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PROGRAM BRIEF[1]

Towards a Child Benefit Scheme

Bangladesh

Capitalizing on the early years is one of the most critical investments a country can make to break the cycle of poverty, address inequality and boost productivity in later life. However, millions of children in Bangladesh are not reaching their full potential because of inadequate nutrition, lack of early stimulation and learning, and exposure to stress. Investments in the physical, mental and emotional development of children – from before birth until they enter primary school – are vital for the future productivity of individuals and for the country's economic prosperity.

[1] The Program Brief series discusses major safety net programs that the Government of Bangladesh implements. The series includes notes on the Old Age Allowance; Allowances for the Widow, Deserted and Destitute Women; and Allowances for the Financially Insolvent Disabled by the Ministry of Social Welfare; Employment Generation Program for the Poorest; Food for Work; Work for Money; Test Relief; and Vulnerable Group Feeding by the Ministry of Disaster Management and Relief; and the Child Benefit Scheme. Many of these programs are supported by the World Bank.

BACKGROUND

Investing in children's human capital is one of the most important policy objectives to reduce poverty and boost shared growth. It will determine the productivity and competitiveness of the future workforce and thus affect the growth trajectory of the country. However, many children in Bangladesh, especially those who live in poverty, have limited access to adequate opportunities for physical, cognitive, and non-cognitive development. For instance, in 2017, 31 percent children under five years of age were stunted, which, though significantly lower than 51 percent in 2004, is still high. Wasting in 2017 was 8 percent which has taken a slower pace of decrease from 15 percent in 2001.[i] More than a fifth of all children under five continued being underweight in 2017. The problem is particularly acute in rural areas.

Poor health and nutrition outcomes as well as limited childhood development leave a dent on children's future productivity from as early as their life in the womb. Therefore, a large body of global literature greatly emphasizes the importance of investing early from the prenatal stage to at least 1,000 days of the child's life. Providing adequate nutrition and stimulation for early childhood development during this critical period can minimize the risk of permanent detrimental impacts on children's intelligence and brain development[ii]. In addition, improved nutrition also reduces the risk of morbidity and health shocks that have devastating effects on households, depleting savings and stifling earning capacity. Programs to promote neonatal and infant nutrition and cognitive development have revealed evidence globally that as a result of the interventions, the earning capacity of those children increased significantly when they grew up[iii].

The poverty rates in Bangladesh are much higher for households with young children than the national average. Nearly half the households with a child aged 0 to 5 years are poor. This indicates that households with young children have unique challenges. This may be because these households are headed by young parents whose labor market career is still at an early stage yielding insufficient incomes. That working women have to give up paid employment outside the house following child birth likely contributes to poverty of these households. Young children from female headed households containing elderly grandparents needing financial support and care are exposed to even greater risks[iv].

The Government of Bangladesh has been implementing a number of programs dedicated to improved infant and maternal health. Major programs in this area began only in 2006 while Bangladesh has had a very young population with high fertility rates since the 1970s. Currently, these programs constitute approximately 3.7 percent of the social protection budget (figure 1). Though the proportion has grown over the last decade, the increase has been much slower compared to allocations to programs targeted towards the elderly, i.e. civil service pensions and Old Age Allowance.[v] Support for older, school going children through stipends has also been significant and has increased over the years.[vi]

Recognizing the wholly inadequate allocation towards very young children's social protection, in 2018 the Government established a Policy Guidance Unit for Child-focused Social Protection (PGU-CSP) under the Cabinet Division to accelerate design and implementation of a Child Benefit Scheme, building upon the success and learnings from existing programs.

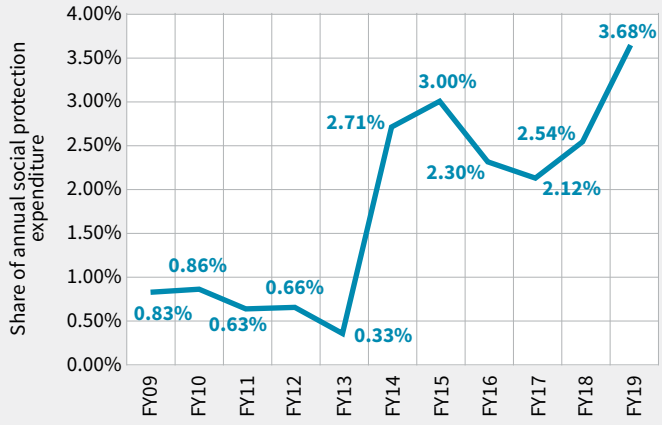

Figure 1: Expenditure on programs related to maternal, neonatal and infant nutrition and health as a percentage of the social protection annual expenditures

Source: Analysis is based on budget archives, Finance Division, Ministry of Finance

Notable programs include the (i) Maternal Health Voucher Scheme which is now known as the Demand-Side Financing of Maternal Health Voucher Scheme; (ii) Maternity Allowance Program for the Poor; (iii) Allowances for Urban Lactating Mothers; and (iv) Income Support Program for the Poorest (ISPP)-Jawtno (figure 2).

