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Conditional Cash Transfers Model of Zakat Distribution for Managing Covid-19 Impact on Health and Education Sectors

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ABSTRACT

Covid-19 pandemic is having negative impact on various sectors. Besides its direct impact on increasing the positivity and fatality rate, the pandemic is also causing an indirect impact on health and education sectors, such as the increase in the number of maternal and baby deaths, reducing participation in routine vaccinations, increasing the number of children dropping out of school and decreasing the quality of education. Distribution of social funds using the Conditional Cash Transfers (CCTs) model shows various positive impacts on the health and education sector in several countries. Therefore, social funds in the form of zakat are vital to be distributed using CCTs to reduce the Covid-19 pandemic's indirect negative impact. Using a qualitative method with a library research approach, the researcher aims to offer technical improvement in the zakat distribution using the CCTs scheme. The distribution of zakat using CCTs to reduce the impact of Covid-19 on health and education can be done by emphasizing mustahiq's commitment to education and health facilities. The implementation of CCTs in the distribution of zakat funds can be carried out through several stages, namely recruitment of mustahiq assistants, mustahiq data collection, verification and validation of mustahiq's data, socialization of commitments, verification of commitment, and evaluation of programs and mustahiq's conditions.

Keywords: Zakat-Distribution; Covid-19 Pandemic; Conditional-Cash-Transfers

INTRODUCTION

The Covid-19 pandemic that has hit the world since 2020 has caused a crisis in various sectors (Wu, 2021). Apart from the direct impact on the health sector, the pandemic also destroys the economic (Borio, 2020) and educational dimensions (Azevedo, Hasan, Diana Goldemberg, Iqbal, & Geven, 2020). The economic crisis caused by the Covid-19 pandemic is one of the worst crises experienced by mankind in history. In the education sector, the Covid-19 pandemic forced all educational facilities at all levels to operate abnormally by carrying out the learning process through online platforms. As a result, the learning process is not optimal, causing spill over problems in the education sector, such as increasing dropout rates, reducing student participation in learning (Azevedo et al., 2020) and reducing the quality of students' academic achievement (Kaffenberger, 2021; Kuhfeld et al., 2020).

Based on the projections carried out by Azevedo et al (2020), the Covid-19 pandemic has the potential to cause 7 million elementary and junior high school students to drop out of school, especially in vulnerable groups such as girls, ethnic minorities, and people with disabilities. As a result, the governments of various countries in the world will experience a loss of 16 percent of total expenditure on the basic education sector. In addition, if there is no intervention, the quality of learning will decrease to the value of 1 year of the educational process (Kaffenberger, 2021) and the goal of equal access to education for the poor by 2030 will not be achieved (Azevedo et al., 2020).

In the health sector, apart from the direct impact in the form of an increase in

the number of infected and dead, which until April 5th, 2021 has reached 132,005,545 infected people and 2,867,776 people who have died, the Covid-19 pandemic also has an indirect impact in the form of an increase in mortality rates for pregnant women and babies, and decreased rates of routine vaccination in children and adults (Dinleyici et al., 2020; Mcdonald et al., 2020). According to the projections with the worst possibility carried out by Roberton et al., (2020) in 6 months, the pandemic has the potential to cause an increase in child mortality to 1,157,000 and 56,700 for maternal in 118 lower-middle-income countries. This indirect impact was caused by the number of health facilities that stopped operating during the pandemic and the reluctance of related parties to check their health and carry out routine vaccinations during the Covid-19 pandemic (Dinleyici et al., 2020; Mcdonald et al., 2020; Roberton et al., 2020).

The distribution of social funds using the Conditional Cash Transfers (CCTs) scheme is one solution that can be used to reduce the indirect impact of the Covid-19 pandemic on the education and health sectors. In simple terms, the distribution of social funds using the CCTs scheme is the distribution of social funds which is followed by certain conditions that must be met by the recipient after receiving the funds (Bergstrom & Dodds, 2021; Dustan, 2020; Kitaura & Miyazawa, 2021; Pescarini et al., 2020), such as the obligation to attend school (Mill, Macours, Maluccio, & Tejerina, 2020; Morais & Sa, 2015) and the obligation to go to health facilities and carry out routine vaccinations (Kusuma, Thabrany, Hidayat, & Mcconnell, 2017; Rahman & Pallikadavath, 2018).

