Social Safety Nets and Health: The Impact of Brazil’s Bolsa Família Program on Health

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VERY PRELIMINARY: PLEASE DO NOT CITE

Abstract
Social safety nets are important for improving the welfare of the poor. In times of economic crisis, the poor will likely suffer a disproportionate share of negative consequences such as increases in morbidity and mortality. Social safety nets can help mitigate some of these negative impacts. They are also important in that they can help the poor exercise certain legal rights. This paper evaluates the impact of a major safety net program in Brazil. The Bolsa Família conditional cash transfer program aims to alleviate poverty in the short-term, break the inter-generational cycle of poverty in the long-term, and help the poor exercise their constitutionally guaranteed right to health. This empirical analysis focuses on the impact of Bolsa Família on infant mortality rates across Brazilian municipalities.
**Introduction**

Recent estimates suggest that in 2005\(^1\) there were over 1.4 billion people (or one quarter of the population in developing countries) living in poverty, surviving on less than $1.25 per day \([1]\). The poor often lack access to basic sanitation, housing, education, and health care. Even when they are granted these rights on paper, they may not be able to access those services due to marginalization and a variety of barriers to access. As a result, they face much worse health and life outcomes. This cycle of poverty and vulnerability continues from one generation to the next, as poor parents are less able to invest in their children’s development, and the children are disadvantaged from the start. Despite significant economic growth and development in the last few decades, deep inequalities and poverty persist. Out of a growing recognition of the need to address these issues, many countries have attempted to create social safety nets to address the needs of the poor.

Social safety nets are important to improving the welfare of the vulnerable and poor, and, in times of economic crisis, they become even more crucial. The current global financial crisis will have major adverse consequences on the poor, who will probably suffer a disproportionate share of the negative impacts of the crisis. In times of financial crisis, there is often an increase in morbidity and mortality among the most vulnerable, which include the poor, the elderly, and the very young. The Mexican economic crisis of 1995 – 1996 was associated with higher mortality among children and the elderly, possibly due to a reduction in income and a straining of the public health system \([2]\). The World Bank estimates that 200,000 – 400,000 additional babies could die each year, between now and 2015, if the economic crisis continues \([3]\). How severely these vulnerable groups are impacted will depend on how well we can mitigate that

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\(^1\) The World Bank publishes updated poverty estimates every few years, based on the most recent global cost-of-living data and country surveys of household consumption.
damage by developing and expanding effective social safety nets. It will be important to examine what type of safety net is most effective, can improve health, and, in times of crisis, buffer negative health impacts.

Over the last decade, conditional cash transfer (CCT) programs have emerged as a popular social safety net in developing countries. They have been widely implemented throughout developing countries such as Mexico, Brazil, and Turkey, and they are now present in over 30 countries. In fact, they are often regarded as nearly “a magic bullet in development” [4]. Given the popularity of CCTs, it is imperative that we better understand the strengths and limitations of these policies so that we can maximize their effectiveness. This paper examines the impact of Brazil’s CCT program, Bolsa Família, on beneficiaries’ right to health. In Brazil, citizens have a constitutionally guaranteed right to health. However, in a country with vast inequalities, many people are not able to fully exercise their rights. Though Bolsa Família began in 2003, there has been little evidence to date about the impact and effectiveness of the program. Social policies need to be based on sound evidence, and this paper will help guide the development of Bolsa Família and other similar programs aimed at alleviating poverty and improving welfare.

**Conditional Cash Transfer Programs**

CCT programs aim to reduce poverty in the short-term by providing cash payments to poor families and to improve human capital in the long-term by encouraging behaviors related to health, nutrition, and education. They are seen as an alternative to traditional forms of social assistance and as a way to break the inter-generational cycle of poverty. Developed countries are considering CCT programs as well. New York City recently started a demonstration CCT
project, Opportunity NYC, modeled after Mexico’s *Oportunidades* program [5]. Even in places where health and education services are widely available, poor families are not always able to access and utilize these services due to a variety of barriers to access, including both direct costs and indirect opportunity costs. By requiring families to comply with a set of requirements in order to receive the cash transfers, CCT programs encourage families to take advantage of available services and help them overcome financial barriers to access. Figure 1 depicts the conceptual framework underlying CCT programs.