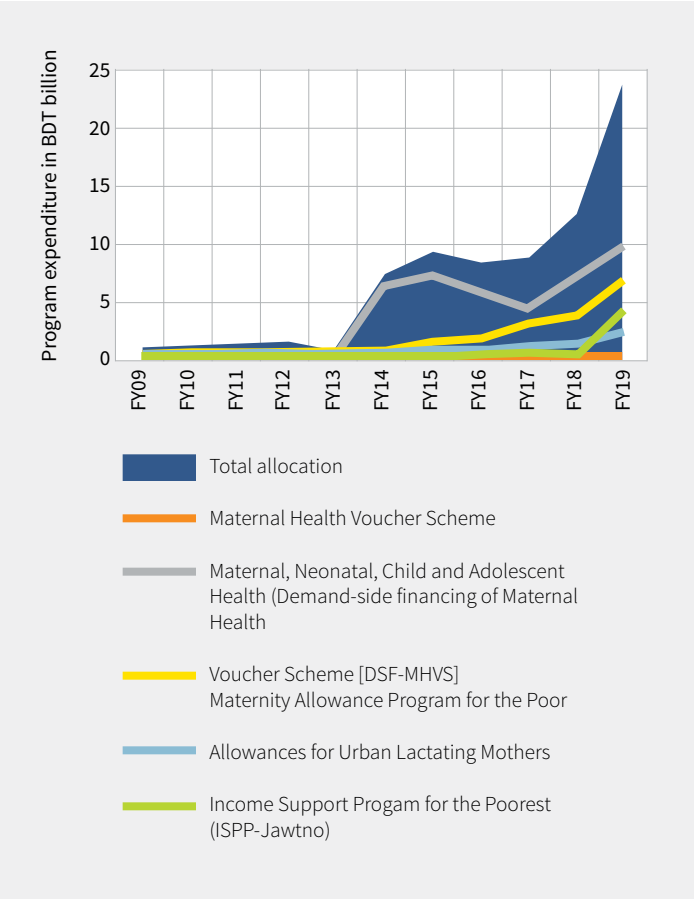

Figure 2: Expenditure on various programs related to maternal, neonatal and infant nutrition and health
Source: Budget documents, Finance Division, Ministry of Finance

I) DEMAND-SIDE FINANCING OF MATERNAL HEALTH VOUCHER SCHEME (DSF-MHVS)

The primary goal of the Maternal Health Voucher Scheme (MHVS) was to reduce maternal mortality in line with the Millennium Development Goals. Designed by the Ministry of Health and Family Welfare with support from the World Health Organization, the program since 2006 was piloted across twenty-one upazilas in twenty-one districts. Currently the MHVS has expanded to fifty-three upazilas. In FY16, the MHVS served more than hundred thousand pregnant women which represented about 3 percent of all pregnancies across the country.

The program is now called Demand-Side Financing of Maternal Health Voucher Scheme (DSF-MHVS). To be eligible for DSF-MHVS, a pregnant woman (up to her second pregnancy) must belong to a household that is landless or owns less than 0.15 acre of land; has irregular income of no more than BDT 3,100 (US$ 37) per month and owns no productive assets.[vii] Once enrolled in the program, a beneficiary is entitled to (i) three ante-natal care (ANC) visits; (ii) facility-based child delivery; (iii) one post-natal care (PNC) visit within 6 weeks of delivery; (iv) services for obstetric complications; (v) payment of BDT 500 (US$ 6) as transport cost to institutional obstetric services – each beneficiary is provided with a booklet of vouchers which she can use each time she avails institutional ANC, PNC or institutional delivery services; (vi) up to BDT 500 (US$ 6) for referral to district hospital; and (vii) cash grant of BDT 2,000 (US$ 24) if the delivery is facilitated by a skilled birth attendant.[vi] The payments flow through the Line Director (LD) of Maternal, Neonatal, Child and Adolescent Health (MNCAH), Ministry of Health and Family Welfare to upazila accounts of MNCAH to beneficiary bank accounts.