So far, CCTs have been implemented in various countries around the world. According to research conducted by Zulkhibri (2016) until 2010, CCTs have been implemented in more than 35 countries with a total of 53 programs. CCTs also have a tremendous impact on the empowerment of the poor in the education, health, and economic sectors (Waziri, Zubir, Ibrahim, Bin, & Bin, 2020). In the education sector, CCTs contribute to increasing student attendance to school in the short term (Attanasio et al., 2010; Cacciamali, Tatei, & Batista, 2010; Dubois, de Janvry, & Sadoulet, 2012; Ravallion & Wodon, 2000), reducing dropout rates (Norbert Schady & Maria Caridad Araujo, 2008; Schultz, 2004), reducing child labour (Attanasio et al., 2010; Skoufias & Parker, 2001), increasing students' academic achievement and increasing the likelihood of students continuing higher education (Mill et al., 2020).

In the health sector, CCTs have a positive contribution to reducing maternal and infant mortality (Ranganathan & Lagarde, 2012), increase vaccination rates (Kusuma et al., 2017), improving health quality (Pescarini et al., 2020), reduce obesity (Charness, Gneezy, Org, & Charness, 2008; Volpp et al., 2008), reduce smoking rates (Giné, Karlan, & Zinman, 2009; Volpp et al., 2009), reduce the number of deaths in the elderly (Barham & Rowberry, 2013; Oliveira, Kassouf, & Aquino, 2017) and other positive impacts (Witvorapong & Ismael, 2016). Seeing the extraordinarily positive impact of distributing social assistance through CCTs, the authors in this study are interested in offering the CCTs scheme in distributing Zakat funds so that Zakat can contribute to reducing the indirect impact of the Covid-19 pandemic on the health and education sector. So far, based on the literature review that the author has conducted, there has been no research that tries to offer technical zakat distribution schemes using CCTs. Previous research with the same theme conducted by Zulkhibri (2016) was only limited to describing the potential of social funds if distributed with the CCTs scheme. So far, no country has used the CCTs scheme to distribute Islamic social funds, either Zakat, Infaq, Sadaqah, or Waqf (Zulkhibri, 2016).

LITERATURE REVIEW

Conditional Cash Transfers and Their Impact on Education and Health Sectors

In general, social assistance funds, both those provided by the government and those provided by private institutions, consist of two types, namely conditional cash transfers and unconditional cash transfers (Son, 2008). Conditional cash transfers are social assistance funds that are given to individuals or groups that are equipped with certain conditions that must be met by the recipient (Santana, Pais, & Silva, 2013). The requirements to become participants need to be met in order to receive assistance. The conditions are also in the form of obligations that must be carried out by someone after receiving the funds. Unconditional Cash Transfers are social assistance funds that are given to certain individuals or groups without certain specific conditions and after receiving assistance, recipients are not bound by certain obligations which are monitored and evaluated (Son, 2008).

CCTs is a social empowerment program that has proven to be effective in alleviating several social problems that exist in several countries (Pena, Urrego, & Villa, 2017; Waziri et al., 2020). This program is a form of investment in the field of human resource development (Mill et al., 2020). The form of implementation is to provide cash assistance to the poor with certain conditions (Crost, Felter, & Johnston, 2016). After receiving this assistance, the person concerned must commit to empowering himself so that he can get himself out of the social problems (Pescarini et al., 2020). This program provides cash assistance that is given regularly. With certain conditions, these requirements can differ from one country to another (Santana et al., 2013). Some countries require recipient commitment to health and education facilities. Some countries require commitment in health only or education only (Zulkhibri, 2016).

CCTs is a program that has been implemented massively in various parts of the world which targets investment in human resource development (Kabeer & Waddington, 2015), from developing children's nutritional and health needs (Kronebusch & Damon, 2019) to ensuring access to education for them, starting from Elementary School until Senior High School. As a large-scale social empowerment program, CCTs have been implemented in various parts of the world (Zulkarnaen, 2020). This program was started in 1990 in Mexico, Bangladesh, and Brazil (Ranganathan & Lagarde, 2012).

