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Lessons for Asia from Latin America and the Caribbean

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Conditions for Success in Implementing CCT Programs: Lessons for Asia from Latin America and the Caribbean

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Abstract

Conditional Cash Transfer (CCT) programs have become the main social assistance interventions in Latin America and the Caribbean (LAC), reaching 129 million individuals in 18 countries in 2010. Programs shared key characteristics such as the payment of cash grants and the incorporation of co-responsibilities, but varied greatly in terms of coverage, infrastructure, routines, and even objectives. In this study, we analyze the experience of six countries (Brazil, Colombia, Honduras, Jamaica, Mexico and Peru) and attempt to identify important lessons for countries that have recently started or that are currently considering the introduction of a CCT. The methodology includes a review of scientific and technical literature, as well as interviews with key government and program personnel. We show that:

i. CCTs are long term interventions, whose budgets grow over time and typically converge to 0.3-0.4% of GDP.
ii. The long term objective of breaking the intergenerational transmission of poverty through the development of human capital requires additional budget allocations for the expansion of the supply of education and health care services.
iii. Beyond the allocation of budget resources, the setup of inter-sector coordination mechanisms (between social protection, health and education), the coordination with local governments and the supervision of the highest government hierarchies are necessary to ensure that CCTs produce human capital development impacts.
iv. The accurate targeting of beneficiaries is key to ensuring program credibility. Beneficiaries are typically selected through a combination of geographical and categorical criteria, followed by means-testing and community validation.
v. Efforts to increase the precision of targeting cannot eliminate errors of both exclusion and inclusion. These can however be mitigated through regular audits, the dynamic management of the registry of beneficiaries, and processes of recertification.
vi. The search for operational efficiency and effectiveness requires considerable (financial and human resource) investments in monitoring and evaluation. Results feed back into program design, producing incremental innovations.
vii. Modern payment systems are needed to reduce the administrative cost of delivering the cash grants, and the opportunity cost of beneficiaries' participation. Countries tend to converge towards the use of bank cards.
viii. The effect of CCT programs on gender inequality has been reduced by the lack of attempts to redefine women's household roles and responsibilities.

Countries attempting to leapfrog early starters in LAC should critically consider the lessons drawn in this report. In addition, they should synchronize program expansion with the speed of the development of education and health supply, as well as of the institutional capacity of both central and local administrations.

JEL classification: I38
Keywords: Conditional cash transfers (CCTs), Latin America and the Caribbean (LAC), financial sustainability, targeting, monitoring and evaluation, program implementation, gender balance

1. Introduction

Conditional cash transfer (CCT) programs are key social protection programs in 18 Latin American and Caribbean (LAC) countries, covering in 2010 about 129 million individuals, or 24% of the population (Stampini and Tornarolli, 2012). The programs aim to alleviate poverty through the transfer of cash grants and foster human capital development through a set of co-responsibilities, or conditionalities, that mainly focus on children's health and education as well as, in some cases, maternal health. CCTs have been replacing the previous generation of anti-poverty programs, which include in-kind transfers (e.g., distribution of food) and price and consumption subsidies.

In this study, we will attempt to provide a critical analysis of concepts related to the implementation of CCT programs by focusing on the following areas: (i) financial sustainability; (ii) building operational foundations (targeting of beneficiaries, monitoring and evaluation); (iii) administrative capacity of central and subnational (local) governments as well as institutional partners (relative to CCT operational functions); and (iv) program strategies to address gender inequality issues. We will review the experiences of six countries (Brazil, Colombia, Honduras, Jamaica, Mexico, and Peru) based on an assessment of the existing literature, interviews with policymakers and program managers, and analysis of available data.

Based on an analysis of what worked as well as of some less-positive experiences in these countries' programs, we will attempt to extract lessons for policymakers from countries—particularly in Asia—who are considering the introduction of a new CCT program or the reform of an existing one. The sample of countries in this analysis has been selected to include variation in country size, location, government structure (centralized versus federal), and stage of economic development, as well as in program size and coverage.

There are several existing studies on CCTs in LAC countries. However, the continuous evolution of these programs and the never-ending accumulation of operational knowledge justify this review and the extraction of the most recent lessons. In our sample of countries, Colombia, Mexico, and Peru are revising their program design, and Brazil is complementing its program with new interventions for the ultra-poor population. Furthermore, after almost 15 years of implementation, there are countless lessons that may be clear in the mind of development practitioners, but that still need to be properly systematized and disseminated. This report aims to provide a useful contribution in this direction.

1.1 Genesis of CCT Programs

After the adoption in the mid and late 1990s of the first CCT programs in Brazil, Mexico, and Honduras, the introduction and rapid expansion of CCTs in the LAC region was motivated by the confluence of high needs for social assistance and favorable economic and political conditions. Four trends drove the creation of CCT programs.

First, over the last two decades of the twentieth century, the economy of the LAC region stagnated, producing high rates of poverty and labor informality. The latter implied that large population groups lacked coverage from traditional social insurance schemes linked to formal employment (Fonseca, 2006).

Second, academics and international organizations intensified the promotion of the concept of "pro-poor growth". This included employment opportunities and public policies aimed at mitigating inequalities, with a special focus on women and traditionally excluded groups. It also incorporated the idea that investments in basic human needs improve productivity and contribute to efficiency and economic growth (Kakwani and Pemia, 2000; Eastwood and Lipton, 2001; Ravallion, 2004). Consequently, it created a more comprehensive definition of poverty, beyond low levels of income and consumption, to also cover education, health, nutrition, and other human development deficits. Social protection policies, including social assistance, began to be conceived as means to develop social capabilities (United Nations Organization, 2001).

Third, revived economic growth expanded the fiscal space for social assistance during the 2000s (shown in table 1). This contributed to the decision of several countries to adopt CCT programs, which, by then, had proven effective as interventions through rigorous impact evaluations of programs in Mexico, Colombia, and Nicaragua.

Table 1. Average Annual Percentage Growth Rate of GDP Per-Capita in Selected LAC Countries, 1980–2011

	Period			
Region/country	1980–2002	2003–2008	2009	2010–2011
OECD[a]	2.8	2.2	-3.8	2.5
LAC	2.1	4.1	-1.6	5.3
Brazil	2.1	4.0	-0.3	5.1
Colombia	3.1	4.8	1.7	5.0
Honduras	2.9	5.4	-2.1	3.2
Jamaica	2.2	1.5	-2.6	0.4
Mexico	2.5	2.7	-6.0	4.7
Peru	1.9	6.8	0.8	7.8

Source: World Development Indicators (accessed on January 11, 2013).
[a] OECD is the Organization for Economic Co-operation and Development.

Fourth, the political economy of the programs contributed to securing support from politicians and voters. They appreciated the fact that CCTs were transparent with their processes of targeting beneficiary groups and required beneficiaries to comply with co-responsibilities, making participation an implicit contract with obligations for both governments and poor households (Fiszbein and Schady, 2009). This ensured that CCTs were seen as a form of redistribution with acceptable technical and moral standards.

1.2 Introduction to the Six LAC CTT Programs Analyzed in This Paper

Table 2 presents the six programs analyzed in this report, providing characteristics that include the targeted population, program coverage and conditionalities, and types of transfer benefits. The oldest program in our sample is Mexico's *Oportunidades*, which started in 1997 under the name of *PROGRESA* (abbreviation for *Programa de Educación, Salud y Alimentación*). The youngest is Peru's *Juntos*, launched in 2005. Honduras' *Bono 10,000* and Colombia's *Más Familias en Acción* are recent, but are revisions of the preexisting *Programa de Asignación Familiar (PRAF)* and *Familias en Acción*.

Key population targets in all cases include poor children, youth, and mothers, but the programs benefit *de facto* whole families. *Oportunidades* covers also poor elderly people (although this component may be discontinued due to the introduction of a new non-contributory pension scheme). Jamaica's Programme of Advancement Through Health and Education (PATH) covers also elderly people (over 60 years old) who do not receive a pension, poor adults between 18 and 59 years of age, and all persons with disabilities. On the other hand, Colombia's *Más Familias en Acción* also covers indigenous and internally displaced people. The decision of some countries to adopt a restricted focus is in some cases due to the existence of complementary programs, such as Brazil's Continuous Cash Benefit, which focuses on poor people who are elderly or have disabilities.[2]

All programs have conditionalities centered on health and education of children and adolescents. Mexico's *Oportunidades* has the most comprehensive health co-responsibilities, requiring that all household members attend health checkups twice a year. All programs but Colombia's also establish health conditionalities for pregnant and lactating women. However, the enforcement of co-responsibilities for these recipients may be highly challenging. For

[2]The benefit is an unconditional cash transfer for poor persons over 65 years old and poor persons with disabilities. It is a monthly transfer of one minimum wage (circa USD 332 in 2013). In 2012, the program covered 3.6 million people.

example, despite being part of the design of Brazil's *Bolsa Família* since it began (in 2003), conditionalities assessments, and therefore transfer of benefits related to pregnant and lactating women, could only be implemented at the end of 2011.

All observed countries but Peru adopt a multiple benefit model, though with different structures. Health/nutrition and education benefits are the most common components (as in Colombia, Honduras, and Mexico), and combinations of benefits vary considerably. For example, a Brazilian family can accumulate up to eight benefits each month. Mexican families can also receive an extraordinary benefit of USD 344 for an adolescent or young adult that completes upper secondary school.

Payments are made monthly in Brazil, and bimonthly in Colombia, Jamaica, Mexico, and Peru. In Honduras, the program was supposed to pay three times per year; however, in practice, it managed to deliver payments only twice a year. As a consequence of lower payment frequency, according to some Honduran policymakers, beneficiaries have used the accumulated transfers mainly for the purchase of durable goods. The program is currently attempting to transition to bimonthly payments.

All programs have placed the responsibilities for change more on beneficiary families (behaviors and attitudes) than on service providers (accessibility and quality). More recently, some programs have also aimed at integrating social assistance with the promotion of beneficiaries' employability (e.g., PATH's Steps to Work program).

Table 2. Basic Characteristics of the Six Selected LAC CCT Programs

Country *Program name:* Program origin	Targeted beneficiaries	Conditionalities	Number of beneficiaries (Reference date)	Frequency of transfer payments	Category and size of transfer payments (per payment period)
Brazil *Bolsa Família:* Began in 2003 from the merger of the following CCT programs: *Bolsa Escola, Bolsa Alimentação, Cartão Alimentação,* and *Auxílio Gás*	*Ultra-poor families* Monthly per capita income of USD 35 or less *Poor families* Monthly per capita income of USD 35–70	*Health* Compliance with scheduled prenatal and postnatal checkups, children's growth monitoring, up-to-date vaccination record; parents' participation in educational health and nutrition seminars offered by local health teams *Education* Enrollment or 6–17-year-olds + attendance ≥ 85% for 6–14-year-olds and ≥75% for 15–17-year-olds	13,872,243 families (March 2013)	Monthly	*Basic* BRL 70 (USD 35) paid only to ultra-poor families, one benefit per family regardless of number of children *Variable* BRL 32 (USD 16) paid to ultra-poor and poor families; maximum of five benefits per family, paid per: • child aged 15 years or younger • pregnant woman, paid only for nine months • breast-feeding mother, paid only for six months *Variable youth* BRL 38 (USD 19) paid to ultra-poor and poor families; maximum of two benefits per family, paid per: • 16–17-year-old adolescent *Additional benefit for ultra-poverty eradication* BRL 70 (USD 35) minus per-capita income; paid only to ultra-poor families (from 2012)

Country *Program name:* Program origin	Targeted beneficiaries	Conditionalities	Number of beneficiaries (Reference date)	Frequency of transfer payments	Category and size of transfer payments (per payment period)
Colombia *Más Familias en Acción:* Began in 2011 as redesign of *Familias en Acción*	Two targeting stages: *Geographic targeting* to identify four municipality categories, based on size and multidimensional poverty index *Family targeting*, based on four criteria: Family score in SISBEN III[a] (with eligibility threshold variable by residence area); Information system of *Red Unidos* (identifies 1.3 million poorest households); registry of internally displaced families; census of indigenous peoples	*Health* For children under 7 years old, attend all growth and development checkups (at local health centers, according to the rules set by the Ministry of Social Protection), plus have complete vaccination record (latter co-responsibility yet to be verified/enforced); participation in educational health seminars offered by local health teams not compulsory *Education* Enrollment for 5–18-year-olds + attendance ≥ 80% and maximum of two repeated years between grades 1 and 11	2,083,315 families (December 2012)	Every two months	*Health and nutrition* COP 100,000 (USD 53); paid to families with children younger than 7 years old, one benefit per family regardless of number of children. Some locations have an additional COP 40,000 (USD 21) benefit paid to families with children aged 7–11 years regardless of the number of children. The two benefits are not cumulative, so maximum amount per family is COP 100,000. *Education* COP 30,000–COP 120,000 (USD 16–USD 63) Amount depends on category of municipality determined in the first stage of targeting; paid per child up to maximum of three children per family, varies by location and school grade. However, indigenous and internally displaced families receive maximum benefit for their children's grade independent from municipality of residence. Some locations have no benefit for primary-school children

Country *Program name:* Program origin	Targeted beneficiaries	Conditionalities	Number of beneficiaries (Reference date)	Frequency of transfer payments	Category and size of transfer payments (per payment period)
Honduras *Bono 10,000:* Began in 2010 as redesign of *PRAF*	Poor families with children aged 0–18 years old, and pregnant and breast-feeding women	*Health* Families must use preventive health services for children under 6 years old and women must receive pre- and postnatal care *Education* Enrollment + attendance ≥ 80% Only one child in multi-child household must comply with benefit category (health or education) to trigger household's payment, but this will change in 2014; compliance with women's pre- and postnatal care co-responsibilities is not verified [b]	345,000 families (July 2012)	Every six months (*de facto*)	*Health* HNL 2,500 (USD 132), for 0–5-year-old children and for pregnant or breast-feeding women *Education* HNL 5,000 (USD 263), for 6–18-year-old children and adolescents *Maximum annual transfer* HNL 10,000 (USD 526) per household. If family is entitled to both health and education benefits, it receives only the latter—in which case compliance with health co-responsibilities is not verified.
Jamaica PATH: Began in 2002	Poor households with the following vulnerable members: • children, from birth to completion of secondary education • elderly (over 60 years old) people without a pension • persons with disabilities • pregnant and lactating women • poor adults (18–59 years old)	*Health* Registration at Government Health Centre, compliance with scheduled checkups (varying by beneficiary's age and benefit category) *Education* For 6–18-year-olds, enrollment + attendance ≥ 85%	130,000 families (February 2012)	Every two months	*Base* JMD 800 (USD 8), introduced in June 2010 for beneficiaries not complying with program co-responsibilities *Education* JMD 1500–2530 (USD 15–25.30), paid for each child in family, value varies according to gender and school grade. For some locations there is no benefit for primary-school children *Other (related to health for households with beneficiary children)* • JMD 1500 (USD 15) for 0-6-year-old children • All other vulnerable categories receive JMD 1800 (USD 18)

Country *Program name:* Program origin	Targeted beneficiaries	Conditionalities	Number of beneficiaries (Reference date)	Frequency of transfer payments	Category and size of transfer payments (per payment period)
Mexico *Oportunidades:* Began/operated as *PROGRESA* from 1997 to March 2002	Poor families living below minimum wellbeing line	*Health* Compliance with scheduled checkups for all household members plus monthly attendance to health education talks *Education* For children and adolescents under 18 years old, and for 18–21-year-olds in high school, enrollment plus regular attendance	5,845,056 households (2012)	Paid every two months Once a year	*Education* • Primary school students: MXN 330–660 (USD 26-51) per child • Secondary school students: MXN 960–1070 (USD 74-83) for boys and MXN 1020–1240 (USD 79-96) for girls • Upper secondary school students: MXN 1620–1850 (USD 126-143) for boys and MXN 1860–2110 (USD 144-164) for girls *Other (linked to health co-responsibilities)* • MXN 690 (USD 53) per adult aged 70 years and older • MXN 230 (USD 18) per child under 9 years old not receiving education benefits, up to three children • Nutrition: Up to MXN 890 (USD 69) for nutrition, per family *In-kind transfers* Food supplements for 6–23-month-old children, undernourished 24–59-month-old children, and pregnant and lactating women *Maximum bimonthly transfer* • MXN 3,420 (USD 265) per family with children in primary school • MXN 5,530 (USD 429) per family with children in high school • For school material: MXN 330 (USD 26) in primary school, MXN 410-415 (USD 32) in secondary and upper secondary school • MXN 4,599 (USD 357) for students who conclude high school before reaching 22 years of age

Country *Program name:* Program origin	Targeted beneficiaries	Conditionalities	Number of beneficiaries (Reference date)	Frequency of transfer payments	Category and size of transfer payments (per payment period)
Peru *Juntos:* Began in 2005	Poor households with children under 19 years old or pregnant women	*Health* 0–6-year-olds, pregnant women, and nursing mothers must attend regular checkups *Education* For 6–19-year-olds, enrollment + attendance ≥ 85%	649,553 (affiliated) (2012)	Every two months	*Fixed single benefit* PEN 200 (USD 78) per household. Unlike other CCT programs, this is a lump-sum payment that does not differ across households

Source: Authors based on programs' websites and interviews with program managers.

[a]For more information on SISBEN, see section 3.1.

[b]From the program operations manual: "Además se promoverá que las mujeres embarazadas acudan al menos a cuatro visitas de control en las unidades de salud, a que realicen su parto en una clínica materno infantil u hospital y a que realicen una visita de control a los 7 y a los 40 días posteriores del parto. Estas acciones no estarán sujetas a sanciones por incumplimiento."

1.3 Documented Impacts of CCT Programs[3]

The primary benefit of CCTs is that they have been effective in reducing the incidence and the depth of poverty. They have increased quantity as well as the variety of food consumed, favoring more nutritious and expensive products such as meat and vegetables (Ruiz-Arranz et al., 2006).

Also, CCTs have produced a drop in child labor supply and consistently led to increased school enrollment and attendance (no matter the country's level of per capita income). In Mexico, three to five years of program exposure contributed to increasing the average duration of schooling by between one-half and one year (see also box 5). There is less evidence that enrollment and attendance led to increased learning outcomes. Beyond the difficulty of rigorously assessing these long-term impacts (due to the incorporation of the initial control group), the problem may be related to the insufficient expansion of service supply, especially in terms of quality. Yet, recently Barham et al. have found that "the short term program effect of a one-half year increase in schooling was sustained, after the end of the program and into early adulthood. In addition, results indicate significant and substantial gains in both math and language achievement scores. Specifically, random exposure to the CCT during critical school years led to a one-quarter standard deviation increase in learning outcomes for young men" (2013, 2).

