talk about broader issues and problems and give good feedback on this experience.</td>
<td>information. Additional training for <em>promotoras</em> so that they could answer beneficiary questions regarding composition of transfers would add value to their role. Monthly meetings are occurring as intended, but their importance suggests that ongoing monitoring is important to assure this practice continues. Also, it may be useful advising <em>promotoras</em> to hold these meetings in public venues where possible, as this might increase their frequency. <em>Promotoras</em> could be encouraged to allow or facilitate the use of monthly meetings for discussing issues beyond program rights and responsibilities.</td>
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<td>monthly meetings: The main information conveyed by</td>
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<td><em>promotoras</em> is the date of receiving benefits,</td>
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<td>followed by information on how the program works and</td>
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<td>program requirements. Fewer beneficiaries said they</td>
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<td>received information on composition of transfers.</td>
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<td>they ask doctors (probably related to health issues).</td>
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<td>(3) <em>Promotoras</em> role in the clinics*: Doctors are very</td>
<td><em>Promotoras</em> play an important role in encouraging beneficiaries to meet conditions, facilitate their uptake of the program’s health care benefits, and help doctors to be more responsive to beneficiary problems. Given the importance of their role, the quality of their training is critical to enabling beneficiaries to take the greatest advantage of what</td>
<td>PROGRESA may want to clarify with doctors the relationship between beneficiaries and <em>faenas</em> and how the <em>promotora</em> is used in this regard (see <em>faenas</em> section below). More <em>promotora</em> training is proposed in (7) below.</td>
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<td>positive about the <em>promotoras</em>, who facilitate</td>
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<td>beneficiary participation in the health services and</td>
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<td><em>faenas</em>, and keep doctors informed of the problems of</td>
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<td>beneficiary families. However, doctors think that</td>
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<td><em>promotoras</em> should be better trained and better</td>
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<td>informed about the program.</td>
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</table>
### Key Findings

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<tr>
<th>Implications For Program Impact</th>
<th>Implications For Policy</th>
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<tr>
<td>(4) <strong>Promotoras role in the schools:</strong> School directors report far less contact with <em>promotoras</em>, though some say that <em>promotoras</em> help in answering their questions and also organize beneficiaries for <em>faenas</em>. Some tensions were reported where <em>promotoras</em> have attempted to monitor school attendance by children and teachers. <em>Promotoras</em> appear to have far less impact on the program via the schools than via the clinics. This may be fine as doctors say they need this assistance while school directors do not.</td>
<td>It is advisable to clarify to <em>promotoras</em>, teachers and school directors their respective roles and responsibilities with regard to beneficiary children’s attendance. There may be other ways that <em>promotoras</em> could assist teachers with regard to the program. The program should improve its guidance on this, as school directors interviewed currently see little useful role for <em>promotoras</em>. School directors also need clarification on the relationship between beneficiaries and <em>faenas</em>.</td>
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</table>

| (5) **Contributions to *promotoras***: Just under 40% of beneficiaries report being asked by the *promotora* to contribute at meetings or to the *promotora’s* activities, with the most common being a monetary or in-kind entrance fee, but other payments and helping the *promotora* with tasks was also reported. There is some evidence that this is more likely to occur when meetings are held using community facilities. *Promotoras* say that these fees cover her transportation costs and other miscellaneous expenses incurred in carrying out PROGRESA-related business that is not covered by the program, such as trips to the municipality related to paperwork or delivering forms for the teacher. It is not clear to what extent they may be charging for trips that are covered by PROGRESA. *Promotoras* say that one of their main problems is expenses they incur in carrying out their job. Charging beneficiaries reduces the value of the transfer, though by a small amount. However, the fees appear to be necessary to enabling her to do tasks that facilitate the functioning of the program. Burdening *promotoras* with additional responsibilities such as delivering forms may reduce her effectiveness is carrying out her formal responsibilities. | Since the program is supposed to cover *promotoras’* necessary transportation expenses, PRORESA should investigate the claims of *promotoras* that they incur expenses that are not covered. Although efforts should be made to prevent *promotoras* from charging for transportation where that is already paid, if they are incurring costs for other necessary tasks, these should be covered by whatever institution is requesting the work. Policy should be clarified and communicated effectively regarding whether *promotoras* should or should not be asked to travel to assist with paperwork. |

<p>| (6) <strong>Pressures on <em>promotoras</em></strong>: <em>Promotoras</em> have to absorb the frustrations of people in their communities. They face pressure from beneficiaries when things do not go as expected, for example if transfers are late or are less than expected. They are also sometimes blamed for non-beneficiary exclusion from the program. Pressure, criticism and social tensions between <em>promotoras</em> and beneficiaries or non-beneficiaries makes it more difficult for them to perform their work, which could have adverse effects on their performance and thus that of the program. <em>Promotoras</em> ask that PROGRESA help them by putting more effort into explaining to beneficiaries the reasons for these problems beneficiaries have and that <em>promotoras</em> are not responsible in these areas. This underscores the importance of clear communication with communities regarding how PROGRESA works and relative roles and responsibilities. This could occur through occasional visits by PROGRESA officials to <em>promotora</em> monthly meetings. PRORESA should |  |</p>
<table>
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<th>Key Findings</th>
<th>Implications For Program Impact</th>
<th>Implications For Policy</th>
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<td>(7) Training for <em>promotoras</em>: Although <em>promotoras</em> are well trained enough to receive very good evaluations from beneficiaries and doctors in terms of how they perform their jobs, <em>promotoras</em> and doctors both say that <em>promotoras</em> need more training then they currently receive. <em>Promotoras</em> in some areas exhibit a lack of understanding of how the program works or do not have updated information. The two main areas for which <em>promotoras</em> and doctors suggest more <em>promotora</em> training is in health care and dealing with people. They are sometimes asked to carry out tasks for which they are not trained nor responsible, such as the health pláticas.</td>
<td>Given how crucial the role of the <em>promotora</em> is and the extent to which the program and beneficiaries depend on her for transferring good information and other assistance, insufficiently trained <em>promotoras</em> can have adverse effects on the beneficiaries’ ability to benefit from the program in terms of the cash transfers, health, nutrition and education.</td>
<td>The program should consider extending the period of training currently given to <em>promotoras</em>, and consider how to strengthen the training to respond to needs identified. The program should ensure that trainers use forms of pedagogy that encourage more participation and indicate whether <em>promotoras</em> have absorbed the material. It is also important that <em>promotoras</em> receive updated information in a timely manner, and that they are able to explain to beneficiaries the reasons for delayed or deducted payments. Additional health training for <em>promotoras</em> could be helpful in enabling them to answer questions of beneficiaries related to what they learn in the pláticas, but PROGRESA should clarify in communities that <em>promotoras</em> should not be giving health pláticas which are not their responsibility. The clinics should have sufficient staff to carry out these duties. In general, the program should ensure that <em>promotoras</em> are fulfilling only the roles for which they are qualified.</td>
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<td>Faenas</td>
<td>Same as (2) below.</td>
<td>Same as (2) below.</td>
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<td>(1) Most PROGRESA and poor non-PROGRESA communities have faenas, where men and/or women come together for communal work that benefits the community, and most people are said to participate. Faenas are not part of PROGRESA operations and are not formally associated with the program. Quantitative results suggest that PROGRESA has not increased the number of faenas or women-only (i.e., PROGRESA beneficiary) faenas. However, focus groups and interviews with doctors and teachers indicate ways in which faenas and the program are being associated, with doctors seeing them as a means of</td>
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<td>Key Findings</td>
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<td>getting people to participate in needed communal work. Although this form of reciprocity was not intended by PROGRESA, the opinion of the doctors is that there are good reasons for requiring these obligations.</td>
<td>Doctors interviewed are strong advocates of faenas. They feel that one of the basic components of PROGRESA that has a major impact on health is hygiene, and where beneficiaries participate in faenas that improve the environment and sanitation, the faenas can enhance the health impact of the program. In increasing time and energy burdens on beneficiaries, they reduce the net impact of the program though probably by a small degree. However, if non-beneficiaries do not participate, this can have negative social impacts on the community.</td>
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<td>(2) There are positive and negative dimensions to faenas. They produce important environmental, health, aesthetic, and social benefits for communities. However, they increase time and energy demands on beneficiaries. Also, in some communities non-beneficiaries do not want to participate in faenas because they do not get PROGRESA benefits. However, in other communities, non-beneficiaries do participate because the work is not associated with the program, they are convinced the work is important or because they hope that by participating they will get included in the program.</td>
<td>The list of benefits that doctors believe are derived from beneficiary participation in faenas should be taken into consideration in PROGRESA’s decision to either try to discourage this practice, or allow it to continue at the discretion of the doctor, school director or promotora. However, the question of non-beneficiary participation should be solved if this practice continues. Linking participation in faenas to PROGRESA benefits may be a good way of introducing elements of self-targeting to the program, and for reinforcing the responsibilities of beneficiaries. These might be distinguished as PROGRESA activities, so as not to interfere with regular community faenas in which beneficiaries and non-beneficiaries participate together.</td>
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REFERENCES


