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## Zimbabwe's social protection system and its harmonized social cash transfer programme

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## **Zimbabwe's social protection system and its harmonized social cash transfer programme**

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# **ZIMBABWE'S SOCIAL PROTECTION SYSTEM AND ITS HARMONIZED SOCIAL CASH TRANSFER PROGRAMME**

Pedro Arruda<sup>1</sup>

## **1 INTRODUCTION**

Zimbabwe is a low-income, land-locked country in Southern Africa with an estimated population of 13,061,239 people, according to the latest census (ZIMSTAT 2012). Two thirds (67 per cent) of Zimbabweans live in rural areas, and 51.9 per cent of the total population are female (ibid.). Between 1996 and 2008, Zimbabwe experienced a systemic crisis with consecutive decreases in gross domestic product (GDP). The crisis generated an extremely high incidence of poverty (people living below the total consumption poverty line) and a deepening of food/extreme poverty (people living below the food poverty line).

Though data on poverty and vulnerability are scarce (e.g. the most recent Poverty Assessment Survey dates back to 2003), the 2016 Zimbabwe Millennium Development Goals Final Progress Report reported that in 2011-2012, 72.3 per cent of the population were living in poverty, and 22.5 per cent were food poor or extremely poor (MEPIP and UNDP 2015). The same report found that poverty was much more prevalent in rural areas (84.3 per cent) than urban areas (46.5 per cent), even though urban poverty seems to be growing at a faster pace (ibid.). The Government of Zimbabwe (2016) and Schubert (2012; 2010) found that an estimated 10 per cent of extremely poor/food poor and 5 per cent of poor people are labour-constrained. There is, however, no gender bias to poverty prevalence (Government of Zimbabwe 2016).

Key drivers of rural poverty include insufficient job opportunities, climate change, unpredictable agricultural seasons, and a lack of or low levels of education (ZIMSTAT 2013; MEPIP and UNDP 2015), whereas in urban areas additional factors include large family sizes and social fragmentation (*Temah-Tsafack* 2013). Migration and high dependency ratios of households, often related to HIV, are also relevant drivers of poverty.

The country is predominantly young, with 41 per cent of its population being 14 years old or under and 55 per cent of the population being of working age (15–64 years old). Two thirds (67 per cent) of people aged 15 or over participate in the labour force, and the overall

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unemployment rate is 11 per cent (ZIMSTAT 2012). Poverty and extreme poverty in Zimbabwe, however, are not limited to unemployed people, since most people work in agricultural activities that yield low and volatile incomes. The National Social Protection Policy Framework (NSPPF) notes that over 2 million people in rural areas (around 15 per cent of the total population of the country, and 22 per cent of the rural population) are food insecure and that child stunting is a severe problem that is becoming more prevalent. Between 2007 and 2011, for instance, the rate of stunting increased from 28.9 per cent to 32 per cent of children (Government of Zimbabwe 2016).

Household income for these populations is often not enough for them to afford a minimum basket of basic food and non-food items, especially in households with high dependency ratios. This is an unfortunate, but common, condition in the country due to the HIV/AIDS epidemics. High mortality and morbidity during the first decades of the epidemics subsequently left many orphans and widows to be cared for by older relatives (*ibid.*). Schubert (2010) notes that the high HIV and AIDS prevalence has led to decreasing life expectancy, has orphaned 25 per cent of Zimbabwean children and has resulted in many households with generational gaps.

From its inception, Zimbabwe's flagship unconditional cash transfer—the Harmonized Social Cash Transfer (HSCT)—was conceived of to address this particular form of vulnerability through an inclusive set of targets to reach out to food-poor and labour-constrained households with high dependency ratios: known proxies for households living with and affected by HIV.

The programme also privileges paying the benefits to female heads of households, and, even more relevant, the initiative includes in its name the goal of operating in harmony with other social protection initiatives. This integration was meant to occur through both efficient case management and referral support by social workers at the local level and a Management Information System (MIS) capable of integrating registries from many initiatives and automatically identifying eligible beneficiaries to enable service providers to reach out to them (Schubert 2010).

Both those goals were meant to benefit from the National Case Management System (NCMS), which was launched in 2010 (two years before the HSCT started paying benefits). This originally intended to promote integration among the many child-sensitive welfare and protective services provided by both the government and non-governmental organisations (NGOs). Up until 2016, however, the NCMS had not fully succeeded in integrating the many initiatives it was set to cover (Kang and UNICEF 2017). Hence, from the beginning the HSCT decided to operate on an MIS and a registry of its own—a decision that smoothed the basic operational routine of the programme but limited its capacity to harmonise with other initiatives.

This text intends to assess Zimbabwe's HSCT by first analysing relevant policy-level features of the country's social protection system. In this section it analyses important policy documents such as the National Action Plan for Orphans and Vulnerable Children (NAP OVC) I, II and III, in addition to the NSPPF and the NCMS. Following this policy-level analysis, the text presents the operational features of the HSCT in more detail. It starts by presenting the programme's institutional history and then presents its eligibility criteria and selection procedures, as well as discussing its payment operations and benefit formulae. After that, the text presents and briefly discusses some of the main findings of impact evaluations of the programme. The analysis presented here goes up to 2016.

