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KAZAKHSTAN: EXTERNAL EVALUATION, BOTA PROGRAMS

Qualitative Assessment of the Conditional Cash Transfer Programme in Akmola, Kyzylorda and Almaty oblasts

Full baseline qualitative report

Ian MacAuslan and Jo Rogers

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Executive summary

Purpose

This report summarises results from a qualitative assessment of BOTA's conditional cash transfer (CCT) programme in three oblasts of Kazakhstan: Akmola, Kyzylorda and Almaty. The BOTA CCT programme makes conditional cash transfers of 3,300 to 4,700 KZT each month (previously 2,700 to 3,900 KZT) to four types of recipients: parents with pre-school age children, pregnant and lactating mothers, parents of children with disabilities and young people aged 16-19 who have completed school and are unemployed, all of whom must pass a proxy means test (PMT) of poverty to qualify. In order to continue receiving transfers, recipients in different categories must enrol their children in pre-school, attend ante- and post-natal state health check-ups and BOTA training sessions, attend training sessions on caring for their children at home or attend youth training. Training sessions are provided by volunteers, who also mobilise communities to enrol and manage programme activities at the village-level. In Akmola and Kyzylorda, the programme is implemented directly by BOTA and began in 2009. In Almaty, the programme is implemented by NGO partners and began in early 2011.

Methodology

The fieldwork for this study took place in seven okrugs. Six okrugs contained programme operations and one was included as a control. The fieldwork was designed to generate qualitative information on programme impacts and operations (except for the target beneficiary group of young people aged 16-19 which was only introduced after the evaluation had begun). Semi-structured interviews and focus groups were conducted with programme beneficiaries of different types, rejected applicants (i.e. those who failed the PMT), and non-applicants. Interviewees and focus group participants were selected to ensure coverage of all beneficiary types and within this, different ages of pre-school children, different stages of pregnancy, and different disabilities. Sampling of beneficiaries and rejected applicants was random within these categories (from BOTA's management information system (MIS) and from lists held by volunteers), but the results are not representative in a statistical sense. In addition, key informants (volunteers, akims, teachers and health workers) were interviewed. Interviews were also taken with BOTA staff and staff from NGO implementing partners. Interview and focus group schedules were semi-structured, and covered a range of potential impacts and operations.

Results from fieldwork

The overall impression coming from this assessment is of the CCT programme having a largely positive impact, with some variation across the beneficiary categories and at the local level in the areas assessed. The fieldwork from Almaty adds little to our understanding of impacts, since the programme is more recent and few payments have been made. However, there are some new indications around targeting and NGO partner implementation arrangements.

The qualitative research indicates that BOTA CCT may have had the following impacts:

Poverty and expenditure

The receipt of cash is reported by households to have net positive impact on the level of households' consumption expenditure, although the amount transferred is small relative to most incomes and other welfare payments and is a significant supplement to the incomes of housholds that do not receive other welfare payments, particularly during winter when other sources of income are scarce. In most cases, recipient households use the money to buy more of the same

goods and services, or to buy the same goods and services more frequently. This impact was obviously much more substantial in Akmola and Kyzylorda where households have been receiving the cash for longer than in Almaty. Some (though fewer) households change their consumption patterns, buying new goods and services or goods and services of a higher quality. There is no evidence that households reduce their income earning from other sources as a result of receiving the transfer: the cash received is an addition, rather than a substitute.

Health services

The qualitative fieldwork to date indicates that the BOTA CCT provides incentives for pregnant mothers to register their pregnancies earlier than they might otherwise, and provides the means for pregnant women to attend ante-natal service and BOTA trainings regularly. Impact on post-natal health service attendance is also positive, but less clearly consistent and the value of post-natal BOTA training is seen as less useful by many mothers, particularly after their first child. Pregnant women and lactating mothers speak favourably of the health and social benefits offered by the BOTA CCT training classes and interaction with the volunteers, and there is demand for ante-natal training to be opened to non-beneficiaries.

Education services

The BOTA CCT programme is reported to have a positive impact on pre-school enrolment and attendance, with the cash being largely used for kindergarten costs and some mothers sending their children to school earlier than they would have otherwise. The qualitative fieldwork to date also indicates that the BOTA CCT programme is stimulating and facilitating communities to create interim pre-school services where none yet exist.

Care for children with disabilities

Overall, the qualitative assessment to date show that the BOTA CCT appears to bring clear positive social benefits to households with children with disabilities as it stimulates communities towards social inclusiveness. The cash transfer constitutes a small part of the expenditures of most households caring for children with disabilities, and at this stage, it is difficult to isolate the incentive effects of the BOTA conditionalities. The impacts of the volunteer inputs and training are generally positive, but more mixed than for training for pregnant and lactating mothers, depending on the skills of the volunteer and the nature of the child's disability.

Operations

The qualitative fieldwork undertaken for this assessment provides feedback from respondents, which enables the conclusions to be drawn that the CCT programme operations are sound in design and implementation, both where directly implemented by BOTA and where implemented through a partner NGO. As detailed in the main body of the report, some areas of operations, particularly around ensuring a clear, common understanding of the PMT among stakeholders, such as volunteers and community members particularly, could benefit from ongoing monitoring and minor adjustments mainly in the interests of minimising errors of exclusion. The extent of errors of exclusion or inclusion can only be confirmed by the quantative part of this evaluation. Guidance for NGO partners to enrol 1.5% of the population in each target village may also need to be revisited as it could be exacerbating errors of exclusion.

Volunteers and training were generally very well received. Training was provided either at home or in groups, and these different modalities had different advantages.

Recommendations for the CCT programme

These findings suggest four immediate areas where BOTA could further strengthen performance:

1. Provide consistent, ongoing and regularly updated information on the PMT to all key stakeholders using a range of communications techniques and building on the existing good practice of training the volunteers and specialists. As part of a contribution to sustainable social protection, understanding and acceptance of the PMT methodology needs to be systematically developed.
2. Reviewing and strengthening further some of the training modules for lactating mothers and disability households in order to supplement existing social benefits.
3. Where CCT has been involved in facilitating the creation of informal pre-school services, provide guidance to NGO partners on ensuring these services have 'good enough' basis for implementation in the medium term while continuing to focus on mobilising communities to demand state provision from their local authorities in the longer term.
4. There may be a case for revisiting the NGO contractual arrangements. This could include a larger provision for overhead, a requirement to demonstrate that other functions will not be affected, and involvement in developing CCT communications materials. Greater emphasis could also be placed on the dissemination of these materials.

Further programme and research recommendations can be found in the main body of the report.

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Abbreviations

CCT	Conditional Cash Transfer
ECD	early childhood development
KZT	Kazakh Tenge
MIS	management information system
NGO	non-governmental organisation
OPM	Oxford Policy Management
PLW	pregnant and lactating women
PMT	Proxy Means Test
TSA	Targeted Social Assistance

1 Assessment context and methodology

1.1 Context

1.1.1 Purpose of assessment report

The objective of this assessment report is to provide independent qualitative feedback on the processes and impacts of the BOTA conditional cash transfer (CCT) programme in Akmola, Kyzylorda and Almaty oblasts.

This report represents a full qualitative baseline report and a follow-up study is planned for a year later.

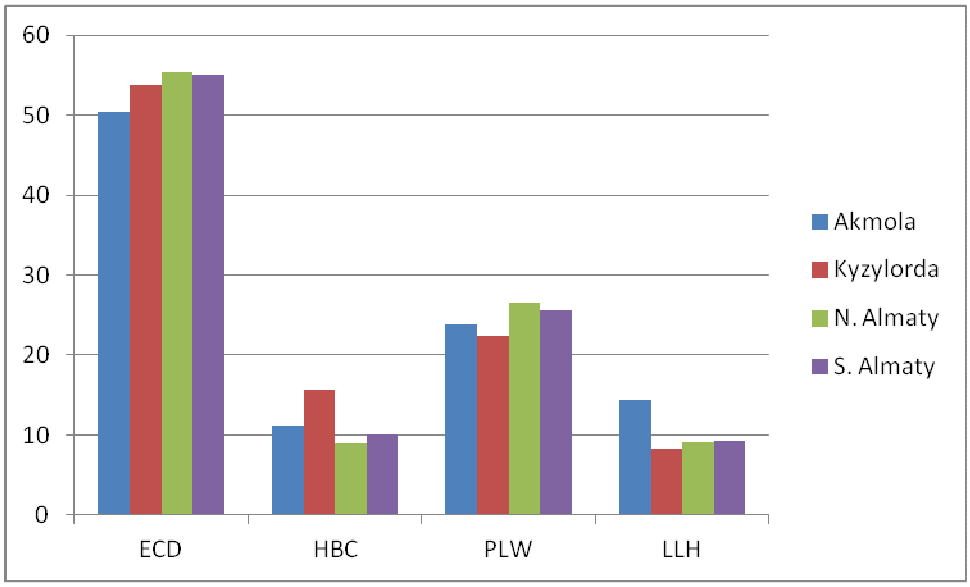
1.1.2 Introduction to the BOTA Foundation CCT

The BOTA Foundation CCT programme is intended to improve the lives of children with families suffering from poverty in Kazakhstan by increasing children's access to health, education and social welfare services. The BOTA CCT is a demand-side programme that seeks to remove monetary and non-monetary barriers to access to existing services.

The programme delivers regular cash payments to four categories of beneficiary within poor households: those with children aged four and over up until they are eligible to start school; those with pregnant women, or women with infants up to the age of six months; and households who have children with disabilities up to the age of 16. Until August 2010 this last category was for children with disabilities from the age of 4–16; the lower limit has now been removed. The fourth category of target beneficiary was introduced in mid-2011 namely young people aged 16-19 who have completed school and are starting employment, support for this category lasts for 6 months; these last beneficiaries are not part of this evaluation.

The BOTA CCT is currently implemented in three oblasts, but with slight differences in implementation modalities and timings. In Akmola and Kyzylorda oblasts, the BOTA CCT is implemented by teams directly employed by BOTA, and began in 2009. The research for this report in those oblasts was conducted in April-May 2011, when payments had been made for over a year in some areas. In Almaty oblast, the BOTA CCT is implemented by two non-governmental organisation (NGO) partners sub-contracted by BOTA, and began in early 2011. The research for this report in Almaty oblast was conducted in November 2011, when at most one payment had been made. The October CCT report shows that the CCT beneficiaries are distributed across all three oblasts and by category as follows:

Figure 1.1 Beneficiaries in each oblast by category, October 2011 (%)



Source: BOTA CCT report October 2011 and authors' calculations

In total, of the 23,145 beneficiaries active at that time, over half were early childhood education development (ECD) recipients. Almost a quarter of beneficiaries are pregnant or lactating women (PLW) and households with disabled children requiring home-based care (HBC) or with 16-19 year olds requiring livelihoods training (LLH) represented around 10 % each of the CCT programme beneficiaries. Within each oblast there is some variation in these proportions, with Akmola oblast for example, having a higher proportion of youth beneficiaries and Kyzylorda of disability beneficiaries than averge. The CCT programme therefore can be described as focusing mainly on on early childhood development.

In each rayon where the BOTA CCT is rolled out, the BOTA CCT team and volunteers should publicise the programme and encourage eligible households to apply. Once a suitable number of households is ready to apply, enrolment specialists visit the rayon and households can apply at the level of their local village or okrug centre by completing a proxy means test (PMT). Selected households should fulfil the basic demographic criteria and pass the PMT (i.e. fall below a certain poverty score).

Selected households then receive regular cash transfers (3,300–4,700 tenge per month per beneficiary household since January 2011) and are expected to fulfil certain conditions in exchange. Households with children aged 4-6 must enrol them in pre-school and the children must attend at least 85% of the time in any given month. Pregnant and lactating mothers must attend government ante- or post-natal medical appointments and classes given by BOTA volunteers. Representatives of households with children with disabilities must attend classes on home-based care given by BOTA volunteers. Young people aged 16-19 who have completed school, must attend classes on careers orientation delivered by BOTA volunteers. The combination of the provision of cash and training to poor households of these different types is expected to stimulate demand for service provision and enable households to pay for it.

The conditionality of the cash transfers and the monitoring and volunteer support around compliance is designed to have impacts on pre-school attendance, pregnancy clinic attendance, and home-based care. If these services are beneficial, then this is expected to have positive impacts on human capital development. In addition, the onus on the recipient to fulfil certain

behaviours may also have implications for social inclusivity and good citizenship. Finally, the cash transfer, human capital development, and social consequences may all have implications for poverty reduction.

1.1.3 Objective of evaluation

This assessment report is a small part of a much larger impact and operational evaluation of the BOTA Foundation's CCT programme, and also its Tuition Assistance Programme (TAP) and Social Service Programme (SSP). The CCT evaluation has the following components, which draw on both quantitative and qualitative fieldwork:

1. An evaluation of the *impact* of the CCT programme.
2. An evaluation of the *processes* or operations of the CCT programme.
3. An assessment of how effectively the programme's *targeting* process is reaching the households it is intending to support.

The impact evaluation attempts to understand the impact of making regular cash transfers, of providing training, and of requiring recipients to fulfil conditions. The process evaluation attempts to evaluate the way in which the CCT programme is implemented against its design and against other benchmarks. The targeting assessment attempts to understand whether the recipients of the CCT cash are those that the programme intended to select, and if not to identify whether this is a result of design or implementation.

This report attempts, using qualitative fieldwork in three oblasts, to provide information on all of these aspects. Given the non-representative nature of the sample of households, it is important to underline that the nature of the qualitative information provided is, by its nature, indicative and not definitive. This qualitative assessment offers nuanced first-person accounts of people's experiences and perspectives of the CCT programme without claiming that these accounts are representative of all similar households' experience. Nevertheless, the qualitative data generated during the interviews undertaken for this assessment, taken together, offers a basis from which to draw conclusions and make recommendations about areas of success and areas of weakness in the CCT programme.

In addition, fieldwork in Almaty oblast provides two further opportunities. First, it allows us to gather baseline qualitative data in communities where the CCT programme has not begun or only just begun to be implemented. Second, it allows us to explore the differences between the direct BOTA implemented programme and the NGO sub-contracted programme.

1.2 Assessment questions

The specific areas covered by this report are:

1. Impacts on:
    a. Poverty – how do households experience poverty, does the CCT reduce poverty of beneficiary households?
    b. Health services – does the CCT programme improve access to health services, awareness of health issues and health outcomes for pregnant and lactating women?
    c. Education – does the CCT programme improve access to education services particularly for children aged 4 to 6?

d. Care for children with disabilities – does the CCT programme improve the quality of home-based care for children with disabilities?
e. Unintended – what are the impacts not anticipated in the programme design?

2. CCT operations, specifically:
    a. Community mobilisation
    b. Enrolment and verification
    c. Registration and provision of bank card
    d. Payment systems
    e. Training
    f. Volunteers
    g. Complaints and communications,
    h. Monitoring and reporting (including conditionalities), and
    i. Implementation arrangements, comparing direct BOTA and NGO implementation.

The hypotheses, specific questions and sources of information are set out in Annex A. These hypotheses and questions were developed into semi-structured interview and focus group discussion guides.

1.3 Assessment methodology

Not all impacts are identifiable through qualitative research. This methodology has been used to explore the impact questions that are most amenable to qualitative research (e.g. changes in attitudes or social relations, or unintended impacts of the programme). This information will eventually also be used to complement the quantitative research once the quantitative survey is completed.

Operations have been assessed qualitatively by:

- Identifying and exploring the perceptions of community members (recipients and non-recipients) of programme processes (targeting, payments, case management) in terms of effectiveness, fairness, responsiveness, etc.
- Discussing programme functioning with the settlement level functionaries to identify settlement-level inefficiencies and scope for improvements.

Qualitative fieldwork used in this report was conducted in April-May and November 2011 in rural areas of the three oblasts, assessing impact (retrospectively in the case of Kyzylorda and Akmola oblasts) and operations (targeting, payment and case management).

The timing of the fieldwork in Almaty oblast (less than a year after the beginning of implementation) means that there is limited information on payments and the impact of the programme. Findings from Almaty oblast are intended to be more useful to understand the use of the NGO implementation model and provide an opportunity to identify and correct any problems in roll-out, rather than to make definitive conclusions about the viability or suitability of the programme.

1.3.1 Selection of locations

Akmola and Kyzylorda oblasts were selected for the initial rapid assessment because the CCT has been operating in those oblasts since 2009 and payments were being made regularly at the time of the assessment. This contrasts with Almaty oblast, where the CCT began operating in early 2011

and where the programme is operating differently (using two non-government organisations (NGOs) as implementing partners). In Akmola and Kyzylorda oblasts, the rayons in which qualitative research took place were selected purposively to maximise the breadth of coverage of the qualitative research. For the household-level research four communities that are receiving the transfer were selected (two per oblast), two more densely populated and with better services, and two more remote. The selected locations include two with a volunteer receiving a good score in the recent volunteer evaluation exercise. The selected okrugs are in Table 1.1.

Table 1.1 Selected okrugs in Akmola and Kyzylorda oblasts

Oblast	Rayon	Okrug	Remoteness	Volunteer score
Akmola	Bulandinsky	Vosnesensky	fairly close to town but rural	high
Akmola	Atbasarsky	Marinovsky	close to town	high
Kyzylorda	Zhalagashsky	Akkumsky	more remote	none evaluated
Kyzylorda	Shieliysky	Sulutyubinsky	more remote	low

Source: OPM.

In Almaty oblast one rayon from the north and one from the south were selected randomly, but aiming to include at least some beneficiary households, which had received their transfers by November 2011 and some that had not. One control okrug, where the community had not even been approached by the BOTA CCT programme, was also included. The control okrug was included in order first to gain a sense of the challenges that face the CCT programme community mobilisers when they approach a new okrug and second to deepen our understanding of the perceptions and experience of poverty among households that have no experience at all of the CCT programme. The selected okrugs are in Table 1.2.

Table 1.2 Selected okrugs in Almaty oblast

Location of NGO sub-contractor	Rayon	Okrug	Recipients enrolled	Recipients with cards	Recipients without cards	Other notes
Esik	Enbekshikazakhskii	Tashkensazskii	50	36	14	not fully covered,
Taldykorgan	Kerbulakskii	Kaspanskii	49	35	14	not fully covered
Esik	Enbekshikazakhskii	Akshiysky	0	0	0	Control

Source: OPM.

1.3.2 Selection of interviewees

The interviewees in all three oblasts were selected purposively for the qualitative study. In total across the three oblasts and seven okrugs we visited, we conducted:

- 93 household interviews
  - 54 beneficiaries
  - 18 rejected applicants
  - 18 non-applicants
  - 3 non-CCT households, one of each type of CCT target beneficiary
- 13 focus group discussions

  - 6 beneficiary (combining all three types of beneficiary)
  - 6 non-beneficiary
  - 1 non-CCT community group combining all three types of CCT target beneficiary
- 19 key informant interviews with teachers, health workers, volunteers and akims.

In addition interviews were conducted with BOTA CCT staff and staff from the sub-contracted NGOs in Almaty oblast.