The evidence on health is less clear cut, but several studies have found positive impacts on the utilization of health services as well as a reduction in morbidity for specific age groups (see Gaarder, Glassmand, and Todd, 2010 for a review). Recently, Rasella et al. (2013) have found that Brazil's *Bolsa Família* has contributed to decreasing child mortality, in particular for deaths attributable to poverty-related causes such as malnutrition and diarrhea.

Despite initial concerns that positive impacts would be offset by negative behavioral changes among adults, such outcomes are not prevalent. The CCTs' benefits have not come at the cost of decreased adults' labor supply (from newfound dependence on social assistance), and CCTs have not generally fostered fertility,[4] or crowded out remittances and other private transfers.

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[3]For a comprehensive review of the literature, see Fiszbein and Schady (2009, 11–21).

[4]Stecklov et al. (2007) found a fertility impact in Honduras, where PRAF may have raised fertility by between 2 and 4 percentage points.

As conditions are costly to monitor and enforce, the literature has investigated whether they are necessary, i.e., whether the same effects could not be achieved through the income effect of unconditional cash transfers (UCTs). "Several recent studies attempt to compare CCT and UCT programs. Baird, McIntosh, and Ozler (2010) evaluate a cash transfer experiment that featured both a conditional (CCT) and an unconditional (UCT) treatment and find that there is an important improvement in school enrollment in the CCT treatment in comparison to the UCT. Akresh, Walque, and Kazianga (2012) also conducted a randomized experiment to estimate the impact of CCTs on demand for routine preventative health services and find that CCTs significantly increase the number of preventative health care visits, while UCTs do not have such an impact. Furthermore, as some beneficiary households in Mexico and Ecuador did not think that the cash transfer program was conditional on school attendance, de Brauw and Hoddinott (2008) and Schady and Araujo (2008) both find that school enrollment was significantly lower among those who thought the cash transfers were unconditional. These findings are consistent with the theoretical arguments by de Janvry and Sadoulet (2006), according to which CCTs should have a larger impact on the conditioned outcomes than UCTs" (Ibarraran and Benedetti, 2013).

2. Financial Sustainability

Countries launching a new CCT program need to strike a balance between the magnitude of the need for social assistance and human capital development, and the country's fiscal means. The first strategic decision to be made for new CCT programs regards the size of the budget. Subsequently, policymakers must decide how to allocate this budget, choosing, among other parameters: (a) the intended beneficiary population (e.g., extreme poor versus all poor); (b) the size of the transfer, and; (c) the duration of the treatment (e.g., fixed or open-ended time period).

The program development process begins with determining program need. As CCTs have at least two objectives, which are alleviating current poverty and fostering the human capital development of children and youth in beneficiary households, need must be assessed along multiple dimensions. Possible measures of the magnitude of poverty include the headcount and the gap indexes. The former estimates the percentage of the population with income below a predetermined poverty line, and hence in need of social assistance. The latter estimates the amount of financial resources that would need to be transferred (theoretically via cash transfers) to the poor to lift them all above the poverty line, and therein eliminate poverty. For example, a poverty gap of 0.1 indicates that each individual in the country would need to transfer the equivalent of 10% of the country's poverty line to the poor to lift all poor people out of poverty.

The specific needs for human capital development determine which types of beneficiary co-responsibilities will be selected. In other words, policymakers identify the objectives they aim to achieve, and make the payment of a cash transfer dependent on compliance with a set of activities that are designed to lead to the achievement of these objectives. Needs vary by country and over time. Program objectives in different contexts may include reduced chronic malnutrition incidence (or reduced numbers of people who are overweight or obese), increased children's vaccination coverage, reduced school dropout and repetition rates. Related actions may include checkups for pregnant women, lactating women and young children, child-growth monitoring, use of preventive health services where micronutrients and food supplements are provided, assistance to nutrition education sessions, and school attendance. The problem to be addressed may include a gender dimension, e.g. when school attendance and achievements are unequally distributed between sexes.

Table 3 attempts to summarize the social assistance and human capital development needs in the six countries covered by this report, as measured in the year the CCT program

was launched (or the closest year with available data). Poverty is measured through the poverty headcount index and the poverty gap index. Education needs are measured through the average number of school years completed by individuals aged 20–24 years. We choose this indicator because it summarizes multiple dimensions of the education system, including enrollment, grade repetition, and early dropout, for individuals who are just above the age range of intervention of CCT programs. CCTs are likely to impact this indicator in the medium to long term. For similar reasons, we proxy health needs through the under-5 mortality rate per 1,000 live births. We acknowledge that the choice of the indicators is limited by availability of data that can be compared across countries (and regions), and does not fully reflect the complexity of the problems that the programs attempted to address. Nonetheless, the selected indicators provide useful insight on the variation in needs across countries and a benchmark for Asian countries considering the introduction of a CCT.

In this distribution, Honduras exhibited both the highest poverty incidence and gap, respectively at 48% and 25%, and the worst health and education indicators. Colombia had high levels of poverty and low levels of schooling, but also the lowest incidence of child mortality (jointly with Jamaica). Mexico, Brazil, and Peru had intermediate incidence of poverty, although Brazil had a relatively higher gap.[5] The country with fewer needs was Jamaica, with the least poor, the smallest gap, the highest levels of schooling, and the lowest incidence of child mortality.

A comparison with Asian countries is hampered by the fact that need indicators are not available at the regional level, with the exception of the under-5 mortality rate. On this point, developing countries in the East Asia and the Pacific region have a similar performance to Latin America and the Caribbean in 2010, while the mortality rate is nearly tripled in South Asia. This suggests that health and nutrition conditions for mothers and young children could be an important priority for new programs in this region.

[5]Countries' decision to introduce a CCT program was more likely based on national official measures of poverty, for example on national poverty lines. We use standardized definitions because these are more easily comparable, and because official measures seldom include the poverty gap. It is however interesting to notice that, at the time of introduction of their CCT programs, Peru, Colombia, and Mexico had official poverty headcount indexes in excess of 50%, Honduras in excess of 65%, and Brazil about 35%.

Table 3. Selected LAC, Asian, and Global Social and Human Capital Needs Indicators

Region/country	Year[a]	Poverty headcount ratio at $2.5 a day (PPP) (% of population)	Poverty gap at $2.5 a day (PPP) (%)	Average years of schooling, 20–24-year-olds	Mortality rate, under-5 (per 1,000 live births)
OECD	2010	n/a	n/a	n/a	5.5
East Asia & Pacific (developing)	2010	n/a	n/a	n/a	22.0
South Asia	2010	n/a	n/a	n/a	64.2
LAC	2010	n/a	n/a	n/a	22.3
Brazil	2001	27.4	13.1	8.8 (2000)	33.6
Colombia	2001	40.0	20.1	8.4 (2000)	24.3
Honduras	1998	48.0	24.9	7.7 (2000)	38.5
Jamaica	2002	14.8	3.5	10.9 (2000)	24.3
Mexico	1997	27.2 (1998)	9.9 (1998)	8.8 (1995)	32.7
Peru	2005	28.9	10.5	9.9	27.5

Source: World Development Indicators, accessed on March 11, 2013.
[a]When data from this year is not available, year of data obtained appears in parentheses.

A country's fiscal means to meet its social assistance and human capital development needs can be measured as a first approximation by the magnitude of government tax revenues. Table 4 reports GDP per capita and government revenues excluding grants measured as a percentage of GDP. Both are measured in the year in which each country started its CCT program (or the closest year with available data) in order to provide a snapshot of the means initially available. Jamaica had the highest financial possibilities, due to a relatively high GDP per capita and the highest relative size of government revenues (at 31.8% of GDP). As an important caveat, it is, however, important to highlight that Jamaica also displayed the highest relative size of central government debt, at 127.4% of GDP. This indicates that the country had limited ability for further borrowing, and that a high share of the revenue was likely to be pre-committed to honor the existing debt. For all other countries, government debt amounted to less than 60% of GDP, and was unlikely to constrain the use of the available revenues. After Jamaica, Brazil and Mexico had the best financial possibilities, due for the former to a relatively high revenue collection and for the latter to the highest GDP per capita in our sample of countries. Colombia and Peru had intermediate means, while Honduras exhibited the lowest means in the sample, with the government collecting only 579 dollars per capita (constant international dollars 2005, after purchasing power parity [PPP] adjustment).

Table 4 also shows that Asian countries had low levels of financial means in 2010, due both to relatively low per capita GDP and to extremely low levels of revenue collection. In the developing countries of the East Asia and the Pacific region, governments collected on average 805 dollars per capita in 2010, or about half of what was collected by Brazil and Mexico when these countries started their CCT program. In South Asia, the figure is as low as 273 dollars per capita, which is less than half of Honduras's 1998 figure. These comparisons imply that countries starting new CCTs in Asia need to give high priority to fiscal considerations, as the programs are likely to experience severe budget constraints. Also, where financial resources are especially limited, it may be important to start with small-scale programs.

Table 4. Selected LAC, Asian, and Global Financial Means Indicators

Region/country	Year[a]	GDP per capita, PPP constant 2005 international $ (1)	Revenue, excluding grants (% of GDP) (2)	Central government debt, total (% of GDP)	Revenue per capita, PPP constant 2005 international $ = (1)*(2)/100
OECD	2010	33,448	22.9	58.6	7,660
East Asia & Pacific (developing)	2010	6,006	13.4 (2009)	n/a	805
South Asia	2010	2,271	12.0	56.5 (2007)	273
LAC	2010	10,180	n/a	n/a	n/a
Brazil	2001	7,902	20.7	55.8 (2006)	1,638
Colombia	2001	6,620	15.2	54.9 (2003)	1,006
Honduras	1998	2,903	20.0 (2003)	n/a	579
Jamaica	2002	7,083 (2005)	31.8 (2003)	127.4 (2003)	2,253
Mexico	1997	10,687	14.7	25.7	1,572
Peru	2005	6,387	17.6	31.2 (2006)	1,126

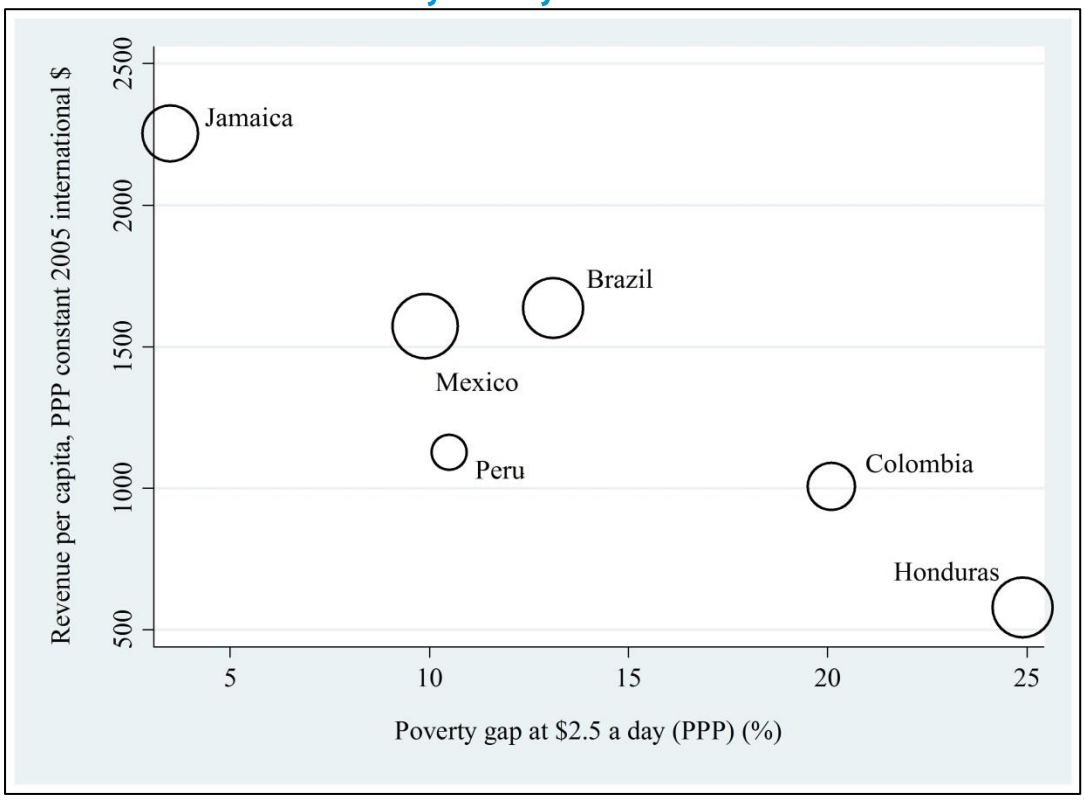
Source: World Development Indicators, accessed on March 11, 2013.
[a]When data from this year is not available, year of data obtained appears in parentheses.

Although LAC countries varied widely in terms of needs and financial means when they started their CCT programs, very little variability can be observed in the size of current CCT budgets. Figure 1 cross-plots poverty gaps and per capita government revenues. Each circle represents one country, with the size indicating the magnitude of CCT budgets in 2011, expressed as percentage of GDP. The evident downward trend indicates that governments in countries with higher poverty gaps tend to manage lower per capita revenue. This is due to a combination of lower per capita GDP and weaker revenue collection capacity, and is likely to

negatively affect the amount of resources that can be dedicated to CCT programs. Yet, probably because these countries are attempting to address more severe poverty and human capital development problems, the size of the circles is surprisingly similar across countries. The only outlier is Peru, which runs the youngest program in our sample, with a budget representing 0.13% of GDP in 2011.

The important stylized fact is that *mature programs in LAC have budgets in the range of 0.3–0.4% of GDP*, irrespective of countries' poverty levels and financial means. The lesson for Asian countries planning the introduction of such programs is to be prepared to allocate a similarly sized budget after about 10 years of operation.

Figure 1. Size of Selected LAC CCT Budgets (Percent of GDP), by Country Needs and Means



Source: Author's elaborations, based on World Development Indicators and United Nations Economic Commission for Latin America and the Caribbean (ECLAC, see http://dds.cepal.org/bdptc/) data.

The second lesson from the LAC region is *that CCT budgets tend to grow over time.* Table 5 shows that the budget of Mexico's *Oportunidades*, expressed as percentage of GDP, doubled over the period 2001–2011; Brazil's budget for CCTs doubled over the period 2003–2008, and Colombia's more than tripled between 2003 and 2010. Honduras represents the only exception, with a temporary drop over the period 2006–2009. However, this country has

greatly increased the budget for CCT programs since the launch of *Bono 10,000* in 2010 (reaching 0.65% of GDP in 2012). The magnitude of these trends is even bigger when considering real expenditure, as the expansion in terms of percentage of GDP took place during a period of sustained GDP growth.

In most cases, budget increases were driven by simultaneous growth in number of beneficiaries and of transfer values. Table 6 shows the evolution of the number of beneficiaries, measured as share of the population living in beneficiary households, with data availability limited to the period 2001–2010. In Brazil and Mexico, the countries running the largest programs, this indicator grew from 12% to 27% and from 15% to 24% respectively.

The size of the beneficiary population grew in all observed cases. More generally, most countries that started CCT programs maintained and substantially expanded their coverage (although it is worth noting that the active rosters of beneficiaries were dynamic and saw inflows and outflows of families and individuals). Nicaragua, which is not analyzed in this study, is the only exception, having implemented a CCT program only between 2000 and 2006 (Stampini and Tornarolli, 2012, 9). It is interesting to notice that although some countries initially conceived the transfers as a discrete, or time-bounded, intervention,[6] CCT benefits are now open-ended[7] in all six countries analyzed in this report.

Table 7 reports the average size of the transfer per beneficiary household, measured in purchasing power adjusted international dollars 2005. It shows that the value of the transfer grew in four out of six countries. The largest changes are observed in Honduras and Mexico, where the transfer tripled and doubled, respectively. Only in Colombia and Peru did the transfers decrease slightly. The trends are much steeper and show no exceptions when the transfers are measured in the local currency or in unadjusted US dollars (not shown in tables).

[6]For example, Mexico initially discussed (but never implemented) a three-year limit for *PROGRESA* beneficiaries, after which their welfare conditions would have needed to be reassessed.

[7] Conditional on meeting poverty and demographic (e.g., having children) criteria which are periodically verified through a process of recertification (see section 4.6).

Table 5. CCT Budgets in Selected LAC Countries, as Percent of GDP

	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Brazil	0.00	0.00	0.01	0.02	0.02	0.03	0.20	0.27	0.31	0.33	0.34	0.37	0.38	0.37	0.36
Colombia					0.01	0.04	0.07	0.07	0.06	n/a	0.17	0.25	0.28	0.35	n/a
Honduras		n/a	n/a	n/a	0.44	0.41	0.42	0.38	0.3	0.29	0.27	0.28	0.24	0.37	n/a
Jamaica						n/a	n/a	n/a	n/a	0.14	0.17	n/a	0.28	0.31	0.32
Mexico	0.01	0.09	0.15	0.17	0.21	0.27	0.3	0.3	0.32	0.32	0.32	0.35	0.39	n/a	0.43
Peru									0.05	0.06	0.15	0.14	0.15	0.14	0.13

Source: Huang et al. (2013).
Notes: Programs considered in this table include Brazil's *Bolsa Família, Bolsa Escola, Bolsa Alimentacao, Cartao Alimentacao* and *Programa de Erradicação do Trabalho Infantil* (*PETI);* Colombia's *Familias en Acción* and *Ingreso para la prosperidad social;* Honduras's *PRAF* and *Bono 10,000;* Jamaica's PATH; Mexico's *Oportunidades;* and Peru's *Juntos*. Expenditure (executed Budget) figures are used wherever available; when this data is missing, budget allocations are considered. Cells are empty for years in which no CCT was implemented, while n/a indicates that the data is not available.