The final section of the text endorses the need for structural measures already contemplated in the NSPPF (Government of Zimbabwe 2016) and in the NAP OVC III (MoPSLSW 2016). These include increasing the government's financial ownership and

integrating the databases of the different programmes. As for the HSCT more specifically, this text recommends a review of the benefit formulae, since the per capita ceiling of additional grants is below the average size of enrolled households.

## **2 RELEVANT POLICY-LEVEL FEATURES OF THE HSCT**

Zimbabwe's longest-standing policy document for social protection is the NAP OVC. Its first phase was enacted in 2004 and covered the period 2004–2010 (MoPSLSW 2008). In 2011, a second version of this document was published to cover the period 2011–2015 (MLSS 2010). In 2016, a third version of this document (covering the period 2016–2020) was released (MoPSLSW 2016), along with the publication of Zimbabwe's first NSPPF (Government of Zimbabwe 2016). The publication of the NSPPF was a landmark for structuring a broader social protection system, since the three NAP OVC have a somewhat narrow focus on protective services, social assistance and OVC and households with children and people living with HIV. Up until the publication of the NSPPF, the pillars of the social protection system—such as pensions and contributory insurance—were not fully covered by the key existing policy documents.

## **3 NAP OVC I, II AND III**

The main instrument for operationalising the goals of the NAP I was the Programme of Support (PoS). The PoS was a mechanism launched in 2006 to coordinate and scale up international financial support for the many welfare and protective initiatives under its umbrella. These would include initiatives run by both government and civil society. In line with the NAP I guidelines, such initiatives were mostly exclusive to OVC and HIV/AIDS, rather than inclusive of OVC and HIV/AIDS. This means they would narrowly target only children and OVCs, as opposed to targeting vulnerable groups more broadly. The NAP I and the PoS were not structured on any central initiative or programme. Rather, they consisted of a multiplicity of fragmented and often small-scale, small-coverage and small-budget initiatives with little linkage and coordination among them. A 2010 assessment of the PoS, commissioned by UNICEF (Jimat Development Consultants 2010), identified the following main challenges (Kang and UNICEF 2017):

- unclear targeting due to multiple different definitions of OVC
- fragmented services, resulting in a mean of (only) 1.6 types of support per child
- a focus on reach (number of children served), rather than the quality of the service provided
- ineffective coordination of decentralised services at provincial, district and ward levels due to the limited capacity of the Department of Social Services
- insufficient focus on learning and sharing good practice among all stakeholders
- delays in developing and sharing operations research materials, which did not inform PoS management
- limited capacity development for government structures
- overlooking poverty as a key driver of vulnerability in the NAP I.

This diagnosis led to structural changes between the NAP I and its successor, the NAP II. The most significant of these changes was a move away from targeting OVC and HIV/AIDS exclusively to tackling all relevant forms of vulnerability and poverty, including those not restricted to OVCs (yet arguably harder to endure for, and at times more prevalent among, this group). The second NAP also substituted its operational arm—the PoS—for a revamped coordination and funding mechanism, the Child Protection Fund (CPF). The CPF not only incorporated an inclusive approach but also went on to try to reduce the system's fragmentation and lack of comprehensiveness by structuring itself on two main pillars, as opposed to a myriad of small-scale, uncoordinated initiatives. These two main pillars were:

- the **NCMS**: a mechanism to enhance the programme's comprehensiveness by linking different initiatives, strengthening case management at all levels and providing a common register for welfare and child protection services; and
- a flagship cash transfer programme to tackle poverty and consumption insufficiency, including OVC and HIV/AIDS, while operating as an opportunity to provide referral services: the **HSCT**.

Compared to the NAP OVC II, the recently enacted NAP OVC III does not bring with it any major shifts in terms of goals and policies. Rather, its focus was on developing administrative mechanisms to improve its capacity to deliver the proposed outputs and outcomes.

The main shifts brought about by the NAP OVC III include the strategy of seeking a greater involvement of families for protecting and promoting children's well-being, in addition to the previous strategy of engaging community members in such activities. The document also calls for more preventive initiatives when it comes to child protection. It also aims at improving the professionalism of its social workers and case management teams. Particularly relevant is the document's call for increasing the HSCT's focus on households with children, since it notes that 19 per cent of the beneficiary households do not have children. Just like the NAP OVC II, the third version of the document is meant to be operationalised by the CPF, to be funded by both the government and development partners. The main difference between the CPF II and its previous version is that budgets are now meant to follow the guidelines of the Medium-Term Expenditure Framework, which is currently being rolled out (MoPSLSW 2016).

## 4 THE NSPPF

As for the recently launched NSPPF, it identifies some of the main challenges deemed to compromise social protection in Zimbabwe, such as:

- fragmented application of the instruments without a proper guiding structure;
- the inadequacy and exclusionary nature of available services;
- a lack of predictability, consistency, transparency and durability in most of the schemes;
- a lack of proper centralised coordination, leading to incoherent, sector-based implementation of social protection under various ministries such as the Ministry of Public Service, Labour and Social Welfare (MoPSLSW), the Ministry of Primary

and Secondary Education and the Ministry of Health and Child Care, which often creates bureaucratic, complex situations;

- a lack of mutually supportive and clear policy objectives, leading to disjointed approaches;
- a lack of awareness among people of what services they can access, their rights and entitlements;
- weak monitoring and evaluation systems;
- poor or no MIS; and
- the existence of various pieces of Zimbabwean laws and policy statements that may not be mutually supportive of each other.