On the supply side, such health services are provided by public, private and Non- Government Organizations (NGO) service providers. The program initially tried to create competition through performance incentives, but new service providers did not respond and public health service providers remain the primary source.[viii] Service providers continue to be incentivized through a seed fund for health services for pregnant women including PNC.

Early pilot results revealed that the program was able to increase the utilization of maternal health services by poor pregnant women through incentives when compared with those pregnant women who were not incentivized.[viv] Women enrolled in the program were more likely to seek ANC and PNC services; and more births were attended by skilled birth attendants, as a result of which the number of stillbirths and neonatal mortality was also found to be lower in DSF areas than in non-DSF areas. Total out of pocket expenditure on ANC, PNC and child birth was also found to be lower in DSF areas.[x]

A diagnostic report[viii] found a few challenges including limited awareness of local authorities about the program's policies

and procedures, delays in payments, targeting of noneligible beneficiaries etc. Increase in the incidence of caesarean deliveries particularly in private health facilities was a key concern. Inadequate quality of services was also a challenge primarily due to overloaded service providers stemming from insufficient human resources at the health facilities.[xiv]

II) MATERNITY ALLOWANCE PROGRAM FOR THE POOR (MAPP) & ALLOWANCES FOR URBAN LACTATING MOTHERS (AULM)

Maternity Allowance Program for the Poor (MAPP) and Allowances for Urban Lactating Mothers (AULM) both focus on maternal and child health. The two key differences between the programs are:

- **Geographic focus:** MAPP focuses on rural areas while AULM focuses on urban areas;
- **Objectives:** The two programs have similar objectives - reduced infant and maternal mortality; improved utilization of PNC and delivery services; and improved breastfeeding and family planning practices. However, while the MAPP emphasizes on improved immunization; reduction of dowry, child marriage and divorce; and increased registration of birth and marriage; AULM emphasizes on increased utilization of ANC, improved standard of living and living conditions.

MAPP began in FY2008 under the Ministry of Women and Children Affairs (MoWCA) and since then has expanded rapidly to become a large national program, focused on rural areas.

Each year, the number of new beneficiaries is determined centrally and at present the program reaches 700,000 women around the country. On the other hand, AULM began in FY11, also under MoWCA, and currently, the number of beneficiaries this program reaches is around 250,000.[xi]

In order to be eligible for MAPP, a woman must (i) be at least twenty years old; (ii) be pregnant with her first or second child during the annual enrolment of the program during July; (iii) have a household income of less than BDT 1,500 (US$ 18) per month; and (iv) not be a previous/existing beneficiary of similar programs. Similarly, an AULM beneficiary has the same demographic criteria with the addition that she must be a working woman. The household income threshold is set at no more than BDT 5,000 (US$ 60).[xii]

Each beneficiary is enrolled in either program for a duration of three years and is entitled to receiving a monthly allowance of BDT 800[xiii] (US$ 9.5), paid through her bank account.[xiv]

While beneficiaries are appreciative of having their individual accounts so that they can have better control over the allowances they receive, many find upazila-based bank branches inconvenient to reach because of the distance. Moreover, the accounts are of “short term” nature based on the tenure of the entitlement. Many beneficiaries do not receive cheques to withdraw their allowances – instead the banks draw the entire allowance amount each time so that account has no savings functions. At the same time, long delays in the transfer of funds from the central level to upazilas lead to less frequent payments to beneficiaries (usually lumped into six monthly or yearly payments instead of monthly payments). Such accumulated payments represent windfall gains which are often used by households for investment purposes e.g. to purchase livestock, poultry and capital items. While that may translate into increased future income contributing to poverty reduction, it has limited immediate effect on food and nutritional intake of children which the programs aim to improve. Moreover, due to delays, women often receive accumulated allowances after the pregnancy so prenatal nutrition is unlikely to benefit from the payments.[xii]