Table 6. CCT Coverage in Selected LAC Countries, as Percent of Total Population

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Brazil	12.2	12.0	20.8	23.0	24.8	25.8	24.5	22.6	26.2	26.9
Colombia	0.9	3.5	3.8	3.5	5.4	7.2	16.3	17.6	25.3	25.3
Honduras	9.9	8.3	6.5	6.1	11.0	9.4	10.9	14.7	10.5	14.1
Jamaica		13.2	15.8	15.7	15.6	19.0	21.5	24.0	26.5	30.6
Mexico	15.4	21.1	20.8	23.8	23.0	23.2	22.9	22.8	23.3	24.0
Peru					0.7	3.2	6.9	8.1	7.8	8.9

Source: Authors' elaborations based on Stampini and Tornarolli (2012).
Note: Programs considered in this table include Brazil's *Bolsa Escola* and *Bolsa Família*, Colombia's *Familias en Acción*, Honduras' *PRAF* and *Bono 10,000*, Jamaica's PATH, Mexico's *Oportunidades* and Peru's *Juntos*. Cells are empty for years in which no CCT was implemented, while n/a indicates that the data is not available.

Table 7. CCT Transfer per Beneficiary Household in Selected LAC Countries, as PPP Constant 2005 International $

	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Brazil						37.1	34.3	33.8	33.9	36.1	38.6	40.5	39.3	49.2
Colombia				n/a	53.9	51.4	49.9	49.1	48.6	50.8	49.3	47.1	46.8	46.7
Honduras	19.8	18.1	16.9	15.8	14.9	14.2	13.5	12.8	n/a	13.0	12.7	12.5	62.9	60.8
Jamaica					n/a	38.2	34.5	30.9	51.9	53.5	45.5	44.3	53.5	51.3
Mexico	43.4	46.1	46.8	56.1	56.5	56.9	58.2	61.1	63.3	70.5	88.4	85.4	97.7	98.8
Peru								60.5	61.2	61.9	60.7	58.8	58.8	58.7

Source: Robles and Loayza (2013).
Note: Programs considered in this table include Brazil's *Bolsa Família*, Colombia's *Familias en Acción*, Honduras' *PRAF* and *Bono 10,000*, Jamaica's PATH, Mexico's *Oportunidades*, and Peru's *Juntos*. Cells are empty for years in which no CCT was implemented, while n/a indicates that the data is not available.

Overall, the evidence presented in this section shows that CCT programs are not frequently downsized. Rather, they tend to grow over time, and Asian countries considering introduction of a program should be aware that they are making a long-term commitment.

Although the budget figures shown above may seem small for flagship social protection programs as important as CCTs, it is worth highlighting that budgets in the order of 0.3–0.4% of GDP are indeed quite large. At first, resources are often found through a reallocation within the social assistance envelope, through the consolidation of existing programs. This was the case for Brazil's *Bolsa Família*, which merged the former *Bolsa Escola* (a conditional cash transfer with education co-responsibilities), *Bolsa Alimentação* and *Cartão Alimentação* (part of the *Fome Zero* anti-hunger program) and *Auxílio Gas* (an energy subsidy) (Lindert et al., 2007). Similarly, Jamaica's PATH replaced the preexisting food stamps, outdoor poor relief, and limited public assistance (ODI, 2006). The Brazilian experience teaches that only when the program has gained momentum and established its reputation, reallocations from other budget lines, outside social assistance, become possible. However, these reallocations are politically costly and can only be done on a limited scale.

In some cases, the political debate on funding centers on the need to substitute generalized subsidies and price controls, which produce market distortions and are characterized by extremely poor targeting, with a targeted and non-distorting cash transfer.[8] Such was the case in Mexico, where some price subsidies were eliminated, although at later stages (e.g., the tortilla subsidy), while others are still in place (e.g., the gasoline subsidy). A rare example of elimination of generalized price subsidies is provided by the experience of the Dominican Republic, which rationalized its generalized gas subsidies in 2008–9, redirecting them only to CCT beneficiaries. The reform produced savings amounting to about USD 136 million per year.

Borrowing is also a funding option in the short term. In particular, countries in LAC have received support from multilateral development banks, especially in the early phases of implementation of CCT programs. In addition to financial support, the LAC countries received technical assistance and knowledge transfers from other countries in which the banks had already supported CCT programs.

[8]The experience of LAC teaches that governments do not typically introduce new taxes in order to fund growing CCT programs. The political cost of raising the tax burden to increase social assistance appears to be too high. Tax reforms aimed at increasing revenues, which are always extremely difficult to negotiate and implement, are more easily justified with the need to increase the supply of social services or infrastructure that benefit the whole population, rather than the poor only.

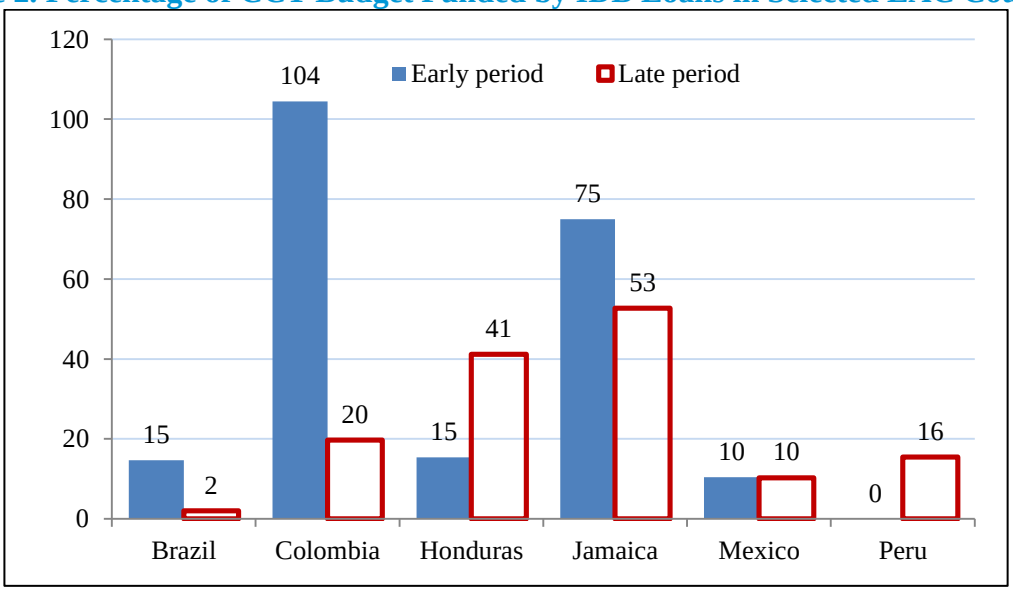
Table 8 presents the value of IDB approvals related to CCT programs in the six countries covered by this report.[9] Disbursements, expressed as the share of national program budgets, are reported in figure 2 for the early and late stages of implementation of each program. This shows that the relative importance of the loans has been decreasing during the period of implementation of the CCT programs in Brazil, Colombia, and Jamaica; it has remained constant in Mexico (see also box 1); it has increased substantially only in Honduras and Peru. As a caveat, it should be noted that the Peruvian *Juntos* is relatively young, so the significance of the breakdown in early and late phases of implementation is limited.

Table 8. IDB Loan Approvals Related to CCT Programs in Selected LAC Countries, in USD Millions

Country	1998	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
Brazil			500			1005									1505
Colombia		270						200	306	300		220			1296
Honduras	45					20		28		20		55		75	243
Jamaica			60							15		50	50	30	205
Mexico				1000			1200				800	800			3800
Peru											50	106		30	186

source: Authors' elaborations based on Huang et al. (2013).
Note: Table includes investment and policy-based loans; emergency loans are excluded.

Figure 2. Percentage of CCT Budget Funded by IDB Loans in Selected LAC Countries

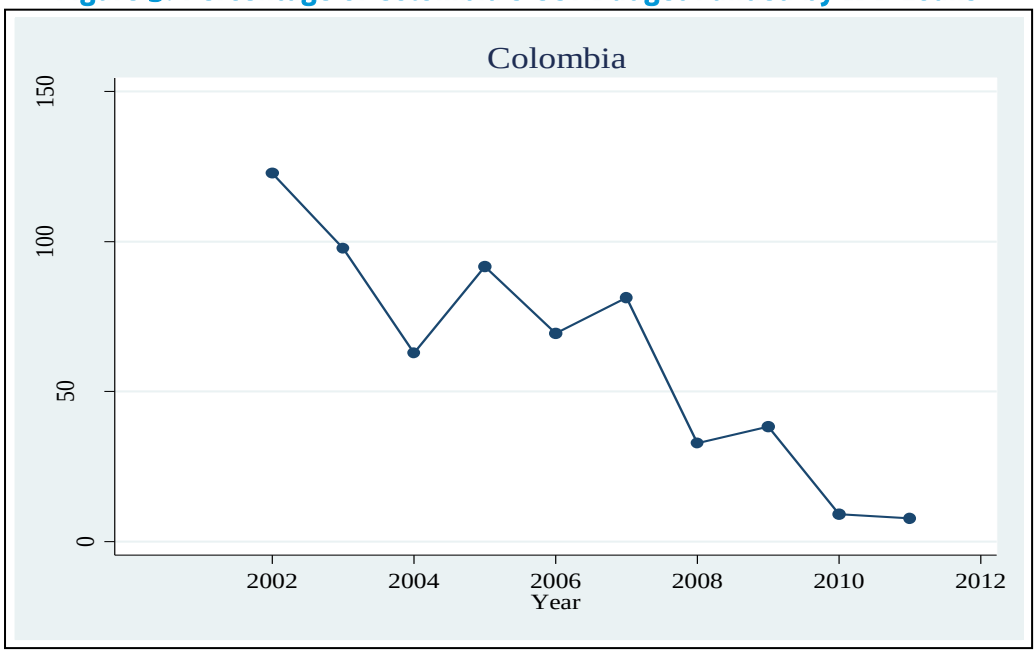


[9] IDB and World Bank are the main lenders to CCT programs in the LAC region. World Bank approvals to date amount to about half of IDB's (source: interview with World Bank staff); detailed data by country and year is not publicly available. The data presented in table 8 includes both investment and policy-based loans. Although money is fungible and there is no guarantee that policy-based loans are directed to the funding of transfers, we make no distinction between the two types of loans, as both are justified by the intention to support CCT programs.

Source: Authors' elaborations based on Huang et al. (2013).
Notes: Early and late period indicate 1996–2004 and 2005–12 for Brazil, 2001–6 and 2007–12 for Colombia, 1998–2005 and 2006–12 for Honduras, 2001–6 and 2007–12 for Jamaica, 1997–2004 and 2005–12 for Mexico, 2005–8 and 2009–12 for Peru. Figure includes investment and policy-based loans; emergency loans are excluded.

Colombia provides an interesting illustration of the decreasing importance of loans from development banks. Figure 3 shows that while IDB loans covered the whole budget of *Familias en Acción* during the first years of the program's implementation, the loans' relevance rapidly decreased. Recently, the Colombian congress has approved a law stating that all CCT current expenditures must be funded through internal revenue sources.[10]

Figure 3. Percentage of Colombia's CCT Budget Funded by IDB Loans



Source: Authors' elaborations based on Huang et al. (2013).

[10] Article 8 of Law 1532 of 2012 (http://www.dps.gov.co/documentos/FA/LEY-FAMILIAS-ACCION.pdf) states "El Gobierno Nacional propenderá por proveer anualmente los recursos para atender el pago de los subsidios de la totalidad de las familias beneficiarias y su operación, de acuerdo al marco fiscal de mediano plazo."

Box 1. *Oportunidades* Human and Financial Resources

Mexico's *Oportunidades* was initially financed entirely through the federal budget. The first loan from IDB was contracted in 2002, while World Bank lending started in 2009. Both development banks keep financing the program and have been supplying technical advice on strategic operational and evaluation subjects. Development banks have also helped build a network among LAC countries implementing CCT programs, facilitating the exchange of experiences and knowledge.

In 2012, *Oportunidades* employed over 7,000 people and had a budget of about MXN 63 billion (circa USD 5 billion). IDB and World Bank each provided about 6% of this budget (12% in total).

Source: Interview with program personnel.

In addition to direct program-budget allocations, it must be considered that large budget needs may simultaneously arise from the necessity to expand the quantity and quality of health care and education services demanded by CCT beneficiaries to comply with program co-responsibilities. Table 9 shows that the public budget for education grew substantially in five out of six countries over the period of CCT program implementation, while it remained constant in Peru. Similarly, the public health budget grew substantially in Brazil, Honduras, and Mexico. Although it is not possible to determine whether these changes are to be attributed to CCT conditions, there is consensus among development practitioners that the increased demand for education and health promoted by the programs require countries to expand service supply. This lesson is particularly relevant for developing countries in Asia, which exhibit substantially lower levels of public expenditure in both education and health (table 9*). As a CCT program evolves, the quantity and quality of health and education services must increase. If they do not, the CCTs will not achieve the long-term objective to develop beneficiaries' human capital*.

Table 9. Public Budgets for Education and Health

	Public spending on education, total (% of GDP)		Health expenditure, public (% of GDP)	
Region/country	In CCT's startup year [a]	2010 [a]	In CCT's startup year	2010
OECD		5.7 (2009)		8.4
East Asia & Pacific (developing)		3.8 (2008)		2.5
South Asia		3.3		1.2
LAC		4.4 (2008)		3.8
Brazil	3.9	5.6 (2009)	3.1	4.2
Colombia	3.7	4.8	5.4	5.5
Honduras	3.23 [b]	7.65 [b]	2.9	4.4
Jamaica	5.4	6.1	2.8	2.6
Mexico	4.2 (1998)	5.3 (2009)	2.1	3.1
Peru	2.7	2.7	2.7	2.7

Source: World Development Indicators, accessed on March 11, 2013.
[a]When data from this year is not available, year of data obtained appears in parentheses.
[b]Data on education for Honduras from ECLAC.

Overall, the evidence presented in this report suggests that Asian countries considering the introduction of a CCT program should:

1. *Make a long-term commitment to CCT program administration, acknowledging the reality that CCT programs are long-term interventions.*
2. *Start small, knowing that CCT programs tend to grow over time, and allow the program design to adapt to lessons learned during the early phases of implementation.*
3. *Be ready to make sufficient fiscal allotments, with program budgets amounting after few years of implementation to about 0.3–0.4% of GDP.*
4. *Consider simultaneously expanding the health and education services budgets, paying particular attention to the need for expanding service coverage while improving the quality of service delivery to meet increased demand generated by program co-responsibilities.*

3 Building Operational Foundations

The implementation of CCT programs encompasses eight operational functions. These are: (1) targeting, or beneficiary selection and registration; (2) monitoring and evaluation; (3) delivery of complementary services (e.g., health and education); (4) customer service (customer care and case management); (5) monitoring beneficiary co-responsibilities; (6) cash transfer payments; (7) auditing (to ensure transparency), and; (8) recertification and "graduation". In this section, we focus on targeting and on monitoring and evaluation, which are key operational foundations. The remaining six functions are analyzed in section 4.

3.1 Targeting

All CCT programs in Latin America and the Caribbean are targeted to the poor. This is due to the need to maximize the poverty alleviation and human capital development impact of limited social assistance resources. Political economy considerations also play a role, with governments seeking support for CCT programs by showing that the programs are efficient, reaching only those really in need.[11]

In the attempt to maximize the accuracy of the selection of the beneficiaries, the six countries analyzed in this report combine four types of targeting mechanisms: (i) geographic; (ii) categorical; (iii) means testing, and; (iv) community validation. Table 10 provides a summary of the solution adopted by each country.

[11]The recent economic crisis has extended the relevance of these considerations to richer countries as well. For example, the United Kingdom is introducing targeting for its previously universal child benefit. Families with one partner earning GBP 60 thousand or more per year will lose the benefit, and families with one partner earning between GBP 50 and 60 thousand per year will lose part of the benefit.

Table 10. Targeting in Six Selected LAC CCT Programs

		Types of targeting				Use of
Country	Program	Geographic	Categorical	Means testing	Community	unified registry
Brazil	*Bolsa Família*	•		Income test		•
	Programa de Erradicação do Trabalho Infantil (PETI)	•	Working children under 16 years old	Income test		•
Colombia	*Más Familias in Acción*	•	Displaced and indigenous families	Colombian Multidimensional Poverty Index	•	•
Honduras	*Bono 10,000*	•		PMT	•	•
Jamaica	PATH			PMT		
Mexico	*Oportunidades*	•		PMT	Discontinued	•
Peru	*Juntos*	•		PMT	•	•

Source: Authors based on programs' websites and interviews with program managers.
Note: PMT = proxy means testing.

Geographic targeting is widely used as the first stage of the process of selection of beneficiaries. It attempts to identify areas (e.g., districts, municipalities, parishes, villages) with high incidence of poverty, malnutrition, or vulnerability, as data from population censuses and nationally representative household surveys are elaborated to produce poverty maps. The process has relatively low cost (conditional on availability of regularly collected data) and works well for the identification of potential beneficiaries in areas with homogeneous socioeconomic attributes (e.g., incidence of poverty above 50%).[12] In Mexico, for example, the rollout of *PROGRESA/Oportunidades* has been driven by the values of a marginality index, calculated on the basis of average local indicators of income, education, and housing characteristics. Geographic targeting was also used to exclude the localities with insufficient supply of health and education services.

Categorical targeting is used to restrict access to the program to households with certain demographic characteristics, which are related to the human capital development objectives to be achieved through program co-responsibilities. For example, Brazil's program

[12] Geographical targeting has also been used to prioritize short-term and temporary interventions responding to environmental disasters. For example, since 2009, *Bolsa Família* has anticipated the payments to all beneficiary families living in municipalities hit by flooding (irrespective of the level of damage experienced by each individual family). The program transfers additional subsidies to beneficiaries' program bank cards to be used for temporary accommodation during reconstruction of dwellings (11 months, on average).

of eradication of child labor *(PETI,* from its Portuguese acronym) targets households with working individuals under 16 years old. Colombia's *Más Familias en Acción* includes, among others, indigenous and internally displaced people, plus the extreme poor identified by the information system of the *Red Unidos.* More generally, CCT programs tend to focus on households with pregnant or lactating women, or women of reproductive age, children, and school-age youth. In some cases, they also include the elderly, individuals with disabilities, and other selected groups.