**Figure 1. Conceptual Framework for CCT Programs** [6]

Poor families are usually identified through a combination of geographic and household level targeting. Once they are enrolled in the program, they must comply with a set of health and education requirements in order to receive their payments. The short-term goals of the program include increased (and better) food consumption, more regular use of routine, preventive health

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2 Figure 1.1: PATH’s Logic Model (Levy, 2007). PATH refers to Jamaica’s CCT Program, Programme of Advancement Through Health and Education.
care services, and increased school attendance. In the longer-term, the goal is to improve health status and education performance.

As CCT programs have expanded rapidly throughout developing countries, many countries have attempted to evaluate their impacts on health. The evaluation of Mexico’s Oportunidades\(^3\) CCT program found that the program had a statistically significant impact on the illness rate, the probability of anemia, and the height of children enrolled in the program [7]. Oportunidades was the first large-scale CCT program in Latin America when it began in 1997, and it has been used as a model for many other CCT programs. A recent systematic review of CCT program evaluations in low- and middle-income countries found evidence suggesting that CCT programs have increased the use of preventive services and have sometimes improved health status [8]. However, many previous studies focus on specific subgroups, such as infants in urban areas [9], and some studies contain methodological limitations such as unreliable data, poor randomization (in the case of randomized controlled experiments), and attrition bias [8].

Despite the growing body of literature about CCT programs, the positive findings of one program cannot necessarily be generalized to another context with different needs and constraints since programs differ in their objectives, components, and target populations. For example, Mexico’s Oportunidades program includes nutritional supplements, varying educational grants based on the grade and gender of the child, health conditionalities applying to all family members including adults, and attempts to strengthen the supply and quality of health and education services. Other countries frequently cite the success of the Oportunidades in the development of their own CCT programs, yet their programs are often designed quite differently, and the success of Oportunidades may not be generalizable to other circumstances. For example, many CCT programs do not include nutritional supplements. If nutritional

\(^3\) Formerly known as PROGRESA, Programa de Educación, Salud y Alimentación.
supplements are the mechanism driving improved health outcomes, CCT programs that do not have a nutritional supplement component are unlikely to achieve the same outcomes as Oportunidades. Until more is known about which aspects of CCT programs are driving the positive outcomes and how, one should be cautious about generalizing findings.

Bolsa Família is now the largest program of this type in the world, covering 46 million individuals (11 million families) throughout Brazil. However, there have been no published peer-reviewed articles that formally evaluate the health impacts of the program. Therefore, one cannot assume that the program has been effective simply because other CCT programs have demonstrated positive outcomes. Furthermore, the Brazilian program has a number of innovative features that differentiate it from many other CCT programs. Even within one country, the impact of a CCT program may not be homogenous. It would be important to examine whether certain municipal factors (e.g., geography, infrastructure) or household factors (e.g., level of poverty, age, family structure) are associated with larger or smaller program impacts. For example, if a CCT program is found to have less of an impact among extremely poor families relative to families that are slightly better off, this would suggest that interventions need to target specific subgroups in order to improve a program’s potential impact. Research on whether programs have a differential impact on select sub-groups has been limited.

It is still uncertain whether CCT programs are sufficient to change behavior and improve outcomes in the long-run, as the oldest programs have only been around for a decade. Conditionalities are a demand-side tool aimed at changing individual behavior. Supply-side tools such as better health and education infrastructure may be necessary as well, and only some CCT programs (e.g., Mexico’s Oportunidades, Honduras’s Programa de Asignación Familiar,  

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4 There are some studies on the impact other cash transfer programs (unconditional and conditional) that pre-dated Bolsa Família, such as Bolsa Escola.
and Nicaragua’s *Red de Protección Social*) have included a supply-side component. CCT programs need a sufficient level of basic services (e.g., education, health, housing, transportation) to ensure that the supply-side can respond to the increased demand created by cash transfers [10]. These programs tend to operate in impoverished areas where there is a great deal of variation in the availability and quality of health care, which will likely affect the ability of CCT programs to function properly and meet their objectives. There is also a lot of geographic variation in program implementation, management, and impact.