CHAPTER 1 — TABLES
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<tr>
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<th>Indicator</th>
<th>Inputs</th>
<th>Process Assessment</th>
<th>Indicator</th>
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<td><strong>Education</strong></td>
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<td>(Improve quantity and</td>
<td>Improved attendance</td>
<td>Dropout/Re-entry levels</td>
<td>Grants for attendance</td>
<td>Take-up of grants</td>
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<td>quality of education</td>
<td>Increase years</td>
<td>Attendance levels</td>
<td>Money for materials</td>
<td>Receipt/use of money</td>
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<td>for children and youths)</td>
<td>Cognitive achievement</td>
<td>Years of education</td>
<td>Performance incentives</td>
<td>Loss of grant</td>
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<td>Test scores</td>
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<td>Improving educational services</td>
<td>Improved school capacity,</td>
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<td>Pre-school education</td>
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<td>infrastructure, equipment;</td>
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<td>Parents’ participation</td>
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<td>student/staff ratios; staff</td>
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<td>performance of adult</td>
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<td>education programs</td>
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<td>Component (Objective)</td>
<td>Impact Assessment</td>
<td>Process Assessment</td>
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<td><strong>Health</strong> (To expand and improve coverage of primary-care services)</td>
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<td>Incidence of premature mortality</td>
<td>Maternal and infant mortality</td>
<td>Improved health services which increase quality and use of public-health resources (including timetables for visits, reduced waiting times, appointment calendars, better opening hours, vaccinations)</td>
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<td>Incidence and duration of excess morbidity symptoms, days lost, physical limitations (respondent reported)</td>
<td>Incidence and treatment of diarrhea, respiratory illnesses, tuberculosis, infectious disease, contagious disease, intestinal disease, sexually transmitted disease, cervicouterine cancer, blood-pressure, diabetes, hearing, sight</td>
<td>Medicine and materials supplies</td>
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<td>Improved household and community preventative care</td>
<td>Vaccinations, anti-parasite treatment, health visits, injuries and first-aid, improved hygiene, self treatment, family planning</td>
<td>Integration with second- and third-level health care</td>
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<td>Parents’ participation</td>
<td>Awareness of role and design</td>
<td>Improved health services (public and private) Health-care visits Education and training especially for pregnant and nursing mothers with small children</td>
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<td>Number and quality of drugs and equipment Health-care-worker/patient ratios</td>
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<td>Attitudes/work habits of health-care-workers Health-care records</td>
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<td>Development and performance of adult education programs</td>
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Table 1.1 continued
Program Objective: Improve Education, Health and Nutrition Status of Poor Households (Especially Females and Children).
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<tr>
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<th>Output</th>
<th>Indicator</th>
<th>Inputs</th>
<th>Indicator</th>
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<tr>
<td><strong>Nutrition</strong> (Improve nutritional status)</td>
<td>Incidence of malnutrition</td>
<td>Child malnutrition&lt;br&gt;Child height, age and weight&lt;br&gt;Food, nutrient and calorie consumption (level and composition)&lt;br&gt;Maternal anthropometry (?)</td>
<td>Nutrition supplements for pregnant and lactating women and young children&lt;br&gt;Finger-prick tests (?)&lt;br&gt;Food grants&lt;br&gt;Education and training</td>
<td>Receipt of supplements, grants and quality training&lt;br&gt;Take-up of supplements and grants&lt;br&gt;Follow-up procedures</td>
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<tr>
<td>Treatment of malnutrition</td>
<td>Prevention of malnutrition</td>
<td>Awareness of role and design</td>
<td>Adult education programs related to PROGRESA</td>
<td>Development and performance of adult education programs</td>
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<tr>
<td>Parents’ participation</td>
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Table 1.1 continued

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<th>Component (Objective)</th>
<th>Output</th>
<th>Indicator</th>
<th>Inputs</th>
<th>Process Assessment</th>
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<tbody>
<tr>
<td><strong>Other</strong></td>
<td>Women empowerment and participation</td>
<td>Improved education, health and nutrition; stated ability to take decisions; activity responsibility; gender attitudes; actual control of resources; higher status within household and community</td>
<td>All aspects of human capital for mothers and daughters</td>
<td>As above</td>
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<tr>
<td>Household Welfare</td>
<td>Family education, health and nutrition status; household consumption, durables and savings</td>
<td>Adult education programs related to PROGRESA</td>
<td>Development and performance of adult education programs</td>
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<tr>
<td>Community Participation</td>
<td>Community awareness, facilitation and attitudes (transport, bribes, theft etc.) Requests for case review</td>
<td>Community meetings Community adjustment of criteria and beneficiaries</td>
<td>Community outreach worker, training and process</td>
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<tr>
<td>Integration with other community and state programs</td>
<td>Existence and use of other programs, substitutes or complements</td>
<td>Information on and existence of other programs</td>
<td>Awareness and existence of other programs</td>
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<tr>
<td>Targeting (poor, facilities)</td>
<td>Errors of exclusion and inclusion relative to other targeting mechanisms</td>
<td>Data collection and analysis; community input</td>
<td>Implications of analysis for design</td>
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<td>Incentives</td>
<td>Take-up of benefits; use of services; expenditure allocations; program attrition</td>
<td>Limits on grants; schooling years targeted; integration with other programs</td>
<td>Appropriate benefit levels received; attrition over time; nature of other programs</td>
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Table 1.2 — Number of Schools Included in the Respective Surveys, by Type of Community and Type of School

A. 1997 Survey

<table>
<thead>
<tr>
<th>Type of School</th>
<th>PROGRESA</th>
<th>Control</th>
<th>Total</th>
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<tbody>
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<td>132</td>
<td>363</td>
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<tr>
<td>Secondary</td>
<td>41</td>
<td>23</td>
<td>64</td>
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<td>Total</td>
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B. 1998 Survey

<table>
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<tr>
<th>Type of School</th>
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<th>Outside Locality, with PROGRESA Beneficiaries</th>
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<td>Primary</td>
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C. 1999 Survey

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<th>Total</th>
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Table 1.3 — Communities and Persons Interviewed In Schools

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<th>STATE</th>
<th>COMMUNITIES</th>
<th>Mestizo/Indigenous</th>
<th>Telesecundaria (TV)/Technical</th>
<th>Secondary School Director Interviewed</th>
<th>Primary School Director Interviewed</th>
<th>Doctor Interviewed</th>
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<tbody>
<tr>
<td>Hidalgo</td>
<td>Atzolcintla</td>
<td>M</td>
<td>TV</td>
<td>•</td>
<td></td>
<td>•</td>
</tr>
<tr>
<td></td>
<td>Orizabita</td>
<td>M</td>
<td>Tec</td>
<td>•</td>
<td></td>
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</tr>
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<td>Palo Perdido</td>
<td>M</td>
<td>TV</td>
<td>•</td>
<td></td>
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<td>I</td>
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<td>Beneficiaries and Non-Beneficiaries Came From the Following 8 Communities:</td>
<td>Promotoras Came from 70 Communities Surrounding:</td>
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<td>-------------------------------------------------</td>
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<td>Zitácuaro, Michoacán</td>
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<td>Huejutla, Hidalgo</td>
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<td>Cadereyta, Querétero</td>
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<td>Chilapa, Guerrero</td>
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<td>San Ildefonso, Estado de México</td>
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CHAPTER 2 — TABLE
Table 2.1 — Summary of Program Induction Variables (%)

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<th></th>
<th>All States</th>
<th>Guerrero</th>
<th>Hidalgo</th>
<th>Michoacán</th>
<th>Puebla</th>
<th>Querétero</th>
<th>San Luis</th>
<th>VeraCruz</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Never had induction booklet</td>
<td>1.37</td>
<td>1.42</td>
<td>1.45</td>
<td>2.11</td>
<td>1.75</td>
<td>0.32</td>
<td>0.29</td>
<td>1.46</td>
</tr>
<tr>
<td>(2) Booklet read or explained</td>
<td>97.0</td>
<td>93.9</td>
<td>97.9</td>
<td>99.0</td>
<td>98.6</td>
<td>97.3</td>
<td>98.8</td>
<td>97.2</td>
</tr>
<tr>
<td>(3) Explanation (very) clear</td>
<td>87.0</td>
<td>75.3</td>
<td>91.4</td>
<td>92.4</td>
<td>91.6</td>
<td>80.2</td>
<td>91.3</td>
<td>92.8</td>
</tr>
<tr>
<td>(4) Excellent knowledge</td>
<td>54.4</td>
<td>40.6</td>
<td>54.2</td>
<td>48.1</td>
<td>57.8</td>
<td>42.6</td>
<td>37.7</td>
<td>57.8</td>
</tr>
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</table>

Note: All numbers relate to the June 1999 survey, except (3) which relates to the October 1998 survey.
CHAPTER 3 — TABLES
Table 3.1— Monthly Amount of Educational Grant (Pesos)

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<tr>
<th>Grade</th>
<th>Boys</th>
<th>Girls</th>
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<tr>
<td>3rd year</td>
<td>60</td>
<td>60</td>
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<tr>
<td>5th year</td>
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<td>90</td>
</tr>
<tr>
<td>6th year</td>
<td>120</td>
<td>120</td>
</tr>
<tr>
<td>Secondary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1st year</td>
<td>175</td>
<td>185</td>
</tr>
<tr>
<td>2nd year</td>
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<tr>
<td>3rd year</td>
<td>195</td>
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</tbody>
</table>

Note: The standard age for primary school entry (1st year) is 5-6 years, so that primary school children are usually in the age group 6-12 years and secondary-school children in the age group 13-18 years. The grant levels are those that existed at the beginning of the program, i.e. in July-December 1997. These are increased in line with inflation every six months.
Table 3.2—Summary of Education Variables (%)