Some of the main solutions advanced by the document to solve those problems include the creation of a single registry and a comprehensive and integrated MIS, as well as the development of a formal and innovative payment system. The document foresees a leading role for the MoPSLSW, which will coordinate many inter-ministerial groups for administering and monitoring social protection initiatives. The MoPSLSW is also responsible for the decentralised social support mechanism that serves many programmes, including the HSCT: the Province and District Social Services Offices. At the ward level, the MoPSLSW plays an enabling role to support the unpaid, volunteer-based Child Protection Committees (CPCs) that also play a key role in case management for the HSCT and other initiatives.

## **5 THE NCMS**

Launched as a PEPFAR-funded pilot in 2010, and subsequently scaled up nationally, this was meant to be a system for linking and promoting mutual awareness among the many government and civil society/NGO initiatives that provide child welfare and protective services so that they could refer cases to each other.

The NCMS started as a pilot in three wards in Umzingwane district, but was soon scaled up to reach 47 districts (with a total of 47 Case Management Officers and 9,365 Community Childcare Workers) in less than three years (Kang and UNICEF 2017). A 2013 assessment of the NCMS, which preceded an unsuccessful NCMS MIS pilot, noted that just a marginal number of the services provided were child protection (i.e. services to tackle child abuse, exploitation and neglect), while the majority of services were providing child welfare services, such as assisting children to access birth registration, health services and school, which are arguably less complex than managing child protection cases (Godwin and Matsika 2013).

A revamping exercise took place from 2014 onwards, along with the roll-out of an NCMS MIS in five districts. This exercise consisted mainly of promoting awareness of the need to provide child protective services among partner institutions and developing qualitative indicators capable of assessing the quality and nature of services provided (rather than merely counting coverage).

An additional challenge regarded statutory services that can only be delivered by the government, which, in many cases, has limited means (logistics and staff) to take action in



a timely manner. A solution was to mainstream the so-called 'buddy system'. These are arrangements whereby NGOs partner with government agencies to enable them to act in areas where NGOs have no authority (such as, for instance, providing transportation for government agents to go and enforce the law in cases of intra-household violence). By the end of 2015, these combined responses had already led to an increase in the number of child protection cases reported and recorded, though such services are still in the minority.

The strengthening of referral capacity under the NCMS follows two main paths. First, by developing case management capacity at district and ward level by strengthening the workforce through the introduction of Case Management Officers and Community Childcare Workers, respectively, to complement the government's public service workforce available to children and families. The second strategy consists of creating a case management MIS capable of integrating HSCT records to facilitate early detection and proactive interventions by child welfare and protection service providers from both governmental and non-governmental institutions (Kang and UNICEF 2017).

However, the HSCT programme ended up developing its own MIS, and the remaining initiatives under the NAP II and the CPF were left to operate using hard-copy records. By February 2014, an NCMS MIS pilot was put in place in five districts, but it not only failed to provide linkages with the HSCT MIS, it also presented compromising administrative shortcomings. The 2014 MIS pilot had little operational use and served more to gather data classifying the kind of child services provided than to actually help institutions gain knowledge on their peers and, therefore, refer cases accordingly. Children who received several different services were registered as different beneficiaries, while in other cases children who received multiple services would only have records for some of the services they received. Similarly, children referred from one partner institution to another would at times be recorded by both such institutions, therefore inflating the figures for coverage and service delivery. Service providers struggled to feed information into the system properly. This was due to bottlenecks of both the forms and the automated MIS, as well as a lack of training on parameters for feeding information (Kang and UNICEF 2017; Palladium Group 2016).

Building up these lessons, a new MIS pilot was launched in February 2017, covering six districts and designed to tackle the challenges that undermined the 2014 pilot initiative. The current approach defines the child (and not the case) as the unit of reference for the NCMS MIS.

## **6 THE HSCT PROGRAMME**

Conceived as a key initiative to operationalise the NAP II strategy, the HSCT is an unconditional cash transfer programme run by the MoPSLSW and officially launched in 2011, with its first payment occurring in February 2012 (Seidenfeld et al. 2016). In accordance with the NAC II, the HSCT was designed to generate the following core impacts by distributing grants varying from USD10 to USD25 per month (paid bimonthly) to food-poor households that are also labour-constrained (Schubert 2010):

- to strengthen the purchasing power in the form of unconditional cash transfers to 55,000 food-poor households which are also labour-constrained;
- to enable beneficiary households to refrain from risky coping strategies such as child labour and early marriage; and

- to increase the consumption of goods and services, hence leading to improved nutrition status, health and education and to reduced mortality, especially among children living in beneficiary households. The programme has a particular target of reducing HIV prevalence among people aged 15–24 years living in households that receive social cash transfer benefits.