**Brazil**

This paper focuses on the Brazilian context. Brazil has traditionally been one of the most unequal countries in the world. The country’s Gini index\(^5\) has remained above 55 over the last 25 years [11]. These inequalities are reflected in the health and education levels of its citizens as well. Per capita gross domestic product (GDP) in Brazil was R\$ 8,694 in 2003, but there were vast regional disparities. For example, per capita GDP in the Northeast region in 2003 was R\$ 4,306, in the Southeast it was R\$ 11,258. According to the United Nations Development Programme’s (UNDP) Human Development Index 2008, which looks beyond GDP to a broader view of well-being, Brazil ranks 70\(^{th}\) out of out of 179 countries on human development [12]. Data from the Brazilian Institute of Applied Economic Research (IPEA) shows that the percentage of poor population (monthly income under half the minimum wage) was 32.0% in 2004, again with major inequalities between the country’s various regions. The Northeast and North regions had the largest proportions of poor population (55.5% and 43.3%, respectively),

\(^{5}\) The Gini index (or coefficient) is a measure of income inequality within a country. 0 indicates perfect equality and 100 indicates absolute inequality.
while the South and Southeast had the smallest proportions of poor population (17.8% and 20.4%, respectively) in 2004 [13].

In terms of health, Brazil now faces the dual burden of chronic diseases, such as heart disease, diabetes, and cancer, and infectious diseases, including HIV/AIDS and neglected tropical diseases. Violence is a growing problem too, and homicide ranks as the third cause of deaths in the general population [13]. The unified health system (Sistema Unico de Saude or SUS in Portuguese) provides universal coverage, but, in reality, access is still far from complete, especially for the poor. Evidence suggests that among the poorest quintile in Brazil, roughly 30% of children do not have complete vaccine regimens [14].

In 1985, Brazil transitioned from a military dictatorship (1964 – 1985) back to democratic rule. The 1988 Federal Constitution established the federal and republican nature of the state (Article 1). The country is made up of 26 states, 5,561 municipalities, and the Federal District. Municipalities are recognized as federated entities with their own government, authority, and autonomy. The Constitution also guaranteed the universal right to health and education. The eradication of poverty and the reduction of social and regional inequalities were defined as fundamental principles of the Federative Republic of Brazil. Simply having a constitutional right to health does not guarantee that a person actually has access to health, and complementary policies may be needed to help citizens exercise their rights as intended by the law. This is the environment from which Bolsa Família emerged.

The Bolsa Família program [15] is a CCT program that was introduced in Brazil in 2003 by President Luiz Inácio Lula da Silva (“Lula”). It was created by Provisional Measure No. 132/03 [16]. It was designed as a reform program that brought together four preexisting cash
transfer programs under a new umbrella agency, the Ministry of Social Development and Hunger Eradication (Ministério do Desenvolvimento Social e Combate à Fome or MDS in Portuguese), in order to improve the efficiency of social programs and to scale up aid and provide universal coverage of Brazil’s poor. Under *Bolsa Família*, poor families with children receive cash payments conditional on taking their children to school and obtaining routine health checkups. *Bolsa Família* is now the largest CCT program in the world in terms of coverage, as mentioned previously, and financing, amounting to R$ 6.7 billion (US$ 3.2 billion) or 0.36% of GDP in 2005 [14]. Household eligibility is determined centrally by MDS based on household survey data on income which is collected by the Single Registry (Cadastro Único or CadÚnico in Portuguese). Because Brazil does not have an official poverty line, the income ceilings for eligibility were set to mimic the most generous cut-offs used in the pre-reform CCT programs so that families would not end up worse off after the reforms. Initially, the income ceilings for eligibility (an “administrative poverty line”) were set at a fixed monthly per capita family income of R$ 100 (US$ 43) for moderately poor families and R$ 50 (US$ 21) for extremely poor families. Currently, the income cut-off is set at R$ 120 (US$ 51) for moderately poor families and R$ 60 (US$ 26) for extremely poor families.

*Bolsa Família* provides basic and variable types of benefits according to family composition and income. All families in extreme poverty receive a base benefit, regardless of their demographic composition. Both extreme poor and moderately poor families receive a variable benefit set according to the number of children in the family and whether the mother is

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6 The four cash transfer programs are: *Bolsa Escola* (school attendance conditional cash transfer program), *Bolsa Alimentação* (nutrition conditional cash transfer program), *Auxílio Gás* (cooking fuel financial supplement), *Cartão Alimentação* (food card scheme).
7 The same currency conversation rate will be used throughout this paper. The rate is 1 Brazilian real = 0.4277 U.S. dollar, obtained from www.xe.com on March 12, 2009.
8 The number of children is capped at three in order to avoid creating an incentive for families to have more children.
pregnant or breast-feeding. Income transfers range from R$ 20 - 182 (US $9 - 78) per family per month. Payments are made preferentially to the woman in each family, which has been common practice with other CCT programs. International experience suggests that women are more likely than men to invest additional income in improving the education, health and welfare of their family, particularly their children [14]. Beneficiary families receive the cash transfers conditional on all age-relevant family members complying with the conditionalities. These key human development conditionalities are listed in Table 1.