In its application, CCT has several key characteristics that differentiate it from Unconditional Cash Transfers. First, generally, the state targets poor households or very poor households (Zulkhibri, 2016). Participants in this program are usually housewives from a family. Second, some countries, apart from providing cash assistance, also provide several nutritional components in the form of supplements to children, pregnant women, and those who are breastfeeding (Kronebusch & Damon, 2019; Zulkhibri, 2016). Third, the amount of assistance given depends on the number of children and the level of education. Fourth, in some countries the value of assistance given to girls is more than that of boys. This is aimed at increasing the school participation rate of girls (Zulkhibri, 2016). Fifth, the amount of assistance provided to middle school students is more than that of elementary school students. This is according to the level of ones needs (Son, 2008).

The main criteria for recipients of CCTs assistance are recipients who are willing to commit to carrying out some of their obligations and responsibilities as participants (Kitaura & Miyazawa, 2021). These responsibilities can be in the form of ensuring the attendance of their children to school with a certain minimum percentage level (Norbert Schady & Maria Caridad Araujo, 2008), checking family members

especially toddlers and pregnant women to health facilities to be checked for health conditions, growth and development and getting an immunization.

Obligations are commitments that must be fulfilled by the recipients. These obligations vary depending on the policies and conditions of each country (Zulkhibri, 2016). Generally, three obligations must be followed, namely the obligation to attend educational facilities, health, and economic activities. For some low-income countries that do not have sufficient educational facilities, the commitment obligation must adapt to existing conditions (Son, 2008).

The CCTs program has had a tremendous impact on the health and education sectors. In the health sectors, this impact results from the recipients' obedience to the required obligations (Kabeer & Waddington, 2015), such as the obligation to check the health conditions of pregnant women, breastfeeding mothers, and toddlers or other obligations that depend on the conditions of each country (Zulkhibri, 2016). Even some countries require leprosy screening (Pescarini et al., 2020), the obligation to stop smoking (Giné et al., 2009; Volpp et al., 2009) and the obligation to lose weight (Volpp et al., 2008).

Ranganathan et al. (2012) concluded that CCTs are programs that have a very good impact on the health sector of poor and developing countries. Some examples are the success of the program of *Opportunides* in Mexico, which was able to double the visits of CCTs recipients to health facilities than those who did not receive it. The same thing happened in Colombia under the program's name *Familias en Accion.* The CCTs program also has a very good impact on increasing immunization rates (Kusuma et al., 2017), healthy and clean living habits, increasing growth and nutritional intake, and reducing the number of free sex behaviour which is the main cause of the spread of the HIV (Kabeer & Waddington, 2015; Ranganathan & Lagarde, 2012).

In the education sector, the CCTs program in general also has a very significant impact on education (Stampini, Martinez-cordova, Insfran, & Harris, 2018). This impact is also generated from the obedience of the recipients to comply with the obligations set by the government as the provider of CCTs (Zulkhibri, 2016). This impact is in the form of reducing dropout rates (Attanasio et al., 2010), especially for vulnerable groups such as girls and people with disabilities (Rawlings & Rubio, 2005). The implementation of CCTs in several countries also has a positive impact on increasing student attendance to school compared to students who do not receive CCTs (Dubois et al., 2012). CCTs recipients also have an increase in academic achievement and have a greater chance of continuing their education at the college level (Del & Estevan, 2013). In addition, the CCTs program indirectly reduces the number of child labourers. This is because students are required to meet the percentage of attendance at school following applicable regulations, thereby reducing children's opportunities to work (Norbert Schady & Maria Caridad Araujo, 2008).

The positive impact resulting from the implementation of CCTs in the short term in the education and health sector is not the main goal. The ultimate goal of implementing the CCTs program is a strategy undertaken to improve the quality of the nation's future generations (Pena et al., 2017; Rawlings & Rubio, 2005; Waziri et al., 2020). CCTs are part of a long-term investment to improve the quality of human resources. This program also aims to get the poor out of poverty by improving the quality of education and health (Ham & Michelson, 2018). Based on existing evidence, the distribution of Zakat funds using the CCTs scheme has the potential to be implemented as a solution to reduce the

negative impact of the Covid-19 pandemic on the health and education sectors.