<table>
<thead>
<tr>
<th></th>
<th>All States</th>
<th>Guerrero</th>
<th>Hidalgo</th>
<th>Michoacán</th>
<th>Puebla</th>
<th>Querétaro</th>
<th>San Luis</th>
<th>Veracruz</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Not receive E1 forms (S3)</td>
<td>6.20</td>
<td>7.81</td>
<td>4.67</td>
<td>5.29</td>
<td>5.98</td>
<td>16.8</td>
<td>3.50</td>
<td>2.93</td>
</tr>
<tr>
<td>(2) Not receive E1 forms (S4)</td>
<td>3.66</td>
<td>7.50</td>
<td>3.33</td>
<td>2.08</td>
<td>5.32</td>
<td>6.41</td>
<td>3.40</td>
<td>2.44</td>
</tr>
<tr>
<td>(3) Registration with E1 (S3)</td>
<td>81.3</td>
<td>76.7</td>
<td>82.7</td>
<td>81.9</td>
<td>83.3</td>
<td>61.2</td>
<td>85.6</td>
<td>81.8</td>
</tr>
<tr>
<td>(4) Registration with E1 (S4)</td>
<td>77.6</td>
<td>81.3</td>
<td>78.3</td>
<td>83.2</td>
<td>73.5</td>
<td>82.2</td>
<td>79.0</td>
<td>77.1</td>
</tr>
<tr>
<td>(5) Charged at registration (S3)</td>
<td>4.97</td>
<td>4.27</td>
<td>4.43</td>
<td>4.48</td>
<td>3.52</td>
<td>6.71</td>
<td>4.74</td>
<td>4.68</td>
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<tr>
<td>(6) Charged at registration (S4)</td>
<td>5.49</td>
<td>7.31</td>
<td>4.70</td>
<td>5.15</td>
<td>6.23</td>
<td>3.50</td>
<td>6.53</td>
<td>4.79</td>
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<tr>
<td>(7) Problems at registration (S4)</td>
<td>1.38</td>
<td>1.17</td>
<td>1.84</td>
<td>1.17</td>
<td>2.02</td>
<td>0.70</td>
<td>1.24</td>
<td>0.97</td>
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<tr>
<td>(8) Not receiving grants (S4)</td>
<td>26.2</td>
<td>38.6</td>
<td>25.8</td>
<td>18.7</td>
<td>30.3</td>
<td>24.9</td>
<td>23.3</td>
<td>24.0</td>
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<tr>
<td>(9) Grants “not given” (S4)</td>
<td>11.6</td>
<td>12.9</td>
<td>10.3</td>
<td>11.3</td>
<td>14.1</td>
<td>7.2</td>
<td>12.0</td>
<td>10.9</td>
</tr>
<tr>
<td>(10) Receive school supplies (S4)</td>
<td>60.0</td>
<td>51.1</td>
<td>65.9</td>
<td>69.1</td>
<td>48.0</td>
<td>67.0</td>
<td>60.6</td>
<td>61.2</td>
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</table>
Table 3.3 — Enrollment Rates By Age and State (1998)

<table>
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<th>Age (Years)</th>
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<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>State</td>
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<td></td>
<td></td>
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</tr>
<tr>
<td>1</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
<td>0.99</td>
<td>0.97</td>
<td>0.95</td>
<td>0.82</td>
<td>0.81</td>
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<td>1.00</td>
<td>1.00</td>
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<td>0.97</td>
<td>0.94</td>
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<td>0.94</td>
<td>0.78</td>
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<td>0.47</td>
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<td>0.98</td>
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<td>0.98</td>
<td>0.85</td>
<td>0.68</td>
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<td>1.00</td>
<td>0.99</td>
<td>0.99</td>
<td>0.92</td>
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<td>1.00</td>
<td>1.00</td>
<td>1.00</td>
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<td>0.92</td>
<td>0.90</td>
<td>0.82</td>
<td>0.64</td>
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</table>

Total 1.00 0.99 0.99 1.00 0.99 0.98 0.83 0.74 0.53 0.38 0.88

Table 3.4 — Enrollment Rates By Age and State (1999)

<table>
<thead>
<tr>
<th>State</th>
<th>6</th>
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<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>Total</th>
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<td>0.99</td>
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<td>0.93</td>
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<td>0.57</td>
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<td>0.76</td>
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<td>0.98</td>
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<td>0.87</td>
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<td>0.70</td>
<td>0.55</td>
<td>0.91</td>
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</tbody>
</table>

Total 0.92 0.97 0.98 0.98 0.98 0.97 0.94 0.87 0.76 0.63 0.45 0.88

Table 3.5 — Adequate Attendance Rates By Age and State (1998)

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
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<tbody>
<tr>
<td>State</td>
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<td></td>
<td></td>
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<td></td>
<td></td>
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</tr>
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<td>1</td>
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<td>0.96</td>
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<td>1.00</td>
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</tr>
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</table>

Total 0.97 0.98 0.97 0.98 0.98 0.97 0.98 0.98 0.98 0.99 0.98 0.97
Table 3.6 — Attendance Rates By Age and State (1999)

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>Total</th>
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<tbody>
<tr>
<td>State</td>
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<td>0.97</td>
<td>0.99</td>
<td>0.99</td>
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<td>0.98</td>
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<td>0.70</td>
<td>0.71</td>
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<td>0.98</td>
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<tr>
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<td>0.88</td>
<td>0.90</td>
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<td>0.89</td>
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<td>0.88</td>
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Table 3.7— Effect of E1 Form on Education Outcomes

<table>
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<tr>
<th></th>
<th>1998</th>
<th>1999</th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>All</td>
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<td>Secondary</td>
<td>All</td>
<td>Primary</td>
<td>Secondary</td>
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</tr>
<tr>
<td>Enrollment</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>State dummies</td>
<td>0.064**</td>
<td>0.006</td>
<td>0.268**</td>
<td>0.154**</td>
<td>0.071**</td>
<td>0.341**</td>
<td></td>
</tr>
<tr>
<td>Locality dummies</td>
<td>0.045**</td>
<td>0.005</td>
<td>0.335**</td>
<td>0.125**</td>
<td>0.082**</td>
<td>0.357**</td>
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</tr>
<tr>
<td>Locality/household variables</td>
<td>0.042**</td>
<td>0.005</td>
<td>0.334**</td>
<td>0.119**</td>
<td>0.076**</td>
<td>0.345**</td>
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</tr>
<tr>
<td>Attendance levels</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>State dummies</td>
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<td>0.309</td>
<td>0.198</td>
<td>0.071</td>
<td>0.125</td>
<td>0.092</td>
<td></td>
</tr>
<tr>
<td>Locality dummies</td>
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<td>0.284</td>
<td>0.245</td>
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<tr>
<td>Locality/ household variables</td>
<td>0.071</td>
<td>0.133</td>
<td>0.136</td>
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<td>0.206</td>
<td>0.251</td>
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<tr>
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<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>State dummies</td>
<td>0.038**</td>
<td>0.034**</td>
<td>0.074**</td>
<td>0.026</td>
<td>0.022</td>
<td>0.034</td>
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</tr>
<tr>
<td>Locality dummies</td>
<td>0.079**</td>
<td>0.077**</td>
<td>0.292**</td>
<td>0.063**</td>
<td>0.068*</td>
<td>0.035</td>
<td></td>
</tr>
<tr>
<td>Locality/ household variables</td>
<td>0.077**</td>
<td>0.076**</td>
<td>0.261**</td>
<td>0.065**</td>
<td>0.072*</td>
<td>0.063</td>
<td></td>
</tr>
</tbody>
</table>

Note: Reported coefficients represent the percentage point impact of not having received the E1 registration form. All regression include individual age and gender dummies. Introducing locality dummies results in those localities with 100% enrollment and adequate attendance rates being dropped from the sample, so that the coefficients reflect the potential program impact only in those localities with less than 100% enrollment and attendance rates.
### Table 3.8 — Changes in Primary School Enrollment Between 1997 and 1998

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>1997 (n=363)</th>
<th>1998 (n=323)</th>
<th>1999 (n=287)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% schools where enrollment:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Increased</td>
<td>38.3%</td>
<td>40.8%</td>
<td>38.1%</td>
</tr>
<tr>
<td>• Decreased</td>
<td>40.7%</td>
<td>38.3%</td>
<td>43.0%</td>
</tr>
<tr>
<td>• Remained the same</td>
<td>21.0%</td>
<td>20.9%</td>
<td>18.9%</td>
</tr>
</tbody>
</table>

Among those who said that it had increased, what was the % increase in number of students?
- **PROGRESA**
  - N/A | 13% | 12% |
- **Control**
  - 5% | 12% |
- **Outside communities**
  - 40% | 4% |

Among those who said that it had decreased, what was the % decrease in number of students?
- **PROGRESA**
  - N/A | 8% | 12.7% |
- **Control**
  - 7% | 10.3% |
- **Outside communities**
  - 4% | 10.7% |

% school directors who said that continued rise in enrollment will cause problems of lack of:
- **Classrooms**
  - N/A | 54.3% | 57.0% |
- **Teachers**
  - 69.2% | 68.0% |
- **Furniture**
  - 66.9% | 68.0% |
- **Supplies**
  - 49.2% | 34.0% |
- **No problem**
  - 3.4% | 8.0% |
Table 3.9 — Changes in School Enrollment Between 1997 and 1998