Table 1. Requirements for Bolsa Família beneficiaries.

<table>
<thead>
<tr>
<th>For families with:</th>
<th>Health Conditionality</th>
<th>Education Conditionality</th>
</tr>
</thead>
</table>
| Children 0 - 17 years old | For all children ages 0 - 7:  
• Vaccine schedules  
• Regular health check-ups and growth monitoring | For all children ages 6 - 15:  
• Enroll in school  
• At least 85% minimum daily school attendance each month  
For children ages 16 - 17:  
• At least 75% minimum daily school attendance each month |
| Adults             | For pregnant or lactating women:  
• Pre-natal checkups  
• Post-natal checkups  
• Participate in health and nutrition seminars offered by local health teams  
[ Nutritional monitoring for women 14 - 44 ] | For parents:  
• If child misses school, inform school of reason  
• Inform local coordinator if child moves schools |

*Bolsa Familia* treats the family as one cohesive unit, not just a sub-set of individuals as was the case under the pre-reform programs. For example, even though families are only paid for up to three children, the conditionalities apply to all children (aged 0 - 17) in the family. Schools and health centers are responsible for sending information about compliance to the municipality every 3 months for the education conditionality and every 6 months for the health conditionality. Payments are directly credited to beneficiaries’ electronic benefit cards (EBCs) on a monthly basis, and families can take their EBCs to a local bank or lottery house to receive the cash.
The three aims of Bolsa Família are:

- Immediate poverty relief through direct cash transfer to families
- Reduction of intergenerational poverty through the strengthening of the right to access of health and education
- Articulation with other public policies in order to develop beneficiary families’ capabilities [16].

Unlike other CCT programs, Bolsa Família explicitly aims to help poor families exercise their legal rights to health.

**Methods**

This paper is part of a series of separate but complementary empirical studies on the Bolsa Família CCT program. It aims to empirically examine the impact of Bolsa Família on infant mortality rates (IMRs) in Brazil by testing the association between differences in coverage in each municipality with differences in infant mortality outcomes, while controlling for potential confounders. Because of Brazil’s decentralized health system, the municipality level is the one most relevant for health policy implementation [17]. Municipalities are also vastly different in terms of socio-economic characteristics, infrastructure, health, etc., and they have been allowed to innovate with the program. In fact local innovation has been encouraged through the creation of Innovation in Management Awards which are given to municipalities [14].

If this study finds differential program impacts across municipalities, follow-up research will be conducted to examine the reasons why some municipalities have achieved better impacts

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9 The infant mortality rate is defined as the number of deaths of infants (one year of age or younger) per 1000 live births.
than others. For example, if certain characteristics such as a weak health infrastructure are associated with low impact, that would suggest that additional supply-side interventions are needed to improve program effectiveness. If innovative practices have allowed a given program to better adapt to local needs and achieve better results, those experiences should be shared with other municipalities and policy makers.

This empirical analysis begins by examining overall IMR in Brazil as a country and then by municipality from 2000\(^{10}\) to 2006, the last year for which data is available. The IMR data are obtained from the National Health System (Sistema Único de Saúde or SUS in Portuguese) database, DATASUS [18]. IMR is an important because the health of children is an important policy priority in many countries. Furthermore, it is a useful measure of the effect of the program because Bolsa Família may affect infant health through a number of different pathways. For example, mothers may receive more regular health care (including pre-natal and post-natal care) due to the health conditionality directly or indirectly because they have greater familiarity with the health care system and lower financial . (Evidence suggests that primary care access is associated with lower post-neonatal mortality and fewer deaths from diarrhea.) Mothers and infants may have better nutrition due to more nutrition monitoring, more frequent check-ups, and more consumption of food. Immunization coverage may also increase as a result of Bolsa Familia, thereby reducing the risk of contracting certain diseases.