A full breakdown of the interviews conducted is in **Error! Reference source not found.** It is possible to return to some of the same households in the follow-up survey, if necessary, to understand how respondents' perceptions and experience of the programme have changed.

Interviews and groups were recorded by MP3 or video, and the team also took rough notes of their observations and retained any physical outputs. The team conducted its analysis using an Excel template derived from an analysis plan.

1.3.3 Household interviews

In each location the team interviewed beneficiary households, rejected applicants and non-applicants for each category of beneficiary (early childhood development (ECD); pregnant and lactating women (PLW); and children with disabilities). These beneficiary households and rejected applicants were identified using BOTA's management information system (MIS) or by the volunteer and CCT implementing team. Non-applicants were identified locally. In the non-CCT community, ECD, PLW households and a family with a child with disabilities were identified through the village school.

The interviewees were disaggregated by the various different categories and, within those, by other key variables that are likely to affect the respondents' experience of the programme (see OPM’s evaluation plan for details):

- The ECD group was disaggregated by age
- PLW were disaggregated by pre- and post-birth and whether the mother was having her first second or third pregnancy.
- Children with disabilities were disaggregated by age and type of disability.

1.3.4 Focus groups

In addition, the team conducted focus groups with a group of beneficiaries and a group of non-beneficiaries (mainly applicants who have been rejected on the grounds of ineligibility, with non-applicants if relevant) in each site. These individuals were sampled in the same way as interviews, but there was some snowball sampling as well for rejected applicants. The focus groups sometimes included members of the household other than the recipient, e.g. male household members where the recipient is female, to probe questions about secondary and unintended impacts including the effect of the transfer on relations between different members of the household. However, the participants were usually female. In the non-CCT community, the focus group was conducted with representatives of each of the three CCT target groups identified through the school.

1.3.5 Key informant interviews

Key informant interviews were selected from initial lists of volunteers, community mobilisation specialists, village level service providers and okrug akims, and from recommendations in the community and the rest of BOTA as appropriate.

1.4 Report structure

The rest of this report presents results of the fieldwork under the following headings:

- Consumption expenditure
- Labour
- Health
- Education
- Children with disabilities
- Unintended impacts
- Operations

Section 3 then offers some conclusions and recommendations for the BOTA CCT going forward.

2 Results from fieldwork

2.1 Consumption expenditure

The receipt of cash has a net positive impact on the level of households' consumption expenditure. In most cases, recipient households use the money to buy more of the same goods and services, or to buy the same goods and services more frequently. This impact was obviously much more substantial in Akmola and Kyzylorda where households have been receiving the cash for longer than in Almaty. Some (though fewer) households change their consumption patterns, buying new goods and services or goods and services of a higher quality. There is no evidence that households reduce their income earning from other sources as a result of receiving the transfer: the cash received is an addition, rather than a substitute.

2.1.1 Socio-economic situation of the BOTA CCT areas

The main sources of income reported by respondents are salaries, part-time work, sales of own produce, and social benefits. However, the types of jobs available depend on the local socio-economic and infrastructural situation, and so are naturally quite varied between areas in terms of the availability and earnings. For example, in one surveyed village in Kyzylorda and one village in Akmola, a railway provides opportunities for full- and part-time work. In Almaty oblast, the villages surveyed were all former communal farms and very few employment opportunities have remained. Some work can be found in nearby towns or in Almaty city. Changes in this socio-economic and infrastructural situation have significant effects on the well-being of households. For example, the collapse of an agro-industrial firm in a village in Akmola reduced both household incomes and led to the decline of associated markets and businesses. This had led to increased migration of male earners to urban areas, which in turn has led to greater household conflict.

Many households, particularly in Akmola and Almaty oblasts, have their own kitchen gardens and livestock. In Kyzylorda, this is rarer as the soil quality is low, the climate is arid, and irrigation is not provided to all households. In Akmola and Almaty oblasts, many households have a kitchen garden, but they are constrained in some villages where water prices are high and households need to pay for water from a central pump or a standpipe in reasonable walking distance.

2.1.2 How does the CCT value compare to household incomes?

The BOTA CCT (3,300 KZT or 4,700 KZT per month from 2011 and before that 2,700 KZT and 3,900 KZT) represents between 10% and almost 100% of a household income, depending on the time of year, the wealth of the family, and the other benefits received (which were typically much greater in value than the CCT). This fluctuation – not only between different households, but within a household at different times of year – underlines the crucial importance of the CCT cash for some families during winter, as in winter jobs are much harder to find. As noted above, incomes are also strongly dependent on area, with incomes much more stable and higher in areas with infrastructure or businesses. This suggestion of area-based income and poverty variation is in keeping with national poverty assessments (see e.g. World Bank 2004). Typically, the CCT value tends to be a smaller percentage of household income where there are children with disabilities as carers' allowance and disability benefits total around 30,000 KZT so the 3,300 KZT is at the very most 10% of household income in these households.

In winter, particularly in villages where salaried jobs are rare, some respondents who were not on other social benefits reported that the BOTA CCT transfers can represent almost 100% of their cash income. For other households, in summer, or for families with salaried jobs, households on

other benefits felt that this was closer to 10%.[1] Strategies for dealing with the lack of cash in winter reported by households in Almaty oblast include taking food products *'on credit and at a mark up'* from the local stores or the produce trucks and paying off the account in the months when employment is available. One mother in a non-beneficiary household in Almaty oblast indicated that if she were able to receive 3,300 KZT from BOTA, this would enable her not only to send her five year old boy to the pre-school group once a week, but also to cover the cost of paying the electricity bill in the winter months.

Average monthly salaries reported by beneficiary households are, for about half of the respondents in these qualitative interviews, less than 20,000 KZT per month, and for a further quarter of respondents between 20,000-30,000 KZT per month. Average salaried jobs reported by respondents interviewed for this evaluation tend to earn between 25,000 and 40,000 KZT per month in Akmola and Kyzylorda, largely from state institutions but also private companies. In Almaty oblast, salaried jobs reported by respondents ranged from 20,000 KZT to around 50,000 KZT per month. However, many beneficiary respondents did not come from families with a salaried individual, and in some villages, salaried jobs were very rare in general. This reflects the instructions given in Akmola and Kyzylorda that staff should exclude households with per capita incomes above subsistence level. In the proxy means test (PMT), households are asked about the income of salaried members. Although this is not used in the PMT model, it is included in the PMT questionnaire to be used by enrolment staff as a basis for excluding households with high incomes. This may explain the exclusion from the BOTA CCT of households with salaried income earners.

More frequently, beneficiary households report earnings from part-time jobs, usually seasonal agricultural work or odd jobs, such as repair work. The income from this source naturally varies but at an average of 10-15,000 KZT per month when work is available is lower than from salaried jobs. Moreover, these jobs are typically much harder to obtain in winter, so the 15,000 KZT per month does not translate into an annual salary of twelve times as much.

A second common source of income, again seasonal and much less in winter, comes from sales of goods produced from animals owned by the household, such as eggs, milk, meat, or sour cream, and from sales from kitchen gardens. In Almaty oblast, at the time of the interviews, several households had just taken in a crop of pumpkins from their allotments for which they can get around 20 KZT per kilo from the wholesalers who come around in trucks to pick up the crop. The sister of one respondent helped out by buying several kilos at 40 KZT. However, the amounts earned from sales of animal and vegetable produce are typically very small, unless the household sells an entire animal, which can earn up to 30,000 KZT.

Where households' own incomes are low, it is also common to receive support from relatives who have salaried jobs, typically provided in food or clothing.

There is a range of benefits and allowances from the state, which many beneficiary households receive. These include children's allowances (up to 1 year and up to 16 years), pensions, allowances for mothers with many children, welfare for children with special needs, disability pensions and targeted social assistance. One focus group in Akmola estimated that 30% of households in their village received at least one of these benefits. Since the BOTA CCT target population is eligible for state benefits as well, almost all BOTA CCT beneficiary households interviewed received at least one benefit.

Probably the least likely benefit to be received by the BOTA CCT beneficiaries was the targeted social assistance (TSA). TSA is a safety net of last resort for households that apply and have

[1] Note that these figures are indicative for very different household types and do not imply anything for average proportions of income constituted by the transfer.

incomes below 40% of the subsistence minimum for their oblast. It transfers a payment equal to the value of the estimated difference between a household's income and the poverty line in the region. BOTA's monitoring and evaluation reports shows that around 5% of beneficiaries households also reported receiving the TSA (BOTA 2010). This coverage appears low, but TSA covers only around 1% of the population nationally (including those who live in the same household as the recipients), so BOTA CCT recipients are actually over-represented.

The BOTA CCT is typically of a much smaller value than these benefits. Table 2.1 sets out the benefits reported by households in research areas. This indicates clearly that for those households receiving other benefits, the BOTA CCT is a small additional transfer.

Table 2.1 State benefits reported by respondents

Benefit	Reported value (KZT/month)
One-off birth allowance	93,000
Child benefit (up to 1 year)	12,000
Child benefit (up to 16 years)	not specified by respondents
Pensions	25,000
Welfare for mothers with many children	6,000-8000
Carer's allowance for carers of children with special needs	15,000
Disability pension	18,000
Targeted social assistance	19,000 (but varies by household)
Survivor pension for widows	10,200
BOTA CCT for pregnant and lactating mothers	4,700
BOTA CCT for ECD and children with disabilities	3,300

Source: OPM / BISAM.

This suggests that the BOTA CCT is less likely than other transfers (such as TSA) to have a significant direct impact on poverty for recipients, because it transfers less cash to them. This is not to say that the direct impact will be zero. However, the poverty impact of the BOTA CCT is more likely to be long-term and to operate through enhancing human and social capital. The size of the short-term poverty impact will be explored in the quantitative survey, though the longer-term impact will only be apparent once the human capital investments have paid off after several years.

2.1.3 What is the cash transfer typically spent on?

Households spend the transfer according to their household needs. Households that are worse off tend to spend on more essential items, such as food and debts, while better off households are able to spend on clothes, medical care, toys and treats. As noted above, this varies by village, following poverty variations.

Some respondents made the point that the transfer – while very valuable to them – is not of sufficient size to make substantial changes to consumption patterns. For example, a monthly electricity payment is around 3000 KZT per month, and the cost of schooling can be anything from KZT 5000-7000 per month per child in the research areas, although some mini-centres are around 3500 KZT per child per month and the informal groups arranged by BOTA for children to attend twice a week cost around 1000 KZT. As one recipient put it, the value of the BOTA CCT *"is not very high, because medicines and other goods/services are very expensive. However, this sum*

covers the expenses for fruits and toys."[2] Further investigation would be useful to assess the specific impact of the CCT money during winter for those households who report that it constitutes 100% of their cash income.

Typically, households spend on items they were previously buying. For example:

> I cannot say that I am buying things that I have never bought before… it is simply that before I bought these things only very rarely, and now much more often…[3]

Within this overall pattern, the different beneficiary types tended to spend on goods and services specific to their children's needs (or their own needs as mothers). In general (though pregnant mothers may be an exception to this) this was not necessarily related to any messaging or training associated with the transfer. This pattern of spending reflects the report from respondents with children that in any case they spend the larger part of their overall household incomes on children's needs – some respondents estimate around 50% is spent on their children and others estimate up to around 70%.

Recipient families with children with disabilities tended to spend most of the transfer on their children's needs, buying nappies, fruits, toys, clothes and spending on outdoor activities. As one recipient put it: "*we deny him nothing*."[4] Parents of pre-school children and pregnant and lactating mothers, in slight contrast, appeared more likely to spend at least part of the transfer on the needs of the whole family, although putting the needs of the beneficiary children and the mother first.

Some pregnant women bought new items, such as vitamin supplements, that were specific to their pregnancy, and that they could not afford without the transfer. It is possible that beneficiary women spend on these additional items in particular (and not other additional items not associated with their pregnancy) because of the messaging and training associated with the transfer.

> [I] spend the transfer for [my older child] only on paying kindergarten fees. The pregnancy benefit is spent more on myself, I buy fruit, go to see the doctor at the Rayon centre. Now with the next transfer I will buy things for the birth…a dressing gown, towel, slippers. I am in my 8th month…[5]

2.1.4 Who decides how the transfer should be spent?

It is typically mothers that decide on spending, often in consultation with other members of the household. This is not only because the recipients of transfers are usually female, except in the case of the pregnant and lactating women (PLW), where all recipients are female[6]. Although systematic data on gender of recipient were not collected in the qualitative research, Figure 29 from the November 2011 beneficiary data provided by the CCT team shows that just over 90% of

[2] Beneficiary household interview with mother of a child with disabilities, Akmola

[3] Beneficiary household interview with pregnant woman who is also a beneficiary for early childhood education, Kyzylorda

[4] Beneficiary household interview with grandmother of a child with disabilities, Akmola.

[5] Beneficiary household interview with pregnant woman who is also a beneficiary for early childhood education, Kyzylorda

[6] Note that the *recipient* is the person nominated to receive the money: for the transfers for children this is usually a parent. This is not the same as the *beneficiary*, who is the target of the transfer, i.e. often the child.

recipients are women. This does not mean that most of the beneficiaries are also female, because many beneficiaries are children who may be boys or girls. BOTA's monitoring and evaluation (M&E) indicates that, for the transfers for early childhood development (ECD) and children with disabilities, the beneficiary children themselves are fairly evenly split between males and females (see e.g. BOTA (2010) where just under 50% of beneficiaries in these two categories are shown to be female).

The proportion of female recipients may vary from village to village. In one village in Almaty oblast, where the vast majority of the population is Uyghur, the recipients interviewed were almost exclusively female and the signing up for benefits was seen as a woman's role '*perhaps because men find it shameful to need and ask for help*[7]'. It would be interesting to compare this to the TSA, another on demand transfer.

The collection point influences the decision-maker on spending. Where the collection point is far from the village and close to the nearest market, the recipient (i.e. the person who collects the transfer) will decide how it should be spent. As one beneficiary respondent put it, "*usually, the grandmother decides, because she herself goes to the town to draw the money. The mother never interferes in this process.*"[8]

In many households, the household head is consulted on spending, if the recipient is not the household head. However, several respondents reported that older children with disabilities participated in decision-making. For instance: "*As the girl is big and she knows that this money is determined to benefit her, she sometimes makes orders to her mother*."[9]

2.1.5 Do beneficiary households feel wealthier after receiving the transfers?

Although the sums provided by the BOTA CCT are not always significant compared to other welfare benefits, overall income and total spending, some beneficiary households reported feeling wealthier as a result of the transfers. For example, participants in a beneficiary focus group in Akmola made the point that:

> Despite the fact that the amount of the welfare is not so great, in some cases it is the only income in a family. Though welfare is not able to stir up the feeling of well-being, it gives confidence to people that next month they will have some money.[10]

The feeling of confidence was a recurrent theme, expressed particularly by recipients with few other sources of income, and noted by respondents while noting that the amount was not very large. The regularity and reliability of the transfer was noted particularly by recipients who had received the benefit over several months in Kyzylorda and Akmola oblasts. Where the transfer had more recently started to arrive, for example in the villages surveyed in Almaty oblast, the recipients were largely still getting used to the idea that they could purchase larger household items that were normally not within their means. Examples cited included second-hand washing machines and microwaves, items of furniture, and curtains. Other ways in which the cash transfer 'savings' were

[7] Beneficiary focus group discussion, Almaty oblast

[8] Beneficiary household interview with mother of a child with disabilities, Akmola

[9] Beneficiary household interview with mother of a child with disabilities, Akmola

[10] Beneficiary focus group, Akmola.

used that were cited by respondents in Almaty oblast included '*clothes for the children', 'having an ultrasound scan done*[11]' and paying for other health services.

Respondents in Almaty were asked to complete small questionnaires on their material situation and well-being. Although the sample sizes are of course very small, and therefore not statistically representative, the results are interesting and tally with these findings above.

- Beneficiary households were less likely to feel they didn't have enough money for food (only 6% felt this, compared to 17% of rejected applicants and 22% of non-applicants). No beneficiary respondents felt they had enough money for all their needs, while a small number of households who were rejected or who had not applied did. This could be interpreted both as a gentle validation of targeting effectiveness, and as an indication that a regular transfer reassures households about their food security.
- The small number who felt that they had money for durables or had enough money were all in households containing children with disabilities. This may reflect some subjective targeting (see below).

2.2 Labour

One of the possible impacts of cash transfers, particularly where some conditionality is involved, is a change to households' labour patterns. There is an important difference between *observing* a change (of more or less labour participation) and *evaluating* a change (saying whether this is good or bad). Sometimes, policymakers worry that cash transfers may cause recipients to work less, and that this is necessarily bad. However, not only is it not usually the case that transfers cause this effect, but it is also arguable that reduced economic labour participation and increased time spent on social care is a positive, not negative, impact.

Overall, there appeared little reduction in the labour participation rates of beneficiary households. For most households, they were underemployed before the transfer (i.e. they sought more employment than they could find), and this continued thereafter. Moreover, the transfer value is relatively small.

Indeed, overall labour participation may have slightly increased as some beneficiaries of the cash transfer with the pre-school attendance condition report being freed up to look for work by their children going to preschool as a result of the BOTA programme. The extent of this apparent impact across all villages, oblasts and households needs to be further explored as the evaluation unfolds:

> My daughter began to go to the preschool institution after the enrolment to the [CCT]. She spends a full day there. ...The main reason was that [I] wanted to find a job, but had nobody to leave my daughter with, and the [CCT] conditions were a good opportunity to bring the idea to life. Fortunately, there was a vacant place in the mini centre at that moment.[12]

This impact is relevant only where a full day of preschool is available and the availability of preschool appears to vary quite considerably across the villages surveyed in the three oblasts. It is probably reasonable to state that where CCT has helped a 4-6 year old child into full-time preschool, and there are no younger siblings requiring full-time care at home, the transfer is

[11] Beneficiary household interview with mother of 4-6 year old child, Almaty oblast

[12] Beneficiary household interview with mother of pre-school child, Akmola

probably making it possible for the parent who has been providing child care, usually the mother, to seek full or part-time employment. However employment opportunities are so scarce in the vicinity of these villages, that it is not at all clear whether this has then led to increased employment.

2.3 Uptake and awareness of antenatal and postnatal health services

2.3.1 Antenatal health services

Antenatal services appear to be commonly used and widely understood by respondents, whether beneficiaries or non-beneficiaries, as both necessary and normal. It is culturally and socially normal to use these services – the BOTA programme is therefore building on existing positive attitudes and behaviours and is not introducing a new concept. This is illustrated by the findings of the Multiple Indicator Cluster Survey carried out by the State Statistical Agency of Kazakhstan and UNICEF in 2006, which recorded that some 99.9% of pregnant women attend antenatal services.

While the quality of state services is not a specific objective of the BOTA CCT programme, this quality has a direct impact on the outcomes of the programme in terms of health status, and is therefore important. Moreover, if the quality is perceived by beneficiaries to be low, there is a risk that the programme's reputation is affected because beneficiaries may question why they should attend services.