<table>
<thead>
<tr>
<th>Enrollment</th>
<th>1997 (n=64)</th>
<th>1998 (n=158)</th>
<th>1999 (n=144)</th>
</tr>
</thead>
<tbody>
<tr>
<td>% schools where enrollment:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Increased</td>
<td>75.6%</td>
<td>82.7%</td>
<td>64.8%</td>
</tr>
<tr>
<td>• Decreased</td>
<td>14.6%</td>
<td>10.0%</td>
<td>22.8%</td>
</tr>
<tr>
<td>• Remained the same</td>
<td>9.8%</td>
<td>7.3%</td>
<td>12.4%</td>
</tr>
</tbody>
</table>

Among those who said that it had increased, what was the % increase in number of students?
• PROGRESA N/A 70.0% 20.8%
• Control 10.0% 24.2%
• Outside communities 29.0% 14.4%

Among those who said that it had decreased, what was the % decrease in number of students?
• PROGRESA N/A 9.5% 11.0%
• Control 9.3% 10.4%
• Outside communities 22.2% 27.1%

% school directors who said that continued rise in enrollment will cause problems of lack of:
• Classrooms N/A 76.9% 80.6%
• Teachers 71.1% 72.0%
• Furniture 80.7% 83.9%
• Supplies 76.3% 71.0%
### Table 3.10 — Days Missed In Last Month (1998)

<table>
<thead>
<tr>
<th>Age (Years)</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>State 1</td>
<td>0.63</td>
<td>0.51</td>
<td>0.39</td>
<td>0.55</td>
<td>0.25</td>
<td>0.59</td>
<td>1.33</td>
<td>1.71</td>
<td>0.40</td>
<td>0.24</td>
<td>0.74</td>
<td>0.66</td>
</tr>
<tr>
<td>State 2</td>
<td>1.20</td>
<td>1.30</td>
<td>1.34</td>
<td>0.57</td>
<td>1.31</td>
<td>1.04</td>
<td>1.98</td>
<td>0.73</td>
<td>0.24</td>
<td>0.09</td>
<td>0.07</td>
<td>1.04</td>
</tr>
<tr>
<td>State 3</td>
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<td>1.05</td>
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<td>1.78</td>
<td>0.06</td>
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<td>2.32</td>
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<td>1.37</td>
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<td>0.14</td>
<td>0.23</td>
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<td>0.68</td>
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</table>

Note:

### Table 3.11 — Days Missed In Last Month (1999)

<table>
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<tr>
<th>Age (Years)</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>State 1</td>
<td>8.58</td>
<td>10.14</td>
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<td>8.86</td>
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<td>10.91</td>
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<td>9.47</td>
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<td>0.44</td>
<td>0.17</td>
<td>0.67</td>
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<td>0.82</td>
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<td>3.12</td>
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<td>4.53</td>
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<td>6.12</td>
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<td>5.60</td>
<td>5.42</td>
<td>5.07</td>
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<td>0.54</td>
<td>0.30</td>
<td>1.54</td>
<td>0.16</td>
<td>8.74</td>
<td>0.71</td>
</tr>
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<td>0.08</td>
<td>0.15</td>
<td>0.26</td>
<td>0.12</td>
<td>3.12</td>
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<td>0.61</td>
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<td>0.93</td>
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<td>1.08</td>
<td>0.87</td>
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<td>0.73</td>
<td>0.36</td>
<td>0.30</td>
<td>0.09</td>
<td>0.10</td>
<td>0.54</td>
<td>3.12</td>
<td>0.97</td>
<td>0.52</td>
</tr>
<tr>
<td>Total</td>
<td>2.30</td>
<td>2.06</td>
<td>1.76</td>
<td>2.23</td>
<td>1.96</td>
<td>1.70</td>
<td>2.28</td>
<td>2.01</td>
<td>2.25</td>
<td>2.77</td>
<td>3.67</td>
<td>2.14</td>
</tr>
</tbody>
</table>
### Table 3.12 — Summary of Education Supply Side Variables (1999, %)

<table>
<thead>
<tr>
<th>Improvements In:</th>
<th>All States</th>
<th>Guerrero</th>
<th>Hidalgo</th>
<th>Michoacán</th>
<th>Puebla</th>
<th>Queretéro</th>
<th>San Luis</th>
<th>Veracruz</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) School Services</td>
<td>66.5</td>
<td>56.0</td>
<td>68.1</td>
<td>66.2</td>
<td>78.1</td>
<td>60.0</td>
<td>69.6</td>
<td>60.8</td>
</tr>
<tr>
<td>(2) Teachers Attendance</td>
<td>62.1</td>
<td>41.0</td>
<td>71.4</td>
<td>54.5</td>
<td>73.3</td>
<td>61.7</td>
<td>63.2</td>
<td>59.1</td>
</tr>
<tr>
<td>(3) Quality of School Services</td>
<td>62.4</td>
<td>48.8</td>
<td>70.0</td>
<td>57.8</td>
<td>66.5</td>
<td>69.1</td>
<td>63.7</td>
<td>59.7</td>
</tr>
<tr>
<td>(4) School Facilities</td>
<td>50.6</td>
<td>38.9</td>
<td>59.6</td>
<td>48.3</td>
<td>51.4</td>
<td>51.5</td>
<td>50.1</td>
<td>48.6</td>
</tr>
<tr>
<td>(5) School Resources</td>
<td>48.9</td>
<td>34.8</td>
<td>55.9</td>
<td>45.4</td>
<td>51.4</td>
<td>54.4</td>
<td>50.3</td>
<td>46.5</td>
</tr>
<tr>
<td>(6) No. of Children Per Class</td>
<td>56.6</td>
<td>57.2</td>
<td>60.6</td>
<td>53.1</td>
<td>59.1</td>
<td>53.7</td>
<td>56.4</td>
<td>53.8</td>
</tr>
<tr>
<td>(7) School Management</td>
<td>52.5</td>
<td>45.4</td>
<td>57.3</td>
<td>45.9</td>
<td>55.9</td>
<td>57.9</td>
<td>55.0</td>
<td>50.6</td>
</tr>
<tr>
<td>(8) Care To Children in School</td>
<td>60.4</td>
<td>50.3</td>
<td>67.2</td>
<td>59.3</td>
<td>62.2</td>
<td>64.6</td>
<td>60.9</td>
<td>57.4</td>
</tr>
</tbody>
</table>
Table 3.13 — The Supply Side: Infrastructure, Installations, Conditions of Primary Schools 1998-1999

A. Conditions of the Schools

<table>
<thead>
<tr>
<th>Conditions of School</th>
<th>1998 (n=323)</th>
<th>1999 (n=287)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opinion of school director about conditions of school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Good</td>
<td>21.8%</td>
<td>22.5%</td>
</tr>
<tr>
<td>• Regular</td>
<td>72.8%</td>
<td>64.5%</td>
</tr>
<tr>
<td>• Bad</td>
<td>5.4%</td>
<td>10.2%</td>
</tr>
</tbody>
</table>

B. Repairs Done in Previous Year

<table>
<thead>
<tr>
<th>Repairs/Improvements</th>
<th>1999 (n=287)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were any repairs or improvements made to the school in previous year? (YES)</td>
<td>N/A 75.3%</td>
</tr>
<tr>
<td>Types of repairs done in previous year</td>
<td></td>
</tr>
<tr>
<td>• Construction</td>
<td>30.0%</td>
</tr>
<tr>
<td>• Painting</td>
<td>62.4%</td>
</tr>
<tr>
<td>• New classrooms</td>
<td>9.0%</td>
</tr>
<tr>
<td>• Sport fields</td>
<td>9.0%</td>
</tr>
<tr>
<td>• New services (water, electricity, latrines)</td>
<td>25.0%</td>
</tr>
<tr>
<td>• Furniture/equipment repairs</td>
<td>22.0%</td>
</tr>
<tr>
<td>• New furniture/equipment</td>
<td>11.0%</td>
</tr>
</tbody>
</table>

C. Equipment and Supplies Acquired During the 1998-1999 School Year (% Schools which Received the Items Last Year), by Type of Community

<table>
<thead>
<tr>
<th>Equipment/Supplies</th>
<th>PROGRESA Communities (n=205)</th>
<th>Control Communities (n=68)</th>
<th>Outside Communities with PROGRESA Beneficiaries (n=14)</th>
<th>Overall (n=287)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geometry sets</td>
<td>38.5%</td>
<td>28.6%</td>
<td>25.0%</td>
<td>35.4%</td>
</tr>
<tr>
<td>Slide or overhead projector</td>
<td>2.2%</td>
<td>4.8%</td>
<td>0</td>
<td>2.6%</td>
</tr>
<tr>
<td>Maps</td>
<td>21.5%</td>
<td>31.0%</td>
<td>33.3%</td>
<td>24.3%</td>
</tr>
<tr>
<td>Blackboards</td>
<td>9.6%</td>
<td>21.4%</td>
<td>33.3%</td>
<td>13.8%*</td>
</tr>
<tr>
<td>Television</td>
<td>1.5%</td>
<td>0%</td>
<td>8.3%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Videotape recorder</td>
<td>0%</td>
<td>0%</td>
<td>8.3%</td>
<td>0.5%*</td>
</tr>
<tr>
<td>Computers</td>
<td>0.7%</td>
<td>2.4%</td>
<td>25.0%</td>
<td>2.6%*</td>
</tr>
<tr>
<td>Lab equipment</td>
<td>2.2%</td>
<td>0%</td>
<td>0%</td>
<td>1.6%</td>
</tr>
<tr>
<td>Encyclopedias, dictionaries</td>
<td>9.6%</td>
<td>16.7%</td>
<td>25.0%</td>
<td>12.2%</td>
</tr>
<tr>
<td>Books</td>
<td>9.6%</td>
<td>16.7%</td>
<td>16.7%</td>
<td>11.6%</td>
</tr>
</tbody>
</table>

