Latin America's experience with CCTs & lessons for India

By Srihari Seshasayee

The past decade has seen numerous innovations in social policy, which go beyond previous approaches like subsidies and non-monetary provisions. One of the most popular incentive-based social innovations has come from Latin America, in the form of conditional cash transfers (CCTs).

This new tool of social equity has found success in a number of Latin American countries, where governments transfer cash grants to the poor upon meeting conditionalities that usually focus on education, and child and maternal health. However, CCTs are in no way a panacea for poverty alleviation; they are provisional, short-term measures that help redistribute income. The main priorities for most developing countries are still related to issues of basic infrastructure, access to clean water, and quality health and education (Stampini and Tornarolli, 2012).

The rapid spread of CCT programs in Latin America over the past decade, to practically every country in the region – except Cuba and Venezuela[1] – has strengthened the argument for targeted social programs, and it raises new questions related to the evolution and efficiency of such programs: why has Latin America, unlike other regions, responded so positively and quickly to implement CCT programs? What can we learn from the diverse Latin

[1] Latin America here includes South and Central America, Mexico Haiti, the Dominican Republic and Cuba.

s? How effective are these targeted programs in
lth and education in Latin America?

In attempting to answer such questions, we must be cautious in arriving at conclusions which may generalize outcomes rather than provide genuine insight into particular programs. It is difficult to determine the extent of impact CCTs can have on the poor, and whether such impacts can be reflected in measurements of poverty and other social indicators. The results will also vary depending on the country, the scale and nature of CCT programs in place.

The CCT programs in Brazil and Mexico – the longest continuously running CCT programs in the world at the moment – have been through empirical analyses and randomized control trails for two decades. This great body of evidence shows that such programs can have positive effects. In a 2009 World Bank Policy Report, Ariel Fiszbein and Norbert Schady note that "what really makes Mexico's program iconic are the successive waves of data collected to evaluate its impact, the placement of those data in the public domain, and the resulting hundreds of papers and thousands of references that such dissemination has generated."[2]

But there have also been criticisms against CCTs: some suggest unconditional cash transfers (UCTs) as an alternative (de Brauw and Hoddinott, 2010), or that governments should instead prioritize broader developmental issues like potable water, basic infrastructure, and healthcare. There have also been allegations of clientelism and reports of severe leakages, which have been

[2] Fiszbein, Ariel, Norbert Rüdiger Schady, and Francisco HG Ferreira. Conditional cash transfers: reducing present and future poverty. World Bank Publications, 2009: 6.

nd an opaque delivery system (Ansell and

Overall, there is a sense that, if CCTs are conceived and executed properly, they can bring about swift and positive results, especially in the areas of school enrolment, child and maternal health (Levy and Schady, 2013). In principle, CCTs are only temporary solutions, and the government's focus must remain on building the capacity and quality of state institutions.

The evolution of CCTs in Latin America

The rapid spread of CCT programs throughout Latin America is the result of joint collaborative efforts to promote CCTs within the region, as well as shared features like inequality and poverty amongst countries in the region (McGuire, 2014). The first set of CCTs in Latin America began in the mid-1990s, with *Bolsa Escola* in Brazil and *Progresa* in Mexico (Paes-Sousa et al., 2013).

The *Bolsa Escola* began in Brasilia in 1995, and covered roughly 20,000 families. Beneficiaries received a fixed monthly cash grant of R$130, subject to certain conditions: only families with children between ages 7 and 14, who had been residing in Brasilia for at least five years could qualify to receive the grants; another condition was a minimum school attendance rate of 80% for children.[3] The program met with considerable success, and expanded to 10 other Brazilian municipalities and states by 1998. In 2003 it finally merged

[3] Carlos Amaral e Silvia Ramos, "Programas de Renda Mínima e Bolsa-Escola Panorama Atual e Perspectivas," *Interface*, 1 (1999): 20-24.

rograms, *Bolsa Alimentação*, *Cartão*

o form *Bolsa Familia* (Lindert et al., 2007).