Perceptions of quality were mixed. Some respondents mentioned the poor quality of state health services. One respondent who was diagnosed with anaemia in the 4th month of pregnancy mentioned that the doctor did not provide information about this condition and its possible consequences, but only prescribed the necessary medicines. So she had to find the respective information about anaemia and get recommendations from her friends "...if nothing hurts or is bothering you, then why bother going there? You go once and that's it."[13]

Others were satisfied with the services they received from the state health care services mentioning "experienced doctors who have been doing their work for many years"[14] and a comprehensive range of ante-natal care which they received including "medical examination, weight control, urinoscopy, blood test, cardiogram, ultrasound examinations, Hb level measurements"[15]. Respondents mention that the state health services provide information about anaemia and other conditions that need to be treated during and after pregnancy.

One anaemic mother of a 3 month old child in Almaty oblast[16] was given prescriptions for vitamins and medicine by the village health service during her pregnancy, but no advice about diet, and she is still anaemic. She found the book[17] given to her in the maternity hospital the most useful in terms of looking after herself and her infant. The book it includes '*articles on breastfeeding, how to put your child to sleep and other things...*'. The health worker[18] interviewed in the same village, confirmed they provide prescriptions for anaemia and have good results ('*they come in with an haemoglobin count of 95-100 and leave us with 120*'). However, she also indicated that they provide dietary advice to anaemic women.

[13] Rejected applicant interview with pregnant woman, Akmola

[14] Beneficiary and non-applicant household interviews with lactating women, Kyzylorda

[15] Beneficiary household interview with lactating woman, Akmola

[16] Rejected applicant, lactating woman, Almaty oblast

[17] 'Nastolnaya Kniga Mama' published by the Ministry of Health

[18] Key informant interview with village midwife, Almaty oblast

Respondents in all three oblasts confirmed that health services are free, but that the cost of travel and some medicines or food supplements has to be borne by the applicant – "*the main obstacle is the lack of money and high cost of a trip to the town*".[19] Some tests that cannot be done locally at the outpatient medical centre in the village require a journey to the nearest town hospital and, some types of medical services do require a payment for example ultra-sound scans. For some, the need to travel quite long distances for check-ups during pregnancy is problematic and contributes to late registration of pregnant women with antenatal services and the skipping of appointments:

> … [I] registered the pregnancy on the 6th month. The major reason is the necessity to go to Atbasar and, accordingly, to spend money for transportation. That is why many mothers do their best to delay the date of visit to the doctor.[20]

These comments on quality and access to ante-natal health services were confirmed in key informant interviews:

> 70 % of pregnant women record pregnancy in time. However … such a situation is observed only in recent years. Formerly, women were more negligent in terms of their health. Now, under stronger control, the situation is improved. Even so, one third of pregnant women record pregnancy later, after 4th month of pregnancy. The major reason of a late pregnancy registration is the necessity to go to the town of Atbasar to visit a doctor.... The cost of a one-way trip is 400 tenge. Another reason not to go to medical examination is the necessity to wait in a queue. As one doctor provides services to 35 settlements, pregnant women and nursing women have to wait for about the whole day.[21]

Both beneficiary women and key informants confirm that the BOTA programme has provided an incentive for earlier registration of pregnancies with state ante-natal health services:

> …there have been several instances when women have come and registered with the ante-natal services at an early stage of pregnancy in order to receive the cash transfer…[22]

> …the benefit from the [BOTA] Foundation helps ensure early registration of pregnancy and full compliance with the doctors' instructions…the percentage of women who register their pregnancy early has risen to almost 98% although before it was about 80%. When BOTA appeared, they became more obedient. We tell them, if you don't come to your appointments your benefit will be stopped and they now come themselves, even earlier than we say. They now have an interest in doing this[23].

[19] Beneficiary household interview with pregnant woman, Akmola

[20] Beneficiary household interview with pregnant woman, Akmola

[21] Key informant interview with village midwife, Akmola

[22] Key informant interview with village midwife, Kyzylorda

[23] Key informant interview, village midwife, Almaty oblast

The transfer has also helped to ensure that women are not constrained by poverty to make the journey to receive the services they need:

> ...With my other pregnancies I didn't go to the doctor regularly because I didn't have the money to get there…but with this pregnancy I went often, every time the doctor ordered it. On the one hand this was my 7th child and I was frightened of complications and on the other, because I had money for the journey from the BOTA Foundation.[24]

Results from field work to date, therefore, point towards the following impacts of the BOTA conditional cash transfer programme on antenatal health service usage:

- earlier registration with antenatal services because it is a condition of registering for the CCT
- more regular attendance at antenatal appointments because cost and distance barriers are addressed by the cash transfer and because the monitoring of compliance with conditions generates incentives to attend (in order to continue receiving cash). It appears for this particular instance that the threat of penalties for non-compliance is at least as significant as the encouragement and training around the benefits of classes.
- where distances to antenatal health services are greater, attendance is likely to be more irregular, more of the transfer is likely to be spent on transport and greater use is made of the local village midwives who offer basic screening check-ups but cannot provide ultra-sound scans or deal with complications or problems during pregnancy.

2.3.2 Post-natal health services

While respondents, whether from beneficiary families or not, generally acknowledge the importance of antenatal health care for both mother and child, they tend to have less time for post-natal health check-ups. Household chores and child care duties, as well as the same cost, distance and time barriers outlined above, are cited in household interviews as reasons for not attending regular health check-ups after the birth:

> …While I went to the doctor regularly before the birth, now I will take the child only if he is ill. I can't go to the doctor every month because I have a lot of work to do at home. The polyclinic is quite far away, about a 30 minute walk. I don't have a car so I have to carry the child myself, we don't have a perambulator either…[25]

Respondents indicate that they attend appointments when they are contacted by the health services to do so. Also there is a perception that taking the child to the doctor too much troubles the child unnecessarily and respondents mention taking their children to the doctor only when they are ill or for vaccines.

> If he is not ill, why go to the doctor…once a month is more than enough for check-ups…[26]

[24] Beneficiary household interview with lactating woman (and early childhood education beneficiary), Kyzylorda

[25] Non-applicant household interview with lactating woman, Kyzylorda

[26] Beneficiary household interview with lactating woman, Almaty oblast

Otherwise, there is willingness to meet the conditionality for lactating women of attending the training run by the BOTA volunteers, but there does not appear to be the same impact on better attendance of health services as for pregnant women perhaps because each lactating woman would attend a health facility only 2 or 3 times following delivery before exiting the CCT programme. Perhaps this is also because women who attended training during pregnancy are aware of anaemia and feel equipped to deal with it. The awareness of anaemia from training during pregnancy, where this was attended, and its consequences for their children as well as themselves is carried through to the post-natal period and therefore the respondents seem to value the opportunity to interact with each other at post-natal training rather than to value the information they are being given at these training sessions about anaemia, diet and health issues.

2.3.3 BOTA training for pregnant and lactating women

Respondents who have been enrolled for longer periods in the CCT, for example in Kyzylorda and Akmola, generally rate the BOTA training highly, compare it favourably with the information they receive from state services and note that while their own health undoubtedly benefits, the whole family, including the children benefit too:

> I never ate tomatoes, but now I have started to make things with tomatoes...fish has calcium, iron, phosphates and ... I started to take this home...[27]

Several respondents noted the usefulness of the training not only in relation to preventing and dealing with anaemia during and after pregnancy, but also in terms of learning about child development, nutrition and care. One respondent preferred the ante-natal training:

> ...the postnatal training sessions were not as useful as the prenatal ones, because they contained general information how to take care of a child properly, as well as about the healthy nutrition of the child.[28]

It is worth noting that her training takes place in her own home with the volunteer visiting her. Other respondents recognise the value of the friendly atmosphere of group training: the opportunity to talk with other women about common problems is a welcome 'break' from household cares and makes them feel like "...a schoolgirl again, [the volunteer] asks questions. It's interesting, for me it is interesting."[29] While valuing the group camaraderie, some women noted that they find it difficult to find the time for training and to make child care arrangements. It might be worth weighing up the benefits of the interaction with other women at group training, particularly in the post-natal period, against the inconvenience of having to find the time and make the child care arrangements of going to training outside the home. Volunteers are also likely to have their own views on what is most convenient, and it seems that there is no strict rule on BOTA's part and that training is arranged by the volunteer in the way that seems to suit best.

All but a very few respondents had heard about the training, but some, mainly in Almaty oblast, had not participated, or had only been given materials to read but had never taken part in either one-to-one or group sessions. In nearly all such cases, the respondents had been enrolled in the CCT for less than 6 months and had either not received, or only recently received the first cash transfer at the time of interview. According to the NGO implementing partners and BOTA staff, in

[27] Beneficiary household interview with lactating woman, Akmola

[28] Beneficiary household interview with lactating woman, Akmola

[29] Beneficiary household interview with lactating woman, Akmola

areas where the CCT is starting up and there have been delays between enrolment and the receipt of bank cards, it is more difficult to enforce conditionalities as trust is still being built between the volunteer and the enrolled, but not yet receiving, beneficiaries. This means that a de facto grace period in attending training has been in force for some beneficiaries in some parts of the more recently enrolled oblasts.

Otherwise respondents who have been enrolled and receiving cash transfers for longer periods displayed detailed knowledge and understanding of anaemia, nutrition in household interviews and gave examples of new knowledge or knowledge which had enriched and extended their existing knowledge. Volunteers and akims confirm in key informant interviews the positive nature of the training for pregnant and lactating women. There are some logistical difficulties in some cases in securing a space to hold group meetings – one volunteer holds meetings in her own home, others visit the women and hold one-to-one training sessions in the beneficiaries' homes. The focus group discussions also indicate the high value given to the training for pregnant and lactating women not only by beneficiaries but also by non-beneficiaries and there is clearly a demand for training to be offered to non-beneficiaries. In newer programme areas, the village health services staff did not know about the content of the training nor that attendance at training is a conditionality for the CCT programme beneficiaries. As the programme beds down in these areas it is likely that their knowledge about the training modules will increase.

Results from qualitative field work to date, therefore, point towards the following impacts of the BOTA conditional cash transfer programme on post-natal health service usage:

- The women are able to meet the requirement to attend a health facility 2-3 times after delivery and before exiting the programme when the infant reaches 6 months. It is not possible to state as clearly as with ante-natal service usage whether this represents an increase in uptake or not. Most respondents see little need in attending post-natal services for themselves or their child except when called by the doctor for vaccinations or other mandatory state health interventions

- There is a need to strengthen the content and structure of the post-natal training sessions to focus not only on anaemia and health issues that affect the mother and child but also to give information not covered in previous training such as infant care, early childhood development, attachment and bonding. The CCT team has developed a training module on early childhood development, bonding, attachment and parenting skills aimed at parents of pre-school children. So far, this module is optional, but parents who took part in the training have found it to be extremely useful and think that it has changed the quality of their parenting[30]. This kind of training content may be more useful for lactating women, than content focused solely on anaemia.

2.4 Uptake of education services

There is a mixed picture presented by the results from Almaty, Akmola and Kyzylorda oblasts in terms of availability of preschool education services in the villages where interviews took place. Respondents in key informant and household interviews report both problems and no problems with availability of places in pre-school education facilities:

[30] Focus group discussion with beneficiaries, Almaty oblast

> There was no waiting list in our case. Actually, the preschool classes are obligatory for children. The state itself provided the required number of places in preschool classes and met other school needs.[31]
>
> The first problem was payment, and the second one was a waiting list.[32]
>
> There is no waiting list, and to the contrary – there are some vacant places.[33]
>
> The village kindergarten can meet only half of the demand for pre-school education. Not all children of pre-school age can get a place in the kindergarten[34]
>
> There is no kindergarten or mini-centre, a preschool group has been set up at the school for the children to attend twice a week on Saturday and Sunday for 3 hours each time. And there is a zero [preschool] class at the school.[35]
>
> There are only two zero [preschool] classes at the school and no other preschool services. Without preschool they cannot start to look for work. Mothers would be willing to pay up to 3000 tenge for preschool education for their children.[36]
>
> There is a mini-centre where 25 children study in two groups – younger and older. It costs 5000 tenge per month. There is a waiting list, but it is only possible to open an additional group if a group of 25 children can be identified. And there simply won't be that many as there is no work in the village and we can't reduce the cost as the cost is only for food. And also there is nowhere to open another group.[37]

While the BOTA CCT programme does not attempt directly to improve the quality of pre-school education, the programme does assume that children benefit from going to pre-school and it tries to stimulate the creation of preschool provision where it does not yet exist. In the surveyed villages, there is an instance of the BOTA programme supporting the creation of an informal preschool group with a class in Russian and a class in Kazakh with the CCT implementation team including the volunteer from the village facilitating discussions between parents, the school director and the akim in order to ensure that a group could be opened. The group operates twice a week for three hours each session and cost 1000 MNT per month per child. There are around 20 children aged 4-6 years in the group. During the summer months, the group functioned three days a week for three hours on weekdays, but during the school year can only operate at weekends as

[31] Beneficiary household interview with mother of child aged 4 years, Akmola

[32] Beneficiary household interview with mother of preschool child, Akmola

[33] Key informant interview with a teacher, Akmola

[34] Key informant interview with Akim, Kyzylorda

[35] FGD with beneficiaries, Almaty oblast

[36] FGD with non-CCT programme area target group representatives, Almaty oblast

[37] Key informant interview with preschool teacher, Almaty oblast

there is no spare classroom available during the week[38]. The service provision seems to have been irregular, in part because parents don't always pay the teacher '...w*hen it was first organised all the mothers were all for it. But when it gets down to actually paying the teacher for her work, the problems started. They don't pay on time, are constantly delaying, the teacher has to run around after them to try and get the money from them...And only after the teacher refused to keep on teaching, some of them started to sort it out.*[39]'.

This type of informal, BOTA stimulated group seems to be particularly prevalent in Almaty oblast. It is not entirely clear why this but it could be that the Balapan programme has not yet reached the whole of Almaty oblast as comprehensively as other oblasts surveyed. According to the BOTA CCT team, the aim is not to create informal education provision, but to support the villages in ensuring a preschool provision that is lasting and that can meet the demand of the villagers. So the aim would be to try and formalise these types of groups as state funded and run mini-centres in the medium term. In the village in question, the akim indicated that the priority is to build a new school in 2012 and maybe, after that has been accomplished, '*there is one building that can be given to build a kindergarten or mini-centre. If it works out, then it will be straight after the building of the new school'*.[40] So the informal group has to serve the community, and the needs of the CCT programme, for at least two more years which would indicate that it is worth the local implementing NGO partners supporting the local communities in trying to find solutions for the type of administration and management issues that seem to be hampering this type of informal provision at least in this case.

Perceptions of quality among respondents are mixed with some respondents praising the education, the premises and the food at the preschool facilities, and others expressing dissatisfaction with some or all aspects of the service. Some of the factors cited by respondents as affecting both quality and access to pre-school include: type of village, size of available buildings, availability of good quality teaching staff, access to equipment, fixtures and fittings, distance and complexity of the journey to pre-school, availability of teaching in Kazakh, Russian or other languages, consistency of the attendance of the teachers in the case of the informal preschool group and the quality of the meals offered at the pre-school facility.

Other issues raised by respondents relate to whether the pre-school provision is full or half day with some beneficiary households giving clear preference to full-day as it permits them to seek and take employment. Key informant interviews also confirm this as an important issue, as is the provision of food at kindergartens:

> There are families who ask the kindergarten head to let a 6 year old child stay at the kindergarten because they don't want to send him to the Zero Class as it is only for half-days and they don't feed the children there...[41]

Most parents are positive about the impact of preschool on the development of their children, including even informal preschool groups for only a few hours a week. They note particularly that their children have started to learn poems, to draw and to sculpt with plasticine and they report positive benefits in terms of speech development and social skills. The satisfaction with the quality

[38] Description of this informal group comes from several sources all in Almaty oblast: Key informant interviews with volunteer, CCT NGO partner staff, Akim and School Director; FGD with beneficiaries; beneficiary household interviews with preschool children

[39] Key informant interview with School director, Almaty oblast

[40] Key informant interview with Akim, Almaty oblast

[41] Key informant interview with preschool teacher, Kyzylorda

and usefulness is in some contrast to current perceptions about state ante- and particularly post-natal clinics, which are still not considered particularly useful, especially by mothers after their first child.

One parent with four children aged three months, two years, five years and eight years, who is a CCT recipient under two categories, but was interviewed as the mother of a preschool beneficiary, stated that she is happy with her daughters' progress at the informal preschool group in the village, but finds the requirement to attend all sessions without exception to be excessive as she has young children and nobody to leave them with when she takes her five year old to preschool. Once, when she warned the teacher in advance that her child would be missing one session, '*the teacher said that if you miss one session, there will be checks and you won't get the benefit*'[42]. This particular parent and teacher seem not clearly to have understood that the BOTA conditionality is for 85% attendance in any given month, or the teacher is taking a harder line than is strictly accurate. The BOTA CCT team confirms that they do hold back payment if a beneficiary has been marked as not fulfilling the conditionality of 85% attendance without a good reason for missing more than this amount and reinstate once they have been marked through the volunteer monitoring system as having recommenced attendance.

On the whole it appears that the BOTA programme is having a positive impact on the numbers of children enrolling in pre-school facilities and on the regularity of attendance. While some children were attending pre-school before enrolment in the BOTA CCT programme, many enrolled only because the transfers made it possible – "*the whole transfer is used on the kindergarten fees which are 3000 tenge and the remaining 600 tenge is used to go to the bank to withdraw the money*"[43]. '*My child attends zero class now, and went to the mini-centre from 5-6 years of age but only because a relative paid the 5000 tenge fee.*'[44] One respondent planned to send her child to preschool classes next year and the conditions of the CCT programme pushed her into doing it a year earlier, about which she is satisfied *"I thought she was still too little and was going to send her next year and then no, it turns out that she herself wants to go..."*[45] In another case, a respondent in Kyzylorda reported that her child had been attending preschool, had been forced to stop because the family couldn't afford the fees and was able to go back again when they became beneficiaries of the BOTA programme. Where there are multiple eligible children, however, not even the cash transfer seems to stimulate the enrolment of all the eligible children in all cases:

> My [first] daughter was enrolled in the pre-school [before the CCT], and [since] it is obligatory to go to school, she attends classes regularly…I have not enrolled my second daughter (4.5 years of age) because it is required to send her in the kindergarten (or mini centre). But we can hardly afford it even if we get the money transfer.[46]

There are large discrepancies in the reported cost of preschool education. In the case of zero class it is free, mini-centres are reported as costing anything from 3000-7000 KZT and informal groups cost around 1000 KZT. The BOTA CCT programme intends the cash transfer to pay for part of the fee for preschool education as it wants to motivate parents to take ownership of the problem of paying for the other part. Given the wide variances in the cost of preschool education fees, this aim is only partially being fulfilled.

