A brief history of Zambia's
Social Cash Transfer Programme

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1 Introduction

Zambia is a lower-middle-income nation in Southern Africa, with a population estimated at 15.5 million people in 2015. Over half (58.2 per cent) of its population is located in rural areas, often at low density and following sparse patterns of territorial occupation that accentuate challenges related to access to public services and markets. In terms of food consumption, 54.4 per cent of the country is living below the poverty line, with 13.6 per cent living below the extreme poverty line (CSO 2015). The country's flagship government-run social protection programme established to tackle this problem is the Social Cash Transfer (SCT), an unconditioned cash transfer programme.

The SCT has undergone several design changes since its inception in 2003, and this Policy Research Brief provides a brief overview of those changes in terms of the programme's targeting, benefit structure and governance, and the findings of impact evaluations between 2003 and 2016.

Since its creation, the programme has had three very different formats. Initially, between 2003 and 2010, it comprised five pilots with limited connections among them. The design followed the **ultra-poor approach** (also known as the 10 per cent inclusive model or IM), since it aimed to cover the poorest 10 per cent of the population of the districts served.

Subsequently, between 2010 and 2014, the programme had two different streams, each with different characteristics. One of them, called the **Child Grant** (CG), specifically aimed to benefit households with children, whereas the **Multiple Category Transfer Grant** (MCTG) targeted other forms of vulnerability.

Finally, since 2014 the programme has been operating in a third format, known as **harmonised targeting** because it has established a single selection criterion (households with high dependency ratios) with the aim of reaching out to different sorts of vulnerable households.

This Policy Research Brief starts by discussing the differences in the targeting mechanisms and coverage figures of the programme's three stages. The following section discusses how the benefit structures have varied in the three stages of the SCT, and then there is a discussion of the different governance structures at each stage. Next follows an analysis of the findings of impact evaluations for the stages of the SCT that have been subjected to evaluation (i.e. the ultra-poor model between 2003 and 2010 and the CG and MCTG models between 2010 and 2014). Finally, the text concludes by summing up the core differences due to modifications of the programme's design that characterised its three stages, and also by analysing the extent to which impact evaluations and other forms of assessment might have contributed to changes in its design over the years.

2 Targeting and coverage

The first format of the SCT, used between 2003 and 2010, had a targeting goal of covering the poorest 10 per cent of people in the districts in which it operated. At that time, beneficiary households were selected solely through community-based selection mechanisms, whereby community organisations ranked households in terms of their poverty level, albeit without any objective or standardised criteria to actually measure poverty levels (Habasonda 2009; Chiwele 2010). The sole exception to this methodology was the Katete pilot, which targeted elderly people and worked somewhat as a universal pension scheme (Habasonda 2009).

For the Kalomo, Kazungula, Chipata and Monze pilots, the sole benchmark guiding social workers to select the poorest households was a call to prioritise the enrolment of 'destitute' and 'incapacitated' or 'labour-constrained households'. Although many policy and programme documents illustrated these conditions by listing several situations that would meet these criteria,[2] these lists were not exhaustive nor ranked the many situations in terms of which were the most pressing or took greater precedence in terms of eligibility for the programme (Garcia and Moore 2012; Hamonga 2006; Permanent Mission of the Republic of Zambia in Geneva 2009).

As mentioned above, between 2003 and 2010 the SCT was not a consistent and homogeneous programme with country-wide coverage. Rather, it comprised five pilots. Indeed, in a sense, that stage could even be seen as some sort of pre-history of the SCT (i.e. a stage marked by pilots that led to the institutionalisation of the SCT at a later stage).

The districts in which pilots were implemented were chosen based on political considerations, the interest of donors and the imperative of experimenting in different contexts—from extremely difficult-to-reach rural areas, such as the Kazungula district, to urban contexts, such as Chipata, passing through predominantly rural areas such as those of Kalomo, Monze and Katete (Garcia and Moore 2012). The first district to receive the intervention, in 2003, was the Kalomo district. Between 2005 and 2007 the SCT was expanded to four other districts: Kazungula (2005), Chipata (2006), Monze (2007) and Katete (2007) (Garcia and Moore 2012; Michelo 2015; van Ufford et al. 2016; Monteiro Costa, Gyoeri, and Soares 2016; Habasonda 2009; Chiwele 2010; Tembo et al. 2014; Chimai and Mulenga 2014).