Mexico's *Progresa* was the first CCT program to include in its policy objectives a reduction in gender inequality.[4] While the cash transfers were targeted at the poor, the recipients of the funds were women, who were chosen to be the *titulares* – female household representatives. A 2013 study by the Inter-American Development Bank (IDB) indicates that "the existing CCT evaluation literature shows that women have wisely allocated the money towards children expenses (nutrition, health, and education), contributing to program effectiveness."[5]

To better understand and evaluate two decades of CCTs in Latin America, where roughly 130 million people are covered by such programs (Stampini and Tornarolli, 2012), it would be worthwhile to parse through three broad lenses:

Cost and funding: Unlike more long-term social welfare programs such as pensions, CCTs take up a relatively smaller portion of government budgets and are, in comparison, cost-effective. In the 2014 Routledge Handbook of Latin American Politics, James McGuire writes that "in Brazil in 2003, conditional cash transfers took up 2 percent of federal spending on social insurance and social assistance; pensions took 87 percent. In Mexico in 2002 the figures were 8 and 73 percent respectively."[6] But some programs, like Mexico's

[4] Paes-Sousa, Romulo, Ferdinando Regalia, and Marco Stampini. "Conditions for Success in Implementing CCT Programs: Lessons for Asia from Latin America and the Caribbean." *IDB Policy Brief*. no. 192 (2013): 64.
[5] Ibid., p.65
[6] James McGuire, *Routledge Handbook of Latin American Politics*, (2014): 215.

5 billion.[7] Government funds account for a majority of CCT budgets, but development banks like the IDB and World Bank also play an important role. In 2001-02, the largest loan in the history of the IDB, of $1 billion, was made to Mexico for *Progresa*.[8] The IDB's loans to Brazil, Colombia and Mexico for CCT programs total more than $6.6 billion.[9] A 2013 report evaluating CCTs in six Latin American countries states that "development banks have also helped build a network among LAC countries implementing CCT programs, facilitating the exchange of experiences and knowledge."[10]

The conditionalities: The wide array of CCTs in Latin America, from *Oportunidades* in Mexico to Chile's *Solidario*, include a diverse mix of innovative features and conditionalities. Although the original programs targeted mainly children and women, many have grown to include the elderly (particularly those who do not receive a pension), differently-abled groups, indigenous families and even internally displaced people in the case of Colombia's *Más Familias en Acción* (Paes-Sousa et al., 2013). The conditionalities have expanded to a varied list including health check-ups, growth monitoring, vaccinations, perinatal and postnatal care, and attendance at health seminars. In Mexico, families can qualify for additional benefits, including food supplements, transfers of 330 Mexican pesos for school

[7] Paes-Sousa et al., (2013): 22.
[8] McGuire, (2014): 215.
[9] Calculations based on Paes-Sousa et al., 2013: 20.
[10] Ibid., 22.

599 Mexican pesos if children complete upper secondary school before the age of 22.[11]

Coverage and share of income: The scale and coverage of the programs in Latin America vary depending on available sources of funding, government priorities, domestic resources, and also on the number of low-income residents in the country. According to Stampini and Tornarolli (2012), the CCT programs cover roughly half of the total population in Ecuador (42%) and Bolivia (57%), while the percentage of beneficiaries for some others like Chile (8%), Costa Rica (4%) and Honduras (14%) are much lower. The transfers make up a sizeable part of recipients' income; on average, CCTs in Latin America account for roughly 20%-25% of the total income of beneficiaries. Stampini and Tornarolli write that "Panama has the most generous program (43% of total income), while the size of the transfers is relatively small (11% or less of total income) in Chile, Colombia, Costa Rica, Guatemala, Jamaica and Uruguay. When the focus is restricted to poor beneficiary households [with income under US$ PPP 2.5], CCTs account on average for 32% of income."[12]