[42] Beneficiary household interview with mother of preschool child, Almaty oblast

[43] Beneficiary household interview with mother of preschool child, Kyzylorda

[44] Beneficiary household interview with mother of preschool child, Almaty oblast

[45] Beneficiary household interview with mother of preschool child, Akmola

[46] Beneficiary household interview with mother of child aged 5½, Akmola

Several respondents refer to the "Balapan" state general education programme as introducing obligatory preschool education and addressing problems of access and quality. Respondents also refer to the “Vseobuch” programme as providing support with school supplies, clothing and other essentials to children from low income families. The BOTA programme appears to fall clearly within the Government policy of working towards offering opportunities for preschool rearing and education to all children regardless of place of residence and family income (by 2020)[47] This clearly offers greater opportunities for creating synergies and extending the impact of the CCT on take up of pre-school education. One key informant, a specialist in the Akim’s office, in a village where an informal BOTA CCT programme pre-school group had been established did not know about the informal group and indicated that she would want to send her child to the group and would be willing to pay the 1000 KZT fee. It could be that there is even greater demand among non-CCT beneficiaries for pre-school provision that could extend the impact even further among 4-6 year olds.

On the whole, the CCT programme appears to be achieving a positive result either by increasing the ability of the families to send their children to preschool regularly or by stimulating communities to establish preschool provision where none exists. There are some nuances relating to quality and access of both formal government provided and informal community organised preschool, but most respondents report positive outcomes in terms of their child’s skills, abilities and speech development. Some respondents report that attendance at full-time preschool has enabled them to seek employment.

In the non-CCT programme area, there is a zero class provision that meets the needs of six year olds for preschool services, but parents interviewed in the focus group discussion indicate a strong need for greater provision of preschool services for four and five year olds. So far, without intervention from the BOTA implementation team, this provision does not seem likely: although parents appear motivated, they perhaps lack the organisation and facilitation that the BOTA CCT programme provides.

The role of the volunteer in relation to ensuring the conditionalities of the pre-school component of the CCT programme are met is more limited than in the other two components. The volunteers use lists from the pre-schools and the Akimat to mobilize potential applicants and they visit the pre-school to check on attendance of beneficiary children. Key informants confirm that children attend regularly, in one case “*because they might lose their place if they don’t…*”[48] and beneficiary households report that children enjoy attending pre-school so there is no issue about regular attendance. A new training module was introduced in 2011 aimed at the parents of 4-6 year olds which is focused on improving parenting skills. This module is currently not compulsory as a part of the conditionalities for this category of beneficiary, but those respondents who had taken part in the parenting skills training offered very positive feedback ‘*my child is finding it easier at school as I now know that I have to give him more attention, not like I did with my older child when I just pushed him away and said don’t bother me I’m busy*’[49] It may be that making this training course compulsory could present an additional opportunity for creating positive benefits to the well-being of preschool children.

The evaluation to date therefore points to the following results in terms of pre-school education which will be explored and unpacked further in the final stage of the qualitative evaluation in 2012:

[47] Development Strategy 2020, Presidential Decree 922 (2010)

[48] Key informant interview with pre-school teacher, Kyzylorda

[49] Participant, mother of preschool child, in FGD with beneficiaries, Almaty oblast

- the BOTA programme, together with the Government 'Vseobuch' and 'Balapan' programmes, have stimulated increased demand for and provision of pre-school places. This has come about both because of the condition attached to the cash transfer which is motivating parents to seek preschool services and the facilitation provided by the volunteers and BOTA implementation teams that helps communities to create preschool services where none exist, and because the cash transfer itself is making pre-school attendance more possible at existing facilities.
- In the cases where the BOTA programme has directly motivated communities to create informal preschool groups, this result can be attributed to the human capital benefits that come from the community mobilization aspects of the programme as well as the conditionality itself. The training provided to community mobilisers and volunteers that helps them to facilitate discussions between parents, teachers, akims and school directors is as important to this result as the question of the injection of cash into the community provided by the CCT programme.
- there are many children who are attending pre-school facilities only because the BOTA programme makes it possible and they would not be attending if the BOTA programme were not operational in their village. There is potential for offering informal pre-school places to non-enrolled children for payment where no other facilities exist – an option that does not sit within the CCT remit, but which could be explored by communities and implementing partner NGOs to add value to the CCT programme.

Further work needs to be done to better understand some of the constraints identified in the fieldwork and how the BOTA programme is having an impact on them:

- patchy meeting of demand for full-time pre-school provision, in some villages there are waiting lists and little being done to meet demand, in others there is mixed part and full-time provision which is meeting full demand and in yet others there is the provision of small amounts of informal provision.
- factors affecting satisfaction of parents with the quality of services. Informal provision of preschool services stimulated by the BOTA CCT programme could be at risk of losing credibility among parents and community members where no stable administrative and management solutions have been established. The NGO implementing partners could provide additional support to facilitate finding solutions to these issues.
-

2.5 Care for children with disabilities

2.5.1 BOTA and state support for children with disabilities

The aim of the BOTA CCT programme support for children with disabilities is, according to the CCT team, twofold: to improve the quality of care provided by parents to their children in the home and to motivate parents to seek services from the state to support them in looking after their child.

State support to children with disabilities who live with their parents combines centre-based rehabilitation services that are mainly medical or quasi-medical such as massage with allowances and benefits and, in some oblasts, outreach services involving visits by social workers to the home of the child for the provision of direct personal care services. Respondents from household interviews in Kyzylorda and Akmola report that the state social services provide home visits to children with disabilities by a social worker from twice to five times a week. In Almaty oblast, respondents report that they are supposed to receive visits from social workers '*but we have no*

social worker in our village'[50]. Respondents in both beneficiary and non-beneficiary households and focus group participants who are parents of children with disabilities value greatly these visits, indicating that their children look forward to them. The BOTA CCT team[51] emphasises that every rayon has a state psychological-medical-pedagogical commission that is responsible for providing expert advice and consultations to parents about the disabilities of their child and the individual programme of rehabilitation that is appropriate for each child.

In addition, children with disabilities are offered twice yearly visits to disability rehabilitation centres where they receive a mix of social and medical services in a residential setting for periods of 15 days to three months at a time. The disability benefits and carers' allowances provided by the state are considerably larger than the amount provided by the BOTA CCT programme with each household receiving around 15,000 KZT in disability benefit and 16,000 KZT as a carers' allowance.

Many of the respondents benefiting from the programme for households with children with disabilities report stable salaries, regular disability benefits and appear to have much higher income levels than other types of beneficiaries. As a result in some cases the BOTA cash transfer is being saved to purchase large items for the child with disabilities "*because there is no need for it at the moment*…"[52] Since disability status of children is not included in the PMT calculation, but income is sometimes asked (and not used in the PMT but may be used as a subjective filter by enrolment staff prior to admitting a potential beneficiary to take the PMT), it is possible that enrolment staff are more likely to include households even if their reported salaries seem high if they have children with disabilities.

Some respondents in Almaty oblast report that they do not receive the social worker support to which they are entitled and that this kind of support would be of more value to them than the cash transfer.

Respondents generally value the medical assistance that they receive from the state, whether in residential or non-residential settings, and feel that it helps their children to develop, while some mention the indifferent attitudes of medical staff. All who receive social worker visits value them highly and feel that they help their children to develop and also to be more socialised. Nearly all respondents recognize the importance of home care for their children – referring to the importance of love, warmth and attention that the family can provide. In some cases, respondents report that they have been offered places in internats for their children, but they have refused either because the conditions were poor or because they did not feel that the care and treatment in the internat would be in the best interests of their children. One mother from a beneficiary household in Almaty oblast stated that '*as long as I am alive, my child will be near me*' as a reason for not placing her child into an internat when this was suggested by the state specialists. One mother from Akmola, whose child is 4 years old, intends to seek an internat place for her child when she is older. One interview conducted in Almaty oblast with the head of a non-applicant household where the child with disabilities in the family had been placed 10 years ago, at the age of six years old, into an internat, stated that the reason for the placement at the time was the complete lack of services to support the guardians of the child, his grandparents, in looking after him. '*I had to go away for a week and when I came back I found that my wife, the child's grandmother, had been ill*

[50] Beneficiary household interview with mother of 13 year old child with mental and physical disabilities, Almaty oblast

[51] Group interview with BOTA CCT headquarters team, Almaty

[52] Beneficiary household interview with mother of 2 children with disabilities, Akmola

and nobody had been taking care of the boy, not even changing his nappies.[53]' The household has since lost contact with the child who is in permanent long-term institutional care. On the whole, most respondents seem committed to providing home based care and seeking educational, health and social services locally even where their child's disability places considerable demands on them.

2.5.2 BOTA training and volunteers and beneficiary households with children with disabilities

The descriptions that respondents give of the training offered to the parents of children with disabilities seem to vary considerably from village to village. This indicates that volunteers are delivering the BOTA training modules in a different way to the modules for the pregnant and lactating women beneficiaries where results seem to be more consistent across the three oblasts and the six villages visited for this evaluation, even given the differences between training delivered during a 'start-up' phase and the training delivered in a more established programme area. In relation to disability, some respondents report not having taken part in any training, another reports participation in training which appeared to be aimed at pregnant women which she found to be not particularly helpful:

> [I] am not interested in the training sessions very much … they are aimed at women who are giving birth... I know a lot about healthy nutrition and proper child care. I am more interested in training on child development. For example, in development exercises, general stretching and movements. Such kind of training will be more useful and interesting for me.[54]

Another reports systematic training with the use of a workbook delivered by the volunteer in the home of the beneficiary which is '*too complicated'* and '*not clear' – 'It would be better to use simple words*'[55] a perception confirmed by another Akmola respondent who couldn't use the workbook because it was in Russian as well as using '*complicated terminology*'[56]. Other respondents find the information easy to understand:

> I am fully satisfied with the work of the volunteer. The volunteer presents the materials in an easy to understand form. If something is not clear, she can give examples[57].

Another respondent found that she didn't have enough time to record all the necessary observations in the carer's workbook, but the training nevertheless appears to be having at least partially the desired impact:

> Before the training I didn't necessarily even think about my child's individual preferences, now I have noticed that she likes mandarines and meat….[58]

[53] Non-applicant household interview with grandfather of 16 year old boy with multiple disabilities, Almaty oblast

[54] Beneficiary household interview with mother of child with disabilities, Akmola

[55] Beneficiary household interview with mother of child with disabilities, Akmola

[56] Beneficiary household interview with mother of child with disabilities, Akmola

[57] Beneficiary household interview with grandmother of child with disabilities, Akmola

It is likely that these differences in the beneficiary households' perceptions of the training on disability represent differences in ability, understanding and experience of the volunteers themselves as well as in the length of time that the programme has been running in the village. The different needs of each disabled child and each family are also varied which also affects the way in which parents perceive and assess the impact of the training.

The BOTA CCT headquarters team emphasises that the training on disability is designed in such a way that, regardless of the abilities and individual training styles of volunteers or the differences in needs, knowledge and understanding of the parents and disabled child, a basic minimum level of information is imparted to the beneficiaries and this is the basic minimum standard with which the CCT programme is satisfied. Anything more, as a result of any given volunteer's individual initiative, knowledge and ability, is a bonus. On the whole, respondents report that the training has been useful in providing new information:

> During the time of my involvement in the programme and as a result of the training I have found out more about methods of treating my child at home. I have received moral support from the volunteer.[59]

> I consider the training to be very useful. The volunteer…comes to my work…and… informs about healthy properties of certain fruits and food products. She tells that it is useful to involve the child in sport. The volunteer brings the Foundation magazines when she delivers the training. I read them together with the child.[60]

In the case of the pregnant and lactating women the field work has shown a fairly unequivocal positive result from the training in both Akmola and Kyzylorda – respondents are fairly consistent in confirming its value and demonstrate a strong knowledge of the content of the training. It seems that it is too early to state unequivocally that the training results in Almaty oblast are having similarly consistent and positive results, but it seems likely that they will as the programme beds down. In the case of training for parents of children with disabilities, the picture is less consistent. Kyzylorda respondents in beneficiary household interviews tend to be more consistently positive about the training and demonstrate a greater understanding of its content than their Akmola and Almaty counterparts. This could be because the programme had been running longer in Kyzylorda at the time of the household interviews so the impact of the training can be felt over more than a year.

2.5.3 Impact on care given to children by parents

Again, the results from the field work tend to give a mixed picture of the impact of the CCT programme on care of children with disabilities. Some respondents state that the training and visits from the volunteer have changed the way they care for their child and have had a positive impact on the child's development:

> During the visit, the volunteer explains the importance of child development. She teaches some skills, such as massage, special exercises and development games. For example, she recommended to play hide-and-seek or to hide toys, that had a good effect upon the physical development of the child. Three months after the first visit of

[58] Beneficiary household interview with mother of child with mental and physical disabilities, Almaty oblast

[59] Beneficiary household interview with mother of child with disabilities, Kyzylorda

[60] Beneficiary household interview with grandmother of child with disabilities Akmola

> the volunteer the girl began to sit down on the chair without any help[61].

Other results of the programme cited by respondents include: feeling that they are receiving support, the child has been pushed by the volunteer to be more sociable with other children, the child looks forward to the volunteer's visits and has started to draw better and acquire other skills.

Results from field work to date can therefore be summarized as follows:

- the BOTA programme, combined with State social, health and education services, appears to be having, depending on the family, either a neutral or a largely positive impact on care provided to children at home, but the consistency and extent of this impact across programme areas appears to be dependent on the knowledge and skills of individual volunteers and the length of time a household has been enrolled, and therefore the number of training sessions attended.
- the BOTA payments are less important to the families with disabilities than to other families as they seem to represent a much smaller proportion of the household budget. The service provided by the state for children with disabilities are largely provided for free, so if households with children with disabilities are using the CCT cash transfer for services, they are generally for optional extra services not provided by the state system.
- Overall, the main benefit to families with disabilities of the BOTA CCT programme appears to be that they 'have been noticed' by the village population and feel more included in the life of the village. This may mean that the conditionality of attending BOTA training is less relevant to these households, but the requirement to enrol children with disabilities in the village is important to ensure their greater inclusion into village life.

2.6 Unintended impacts

This section sets out fieldwork results on impacts that were not anticipated or expected but arose during fieldwork. It discusses impacts on divisions within communities, birth rates, gender issues and prices.

2.6.1 Divisions within the communities

Respondents report that the CCT has not caused divisions between recipients and non-recipients in any of the programme areas surveyed for this evaluation. The invariable response was 'I haven't heard of any'. The negative perceptions of some rejected applicants interviewed in focus group discussions and in household interviews, however, indicate that there are issues about the perceived 'fairness' of the CCT programme among some members of the communities where interviews and focus groups took place for this evaluation. The quantitative component of this evaluation is designed to address questions of whether the CCT programme is being successful in targeting the households that it wants to target. This qualitative element of the evaluation can explore some of the *perceptions* that interviewees report about fairness. On the whole, anxieties about the questions in the PMT and the reasons for rejection tend to offer a way of expressing a sense of unfairness among some rejected applicants who felt they were unfairly rejected.

> …the participants were displeased with rejection and with the test questions. The availability of employed family members and livestock in the household were among the reasons for rejection. Generally, according to the respondents, they could accept it

[61] Beneficiary household interview with mother of child with disabilities, Akmola

> normally if this approach had been applied to all the BOTA test participants. However, observing the village households of their friends and neighbours, one can find a beneficiary of the BOTA payments where two family members have stable work, the family has livestock and even a car….[62]

Another rejected applicant reported that she thought the reason for her household being rejected was that both her and her husband had completed secondary technical education and felt that it was unfair that other families that she knows were enrolled even though they live better than her '*I have a friend, she gets the money, although they live better than us. Their housing is alright, her mother has a job.'*[63]

The same rejected applicant also reported that she was subsequently told that she had been rejected because she 'dressed too well' at the enrolment and that if the enrolment team had known that her house was in such a poor state, she would have been enrolled. It is not only the non-beneficiaries who express concern about the fairness of the PMT:

> …there were extremely poor families that were not enrolled in the Program … for example a neighbouring family with five children, one of them matched the category of the BOTA CCT Program. The main reason of refusal was that the head of that family worked at the railway and earns 50,000 tenge. However, according to the beneficiary, it was the only income in the family for 5 members and the family has no subsidiary earnings and private farm holding. (livestock). And the available home appliances are very old and were produced in Soviet times. The mothers with children with special needs said that their husbands worked at the railway too, but they became the Program beneficiaries. According to the beneficiaries, it was unfair..[64]

Some issues arising from these perceptions of beneficiary focus group participants are discussed below in section 2.7.3 on targeting, but two points are worth highlighting here. First, enrolment specialists should perhaps not be in a position to provide feedback to rejected applicants, since the calculation using the PMT is not designed to be transparent or to be dependent on single factors. These subjective explanations may exacerbate tension because they highlight apparent inconsistencies (e.g. some salaried households are selected and some are not), when in fact the selection criteria are more complex. Second, these results do not endorse the request for additional questions in the PMT, but do point towards a need for better explanation from BOTA of the process.

2.6.2 Social awareness and mobilisation, gender and inclusive education

There are indications in some villages that the BOTA CCT programme has motivated greater social awareness and mobilisation in terms not only of the beneficiaries' demand for improved services, but also in terms of the local authorities' attitudes towards social problems. This quote from an akim provides an example:

[62] Focus group discussion with non-recipients, Akmola

[63] Household interview with rejected lactating woman, Almaty oblast

[64] Focus group discussion with beneficiaries, Akmola

> …the programme nudges not only the villagers, but also [the Akim] as well, to be more lively with our affairs…in other words new horizons [in terms of awareness] have opened up in relation to pregnant and lactating women, children with disabilities and other social problems, such as with the infrastructure of the village[65]

However, the same interviewee noted that there were some limits to demands from beneficiaries:

> The demand for pre-school places has increased, but none of the villagers has yet addressed [the Akim] with a request to build a new building…[66]

Gender issues

Other indications show that in some villages, the CCT programme may be having an impact on gender issues. The programme appears to be run largely by women and for women and their children. The vast majority of volunteers are women and, according to CCT reports, 90% of recipients are women and therefore most, if not all, of the individuals who are participating in training are women. One NGO partner noted that the programme is worthwhile for the changes it is making for these women:

> In these villages…women sit at home…we have come and they have new information, training…I look at them and it makes me happy that their eyes are lit up with enthusiasm, they are receiving new information, opening up new possibilities... We have villages where there are three volunteers, some have four some six volunteers and we see how they are getting to know each other, meeting, talking to each other.[67]

Other key informants report similar increase in confidence among programme recipients, increases in status for volunteers in their villages and other ways in which the programme appears to be empowering, and expanding the horizons of, the female population in some villages. Even the use of the bank cards is reported by some respondents as a way of introducing village women who otherwise lead isolated lives, to the modern world:

> The journey to town costs 1000 KZT which doesn't leave much from the cash transfer for paying for preschool… but this system (the cash machine) is absolutely right in terms of the development of the awareness and knowledge of village women, women who don't normally leave the home and who have completely fallen behind the modern world and here they are offered an opportunity, at least once a month to travel to Saryozek, see how other people live, their vision begins to widen, now they have learned how to use a cash machine – this is progress![68]

[65] Key informant interview with Akim, Kyzylorda

[66] Key informant interview with Akim, Kyzylorda

[67] Key informant interview with implementing NGO partner, Almaty oblast

[68] Key informant interview with volunteer, Almaty oblast

> I see the women walking around with their [bank] cards, they are full of it, confident, yes…I see them, how they have changed,[69]

Others report even more considerable growth in status, empowerment and changes in their personal circumstances as a result of their involvement in the programme:

> I had divorced my husband, and am on my own, I have three children… Since getting this job, I feel that I am more respected in the village. People greet me when they see me, they know who I am. I enjoy going to visit the women, the training … I have new skills and knowledge.[70]

This may be an unintended impact that BOTA will want to explore further in the second stage of the qualitative evaluation in 2012

Inclusive education

Another valuable and interesting unintended impact which BOTA may want to build on and explore further was identified in one community in Almaty oblast, but it is likely that this is not an isolated instance. A child with motor disabilities whose household was enrolled in the CCT programme in relation to the child's disability, has started to attend the informal preschool group that has been set up as a result of the BOTA CCT intervention in the community.