Means testing is used to identify poor households within those that satisfy the geographical and categorical criteria. Many countries collect applicants' information and use it to calculate a proxy means score (a formula combining information on assets and demographic characteristics), that is compared with a predetermined eligibility threshold. The process is known as proxy means testing (PMT). The well-known term hides a very heterogeneous set of concepts and formulas. For example, Jamaica estimates a consumption model based on a simple linear regression model (OLS), while Mexico has for a long time defined a poverty score based on discriminant analysis (from the start of the program in 1997, to the adoption of a linear regression model in March 2010).[13]

Recently, Colombia's *Más Familias en Acción* has adopted the new Colombian Multidimensional Poverty Index, elaborated by the National Department of Planning and used for the selection of beneficiaries of several social assistance programs. The dimensions, variables, weights, indicators, and cutoff points of this index are summarized in table 11. It is interesting to notice that five broad dimensions capturing childhood conditions, education, health, employment, housing, and access to public utilities are given the same relative importance, with a coefficient of 0.2. This reflects the political difficulty to rank different dimensions of wellbeing. It is also suggestive of the technical difficulty of designing theoretical frameworks that combine causes, covariates, and moderators of household socioeconomic conditions. Yet, it is important to highlight that small changes in the formulas (in either components or coefficients) can fundamentally alter the chances of eligibility of an important number of households.

[13] Mexico's *PROGRESA* initial proxy means formula was based on the following variables: (a) household: dependency index, female-headed, presence of children under 12 years old; (b) household head: age, informal wage employment, level of education; (c) dwelling: crowding, type of bathroom, dirt floor, type of heating; (iv) asset ownership: car or truck, refrigerator, washing machine; (v) dummies for rural residence and residence in various regions.

Table 11. Description of the Colombian Multidimensional Poverty Index

Dimension	Variable	Indicator	Cutoff Point
Household education conditions (0.2)	Education achievement (0.1)	Average education level for people, age 15 and older, living in a household	9 years of schooling
	Literacy (0.1)	Percentage of people living in a household, age 15 and older, who know how to read and write	100%
Childhood and youth conditions (0.2)	School attendance (0.05)	Percentage of children between the ages of 6 and 16 in the household attending school	100%
	No school lag (0.05)	Percentage of children and youths (7–17-year-olds) within the household not suffering from school lag (according to the national norm)	100%
	Access to childcare services (0.05)	Percentage of children between the ages of 0 and 5 in the household with simultaneous access to health, nutrition, and education services	100%
	Children not working (0.05)	Percentage of children between the ages of 12 and 17 in the household who are not working	100%
Employment (0.2)	No one in long-term unemployment (0.1)	Percentage of a household's economically active population (EAP) not facing long-term unemployment (more than 12 months)	100%
	Formal employment (0.1)	Percentage of a household's EAP that is employed and affiliated with a pension fund (formality proxy)	100%
Health (0.2)	Health insurance (0.1)	Percentage of household members over the age of 5 who are insured by the Social Security Health System	100%
	Access to health services (0.1)	Percentage of household members with access to a health institution in case of need	100%
Access to public utilities and housing conditions (0.2)	Access to water source (0.4)	Urban households are considered deprived if lacking public water system Rural households are considered deprived when the water used for preparation of food is obtained from wells, rainwater, spring source, water tank, water carrier, or other sources	1
	Adequate elimination of sewer waste (0.04)	Urban households are considered deprived if they lack a public sewer system Rural households are considered deprived if they use a toilet without a sewer connection, a latrine, or simply do not have a sewage system	1
	Adequate floors (0.04)	Households with dirt floors are considered deprived	1
	Adequate external walls (0.04)	An urban household is considered deprived when the exterior walls are built of untreated wood, boards, planks, *guadua*, or other vegetation; zinc; cloth; cardboard; waste material; or when no exterior walls exist A rural household is considered deprived when the exterior walls are built of *guadua* or other vegetation; zinc; cloth; cardboard; waste materials; or when no exterior walls exist	1
	No critical overcrowding (0.04)	Number of people sleeping per room, excluding the kitchen, bathroom, and garage.	Urban: >2 Rural: >3

Source: Angulo-Salazar et al. (2013, 21–22).

The main alternative to the use of PMT is represented by the Brazilian choice to base eligibility on declared per capita income, which is compared with a predetermined poverty line. PMT and income testing differ substantially in the type of beneficiaries they are best

suited to identify, in the temporal allocation of program administrative burdens and in their perceived transparency:

- PMT tends to identify the chronic poor, as it relies on measures of physical and human capital assets (such as housing and education) that do not change rapidly over time. Income testing is based on a more volatile measure of welfare, and can include also the temporarily poor (also known as transient poor).
- Income testing is initially easier to implement, but requires continuous verification of beneficiaries' living standards and demands substantial audit and monitoring capacity at the local level. PMT administrative efforts are frontloaded, and include data collection and elaboration and verification of declared assets. There is less need for frequent recertification, as chronic poverty is a long-term condition.
- Finally, it is important to notice that the rationale behind the use of a PMT can be more difficult to communicate to potential beneficiaries, and may be perceived as less transparent (a black-box approach). On the other hand, it is based on characteristics that are easier to verify than income is and could be the preferred alternative if a vast segment of the workforce is informal.

Targeting through community validation is sometimes used as the last step of the targeting process. The rosters of selected beneficiaries are submitted for validation by community members. The rationale is that personal knowledge on the living standards of the applicants can be exploited to minimize errors of both inclusion and exclusion. The exercise can also foster community mobilization and responsibility for targeting, empowering disadvantaged groups and enhancing the programs' political capital (Samson, van Niekerk, and Mac Quene, 2010).

In Colombia, community validation is used for the targeting of indigenous peoples. In Peru, the process engages community members, local authorities, and, when possible, local representatives of the ministries of Education and Health (Perova and Vakis, 2009). Results of community validation have been mixed. Although the process has contributed to filtering out approximately 10% of initially selected households, which were found to be better off in terms of small-business or livestock ownership, it appears that neighbors are often reluctant to point out cases of errors of inclusion, as this could damage community relations (Jones, Vargas, and Villar, 2008). Similarly, teachers and doctors could fear resentment for excluding students and patients (Samson et al., 2010).

Community validation was also used as the last step of targeting during the first phase of rural expansion of Mexico's *Oportunidades*. It involved the submission of the list of eligible households to community assemblies for public validation, and gave families the opportunity to opt out of the program (Orozco and Hubert, 2005). This step, however, was later discontinued (Azevedo and Robles, 2013).

The process was similarly discontinued in other countries not covered in this report (e.g., Nicaragua). Overall, while it proved effective in reducing under-coverage (e.g., bringing deserving families into the program that were initially incorrectly excluded), it was rather ineffective in reducing leakages (e.g., excluding undeserving families that were incorrectly admitted). Some countries found that leakages were best dealt with through data review and re-survey processes.

Although the combination of various targeting methodologies can improve the accuracy of beneficiary selection, errors of exclusion (i.e., under-coverage) and inclusion (i.e., leakage) cannot be completely eliminated.

Efforts to reach full coverage of the targeted population, especially when expansion takes place in an accelerated process, may lead to considerable leakage. This may be due to the fact that the infrastructures in charge of enlisting beneficiaries and paying the transfers can be installed more quickly than those in charge of monitoring and auditing.

In the case of PMT, errors are also due to the fact that the score calculated through a combination of assets and other household characteristics is only a proxy measure of poverty, the real construct that the policymaker is attempting to address. PMTs are not perfect, and a fair share of errors should be expected.

When programs target only the extreme poor, it is likely that most leaked benefits are paid to the moderate poor, so that the inclusion of non-poor families remains a negligible problem. However, when CCT programs attempt to cover all the poor, and move the eligibility threshold very close to the poverty line, it is to be expected that a significant share of program resources will end up in the hands of non-poor beneficiaries.

The problem of incorrect identification of the poor will be more serious in countries with low poverty-headcount ratios, as PMT formulas tend to perform better around the population means of the distribution of consumption or income, i.e., the estimated construct. When the incidence of poverty is low, the PMT will be requested to estimate consumption or income on the left tail of its distribution, and the performance of the test will decrease.

Table 12 shows estimates of coverage and leakage for five out of the six countries analyzed in this report. The measures are based on standardized income poverty lines of 2.5

and 4 dollars per capita per day, after purchasing power adjustment. When using the 4-dollar threshold, which is closer to most national poverty lines in LAC, Peru's *Juntos* has the lowest leakage, with only 11% of non-poor beneficiary households. This good performance is partly explained by low program coverage, with less than one-third of poor families receiving the CCT. Brazil's *Bolsa Família* exhibits the second lowest rate of leakage, followed by Mexico's *Oportunidades*.

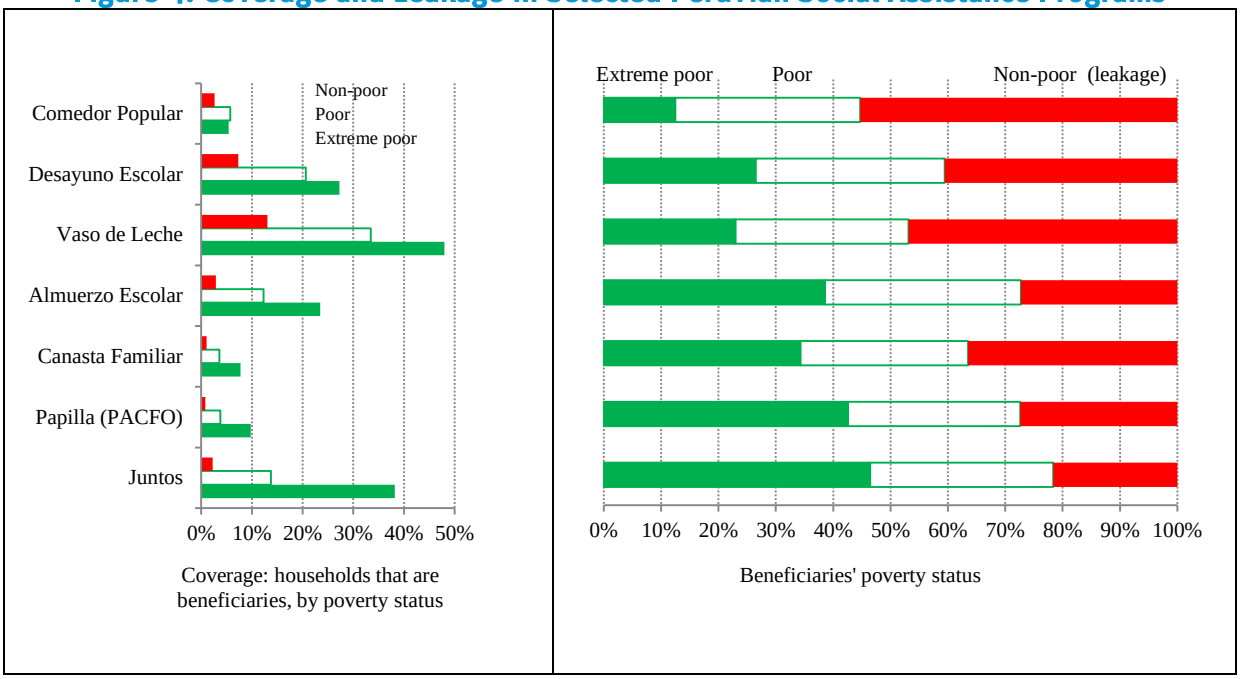
Table 12. Coverage and Leakage in Selected LAC CCT Programs

Country	Program	Year	% of individuals with per capita income <2.5$ in the program	% of beneficiaries with per capita income >$2.5	% of individuals with per capita income <4$ in the program	% of beneficiaries with per capita income >$4
Brazil	*Bolsa Família*	2009	55.1	50.0	46.8	28.1
Colombia	*Familias en Acción*	2010	53.4	71.4	49.9	49.4
Jamaica	PATH	2010	56.0	77.9	50.5	40.5
Mexico	*Oportunidades*	2010	53.4	61.4	42.5	35.8
Peru	*Juntos*	2010	37.4	33.1	28.5	11.3

Source: Stampini and Tornarolli (2012).

Although leakage should to a certain extent be expected, under-coverage, coupled with limited resources for social assistance, makes the quality of targeting an issue of paramount importance. Leakage to the non-poor reduces the effectiveness for both poverty reduction and human capital development, and represents a lost opportunity. In addition, leakage can produce resentment among the excluded and foster political aversion to CCTs. In the face of these concerns, it is therefore important to remember that CCTs are generally better targeted than pre-existing social assistance programs. Figure 4 provides an example of the quality of targeting of Peru's *Juntos* in relation to other social assistance programs. Figures are not consistent with Table 12 because of the adoption of a national poverty line, which is compared with per capita consumption (instead of income). The figure shows that *Juntos'*s inclusion errors are about half of those of the *Vaso de Leche* (Glass of Milk), the only program with a comparable level of coverage.

Figure 4. Coverage and Leakage in Selected Peruvian Social Assistance Programs



Source: Stampini and Merino-Juárez (2012, 66).

Careful and dynamic management of high-quality registries of beneficiaries (a key element of the implementation process) contributes to the superior targeting performance of CCT programs. In Brazil, authorities have elaborated a comprehensive monitoring system that relies on a modern unified registry of beneficiaries (box 2), in part because self-declared income is potentially more prone to misrepresentation by program applicants. This monitoring system is designed, funded, and maintained by the federal government through the *Caixa Economica* federal bank. Local administrations are in charge of enlisting the beneficiaries (with support from the states), and of ensuring the accuracy of the related rosters. As an incentive to recertify enrolled beneficiary families every two years, the municipal governments receive financial incentives in the form of administrative cost subsidies (proportional to performance in the recertification process).

Box 2. The Unified Registry (*Cadastro Único*)

Objectives. **The unified registry is the main tool for identifying the Brazilian poor population, which is eligible for the *Bolsa Família* and/or other programs. It records 10 sets of variables, covering family and individual characteristics such as income, employment, education, and possession of identity documents.**

Target population for the single registry. **The registry includes families with monthly per capita income at or below half of the minimum wage, or a monthly total income at or below three times the minimum wage (or three family members earning the minimum wage). Specific strategies are employed to register minorities and the ultra-poor (those with monthly per capita income of USD 35 or less). In December 2012, the registry contained information on about 24.9 million families.**

Methods of classification. **In general, one family representative reports the income of all family members during an interview with a program officer. The interview usually takes place in a public building, although the federal government has attempted to promote the use of home interviews.**

Index of Family Development. The Unified Registry calculates the index on the basis of five components, 25 subcomponents, and 60 indicators related to health, education, housing, income, labor, and access to public policies. The index shares the philosophical approach of the United Nations Human Development Index and is similar to a proxy means test. It aims at assessing each household's level of vulnerability, and could theoretically indicate the type of social services required by the family (like a PMT). In practice, however, the index is not routinely used for this purpose.

Strategies to prevent and correct underreporting of family income.

Geographical targeting. Using population censuses and national household surveys, the federal government estimates the number of poor in each Brazilian municipality. This estimate represents an upper bound to the number of beneficiaries, and prevents disputes among municipalities for resource allocation.

Periodic recertification. Each registry should be recertified no later than every two years. This rule aims to prevent the retention of families that are no longer eligible, due for example to changes in income or family composition.

Index of Decentralized Management. This index represents the main incentive for local managers to improve the accuracy of the unified registry. The municipality can receive up to USD 1.66 per record if: (i) the local Registry is consistent with estimates of demographic characteristics from other sources; (ii) the data is up to date; (iii) the data related to education and health conditionalities is consistently filled. Transfers linked to this index are an important source of funding for the local administrations, which can use them to improve technological capacity and fund programs associated with *Bolsa Família*.

Incentives to beneficiary families. Families that spontaneously report that their earnings have grown above the eligibility threshold can retain the *Bolsa Família* bank card. This accelerates the reinsertion in case of need, with fast-track reincorporation when income drops below the eligibility threshold.

Audits. The auditing routine of the *Bolsa Família* includes electronic validation of the data and visits to the municipalities by program staff or in collaboration with other agencies.

Source: Interview with program personnel.

Inclusion and exclusion errors can be further reduced during implementation by designing and implementing good validation and grievance redress mechanisms. Validation arrangements should be carefully designed to avoid local capture and undermining of the PMT methodology. Studies on media behavior focusing on Brazil's *Bolsa Família* find that errors of inclusion attract more attention than those of exclusion. The former are more severely denounced, although the government can reduce the criticisms by adopting clear, credible and transparent procedures (Lindert and Vincensini, 2010).

Additionally, transparency can be increased by publishing the names of all potential beneficiaries at the local level, and hearing complaints and grievances related to inclusion and exclusion errors. In 2005, *Bolsa Família* published the complete list of beneficiaries on the web. At the time, the program was subject to severe criticism for allegedly having little control over eligibility and compliance with program co-responsibilities. Overall, the initiative was welcomed by the stakeholders. Little concern was raised in relation to violation of beneficiaries' privacy.

In Jamaica, the government has instituted several mechanisms to reduce targeting errors, including the implementation of a Beneficiary Identification System, home visits, recertification, database crosschecks, and the establishment of appeal committees to reassess the situation of households at the margin of eligibility (Basset and Blanco, 2011).

Also, in Colombia, the credibility of *Familias en Acción* is at least partly due to the reputation enjoyed by the System of Identification and Classification of Potential Social Programs Beneficiaries, known as SISBEN (*Sistema de Identificación y Clasificación de Potenciales Beneficiarios para Programas Sociales*) among all segments of the Colombian society. SISBEN is generally perceived as an objective and transparent system for identifying poor families (Ayala, 2006), although recent contributions to the literature document instances of manipulation of the poverty index around the eligibility threshold, particularly in correspondence with local elections (Camacho and Conover, 2009).

Some additional challenges and considerations are worth mentioning. First, targeting and management of the registry of beneficiaries may require different mechanisms in rural and urban areas. For example, a panel study on Mexico's urban areas finds high mobility around the extreme poverty threshold: only 7% of people defined as extremely poor in 2002 were still so in 2007. This dynamic has implications for the choice of a means-testing method, and points to the need of frequent recertification.

Second, rural areas may be characterized by people who lack of identification documents and have poor access to services, and by cultural differences (related to language, concept of family, time reference, etc.) that hamper the incorporation of eligible households. Accordingly, some population groups may be hard to reach despite communication campaigns. Interviews of Colombia's *Más Familias en Acción* potential beneficiary families reveal that many did not know about the program or missed the deadlines to apply. Other factors for non-participation include distance from schools, health centers, and banks, and high transportation costs to reach them (Baez and Camacho, 2011).

Third, PMT formulas require periodic revisions to reflect the changing correlation between assets and poverty. For example, while ownership of a mobile phone could indicate wealth in the early stages of CCT implementation, at the end of the 1990s, its meaning has radically changed over time. Nowadays, if the variable is maintained in the formula, its weight should be recalculated.