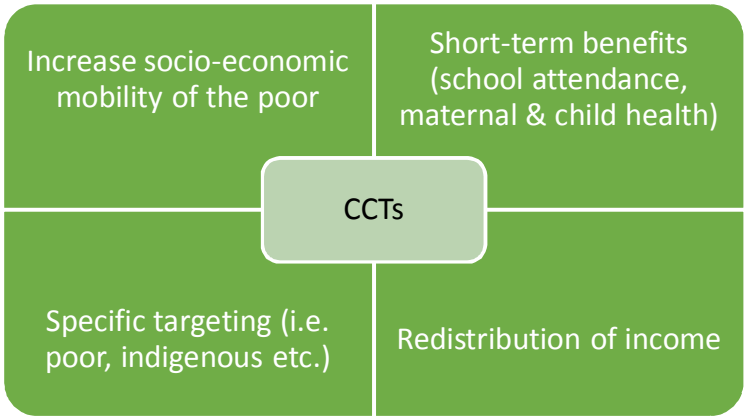
The impact of CCTs

Given that roughly one-fourth of Latin America's total population are now covered by CCT programs, what have been the impacts of these programs over the past few years? Are these reflected in social indicators such as poverty levels, the Gini coefficient, school attendance, and graduation rates?

[11] Paes-Sousa et al., (2013): 8.
[12] Stampini, M., and L. Tornarolli. The growth of conditional cash transfers in Latin America and the Caribbean: did they go too far?. IDB Policy Brief, No.185, (2012): 11.

of CCTs in Latin America, we must first note the behind CCTs: they are devised to increase social mobility, and cannot be viewed solely as a means to reduce poverty rates (de Janvry et al., 2005). Although there are short-term benefits, the results will be reflected mostly in the long-run once intergenerational poverty cycles are broken. The impact of CCTs can be seen through four dimensions, as highlighted in the diagram below.

Diagram 1. Dimensions of CCTs



In general, CCT programs are designed to increase the **socio-economic mobility** of the poor. It would be irrational to expect CCT programs to immediately lift people out of poverty, or to have a direct effect on reducing poverty levels. While the cash grants are certainly beneficial, the outcomes may only be reflected in a family after multiple generations. The problems of poverty are multi-generational and a host of changes would need to take place if a family is to be released from the cyclical poverty trap. It is also difficult to measure the generational impact of CCT programs, since data can only be gathered through evaluations once the program has already been in place for a

usa et al., (2013), "All CCT programs in LAC
or education and health care services in order to increase the human capital of poor children and break the intergenerational poverty cycle."[13]

Cash transfers are expected to generate **short-term benefits**, and have been proven to positively affect school enrolment and maternal health in Latin America. These programs must be distinguished from longer-term measures taken by the government in the fields of education and health, such as improving educational infrastructure and facilitating better access to affordable healthcare facilities. As McGuire notes, "impact evaluations of Mexico's *Oportunidades* and of Brazil's *Bolsa Familia* generally find that they had beneficial effects on income poverty, school attendance and enrollment, nutrition, stunting, child labour, and the utilization of basic health services."[14] There are similar findings in other countries too. For example, the CCT program *Red de Protección Social* in Nicaragua, from 2000-02, led to a "statistically significant half grade (or 22%) increase in the highest grade attained, a 14.2 percentage point (or 18%) increase in the enrollment rate, and a 4.0 day (62%) reduction in the number of days missed of school in the past month."[15]

Rather than being viewed as a tool for poverty reduction, cash transfers can be viewed as a mechanism to **redistribute income**; many studies have found

[13] Paes-Sousa et al., (2013): 49.
[14] McGuire, (2014): 206.
[15] Barham, Tania, Karen Macours, and John A. Maluccio. *More Schooling and More Learning?: Effects of a Three-Year Conditional Cash Transfer Program in Nicaragua after 10 Years.* No. 81801. IDB, (2013): 17.