> My child wants to go to school too, to be with the other children. I asked if she can go to the group and they said yes and we don't have to pay. I go with her each time and stay with her to help.[71]

If BOTA were to encourage volunteers and NGO implementing partners to facilitate involvement of children with disabilities in preschool education, this could go a long way to taking forward inclusive communities and ensuring the benefits of inclusive education for all children in the community.

2.6.3 Impact on birth rates

Birth rates in Kazakhstan have been steadily increasing since 2007[72] and the government provides one-off birth grants of around 45,000 KZT and benefits for young children up to 1 year of age which in part has aimed to increase the birth rate. This package of support is much larger and lasts for longer than the BOTA CCT benefits. Direct responses to questions about unintended impacts on the birth rate – 'Have you heard of anyone deliberately getting pregnant in order to receive the benefit?' – clearly indicate that this is not the case. However, the BOTA benefit, combined with the larger package of state payments, in the perception of some respondents, may be contributing to some of the family planning decisions of some of the women in the villages where interviews took place:

> [I] registered with the health services at 3 months. At first I wanted to get rid of the child because I didn't know how I would feed the other children. But when [I]… went and heard about the BOTA

[69] Key informant interview with midwife, Almaty oblast

[70] Key informant interview with volunteer, Almaty oblast

[71] Participant in FGD, mother of child with physical disabilites, Almaty oblast

[72] Agency of Statistics of Kazakhstan (2010). *Men and Women of Kazakhstan. Statistical Data*. (Женщины и Мужчины Казахстана. Статистический сборник)

> Foundation, I decided to keep the child, because the money could help with the birth.[73]

If women are not getting pregnant in order to register for the cash transfer and the state birth benefits, it could be that they are a) not terminating pregnancies that they otherwise would have done because they see the CCT programme and the state birth benefits as a source of support to get them through the birth and the first years of life; b) carrying their babies to full term because of earlier registration with ante-natal health services, earlier medical interventions when complications have occurred and/or better diet and healthier lifestyle during pregnancy. One key informant offers the perception that:

> In the last 2-3 years, because of social support, like the BOTA Foundation, the number of newborns has increased[74].

The demographic trend confirms the observation that the number of newborns has increased, but it is unlikely that the BOTA programme is directly impacting the birth rate and much more likely that it is a result of increased economic stability and the birth-related packages of support offered by the state. One midwife commented during interview, '*there are more births because people are feeling more economically stable and secure*'[75].

2.6.4 Prices

Respondents are very clear that while prices have increased during the period of BOTA CCT programme operation, this is not due to the BOTA CCT programme but to economic changes in Kazakhstan. This perception can be confirmed with reasonable confidence by examining price changes in areas outside Almaty oblast, Kyzylorda and Akmola, which show that prices have doubled since 2000.[76]

2.7 Operations

This section summarises results on various aspects of the CCT operations and offers an overview of the differences in operations observed in areas where BOTA implemented directly (Akmola and Kyzylorda) and areas where implementation was by partner NGOs.

2.7.1 Mobilisation

Information was typically spread fairly effectively through the communities where fieldwork was conducted in Kyzylorda and Akmola, through the efforts of the volunteer and local government officials, and through effective word-of-mouth communication common in rural areas. Respondents were generally informed about the programme in enough time to prepare for the enrolment process. Some beneficiaries (not only pregnant women) were informed about the programme while they were in hospital, either for the first time or after the volunteer had previously informed them. In these cases, they were usually directed straight to an enrolment test.

[73] Beneficiary household interview with lactating woman (and early childhood education beneficiary), Kyzylorda

[74] Key informant interview with Akim, Kyzylorda

[75] Key informant interview with village midwife, Almaty oblast

[76] See for instance http://data.un.org/CountryProfile.aspx?crName=Kazakhstan#Economic.

In Almaty oblast, information was spread in similar ways, but respondents were less consistently sure that the reach of information was consistently wide enough. Some parts of an okrug where the CCT is operating might, for example, be better informed than others as the process of mobilisation and enrolment was taking place in stages. Settlements in the okrug that were not yet mobilised at the time of the interviews will be incorporated into the next stages of mobilisation and enrolment later in the year.

It appears that the differences between Akmola and Kyzylorda on the one hand, and Almaty on the other, are more likely to be related to teething problems than anything inherent in the NGO model, so this does not at this point imply that any change in overall approach is necessary.

In larger and more urban areas, the system of informing the population appeared noticeably less effective in both Akmola and Kyzylorda, although word-of-mouth still functioned to some extent. Moreover, families speaking different languages from the majority of the population (i.e. Kazakh speakers in Akmola and Russian speakers in Kyzylorda) felt that they discovered more slowly or less completely about the programme.

Although respondents were found to be informed about the programme, two types of shortcomings appeared. First, there are some individuals who were not well informed about the programme, and this lack of information generated suspicion which deterred them from applying when they otherwise might have. This suspicion was heightened because of demands from local government administration or the volunteers to bring their documents 'immediately' for registration. For instance:

> During her calls, the volunteer did not explain clearly the main idea and conditions of the Program. The respondent was asked to come to the certain place and to bring the documents immediately, which made her distrustful.[77]

Second, some of the phrasing of the way the programme is introduced may put people off. For instance, one non-applicant for the grant for children with disabilities reported that "*there is one point that can be an obstacle for the participation in the program: the use of the word 'invalid', that once again reminds about the disease.*"[78]

In both such cases, however, the suspicion and off-putting phrasing would probably have been overridden if there had been an overwhelming need. As this non-applicant puts it:

> [I] first obtained first information about the Bota Foundation from the official of the local administration (Selsoviet), who told about testing and asked to bring the required documents (The ID card, RNN (taxpayer identification number) etc. It evoked a suspicion, which made me distrust the Foundation, and considered it was a fraud, so I did not go to testing, pretending I had nobody to leave the children with. In addition, we have enough money to provide for the children without the Foundation support.[79]

[77] Non-applicant household interview with mother of young child, Akmola.

[78] Non-applicant household interview with mother of child with disabilities, Akmola.

[79] Non-applicant household interview with mother of young child, Akmola.

2.7.2 Enrolment process

Most respondents felt that enrolment was a reasonably straightforward process (see section 2.7.3 for results on the PMT). Enrolment was normally carried out in people's villages (meaning transport costs were negligible), but in some cases they had to travel to oblast centres. The most significant problems with enrolment were queuing time (particularly in large centres) and long gaps between mobilisation and enrolment.

The enrolment process itself was fast, lasting up to 30 minutes. However, in the areas visited in all three oblasts, there were often long queues – of up to six hours – for enrolment, particularly in large district centres where many people enrolled. The long queuing time was often reported as problematic, particularly since there were often insufficient seats and given that some applicants missed work to apply, and some respondents left with a negative perception of the foundation. Others were content to have time to discuss with their neighbours. This very long queue time was lengthened further by power cuts, which rendered the enrolment computers inoperable, and when a single enrolment specialist was responsible for enrolment, testing and making copies. On some occasions, moreover, the enrolment team failed to arrive by the specified time, meaning that a large crowd had gathered before they began.

Individual application times were further lengthened if the enrolment specialists requested that applicants return home for more documents, meaning that they then had to rejoin the queue at the back. This happened to several applicants interviewed, who felt that they had not received adequate information in advance of their application. On the whole, applicants (both rejected and beneficiaries) compare the level of documents required for the PMT favourably to the kind of documentations required to apply for state benefits. In particular, the applicants appreciate that there is no requirement for official registration documents.

Rejected applicants in Akmola were particularly vocal in their complaints. For example:

> Many participants were not informed about the main idea and conditions of the programme. The BOTA Foundation representatives did not introduce themselves, since there was a long queue. In addition, the applicants were displeased with behaviour of people who carried out the test: they were tired and unfriendly and did their job just to complete it as soon as possible. They asked the questions without any explanations (i.e. the purpose of the test). The faces of BOTA representatives showed: "Do not ask any more, just answer the questions and go away!" The PMT questions were humiliating; a person answering such questions gets confused and may say because of shame that he/she has a washing machine thought he/she does not have it. It would be better to demonstrate the conditions in reality, than to ask him and to make the respondent blush.[80]

There are clear drawbacks with full disclosure to potential beneficiaries of the PMT methodology (particularly the opportunities this would present for manipulation). Nevertheless, this objection to the PMT and enrolment process is important, and strongly suggests, together with other reactions to the PMT detailed below, that it may be worth investing further in explaining and clarifying the meaning of the PMT, or to risk losing the confidence of some parts of the population. This explanation could therefore involve explaining that while some PMT questions may appear

[80] Focus group with non-beneficiaries, Akmola.

strange, the test calculates poverty from a range of different questions, with answers combined, without fully explaining exactly how this calculation is done.

In Almaty oblast, all applicants, whether rejected or beneficiaries, tend to indicate that the enrolment process including the behaviour of the staff, the answering of questions for the PMT and even the need to wait, was largely acceptable. There have been some problem areas with lack of understanding about the order in which villages and beneficiary categories have been enrolled. In one village, for example, only preschool and disability beneficiaries were enrolled in the first instance and subsequently, in a 'top-up' enrolment conducted in the same village to improve coverage and capture new potential beneficiaries, pregnant and lactating women were enrolled. In another part of the oblast, all villages where the evaluation was taking place were enrolled at the expense of 'top-up' enrolments, so long waits were taking place between enrolment sessions.

Beneficiaries in Akmola tended to emphasise that they were satisfied with the politeness of the staff more than rejected applicants did:

> There were no technical problems and conflicts during the meeting. The Foundation representatives were polite and attentive. They spoke fluent Kazakh, gave explanations and answered the questions. The procedure was well arranged, the PCs operated without failures.[81]

The long queue time was limited in two ways. First, applicants imposed some social regulation on the queuing, usually allowing older applicants to move to the front of the queue. Second, in some places volunteers were able to divide up the applicants into smaller sub-groups that could be given specified slots during the day. However, this was more difficult in larger enrolment centres where applicants from several areas overlapped.

Differences between enrolment in villages and large town centres were also evident in the time taken to explain the programme to applicants. In villages, volunteers were able to use the enrolment time to provide full details of the programmes, but this did not occur in large centres.

The infrequency of and long gaps between enrolment visits to villages mean that some potential beneficiaries have had to wait almost a year to have a second opportunity to enrol:

> I would like to take part in the programme because we really need help. But the first time there was an enrolment process I couldn't go. And then when the commission was supposed to come back again, and I had collected all the necessary documents, they didn't come. The enrolment takes place very rarely, the last time was in summer last year…I hope to enrol next time they come, if the child isn't yet older than six months.[82]

Some other types of applicants, such as women who were near the end of their pregnancy when they first heard about the programme, are likely to miss entirely the opportunity to enrol. Similarly, older preschool children may miss a window for enrolment if there are long gaps between enrolment sessions. This appears to be a particular consideration in programmes that are in a starting up phase – for example in some parts of Almaty oblast there will be more than eight months by the time a second enrolment round is undertaken.

[81] Beneficiary household interview of mother of child with disabilities, Akmola.

[82] Non-applicant household interview with lactating woman, Kyzylorda

It seems likely that these gaps between enrolments are contributing to errors of exclusion and in the case of pregnant and lactating women where the period of time for receiving the cash transfers is more limited than for other beneficiary categories, the long gap is particularly a cause for frustration. Some key informant interviews indicate that the logistics of communications and planning for enrolment missions to villages could be usefully reviewed in order to streamline administration and use of volunteer and other resources:

> Yes, the commission doesn't come if there are not at least 20 potential applicants. It is not a problem to get them together. But the problem is that the BOTA staff never warn us in advance when they will be coming. Yes, they phone a week before and ask if there are enough people and say that they might come the following week, but they don't give an exact date. Then they phone the night before and say that I should gather the people together and they are planning to come. This causes all sorts of problems because I don't have time to phone everyone in the morning and many then complain that I didn't invite them. I think that if I manage to get together five people, the commission should come.[83]

Some household interviews also confirm the existence of problems with organizing enrolment and the problem of long gaps between enrolment opportunities:

> …but when the commission came, I didn't have any of the documents that I needed at home as my husband had taken them to the town. At that moment my child was going through the medical educational commission [that confers the disability status]. We tried once before to go to the enrolment, but when we arrived at 10 in the morning and waited in the queue, we were told that today they can't see people today as the commission has to go to a different village. In the end around 20 people couldn't go through the enrolment process, they said they would be seen next time[84].

There needs to be greater clarity for volunteers and implementing teams about the rules for enrolment – in some villages, for example, the volunteer has been gathering copies of documents for households that were not able to enrol during the first enrolment round and holding on to them while waiting for the next enrolment round. At the time of the interview she had gathered documents from 60 households.[85] This sort of informal 'pre-enrolment' could be contributing to raising false expectations and creating misunderstanding among potential beneficiary households. For example, one respondent during a non-applicant household interview indicated that she had '*submitted her documents to the volunteer' several months ago, but 'still had not received her card to withdraw cash*. When prompted as to whether she understood that submission of documents is not in itself enrolment, she indicated clearly:

> Yes, I know, the computer test, but I don't know why I haven't yet heard anything. It has been several months now, the payment will be quite big the first time.

[83] Key informant interview with Volunteer, Kyzylorda

[84] Non applicant household interview with mother of child with disabilities, Kyzylorda

[85] Key informant interview with Volunteer, Almaty oblast

Key informant interviews indicate that this delay in running top up enrolments in Almaty is partly caused by the processes of programme start up and the drive to reach as large a number of evaluation okrugs as possible before going back to other areas. While there are probably good administrative reasons for this delay, there are clearly risks in this kind of 'pre-enrolment' and apparent miscommunication by volunteers of the enrolment process that may need to be carefully managed.

Overall, nevertheless, enrolment procedures compare reasonably well with those of other welfare programmes, where more documents are required, where respondents can encounter aggressive negative attitudes from state officials and where respondents indicate they have to re-enrol every month.

- BOTA may consider increasing the frequency of enrolments to a minimum of 3-4 months in each village. This would naturally have a cost, and it would be useful to link the findings of this report to the costing study to assess whether the payoffs from this change are worth the cost.
- It may be appropriate to introduce rules and procedures about 'pre-enrolment' type activities by the volunteers to minimise possible misunderstanding and expectations that cannot be fulfilled among potential beneficiaries. At the same time, these rules and procedures could be phrased to reduce the exclusion error at the point when volunteers are gathering potential applicants. If enrolment sessions are to be held regularly, it seems most appropriate for volunteers not to screen too many potential beneficiaries out on the grounds of perceived lack of poverty and to let this process take place through the PMT, which has the advantage of being cheap to administer. The volunteers' role should therefore be restricted to informing all individuals who meet the categorical criteria about the programme, informing them that there will be a poverty screening, checking their documentation, helping them fill in the form as needed, and informing them about the regular enrolment sessions.

2.7.3 Targeting and PMT

While the enrolment process was considered to be well managed, there were some more substantial criticisms of the PMT and targeting that resulted, as already indicated in section 2.6.1 above. To a certain extent, this is to be expected, since PMTs are imperfect targeting tools by design (i.e. they are not able to reduce inclusion and exclusion errors to 0) and because PMTs always ask questions that appear irrelevant to many people taking the test. Moreover, rejected applicants from most programmes have negative perceptions of the targeting process. All types of issues (targeting error, perceived irrelevance and upset rejected applicants) were evident here. In addition, there were some tensions generated as a result, and these were detailed in section 2.6.1 and will not be repeated here.

Many respondents (particularly but not only beneficiaries) felt that the targeting had been effective in pre-selecting 'needy' people and that the volunteer had been instrumental in this, this meaning that most people selected were needy. For example, participants in a focus group of beneficiaries in Akmola felt that:

> The programme provides assistance to the very families that actually need the material support. The volunteer selected only actually needy people, as she has lived in the village for a long time and knows the financial state of many families well…there were no persons among the beneficiaries, who do not match the criteria of the programme.

Many rejected applicants agreed that most selected people were needy:

> many people, who passed the PMT, were needy ones…I am a bit more successful, as compared with other people, especially pregnant women.[86]

However, this is not to say that targeting could not be improved. Both interviewees and fieldwork teams observed (in a non-scientific way) some errors of inclusion, where relatively wealthy households were included onto the programme, and exclusion, where needy households were not included. For instance, an akim reported that "*there are some extremely poor families that were not enrolled in the programme*."[87]

Potential exclusion errors are perhaps more worrying because the PMT was designed explicitly to minimise exclusion errors.[88] The scale (how many needy people were excluded?) and magnitude (how needy were those excluded?) of these errors (as well as inclusion errors) will be assessed in the quantitative baseline report. The present assessment allows us to raise the possibility that they will occur, but also to identify various potential sources of these errors.

First, it is possible that these errors were not the result of poor implementation or bias, but because the PMT is an imperfect instrument in general. The BOTA PMT guidelines present a clear exposition of the 'in-built' errors in the PMT, and the magnitude of these errors will be assessed in the quantitative report.

Second, some respondents argued that possibly some potential applicants were not informed by the volunteer as the volunteer was making pre-judgements about whether the household is 'needy' enough to pass the PMT. A recommendation to reduce this possibility was made above and will be reiterated below.

Third, there is some evidence that enrolment specialists are also making subjective judgements about individuals who come to take the PMT, potentially rejecting them on the basis of appearance or reported income even if they might have passed the PMT (in an early draft of the PMT questionnaire enrolment specialists were asked to make a subjective verification of eligibility based on reported income). Some rejected applicants felt that staff made subjective judgements on their well-being before they had taken the test, based on their appearance or manner of speaking. One applicant in Kyzylorda reported being refused because she was wearing her wedding jewellery. If this filtering out process does take place, it may explain why households with disabilities appear to be selected even where their incomes are high, while other beneficiary types are not: enrolment specialists are making a (perhaps correct) subjective judgement about the eligibility of the applicant that includes other characteristics.