## 7 INSTITUTIONAL HISTORY

The HSCT derives from conditional and unconditional cash transfer pilots that existed between 2009 and 2012 in the provinces of Mashonaland East and Manicaland. These pilots targeted poor households (the poorest 20 per cent, as estimated through a housing- and asset-based proxy means test—PMT) with orphans, that were child-headed or that contained people with disabilities or chronic illness. By 2011, it reached 4,083 households containing 12,155 OVC (CRS 2009; 2011; Nyamukapa 2016).

To some extent, the HSCT has evolved from previous cash transfer initiatives in the country, such as Zimbabwe's Emergency Cash Transfer (ZECT) programme, which delivered a four- to five-month benefit of a 50–50 mix of cash and food, between November 2009 and March 2010. The ZECT was a pilot run by Concern Worldwide and the World Food Programme (WFP). In 2009 it covered 19,564 persons in Gokwe North, Gokwe South and Nyanga districts, and in 2010 it expanded to an additional 20 wards, reaching 58,866 beneficiaries (Kardan, MacAusalan and Marimo 2010).

With the purpose of shifting from small-scale pilots to a national, large-scale programme, in 2010 a pilot census was undertaken in Ward 5 of Goromonzi district to assess the equity of potential eligibility criteria to be used by the national programme. The 2010 pilot census showed that a selection criterion aiming to cover labour-constrained and food-poor households would be capable of covering most categories of vulnerable people, such as OVC, households living with or affected by HIV/AIDS, people with disabilities, and child-, female- and elderly-headed households. It also showed that one such selection criterion could potentially have the merit of including such categories without exposing households, and without creating too many eligibility criteria that could make the programme's operation more complicated and compromise its legitimacy (Seidenfeld et al. 2016).

This exercise also served to generate estimates of the programme's target population. Combining data from the 2010 pilot census with extrapolated data from the latest Plan for Achieving Self-Support available at the time (2003), the ZimVAC Report 2010 and the National Nutrition Survey 2010, Schubert (2010) estimated that some 250,000 households (totalling approximately 750,000 children) would fit the programme's eligibility criteria nationwide. Due to budgetary and operational limitations, however, the programme was not meant to enroll all its target population at once. Rather, it was set to cover 55,000 households within the first three years, through a gradual expansion set to cover the poorest district of each of the 10 provinces every year for the first three years. All eligible households in covered districts were meant to be enrolled, with the expectation of covering 24,000 households in the first year, 24,000 households in the second year and the remaining 7,000 households in the third year (*ibid.*).

Though the first year (2012) managed to meet the goal of covering the poorest district of each of the 10 provinces, the second year (2013) only managed to include six additional districts. The third year (2014) only included four additional districts. In terms of the number

of households, coverage was also below the goals for the first two years. But, by the end of the third year, it succeeded in reaching the goal of covering 55,000 households. Between 2014 and 2015 (the latest year for which data on coverage were found), however, there was no expansion of programme coverage, either in terms of districts or in terms of households (Seidenfeld et al. 2016).

The programme was meant to be funded by donors and the government on a 50–50 basis, but despite the government committing budgetary allocations since 2012, actual releases of funds have always been very low. In 2014, for instance, the government budgeted USD3 million to the programme, but only 10 per cent of this value was actually disbursed (ibid.).

## 8 ELIGIBILITY CRITERIA AND SELECTION PROCESS

As mentioned above, the programme aims to cover households that are both food poor and labour-constrained. Labour-constrained households are defined as follows (ibid.):

- Those with no able-bodied, fit-for-work household member in the age group 18–59
- Those with a dependency ratio of over three dependents per able-bodied, fit-for-work household member
- Those with a dependency ratio between two and three when there is at least one household member with a severe disability or chronic illness who requires intensive care.

Food poverty is estimated through a PMT. Up until 2014, the PMT operated in such a way that households matching three of the poverty indicators collected by Form 1 (completed only by pre-selected households) would already qualify as eligible. From 2014 onwards, the PMT was altered so that households had to match at least five of the poverty indicators collected by Form 1 to be considered food poor (Seidenfeld et al. 2016).

The process for selecting beneficiaries consists of a census in districts covered by the HSCT to identify a first set of potentially eligible households. This is based on a reduced set of information collected through Form 0. Following this census, a second survey team revisits the potentially eligible households and collects a larger set of information through Form 1, while also taking the opportunity to verify whether the previously declared housing and demographic information matches the reality. Form 1 collects slightly different information for urban and rural households. This information is sent to the MoPSLSW's headquarters, where it is digitised and used to run the PMT. The collection of information for both forms is meant to be undertaken by private companies or civil society organisations to be hired and monitored by the District Social Service Officers (DSSOs) (Schubert 2010), though Seidenfeld et al. (2016) point out that ZIMSTAT often undertakes this work.

The PMT results allow the HSCT MIS to flag a list of households to be enrolled in the programme. This list is sent to DSSOs, who are meant to check a random sample of forms to validate the consistency of the PMT. In addition, since 2013, the list automatically generated by the PMT has been subjected to community verification. The community cannot alter the PMT list *per se*, but it can point to incorrect or missing information on certain households so that their PMTs can be recalculated based on a more accurately filled Form 1 (Seidenfeld et al. 2016).