Finally, caution should be used in the design and implementation of a PMT, especially if the same formula is used for both initial selection and later recertification. In order to avoid reverse incentives, a PMT should exclude all variables that are related to program outcomes (e.g., children's school attendance).

Similarly, governments should carefully consider the pros and cons of including employment related variables in means testing methods. For example, unemployment and informal employment (e.g., worker does not contribute to social security) are highly correlated with poverty, and can improve the performance of PMT formulas. However, their inclusion risks to reduce labor supply, which could in turn create a poverty trap and long-term dependence on social assistance. As a rule of thumb, it would be advisable to exclude all questions on employment from CCTs application process.[14]

Overall, the evidence presented in this report suggests that Asian countries considering the introduction of a CCT program should be cognizant of the following lessons:

1. *The quality of beneficiary selection strongly affects the credibility and the political capital of CCT programs.*

[14]In some countries, the application forms include questions on employment, although these are not used to calculate the applicant's proxy means score. As potential beneficiaries may not be aware that employment-related variables are excluded from eligibility calculations, these questions are likely to generate negative effects on labor supply, as applicants and existing beneficiaries may think that they will lose the benefits if they find a good job.

2. *A careful combination of various targeting mechanisms (geographic, categorical, means testing, and community validation) can improve the quality of beneficiary selection.*
3. *The choice of the type of means testing is related to the type of poverty the government intends to address, and the temporal profile of available administrative resources. PMT tends to identify the chronic poor, and requires a frontloaded administrative effort. Income testing can be used to incorporate the transient poor and requires frequent verification of beneficiaries' living standards; it may be risky to implement in contexts of high labor informality, and it demands good capacity in local governments.*
4. *Despite the best efforts, errors of both inclusion and exclusion cannot be eliminated. There is a tradeoff between under-coverage and leakage: decreasing under-coverage by moving the eligibility threshold toward (and beyond) the poverty line necessarily implies an increase in errors of inclusion. The choice is a function of governments' policy objectives. The experience of LAC indicates that leakage of about 25% for programs reaching over 50% of the poor should be considered acceptable. With these figures, CCTs outperform most preexisting social protection programs and nominally pro-poor subsidies. The idea can be carefully conveyed to the population and the media, explaining that errors of inclusion are a necessary cost for achieving important objectives of poverty reduction and human capital development.*
5. *To increase the accuracy of beneficiary selections, the construction of high quality registries of beneficiaries is of paramount importance. Unified registries also help in running CCT operations (monitoring, payment, recertification, etc.).*

3.2 Monitoring and Evaluation

As CCTs involve the distribution of cash, they can be the target of criticism on grounds of political manipulation of the pool of beneficiaries, both through selective incorporation and management of the registry of beneficiaries. For this reason, CCT programs have put unprecedented efforts into generating solid evidence on their effectiveness and efficiency, showing their ability to reach the intended beneficiaries and reduce poverty while increasing human capital. This has been done through the continuous collection of administrative data on program inputs and outputs (i.e., monitoring), and through the generation of evidence on program outcomes and impacts (i.e., evaluation). Monitoring and evaluation have greatly contributed to increasing CCT credibility and ability to survive political changes.

Monitoring is usually performed by program personnel. It requires the setup of advanced management information systems (MISs), which record a wealth of information including applicants' socioeconomic characteristics, eligibility status, date of program incorporation, compliance with co-responsibilities, payment of transfers, and whether individuals and households are still active beneficiaries or have exited the program. The best MISs also involve the recording of program inputs, in terms of both budget and human resources, with the objective to determine the cost of program components.

Evaluation, on the other hand, is most credible when performed by an independent party. It focuses mainly on processes, results, and efficiency/effectiveness. In the former case, it aims to document whether and how important CCT operational processes work. For example, it may attempt to document and assess the series of actions that lead to beneficiary screening and incorporation; why some beneficiaries fail to comply with program co-responsibilities; or whether beneficiaries easily receive program payments. It is typically based on interviews with program operational personnel, and on interviews and focus groups with applicants and beneficiaries. Table 13 provides a list of areas of investigation and methods for process evaluations.

Table 13. Process Evaluation: Areas of Investigation and Methods

Areas of investigation	Methods
Implementation • **Quality of training** • **Quality of facilities and service delivery, and profile of the workforce** • **Incentives for performance** • **Role of supervision** • **Facility quality** • **Counseling quality** ***Uptake and utilization of interventions*** • **Access and exposure to services** • **Satisfaction with service** • **Changing behaviors and attitudes** ***Contextual factors*** • **Role of other programs/ interventions** • **Role of family and community members**	*Qualitative* • Review of program documents (manuals, job aids) • Structured direct observations • Home-based interviews (qualitative or quantitative) with beneficiaries • Interviews (qualitative or quantitative) with policymakers and practitioners • Focus group discussions with beneficiaries *Quantitative* • Secondary data • Pre- and post-training assessments • Household surveys • Interviews at facilities

Source: Adapted from Haddad, Paes-Sousa, and Menon (2012).

Impact evaluations aim to measure the existence and the magnitude of causal effects of program participation on poverty and access to schooling and health care, as well as on any other program-related objective. They are the most technically complicated, as they require the comparison of a sample of beneficiaries with a rigorously selected control group, which needs to be equivalent to the treated in terms of observable and unobservable characteristics. The most rigorous methodology involves an experimental design, with random selection of program beneficiaries or areas where the program operates. A frequently used non-experimental technique is based on regression discontinuity, and is feasible when eligibility is determined by the comparison between a household score and a threshold (such as in the case of PMT).

Efficiency and effectiveness are assessed through cost-benefit analysis (does the value of the results justify program costs?), cost-effectiveness analysis (does the program combine inputs optimally for the achievement of a certain result?), and evaluations of targeting accuracy. These types of analysis are based on data on inputs, outputs, outcomes, and impacts collected by the program or through household surveys.

Both monitoring and evaluation ultimately aim to generate evidence-based decision-making. They show program strengths and weaknesses, and point to areas where further investigation and reform are needed. For example, impact evaluation may show that the

program is failing in its attempt to increase utilization of health services, and process evaluation may shed light on the reasons. Monitoring may highlight that an important share of beneficiaries is not complying with health care co-responsibilities, and process evaluation will be needed to explain why and to identify possible solutions.

The experimental impact evaluation built into the initial rollout of *PROGRESA/ Oportunidades* over the period 1997–99 has greatly contributed to the credibility of the program and more generally to that of CCTs. Out of 506 rural localities located in seven states (for a total of about 24,000 households) participating in the evaluation, 320 were randomly assigned to the treatment group (with transfers starting in 1998) and 186 constituted the control group (with postponed program entry). Detailed data was collected twice a year for all households, from the second half of 1997 to 2000. New evaluation surveys were conducted in 2003 when the program was further extended with the addition of a quasi-experimental control group, and in 2007.[15] To give an idea of how influential this impact evaluation turned out to be, it suffices to say that over 1,000 related scholarly articles can be found on the internet.[16] According to Fiszbein and Schady, "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" (2009, 6).

Oportunidades' evaluation agenda is submitted each year to the National Committee of Coordination, which includes representatives of all involved sectors. The ministries of health and education are invited to participate in the studies in order to improve their quality and preserve good political articulation among the institutional partners.

The evaluation agenda is then assessed and approved by *CONEVAL* (the Spanish acronym for National Council for the Evaluation of Social Development Policies). Established in 2004,[17] *CONEVAL* is responsible for evaluating all social programs and monitoring the evolution of poverty using both income-based and multidimensional definitions, thereby producing useful information for program managers. Figure 5 provides

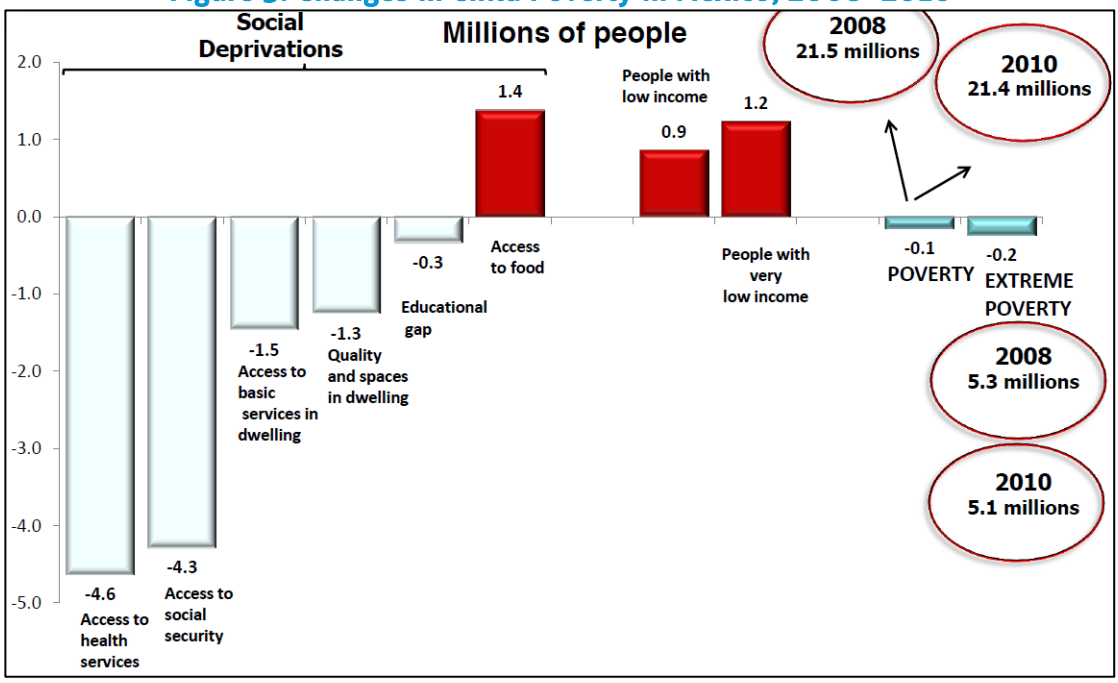
[15]The non-experimental nature of this second wave of evaluation has reduced the credibility of the results, so that most of the existing literature focuses on data from rural areas and the early stages of program implementation.

[16]A search for "'Oportunidades' AND 'impact evaluation'" on scholar.google.com on March 21, 2013, returned 1,380 results.

[17]In the same year, the law on transparency and access to information established that all social programs should publish information on their budget and results. The law set the obligation for program managers to respond to requests of data and other information (e.g., by academics, social organizations, or individuals).

an example of the analytical work performed by *CONEVAL*. It shows that while children's access to health care, access to social security, dwelling characteristics and education indicators improved between 2008 and 2010, income and access to food dropped. This type of analysis can help refocus social assistance programs.

Figure 5. Changes in Child Poverty in Mexico, 2008–2010



Source: Hernández-Licona (2012).

Until a few years ago, evaluation results were eventually validated through an academic committee composed of respected members of academia and of government officials from health and education ministries. The results, as well as the data produced by an impressive monitoring system producing bimonthly indicators (Basset and Blanco, 2011), were fed back into program design.

For example, monitoring and evaluation produced evidence that led to the extension of education grants to high school students. Subsequently, the program added Youth with Opportunities (*Jovenes con Oportunidades*), a saving plan with transfers at completion of each grade from ninth grade through upper secondary graduation, at which savings can eventually be cashed. Similarly, micronutrient effectiveness studies led to a dramatic change in the integral strategy for nutrition within *Oportunidades* (including complementary feeding and micronutrient supplementation) and represent another example of policy change brought about by the monitoring and evaluation agenda.

In the sample of programs considered in this report, Colombia's *Familias en Acción* and Honduras' PRAF also incorporated rigorous impact evaluations from the very beginning, while Brazil's *Bolsa Família*, Jamaica's PATH, and Peru's *Juntos* did not. In these cases, policymakers and program managers' strategic decisions relied mostly on non-experimental evaluations (e.g., Perova and Vakis, 2009 for *Juntos*) and monitoring data.

Bolsa Família started the construction of a comprehensive monitoring and evaluation system, based on two complementary structures, two years after the program was launched. First, the Department of the Unified Registry, placed under the Secretariat of Citizenship Income, became responsible for guaranteeing the integrity and the accuracy of the roster of beneficiaries. Second, the Secretariat for Evaluation and Information Management became responsible for evaluating all programs of the Ministry of Social Development and Fight against Hunger (hereafter Ministry of Social Development, or MDS). It develops monitoring systems, disseminates evaluation techniques within the Ministry, as well as among state and municipal governments (see box 3). In 2012, it contracted or produced in-house 28 evaluation studies, of which six were focused on *Bolsa Família*.

Box 3. Main Activities of Brazil's Secretariat for Evaluation and Information Management

Brazil's Secretariat for Evaluation and Information Management:

- **Designs monitoring indicators and evaluation surveys**
- **Tracks and summarizes social reports produced by national (e.g., Population Bureau) and international institutions (e.g., United Nations agencies and development banks)**
- **Computes relevant monitoring indicators**
- **Performs evaluation studies, prioritizing those based on secondary data**
- **Hires qualitative or quantitative surveys on program management–related subjects**
- **Disseminates results (e.g., through policy briefs, workshops, courses, or videos)**

Source: Interview with program personnel.

Jamaica's PATH relies on an advanced MIS and "process evaluations to examine the quality of service delivery, develop a proposal of service standards, and inform the design of an internal system of spot checks" (World Bank, Safety Nets How To version 1, http://siteresources.worldbank.org/ SAFETYNETSANDTRANSFERS/Resources/281945-

1291746977764/10-me.pdf). Evidence obtained from internal monitoring processes has led to a number of changes to the program's original architecture. These include: (a) the introduction of a tiered and gender differentiated payment system for school children, in response to findings that dropout rates among older boys were higher than among coetaneous girls; (b) increased transfer amounts in response to the food, financial, and fuel crises, and; (c) the inclusion of a base payment to provide a social protection floor for the poorest beneficiaries (UNICEF's Office for Barbados and the Eastern Caribbean, 2011). Internal monitoring has also been crucial for effective service delivery. Its success depends on using monitoring and evaluation as a tool for better management rather than as a threat, and on creating a reward-based culture to encourage quality of service delivery. Among the adopted tools are staff rewards systems, such as "best parish manager" awards to foster commitment to quality within implementing bodies (UNICEF's Office for Barbados and the Eastern Caribbean, 2011).

For Colombia's *Más Familias en Acción*, monitoring is a joint responsibility of federal and municipal governments. The program uses a comprehensive monitoring system that follows beneficiary families through the various stages of program implementation, such as: (i) beneficiaries' registration and status (registered, beneficiary, withdrawn); (ii) compliance with program co-responsibilities; (iii) payment of transfers; and (iv) complaints and case management. The program also uses spot checks, or sample-based site monitoring, to review program operations in different localities. The process is based on interviews with participants, program personnel, and local authorities, and uses structured questionnaires covering 400 indicators of critical program aspects. Results are used to assess regional variation in program performance and determine whether changes in procedures, staff training, or other inputs may be needed. For example, spot checks revealed problems with long wait times for payments, which motivated management to work with banks to reform the payment process (Basset and Blanco, 2011).

Countries considering undertaking CCT programs need to be aware that high-quality monitoring and evaluation requires considerable budgeted resources. For example, the Brazilian Department of the Unified Registry had a budget of USD 7.7 million in 2012, and employed 29 professionals (10 civil servants and 19 contractual workers). The Brazilian Secretariat for Evaluation and Information Management had a budget of USD 7.4 million, and employed 65 professionals. *Más Familias en Acción*'s National Coordination Unit had a more limited budget of USD 2.45 million over the period 2008–2012, and employed 35 professionals (table 14).

Table 14. Resources Allocated to Monitoring and Evaluation in Selected LAC CCT Programs

Program	Country	Structure	Staff count	Budget (USD)	Number of published studies in 2012	Main client
Bolsa Família	Brazil	Secretariat for Evaluation and Information Management Department of the Unified Registry	65 29	7,4 million (2012) 7,7 million (2012)	28 studies (6 about Bolsa Família)	Minister Secretary of the *Bolsa Família*
Más Familias en Acción	Colombia	National Coordination Unit	8 federal-level, 27 regional-level	2.45 million (2008–2012)	1 impact evaluation study	Minister

Source: Interview with program personnel.

These investments are necessary to guarantee programs' reputations and political support, particularly to protect CCT programs (and their beneficiaries) against the risk of being discontinued when governments change. More generally, in the LAC experience, the culture of evaluation has grown around CCT programs to extend to other public policies, increasing program accountability and a culture of management for results (Fiszbein and Schady, 2009).

The journey has yet to be completed. Program managers still complain about: (a) public administrations' scarce sympathy towards monitoring and evaluation; (b) opposition towards the long life cycle of rigorous evaluation processes, and; (c) the inadequacy of the existing procurement frameworks for contracting long-term studies and high-quality research services.

Considering LAC experience with CCT monitoring and evaluation, Asian countries planning to introduce CCT programs should keep the following lessons in mind:

1. *Monitoring and evaluation systems, including the construction of sophisticated MISs, require substantial financial resources and the recruitment of highly qualified personnel.*
2. *Monitoring and evaluation systems must be an integral part of program design and development from a very early stage.*
3. *Monitoring and evaluation teams are more credible and effective when they are independent from program management, and have access to upper management within a ministry or the presidency.*
4. *The data generated by monitoring and evaluation systems is fundamental to identify implementation bottlenecks and possible solutions (incremental tweaks to program design) that can enhance poverty reduction and human capital development.*

5. *The dissemination of the results of regular evaluations is fundamental to maintain the credibility of the programs and ensure their political sustainability.*

4 Administrative Capacity of Central and Subnational Governments, and Other Institutional Partners

The implementation of CCT programs *r*equires a complex institutional framework. Depending on their administrative culture, countries may adopt a vertical or horizontal implementation model. In a vertical model, the central government retains most operational responsibilities by setting up and overseeing dedicated program structures at various subnational levels. In a horizontal model, program implementation is largely performed by subnational governments. Mexico provides an example of the vertical model. Mexico's National Coordination of *Oportunidades* established 32 state delegations, which organized state technical committees where *Oportunidades* state delegates interact with state secretaries of health and education and other stakeholders. In our sample of countries, also Jamaica and Peru[18] rely on a vertical model.

The vertical model allows for faster and more homogeneous program implementation, and produces more centralized institutional memory. On the negative side, the vertical model may produce administrative conflict between the national/federal and subnational governments, competition with overlapping local programs (especially in affluent states and municipalities),[19] and lack of local ownership with consequent poor implementation by non-cooperating subnational authorities. In a small country such as Jamaica, the vertical model can work without creating political conflicts. However, in larger countries, CCT program implementation can became very difficult without a good partnership between national and subnational governments (Ayala, 2006).