The point about the subjective screening by the volunteers and enrolment specialists is not that it necessarily reduces targeting accuracy. Given that the PMT is not 100% accurate anyway, this subjective screening could actually improve targeting accuracy. However, BOTA should be aware that there are also significant risks that subjective screening leads to exclusion, and tends to increase the power of the individuals doing it, which may have undesirable social consequences in the longer-tem or raise the returns to bribery. The quantitative report will provide more information on the scale and magnitude of this apparent problem, but it may be sensible for BOTA to consider reducing the scope for subjectivity in the targeting process.

[86] Rejected applicant interview, Akmola.

[87] Interview with akim, Akmola

[88] BOTA, (2008), 'PMT guidelines'.

In some enrolment processes (but certainly not everywhere), there were more significant specific problems reported. First, some respondents reported the presence of the akim at the enrolment site, and were worried that the akim may have been able to influence the process to exclude those with whom they were in conflict. Second, some rejected applicants reported that some applicants were asked not to fill in their details but to sign a blank paper saying that they would fill in their details later. Third, some rejected applicants intend to retake the test, based on the lack of verification but also on feedback from the specialists who informed them they could have passed had they specified a lower income or less property. In some cases, respondents indicated that they did retake the test in subsequent enrolments and passed the PMT by, for example, indicating that the livestock in their household belongs to a relative. This represents a significant breach of procedure, not only raising the possibility of significant errors and fraud, but also compromising the appeals process. It also compromises the PMT process itself, which is based on a calculation of a combination of different indicators, not a specific criterion such as income or poverty.

These observations (together with observations from pilot research) indicate that there was scope in the enrolment process for manipulation, as people could either be asked to take the test again, or could enter false data without verification, and that in some cases this scope was abused. There is no strong evidence that this is very widespread, but even the isolated incidences where they occur represent serious lapses from best practice and are clearly not as the programme design intended. It is important that they are addressed to ensure practice follows design and to prevent a loss of confidence in the programme.

Respondents also felt that inclusion errors were driven by the way the process was run: that in some cases, the enrolment specialists did not verify the information provided by applicants by making home visits.

This relates to wider concerns about the PMT questions themselves, in three areas particularly. In addition to the two major concerns about the relevance of the questions on household appliances and the usefulness of information on salaried income (see section 2.6.1), the third gap perceived by household respondents was the absence of questions on health problems, which can involve substantial recurrent expenses. Beneficiaries felt these confusions just as much as rejected applicants. The NGO partners also raised questions about definitions in the PMT, for example, an applicant can truthfully answer no to the question ‘do you have a truck’ when the enroller knows that he has a tractor and can then pass the PMT as his ownership of a tractor is not registered in the system.

Note that these concerns were not about the way in which the PMT was implemented, but about the PMT questions themselves. Coupled with perceived errors of inclusion (primarily), these concerns are not surprising.

Key informant interviews with NGO partners and household interviews with rejected applicants indicate that the appeal process may need to be further explained to volunteers and applicants. A case was cited of a successful appeal where the PMT score was overturned following the applicant registering her non-agreement with the score when she did the test and after a home visit by the enrolment team. Another rejected applicant who felt that she had been unfairly excluded did not appeal. When the NGO partner was asked why this particular applicant had not appealed, the response was that she probably didn’t know she could.

There is a delicate balance between permitting appeals to correct mistakes in data entered into the PMT form and obvious errors in the selection process where the PMT excludes needy cases, and institutionalising a process where any applicant can appeal to the subjective judgements of the enrolment staff and volunteers. The purpose of the PMT – and the overall design of the targeting system – is to provide an objective assessment of need. In some cases, this will lead to incorrect

conclusions about the need of a household. However, if any applicant can overturn the PMT conclusions if they are sufficiently empowered, this may have the consequence of increasing the probability of wrongly including those applicants that are socially and politically connected and confident, but not those who are generally marginalised.

Concerns about the PMT understanding have been communicated to the BOTA CCT headquarters team, and training has been conducted with the NGO partners (and other stakeholders). However, BOTA could consider the value of continuing education about the PMT, particularly if this is to serve as a model for social protection targeting in Kazakhstan in the longer-term, since it does not appear to have been sufficiently understood and accepted at present. One possibility to improve the communications messages around this is to conduct a focus group with some applicants, volunteers and NGO staff to clarify the exact concerns and gaps in knowledge.

- In future roll-out, BOTA may consider explaining explicitly that the PMT questions are not directly designed to identify households in poverty, so some questions may appear strange. This explanation need not extend to full disclosure about exactly how poverty scores are calculated, but should do more to reassure applicants that the process is being followed.
- Attention needs to be paid to ensuring that the volunteers and enrolment specialists are aware of the appeals procedure and communicating this procedure to applicants before they take the PMT as part of the information about the PMT process and/or subsequently to rejected applicants.
- Roll-out enrolment specialists should be warned to take pains not to make subjective pre-judgements but to follow up with verification visits where they are concerned. This may require some adjustment to their incentives.

2.7.4 Payment

Very few difficulties were reported with the payment process in Akmola and Kyzylorda and in Almaty oblast the main reported difficulties were related to delays in receiving bank cards, delays that had been caused by the bank in coping with the issuance of cards in the timeframe required by BOTA. Only one respondent suggested changing the payment system. Although many beneficiaries had not used a bank card before, they experienced no significant difficulties with this, and found the system smooth. The bank system has advantages over other welfare programmes (such as those received through Kazpost) in that there are no delays in withdrawing the money and no long queues. The problems with the bank system are the long wait between enrolment and first obtaining the card, the charges for withdrawal (which are unexpected to some without experience of banking), and the long distance to the nearest ATM in remote villages.

Some respondents report delays in getting the bank card after they have been registered. There are negative and positive consequences of this. More straightforwardly and negatively, delays in receiving the bank card and payments meant that some beneficiaries could not afford the kindergarten fees after their registration as part of complying with the conditions. This meant that some had to borrow or take advances to cover their fees, at some financial cost. The delays also meant that some beneficiaries lost faith in the programme, and refused, initially at least, to attend training. The NGO partners in Almaty oblast have found that the wait for the bank cards has affected levels of trust in their organisation and have found this frustrating at times.

While this delay is most usually mentioned as a complaint, it seems to have some unintended benefits as several respondents mention that the cash benefit is saved up for from 2-5 months while they wait for their card and this means they can make a large purchase (like a pram) straight away when they get the card. Where beneficiaries have had to wait longer for cash, and especially where they have received several months' of payments for two categories of beneficiary in one

household (for example in Almaty oblast where waits have been longer than in Kyzylorda and Akmola), some beneficiaries report being able to purchase large household items such as a second-hand washing machine and microwave. In this particular case the washing machine is not functioning as there is no running water in the house, but the respondent felt it was unlikely that she would again have such an opportunity to purchase such household appliance and that '*perhaps she is foolish, but she lives in the hope that there might be running water in her home one day*'[89]

The absence of an ATM in more remote villages was slightly problematic and can cost up to 800 KZT in transport costs (a substantial proportion of the transfer), but not of great significance since beneficiaries often shopped anyway in centres where there were ATM cards. Recipients have also responded by forming groups and sending one person to collect the cash on all others' behalf:

> On the one hand, the reception of money via a bank card is deemed very convenient. None of the respondents faced any problem during the bank card issue, there were no cases recorded the necessity to wait for a long time for a card. However, during the survey, the following serious problem was determined: the necessity to go to the town ... to draw money. The cost of the trip makes up 800 tenge... To minimise the mandatory transportation expenses, the majority of the beneficiaries have to combine into groups and send one person from any family to draw the money for several households.[90]

These results suggest that it might be sensible in future to:

- Try to reduce the period between registration and the provision of a bank card since this can lead to distrust, but allow saving for large items as long as this does not jeopardise the ability of the beneficiaries to meet the conditionalities.

2.7.5 Volunteers and training

Specific issues around the impact of role of volunteers and training have been examined in the sections above. This section will focus on the logistics.

In general, feedback from beneficiaries on volunteers and training was positive. There were very few examples of negative feedback on volunteers, even though the survey villages in Kyzylorda and Akmola were deliberately selected to contain a mix of volunteer quality, according to their evaluations. Contact with the volunteer tends to be stronger and more personal in smaller communities, where the volunteer may have previously been known the beneficiaries.

The volunteers themselves present a more complex picture of their work. They report a sense of satisfaction and fulfilment from their work with beneficiaries. Some volunteers report frustrations with the compensation they receive, and that the full range of activities they conduct is not recorded. For example:

> I am provided with remuneration (6,000 tenge) and units for mobile communication (700 tenge). But the remuneration is paid for conducting at least 15 training sessions. This is not satisfactory because we often failed to carry out the specified number of training

[89] Beneficiary household interview with mother of preschool child and 3 month infant, Almaty oblast

[90] Report of a focus group with beneficiaries, Akmola.

> sessions, especially the second volunteer who is often paid not every month, but once in two months. This volunteer has children from preschool institutions and the Kazakh-language schools and she works every month with them. For example, the volunteer works with a child with special needs, two pregnant women and children of preschool age, but only the pregnant women are taken into account, irrespective of the other work done. The disadvantage of the programme is that no recording is provided in this respect.
>
> Another minus is that many training sessions for volunteers are carried out in Atbasar, but no transportation costs are covered. As the training is mainly carried out in the early in the morning, the volunteers have to get there by taxi that costs 400 tenge and sometimes return by taxi too. The transportation expenses should be paid. The distance from their village to Atbasar is 60 km, but volunteers from other settlements live at a distance of 100 km.[91]

Some volunteers also report frustrations with logistical issues, being used by beneficiaries as a conduit for complaining about problems to BOTA as they are in the 'frontline' and also having to use their own money to pay for expenses related to their work, even to the extent of running training in their own homes when the Akimat has not provided a space. Given the apparent success of the training aspects of the programme and the workload of volunteers in mobilising and then monitoring the beneficiaries, it may be worth BOTA considering strengthening the volunteer role by making it a paid community worker post with proper compensation and more rigorously managed responsibilities and accountability. This may help to ensure a more uniformly high level of programming and reduce the reliance on individual personalities and their individual abilities to mobilise local resources and create the necessary linkages with the local authorities.

The BOTA CCT headquarters team has concerns about the sustainability of such an approach as well as concerns about the extent to which it could push up the cost of administering the CCT programme. The BOTA CCT headquarters team also points to requirements of Kazakhstan financial and tax reporting which requires a nominal level of activity to be named (15 training sessions per month) in order to address tax issues when paying volunteers. Given that the volunteers are carrying out a much wider range of work and activities, which is not reflected in this payment system, it might be worth revisiting in order to better reflect the range and type of work the volunteers are engaged in.

Some volunteers in Akmola and Kyzylorda seem to already be fulfilling state funded jobs as social workers or health workers in which case they are doing their own jobs and adding the BOTA tasks on top – this clouds the answer to the question of BOTA's impact as opposed to the impact of existing state services and programmes. Other volunteers are either eligible to be beneficiaries or are actually beneficiaries at the time of becoming volunteers and this has caused problems with other beneficiaries and indicates a need for a clearly stated policy on what happens to cash transfers when a beneficiary becomes a volunteer and on the rules for handling volunteer recruitment. According to some key informant interviews, it seems that there hasn't always been a very wide choice of candidates for volunteers and this has probably affected the quality of the volunteer work in some areas. One NGO partner estimates that around 40-50% of volunteers in their area perform to a high standard and are truly motivated as volunteers to carry out their duties and *'the other 50% we have to ride quite hard to make sure they are doing what they are supposed to do'.*

[91] Interview with volunteer, Akmola

Beneficiaries appreciated the flexibility that volunteers offered of either holding group training in a shared space (with associated social benefits) or visiting beneficiaries' households (reducing travel and childcare time and cost). Sometimes it appears that group training was not possible for lack of space. However, beneficiaries greatly preferred having a choice, rather than having a single option:

> Training is performed with each mother individually at her place. On the one hand, it is very convenient to them, because it does not cause the need to leave the child with somebody else, on the other hand pregnant women and nursing women want to meet other mothers to share their experience and to take training together for better understanding and memorising.[92]

The training materials are not always in the preferred language of the beneficiary, but the volunteers usually bring additional materials to ensure comprehension. For example, a beneficiary in Akmola reported that:

> The training is carried out in Russian, but as it is easier for me to speak and understand the Kazakh language, the volunteer brings a workbook in Kazakh. However, there is no language barrier during the training. According to the respondent, the volunteer presents the materials in an easy to understand form.[93]

There are some examples where participants in training struggle fully to understand the technical terminology that is occasionally used in the training and are afraid to ask. For example, the term 'social environment' was used in Akmola, but not fully understood.

Training was thought to be useful not only for programme beneficiaries but for others, as an akim pointed out:

> …it is necessary to run more training and more often not only for the beneficiaries but for all the villagers…[94]

The role of the volunteers and mobilisers being developed by the BOTA CCT programme appears to represent a new and innovative community social worker role and, as the programme expands to further oblasts, represents a considerable new workforce with an important new skill set that BOTA can leave behind. Given the importance of this investment and potential legacy, BOTA may want to consider options for making work with volunteers more systematic and sustainable. Ideas discussed with the BOTA CCT team include the institutionalisation of the volunteer training modules into the system of further education and adult education as a recognised qualification.

It is too early to say if there are any clear advantages or disadvantages to operating the volunteer system through partner NGOs rather than directly.

2.7.6 Communications

Beneficiaries report good communication once they are on the programme, aside from some confusion around the registration and the provision of the bank card as noted above. This

[92] Focus group with beneficiaries, Akmola

[93] Beneficiary household interview, Akmola.

[94] Key informant interview with Akim, Kyzylorda

communication largely took place through the volunteers who are easily accessible by telephone and in person and who would then refer any significant complaints on to BOTA foundation staff. However, some beneficiaries note that it might be more effective to provide them with contact numbers at BOTA directly:

> …in case of any questions first of all we ask the volunteers, but it would be better to have the contact numbers of other employees of the BOTA Foundation. Though we have not faced the problems which the volunteer could not resolve, it would be better to have the contact numbers of someone else from the BOTA Foundation.[95]

Non-beneficiaries tended to be much less happy with the accessibility of both volunteers and staff, and if they have complaints (relating to targeting) do not know where to address them. It may be that providing this service would contribute to improving targeting performance.

One issue noticed by the evaluation team was that there were in general limited leaflets and CCT communications materials on public display in the villages noted, particularly in Almaty. Communication through these modalities is likely to be effective, and BOTA has invested quite considerably in developing these materials. It would be appropriate to devote some resources to ensuring that, together with the NGOs (and see the point below about joint branding), these materials are now effectively distributed in target areas.

2.7.7 NGO Implementing partners

The evaluation has not gathered data specifically to compare the two different approaches in implementing the CCT programme. However, the interviews undertaken to date do offer some scope for exploring the difference in implementation approaches between Kyzylorda and Akmola where BOTA directly implements the CCT programme and the Almaty oblast approach, soon to be replicated in future roll-out, where NGO partners implement the programme with oversight from the BOTA CCT headquarters team.

Administration and logistics

The BOTA CCT headquarters team sees the model of contracting NGO implementing partners as mainly ensuring more streamlined administration of the CCT programme. Financial accounting issues can be handled locally in the oblast where the implementation is taking place, for example, and this saves the headquarters both time and money. It was not possible in this evaluation to verify whether this assumption holds true, but the BOTA CCT team confirms that the implementation by NGO partners in Almaty oblast has considerably reduced the administrative burden on the BOTA headquarters.

The BOTA CCT team has pre-defined a core team that the NGO implementing partners have to employ in order to be able to implement the CCT programme as designed by the BOTA team and based on lessons learned from implementation in Kyzylorda and Akmola. The NGO partners feel that the team is fit for purpose, but the following logistical and management issue emerged from observations of the evaluation team during this stage of the evaluation: the functions of the enrolment team are critical in terms of the pace at which enrolment can take place and the length of time between enrolment for each village. In each team, there are four team members dedicated only to enrolment and a further two mobilisers who are also authorised to enter data into the database used for the PMT enrolment procedure. It is possible that increasing the number of authorised ‘enrollers’ to eight rather than six could help the teams to reduce the enrolment

[95] Focus group with beneficiaries, Akmola

intervals. The BOTA CCT headquarters team feels strongly that this would push up the costs of implementing the CCT programme beyond an acceptable level, and the NGO implementing partners have concerns about whether additional enrollers would push the additional administrative workload up to unacceptable day to day levels and therefore require even greater administrative support. These concerns are justified. However, it might be worth reconsidering the 'pay-off' in terms of reduced waiting times between enrolment sessions in each village, and this assessment should be made in conjunction with a costing study.

The two NGO implementing partners have taken slightly different approaches to enrolment in the rayons for which they are separately responsible. In one case the wait between enrolments is lower as the team has carried out top up enrolments on its way to and from villages on the roll-out plan. In the other case, the plan has been pursued to enrol all villages and only then return to do top-up enrolments. Both approaches have advantages, but in the latter case, the delay between enrolment sessions is probably leading to more exaggerated errors of exclusion. Another difference in enrolment approaches noted during interviews for this assessment, appears to have been caused by a misunderstanding. In one village the volunteer mobilised only disability and preschool beneficiary households as she had misunderstood that all types of beneficiaries should be mobilised for enrolment at the same time. Top up enrolment therefore targeted pregnant and lactating women rather than further enrolment of the previously enrolled categories.

Mobilisation and targeting

The NGO partner implementation model appears to offer a way for BOTA to make fast start up of the CCT in a new oblast partly because it is able to build on the experience, contacts and existing community networks of its partners. The CCT team feels that the start up is not 'fast', but is carefully planned and the result of the learning from the implementation in Kyzylorda and Akmola over the previous two years.

The NGO partners have been given targets by the BOTA CCT team to enrol 1.5% of each village, which presumably falls out of the overall BOTA target of reaching 1.5% of the population of Kazakhstan by the end of the programme in 2014. The NGO partnership recognise this as a general rule of thumb rather than a fixed target as they are finding that more than 1.5% of the populations in the rayons they are targeting meet the CCT enrolment criteria. Both NGOs have exceeded their target of 4000 households each by the end of 2011 and the question arises whether the 1.5% target, if applied across all oblasts, will jeopardise the intention to roll out to other oblasts as the overall target might be reached in existing oblasts.

It could be that the targets for enrolment need to be articulated differently in future roll-out and be based on assessments of poverty levels in the target oblasts rather than on a blanket administrative target. Attention also needs to be paid to the levels of enrolment of each type of beneficiary household. Based on the observations of the evaluation team during this assessment, the CCT appears to be reaching a high percentage of households with children with disabilities in each village (at least 50%) and lower proportions of the other two categories where poverty levels play a greater role.