* Indicates statistically significant difference between the three groups (Chi-Square test; p< 0.05).
D. Overall Improvements, Support Received by the School since PROGRESA Initiated, by Type of Community

<table>
<thead>
<tr>
<th>Equipment/Supplies</th>
<th>PROGRESA Communities (n=205)</th>
<th>Control Communities (n=68)</th>
<th>Outside Communities with PROGRESA Beneficiaries (n=14)</th>
<th>Overall (n=287)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did overall conditions of school improve since PROGRESA started (YES)</td>
<td>54.9%</td>
<td>63.9%</td>
<td>50.0%</td>
<td>56.0%</td>
</tr>
<tr>
<td>What types of improvements or support did your school receive?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Water installed</td>
<td>17.2%</td>
<td>31.8%</td>
<td>33.3%</td>
<td>19.9%</td>
</tr>
<tr>
<td>• Latrines built</td>
<td>42.1%</td>
<td>36.4%</td>
<td>57.1%</td>
<td>42.0%</td>
</tr>
<tr>
<td>• New classrooms</td>
<td>19.7%</td>
<td>23.1%</td>
<td>-</td>
<td>19.5%</td>
</tr>
<tr>
<td>• Electricity</td>
<td>32.1%</td>
<td>41.7%</td>
<td>20.0%</td>
<td>33.1%</td>
</tr>
<tr>
<td>• Floor/walls improvements</td>
<td>26.7%</td>
<td>21.7%</td>
<td>42.9%</td>
<td>28.7%</td>
</tr>
<tr>
<td>• New furniture or equipment</td>
<td>25.0%</td>
<td>3.7%</td>
<td>16.7%</td>
<td>22.3%</td>
</tr>
<tr>
<td>• Didactic material</td>
<td>56.4%</td>
<td>60.0%</td>
<td>66.7%</td>
<td>57.4%</td>
</tr>
<tr>
<td>• More teachers</td>
<td>8.8%</td>
<td>9.1%</td>
<td>14.3%</td>
<td>9.1%</td>
</tr>
<tr>
<td>• More stimuli for teachers</td>
<td>31.1%</td>
<td>32.0%</td>
<td>0.0%</td>
<td>30.2%</td>
</tr>
</tbody>
</table>
### Table 3.14 — The Supply Side: Infrastructure, Installations, Conditions of the Schools, 1998-1999

#### A. Conditions of the Schools

<table>
<thead>
<tr>
<th>Conditions of School</th>
<th>1998 (n=158)</th>
<th>1999 (n=144)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Opinion of school director about conditions of school</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Good</td>
<td>24.0%</td>
<td>31.5%</td>
</tr>
<tr>
<td>• Regular</td>
<td>59.7%</td>
<td>54.1%</td>
</tr>
<tr>
<td>• Bad</td>
<td>16.2%</td>
<td>9.6%</td>
</tr>
</tbody>
</table>

#### B. Repairs Done in Previous Year

<table>
<thead>
<tr>
<th>Repairs/Improvements</th>
<th>1999 (n=144)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Were any repairs or improvements made to the school in previous year? (YES)</td>
<td>N/A</td>
</tr>
<tr>
<td>Types of repairs done in previous year</td>
<td></td>
</tr>
<tr>
<td>• Construction</td>
<td>27.7%</td>
</tr>
<tr>
<td>• Painting</td>
<td>57.4%</td>
</tr>
<tr>
<td>• New classrooms</td>
<td>37.6%</td>
</tr>
<tr>
<td>• Sport fields</td>
<td>6.9%</td>
</tr>
<tr>
<td>• New services (water, electricity, latrines)</td>
<td>29.7%</td>
</tr>
<tr>
<td>• Furniture/equipment repairs</td>
<td>18.8%</td>
</tr>
<tr>
<td>• New furniture/equipment</td>
<td>18.8%</td>
</tr>
</tbody>
</table>
C. Equipment and Supplies Acquired During the 1998-1999 School Year (% Schools which Received the Items Last Year), by Type of Community

<table>
<thead>
<tr>
<th>Equipment/Supplies</th>
<th>PROGRESA Communities (n=45)</th>
<th>Control Communities (n=9)</th>
<th>Outside Communities with PROGRESA Beneficiaries (n=90)</th>
<th>Overall (n=144)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geometry sets</td>
<td>11.5%</td>
<td>0</td>
<td>25.6%</td>
<td>19.6%</td>
</tr>
<tr>
<td>Slide or overhead projector</td>
<td>0.0%</td>
<td>0</td>
<td>4.7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Maps</td>
<td>23.1%</td>
<td>0</td>
<td>9.3%</td>
<td>13.7%</td>
</tr>
<tr>
<td>Blackboards</td>
<td>34.6%</td>
<td>0</td>
<td>32.6%</td>
<td>31.5%</td>
</tr>
<tr>
<td>Television</td>
<td>42.3%</td>
<td>50.0%</td>
<td>16.3%</td>
<td>27.4%</td>
</tr>
<tr>
<td>Videotape recorder</td>
<td>7.7%</td>
<td>0</td>
<td>11.6%</td>
<td>9.6%</td>
</tr>
<tr>
<td>Computers</td>
<td>0.0%</td>
<td>0</td>
<td>4.7%</td>
<td>2.7%</td>
</tr>
<tr>
<td>Lab equipment</td>
<td>19.2%</td>
<td>0</td>
<td>9.3%</td>
<td>12.3%</td>
</tr>
<tr>
<td>Encyclopedias, dictionaries</td>
<td>7.7%</td>
<td>0</td>
<td>2.3%</td>
<td>4.1%</td>
</tr>
<tr>
<td>Books</td>
<td>7.7%</td>
<td>0</td>
<td>9.3%</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

D. Overall Improvements, Support Received by the School Since PROGRESA Initiated, by Type of Community

<table>
<thead>
<tr>
<th>Equipment/Supplies</th>
<th>PROGRESA Communities (n=45)</th>
<th>Control Communities (n=9)</th>
<th>Outside Communities with PROGRESA Beneficiaries (n=90)</th>
<th>Overall (n=144)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did overall conditions of school improve since PROGRESA started (YES)</td>
<td>67.4%</td>
<td>44.4%</td>
<td>50.6%</td>
<td>55.6%</td>
</tr>
</tbody>
</table>

What types of improvements or support did your school receive?

<table>
<thead>
<tr>
<th>Improvement</th>
<th>PROGRESA Communities (n=45)</th>
<th>Control Communities (n=9)</th>
<th>Outside Communities with PROGRESA Beneficiaries (n=90)</th>
<th>Overall (n=144)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Water installed</td>
<td>20.6%</td>
<td>0</td>
<td>27.0%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Latrines built</td>
<td>55.9%</td>
<td>0</td>
<td>32.8%</td>
<td>39.0%*</td>
</tr>
<tr>
<td>New classrooms</td>
<td>44.1%</td>
<td>16.7%</td>
<td>37.5%</td>
<td>38.5%</td>
</tr>
<tr>
<td>Electricity</td>
<td>33.3%</td>
<td>0</td>
<td>23.0%</td>
<td>25.3%</td>
</tr>
<tr>
<td>Floor/walls improvements</td>
<td>30.3%</td>
<td>0</td>
<td>21.7%</td>
<td>23.5%</td>
</tr>
<tr>
<td>New furniture or equipment</td>
<td>43.8%</td>
<td>20.0%</td>
<td>30.3%</td>
<td>34.0%</td>
</tr>
<tr>
<td>Didactic material</td>
<td>27.3%</td>
<td>0</td>
<td>14.3%</td>
<td>17.8%</td>
</tr>
<tr>
<td>More teachers</td>
<td>28.6%</td>
<td>0</td>
<td>27.9%</td>
<td>26.7%</td>
</tr>
<tr>
<td>More stimuli for teachers</td>
<td>3.1%</td>
<td>0</td>
<td>1.6%</td>
<td>2.0%</td>
</tr>
</tbody>
</table>
Table 3.15 — Opinions and Perceptions of School Directors about the Impact of PROGRESA on Beneficiary Students and their Families