ZAKAT AND ITS ROLE IN SOCIAL EMPOWERMENT

Zakat comes from the Arabic Language, namely *az-zakah*. It is the *masdar* of *fi'il madli zaka*, which means purification. It also means holy (Sari, Beik, & Rindayati, 2019). This asset is called Zakat because the remaining assets that have been spent can grow because of the prayers of the *mustahiq*. Zakat is one of the pillars of Islam. It is obligatory based on *qath'i* arguments and is a matter of *ma'lum fiddin bid dharurah*, so that denial of the obligation of zakat leads to *kufr* (Kabir Olawale Paramole, 2020).

The obligation of zakat is based on the understanding that all assets owned by humans and the universe are essentially the property of Allah SWT. Ownership by humans is relative which is only entrusted with a mandate to make the best use of it to facilitate life (Akmal, Mellina, Jamal, & Zakarsyi, 2020). Paying zakat to those in need is one of the trustworthy behaviours (Adhiatma & Fachrunnisa, 2021). This action is not only an obligation but is an absolute way to purify one's property and soul from being greedy and stingy.

Zakat is one of the philanthropic instruments in Islam that distinguishes Islam from other religions and distinguishes the Islamic economic system from other economic systems. Zakat is an obligation ordered by Allah SWT to improve the socio-economic conditions of the Muslim Ummah (Mohd Khalil, Amin, & Azman, 2020). Several studies have proven the positive role of zakat to improve economic conditions (Sari et al., 2019), especially in its role in alleviating poverty and income inequality, such as research conducted by Abdul Rasool et al., (2020) which proves that zakat has a positive impact on improving the quality of life of *mustahiq* based on *Maqashid Sharia* values. Zakat has a central role in distributing wealth from the rich to the poor (Hussain, 2019). In addition, several programs for distributing zakat also have an impact on the achievement of the Sustainable Development Goals (SDGs). As explained by Hudaefi, Aziz, & Saoqi (2020) which proves that the program for distributing zakat by BAZNAS in the form of sanitation facilities is useful in achieving SDG number 6. This program contributes to reducing the number of diarrhoea sufferers in Kendal, Boyolali, Indonesia. The zakat obtained by *Mustahiq is* very useful as a medium to meet the needs of daily life (Trianto, Siregar, & Nasution, 2020). In addition, these funds in the long term will remove the *mustahiq* from poverty and reduce income inequality (Sari et al., 2019).

Zakat also has a very effective role during the Covid-19 pandemic, especially in helping the government's role in reducing the negative impact of the pandemic. The contribution is in the form of distributing zakat targeting mustahik who are affected by the pandemic, as has been done by BAZNAS by assisting the informal sector that is vulnerable to get affected by the pandemic (Hudaefi, 2021). The Covid-19 pandemic has also increased the generosity of the Islamic community in Indonesia. This is evidenced by the increase in the realization of zakat receipts in 2020, especially during Ramadan 1441 H. This increase is not only due to increased public awareness but also due to excellent marketing methods and zakat campaigns through digital platforms (Hudaefi & Irfan Syauqi Beik, 2021). Given the importance of the role of zakat in reducing the impact of the pandemic, this study aims to offer a model for distributing zakat funds using the Conditional Cash Transfer model as a solution to alleviate the negative impact of the pandemic on the health and education sectors.

RESEARCH METHODOLOGY

In this study, the authors use a qualitative method with a literature study approach (Library Research) from various available sources of literature data such as research journals, research reports, books, working papers, and policy briefs. The types and depth of literature reviewed can be seen in Table I. All literature is used to develop a *mustahiq* zakat social empowerment model with the Conditional Cash Transfers scheme approach. Of the various CCTs models that have been developed by experts/ researchers, the authors carry out integration and combination. Then, they offer *mustahiq* zakat empowerment model with the CCTs approach, which aims to maximize the potential of zakat as a philanthropic instrument to solve social problems experienced by *mustahiq* after the Covid-19 pandemic, especially regard to its impact on education and health sectors.