The evaluation team has previously noted that the 1.5% target may not accurately reflect the number of households in Kazakhstan that could qualify for BOTA assistance. If recent data are available, it may be worth calculating the expected number of beneficiaries in each area, and then re-specifying a different target for each oblast given variations in poverty rates. This may help to address problems of over-enrolment and to allocate resources most efficiently based on need. Given data limitations, however, this assessment is not the appropriate place to reach definitive conclusions on this, and the issue will be raised and analysed more substantively in the quantitative baseline report.

Building sustainable NGO capacity

One of the objectives of the BOTA foundation that is gaining more pertinence as the funding draws to a close is the building of sustainable social protection capacity in Kazakhstan. Operating through NGOs is clearly an important part of achieving this objective. This section considers how the current contracting model affects this, and makes some suggestions for how it could contribute further to building NGO capacity to design and implement social protection.

Of course, the NGOs with which BOTA is partnering entered into the agreement to work with BOTA freely, and they derive various benefits from this partnership (and are therefore continuing it). However, if building sustainable social protection capacity is an important objective for BOTA, there are two risks around the current CCT contracting and implementation arrangement that would repay attention.

First, there appears a risk that the current model is leading NGOs to devote less management time and attention to their regular operations than would normally be appropriate because this time is devoted instead to the BOTA CCT and the NGOs have not taken on additional managers for the CCT. While the budget for implementation is enough to cover the direct costs of the programme, it does not adequately cover management and development costs for the NGOs. It is not clear whether this was because the NGOs did not adequately budget this time in their proposals, or because they were encouraged not to through the competition, or both. In either case, the NGOs are in agreement with the terms of their contracts and have no interest in raising this issue with BOTA.

However, in the view of the evaluation team, there is a risk that the NGOs will be left in three years without funding and with their other activities slightly neglected – even though the regular programme staff are continuing to work on other activities. Consideration might be given by BOTA to developing an NGO partner contract that permits a percentage of funds to be used for the NGO's own ongoing development while delivering the BOTA programme. These funds might permit, for example, the NGO to hire a development director or other senior manager to continue focusing on the NGO's own programmes and future strategic growth while the NGO director's attentions are directed towards the CCT contract implementation.

Second, while the NGOs benefit from participating in the programme to the extent that they are connected with the CCT, and the CCT is popular, this benefit is limited in the long-term by the presentation of the CCT as a specifically BOTA programme. Due to the branding of the materials and naming of the programme (both are specific to BOTA and do not include NGO logos or names), it is largely associated with BOTA rather than the NGOs. From the point of view of sustainable social protection capacity, this is undesirable.

One issue that may need to be addressed by BOTA going forward is therefore the way in which the identity and visibility of NGO partners is subsumed into the wider 'BOTA Foundation' identity. Consideration could be given to creating simple communications materials about the CCT programme with room for each NGO partner to add their logo and information about their organisation to the materials. This would also be an opportunity to address the general lack of visible materials communicating about the programme that was observed in some of the villages visited for this assessment.

Added value?

The evaluation to date has not highlighted any particular differences in the overall outcomes for beneficiaries or for the implementation and administration of the CCT programme between the NGO partner implementation model and the directly administered model. However, the unintended impacts noted above in terms of, for example, gender issues and the empowerment of women, are

more clearly expressed by respondents from Almaty oblast than the other two oblasts. This could be coincidence, or it could be that the NGOs bring a more sensitised approach to community development into which the CCT programme can fit. The NGOs therefore can see the differences the programme is making for women in a way that the BOTA implementation team may not. Similarly, the NGOs may be paying more attention to issues such as gender, community development, ethnicity and other key local issues as these represent the foundation of all their previous work and they communicate these issues to their volunteers, take note of them themselves and are able to articulate these kinds of impacts.

2.8 Discussion of other issues to emerge from this evaluation

During this evaluation a number of issues have emerged which BOTA may want to consider, but which are not necessarily critical to ensuring the further strengthening of the CCT programme as it is rolled out as planned. The assessment in Almaty oblast has shown clearly that the CCT programme team has developed a sound approach to managing roll out and minimising risks to the programme implementation and to BOTA as a whole. The areas which the team may want to take into consideration, but which have not been included into the explicit recommendations made below, include:

a) At this stage of the evaluation, the team was asked to think more about the conditionalities and poverty impact during analysis. Emerging from this is the idea that the CCT programme, while treated as one whole programme, is actually trying to achieve three (now four) quite different goals with the three (now four) quite different beneficiary groups being evaluated, using the same instrument of cash transfers and conditionalities. While there is some differentiation of the programme design in terms of the cash value (women receive more) and specific conditionalities, it may be appropriate to revisit some of the conditions, particularly around the state ante- and post-natal clinics, to ensure that these are most appropriate for inculcating positive behaviour and building human capital and reducing poverty in the long run. This is not intended as a criticism of the current arrangements, but as a question that might deserve further thought if BOTA aims to offer the CCT as a model for delivering state means-tested benefits. This is a theme that can be explored in more detail in subsequent rounds of the quantitative and qualitative evaluation.

b) The impact on poverty in households with children with disabilities appears to be smaller, than for other types of beneficiary household, perhaps because the same income thresholds have not been applied to these households at the time of enrolment. This implies that the short-term poverty impacts are likely to be small compared to larger transfers. We expect the poverty impact, in terms of percentage increases in consumption expenditure, to be smaller for disability beneficiaries. However, this does not necessarily mean that other impacts are likely to be smaller, since the CCT is conditional and delivers other support. In addition, there may be longer-term poverty impacts through the human and social capital development. The short-term poverty impacts will be assessed in the quantitative follow up survey. Assessing long-term poverty impacts would require following a cohort of beneficiaries and a comparison cohort over a much longer period – probably through to adulthood. This would be fascinating and important (and very unusual) research but is presumably beyond the scope of BOTA's current funding. It may, however, be appropriate for the World Bank to fund this.

c) There is potential for offering informal pre-school places to non-enrolled children for payment where no other facilities exist – an option that does not sit within the CCT remit, but which could be explored by communities and implementing partner NGOs to add value to the CCT programme. This idea is mentioned below in a recommendation concerning ways to strengthen the medium term management and administration of informal pre-school services created as part of the CCT programme.

d) Given recent debates globally on the effectiveness and impact of conditional cash transfer programmes as a whole, might be worth reconsidering the BOTA CCT design to take into account ideas about whether there a trade-off between the human capital development and poverty impacts, and the design features that affect this trade off? A recent World Bank workshop on conditional cash transfers discussed this possibility, but concluded that evidence for this trade off was not conclusive.[96] However, it was also noted that while conditions (or even perhaps just increased awareness and salience of services) seem to have a positive impact on service use that is additional to the positive impact of the cash, the amount of cash required to have this positive impact may be quite low. In other words, small cash transfers with conditions may have similar impacts on service use to large unconditional cash transfers. The latter, though, are likely to have more significant poverty reduction impacts through the larger cash transfer, which raises the issue of a trade off between objectives. The results of this qualitative study to date suggest that the BOTA CCT, which transfers relatively small amounts of cash with conditions, may be in the former category.

This discussion raises the issue of how the BOTA CCT compares with other cash transfers in Kazakhstan, given that it operates through slightly different causal mechanisms. The nearest comparator may be targeted social assistance (TSA), which transfers more cash (the difference between household incomes and the poverty line) without conditions to households with incomes below 40% of the poverty line.

The quantitative evaluation will identify the extent to which recipients of the BOTA CCT are also receiving other transfers including the TSA, and how much they receive. The question of the impact of the CCT on the poverty and short-term human capital development of target households will be explored further in the quantitative evaluation. If other studies have been published on the impact of the TSA on poverty in target households (rather than on the national headcount) then it may be possible to offer some comparisons.

96 http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTSOCIALPROTECTION/EXTSAFETYNETSANDTRANSFERS/0,,contentMDK:23038737~pagePK:210058~piPK:210062~theSitePK:282761,00.html, accessed December 2011.

3 Conclusions and recommendations

This section sets out some conclusions emerging from the results of the qualitative evaluation fieldwork which can be further verified and tested against the quantitative evaluation results as they become available.

3.1 Summary conclusions

The overall impression coming from the qualitative field work to date is largely positive, with some variation at the local level and across the beneficiary target groups. The qualitative research indicates that overall, the BOTA CCT appears to be having the following impacts:

Poverty and expenditure

- The receipt of cash is reported by households to have had a net positive impact on the level of their consumption expenditure. In most cases, recipient households use the money to buy more of the same goods and services, or to buy the same goods and services more frequently. This impact was obviously much more substantial in Akmola and Kyzylorda where households have been receiving the cash for longer than in Almaty. Some (though fewer) households change their consumption patterns, buying new goods and services or goods and services of a higher quality.
- There is no evidence that households reduce their income earning from other sources as a result of receiving the transfer: the cash received is an addition, rather than a substitute.
- While the amount transferred is small relative to most incomes and other welfare payments, the regularity of the transfer, where this has been established in Kyzylorda and Akmola, seems to have instilled a sense of confidence in recipients, and is a very significant supplement to the incomes of households who do not receive other welfare payments, particularly during winter when other sources of regular income are scarce.
- The impact on poverty in households with children with disabilities appears to be smaller, than for other types of beneficiary household, perhaps because the same income thresholds have not been applied to these households at the time of enrolment.
- Where there have been delays to the cash transfer, particularly where these delays have been lengthy in Almaty oblast, this has permitted some households to purchase items that would normally be completely outside their reach.
- Recipients tend to spend the transfer to bolster existing expenditure streams, but focus their spending where possible on the final 'beneficiary' – the children or mothers who are the basis for selection. This leads to slight improvements in their well-being.

Health services

Pregnant and lactating women represent around 25% of beneficiaries in the CCT programme. Results from qualitative fieldwork to date point towards the following impacts of the BOTA conditional cash transfer programme on antenatal health service usage:

- Ante-natal health services are quite commonly used as a matter of course, and the BOTA programme builds on these positive attitudes. This assessment appears to confirm that women are registering earlier with antenatal services because it is a condition of registering for the CCT
- While state health services are free, there are travel and medicine costs that are borne by the patient, and there are some problems reported with the quality of services provided. This assessment seems to confirm more regular attendance at antenatal appointments because cost and distance barriers are addressed by the cash transfer and because the monitoring of

compliance with conditions generates incentives to attend (in order to continue receiving cash). It appears for this particular instance that the threat of penalties for non-compliance is at least as significant as the encouragement and training around the benefits of classes.

- where distances to antenatal health services are greater, attendance is likely to be more irregular, more of the transfer is likely to be spent on transport and greater use is made of the local village midwives who offer basic screening check-ups but cannot provide ultra-sound scans or deal with complications or problems during pregnancy.

And on post-natal health service usage:

- Post-natal attendance at medical services is less routine than ante-natal attendance, as childcare duties add to the time and cost barriers that inhibit the uptake health services per se. The women are able to meet the requirement to attend a health facility 2-3 times after delivery and before exiting the programme when the infant reaches 6 months. It is not possible to state as clearly as with ante-natal service usage whether this represents an increase in uptake or not. Most lactating mothers see little need in attending post-natal services for themselves or their child except when called by the doctor for vaccinations or other mandatory state health interventions

Overall, pregnant and lactating women speak favourably of the health and social benefits offered by the BOTA CCT training classes and interaction with the volunteers. There is demand for training to be opened to non-beneficiaries.

Education services

Children aged 4-6 years are the largest single beneficiary group in the BOTA CCT programme with over 50% of beneficiaries in this category. The qualitative fieldwork to date points to the following impacts for this group:

- the BOTA programme, together with the Government 'Vseobuch' and 'Balapan' programmes, have stimulated increased demand for and provision of pre-school places. This has come about both because of the condition attached to the cash transfer which is motivating parents to seek preschool services and the facilitation provided by the volunteers and BOTA implementation teams that helps communities to create preschool services where none exist, and because the cash transfer itself is making pre-school attendance more possible at existing facilities.
- In the cases where the BOTA programme has directly motivated communities to create informal preschool groups, this result can be attributed to the human capital benefits that come from the community mobilization aspects of the programme as well as the conditionality itself. The training provided to community mobilisers and volunteers that helps them to facilitate discussions between parents, teachers, akims and school directors is as important to this result as the question of the injection of cash into the community provided by the CCT programme.
- there are many children who are attending pre-school facilities only because the BOTA programme makes it possible and they would not be attending if the BOTA programme were not operational in their village.

Further work needs to be done to better understand some of the constraints identified in the qualitative fieldwork and how the BOTA programme is having an impact on them:

- uneven meeting of demand for full-time pre-school provision, in some villages there are waiting lists and little being done to meet demand, in others there is mixed part and full-time provision which is meeting full demand and in yet others there are small amounts of informal provision.
- factors affecting satisfaction of parents with the quality of services. Informal provision of preschool services stimulated by the BOTA CCT programme could be at risk of losing

credibility among parents and community members where no stable administrative and management solutions have been established.

- Parenting skills training appears to be highly valued by those who have participated in it.

Care for children with disabilities

State support to children with disabilities is varied, involving both outreach and residential care. Most carers value home-based care very highly, even before the BOTA CCT. Qualitative fieldwork to date point to the following conclusions:

- The BOTA programme, combined with State social, health and education services, appears to be having, depending on the family, either a neutral or a largely positive impact on care provided to children at home. The consistency and extent of this impact across programme areas appears to be dependent on the knowledge and skills of individual volunteers, the type of disability of the child and the length of time a household has been enrolled, and therefore the number of training sessions attended.
- The BOTA payments are less important to the families with disabilities than to other families as they seem to represent a much smaller proportion of the household budget. The service provided by the state for children with disabilities are largely provided for free, so if households with children with disabilities are using the CCT cash transfer for services, they are generally for optional extra services not provided by the state system. Otherwise, the funds tend to be saved up for a large item, often a gift for these children. It is difficult to isolate the incentive effects of the BOTA CCT for this category of beneficiary
- Overall, the respondents in this category of beneficiaries point to an overall sense of social inclusion which they sense as a result of their communities paying attention to them through the programme. They describe that they 'have been noticed' by the village population and feel more included in the life of the village. This may mean that the conditionality of attending BOTA training is less relevant to these households, but the requirement to enrol children with disabilities in the village is important to ensure their greater inclusion into village life.

Unintended impacts

- While respondents generally express satisfaction with the programme as a whole, and the targeting process is not generating divisions within the community as such, some non-recipients express significant resentment and upset at not being selected. This is probably based on some confusions around the PMT process. On the other hand, there were some reports of greater social awareness resulting from the programme.
- In some cases the programme may be bringing gender benefits by offering opportunities for women in some communities to become more active, acquire new knowledge and information and 'expand their horizons'. In other cases, the programme may be contributing to more inclusive societies for children with disabilities and their families.

Operations

Overall, operations appear to be running effectively with some variations and nuances that are discussed in detail in the main body of this report. The qualitative fieldwork undertaken for this assessment provides feedback from respondents, which enables the following general conclusions about operations to be drawn:

- Mobilisation was effectively run through volunteers and local government, and through word of mouth. The spread of information appears most effective in smaller rural communities rather than in larger urban areas where the social networks are less comprehensive.

- The enrolment process was generally found to be smooth and generally well implemented. Some instances were reported of long queues. More regular and frequent enrolment missions could help to reduce some instances of exclusion that were indentified in this assessment.
- Volunteers tend to mobilize households for enrolment that they perceive as meeting the 'poverty' criteria of the programme. This kind of filtering or 'pre-enrolment' by volunteers and in some cases by enrolment specialists asking about household income may be affecting targeting and contributing to errors of exclusion, while possibly reducing inclusion. This will be assessed further through the quantitative part of this evaluation.
- There are no significant differences in delivery identified at the local level between the NGO partner implemented operations and the direct BOTA delivered operations. The same problem areas appear in both types of operation and the same benefits. It is possible that the history and experience in community development programming of the NGO partners contributes to a richer implementation in terms of generating social benefits, but this deserves further exploration in the next stage of the evaluation. The main differences in the delivery mechanism are felt at BOTA's head office in Almaty, where the administrative burden is felt to be lower in the case of the NGO partnerships than with the BOTA oblast offices.
- The PMT in general delivered results that were broadly considered fair, but there were some significant perceived errors of inclusion and exclusion, particularly amongst rejected applicants. The PMT appears to be generally misunderstood by many stakeholders in the implementation process.
- The payment process was effective and the preferred mechanism of almost all respondents. The remoteness from ATMs was a challenge for some, but recipients usually found mechanisms to reduce this problem. Where there have been delays between enrolment and the receipt of bank cards, whether caused by the banks or by administrative issues related to roll-out of the evaluation, these have enabled households to 'save' their CCT payments in some cases for the purchase of items normally outside their reach and in others to have been problematic for households who enrolled in pre-schools that they could not afford without the cash transfers.
- Volunteers and training were generally very well received. Training was provided either at home or in groups, and these different modalities had different advantages, and participants preferred a choice.

3.2 Recommendations for the CCT programme

This qualitative evaluation aimed to assess the extent to which the conditionality of the cash transfers and the monitoring and volunteer support around compliance is having an impact on the increased access and use of pre-school, ante and post-natal health services and improved home-based care all of which are expected to have positive impacts on human capital development. In addition, the onus on the CCT recipient to fulfil certain behaviours may also have implications for social inclusivity and good citizenship. Finally, the cash transfer, human capital development, and social consequences may all have implications for poverty reduction.

The conclusions above set out that the CCT programme can be found, by this qualitative assessment, to be having a clear and reasonably unequivocal impact on take up and use of pre-school and ante-natal health services and a more equivocal, but nevertheless beneficial, impact on post-natal health service use and improved home-based care. In addition, it appears that there could be some interesting impacts emerging in terms of social inclusivity and good citizenship. The cash transfers themselves are reported to be having some impact on short-term poverty reduction.

The CCT programme operations have been found to be sound in design and implementation, both where directly implemented by BOTA and where implemented through a partner NGO. Some areas of operations, particularly around ensuring a clear, common understanding of the PMT among stakeholders at all levels, could benefit from ongoing monitoring and minor adjustments mainly in the interests of minimising errors of exclusion. The extent of errors of exclusion or inclusion can only be confirmed by the quantative part of this evaluation. The recommendations offered here, are therefore offered in a spirit of strengthening further a programme that has already been found to be strong and are based on the fully detailed presentation of the qualitative evaluation results that form the main body of this report as well as on the summarised conclusions in this section above.