rect or indirect effects on inequality in Latin
2009; Paes-Sousa et al., 2013). In the case of Brazil, it can also be viewed through the prism of reducing regional inequality, .i.e. inequality between different provinces in Brazil. According to a 2012 article in the Journal of Regional Science, two social programs in Brazil, the *Bolsa Familia* and the *Benefício de Prestação Continuada*, are "responsible for more than 24 percent of the reduction in inequality, although they account for less than 1.7 percent of the disposable household income. This results from their clearly pro-deconcentration profiles as compared to the other sources, both labor and nonlabor."[16] Studies have shown similar effects for CCTs in Mexico too. In the 2010 book '*Declining inequality in Latin America: a decade of progress?*' the authors write that "*Progresa/Oportunidades* is an example of 'redistributive efficiency.' With as little as 0.36 percent of GDP and 4 percent of redistributive spending, the program accounts for 18 percent of the change in the post-transfer Gini and 81 percent of the change in the Gini after inclusion of programs targeting the poor."[17]

One of the most distinctive characteristics of CCT programs is the ability to **target specific issues** or particularly neglected groups in society. In Brazil, for example, the *Bolsa Familia* covers 74% of poor households.[18] These programs have been an effective part of the solution to issues like gender

[16] Silveira-Neto, Raul M., and Carlos R. Azzoni. "Social policy as regional policy: market and nonmarket factors determining regional inequality." *Journal of Regional Science,* 52, no. 3 (2012): 433-450.
[17] Esquivel, Gerardo, Nora Lustig, and John Scott. "A decade of falling inequality in Mexico: market forces or state action?." *Declining inequality in Latin America: A decade of progress* (2010): 198.
[18] Suplicy, Eduardo, (2014). Note: Poor households are identified as those with incomes below the national poverty line of R$140 per month.

infant mortality; programs have also met with success when directed specifically at indigenous groups. According to a 2005 World Bank study, Mexico's CCTs "had a robust differential impact on indigenous children, especially those who are bilingual." The authors add that "child labor incidence decreased after *Progresa/Oportunidades* by 8 percent between 1997 and 2000. The higher effect was noticed for 15 year old indigenous children in the treatment group, with a 26 percent decrease in child labor incidence followed by a 25 percent decrease for the entire treatment group."[19]

The generally positive impacts of CCT programs in Latin America continue to be examined through robust impact evaluations, data monitoring and household surveys. Many CCTs have become the mainstay of social protection programs in Latin America, and have been integrated with other long-term social programs. There remain criticisms relating to clientelism and corruption, but these are generally possible to rectify if processes are made more transparent and also if CCTs are regularly evaluated and updated to changing realities (Paes-Sousa et al., 2013).

CCTs in India: feasibility and challenges

Conditional cash transfer programs have proliferated throughout Latin America, and have operated in small numbers in countries like Costa Rica, with 190,000 beneficiaries, and in large numbers in countries like Brazil, with 52 million beneficiaries (Stampini and Tornarolli, 2012). They have been

[19] Bando, Rosangela, et al. *Child labor, school attendance, and indigenous households: evidence from Mexico.* Vol. 3487. World Bank Publications, 2004.

mprove targeting, and reduce leakages and

The Latin American experience with CCTs is proof that they can work if implemented well, but would such programs be feasible for a country of 1.2 billion people like India, where two-thirds of the total population lives in rural areas with poor connectivity?[20] There are 363 million people in India living below the poverty line,[21] and 260 million of them live in rural areas. The main obstacles for CCTs in India would be those related to access, identification, classification, monitoring and evaluation of poor households. A number of structural questions must also be answered: should CCT programs be driven from the top-down or started first in smaller municipalities and then scaled up? What conditions should be imposed on the beneficiaries, and how will these be enforced? How will the lack of access to education and health facilities affect the targeted beneficiaries?