Under both programs, Community Based Organizations (CBOs) and NGOs arrange training for beneficiaries on pregnancy, child birth, neonatal care and other social and developmental aspects. According to an evaluation,[xv] MAPP beneficiaries were found to be more likely to utilize ANC and PNC services than women who did not receive any intervention. The study also suggested that MAPP beneficiaries’ knowledge on breastfeeding was slightly better than non-beneficiaries, but that did not lead to better breastfeeding practices. Similarly, no significant effect was noticed in the incidence of institutional delivery among MAPP beneficiaries. A cause for such mixed outcomes could potentially have been delayed training in many instances resulting in many beneficiaries not receiving any training during pregnancy. Moreover, in case of sessions on neonatal care, it was found that mothers have difficulty attending sessions with their new-born babies. Having to tend to the baby during the session constrained the mother’s ability to concentrate on training contents. At the same time, there were also concerns about the educational attainment and knowledge of the trainers on the training content.[xii]

MoWCA recognizes many of these challenges and, with support from World Food Programme (WFP), has recently designed the

Improved Maternity and Lactating Mother Allowance (IMLMA) Programme which aims to combine the two existing programs and facilitate rolling enrolment, provide monthly Government to Person (G2P) payments and improve behavioral change communication.

III) INCOME SUPPORT PROGRAM FOR THE POOREST (ISPP-Jawtno)

Global evidence suggests that, if implemented well, conditional cash transfers (CCT) can contribute to poverty reduction and improved human development outcomes.[xvi] By making payments to households, conditional upon compliance with co-responsibilities, CCTs can stimulate behavioral changes, contributing to improved household wellbeing and preventing intergenerational transmission of poverty in the long run.

The Government of Bangladesh was among the first to implement a CCT through the Female School Stipend Program in the 1990s which had a major contribution to increasing girls' enrollment in secondary schools.[xvii] This paved the way for numerous other programs around the world which have shown impressive health and education outcomes.

In 2011, the Local Government Division, with the support of the World Bank, implemented a pilot CCT initiative, Shombhob, focusing on improving nutrition for children aged 0 to 36 months and education outcomes for primary school children, through bi-monthly cash transfers to nearly 16,000 poor households in two upazilas in Rangpur.[xi] The 13-month pilot significantly improved the knowledge of mothers about of exclusive breastfeeding; increased dietary diversity; and reduced the incidence of wasting of children aged between 0-14 months at the time of enrollment.[xvii]

Based on the positive outcomes and findings from the pilot, the Government scaled up the CCT to 43 of the poorest upazilas[xviii] with a high likelihood of malnutrition, focused on improving nutrition and cognitive development of children from conception to five years. The Income Support Program for the Poorest-Jawtno (ISPP) aims to provide income support to poor households while increasing the mothers' use of child nutrition and cognitive development services and enhancing local level government capacity to deliver safety nets. A unique feature of the ISPP-Jawtno program is its focus on the full spectrum of a child's early years with a great emphasis on overall development, beyond health and nutrition, up to the age of five. Through the child nutrition and cognitive development (CNCD) sessions, caregivers are counseled on various topics, including nutrition, hygiene and safety, and developing motor skills and cognitive awareness.[xviv]

Human brain development is greatest at the very young age.[xx] Through the conditional cash transfer, Jawtno aims to enhance households' ability to make the most of the timing of brain development as presented in Figure 3.