Inital ideas for further strengthening the BOTA CCT programme for subsequent rounds that emerge from this evaluation as a whole can be summarised as follows:

1. To address issues of whether specialists and volunteers can be even more effective in fulfilling their functions to ensure that the mobilisation and PMT enrolment process is as objective and even-handed as possible particularly in relation to minimizing errors of exclusion

- Providing mobilisers and volunteers with a common set of communication materials about the CCT that can be posted in public places such as the village health services, schools, preschools, akims and shops, could help to ensure less misunderstanding about the programme and the criteria for enrolment among community members.
- BOTA may consider explaining explicitly to potential applicants that the PMT questions are designed not as a direct identification of households in poverty, but as proxies for poverty, in order to explain why some questions may appear strange. This explanation need not imply full disclosure on the workings of the PMT (and this would risk manipulation), but should increase applicants' acceptance of the process.
- Enrolment specialists should be warned to take pains not to make subjective pre-judgements but to follow up with verification visits where they are concerned. If an appeal process exists, this needs to be communicated fairly and clearly to all applicants in order to reduce the risk of the most disempowered not being able to take advantage of this procedure.
- Volunteers may need to be compensated for all activities, by having a contract that recognises not only the formal training sessions that they undertake but also the case management and additional support they provide. However, this needs to be carefully balanced with the services and transfers that the recipients receive and with the requirements of the tax authorities.
- BOTA may consider increasing the frequency of enrolments to a minimum of 3-4 months in each village, and ensuring that NGO partners, going forward, are aware of this as a minimum standard during programme start up and beyond. BOTA may want to agree protocols for enrolment and re-enrolment in each community targeted by NGO partners. These changes should be actively considered in conjunction with a costing study to assess the appropriate allocation of resources.
- Ensure that volunteers are informed about the SSP and TAP programmes and encourage them to see the SSP programme as a way of further mobilizing resources to address the social problems in their communities. Task CCT volunteers with informing their Akims, school directors and other relevant local officials about the SSP. Offer grant-writing training to CCT volunteers to help them facilitate project development for action grants at the local level.

2. To address issues of whether volunteer training can be delivered more consistently across the beneficiary categories and the implementation areas in order to capitalize even further on the human development gains that have currently been noted by this evaluation

- Post-natal training sessions could be strengthened to focus not only on anaemia and health issues that affect the mother and child but also to give information not covered in previous

training such as infant care, early childhood development, attachment and bonding. The parent training module offered to preschool beneficiaries could be adapted for this purpose.

- Volunteer preparation for training sessions for children with disabilities could be checked and strengthened to ensure consistent delivery of these sessions and to take into account the differing needs of children and their families depending on the nature and extent of their disabilities. The purpose of this type of training needs to be clearly communicated to beneficiaries as well as volunteers and specialists.
- Holding enrolment sessions in villages, rather than rayon centres, could be considered (within the resource constraints), both to improve enrolment performance and also to provide a good opportunity to inform people about the programme.

3. To address other operational issues that emerged during this evaluation

- Provide guidance to NGO implementing partners on ways to manage informal provision of preschool services stimulated by the BOTA CCT programme while maintaining the goal of supporting the local community to establish its own sustainable provision in the long term. This could include:

  - mobilizing volunteers, parents and village Akim to apply to SSP for grants to support the creation of informal pre-school provision – enterprising parents/volunteers could create a small enterprise for administering informal pre-school provision across several neighbouring villages with start up funds from a small action grant. This could include offering informal pre-school services to non-CCT households

  - organizing parents to create 'informal pre-school mutuals' where an organizing committee handles all issues of payment, service quality, liaison with the teachers, school director and Akim

  - sub-contracting a smaller local NGO to handle administration, payments and other aspects of informal pre-school provision across a number of neighbouring villages/districts
- Try to reduce the period between registration and the provision of a bank card since this can lead to distrust, but allow and encourage saving for large items. Lessons about what to expect from banks can be learned from the existing programme implementation.
- BOTA may wish to consider revisiting the contracting arrangements for NGOs in subsequent rounds to ensure a focus on building sustainable capacity as well as strong CCT implementation. This will involve some form of cost, but it may be sensible to take lessons from the Social Service Programme to ensure that there are synergies between the programmes.
- BOTA may also wish to revisit the communication materials by involving partner NGOs and beneficiary focus groups in developing the materials with the twin objectives of ensuring the partner NGOs have full ownership of the joint materials and that the messages are communicated in language and images that are meaningful and clear to their potential audience.
- The regularity of the transfers is important to their success, and efforts should be made to ensure that this is maintained.
- Additional thought could be given to addressing problems of distance to health facilities for those seeking health services, perhaps by considering linking the transfer value to distance from health facilities to cover transport costs.

3.3 Recommendations for the CCT evaluation

The fieldwork also indicated some issues that could be explored more fully in subsequent rounds of the quantitative and qualitative evaluation:

- The impact of the cash transfer at different times of year, particularly for households not receiving other benefits.
- The extent to which, where distances to ante-natal health services are greater, attendance is likely to be more irregular, more of the transfer is likely to be spent on transport and greater use is made of the local village midwives who offer basic screening check-ups but cannot deal with complications or problems.
- Understanding the role of the Government 'Vseobuch' and 'Balapan' programme in stimulating and meeting demand for pre-school.
- The patchy meeting of demand for full-time pre-school provision, in some villages there are waiting lists and little being done to meet demand, in others there is mixed part and full-time provision which is meeting full demand. The role and impact of informal provision which BOTA CCT has been instrumental in establishing.
- The factors affecting satisfaction of parents with the quality of services including the informal services that BOTA CCT has been involved in creating.
- The proportion of household budgets constituted by BOTA payments for families with disabilities compared to other families as they seem to represent a much smaller proportion of the household budget.
- Whether there are social divisions caused by the transfer or changes in the perception of the role of assistance caused by poverty based targeting (also relevant for targeted social assistance) as opposed to universal transfers.
- The extent to which the BOTA CCT creates additional social awareness amongst both citizens and local authorities.
- The extent to which BOTA CCT is empowering women and facilitating the social inclusion of children with disabilities
- The differing net payments received by households after travel and transaction costs, varying by distance to centres.
- The relationship between quality of volunteer (which BOTA could assess through tests, building on existing exercises) and the BOTA CCT impact on technical knowledge of pregnancy and child care.
- If it is considered useful to understand the impact on poverty reduction of CCTs in Kazakhstan, there needs to be a long-term tracking of the beneficiaries of this programme compared with a randomly selected group of control individuals (that could come from the existing evaluation control sample). This would assess the impact of having received the human capital benefits that are presumed to pay off in terms of reducing poverty (for instance increasing productivity and health) in the long-term (when these children reach adulthood). While this is probably outside the scope of BOTA's activities and budget, it may be worth the World Bank or other stakeholders considering funding this.

References

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Annex A Question matrix

Table A.1 Impact areas and detailed questions

Area of impact and hypothesis	Detailed questions	Source of information
1. Poverty Hy: CCT programme will reduce poverty in beneficiary households	• What proportion of recipient incomes comes from BOTA? • How does BOTA compare with state benefits households receive (child support, disability, pensions, TSA)? • What do recipients spend BOTA transfers on? (Essentials, productive investments, education, health, 'luxury') • Are recipients able to purchase goods or services they were previously unable to afford? Which? • Are the BOTA transfers used for one individual in the household or as a family income transfer? • Who decides how the BOTA transfers should be spent? • Who benefits the most from the BOTA transfers? • How does the value of the transfer compare with the cost of essential goods and services (e.g. food, kindergarten, medicine)? • By the time households have spent on transport to collect the transfer and meet conditions, and spent on meeting the conditions, is there a net income benefit to recipients? • Has the BOTA transfer affected the cost of goods or services? • Do recipients feel wealthier after receiving BOTA transfers? Compared to previously, and compared to others living nearby? • Do recipients do less or more work because they receive BOTA transfers? • Do recipients spend less or more time on child care because they receive BOTA transfers? • Has beneficiary households' time use changed in other ways?	• Beneficiary household interviews (all types) • Non-beneficiary household interviews (all types) • Beneficiary household focus groups • Non-beneficiary household focus groups • Key informant interview with volunteer • Key informant interview with health worker • Key informant interview with akimat • Other key informant interviews as relevant.
2. Uptake of health services and awareness of health issues Hy: CCT programme will improve access to health services, awareness of health issues	• Do PLW regularly attend state ante- or post-natal classes after registering their pregnancy (distinguish pregnant and lactating)? • What do the consultants/classes provide (advice, vaccinations, measurements, etc.)? • Is this considered normal and useful? • What do they learn from these classes (e.g. about anaemia, healthcare, reproductive health)? • What is the state of people's knowledge (e.g. about anaemia, healthcare, reproductive health)? • What are the gaps in their knowledge not filled by classes (distinguish 1st, 2nd, 3rd pregnancy)? • What is the cost of attending these classes (including transport, time and any medical costs)? • What are perceptions about the quality of maternal healthcare? • What are the reasons not to attend classes? • Does the BOTA transfer encourage them to register pregnancy earlier?	• PLW beneficiary household interviews • PLW non-beneficiary household interviews • Beneficiary household focus groups • Non-beneficiary household focus groups • Key informant interview with volunteer • Key informant interview with health worker • Key informant interview with department of health interviews • Other key informant interviews as

Area of impact and hypothesis	Detailed questions	Source of information
and health outcomes for pregnant and lactating women (PLW)	• Do beneficiaries attend ante- or post-natal classes more? Why? (Conditions or having extra money) • Do beneficiaries attend BOTA trainings regularly? Why? • Have they gained any knowledge from attending trainings (e.g. about anaemia, healthcare, reproductive health)? • Are there any social benefits? • What do the trainings provide that is not already known or given in state consultations/classes (distinguish 1st, 2nd, 3rd pregnancy)? • Do beneficiaries now feel differently about the value of ante-and post-natal consultations/classes and care? • Are beneficiaries now behaving differently with regard to maternal health practice?	relevant.
3. Uptake of education services Hy: CCT programme will improve access to education services	• Were children aged 4-6 enrolled in pre-school facilities before the BOTA CCT? Distinguish between different types of pre-school (minicentre, kindergarten, zero class, school no. 1, etc.) and full time vs part time. • Did they regularly attend? Why, or why not? • How good is pre-school quality (teaching, building, toys, heating, etc.)? Distinguish between different types of pre-school • What are the perceived benefits of pre-school (education, socialising, development, giving time to parents, providing food, etc.)? Distinguish between different types of pre-school and f/t vs p/t • What are the barriers to attending pre-school (cost of fees, cost of food, cost of uniforms, cost of transport, waiting list too long, child needed elsewhere)? Distinguish between different types of pre-school and f/t vs p/t • Are BOTA beneficiaries now enrolled in pre-school more? Why? • Have BOTA beneficiaries shifted from part time to full time pre-school attendance? Why? • Are BOTA beneficiaries now attending pre-school more? Why? • Are BOTA beneficiaries learning more at pre-school? Why? • Are there any other improvements in BOTA beneficiaries (aged 4-6)? What? Why? • Does the BOTA cash transfer help overcome barriers to attending pre-school? How? • Does the support given by BOTA volunteer help overcome barriers to attending pre-school? How? • Does the BOTA provision of the Family Resource Centre help overcome barriers to attending pre-school? How?	• ECD beneficiary household interviews • ECD non-beneficiary household interviews • Beneficiary household focus groups • Non-beneficiary household focus groups • Key informant interview with volunteer • Key informant interview with school teacher • Key informant interview with department of education interviews • Other key informant interviews as relevant.
4. Improved care for children with disabilities Hy: CCT programme will improve quality of home-based care for	• What are the main types of disability? (Separate physical and mental) • What are the needs of children with disabilities? (Separate physical and mental) • What are the needs of families with children with disabilities? (Separate physical and mental) • What are the current home-based care practices for children with disabilities? • What benefits do children with disabilities receive (without BOTA)? • What education, health and other social services do children with disabilities receive (without BOTA)? • What are the benefits of those services? • What are the barriers to accessing those services (cost of consultation, cost of food, cost of medicines, cost of transport, other)?	• Disability beneficiary household interviews • Disability non-beneficiary household interviews • Beneficiary household focus groups • Non-beneficiary household focus groups • Key informant interview with volunteer • Key informant interview with disability

Area of impact and hypothesis	Detailed questions	Source of information
children with disabilities	• What are the main gaps in service provision for children with different disabilities? • What are the perceived benefits of home-based care? • What are the perceived problems with home-based care? • What are the perceived benefits of institutional care? • What are the perceived problems of institutional care? • Have the BOTA cash transfers helped recipients to care for children at home? How? • Have the BOTA cash transfers helped recipients to provide other sorts of care for children? How? • Do beneficiary caregivers attend BOTA trainings? Why? • What knowledge do beneficiary caregivers learn at BOTA trainings (on home-based care, interactions with child, socialising)? • What social benefits do BOTA trainings provide? • What 'technical' support (e.g. knowledge of care-giving) do volunteers provide to beneficiary caregivers? • What social support (e.g. feeling of inclusivity) do volunteers provide to beneficiary caregivers?	services • Other key informant interviews as relevant.
5. Unintended impacts.	• Does the CCT programme generate any conflict within beneficiary households? Why? • Does the CCT programme generate any conflict between households? Why? • Does the CCT programme generate any incentives for additional pregnancies? • Are there any other impacts of the CCT programme?	• All

Table A.2 Operations and detailed questions

Operational area	Detailed questions	Source of information
1. Community mobilisation	• How did people find out about the programme? • What is the coverage of knowledge about the programme (i.e. what proportion of people know about the programme)? • What is the extent of knowledge about the programme (i.e. do people generally know about the payment, volunteers, training, conditions, how to enrol)? • When did people discover about the programme? Was this sufficiently in advance of enrolment for them (what about e.g. people who became pregnant just after enrolment)? • Were people always informed about the programme before they took the PMT? • Do people know how to enrol (e.g. can husbands enrol, do you need NIIN, RNN)? • What recommendations did beneficiaries, non-beneficiaries and other key stakeholders make on community mobilisation?	• Beneficiary household interviews (all types) • Non-beneficiary household interviews (all types) • Beneficiary household focus groups • Non-beneficiary household focus groups • Key informant interview with volunteer • Other key informant interviews as relevant.
2. Enrolment and verification	• Where do people enrol? • How long does it take to get there and home? • How much does it cost to get there and home? • Is this out of their normal routine (or do they make a special journey)? • How long does it take to enrol? • Was the enrolment process fair? Why, or why not? Distinguish beneficiaries and rejected. • Was the enrolment process open? Why, or why not? Distinguish beneficiaries and rejected. • Was the enrolment process implemented properly? Why, or why not? Distinguish beneficiaries and rejected. • What were the barriers to enrolment? (Not having an ID card, not having a tax number) • Were there people excluded wrongly from the programme? Why? • Were there people included wrongly from the programme? Why? • How does the enrolment process compare with that of the government or other organisations? (Positively and negatively) • What recommendations did beneficiaries, non-beneficiaries and other key stakeholders make on how enrolment could be improved?	• PLW beneficiary household interviews • PLW non-beneficiary household interviews • Beneficiary household focus groups • Non-beneficiary household focus groups • Key informant interview with volunteer • Key informant interview with health worker • Key informant interview with department of health interviews • Other key informant interviews as relevant.
3. Registration and provision of bank card	• How long did it take to be provided with a bank card? Why did it take this long? • Were people back paid for months that elapsed during the delay between enrolment and first payment? • How was the bank card provided? • What is the total cost to recipients of registration (transport, time, cost)? • How does this compare with other programmes? • Did this process encourage recipients to use other banking services? • Were there any difficulties with the registration and provision of bank card?	• Beneficiary household interviews • Beneficiary household focus groups • Key informant interview with volunteer • Key informant interview with banking staff • Other key informant interviews as relevant.

Operational area	Detailed questions	Source of information
	• What recommendations did beneficiaries and other key stakeholders make on how registration could be improved?	
4. Payment	• Where did people have to travel to collect money? • How often did people collect money? • What were the costs of collecting money (transport, time, etc.)? • Did collection involve changing recipients' normal routine (i.e. did they have to make special trips to collect money)? • Were there any charges made for withdrawing money or checking balances? • Were there any problems with the payment process (such as non-payment, delays, etc.)? • How were these resolved? • Did recipients use banks for other services (such as savings, loans, etc.)? • Has recipients' demand for financial services changed? • How does the payment process compare with payment processes for government programmes? • What recommendations did beneficiaries and other key stakeholders make on how the payment process could be improved?	• Beneficiary household interviews • Beneficiary household focus groups • Key informant interview with volunteer • Key informant interview with banking staff • Other key informant interviews as relevant.
5. Trainings	• Were the trainings always run on time? • Were the trainings well attended? • Are the trainings always accessible (cost, timing, location, etc.)? Why or why not? • What recommendations did beneficiaries and other key stakeholders make on how the trainings could be improved?	• Beneficiary household interviews • Beneficiary household focus groups • Key informant interview with volunteer
6. Volunteers	• Do recipients feel the volunteers are adequately accessible? Why, or why not? • What recommendations did beneficiaries and other key stakeholders make on how the volunteers arrangements could be improved?	• Beneficiary household interviews • Beneficiary household focus groups • Key informant interview with volunteer
7. Complaints and communications	• How do beneficiaries and non-beneficiaries make complaints about programme-related issues? • Do beneficiaries and non-beneficiaries feel that these complaints are adequately addressed? Why, or why not?	• Beneficiary household interviews • Beneficiary household focus groups • Key informant interview with volunteer
8. Monitoring and reporting.	• Are beneficiaries and recipients consulted on their views on the programme? How? • Do beneficiaries participate in monitoring processes? Does this disrupt their normal routine?	• Beneficiary household interviews • Beneficiary household focus groups

Annex B Fieldwork conducted

Table B.1 Household interviews conducted

Oblast			Akmola		Kyzylorda			Almaty		TOTAL
Settlement			**A**	**B**	**C**	**D**	**E**	**F**	**Control**	
ECD	Beneficiary	Older	1	2	1	2	3	3	1	19
		Younger	2	1	2	1				
	Rejected		1	1	1	1	2	2		8
	Non-applicant		1	1	1	1		1		5
PLW	Beneficiary	Pregnant	2	1	2	1		1	1	8
		Lactating	1	2	1	2	3	2		11
	Rejected		1	1	1	1	1	1		6
	Non-applicant		1	1	1	1	1	2		7
Disability	Beneficiary	Physical	2	1	2	1	1	3	1	17
		Mental	1	2	1	2				
	Rejected		1	1	1	1	2			6
	Non-applicant		1	1	1	1				4
Total	Beneficiary		9	9	9	9				55
	Rejected		3	3	3	3				20
	Non-applicant		3	3	3	3				19
	TOTAL		**15**	**15**	**15**	**15**	**13**	**15**	**3**	**94**

Table B.2 Focus groups conducted

Oblast		Akmola		Kyzylorda		Almaty		TOTAL
Settlement		**A**	**B**	**C**	**D**	**E**	**F**	
	Beneficiary	1	1	1	1	1	1	6
	Non-beneficiary	1	1	1	1	1	1	6
	TOTAL	**2**	**2**	**2**	**2**			**12**

Table B.3 Key informant interviews conducted

Oblast		Akmola		Kyzylorda		Almaty		TOTAL
Settlement		**A**	**B**	**C**	**D**	**E**	**F**	
	Volunteer	1	1	1	1	1	1	6
	Akim	1	1	1		1	1	5
	Pre-school teacher	1			1	1		3
	Health worker/midwife		1	1			1	3
	TOTAL	**3**	**3**	**3**	**2**			**17**