Brazil uses a more horizontal model of CCT program implementation. Most of the implementation of *Bolsa Família* is performed by Brazil's 5,700 municipal governments based on contracts signed with the federal government.

Colombia's model employs elements of vertical and horizontal implementation systems. The national and local governments sign co-responsibility agreements that define the responsibilities of each. Among the responsibilities of the local government is the designation of the staff liaison (*enlace*), who is responsible for coordinating and implementing the program at local level, sustaining the information system, training health

[18] *Juntos* is part of the Ministry of Development and Social Inclusion. Its implementation relies on territorial units, which report to the national headquarters in Lima.

[19] In 2012, the Mexican state governments were running 813 economic welfare programs (Inter-American Development Bank, 2013).

and education staff on CCT-related topics, training mothers, consolidating data related to the conditionalities collected by the health and education teams, and acting as program ombudsperson.

In all cases, regardless of implementation structure, national authorities retain responsibility for defining the policy agenda, planning (of design and evaluation), setting the "rules of the game," and budgeting.[20] CCT programs tend to be housed either in a strong social development ministry, or in a strong program executing agency ascribed to a ministerial entity but with various degree of administrative, strategic, and technical autonomy (e.g., in Mexico). Program implementation generally implies the creation of a national steering committee, and of local coordination committees (with the same sectoral composition as the national-level committee) tasked with carrying out coordination arrangements mandated by the national level. Some countries' CCT programs have strong coordination links with municipal governments, too, which share the responsibility for the delivery of basic health and other social services (Ayala 2006). Table 15 provides a summary of different CCT programs' institutional frameworks.

[20]Political sustainability is enhanced when CCTs are established by law (e.g., rather than by decree), and when the law stipulates the sources of funding.

Table 15. Institutional Frameworks of Selected LAC CCT Programs

Country, program	Institutional framework
Brazil, ***Bolsa Família***	*Ministry of Social Development (MDS)* Overall coordination *Secretariat of Citizenship Income* *Overall supervision* *Secretariat for Evaluation and Information Management* Monitoring and Evaluation *States* Monitor overall state implementation and coordination *Municipalities* Register all poor households into the national unified registry; monitor conditionality compliance in education and health; set up social councils responsible for the overall monitoring of *Bolsa Família* implementation at the municipal level *Service providers (ministries of education and health)* Responsible for the provision of universal public education and health services through schools and health centers *Caixa Economica federal bank* Benefit payment, directly to beneficiaries
Colombia, ***Más Familias en Acción***	*Administrative Department of Social Prosperity* Overall coordination (replaced the Administrative Department of the Presidency in 2011) *Investment Fund for Peace, through the National Coordination Unit* Overall supervision, encompassing: design, coordination, planning, monitoring and evaluation, implementation, and financing *Regional Coordination Unit* Promotes coordination between federal government and municipalities *Municipalities* Provide health and education services and designate a staff member (*enlace*) to serve as the interface between beneficiaries and public institutions *Local banks* Benefit payment, directly to beneficiaries
Honduras, ***Bono 10,000***	*State Secretariat of the Presidential Office* Direction/Management *PRAF* Operations and Coordination of the Bono 10,000 *Banco Nacional de Desarrollo Agrícola* Benefit payment, through mobile automated teller machines placed at selected payment points (e.g., schools, community centers)
Jamaica, **PATH**	*Ministry of Labour and Social Security* Coordination and management *Parish offices (local administrative unit)*

	Handle the local operations of the program *Post offices* Benefit payment
Mexico, *Oportunidades*	*Ministry of Social Development* Overall coordination *National Coordination Unit* Supervision *National Council* National program coordination. It comprises secretaries of state for education, health, social security, and social development, as well as state governments *State Coordination Councils* State program coordination. They comprise state secretaries of education, health, and social development, state coordinator of the program, and state representative of the Ministry of Social Development *Direction of Articulation for External Evaluation of the National Coordination Unit, General Direction of Monitoring and Evaluation of the Social Programs of SEDESOL (Secretaría de Desarrollo Social)* Monitoring and evaluation *State coordinators* Monitor conditionality compliance *Banks and program offices* Benefit payment, directly to beneficiaries, either in cash or through deposits in personal bank accounts
Peru, *Juntos*	*Ministry of Development and Social Inclusion* Coordination and management *Juntos program staff* Monitors compliance with program conditionalities *Banks* Benefit payment, directly to beneficiaries

Source: Interview with program personnel.

Health and education representatives typically sit in all national and subnational steering committees because the coordination with the supply of education and health is particularly important in ensuring that CCT programs achieve their human capital development objectives. In some cases, CCTs may become part of a broader anti-poverty policy, requiring even wider coordination, as in the case of *Brasil Sem Miseria* (Brazil Without Ultra-Poverty; see box 4).

Box 4. *Brasil Sem Miseria*

Brazil has recently placed *Bolsa Família* at the core of an ambitious project to eradicate ultra-poverty by 2014. The *Brasil Sem Miseria* Plan articulates actions from 18 ministries. Its governance involves the following bodies:

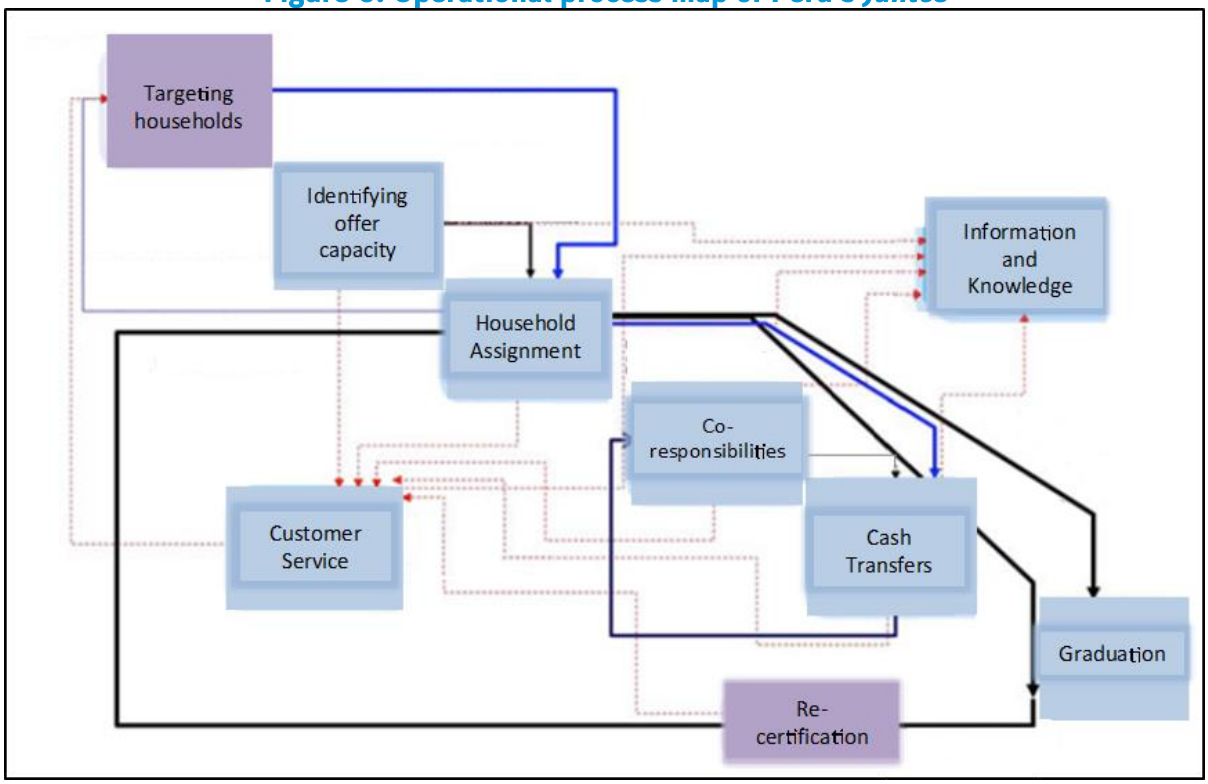
1. **The National Management Committee, which includes the Minister of Finance, the Head of the Presidential Chief of Staff, the Minister of Planning, and the Minister of Social Development;**
2. **The Program Coordination Committee, which revises the whole policy agenda, including *Bolsa Família* and occasional programs that are not part of the plan, but whose outcomes may interact with the plan's objectives;**
3. **The Executive Board, which is composed of the deputy ministers of the 18 ministries and in charge of day-to-day management;**
4. **The Inter-Ministerial Monitoring Team, made up of staff of the 18 ministries, in charge of the monitoring process.**

The model includes situation rooms within the Ministry of Social Development that are tasked with monitoring and management. In these rooms, ministry personnel use information technology to follow the performance of the programs committed to fight ultra-poverty in the country, identify bottlenecks, and coordinate stakeholders' actions through regular meetings or workshops. Brazilian policymakers have pointed out that the situation rooms have helped identify problems and solve conflicts and, in some circumstances, have led to program reforms.

Source: Interview with program personnel.

As introduced in section 3, CCTs operational functions include: (1) targeting; (2) monitoring and evaluation; (3) delivery of complementary services; (4) customer service; (5) monitoring of co-responsibilities; (6) cash transfer payments; (7) auditing, and; (8) recertification and "graduation". Institutional actors can accumulate different functions, and roles can change over time. Figure 6 illustrates the example of Peru's *Juntos*. The first two functions were classified as operational foundations and discussed in section 3. In the remainder of section 4, we explore the six remaining processes and the administrative capacity required to deliver them.

Figure 6. Operational process map of Peru's *Juntos*



Source: Adapted from *Juntos'* website: http://www.juntos.gob.pe/?page_id=760

4.1 Delivery of Complementary Services (Health and Education)

All CCT programs in LAC aim at increasing the demand for education and health care services in order to increase the human capital of poor children and break the intergenerational poverty cycle. Educational objectives include higher enrollment and attendance rates, less repetition and dropout, and ultimately increased grade progression and school completion. Health-related objectives are more heterogeneous. For example, Brazil aims at fostering prenatal and postnatal consultations, increasing child vaccination, and increasing the registry of nutritional data for children up to 7 years old (e.g., height, weight, breast-feeding). In Peru, a key objective is to reduce the incidence of children's chronic malnutrition, especially in rural areas (as established in the *Plan Bicentenario, Lineamientos básicos del MIDIS*).

Although cash transfers are the most visible aspect of CCT programs, many countries place more emphasis on service provision, considering the transfers as incentive for improving human capital development rather than a tool for the alleviation of current

poverty.[21] The coordination between social protection/assistance and the provision of education and health services is therefore fundamental. Yet, it also remains a challenge. In many countries in LAC and Asia, CCT programs have been housed in the ministries in charge of social protection (social development or equivalent). These ministries were traditionally in charge of smaller social assistance programs, and most staff had a social work background. Most programs were vertically structured, with little interrelation among units. In contrast, CCTs have an unprecedented scale, in terms of both budget and number of beneficiary households. They require human resources with multi-sector skills that are usually available only across ministries. They demand horizontal connections across operational units. The process of bringing the ministries of education and health on board and obtaining their buy-in and full support for the programs is extremely complicated. It requires full support from the highest government agencies and officials.

In some cases, service provision depends on fragile structures (either governmental or private, including non-governmental organizations) that deliver services with substantial weaknesses in terms of coverage, quality, and continuity. This makes it difficult to plan a homogeneous countrywide pattern of services. Some countries may plan to expand their network of education and health-care facilities jointly with the rollout of the CCT program. For example, Honduras hoped to expand its supply of health and education in order to serve *Bono 10,000* beneficiaries in many areas. The process had to include building the infrastructure, recruiting and training staff, defining service protocols, developing monitoring routines, and developing partnership with public and private service providers. This is a risky strategy, as the delivery of the transfers can be implemented far more rapidly than the construction and operation of new schools and health centers. Political pressure to accelerate the former may lead to a *de facto* unconditional transfer program.

Similarly, sometimes program managers hoped that increased service supply would be fostered by bottom-up political pressure from the communities of beneficiary households (driven for example by beneficiary mothers and local leaders). In these situations, local authorities tend to welcome CCT programs and the benefits of the related cash inflows to the

[21] The political narrative in LAC countries introducing a CCT program oscillated between two approaches: development of human capital and social rights guarantees. The former places an emphasis on the effectiveness of the co-responsibilities, and on the temporariness of the intervention, which is expected to lead to graduation from the program. The latter emphasizes the correct identification of the poor as beneficiaries and reaching full coverage. In practical terms, improving targeting is easier than obtaining substantive graduation results, as graduation is linked to complex events that are beyond the reach of social policy interventions.

local economies. Local authorities also see the chance to strengthen their political position by working with program beneficiaries (Castañeda, 2009). Nonetheless, experience in LAC teaches that bottom-up pressure is unlikely to produce the required expansion of education and healthcare service supply.

In actuality, limited service coverage in many countries has weakened the efficacy of the conditional transfers, or produced a relaxed interpretation of the conditionalities. For example, Mexico, despite major efforts reflected in expanded budget commitments over the last decade, still faces considerable challenges for providing adequate education and health services to all potential CCT beneficiaries (table 16). Eligible people living in localities without an adequate supply of schools and health services have not been incorporated to *Oportunidades*. Instead, they are directed to an unconditional cash transfer program, the Food Support Program (Soares, 2012). Difficulty in accessing schools also meant that over four million children and youths (8 to 21 years old) from *Oportunidades* beneficiary households did not receive the education benefit in 2011.

Even Brazil, one of the richest countries in our sample, has faced huge heterogeneity in terms of coverage and quality of complementary services. In response to these difficulties and as part of the effort to reach the ultra-poor beneficiaries of *Bolsa Família*, over the period 2012–2013, the country is building 2,100 new basic health facilities and implementing a full-time-study policy for 17,500 primary schools.

Table 16. Challenges in Education and Health Service Provision for *Oportunidades'* Beneficiaries, 2013

	Education	Health
Access	• Lack of access to good quality schools, particularly at secondary schools and in rural areas • Poor supply of early-childhood development initiatives	• Limited supply in marginal localities • In areas with better coverage, weak linkages between the beneficiaries and health centers • Limited supply of self-care workshops • Delay in provision of health services to newborns
Quality	• Main teaching method in rural areas is tele-education (TV courses) • Lack of attractive content for secondary school students • Despite being frequent (and often the only available alternative), non-formal education is not accepted by the program	• Lack of personnel and supplies to perform services • Lack of specific training for dealing with indigenous population in both rural and urban areas
Management	• Lack of coordination in schools with a high density of beneficiaries, as implementation of programs that interest beneficiaries is weak	• Lack of operational articulation

Source: Adapted from Inter-American Development Bank (2013).

Overall, countries building and implementing new programs can learn from CCT program experiences in LAC that program co-responsibilities must be designed in line with the existing network of services and the budget available for program expansion. Strong political support from the highest government ranks is needed to produce the required inter-sector coordination and investments.

4.2 Customer Service

A customer care and case management program element is required to handle the relationship between the program and beneficiary households. Most customer service interactions regard requests of information and guidance, the application process, and complaints on program malfunctioning. In Brazil, for example, the program's relationship center is run by a private company that is responsible for providing information on all social protection programs under the Ministry of Social Development, and for collecting complaints, suggestions and compliments. It operates via telephone (24-hours-a-day service), mail, e-mail, fax, and face-to-face assistance; a chat service is forthcoming. The center employs 232 contractual staff. In 2012, it attended to 3.8 million calls and replied to 108,000 messages. Most calls were related to registry verification (43%), payments (9.8%), and value of the benefit (9.7%).[22]

Similarly, customer service for Peru's *Juntos* operates via e-mail, phone, and face-to-face assistance. Most questions raised regard reviews of the family's status in case of rejected application or exclusion from the program, and updates of beneficiary-household information. In the latter case, information is often updated to: include a new household member; change the school or health unit of reference of a beneficiary; change the household's address, person of reference, or bank account information. Complaints by *Junto*'s beneficiaries are mostly related to health and/or education facilities being very far from the household, poor service quality from health and education facilities or banks, bad management by local program staff or Local Transparency Committees, and missing or incomplete payments.

The following lessons can be drawn from LAC's experience with CCT customer-service implementation:

1. *Customer services play an important role in connecting program managers to the program's base of beneficiaries and provide useful feedback for program*

[22]Internal report of the Relations Center of Brazil's Ministry of Social Development and Fight against Hunger, January 15, 2012.

improvement. The information collected by these services must be elaborated and consolidated to inform management decisions.

2. *The early phases of beneficiary registration and transfer payments are likely to generate high demand by beneficiaries for clarification and case assessment. It is therefore of strategic importance that these phases are preceded by the setup of support units aimed to help customers understand procedures, request status verification, and channel complaints when needed.*
3. *Customer services are more efficient when they are separated from basic operations (such as beneficiary registration and payment), because the clients can be given the full attention of staff members and focus can be put on improving response time.*

4.3 Monitoring Co-Responsibilities

In addition to the primary monitoring and evaluation operation issues addressed in section 3, monitoring of compliance with program co-responsibilities is usually tasked to education and health service providers. They record data that is either delivered to local authorities for consolidation and transfer to national health or education authorities (e.g., Brazil) or local staff of the CCT program (e.g., Mexico's *enlace*), who are responsible for consolidating and delivering it to the national coordination officers of the CCT program.