While IMRs in Brazil have improved significantly over the past several decades, from 115.3 per thousand live births in 1960 to 95.2 in 1970 to 70.1 in 1980 to 48.1 in 1990 to 26.9 in

\(^{10}\) Annual IMR data by municipality appear to be available from the 1978 onwards, but the quality of data has not been examined yet. The year 2000 has been chosen as the start date for this analysis because it precedes the start of the Bolsa Familia program by three years, and data is also available for the three years following the start date (until 2006).
2000 to 18.6 in 2006 [19], these rates are still high by in comparison to other countries in the region (see Table 2).

Table 2. Infant Mortality Rates (per 1,000 live births) in Select Latin American Countries

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Argentina</td>
<td>24.75</td>
<td>16.76</td>
<td>14.14</td>
</tr>
<tr>
<td>Bolivia</td>
<td>89.00</td>
<td>63.00</td>
<td>49.80</td>
</tr>
<tr>
<td>Brazil</td>
<td>48.10</td>
<td>26.90</td>
<td>18.60</td>
</tr>
<tr>
<td>Chile</td>
<td>17.60</td>
<td>9.70</td>
<td>8.14</td>
</tr>
<tr>
<td>Colombia</td>
<td>26.30</td>
<td>20.40</td>
<td>16.65</td>
</tr>
<tr>
<td>Costa Rica</td>
<td>16.00</td>
<td>12.50</td>
<td>10.70</td>
</tr>
<tr>
<td>Cuba</td>
<td>10.70</td>
<td>7.20</td>
<td>5.02</td>
</tr>
<tr>
<td>Peru</td>
<td>58.40</td>
<td>33.30</td>
<td>21.20</td>
</tr>
<tr>
<td>Uruguay</td>
<td>20.10</td>
<td>14.10</td>
<td>10.90</td>
</tr>
<tr>
<td>Venezuela</td>
<td>26.90</td>
<td>20.70</td>
<td>17.65</td>
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Furthermore, there are significant disparities across different regions in Brazil, both in absolute levels and in rates of decline. The South and Southeast of Brazil are the wealthiest and most developed regions of Brazil, and the IMRs were 23.59 and 27.46, respectively, in 2000. In contrast, the North and Northeast regions, which are the poorest in the country, have IMRs of 41.14 and 64.25, respectively, for this same time point.
Table 3. Infant Mortality Rates (per 1,000 live births) in Brazil, By Region

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>Brazil</td>
<td>28.7</td>
<td>27.8</td>
<td>26.6</td>
<td>25.8</td>
<td>25.1</td>
<td>24.3</td>
</tr>
<tr>
<td>North</td>
<td>28.6</td>
<td>27.7</td>
<td>27.4</td>
<td>26.6</td>
<td>25.8</td>
<td>25.0</td>
</tr>
<tr>
<td>Northeast</td>
<td>43.0</td>
<td>41.4</td>
<td>39.5</td>
<td>38.2</td>
<td>36.9</td>
<td>35.6</td>
</tr>
<tr>
<td>Southeast</td>
<td>20.7</td>
<td>20.2</td>
<td>19.5</td>
<td>18.9</td>
<td>18.3</td>
<td>17.7</td>
</tr>
<tr>
<td>South</td>
<td>18.4</td>
<td>17.9</td>
<td>17.8</td>
<td>17.2</td>
<td>16.7</td>
<td>16.1</td>
</tr>
<tr>
<td>Center-West</td>
<td>21.0</td>
<td>20.4</td>
<td>20.7</td>
<td>20.1</td>
<td>19.5</td>
<td>18.9</td>
</tr>
</tbody>
</table>

Source: Instituto Brasileiro de Geografia e Estatística [20].

Next, this analysis will utilize the geographic variation in Bolsa Família coverage to examine the program’s impact on IMRs. Data on Bolsa Família coverage will be obtained from the program database [21]. Regionally\(^{11}\), there are very different levels of Bolsa Família coverage, as shown in Table 4.