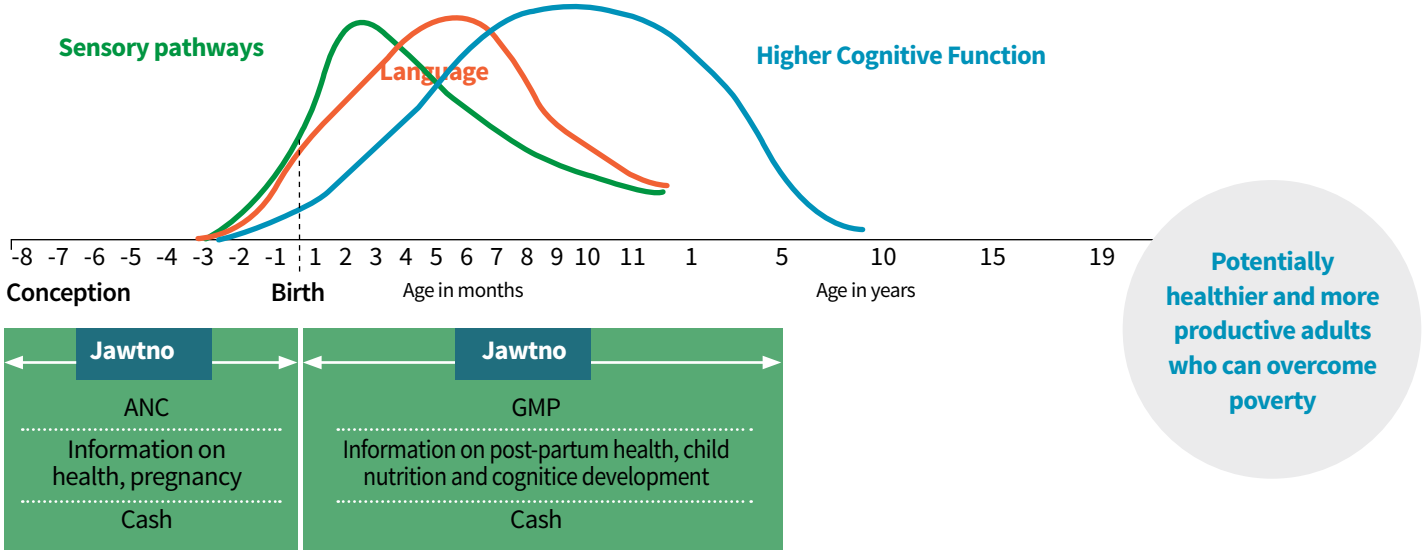

Figure 3: ISPP's theory of change for improved cognitive development

For a woman to be eligible for ISPP-Jawtno, she must (i) belong to a poor household; and (ii) either be pregnant or have a child below the age of five years (only for the two eldest children). Beneficiaries must comply with specific co- responsibilities based on her profile (Table 1).

In line with the Government's safety net strategy for objective targeting of the deserving poor, ISPP-Jawtno is designed to identify beneficiaries using the National Household Database (NHD), which contains household poverty scores based on a proxy means test (PMT) formula. Until the NHD becomes operational for safety net programs, the program uses community-based targeting to identify beneficiaries.

Applicants to the program must meet defined poverty criteria, which include land ownership, occupation of household head, asset ownership and average household income. The application is vetted by the community and following a verification visit, the final list of beneficiaries is prepared.

Once beneficiaries are identified, they are enrolled into ISPP-Jawtno. The enrolment process includes collecting the household's basic demographic information - NIDs, birth certificates/immunization cards, and pregnancy test results – as well as the beneficiary mother's fingerprints. All the data feeds into a management information system (MIS) that has been developed by the Project for improved program administration. Each enrolled beneficiary receives a 'Jawtno cash card' which is biometrically-enabled to serve as her beneficiary ID as well as her instrument for cash withdrawal.

ISPP-Jawtno's co-responsibilities require support from local public health service providers, in particular community clinics managed by the Ministry of Health and Family Welfare. For the ANC and growth monitoring and promotion (GMP) co-responsibilities, beneficiaries avail services from their closest health center and record their attendance by swiping their Jawtno cash cards. Since community clinics have minimal staffing capacity, ISPP has procured the services of an NGO, BRAC, to support community clinics in providing ANC and GMP services and recording beneficiaries' attendance.

ANC, GMP and CNCD services are prudently scheduled and managed to make sure that each beneficiary receives the customized session that serves her and her child/ren's needs.

ISPP-Jawtno's beneficiaries receive quarterly payments through the Bangladesh Post Office (BPO) using the Jawtno cash cards. Payment camps are organized at the union, close to where beneficiaries live as opposed to upazila level bank branches common for other safety net programs. The program is also exploring use of other payment providers to improve beneficiaries' ease of access to their funds.

ISPP-Jawtno receives grievances through its union-based safety net cell (SNC), staffed by a safety net program assistant (SPA). The SNC's vision is to become a one-stop-shop service center for safety nets in each ISPP-Jawtno union. For the time being, the SPAs help implement ISPP-Jawtno and serve as the beneficiary interface of the Project, which includes troubleshooting beneficiary problems with targeting, enrolment, services and payments.

Table 1: ISPP-Jawtno's coresponsibilities

Category of beneficiary	Co-responsibility	Benefit amount (BDT)	Payment condition	Maximum payment per quarter
Pregnant women	Up to four ANC visits during pregnancy	BDT 1,000	No visit, no payment	BDT 1,000 – 2,000
All beneficiary mothers with children aged 0-24 months	Take child for height and weight check every month	BDT 700 per visit plus a bonus of BDT 700 if all three visits are completed in a quarter	Payment allowed if at least two visits have been completed in a quarter	BDT 2,800
All beneficiary mothers with children aged 25-60 months	Take child for height and weight check every 3 months	BDT 1,500	No visit, no payment	BDT 1,500
All beneficiary women	Attend child nutrition and development counseling sessions every month	BDT 700 per visit (total of BDT 2,100 in one quarter, irrespective of the number of children enrolled plus bonus BDT 700 if all three visits are completed in a quarter)	Payment allowed if at least two visits have been completed in a quarter	BDT 2,800

WAY TOWARDS THE CHILD BENEFIT SCHEME

Building human capital is an essential step to ensure a country's productivity and strengthen household resilience. This is particularly critical for Bangladesh at a time when the country needs to take advantage of its demographic dividend.