Background of existing social programs in India

India has more than 200 active social programs in its 29 states and seven union territories (Planning Commission, 2013). The biggest program, the National Rural Employment Guarantee Scheme (NREGS) guarantees each rural household 100 days of wage employment (to do unskilled manual work) each year; unlike the CCTs in Latin America, the NREGS places little or no conditions. Although the implementation of the NREGS has been shaky, with

[20] CIA World Factbook, https://www.cia.gov/library/publications/the-world-factbook/fields/2212.html
[21] Planning Commission. "Report of the Expert Group to Review the Methodology for Measurement of Poverty." *June, Government of India,* (2014): 5.

tion, its scale is unprecedented. According to a 2014 study, it is "the largest workfare program globally, covering 11% of the world's population. The Government of India's allocation to the program for fiscal year April 2013-March 2014 was Rs.330 billion (US $5.5 billion), or 7.9% of its budget."[22]

Some of India's social programs are in the form of CCTs, but most are in the pilot stage. The question of whether to implement national-level CCTs in India is a complex one, but it is one that is worth asking as the government proceeds with multiple pilots of different designs throughout the country; these CCT programs could potentially be integrated with the existing social welfare programs. At present, the most notable CCT program in India is the *Janani Suraksha Yojana* (JSY).

Launched in 2005 under the National Rural Health Mission, JSY seeks to "reduce maternal and neo-natal mortality by promoting institutional delivery, i.e. by providing a cash incentive to mothers who deliver their babies in a health facility."[23] It is a nation-wide program, which provides a cash benefit of Rs.1,400 (in rural areas) or Rs.1,000 (in urban areas) to women below the national poverty live who give birth in government-affiliated health facilities.[24] An important feature of this scheme is the role of the Accredited Social Health Activist, or ASHA, who is responsible for a multitude of tasks: to identify and register beneficiaries, assist women in receiving health check-ups, identifying

[22] Muralidharan, Karthik, Paul Niehaus, and Sandip Sukhtankar. "Building State Capacity: Evidence from Biometric Smartcards in India." *NBER Working Paper No 19999* (2014).
[23] India, UNFPA. "Concurrent assessment of Janani Suraksha Yojana (JSY) in selected states." (2009).
[24] Mission directorate, National Rural Health Mission, Health & Family Welfare Department, Government of Orissa, India. *Operational guidelines for implementation of janani suraksha yojana.* http://angul.nic.in/jsy.pdf

delivery, escorting pregnant women to health
the child, postnatal visits within one week of safe delivery, and finally, to counsel matters related to breastfeeding and family planning. For all their assistance, the ASHA is paid a nominal package of Rs.600 (in rural areas) or Rs.200 (in urban areas).

While most evaluations find that the number of births in health facilities have increased, the impact of JSY on maternal and infant mortality is difficult to determine. But there remain a number of challenges related to the implementation of the program. Notably, a 2009 UNFPA study concluded that while the findings indicate "a huge increase in institutional deliveries in the low performing states," the administration must utilize spare capacity in the private sector to provide institutional health services.[25] Due to irregular payments to the ASHAs in some states like Bihar where only 20.7% receive regular payment, the study adds that "grievance cells should also be set up to look into the complaints related to non-payment of ASHAs."

CCTs vs UCTs in India

In 2013, the Indian government deposited funds (for 28 welfare schemes) directly to roughly 250,000 people, amounting to Rs.23 crore ($4.2 million).[26] This is a departure from the usual method of social assistance through subsidies, and is called the Direct Benefit Transfer (DBT). According to India's Ministry of Finance, the "purpose of Direct Benefits Transfer is to ensure that benefits go to individuals' bank accounts electronically, minimising tiers

[25] India, UNFPA. "Concurrent assessment of Janani Suraksha Yojana (JSY) in selected states." (2009).
[26] Ministry of Finance, "Direct Benefit Transfer." http://www.dbtmis.planningcommission.nic.in/

educing delay in payment, ensuring accurate [illegible] curbing pilferage and duplication."[27] This new method of payment will be linked to India's Unique Identification system (also called *Aadhar*), which like Brazil's *Cadastro Único* places everyone in a single electronic database linked to government and banking services.[28] But the DBT should be distinguished from CCTs, since it doesn't place any specific conditions for its beneficiaries.