Retargeting is meant to take place every two years; in between, households that undergo structural changes (mostly due to death or divorce of a family member) should go through the same selection process to see if they still meet the eligibility criteria. In reality, however, retargeting has not been taking place with that frequency.

## **9 PAYMENT**

The HSCT consists of a variable benefit with grants increasing per capita up to a maximum of four persons per household. Benefits start at USD10 per month, and increase by USD5 per person up to a maximum of four persons per household (hence the maximum grant a household can receive is USD25) (Schubert 2010). Payments are preferably disbursed to female heads of households. This benefit formula was chosen using the WFP and the Public Works Programme benchmark of yielding an average of USD20 per month per household (Seidenfeld et al. 2016).

The payment operations take place every other month, because it takes a logistical effort to gather all beneficiaries at pay-points and distribute the benefits with the support of private security companies and under the supervision of DSSOs and CPCs. CPCs play the role of gathering beneficiaries and ensuring that they are paid the right amount, while also providing sensitive information to beneficiaries at the pay-points. Since 2014, some districts have started piloting forms of electronic payment (*ibid.*).

Besides the cash grant, the HSCT also aims to promote the provision of social assistance and child protection services, hence the ‘Harmonized’ in the programme’s name. As already seen, however, the strategy of promoting these services through an automated system that flags HSCT beneficiaries that could benefit from other initiatives, and vice versa, is not yet functional, since the HSCT MIS and the NCMS MIS are separate.

## **10 IMPACT EVALUATION FINDINGS**

The trajectory of cash transfer initiatives in Zimbabwe is marked by several impact evaluations, impact assessments and process evaluation studies. The conditional and unconditional pilots that took place in Mashonaland East and Manicaland, for instance, have been evaluated (through a randomised controlled trial) for their impacts on children’s health and development, as well as in terms of the social perceptions of its processes. This revealed that the programme had desirable impacts on birth registration, vaccination, school attendance and school materials such as uniforms. Impacts on birth registration and school attendance among children aged 13–17 years were stronger for the conditioned cash transfers, whereas the impact on vaccination was similar across both groups, as neither of them significantly increased the proportion of children with a complete vaccination record (Robertson et al. 2013; Nyamukapa 2016). The process evaluation demonstrated that the categorical criteria for selecting beneficiaries are too narrow and lead to the perception that other equally vulnerable people were unduly left out of the programme (Schubert 2011). This influenced the government’s decision to roll out the HSCT using broader selection criteria to cover food-poor, labour-constrained households.

Interestingly, the impact evaluation of these pilots used, among other sources, data from the Manicaland HIV/STD Prevention Project. But despite the declared goal of engaging cash transfer initiatives in the fight against HIV, the impact evaluation of these pilots has not taken advantage of HIV-related information that could have been extracted from the Manicaland HIV/STD Prevention Project database. Hence, it did not assess the programme's impacts on prevalence, access to HIV services or the population's overall knowledge, attitudes and practices.

The ZECT was subjected to a qualitative impact assessment through focus group interviews. Its final results were published in 2010 by Oxford Policy Management, Concern Worldwide and the WFP (Kardan, MacAusalan, and Marimo 2010). The overall findings suggested that beneficiaries were able to purchase goods they needed, even if not always at local markets. Consumption increases were sharper among labour-constrained households; in most families, consumption did not increase much, but they did see a substantial reduction in child labour (*maricho*). There was a positive effect on education and health expenditures, though smaller than the impact observed for food expenditures. Desirable impacts were also found for intra-household relations, whereas the programme had overall negative impacts on community relations, raising social tensions exacerbated by the targeting process. The study, however, did not assess any impact or potential impact on HIV.

The HSCT programme was subjected to a process review (Handa and Seidenfeld 2014) and a 12-month randomised controlled trial impact evaluation (AIR 2014) that compared households from districts covered in the second phase of the programme against those from districts which were expected to be covered by the programme in its fourth phase. It measured impacts in the areas and sub-areas listed in Table 1. This table presents variables used as proxies for measuring impacts in each area and sub-area assessed by the study, as well as the impacts measured for each of them. Cells marked in green highlight variables where desirable and statistically significant impacts were found for the general sample. Those marked in red denote areas where statistically significant undesirable impacts were found. The remaining cells, without a colour, indicate areas where the programme was not found to have significant impacts for the general sample (though in many cases there were impacts for specific subgroups).