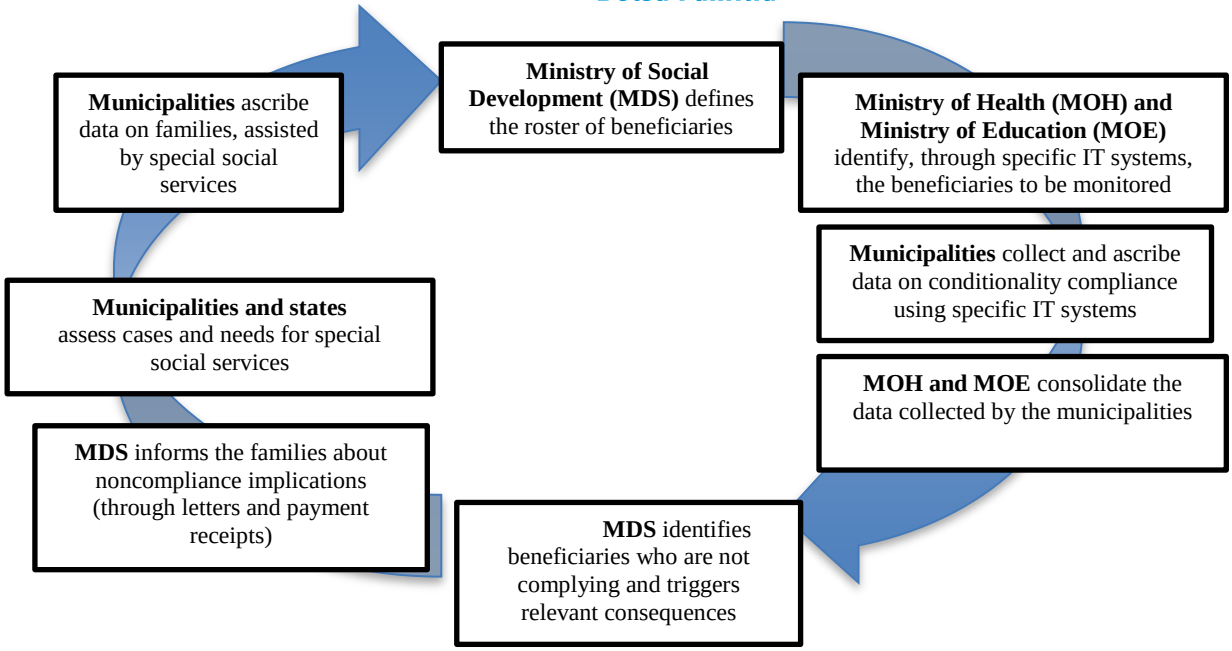
Figure 7 presents the Brazilian model, with interactions among the ministries of health, education, and social development, plus their subnational administrations. Healthcare and education compliance data are collected, respectively, every six months and two months. Consequently, non-compliance with education co-responsibilities has more immediate consequences on the interruption of the cash transfer than missing a visit to the health centers.

An interesting feature of *Bolsa Família*, specifically, is that failure by a beneficiary to comply with his or her co-responsibility eventually triggers the interruption of all payments to the whole family. The interruption is not immediate, as it is preceded by a series of warnings (delivered through bank receipts of previous transfers, before payments are blocked) and verifications by the local authorities. On the contrary, in Mexico's *Oportunidades* failure to comply with schooling conditionalities does not trigger the interruption of all payments. Beneficiary households stop receiving the *beca* (i.e., the scholarship component of the CCT) but keep receiving the base benefit unless they fail to comply with healthcare co-responsibilities. This lack of interdependencies may reduce the

incentive for children to enroll in and attend school while contributing to the explanation for the high incidence of secondary school dropout among children from beneficiary households.

An even weaker interpretation of program co-responsibilities is provided by the case of Honduras. For health, verification of compliance is limited to being enrolled in (rather than regularly attending) the health center. In addition, compliance by one member is sufficient to trigger the payment (regardless of whether other family members are enrolled in the health center registry). The same applies to education co-responsibilities: attendance by one child is enough for the payment of the transfer even if other children fail to attend school. These co-responsibility requirements are currently in the process of being strengthened.

Figure 7. Routine for Monitoring Conditionalities in Brazil's *Bolsa Família*



Source: MDS (2012).

The following lessons can be extracted from the experience of LAC countries:

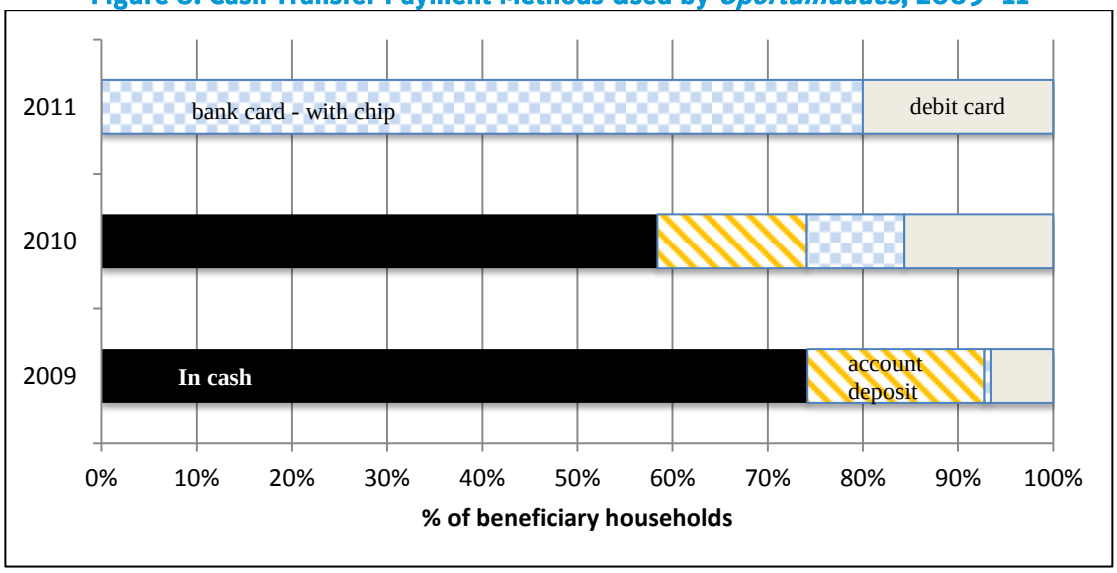
1. *Although the threat to interrupt the cash transfer is a powerful incentive to comply with program co-responsibilities, the interruption may further aggravate beneficiaries' difficulties. Failure to comply may be due to external causes such as lack of transportation, teachers' and doctors' absenteeism, situations of domestic violence, programs' operational glitches, etc. It is therefore important to investigate the reasons for noncompliance and take corrective measures where needed. Social workers play an important role in this process.*

2. *Data on compliance with program co-responsibilities can provide precious information on the performance of CCT complementary services. In many countries, the knowledge produced through the monitoring of the conditionalities induced important innovations, such as the payment of transportation for pregnant women attending prenatal consultations in Brazil. The experience of Mexico's National Council of Oportunidades shows that co-responsibilities monitoring data can also feed the dialogue between the program and other institutional partners (e.g., ministries of education and health), speeding the adoption of appropriate corrective interventions.*

4.4 Cash Transfer Payments

After years of cash delivery through program offices or mobile cash machine, most programs have recently been transitioning toward payments through the banking system. As shown in figure 8, over 70% of Mexico's *Oportunidades* beneficiaries received their transfer in cash in 2009, while this form of payment had virtually disappeared two years later. In 2011, all payments were performed through bank or debit cards, up from less than 10% in 2009. Honduras represents an exception to the trend, with close to all payments still delivered in cash, and only small pilot programs involving the use of banks and cell phones (despite the capillary distribution of rural savings cooperatives).

Figure 8. Cash Transfer Payment Methods Used by *Oportunidades*, 2009–11



Source: *Oportunidades*.

There are several reasons for the increasing use of bank systems. First, they can reduce the administrative costs of delivering the benefits. Second, bank payments are believed to increase transparency by reducing the chances of corruption and ensuring that the transfers reach the intended beneficiaries. Third, such payments are meant to cut wait and collection time, thereby reducing the opportunity cost of receiving the transfers. Fourth, bank payments can contribute to financial market development, by facilitating the incorporation of previously unbanked households (e.g., in Colombia). Fifth, the development of dedicated information technology systems contributes to monitoring and evaluation, increasing the frequency of reports on the payment process. Finally, ownership of bank cards may increase beneficiaries' sense of belonging to the CCT program.

The banks provide four options to CCT beneficiaries in LAC:

1. Electronic withdrawals: the household representative cashes the benefit at automatic teller machines using a bank card with personal identification number;
2. Offline withdrawals: the household representative can cash the benefit only at bank branches;
3. Special withdrawals: scheduled payments are performed by mobile bank teams;
4. Virtual accounts: in 2013, Colombia's *Más Familias en Acción* is launching a new virtual account system for beneficiaries in selected municipalities. Beneficiaries receive a mobile-phone text message indicating a code and the deposited benefit amount. They then cash the benefit at a cash machine by typing in the code and answering a personal question. The operation does not require a bank card.

In Brazil, *Bolsa Família*'s payments are paid through the *Caixa Economica*, a public bank that also hosts and runs the unified registry of beneficiaries. The *Caixa* has organized the most consistent payment routine among the observed countries. To handle the large number of transactions, beneficiaries are assigned a different day of payment based on the last digit of the social identification number of the family representative. The deposited benefit must be cashed within 90 calendar days, which has occurred in 96% of cases. Any non-cashed benefit is returned to the Federal Treasury.[23]

Caixa transaction receipts are also used by *Bolsa Família* for communication purposes. For example, beneficiaries are informed of the failure of a member to comply with

[23]Information collected through interview with program personnel. In 2012, the first day of *Bolsa Família* payments was in most cases (5 out of 12 months) on the 18th day of the month, with variation from the 10th to the 20th.

program co-responsibilities, and that this will trigger a future interruption of the payments if the problem persists. Beneficiaries can also be requested to provide missing information to complete their records. If the transfer has been blocked, the receipt explains the reason and recommends the corrective actions.[24]

In most cases in LAC, bank cards distributed to CCT beneficiaries only allow withdrawal of program transfers with no access to additional bank products. Program managers are generally concerned that access to a broader range of products would imply fees and erode the net value of the benefits. Nonetheless, after contracting no or low fees, CCT programs are starting to experiment with the addition of selected bank services.

For example, Brazil's *Caixa Economica* designed an upgrade to the traditional *Bolsa Família* Social Card (Social Account), including access to selected additional products. One important advantage of the New *Bolsa Família Caixa* Bankcard *(Caixa Fácil* Account) is the elimination of the 90-day withdrawal deadline, which introduces the possibility to have savings. The two options are described in table 17.

[24]One related example of message on the receipt is: "the record of a child or youth of your family (6 to 18 years old) is missing the information regarding to the school that he or she is engaged in. The persistence of this problem will lead to the suspension of the benefit. Please, update the family record in the *Bolsa Família* office of your municipality."

Table 17. Comparing Social and *Caixa Fácil* Accounts of *Bolsa Família* Beneficiaries

	Traditional *Bolsa Família* Social Card (Social Account)	New *Bolsa Família Caixa* Bankcard (*CAIXA Fácil* Account)
Layout		
Access to card	Produced automatically when the family enters the program	After the family representative voluntarily opens the *Caixa Fácil* account
Card delivery	By mail or in a *Caixa* branch	
Card activation and password selection	6-digit password registered in a branch or lottery house by the person of reference of the family, after receiving the card	4-digit password registered in a branch by the person of reference of the family, after opening the account
Benefit withdrawal	One single withdrawal of the monthly benefit	Up to 4 withdrawals in a month, free of additional charges
Time limit for cashing benefits	90 days, the remained values are recollected and returned to the Brazilian treasury	No time limit
Schedule of payments	No difference	
Value of payments	No difference	

Source: Interview with program personnel.

Considerable efforts have been made by some countries to extend the bank network to smaller communities. Unfortunately, in some instances, these efforts have been hampered by low commercial return in remote regions, where many CCT beneficiaries reside. Where banks are not available, CCT programs have used networks of alternative service providers to distribute payments. These include post offices (in Jamaica), lottery offices, certified bakeries and markets (in Brazil). Where no alternative service providers or banks are available, such as in some parts of Honduras, program staff visit the communities of beneficiaries to distribute the cash transfers.

In addition to the challenge of accessing payment points, CCT beneficiaries have reported a number of additional problems that require program managers' attention. These include: blocked payments that are not explained; subtraction of fees; limitations to the use of bank cards, with spending constraints on select categories of goods; retention of bank cards by cash machines or bank staff. Other problems with cash machines include: malfunctioning cash machines; insufficient availability of cash for the payment of the transfer; limits set by the program on which cash machines may be used for the transfer and on when these may be

accessed. Finally, in remote locations with difficult access, cases have been reported in which one person withdrew funds from accounts of multiple beneficiaries (against program rules).

As the inability to collect the transfer can be highly frustrating and a great inconvenience, customer service plays a very important role in the handling of payment-related complaints. In order to properly address these cases, customer service representatives need updated information on any recent changes to payment rules, agreed upon by government authorities and banks; the roster of beneficiaries, including new and recently expelled families; basic information on beneficiaries (name of members, address, identification number) and benefits (type, value, and payments timeline); and previously unclaimed benefits.

Overall, LAC countries' experience with transfer-payment processes shows that:

1. *Most programs tend to transition to the use of bank systems, and more specifically of bank cards, for the payment of transfers.*
2. *Engaging the bank network requires substantial negotiation to define minimum service standards (to ensure quality for CCT beneficiaries, e.g., in terms of flexibility of cashing options) and a reasonable upper bound to the payment of fees (if charged). This negotiation may also lead to an expansion of services for CCT beneficiaries beyond the payment of the transfer.*
3. *Payments through cell phones represent the next frontier, either as the main form of payment (e.g., in specific areas of Colombia) or as a complement to more traditional platforms (e.g., in Brazil and Honduras).*

4.5 Audits and Transparency

Audits have a role in monitoring and evaluation, as discussed earlier, so here we will highlight specific cases of complementary top-down and bottom-up strategies to increase accountability and transparency. Top-down approaches typically include formal audits and internal monitoring by the central government. Bottom-up strategies aim to generate social accountability through the direct involvement of the communities of program beneficiaries.

Routine controls by the central government require intensive use of information technology, complemented by conventional site visits to operational units to verify the accuracy of records (e.g., are teachers reporting well on compliance with the program's co-responsibilities?). Brazil provides a good case study. Both the consistency and reliability of Brazil's unified registry of beneficiaries are tested through data matching with other public information systems, such as the national formal employment registry, the retirement and

pensions registries, and the death registry. In 2009, for example, a collaboration between the Ministry of Social Development and the Brazilian Court of Audit identified inconsistencies in 878,026 records of *Bolsa Família* beneficiaries and 1,467,932 records of registered non-beneficiary families. After fieldwork was conducted to determine the source of the discrepancies, 194,869 beneficiary families were expelled from the program. Also, 629,692 non-beneficiary families updated their records, and when 838,240 more failed to do so, they were eliminated from the registry.

Some strategies to increase transparency have a bottom-up social accountability element but involve considerable technology resources. For example, certain countries have made an effort to avoid errors of inclusion by publishing the full roster of their program's beneficiaries on the internet. Three examples are Brazil, Honduras, and Mexico. Brazil's roster of beneficiaries, which is organized by state, municipality, or family, can be found at https://www.beneficiossociais.caixa.gov.br/consulta/beneficio/04.01.00-00_00.asp. Honduras's roster is organized by department and can be found at http://www.praf.hn/drupal/?q=node/8. Finally, Mexico's roster of beneficiaries, which is organized by household, specific benefit, adults, children, and transferred values can be found at http://www.oportunidades.gob.mx/Portal/wb/Web/oportunidades_padron.

Another example of social accountability approach is provided by the involvement of the mothers who are beneficiaries in Colombia's *Más Familias en Accion,* through initiatives aimed at raising citizens' participation and social control. First, the women attend the annual municipal assembly of the beneficiary mothers, where their representatives are elected for a two-year term. The assembly hosts the presentation of the program annual report, and is attended by the mayor. Second, the elected representative mothers compose a committee that monitors the program operations in the municipality, participates in the planning of the strengthening of the social networks, and liaises with the program institutional partners.

Overall, LAC countries' experiences suggest that systematic electronic audits, regular audit visits in a sample of localities (spot checks) and community auditing can be combined to increase transparency and ensure that program managers are constantly aware of implementation challenges on the ground.

4.6 Recertification and "Graduation"

Although the first CCTs were at times conceived as temporary programs, they soon converted into open-ended interventions, with automatic exit only when the beneficiary

households no longer fit categorical eligibility criteria (e.g., children reached a certain age or completed school; see tables 2 and 18). The combination of program expansion and sustained economic growth in LAC over the last decade has determined several cases in which the number of beneficiaries has reached or overcome the number of poor in the country (Stampini and Tornarolli, 2012; Cecchini and Madariaga, 2011). The phenomenon can only partly be explained by errors of inclusion due to the imperfect performance of means testing methodologies and their operational implementation (as discussed in section 3.1). More importantly, income growth and the modification of the demographic profile are likely to have raised several beneficiary households incorporated in the early waves of program expansion above the poverty line or above the eligibility threshold.

Consequently, graduation and recertification have risen to the forefront of the policy debate in virtually all LAC countries implementing CCT programs. "Graduation" means that households have risen above the poverty line and have reached a condition that no longer requires CCT assistance. Ideally, the household will have achieved a sustainable independence, through increased productivity and income generation capacity. Graduation may be a result of program participation, either because the co-responsibilities allowed the beneficiaries to accumulate sufficient human capital, or because the transfers stimulated additional economic activities. It may be fostered by complementary social assistance services provided in parallel to CCTs. It may, however, also derive from factors entirely external to social assistance, such as generalized growth in employment opportunities. This last consideration implies that graduation will not rank as high in the policy debate in case of poor economic performance of the country.

The term recertification indicates the process of revision of beneficiary households' eligibility. Households are screened using the latest targeting mechanisms adopted by the program. This often implies the application of an updated means testing formula to reflect the changing correlation between poverty and demographic characteristics and asset ownership. In Brazil, recertification takes place every two years, reflecting the fact that households are tested for income poverty, which is highly volatile. In Mexico, households are recertified every 5 years (with a continuous process screening 20% of beneficiary households every year). In Colombia recertification is conducted every four years (table 18). Longer intervals

are motivated by the use of PMT capturing structural poverty, which is much less volatile than household's income.[25]

The beneficiary household's recertification may lead to (a) continuation in the program, (b) modification of the benefits, or (c) exit from the program (not necessarily due to graduation). For example, in Mexico, recertification has implied the calculation of a new PMT score (*puntaje*). If this is above the 0.383 threshold, the household continues to be eligible. If the value is between 0.077 and 0.383, the household graduates to the *Esquema Diferenciado de Apoyos (EDA). EDA* is a reduced-support scheme that includes education benefits for secondary and upper secondary school students as well as access to a basic health care package. The household automatically exits *EDA* after three years. Finally, if the *puntaje* is below 0.077 the household is no longer eligible and is removed from the registry of beneficiaries (González-Flores, Heracleous, and Winters, 2012).