One such DBT scheme was rolled out in Kotkasim in Rajastan, where instead of purchasing low-priced kerosene (often used to light domestic lamps) from local government shops, residents bought kerosene at market prices, and received a cash transfer from the government to make up for the difference between the subsidized price and the market price. This unusual cash transfer was devised to reduce the "illegal diversion of subsidised kerosene," and reportedly led to a "net savings of 79 per cent in kerosene subsidies."[29] But the scheme's effectiveness and relevance on a state or national level is questionable given the variances in the level of subsidy and the constantly changing market price of kerosene and its derivatives.

Another pilot UCT program in India was launched in 2011 in the state of Madhya Pradesh, in partnership with the Self Employed Women's Association of India and UNICEF. A monthly transfer of Rs.200 for adults and Rs.100 for children (which was deposited in the mother's bank account) was sent as a

[27] Ibid., 1.
[28] Chauhan, Chetan. "Direct benefit transfer plan set for expansion." *Hindustan Times*, Sep 20, 2014.
[29] Bhatti, Bharat, and Madhulika Khanna. "Neither effective nor equitable." *The Hindu*, Dec 4, 2012.

ly 1,100 households living below the poverty
isites were attached, and perhaps the most significant intervention was the opening of bank accounts for all beneficiaries. The grant recipients are reported to have used this income to buy basic household appliances, foodstuffs and utensils, school supplies and so on. After a period of 18 months, impact evaluation studies indicate an improvement in nutrition levels (particularly of girls), increased school attendance and a reduction in bonded labour.[30]

Despite the existence of a number of pilot UCTs in India, there remains little evidence that UCTs can be more effective than CCTs. Placing conditions would definitely require additional mechanisms to monitor and evaluate the programs, but we have learned from the Latin American experience that there is much to gain from a more focused system of targeting.

Challenges to CCTs in India

Given the sheer scale of India's poor and vulnerable population, and the large array of tasks to be completed if and when India implements cash transfers on a national scale, there are bound to be numerous challenges. One of the main complications confronting India is the lack of access to its poor through a national identification database (though one such database, the *Aadhar*, is currently being built). The poor themselves lack access to affordable and quality healthcare. An article in the *PLOS Medicine* journal states that "due to chronic low government expenditure on health care, there is only one primary

[30] Standing, Guy. "India's experiment in basic income grants." *Global Dialogue* 3, no. 5 (2013): 24-26.

people, one government doctor for about [illegible] ost public health facilities do not have adequate medicines."[31] Furthermore, a large number of the poor in India are not linked to financial institutions. According to a 2012 World Bank study, only 35% of adults in India have an account with a formal financial institution.[32]