TABLE 1

**Summary of findings from the HSCT impact evaluation**

0	Sub-area	Dependent Variable	Program Impact
RESILIENCY (ASSETS, LIVELIHOOD AND RISK COPING)	Percentage of households raising or owning livestock	Calf	-1.73
		Ox	-1.2
		Cattle Adult Female	0.22
		Goats	9.10**
		Chickens	4.55
		Donkeys, Mule	2.36
		Sheep	-0.54
	Number of Livestock owned	Calf	-0.05
		Ox	-0.07
		Cattle Adult Female	-0.01
		Goats	0.17
		Chickens	0.26
		Donkeys, Mule	0.06
		Sheep	-0.01
	Proportion owning agricultural assets	Hoe	-0.94
		Axe	2.1
		Panga machete	4.73
		Sickle	10.06**
		Watering Can	-1.64
		Chains	2.45
		Yokes	3.38
		Ox Plough	-0.11
		Chicken House	2.63
	Ownership of productive assets (number)	Hoe	0.22
		Axe	0.07
		Panga machete	0.04
		Sickle	0.13**
		Watering Can	0.07
		Chains	0.02
		Yokes	0.08
		Ox Plough	0.01
	Impacts of HSCT on Crop Production	Chicken House	0.03
		Total harvested (kgs)	-120.36
		Log of total harvested	-0.54*
		HH harvested maize	-0.01
		HH harvested sorghum	-0.05
		HH harvested groundnut	0.07**
		Millet	0.05
		HH harvested roundnut	0.05**
	Impacts of HSCT on Non-farm enterprise (NFE)	HH harvested cowpeas	-0.01
		NFE	0.05**
		Own NFE asset	-0.04
		Log value of assets (if own)	-1.08
	Impacts of HSCT on Transfers	Rec'd gifts of cash/food	0.08
		Value cash+food (if received)	-24.58
		Rec'd programmes	-0.04
		Value received	21.93
		Rec'd BEAM	-0.03
		Rec'd labour or ag. Tools	0.03
		Sent cash or food	0.03
		Value of food/cash given (if sent)	-47.38
		Offered labour/tools	0
	Impacts of HSCT on Debt: With Panel Weights	Have loan prior to April 2012	0
		Amount of old loan outstanding (if have) (\$)	-17.29
		Taking loan L12 months	-0.01
		Amount current loan (\$)	-10.74
		Taken credit L12 months	0.07
		Amount of credit outstanding	-17.19**
	Experience of any shock: With Panel Weights	Any shock	-0.06
		Shock from high food prices	-0.03
		Shock of inability to pay loan	-0.03*



Area	Sub-area	Dependent Variable	Program Impact
POVERTY, FOOD SECURITY AND WELL-BEING	Monthly consumer expenditure per person	Total	2.74**
		Food	1.56
		Household items	0.26
		Education	0.08
		Health and Hygiene	0.37
		Transport & Communications	0.46**
		Clothing items	-0.01
		Alcohol & Tobacco	-0.01
	Poverty	Headcount - Total Poverty Line	0.00
		Headcount - Food Poverty Line	0.02
		Poverty Gap	0.00
		Squared Poverty Gap	0.00
	Food Security	HFIA scale	-0.11
		Severely food insecure (%)	0.07
		Moderately food insecure (%)	-0.06
		Mildly food insecure (%)	-0.02
		Food secure (%)	0.02*
		Diet Diversity Score	0.70**
	Diet Diversity	Cereals	0
		Roots and Tubers	0.04
		Vegetables	0
		Fruits	0.25**
		Meat	-0.02
		Eggs	-0.03
		Fish	0.01
		Pulses & Legumes	0.13***
		Dairy	0.08**
		Fats	0.11**
		Sweets	0.11***
		Misc. (condiments and beverages)	0.03**
		Subjective Well-being (SWL)	1.13**
		Likely to have food shortage in next year	-0.05
		Likely to seek financial help in next year	-0.02
		Likely to fall ill next year	-0.03
	Well-being		
	Sub-area	Dependent Variable	Program Impact
HEALTH AND MATERIAL WELL-BEING OF CHILDREN	Impacts on Health	Chronically ill	0
		Chronically ill people receiving Home Based Care	0.01
		Chronically ill people receiving some kind of care	0.09
		People with disability	0
		Disabled population receiving care	-0.12**
		Morbidity (if sick/ injured in last 30 days)	0
		Sick/ injured people who sought curative care	-0.02
		Sick/ injured people who spent \$ for treatment	-0.04
	Impacts on Health of Children 0-5 years of age	Children who had diarrhoea/fever/cough in last two weeks	0.15***
		Children who sought care for diarrhoea/fever/cough	-0.18**
		Children who have health card	0.03
	Impacts on Anthropometric outcomes, Aged 0-6 months at Baseline	Z-score weight/age	-0.25
		Z-score height/age	-0.05
		Z-score weight/height	-0.26
		< -2 height/age	0.3
		< -2 weight/height	0
		< -2 weight/age	-0.01
		< -3 height/ age	-0.02
		< -3 weight/age	0.03