Although Bangladesh has managed to significantly improve overall human development outcomes, under five stunting and wasting continue to be major problems. Preventing early chronic malnutrition is the first step in creating and protecting human capital – this can only be done through both providing adequate health and nutrition services and helping households utilize such services.

The Government is planning to launch a comprehensive Child Benefit Scheme, the implementation plan for which will be developed by MoWCA. According to the plan for the Scheme, it is expected to support children's socio-economic environment to fulfill long-term strategic needs of increasing their earnings ability and lifting their households out of poverty. The scheme will build on the achievements and lessons of the existing maternal and child health programs discussed in this note.

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[i] Bangladesh Demographic Health Survey, 2000-2017/18

[ii] Hawley, T. 2000. "Starting Smart: How Early Experiences Affect Brain Development." Zero to three Press

[iii] Gertler, P. et al. 2014. "Labor Market Returns to an Early Childhood Stimulation Intervention in Jamaica." Science 30, vol 344 (6187): 998-1001

[iv] National Social Security Strategy, 2015

[v] At the same time, it should be noted that a well-functioning old age allowance or pensions system with wide coverage contributes to child care as financially better off elderly parents require less support from their grown-up children which enables those adults to provide more support for their own children.

[vi] Osmani, Ahmed, Ahmed, Hossain, Huq and Shahan, Strategic Review of Food Security and Nutrition in Bangladesh

[vii] Budget documents, Health Services, Ministry of Health & Family Welfare

[viii] Ahmed, S; Khan MM; A maternal health voucher scheme: what have we learned from the demand-side financing scheme in Bangladesh?

[viv] Khan, MM; Khan, MA Rahman; Report on the Diagnostic Study of DSF-MHVS Bangladesh, Maxwell Stamp, Strengthening Public Financial Management for Social Protection (SPFMSP) Project, 2016

[x] Economic Evaluation of Demand-Side Financing (DSF) For Maternal Health in Bangladesh, Ministry of Health and Family Welfare, supported by GIZ

[xi] MoWCA/WFP, 2018

[xii] no more than BDT 8,000 in areas where enrolment is conducted by Bangladesh Garment Manufacturers and Exporters Association (BGMEA) and Bangladesh Knitwear Manufacturers and Exporters Association (BKMEA)

[xiii] Increased from 2 years and BDT 500 per month (MoWCA) in the FY19 budget

[xiv] A Diagnostic Study on Maternity Allowance (MA) and Lactating Mothers Allowance (LMA) Programmes of Ministry of Women and Children Affairs, Ministry of Finance, SPFMSP Project

[xv] Jetha, 2011

[xvi] Fiszbein and Schady, 2009

[xvii] Ferre, Celine; Sharif, Iffath; 2014; World Bank; Can Conditional Cash Transfers Improve Education and Nutrition Outcomes for Poor Children in Bangladesh?

[xviii] The 44 upazilas fall within Gaibandha, Jamalpur, Kurigram, Mymensingh, Nilphamari, Lalmonirhat and Sherpur districts.

[xviv] The CNCD curriculum was developed by the Child Development Unit of icddr,b and based on research and findings of international and local best practice.

[xx] C.A. Nelson in "From Neurons to Neighborhoods, 2000"

For more information:

https://bit.ly/2B7FBSW

Overview on Bangladesh's safety net program: World Bank. 2016. Bangladesh Social Protection and Labor Review: Towards Smart Social Protection and Jobs for the Poor. Bangladesh Development Series,no. 33;. World Bank, Dhaka, Bangladesh.

https://bit.ly/2TWVVx9

This Program Brief has been prepared by **Rubaba Anwar** and **Aneeka Rahman**, Social Protection & Jobs Global Practice, World Bank, with kind support of the Korea-World Bank Partnership Facility (KWPF).

World Bank Office Dhaka
Plot- E-32, Agargaon, Sher-e-Bangla Nagar
Dhaka-1207, Bangladesh
Tel: 880-2-5566-7777, Fax: 880-2-5566-7778
www.worldbank.org/bangladesh

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