<table>
<thead>
<tr>
<th>Types of Changes</th>
<th>PROGRESA Communities (n=205)</th>
<th>Control Communities (n=68)</th>
<th>Outside Communities with PROGRESA Beneficiaries (n=14)</th>
<th>Overall (n=287)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beneficiary families are:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Better organized</td>
<td>69.3%</td>
<td>76.7%</td>
<td>66.7%</td>
<td>70.2%</td>
</tr>
<tr>
<td>• Better united</td>
<td>57.5%</td>
<td>71.4%</td>
<td>62.5%</td>
<td>59.7%</td>
</tr>
<tr>
<td>• More divided</td>
<td>33.8%</td>
<td>16.7%</td>
<td>33.3%</td>
<td>31.5%</td>
</tr>
<tr>
<td>• Have increased problems</td>
<td>28.9%</td>
<td>28.0%</td>
<td>37.5%</td>
<td>29.1%</td>
</tr>
<tr>
<td>• More interested in education of their children</td>
<td>78.1%</td>
<td>84.8%</td>
<td>90.0%</td>
<td>79.6%</td>
</tr>
<tr>
<td>• Participate more in school activities</td>
<td>76.4%</td>
<td>79.3%</td>
<td>70.0%</td>
<td>76.5%</td>
</tr>
<tr>
<td>Beneficiary students:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Attend school regularly</td>
<td>96.5%</td>
<td>95.1%</td>
<td>92.3%</td>
<td>96.0%</td>
</tr>
<tr>
<td>• Are more serious about their homeworks</td>
<td>70.3%</td>
<td>86.0%</td>
<td>63.6%</td>
<td>72.8%</td>
</tr>
<tr>
<td>• Improved their performance</td>
<td>68.0%</td>
<td>75.7%</td>
<td>60.0%</td>
<td>68.9%</td>
</tr>
<tr>
<td>• Are more interested in school</td>
<td>73.0%</td>
<td>81.4%</td>
<td>70.0%</td>
<td>74.4%</td>
</tr>
<tr>
<td>• Perform less well than other students</td>
<td>13.9%</td>
<td>14.7%</td>
<td>22.2%</td>
<td>14.4%</td>
</tr>
<tr>
<td>• Perform just the same as other students</td>
<td>74.4%</td>
<td>80.0%</td>
<td>63.6%</td>
<td>74.8%</td>
</tr>
<tr>
<td>Types of Changes</td>
<td>PROGRESA Communities (n=45)</td>
<td>Control Communities (n=9)</td>
<td>Outside Communities with PROGRESA Beneficiaries (n=90)</td>
<td>Overall (n=144)</td>
</tr>
<tr>
<td>----------------------------------------</td>
<td>-----------------------------</td>
<td>---------------------------</td>
<td>--------------------------------------------------------</td>
<td>-----------------</td>
</tr>
<tr>
<td>Beneficiary families are:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Better organized</td>
<td>69.2%</td>
<td>42.9%</td>
<td>64.1%</td>
<td>64.5%</td>
</tr>
<tr>
<td>• Better united</td>
<td>57.1%</td>
<td>42.9%</td>
<td>54.8%</td>
<td>54.8%</td>
</tr>
<tr>
<td>• More divided</td>
<td>17.6%</td>
<td>28.6%</td>
<td>20.8%</td>
<td>20.4%</td>
</tr>
<tr>
<td>• Have increased problems</td>
<td>8.6%</td>
<td>14.3%</td>
<td>18.3%</td>
<td>15.0%</td>
</tr>
<tr>
<td>• More interested in education of their children</td>
<td>90.5%</td>
<td>66.7%</td>
<td>86.3%</td>
<td>86.3%</td>
</tr>
<tr>
<td>• Participate more in school activities</td>
<td>92.5%</td>
<td>62.5%</td>
<td>70.1%</td>
<td>76.8%</td>
</tr>
<tr>
<td>Beneficiary students:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Attend school regularly</td>
<td>95.1%</td>
<td>88.9%</td>
<td>96.6%</td>
<td>95.7%</td>
</tr>
<tr>
<td>• Are more serious about their homeworks</td>
<td>87.8%</td>
<td>90.0%</td>
<td>79.5%</td>
<td>82.8%</td>
</tr>
<tr>
<td>• Improved their performance</td>
<td>66.7%</td>
<td>88.9%</td>
<td>62.2%</td>
<td>65.4%</td>
</tr>
<tr>
<td>• Are more interested in school</td>
<td>78.0%</td>
<td>90.0%</td>
<td>69.6%</td>
<td>73.8%</td>
</tr>
<tr>
<td>• Perform less well than other students</td>
<td>9.1%</td>
<td>12.5%</td>
<td>5.4%</td>
<td>7.0%</td>
</tr>
<tr>
<td>• Perform just the same as other students</td>
<td>72.2%</td>
<td>77.8%</td>
<td>73.4%</td>
<td>73.4%</td>
</tr>
</tbody>
</table>
CHAPTER 4 — TABLES
Table 4.1 — Strategies in the Basic Health Services Package

1. Basic sanitation at the family level
2. Family planning
3. Prenatal, childbirth and puerperal care
4. Supervision of nutrition and children's growth
5. Vaccinations
6. Prevention and treatment of outbreaks of diarrhea in the home
7. Anti-parasite treatment
8. Prevention and treatment of respiratory infections
9. Prevention and control of tuberculosis
10. Prevention and control of high blood pressure and diabetes mellitus
11. Accident prevention and first-aid for injuries
12. Community training for health care self-help

Note: Actions aimed at identifying and treating hearing and sight problems that inhibit the learning capacity of children and young people will also be incorporated.

Table 4.2 — Annual Frequency of Health Care Visits Required by PROGRESA

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Annual Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Children</strong></td>
<td></td>
</tr>
<tr>
<td>Newborn to one year of age</td>
<td>7 check-ups: 7 and 28 days; 2, 4, 6, 9 &amp; 12 months</td>
</tr>
<tr>
<td>One to two years</td>
<td>4 check-ups: one every three months</td>
</tr>
<tr>
<td>Three to five years</td>
<td>3 check-ups: one every four months</td>
</tr>
<tr>
<td>Six to eleven years</td>
<td>2 check-ups: one every six months</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td></td>
</tr>
<tr>
<td>Of childbearing age</td>
<td>4 check-ups: one every three months</td>
</tr>
<tr>
<td>Pregnant</td>
<td>5 check-ups during prenatal period.</td>
</tr>
<tr>
<td>During purpureum and lactation</td>
<td>2 check-ups: in immediate purpureum and during lactation</td>
</tr>
<tr>
<td><strong>Adults and youths</strong></td>
<td></td>
</tr>
<tr>
<td>Young adults</td>
<td>One check-up per year</td>
</tr>
<tr>
<td>Senior citizens</td>
<td>One check-up per year</td>
</tr>
</tbody>
</table>
Table 4.3. — Micronutrients Contained in the Food Supplements

<table>
<thead>
<tr>
<th>Nutrient</th>
<th>Pregnant and Lactating Women</th>
<th>Children</th>
</tr>
</thead>
<tbody>
<tr>
<td>Iron</td>
<td></td>
<td>Iron</td>
</tr>
<tr>
<td>Zinc</td>
<td></td>
<td>Zinc</td>
</tr>
<tr>
<td>Vitamin B12</td>
<td></td>
<td>Vitamin A</td>
</tr>
<tr>
<td>Vitamin C</td>
<td></td>
<td>Vitamin C</td>
</tr>
<tr>
<td>Vitamin E</td>
<td></td>
<td>Vitamin E</td>
</tr>
<tr>
<td>Folic acid</td>
<td></td>
<td>Riboflavin</td>
</tr>
<tr>
<td>Iodine</td>
<td></td>
<td>Vitamin B12</td>
</tr>
<tr>
<td>Vitamin C</td>
<td></td>
<td>Folic acid</td>
</tr>
</tbody>
</table>

Table 4.4 — Summary of Health Variables (%) (Survey of Beneficiaries)

<table>
<thead>
<tr>
<th>Health Variable</th>
<th>All States</th>
<th>Guerrero</th>
<th>Hidalgo</th>
<th>Michoacán</th>
<th>Puebla</th>
<th>Querétaro</th>
<th>San Luis</th>
<th>Veracruz</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Registered</td>
<td>97.4</td>
<td>95.3</td>
<td>98.0</td>
<td>97.3</td>
<td>99.0</td>
<td>93.6</td>
<td>97.9</td>
<td>97.0</td>
</tr>
<tr>
<td>(2) Charged For Consultation</td>
<td>10.5</td>
<td>16.9</td>
<td>10.9</td>
<td>6.31</td>
<td>17.4</td>
<td>5.31</td>
<td>12.7</td>
<td>4.31</td>
</tr>
<tr>
<td>(3) Charged For Medicines</td>
<td>6.34</td>
<td>18.6</td>
<td>9.60</td>
<td>6.91</td>
<td>21.3</td>
<td>41.5</td>
<td>7.71</td>
<td>4.13</td>
</tr>
<tr>
<td>(4) Not Receive Appoint’s Book</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- SEGUIM3</td>
<td>22.0</td>
<td>25.7</td>
<td>18.6</td>
<td>23.8</td>
<td>18.6</td>
<td>66.7</td>
<td>24.7</td>
<td>26.7</td>
</tr>
<tr>
<td>- SEGUIM4</td>
<td>3.17</td>
<td>1.21</td>
<td>1.62</td>
<td>1.85</td>
<td>2.87</td>
<td>11.0</td>
<td>5.7</td>
<td>2.85</td>
</tr>
<tr>
<td>(5) Seen On Appointed Day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- SEGUIM3</td>
<td>95.0</td>
<td>94.2</td>
<td>97.5</td>
<td>96.7</td>
<td>94.0</td>
<td>79.0</td>
<td>96.0</td>
<td>92.7</td>
</tr>
<tr>
<td>- SEGUIM4</td>
<td>97.0</td>
<td>98.6</td>
<td>97.5</td>
<td>93.2</td>
<td>99.1</td>
<td>99.0</td>
<td>95.2</td>
<td>96.4</td>
</tr>
<tr>
<td>(6) Not Available Appointed Day</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>- SEGUIM3</td>
<td>5.00</td>
<td>6.32</td>
<td>3.28</td>
<td>5.43</td>
<td>3.93</td>
<td>12.4</td>
<td>2.47</td>
<td>6.72</td>
</tr>
<tr>
<td>- SEGUIM4</td>
<td>3.40</td>
<td>6.69</td>
<td>3.34</td>
<td>5.19</td>
<td>1.36</td>
<td>6.79</td>
<td>4.20</td>
<td>4.19</td>
</tr>
<tr>
<td>(7) Appoint. Time Convenient</td>
<td>94.8</td>
<td>93.6</td>
<td>93.8</td>
<td>90.1</td>
<td>97.6</td>
<td>93.9</td>
<td>96.0</td>
<td>94.4</td>
</tr>
</tbody>
</table>