Table 1. Type and amount of literature

No	*Literature*	*Amount*
1	Research Journal	49
2	Research Report	1
3	Working Paper	4
4	Book	1
5	Policy Brief	1

DISCUSSION

As part of the social assistance funds, zakat funds can also be distributed using the CCT mechanism. This is not a difficult thing to do. We only need to imitate the patterns that have been implemented by other countries in implementing CCTs by making minor modifications and adjustments. In Indonesia, we can follow the pattern that has been implemented by the Family Hope Program (PKH) under the Indonesian Ministry of Social Affairs (Nur Cahyadi et al., 2018). The implementation of CCT in other countries focuses on improving the quality of health and family education as a buffer for the quality of state's human resources (Son, 2008)s. This step is very appropriate because the health and access to education of poor families will affect improving human quality (García, Harker, & Cuartas, 2019).

The implementation of CCTs in the distribution of zakat to reduce the negative impact of the Covid-19 pandemic on the education and health sector can be carried out by Amil Zakat by requiring a component of a health and education commitment to *Mustahiq*. This commitment is in the form of participation in educational facilities according to age levels with a certain percentage of attendance. The percentage of attendance that is generally achieved by various countries is between 60-80% (Kabeer & Waddington, 2015; Zulkhibri, 2016). The commitment to health facilities is to regularly check their health conditions at health facilities, especially for recipients who are pregnant or have toddlers so that it will reduce the potential mortality rate for pregnant women and children under five years. In addition, a commitment to routine vaccination is also required to prevent the occurrence of dangerous diseases (Ranganathan & Lagarde, 2012).

Learning from the practices carried out by various countries, to distribute zakat with the CCT mechanism, the *amil zakat* can do it in several stages. The first stage is to prepare Human Resources (Rawlings & Rubio, 2005; Son, 2008) who work as companions for *mustahiq* who accompany *mustahiq* zakat in a participatory manner to ensure all business processes of distributing zakat with the CCTs scheme so that the purpose of the distribution can be achieved properly. The chosen companion must have the ability to provide community assistance and have a good understanding of zakat.

The second stage is to collect data on the community who will become *mustahiq* zakat. At this stage, the amil can cooperate with the government who knows directly the socio-economic conditions of the community (Son, 2008). The selection of *mustahiq* must be based on clear and measurable criteria, both from the aspect of

fiqh and positive legal rules. In fiqh, we can refer to the rules regarding *asnaf* zakat. In selecting participants, we must apply a priority scale. Since there are so many families from the middle to lower class in society, we must choose the poorest from the poor.

After we get the data on the beneficiaries, the amil can deploy community assistants who have been previously recruited to carry out validation and verification in the field. The facilitator must ensure that the data that is entered is feasible so that there is no potential conflict in the field due to social jealousy. At this stage, the assistants must record the socio-economic conditions of the *mustahik* to facilitate the evaluation process per quarter/semester (Nur Cahyadi et al., 2018).

After the recipient data and socio-economic conditions are well recorded with high accuracy, the next step is to carry out the assistance process for fulfilling the requirements of the CCTs mechanism which is borne by the *mustahiq*. The companion must explain what are the obligations of the *mustahiq* zakat that must be fulfilled and try to raise awareness of the *mustahiq* that this obligation is for their good(Galiani & Mcewan, 2013).