Area	Sub-area	Dependent Variable	Program Impact
ADOLESCENTS	Risky sexual behaviours	Ever pregnant females aged 12-20 at baseline	-0.01
		Marriage and Co-habitation among adolescents aged 12-20 at baseline	-0.02*
		Sexual Debut among adolescents aged 12-20 at baseline	-0.13***
		Lifetime transactional sex among adolescents aged 13-20 at baseline	0.01
		Adolescents aged 13 to 20 at baseline who ever experienced forced sex	-0.03**
		Adolescents who ever drank alcohol	0
	Impacts on Characteristics of Adolescent Recent Sex, Aged 13 to 20 at baseline	Age first sex	0.23
		First sex consensual	0.02
		First sex - condom used at first sex	0.27**
		Partner age at first sex	0.89
		Unprotected sex, last 3 months	0.49
		Number sex acts, last 3 months	5.06
		Number partners, last 12 months	0.07
		Age of most recent partner	1.71
	Impacts on adolescents Mental Health, Aged 13 to 20 at baseline	CES-D	0.85
		Not depressed	-0.05
		Hope scale	0.3
	Impacts on HIV Testing and Self-Perceived HIV risk, Aged 13 to 20 at baseline	HIV test-lifetime	-0.19***
		Self-preceived HIV risk Moderate/ High	-0.03
		HIV test, last 12 months	-0.09*
		Received HIV results	0
	Impacts on Adolescent 12-Month Reports of Physical Violence, Aged 13 to 20 at baseline	Experienced physical violence, last 12 months	0.16**
		Threatened with knife/ gun, last 12 months	0.01
		Punched/ kicked, last 12 months	0.07
		Slepped/pushed, last 12 months	0.16**
		Experienced severe physical violence, last 12 months	0.09
	Sub-area	Dependent Variable	Program Impact
CHILD EDUCATION AND LABOUR	Impacts on Enrollment and Grade Progression	Enrollment in primary	0.01
		Enrollment in secondary	0.03
		Grade progression primary	0.01
		Grade progression secondary	-0.02
	BEAM Scholarships	Received BEAM primary	0
		Received BEAM secondary	-0.06**
	Impacts on Education School Attendance: Using Full Sample Weights	Primary Attendance	-0.04
		Secondary Attendance	-0.07**
	Impacts on Child Labour	Individual in maricho labour last year	-0.03
		Days of work in maricho labour last year	2.03
		Individual in wage employment last year	0
	Impacts on Child Labour and Children Time Use by Genre: Using Full Sample Weights	Individual was engaged in domestic chores yesterday	-0.07
		Hours employed for all domestic chores yesterday	-0.21
		Individual involved in any farming activities last rainy season	-0.04
		Days worked in farming activities last rainy season	-2.6

Source: Author's elaboration based on AIR (2014).

The most positive impacts were found for small households with less than five persons. This is because the benefit formula only yielded additional benefits per capita for up to a maximum of four people per household. Families with more members than this, therefore, receive a smaller per capita benefit, which subsequently yields lower impacts or no impact at all. This is worrying, as the median size of households benefiting from the programme is five persons.

Overall, the programme was not found to increase permanent income, or at least that was not captured after only six payments. The money received by beneficiaries, however, was primarily used to pay debts and to invest in productive assets. As a result, the programme



had no impacts on any poverty indicator (i.e. poverty headcount, poverty gap and squared poverty gap). The only exception was the positive impact it had in reducing the prevalence of food poverty for households with four members or fewer.

Unlike poverty and food security, the programme had desirable impacts for diet diversity and subjective well-being among all sub-samples. There were also desirable impacts enabling more households to own livestock, though households that already had some livestock did not seem to have managed to increase the quantity of livestock they owned. This is different, for instance, from the ownership of sickles, which became more prevalent among all beneficiaries and also available in larger quantities.

The overall quantity of crops produced decreased slightly but significantly, which seems to be due to a shift from heavier crops, such as maize, sorghum and groundnuts. The impacts on *non-farm enterprise*—found for all sizes of household—were limited to an increase in the number of households engaging in such activities, but there was no increase in the productivity of *non-farm enterprise per se*.

A very interesting finding was that on the impacts of the HSCT on other transfers. In general, there were no statistically significant impacts, but small households were found to receive less assistance—specifically, less assistance from the Basic Education Assistance Module (BEAM) programme. This corroborates a similar finding from qualitative evaluation studies that portrayed a predisposition of social workers to distribute social programmes among community members, as opposed to concentrating one basket of services on the group deemed to be most vulnerable according to the HSCT targeting methodology (Handa and Seidenfeld 2014). This ‘misleading’ operational shortcoming might also be the reason for the HSCT’s negative impact on the provision of health care to people with disabilities and to large households with children under the age of five. Although there is no evidence of health care workers denying services to HSCT beneficiaries, it is possible that they receive less proactive referral support, which social workers might be offering more to non-HSCT beneficiaries, under the false pretense that HSCT beneficiaries are already better off and that, therefore, other protective opportunities should be preferably offered to non-HSCT beneficiaries.

The care-seeking behaviour of people with chronic illness (who represent around 8 per cent of the beneficiaries), however, has improved significantly, and so has this group’s actual access to health care (including home-based care).

In terms of health-related outputs, desirable impacts of the programme on health and child well-being were only noticeable for sub-groups such as small and labour-constrained households. There were no impacts on the three usual anthropometric indicators for children (i.e. stunting, wasting and underweight), even if stratifying by household size.

The only indicators on child education that were affected positively by the HSCT were school enrolment for boys and grade progression for children from small households. Corroborating the findings for the HSCT’s effects on other transfers, there was a worrying, statistically significant undesirable impact on access to BEAM scholarships. Analysis of the educational situation of treated and control groups at baseline suggests that this negative effect might be a consequence of the lower level of access of the treated group to this scholarship at baseline, as opposed to already high levels of access by the treated groups at baseline. The overall high levels of primary education indicators of the treated group, as opposed to overall low indicators observed for the control group at baseline, might also explain the lack of impacts over those areas by midline.