Note: All percentages are based on SEGUIM4 except where explicitly stated otherwise.
Table 4.5 — Results From Health Outcome Regressions (Survey of Beneficiaries)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Child Visits</th>
<th>Clinic Visits</th>
<th>Tubercul.</th>
<th>Tetanus.</th>
<th>Polio.</th>
<th>Measles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Guerrero</td>
<td>-0.073**</td>
<td>-0.148**</td>
<td>-0.931**</td>
<td>-0.002</td>
<td>-0.025</td>
<td>-0.027</td>
</tr>
<tr>
<td>Hidalgo</td>
<td>0.069</td>
<td>-0.028**</td>
<td>-0.167**</td>
<td>-0.010</td>
<td>-0.006</td>
<td>-0.009</td>
</tr>
<tr>
<td>Michoacán</td>
<td>-0.053**</td>
<td>-0.058**</td>
<td>-0.629**</td>
<td>-0.023</td>
<td>-0.059**</td>
<td>-0.033</td>
</tr>
<tr>
<td>Puebla</td>
<td>0.022**</td>
<td>-0.008</td>
<td>-0.034</td>
<td>-0.008</td>
<td>0.020</td>
<td>0.108**</td>
</tr>
<tr>
<td>Querétero</td>
<td>-0.068**</td>
<td>-0.211**</td>
<td>-1.278**</td>
<td>0.021</td>
<td>0.006</td>
<td>-0.107*</td>
</tr>
<tr>
<td>San Luis</td>
<td>-0.015</td>
<td>0.084**</td>
<td>0.270**</td>
<td>0.014</td>
<td>-0.032</td>
<td>0.012</td>
</tr>
<tr>
<td>IMSS</td>
<td>0.005</td>
<td>-0.037**</td>
<td>-0.222**</td>
<td>-0.022**</td>
<td>0.041**</td>
<td>-0.059*</td>
</tr>
<tr>
<td>Mobile Clinic</td>
<td>0.003</td>
<td>0.033**</td>
<td>0.204**</td>
<td>-0.004</td>
<td>0.065**</td>
<td>0.009</td>
</tr>
<tr>
<td>Not Registered</td>
<td>-0.103**</td>
<td>0.003</td>
<td>-0.731**</td>
<td>-0.075**</td>
<td>-0.097</td>
<td>0.134</td>
</tr>
<tr>
<td>Child’s Age</td>
<td>-0.007**</td>
<td>-0.040*</td>
<td>0.014</td>
<td>-0.010</td>
<td>0.005</td>
<td>-0.012</td>
</tr>
<tr>
<td>Male Child</td>
<td>0.022**</td>
<td>0.009</td>
<td>0.033</td>
<td>-0.006</td>
<td>0.004</td>
<td>0.028</td>
</tr>
<tr>
<td>Age*Gender</td>
<td>-0.007**</td>
<td>-0.001</td>
<td>-0.024</td>
<td>0.008</td>
<td>0.007</td>
<td>-0.019</td>
</tr>
<tr>
<td>Previous Vaccn.</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-0.025</td>
<td>-0.060</td>
<td>0.019*</td>
</tr>
<tr>
<td>Appnt. Book</td>
<td>0.045*</td>
<td>0.034</td>
<td>0.418*</td>
<td>0.037</td>
<td>-0.050</td>
<td>-0.086</td>
</tr>
</tbody>
</table>

Note: All results are from probit regressions, except Clinic Visits which are OLS. * and ** denote statistically significant at 1% and 5% levels respectively, based on robust standard errors. Probit coefficients represent marginal probability impact for continuous variables and discrete probability change for dummies.

Table 4.6 — Reasons Reported by Health Staff in Survey of 317 Clinics for Increases in Demand for Health Services since Previous Year

<table>
<thead>
<tr>
<th>Reasons for Increase in Demand</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health campaign</td>
<td>10</td>
<td>3.2%</td>
</tr>
<tr>
<td>Poor sanitary/health conditions in region</td>
<td>9</td>
<td>2.8%</td>
</tr>
<tr>
<td>Natural disaster</td>
<td>3</td>
<td>0.9%</td>
</tr>
<tr>
<td>PROGRESA because it created awareness</td>
<td>115</td>
<td>36.4%</td>
</tr>
<tr>
<td>PROGRESA because of its requirements of attendance by beneficiaries</td>
<td>181</td>
<td>57.3%</td>
</tr>
<tr>
<td>Other</td>
<td>36</td>
<td>11.4%</td>
</tr>
</tbody>
</table>
Table 4.7 — Problems that the Increased Demand for Health Services since the Previous Year is causing in the Health Centers (Survey of 317 Clinics)

<table>
<thead>
<tr>
<th>Problems that Increase in Demand Caused</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of doctors</td>
<td>61</td>
<td>23.8%</td>
</tr>
<tr>
<td>Lack of support personnel</td>
<td>55</td>
<td>21.5%</td>
</tr>
<tr>
<td>Lack of equipment</td>
<td>63</td>
<td>24.5%</td>
</tr>
<tr>
<td>Lack of drugs</td>
<td>128</td>
<td>50.0%</td>
</tr>
<tr>
<td>Lack of space</td>
<td>50</td>
<td>19.5%</td>
</tr>
<tr>
<td>Lack of training</td>
<td>34</td>
<td>13.3%</td>
</tr>
<tr>
<td>Excess work</td>
<td>94</td>
<td>36.7%</td>
</tr>
<tr>
<td>Clientele is very demanding</td>
<td>84</td>
<td>32.8%</td>
</tr>
<tr>
<td>No problems</td>
<td>56</td>
<td>22.3%</td>
</tr>
</tbody>
</table>

Table 4.8 — Summary of Health Supply and Nutrition Variables (%) (Survey of Beneficiaries)

<table>
<thead>
<tr>
<th>All States</th>
<th>Guerrero</th>
<th>Hidalgo</th>
<th>Michoacán</th>
<th>Puebla</th>
<th>Querétaro</th>
<th>San Luis</th>
<th>Veracruz</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lectures not given</td>
<td>2.92</td>
<td>2.20</td>
<td>4.46</td>
<td>2.84</td>
<td>4.62</td>
<td>3.52</td>
<td>3.89</td>
</tr>
<tr>
<td>Attended lectures</td>
<td>97.4</td>
<td>93.6</td>
<td>98.2</td>
<td>97.8</td>
<td>98.3</td>
<td>92.8</td>
<td>97.8</td>
</tr>
<tr>
<td>Drug shortage</td>
<td>53.4</td>
<td>64.2</td>
<td>53.7</td>
<td>62.6</td>
<td>53.8</td>
<td>73.8</td>
<td>40.9</td>
</tr>
<tr>
<td>Improvement In services</td>
<td>75.0</td>
<td>63.2</td>
<td>70.0</td>
<td>70.0</td>
<td>75.5</td>
<td>47.5</td>
<td>75.5</td>
</tr>
<tr>
<td>Staff disposition</td>
<td>70.1</td>
<td>71.9</td>
<td>70.9</td>
<td>67.4</td>
<td>79.2</td>
<td>74.5</td>
<td>72.6</td>
</tr>
<tr>
<td>Treatment</td>
<td>68.9</td>
<td>71.5</td>
<td>70.5</td>
<td>66.5</td>
<td>75.2</td>
<td>71.8</td>
<td>69.5</td>
</tr>
<tr>
<td>Medicine avail.</td>
<td>59.7</td>
<td>63.8</td>
<td>66.1</td>
<td>61.7</td>
<td>62.3</td>
<td>69.8</td>
<td>62.8</td>
</tr>
<tr>
<td>Consult time</td>
<td>56.1</td>
<td>63.0</td>
<td>57.6</td>
<td>53.0</td>
<td>56.4</td>
<td>60.2</td>
<td>58.5</td>
</tr>
<tr>
<td>Waiting time</td>
<td>51.3</td>
<td>59.0</td>
<td>53.2</td>
<td>48.8</td>
<td>62.1</td>
<td>62.2</td>
<td>53.3</td>
</tr>
<tr>
<td>Consult cost</td>
<td>50.6</td>
<td>64.3</td>
<td>50.5</td>
<td>54.3</td>
<td>47.2</td>
<td>48.3</td>
<td>45.4</td>
</tr>
<tr>
<td>Medicine cost</td>
<td>49.9</td>
<td>62.1</td>
<td>49.7</td>
<td>53.6</td>
<td>48.2</td>
<td>44.2</td>
<td>45.2</td>
</tr>
<tr>
<td>Mobiles more frequent</td>
<td>37.4</td>
<td>54.9</td>
<td>33.4</td>
<td>32.3</td>
<td>46.2</td>
<td>44.5</td>
<td>33.3</td>
</tr>
<tr>
<td>Mobiles stay longer</td>
<td>42.4</td>
<td>60.0</td>
<td>39.7</td>
<td>37.4</td>
<td>47.6</td>
<td>53.8</td>
<td>39.2</td>
</tr>
<tr>
<td>Never receive supplement</td>
<td>11.5</td>
<td>13.2</td>
<td>9.45</td>
<td>12.4</td>
<td>13.4</td>
<td>10.9</td>
<td>14.1</td>
</tr>
<tr>
<td>Supplement deficit (days)</td>
<td>19.7</td>
<td>25.9</td>
<td>27.9</td>
<td>29.8</td>
<td>16.0</td>
<td>12.3</td>
<td>14.6</td>
</tr>
<tr>
<td>Not know when To return</td>
<td>57.4</td>
<td>60.9</td>
<td>46.1</td>
<td>53.4</td>
<td>50.3</td>
<td>54.8</td>
<td>52.7</td>
</tr>
</tbody>
</table>