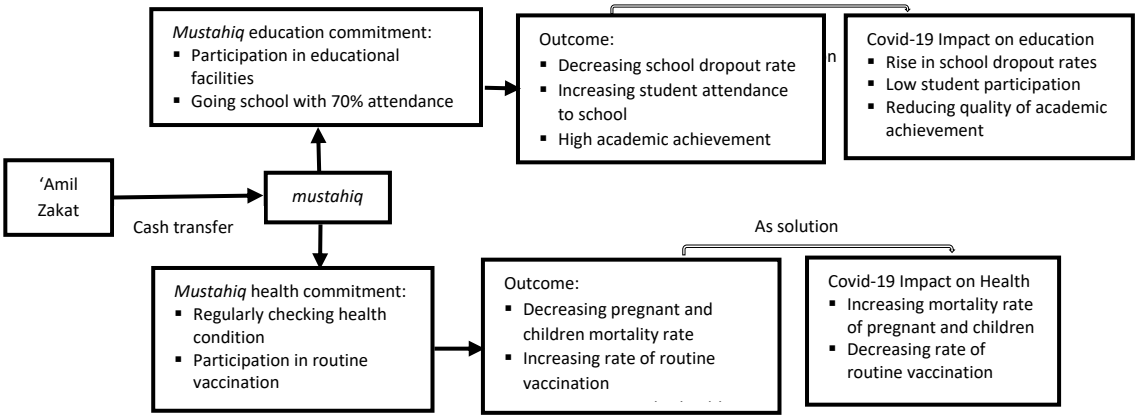
The obligation that *mustahiq* must do is the obligation to access education and health services with certain terms and percentages (Ranganathan & Lagarde, 2012). Obligations to health and education facilities are generally carried out by all CCTs mechanisms around the world (Kabeer & Waddington, 2015). The goal is that *mustahiq* are empowered from the aspect of education so that they have extensive knowledge which in the long term will contribute to improving the quality of life (Mill et al., 2020). For the health sector, the goal is that *mustahiq* have a healthy body so that they are protected from various dangerous diseases (Olson, Gardner, & Anne, 2019).

Commitment to educational services means that every member of the family-owned by CCTs participants must not drop out of school and must be registered in educational facilities according to their age level. After being registered, students must be diligent in attending the learning process with attendance provisions with a certain percentage (Dubois et al., 2012). Access to educational facilities with the aim that family members of *mustahiq* get an education because good education will increase the chances of improving the socio-economic conditions of the recipient family (Norbert Schady & Maria Caridad Araujo, 2008).

Commitment to health services means that every member of the family-owned by CCT participants with the category of toddlers, pregnant women, and the elderly must routinely have themselves checked into health facilities according to the provisions determined by the government (Ranganathan & Lagarde, 2012). For toddlers and pregnant women, the government has provided health facilities that are held once a month. For the elderly (seniors) in some areas, the government has provided health for the elderly or to existing community health centers (Kabeer & Waddington, 2015). The *mustahiq* must be ensured to attend posyandu with the provisions of a certain percentage. Regular attendance at health facilities is very important to be a component of requirements because health is the main requirement for building a prosperous family. In the next stage after all commitments are conveyed to the *mustahiq*, the assistant is tasked with ensuring that all these commitments are fulfilled by the *mustahiq*. Assistants need to carry out field verification of the education and health facilities to ensure that the *mustahiq* fulfil their commitments properly. Facilitators must-see attendance at schools and health facilities (Son, 2008).

All verification activities must be properly recorded, both offline and online based on the application. Every *mustahiq* who does not comply with the commitment must be given appropriate sanctions, not to punish but to raise awareness (Rawlings & Rubio, 2005). Every certain period, the zakat institution together with the companion evaluates the program that has been implemented, including the condition of the *mustahiq*, for those *mustahiq* who feel that they already have an increase in welfare, it is necessary to consider being excluded from participation to be replaced by other participants who are more in need. The number of participants excluded from participation will indicate the effectiveness of the program. The more people that are excluded; it means that more families are becoming prosperous.

Figure 1. Illustration of CCTs Model of Zakat Distribution for Managing Covid-19 Impact on Health and Education Sectors



CONCLUSION

CCTs as a model for the distribution of social funds show various positive impacts on the socio-economy, education, and health in various countries including Indonesia. The social fund distribution model with CCTs is considered a robust program if it is applied with effective management of the zakat distribution, especially during and after the Covid-19 pandemic to minimize the impact of the pandemic on the health and education sectors. The research was conducted using a quantitative method with a library research approach to survey various scientific literature regarding zakat and CCT. The implementation of CCTs in the distribution of zakat funds can be carried out through several stages, namely recruitment of *mustahiq* assistants, *mustahiq* data collection, verification, and validation of *mustahiq*'s data, socialization of commitments, verification of commitment and evaluation of programs, and *mustahiq*'s conditions.

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