In 2011, Mexico's *Oportunidades* recertified 1.1 million beneficiary households. Of these, 49% were determined to be poor and eligible to remain in the program, 19% were supposed to be redirected to *EDA*, and 32% were deemed no longer eligible. Yet, these changes of status were neither fully implemented nor implemented in a timely manner, proving once again that any recertification policy faces strong headwinds at the moment of being implemented.

In Brazil, *Bolsa Família* beneficiary families receive a notification indicating an office they need to visit for their recertification interview (which leads to an update of the Unified Registry). If families fail to attend the interview within a given period, their benefit is first suspended and then cancelled if they never attend an interview. There are no additional consequences for failing to recertify, such as retroactively rescinding benefits paid during the permissible time frame for the interview. As a result, the experience shows that families that are no longer eligible intentionally fail to attend the interview as a strategy for receiving the benefit for the longest possible period.

In Mexico, following a vertical operations/administrative model, local program offices' recertification processes are funded by the federal government. On the contrary,

[25]For anti-poverty programs in the US, "recertification is annual for most beneficiaries, except for certain chronic poverty groups (for whom it is less frequent, 24 months; e.g., elderly poor). Re-certification is automatically scheduled and recorded in the benefit system during the interview/eligibility process. Beneficiaries receive a reminder in advance of their recertification date and lose benefits if they do not come to the local welfare office and provide all needed information and documentation for recertification" (Castañeda et al., 2005, 17).

municipalities in Brazil are in charge of the recertification, as agreed through a contract with the central government. Brazil's process includes a strong communication strategy (especially outreach through radio and TV). The municipalities receive a financial incentive for complete and timely recertification.

The observed processes of recertification and "graduation" have produced important lessons:

1. *While increasing coverage is politically easy, the implementation of effective recertification and graduation policies is complex and bound to face opposition.*
2. *Graduation is not an intended short-term outcome of standard CCT programs, as these do not include mechanisms aimed to increase the productivity of adults in beneficiary households.*
3. *Periodic recertification has been useful to limit leakage to the non-poor and adjust the value of the benefits to changes in beneficiary households' demographic characteristics and socioeconomic status.*
4. *The planning and implementation of recertification and graduation policies should carefully assess all technical (gradualism, geographical concentration of exit flows, etc.) and policy (coordination with other governmental programs) aspects that could help overcoming political constraints and opposition.*

Table 18. Recertification and Exit from Selected LAC CCT Programs

Country, program	Recertification	Compulsory loss of specific benefits
Brazil, *Bolsa Família*	Every 2 years	At age 17 (at age 16, child benefit is converted into adolescent benefit) Breast-feeding women, 6 months after childbirth
Colombia, *Más Familias en Acción*	Every 4 years	At age 18 for the Education Benefit, and at age 7 for the Health Benefit
Honduras, *Bono 10,000*	First recertification planned for 2013–14	At age 18
Jamaica, PATH	Not fully implemented	End of secondary school
Mexico, *Oportunidades*	Every 5 years (with continuous screening of 20% of households per year)	At age 22 or end of upper secondary school
Peru, *Juntos*	Not widely implemented	At age 19 or end of secondary school or migration to non-priority district (under 40% of poor population)

Source: Interview with program personnel.

5 Program Strategies to Address Gender Inequality Issues

Mexico's *PROGRESA*/*Oportunidades* is the only program in our sample that explicitly contained the objective of affecting gender inequality in its policy statement.[26] More precisely, the program aimed at empowering women in the household and in the community. This had to be accomplished through the following strategies:

1. Make mothers the recipient of the cash transfer. All mothers over 14 years old (15 and older) were entitled to be beneficiary household representatives, hence the recipient of the transfer. In exceptional cases, also girls under 15 years old could be accepted as representatives.
2. Improve women's health before and after child delivery, through medical checkups for pregnant women and breast-feeding mothers.
3. Promote women's leadership and citizenship through workshops focusing on gender equity and women's capabilities.

   Some of the program's gender equity impacts are summarized in box 5

[26]For the purpose of this report, impacts on gender inequality include: enhanced women's economic autonomy, improved gender relations through the redressing of unequal distribution of decision-making power within the household and community, modified gender differences in the distribution of childcare and other responsibilities.

Box 5. Gender Impacts of Mexico's *Oportunidades*

- **Mid-term impact evaluation in rural areas points out that maternal mortality was reduced by 11% due to program interventions.**
- **Long-term impact evaluation in rural areas points out that girls achieved an additional 0.85 grades of schooling while boys received 0.65 grades of schooling (both compared with non-beneficiary children).**
- **Qualitative studies have found that:**
  1. **Women's empowerment has been proven to protect against household violence.**
  2. ***Oportunidades* has been instrumental in transforming the traditional role of women. Communities and families have higher expectations about young women's futures.**
  3. ***Titulares*, the female household representatives, feel more self-confident and enjoy building networks with other women.**

Source: Davila (2013).

Although no other programs had gender objectives, they all preferentially involved women by selecting them as the family representatives. For example, in Peru's *Juntos*, a male or female outside the age range of 18–70 years can only be a family representative when all women in that age range are absent from the home or unable to receive the payment. In Brazil's *Bolsa Família*, women represented 93% of beneficiary family representatives in 2011. Box 6 describes the average characteristics of these representatives. The existing CCT evaluation literature shows that women have wisely allocated the money towards children expenses (nutrition, health, and education), contributing to program effectiveness. Women's receipt of a predictable and reliable source of income produced some level of empowerment for them within their communities, and contributed to improving beneficiary women's self-esteem and confidence (Adato et al., 2000; Adato and Roopnaraine, 2004).

Box 6. Average Characteristics of *Bolsa Família*'s Family Representatives, 2011

***Bolsa Família*'s average family representatives are:**

1. **Mothers**
2. **Residents of urban areas in the Brazilian Northeast Region (one of the poorest)**
3. **Members of a family with 3.8 members**
4. **38 years old, of mixed race, with incomplete primary education**
5. **Unemployed**
6. **Mothers of children with access to public education, but with school grade delays**
7. **Receiving a monthly benefit of USD 60, which increases the monthly per capita income of the family by 61.3%**

Source: MDS (2011).

A few programs have explicitly addressed gender imbalances (while not naming gender equity as an objective) by introducing gender-differentiated school-related transfers to reduce the gap in educational outcomes between boys and girls. For example, Jamaica set higher transfers for boys to reduce their worrisome secondary school dropout rates (Table 19). In other countries, the concerns are for girls' secondary education, due to dropouts caused by early marriage and/or pregnancy and increased domestic work duties.[27] Mexico's *becas* (school related component of the cash transfers) are 10% higher for girls than for boys, and produced a 10 percentage-point impact differential on primary school enrollment: this increased by 20 percentage points for girls, against 10 percentage points for boys (Molyneux, 2007).

Table 19. Monthly Value of the Cash Transfers Related to School Attendance in Jamaica's PATH

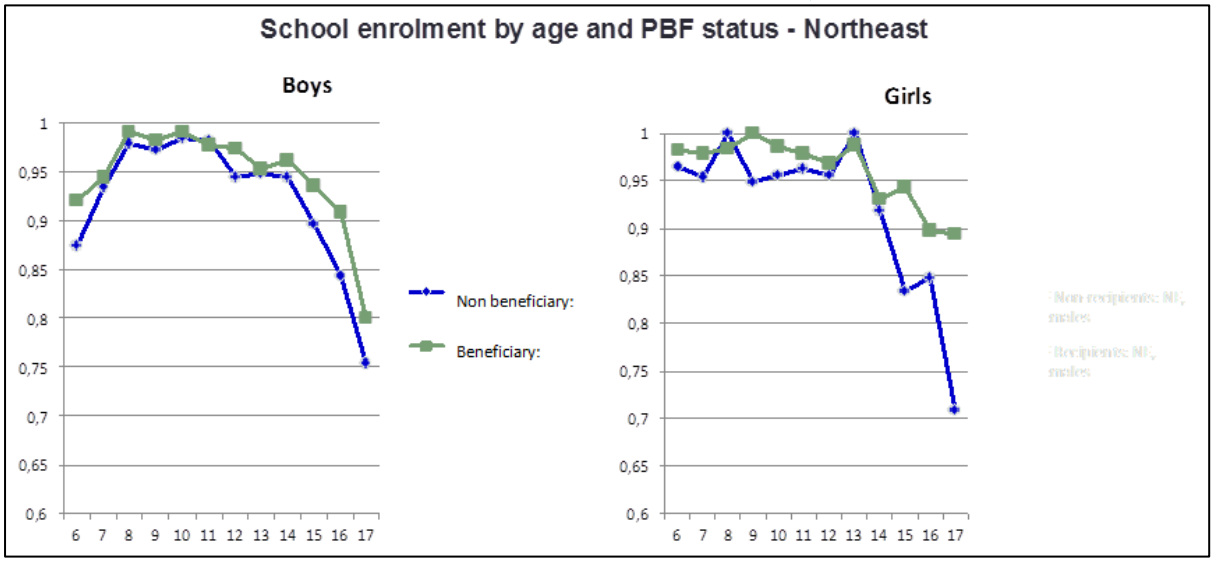
School level	Boys	Girls
Primary	JMD 825	JMD 750
Lower secondary	JMD 1,075	JMD 975
Upper secondary	JMD 1,265	JMD 1,150

Source: IDB Loan Proposal (JA-L1037). *Note:* JMD 100 ≅ USD 1

[27] Some programs in Asia have addressed gender inequality in education and may provide complementary models. For example, Yemen's "Advocating for Girls' Education" contributed to increasing girls' enrollment from 49% in 1998–99 to 78% in 2008–09, reducing by half the gap with male enrollment (World Bank, 2013). Bangladesh' Female Secondary School Assistance Program, launched in 1993, "has provided tuition stipends aiming to increase girls' access to secondary education. In the past two decades, Bangladesh has experienced significant poverty reduction and profound social transformation with the widespread entry of girls into the education system and women into the labor force" (World Bank, 2013).

In Brazil, where benefits to boys and girls are monetarily equal, the educational conditionality has worked better for girls. Figure 9 shows a 20 percentage-point impact of *Bolsa Família* on girls' school enrollment at age 17 (with reference to the Brazilian Northeast region). (IFPRI/MDS, 2010) The program is less effective at slowing boys' dropout, as boys start early to help parents in the family's agricultural activities. In Brazil and Mexico, CCTs have contributed to inverting the educational gender gap.

Figure 9. Impact Evaluation of *Bolsa Família* on Children and Adolescents' School Enrollment in the Brazilian Northeast, 2008



Source: IFPRI/MDS (2010). Note: PBF = *Bolsa Família*

The programs of Mexico, Brazil, Jamaica and Peru have aimed to improve women's health by including health co-responsibilities for pregnant and lactating women. These require regular visits to health facilities for routine checkup and additional procedures depending on the evolution of pregnancy and delivery.

Some CCT programs further address gender imbalances by including specific activities focusing on building women's awareness of their rights and violence prevention (through educational information sessions in Mexico and Colombia), access to civil identification (in Brazil), and linking beneficiaries to employment training or income generation opportunities (Brazil and Mexico[28]) or childcare services (Mexico[29]).

[28] In Mexico, the CCT transfer was combined with productive capital from another program, *INDESOL/BID* for a group of rural beneficiaries (Espinosa, 2006).

[29] *Estancias Infantiles para Madres Trabajadoras*, a daycare service intended for mothers working or studying, is offered to the *Oportunidades* beneficiaries in some states only.

In theory, the combination of increased purchasing power and increased access to healthcare services could improve women's wellbeing. Cash transfers could improve the access to quality food and hygienic products, while access to healthcare could lead to early detection and treatment of existing health conditions. However, three main limitations remained:

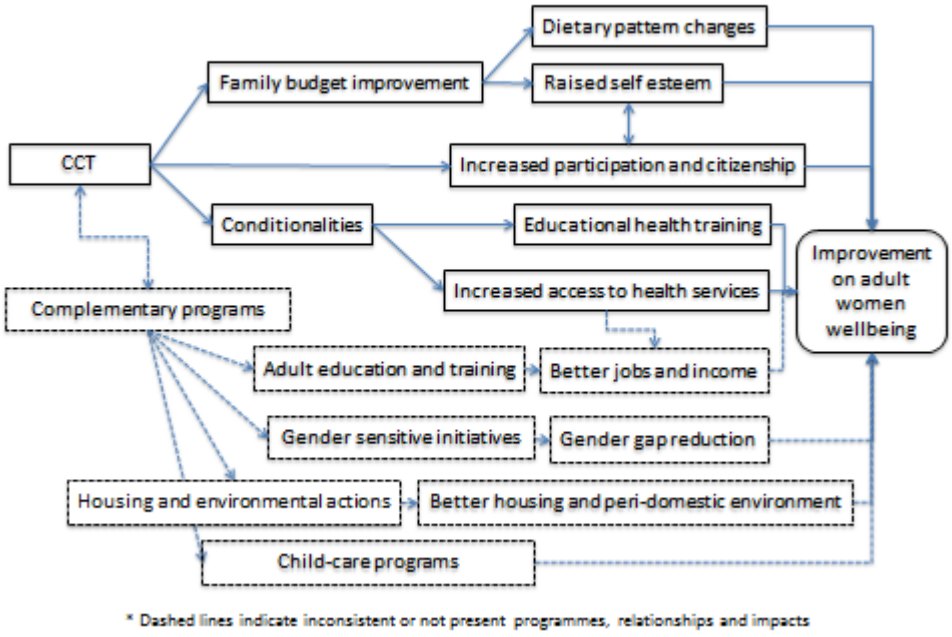
1. CCTs did not address the problem of unhealthy housing conditions. Females tend to be the household members charged with domestic duties, so this disproportionately affects females. Additionally, poor housing affects the health of pregnant women and newborns, and females tend to be the main caregivers in the household. Only in 2011 did Brazil begin a set of housing improvements and peridomestic environmental interventions focusing on *Bolsa Família* ultra-poor beneficiaries.
2. CCTs women health focus was limited to prenatal and postnatal care, which cover only a small fraction of women's life and potential health problems (only Mexico's *Oportunidades* extends health co-responsibilities to females of all ages). Furthermore, in many countries health co-responsibilities failed to evolve with the fast development of public health service provision (greater availability of a broader range of preventive and curative services addressing women's health needs, such as in Brazil and Colombia).
3. The quality of the health services remained highly heterogeneous.[30] The institutions responsible for CCTs paid little attention to the quality of the healthcare services provided to female beneficiaries.[31] This represents a lost opportunity, as women in general are the promoters of change within their families.

Overall, women's welfare is far more complex than access to transfers or healthcare during pregnancy, so figure 10 presents a comprehensive framework explaining the relationship between CCTs and complementary interventions focusing on women's wellbeing. It encompasses both implemented gender initiatives and those that LAC countries have failed to incorporate.

[30]For example, in many areas of operation of *Juntos* there is no or poor provision of public health services.

[31]In some cases, it is possible that program authorities were attempting to avoid political conflicts with the Ministry of Health.

Figure 10. Framework for Public Policy Interventions Focusing on Women's Wellbeing



In addition to the above mentioned limitations, some concern was raised that the payment of cash transfers to women could increase violence within the home over control of the additional financial resources. Although research in this area is scarce, partly due to the difficulty to obtain data, few studies find evidence of increased domestic violence (Arnold, Conway, and Greenslade, 2011). Also, other studies in LAC countries show that cash transfers decrease domestic psychological violence when women have education above primary schooling. However, for women with primary schooling or less, cash transfers can increase domestic psychological violence when the level of education of the woman is equal to or higher than her partner's (Hidroboa and Fernald, 2013).

Importantly, a recent stream of literature highlights that although most CCT beneficiaries are women, this does not mean that the programs are gender sensitive. Women were chosen as beneficiaries not in their own right, but as mothers of children. They became the operational beneficiaries of the transfers but were not entitled to the transfers as subjects, themselves, of the right to social protection. As such, CCT programs placed a considerable burden on beneficiary mothers, increasing their childcare responsibilities and reinforcing the traditional understanding that women are solely responsible for children's development. CCT programs *de facto* put women in charge of verifying that children complied with program conditionalities, without questioning the unequal subdivision of household labor, and preventing them from seeking personal development and economic independence. CCTs

reinforced gender-stereotyped roles and did nothing to include men in childrearing and domestic responsibilities (Molyneux, 2008; Rodriguez Enriquez, 2011). This effect may have perverse long-term impacts, such as leaving women without professional skills and no source of income once the children grow and the family stops qualifying for the payment of the transfer.

Moving forward, the challenge for both LAC and Asian countries is to design a new generation of CCT programs that address gender inequalities. The new programs would need to encourage shared responsibility for domestic and care work, develop incentive schemes that ease the pressure on women for complying with co-responsibilities, and link women with opportunities to acquire productive skills that broaden their role beyond that of caregivers.

6 Conclusions

This report attempted to harvest the analytical and operational knowledge collected in LAC during fifteen years of implementation of CCT programs. LAC provides the opportunity to observe an interesting mix of small and large low- and middle-income countries with different institutional structures. We studied the experience of LAC countries and extracted lessons for Asian countries that have more recently started or are currently considering the introduction of CCT programs.

CCT programs have become the backbone of LAC systems of social assistance. They enjoyed favorable political economy features, including the objective to break the intergenerational transmission of poverty through health care and education, and the incorporation of a contract with beneficiary households, with payments conditioned on compliance with predetermined co-responsibilities. They produced an unprecedented monitoring and evaluation effort, which demonstrated their effectiveness through rigorous studies. Additionally, they benefited from a period of sustained economic growth that amplified their poverty- (and inequality-) reduction effects while expanding the fiscal space for social protection. For these reasons, they grew in terms of both coverage and budgets, and survived electoral cycles (with new governments at most renaming, reforming, or expanding existing programs).

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. 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.

Program credibility and efficiency also require investment in customer service (to ensure that citizens find an answer to questions and complaints), audits (to reduce errors of inclusion and guarantee that resources are spent according to program rules), careful verification of beneficiaries' compliance with program co-responsibilities, and setup of efficient payment systems.

The successful coordination (synergy) with the actions of the ministries of education and health, and with local administrations, possibly constitutes the main challenge for the implementation of effective CCT programs. For this to happen, it is necessary that line

ministries and local governments perceive the program as an opportunity to achieve their own objectives, and are compensated for the additional burden that is generated by CCT-driven increases in demand.

We hope that the analysis of successful experiences and errors in LAC countries presented in this report feeds the policy debate in Asian countries, and improves their chances to set up effective and efficient CCT programs.

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