Note: All percentages are based on SEGUIM4, except for questions (3) and (4) which are based on SEGUIM3.
Table 4.9 — Number and Percentage of Clinics where Various Staff Members are Reported to Give Health Education Lectures (Survey of Health Centers)

<table>
<thead>
<tr>
<th>Staff Member who is said to Give Nutrition/Health Education Sessions</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>212</td>
<td>67.3%</td>
</tr>
<tr>
<td>Nurse</td>
<td>195</td>
<td>61.5%</td>
</tr>
<tr>
<td>Intern</td>
<td>95</td>
<td>30.2%</td>
</tr>
<tr>
<td>Assistant nurse</td>
<td>111</td>
<td>35.2%</td>
</tr>
<tr>
<td>Primary health care technician</td>
<td>44</td>
<td>14.0%</td>
</tr>
<tr>
<td>Community workers/assistants</td>
<td>63</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

Table 4.10 — Number and Percentage of Health Centers who have Different Types of Personnel (Survey of Health Centers)

<table>
<thead>
<tr>
<th>Facility has at Least One of the Following</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doctor</td>
<td>223</td>
<td>70.3</td>
</tr>
<tr>
<td>Intern</td>
<td>146</td>
<td>46.1</td>
</tr>
<tr>
<td>Nurse</td>
<td>210</td>
<td>66.2</td>
</tr>
<tr>
<td>Assistant nurse</td>
<td>174</td>
<td>54.9</td>
</tr>
<tr>
<td>Primary health care technician</td>
<td>81</td>
<td>25.6</td>
</tr>
<tr>
<td>Community workers</td>
<td>229</td>
<td>72.2</td>
</tr>
<tr>
<td>Voluntary helpers</td>
<td>206</td>
<td>65.0</td>
</tr>
</tbody>
</table>

Table 4.11 — Number and Percentage of Health Centers Reporting Sufficient Availability of Different Supplies (Survey of Health Centers)

<table>
<thead>
<tr>
<th>Supplies</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reagents/chemicals</td>
<td>263</td>
<td>83%</td>
</tr>
<tr>
<td>First aid supplies</td>
<td>251</td>
<td>79.2%</td>
</tr>
<tr>
<td>Surgical instruments</td>
<td>219</td>
<td>70.2%</td>
</tr>
<tr>
<td>Medical equipment</td>
<td>218</td>
<td>69.5%</td>
</tr>
<tr>
<td>Paper, forms</td>
<td>170</td>
<td>54.1%</td>
</tr>
<tr>
<td>Didactic/educational material</td>
<td>211</td>
<td>67.2%</td>
</tr>
</tbody>
</table>
Table 4.12 — Number and Percentage of Health Centers Reporting Providing the Nutritional Supplement to Different Population Groups (Survey of Health Centers)

<table>
<thead>
<tr>
<th>Population Groups Targeted by PROGRESA who Receive the Supplement</th>
<th>Number of Health Centers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROGRESA children 4-24 mos</td>
<td>284</td>
<td>91.3%</td>
</tr>
<tr>
<td>PROGRESA children 2-4 years with malnutrition</td>
<td>275</td>
<td>88.4%</td>
</tr>
<tr>
<td>PROGRESA pregnant women</td>
<td>277</td>
<td>89.1%</td>
</tr>
<tr>
<td>PROGRESA lactating</td>
<td>260</td>
<td>83.6%</td>
</tr>
<tr>
<td>Non-PROGRESA children 2-4 years of age with malnutrition</td>
<td>228</td>
<td>73.3%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Population Groups not Targeted by PROGRESA who Receive the Supplement</th>
<th>Number of Health Centers</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>PROGRESA children 2-4 years who are not malnourished</td>
<td>166</td>
<td>53.4%</td>
</tr>
<tr>
<td>Non-PROGRESA children 4-24 months of age</td>
<td>157</td>
<td>50.5%</td>
</tr>
<tr>
<td>Non-PROGRESA children 2-4 years of age without malnutrition</td>
<td>99</td>
<td>31.8%</td>
</tr>
<tr>
<td>Non-PROGRESA pregnant women</td>
<td>208</td>
<td>66.9%</td>
</tr>
<tr>
<td>Non-PROGRESA lactating women</td>
<td>185</td>
<td>58.4%</td>
</tr>
</tbody>
</table>
Table 4.13 — Food Supplement Regressions (Survey of Beneficiaries)

<table>
<thead>
<tr>
<th></th>
<th>Level of Food Supplement Deficit</th>
<th>How Long Did Food Supplement Last (Days)?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Constant</td>
<td>22.78*</td>
</tr>
<tr>
<td></td>
<td>Guerrero</td>
<td>3.25</td>
</tr>
<tr>
<td></td>
<td>Hidalgo</td>
<td>5.24</td>
</tr>
<tr>
<td></td>
<td>Michoacán</td>
<td>7.09</td>
</tr>
<tr>
<td></td>
<td>Puebla</td>
<td>-6.72**</td>
</tr>
<tr>
<td></td>
<td>Querétaro</td>
<td>-10.5*</td>
</tr>
<tr>
<td></td>
<td>San Luis</td>
<td>-8.16*</td>
</tr>
<tr>
<td></td>
<td>IMSS</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Mobile</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Not registered</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Not told when to return</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Appointment book</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Days of supplement supply</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Number of feeds</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>No. of others consuming</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>No. kids 3-5 years</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>No. kids 6+ years</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>Number of observations</td>
<td>1752</td>
</tr>
<tr>
<td></td>
<td>R-squared</td>
<td>0.01</td>
</tr>
</tbody>
</table>

Note: Other variables were included in regressions, e.g., household assets and composition. Base category is those registered in health centers in Veracruz state. * and ** denote statistically different from zero at the 1% and 5% levels, respectively, and are based on heteroskedasticity-corrected standard errors.
Table 4.14 — Number and Percentage of Health Centers who Reported having the Following Problems with PROGRESA Beneficiaries (Survey of Health Centers)

<table>
<thead>
<tr>
<th>Problems encountered with PROGRESA beneficiaries</th>
<th>N</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Request their attendance to be registered even if they did not attend</td>
<td>102</td>
<td>33.0%</td>
</tr>
<tr>
<td>Request immediate attention</td>
<td>98</td>
<td>31.7%</td>
</tr>
<tr>
<td>Get upset when drugs are not provided along with prescription</td>
<td>111</td>
<td>35.9%</td>
</tr>
<tr>
<td>Do not want to pay for the drugs</td>
<td>30</td>
<td>9.7%</td>
</tr>
<tr>
<td>Complain that lab work and x-rays are not free</td>
<td>30</td>
<td>9.7%</td>
</tr>
<tr>
<td>Complain they are badly treated</td>
<td>29</td>
<td>9.4%</td>
</tr>
<tr>
<td>Do not comply with their programmed visits</td>
<td>81</td>
<td>26.2%</td>
</tr>
<tr>
<td>Do not attend education sessions</td>
<td>62</td>
<td>20.1%</td>
</tr>
<tr>
<td>They live too far away</td>
<td>46</td>
<td>14.9%</td>
</tr>
</tbody>
</table>
CHAPTER 5 — TABLE
Table 5.1 — Summary of Community *Promotora* Variable (%)

<table>
<thead>
<tr>
<th></th>
<th>All States</th>
<th>Guerrero</th>
<th>Hidalgo</th>
<th>Michoacan</th>
<th>Puebla</th>
<th>Queretaro</th>
<th>San Luis</th>
<th>Veracruz</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Know the <em>promotora</em></td>
<td>98.3</td>
<td>98.4</td>
<td>98.9</td>
<td>97.9</td>
<td>98.7</td>
<td>97.2</td>
<td>98.1</td>
<td>98.1</td>
</tr>
<tr>
<td>(2) Regularly meet <em>promotora</em></td>
<td>77.9</td>
<td>69.4</td>
<td>82.3</td>
<td>83.1</td>
<td>87.8</td>
<td>88.6</td>
<td>65.8</td>
<td>74.9</td>
</tr>
<tr>
<td>(3) Never met <em>promotora</em></td>
<td>2.73</td>
<td>6.65</td>
<td>1.24</td>
<td>1.37</td>
<td>2.12</td>
<td>2.32</td>
<td>2.25</td>
<td>3.86</td>
</tr>
<tr>
<td>(4) Forced to contribute</td>
<td>5.10</td>
<td>14.0</td>
<td>3.82</td>
<td>6.10</td>
<td>2.60</td>
<td>2.83</td>
<td>5.26</td>
<td>4.04</td>
</tr>
</tbody>
</table>