Another worrying finding is that the programme has a statistically significant undesirable impact on secondary education attendance by small households covered by the HSCT. This is probably related to the negative impacts of the HSCT on access to BEAM scholarships.

A positive finding was that the programme has not caused any sort of increase in child labour. Indeed, it led to a statistically significant reduction in the number of days worked in farming activities during the previous rainy season by girls and by children from smaller households, as well as to a reduction in *maricho* labour among larger households.

Interestingly, the study measured impacts on many adolescent behaviours, including several relevant input indicators associated with HIV, such as present and past risky sexual behaviours, access to voluntary counselling and testing, and exposure to violence and mental illness. Though the study found desirable and statistically significant impacts in terms of delaying marriage and sexual debut, reducing exposure to forced sex and increasing condom usage, it also found negative and statistically significant impacts on the current and lifetime reports of ever testing for HIV, as well as an increase in exposure to physical violence in the preceding 12 months.

UNICEF Zimbabwe's stakeholders, however, advised caution on the interpretation of the findings for the youth module of the impact evaluation, even when there were statistically significant impacts. Unpublished secondary analysis of those findings made by Innocenti at the request of UNICEF Zimbabwe question the quality of the data for this specific module of the impact evaluation, and it discourages trend analysis and suggests totally discarding the findings for forced sex between the baseline and the midline.

## 11 CONCLUDING REMARKS

Since 2010, Zimbabwe has been building up an NCMS that is meant to integrate the records of the many child care and protection initiatives available in the country. This system is expected to automate the matching between the services available and potential beneficiaries. Such an improvement would be a major support to case management at the local level, since there are a great many small-scale, fragmented initiatives. The automation of records, however, has not yet been developed to an extent that it can actually enable matching, though a pilot started in February 2017 is expected to promote great advances in that area. Nevertheless, up to now the NCMS has enabled the training and institutional strengthening of health and social workers at the local level, capacitating them to improve case management even without the support of a fully functional MIS.

A major shortcoming is that the NCMS is not integrated with the other main component of the social protection system of Zimbabwe: the HSCT. Both the NCMS and the HSCT were conceived of as instrumental pillars of the country's social protection system, but they have not yet been integrated with each other. Hence, each of the initiatives has its own MIS (with the NCMS counting only on a pilot MIS with coverage limited to six districts), and there is low convergence of coverage between the HSCT and the initiatives under the NCMS umbrella.

The HSCT is derived from previous cash transfer pilot experiences dating back to 2009. Unlike its predecessors, however, the HSCT (launched in 2011 and delivering payments since 2012) chose to define its eligibility criteria to cover households with high dependency

ratios rather than nominally defining a vast number of household characteristics deemed to signify vulnerability (i.e. child-headed, widow-headed, elderly-headed, with OVC, people with disabilities and/or chronic illness etc.). This was found not only to simplify the programme and increase its legitimacy but also to work equally efficiently to cover these categories and, particularly, to cover households living with, affected by or vulnerable to HIV, including households with OVC.

In addition to the lack of integration between the NCMS and the HSCT MIS, assessments of the 2014 NCMS MIS pilot found problems limiting its operational use. Some NCMS stakeholders declared perceiving it more as an additional task (that of duplicating information already existent in hard copy) than as an enabler capable of simplifying their daily routines. And even the use of the 2014 NCMS MIS pilot for monitoring purposes was not without problems, since there were unclear parameters for entering information into the system. Nevertheless, recent conversations with UNICEF stakeholders indicate that the 2017 NCMS MIS pilot was designed to avoid such problems.

The programmes under the NCMS umbrella also present a bias towards delivering child welfare services, rather than protective services. This is partially due to the lack of a mandate from NGOs to undertake certain juridical and law enforcement roles. There have been efforts to mitigate this by both encouraging partners to provide more child protection services and stimulating the so-called 'buddy system'. This system enables NGOs to provide government institutions with the logistical support and technical backstopping to undertake statutory functions in cases of child abuse, exploitation etc.

The HSCT MIS fulfils its basic role of automatically processing and presenting the scores of the PMT and the categorical verification results, flagging households to be enrolled in the programme accordingly. It also enables basic monitoring of coverage and payment disbursements. It fails, however, to integrate with other social registries that could automate the flagging of beneficiaries of other services entitled to the HSCT benefit, and vice versa.

In light of these challenges, it would be advisable for the HSCT to at least harmonise its administrative records with those of the BEAM and the Assisted Medical Treatment Order (AMTO). This is because HSCT beneficiaries are also meant to benefit from these other initiatives. Such integration is all the more pressing if one recalls that the HSCT impact evaluation study revealed that HSCT beneficiaries are systematically excluded from the BEAM, as social workers have a predisposition to distribute programmes among as many community households as they can, rather than concentrate them among those households deemed by the HSCT targeting methodology to be most in need. In addition, the BEAM and AMTO are also government-led, large-scale programmes which would be much easier to manage than, for instance, a large set of different and fragmented initiatives such as those under the NCMS.

Finally, the HSCT should also consider increasing the value of its benefit, since most households have more than five members, therefore rendering the current benefit per capita too small to reduce the poverty gap as intended by the programme goal.

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