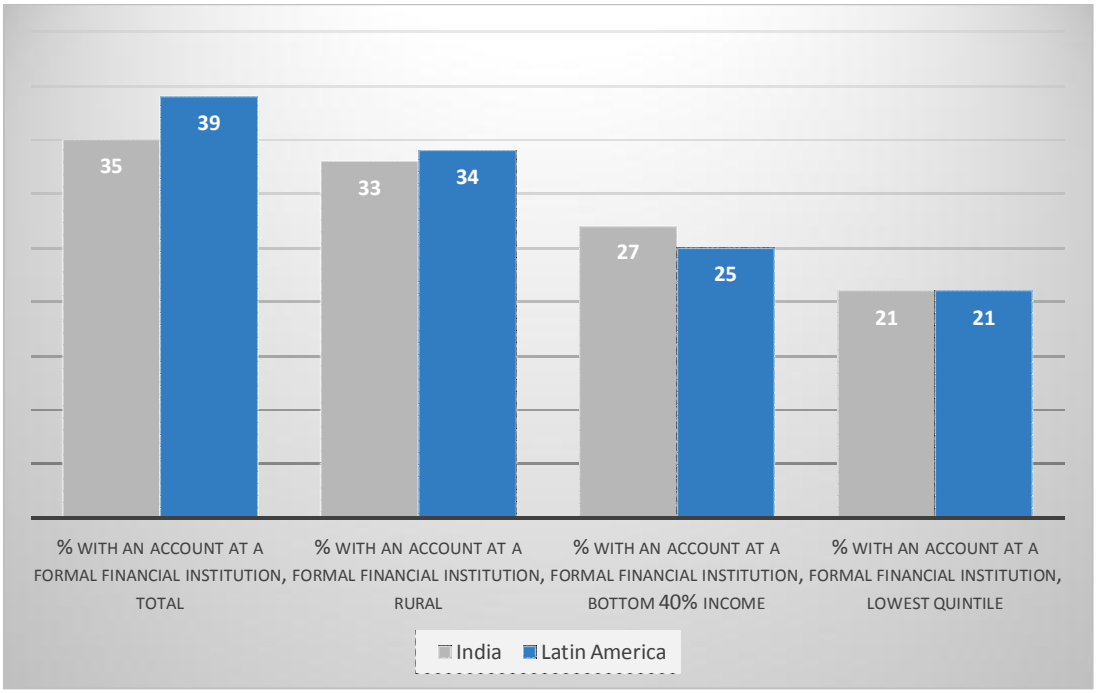
Two Indian scholars at the Harvard Kennedy School, Kartik Akileswaran and Arvind Nair, stress that the Indian state is not ready for the switch to cash. Their argument is based on two primary rationalizations: first, India requires "significant additional capability in identifying households and in linking households to bank accounts" and secondly, the "increase in economic welfare will only be realised if the cash transfer is equivalent in purchasing power to the subsidy." The authors also believe that the government's implementation strategy lacks the ability to adapt to the above-stated shortfalls; their only suggestion, which remains sound, is that India should "emulate the successful bottom-up implementation approach of Brazil's *[Bolsa] Família* with gradual scale up from the regional to the national level."[33]

Surprisingly, however, even though the authors stress India's lack of financial inclusion as an impediment for CCT programs, India's financial inclusion data is not very different from Latin America, which has successfully implemented CCTs. Of the bottom 40 percent of the population by income in India, 27%

[31] Devadasan, Narayanan, et al. "Monitoring and evaluating progress towards universal health coverage in India." *PLoS medicine* 11.9 (2014): e1001697.
[32] India, Financial Inclusion Data, World Bank http://datatopics.worldbank.org/financialinclusion/country/india
[33] Nair, Arvind, and Kartik Akileswaran. "India's cash transfer model: a rushed and flawed welfare scheme?." *The Guardian*, Aug 19, 2013.

igher than the share of the bottom 40 percent of the population in Latin America with a bank account at 25%.[34] In both India and Latin America, 21% of the bottom income quintile have a bank account; and 34% of those in rural Latin America have a bank account, compared with 33% of those in rural. These statistics show that India and Latin America share a similar level of financial inclusion (see chart below).