Table 4. Coverage of Bolsa Família Program, By Region (as of December 2008)

<table>
<thead>
<tr>
<th>Location</th>
<th>Total Population (IBGE 2004)</th>
<th>BF Beneficiary Families (12/2008)</th>
<th>% of Total Population</th>
<th>% of Total Beneficiary Families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Brazil</td>
<td>182,062,687</td>
<td>10,557,996</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>North</td>
<td>14,434,103</td>
<td>1,075,885</td>
<td>7.93</td>
<td>10.19</td>
</tr>
<tr>
<td>Northeast</td>
<td>47,551,657</td>
<td>5,084,806</td>
<td>26.12</td>
<td>48.16</td>
</tr>
<tr>
<td>Southeast</td>
<td>77,577,233</td>
<td>2,637,339</td>
<td>42.61</td>
<td>24.98</td>
</tr>
<tr>
<td>South</td>
<td>26,700,570</td>
<td>853,526</td>
<td>14.67</td>
<td>8.08</td>
</tr>
<tr>
<td>Center-West</td>
<td>12,816,395</td>
<td>545,818</td>
<td>7.04</td>
<td>5.17</td>
</tr>
</tbody>
</table>

Sources: Instituto Brasileiro de Geografia e Estatística [20] and Ministério do Desenvolvimento Social e Combate à Fome [21].

\(^{11}\) At the time of this draft, data at the municipality level were still being gathered. They will be presented in subsequent drafts.
A disproportionate share of beneficiaries is found in the North and Northeast regions of the country, regions that are poorer and less developed than the rest of the country. These are also the regions with the worst health statistics, as illustrated by the example of infant mortality rates (Table 3).

For the statistical analysis, different model specifications and estimators will be considered. First, a fixed effects (FE) specification will be considered. The advantage of this model is that it can correct for serial correlation of repeated measures and control for unmeasured time-invariant municipal characteristics (e.g., geography, culture, history, etc.). An alternative random effects (RE) model will also be considered, and the Hausman test will be used to decide between the two model specifications.

While IMR is an important reflection of population health, it is just one of many measures of health. Additional health measures (e.g., morbidity, nutritional status, weight, vaccinations) may be examined. Data on some of these measures are now available through the Food and Nutrition Surveillance System (Sistema de Vigilância Alimentar e Nutricional or SISVAN in Portuguese) [22], but the data are not reported consistently across the country, and they are only available for Bolsa Família beneficiaries since the second half of 2006. Also, it may be possible to consider other outcomes such as maternal mortality and infectious diseases.

**Policy Implications**

Based on the growing body of evidence about the positive health impacts of CCT programs, one would expect to see a similar impact with Bolsa Família. If there is no significant impact of Bolsa Família, it may be that the existing health infrastructure is inadequate to respond to the increased demand for health care services. If this is true, CCT programs will need to
incorporate supply-side tools such as strengthening the health care infrastructure or providing appropriate compensation or incentives to providers.

CCT programs like *Bolsa Familia* are becoming more widespread in developing countries, and they are even being experimented with in developed countries such as the United States. Policymakers have reacted enthusiastically to early evidence on the effectiveness of CCT programs, yet there remains a lack of evidence on the longer-term impacts of these programs and on the relative importance of different components of the program. This study’s findings will have important implications for how the *Bolsa Familia* program and programs similar to it should be changed or expanded in the next few years.

This paper will provide needed evidence about how successful the *Bolsa Familia* program has been in achieving its objectives. Until more is known about the replicability of CCT programs in different settings, studies should continue to evaluate the impact of CCT programs on an individual basis to ensure that each program is achieving its objectives. Some program design differences, such as the exact age cut-offs, may only result in marginal differences. Other design differences, such as whether nutrition supplements are included, will likely have a more significant effect on how successful a program is in achieving its objectives. Differences within a program, as encouraged by the decentralized nature of the Brazilian system, may also result in differences in program impacts.

The law may guarantee certain rights, but additional complementary policies and programs may be necessary to enable people to actually exercise those rights, especially the poor and vulnerable. CCTs are one such complementary strategy. CCT programs hold a great deal of promise to combat poverty, reduce inequities, and build human capital. However, there are still many unanswered questions regarding CCT programs. While we should remain optimistic about
the potential of CCT programs, that optimism should not be blind, and we should apply a healthy
dose of skepticism to the development and evaluation of these programs so we can truly
maximize their potential. Furthermore, CCTs are not the only form of social protection, though
they have emerged as one of the most popular tools in recent years. CCTs focus on families with
children, and other vulnerable groups, such as the elderly, need to be the target of other
complementary social policies.
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