Chart 1. Financial inclusion in India & Latin America (source: Financial inclusion data, World Bank)



[34] Latin America & Caribbean, Financial Inclusion Data, World Bank, http://datatopics.worldbank.org/financialinclusion/region/latin-america-and-caribbean

nd, the real demand is for pragmatic solutions. The government's decision to go ahead with the DBT has to be seen in this context; it is a plea to reduce the level of corruption by removing middlemen and initiating a more transparent system. Three broad solutions, or ideas, could help minimize the government's obstacles and make the transition to DBTs easier:

1. In December 2012, Dr. Sameer Sharma, a member of the Indian Administrative Service, suggested that cash transfers should be a "mix of categorical, for example, paying Rs.500 to all the poor, and conditional transfer, say, another Rs.300 for children regularly attending school." He adds that "to minimise risk of spending disproportionately on things like liquor, conditional cash transfer has to complement direct transfers. Conditional transfers will take care of specific policy objectives, say, of poverty reduction, developing markets, removing social and economic discrimination."[35] This could offer a practical way of combining the benefits of both UCTs and CCTs.
2. While it is true that only roughly one-third of Indians have a bank account, we must keep in mind that 886 million Indians (71% of the population) have mobile phone connections.[36] This vast network can be leveraged through innovative mobile banking models – where money is transferred directly to mobile phones in case the beneficiary does not

[35] Sharma, Sameer. "Direct Cash Transfer scheme: India must learn from Latin America and Kenya." *The Economic Times*, Dec 12, 2012.
[36] ITU, "Mobile-cellular subscriptions." http://www.itu.int/en/ITU-D/Statistics/Documents/statistics/2014/Mobile_cellular_2000-2013.xls.

rma suggests that another innovation "could identity using the camera of the mobile phones." India can learn from the positive experience of African countries like Kenya and Tanzania, where the total value of transactions made in 2013 through mobile money were more than 50% of the countries' GDP.[37]

3. In the case of CCTs, while lack of sufficient public healthcare services is an impediment, the role of private healthcare can be seen as an opportunity. India's private healthcare industry holds itself to global standards in many respects, and a number of foreign patients choose India as their destination for low-cost, high-quality healthcare services. In conjunction with the private sector, the government could work towards increasing access to healthcare in rural areas and integrate social assistance programs with private health facilities.

Conclusion

The success of CCT programs in Latin America have been highlighted in numerous studies over the past few years, not only by scholars in academia, but also by government technocrats and financial institutions like the IDB and World Bank, which have played a role in the evolution of CCTs in Latin America. There are some lessons we can take from these analyses.

Although CCTs have been championed by Latin America, we must keep in mind that instead of replicating the same models, countries must devise one

[37] "Mobile money in developing countries." *The Economist*, Sep 20, 2014.

mic environments. For instance, the Indian government may need to put in place similar conditions of regular health checkups or 80%-90% school attendance in rural areas where health facilities are scarce or at times don't even exist, or in rural government schools where teachers are often absent due to insufficient pay.

The 2013 IDB Policy Brief, titled *Conditions for Success in Implementing CCT Programs: Lessons for Asia from Latin America and the Caribbean*, contains sound evidence and advice for countries in Asia looking to implement CCT programs. The authors write that "although CCTs have a simple conceptual idea and a fascinating objective, their implementation requires a complex inter-institutional framework and the investment of a considerable amount of financial and human resources." They add that the "transparent and precise targeting of poor households; the monitoring and evaluation of program inputs, outputs, and impacts; and the dynamic management of the registry of beneficiaries (including regular recertification) are key to ensuring the credibility of the programs and their growth in the face of less efficient concurrent social assistance initiatives."[38]

The lesson then is to customize CCTs, and after launching them in pilot schemes, scale up from the bottom. The leakages from CCTs can also be fixed by making systems more transparent and tracking payments electronically. The experience of Mexico, which has switched fully from cash to electronic transfers since 2011, has taught us that electronic transfers can be cost-

[38] Paes-Sousa et al., (2013): 71.

icker, and also increase financial inclusion

all, CCTs are not a cure-all for poverty alleviation, and the focus for India will remain on development issues related to infrastructure and connectivity, provision of public goods and services especially to those in the rural areas, the creation of more jobs and economic growth.

Srihari Seshasayee is a Senior Researcher in the Latin America Studies Programme and engages with research institutions and scholars from the region.

He is currently pursuing a Masters in Latin American Studies programme at Stanford University.