A 2009 report by the Permanent Mission of the Republic of Zambia in Geneva to the Office of the High Commissioner provides official figures on the coverage of these pilots just before the SCT started its second stage, with different targeting and selection mechanisms used from 2010 to 2014. According to this source, the five pilots covered a total of 7,337 households and another 4,580 individuals. Because the Kalomo, Kazungula, Chipata and Monze pilots targeted households, and not individuals, their coverage figures are presented in terms of households. The Katete pilot, however, targeted individuals; hence, its coverage figures are presented in terms of individuals. The pilot in Kalomo covered 3,573 households, in Monze covered 1,900, in Chipata covered 1,190, and in Kazungula covered 674.

From 2010 to 2014, however, the SCT acquired both more scale and institutional strength, as its spread across the country's districts was meant to standardise its operations (as opposed to the pilots, which were purposefully set up to operate with certain differences to find out which arrangement would work best). Between 2010 and 2014 the programme's targeting was subdivided into two streams: the CG and the MCTG.

The CG aimed to enrol all households with children under 5 years old, starting with districts with the highest child mortality rates (Shagbom'bo, Kalabo, Kaputa, Zambezi and Milenge). The MCTG aimed to enrol all extremely poor households with elderly people and orphans, or widows and orphans, as well as those with members with disabilities, starting with districts chosen among the poorest ones (Zambezi, Serenje and Luwingo). It would not be, however, until the next stage of the programme, from 2014 onwards, that it would count on an objective way to estimate poverty. Between 2010 and 2014 that particular aspect was determined solely by the impression of social workers and community members involved in the selection process, even though their matching with the categorical criteria was subjected to more objective validation (van Ufford et al. 2016).

By 2014 the CG stream of the SCT had reached 28,000 households, 94 per cent of which were living below the extreme poverty line prior to receiving the programme (at that time,

extreme rural poverty was at 74 per cent). As for the MCTG, by 2014 it had reached 17,700 households, 95 per cent of which were living below the extreme poverty line prior to receiving the programme (MCDSW and AIR 2016a; AIR 2016a; MCDSW and AIR 2016b; AIR 2016b).

The third and current stage of the SCT, which started in 2014, was marked by the decision to keep those beneficiaries previously enrolled through the CG and MCTG selection criteria, though new beneficiaries would have to be selected through a new targeting method. Known as harmonised targeting, this consisted of targeting extremely poor households with dependency ratios equal to or greater than three. This solution was perceived as a way to reach out to the poorest population being omitted by the previous targeting methods, while ensuring programme enrolment for many beneficiaries who would previously have been selected either by the CG or the MCTG. The new targeting method was not only meant to render the programme more progressive, but it also had the potential to make its administration easier by no longer having to operate a programme with two different targeting and selection processes (van Ufford et al. 2016).

In this way, since 2014 the SCT has expanded its coverage by targeting extremely poor households considered labour-constrained due to not having any members who are fit to work, or by having dependency ratios equal to or greater than three (dependent members include those younger than 19, those older than 64 and those aged 19–64 with a chronic illness or disability). The current model is set to gradually cover all districts of Zambia, starting with the poorest ones (with the highest poverty ratios) according to the 2010 Living Conditions Monitoring Survey (ibid.).

Another innovation is that, since 2014, the SCT has incorporated a proxy means test (PMT) in its selection process; therefore, a household's poverty level is no longer solely decided by the impressions of community workers and social assistants. Rather, families have been ranked according to poverty scores based on a form that collects information on their socio-demographic characteristics and living conditions. This does not mean that community and social workers' impressions and deliberations are no longer part of the selection process, since they still play a fundamental role in screening households to be ranked by the PMT, and even in requesting reviews of cases they consider incorrectly assessed. According to the Ministry of Community Development and Social Welfare (MCDSW 2015), the selection process since 2014 can be described as follows:

a. Volunteer social workers in the community (members of the Community Welfare Assistance Committee—CWAC), with the support of local leaders, identify households that meet the first two eligibility criteria: i) residency; and ii) incapacity/labour constraint.

b. Designated interviewers, mostly teachers, known as enumerators, visit households identified in the first stage to collect more information about them.

c. The information collected from households during enumeration (stage 2) is entered into the SCT Management and Information System (MIS) to produce a list of eligible

households limited to the 15 per cent with the highest vulnerability scores in the PMT.

d. The list of eligible households generated by the MIS is shared with the community, allowing community members to propose removing better-off households from the list

(leading to a final list of beneficiaries covering 10 per cent of the area's population).

e. Selected households are notified and provided with information about the operation of the programme and their entitlements.

TABLE 1
Targeting and selection process of the SCT over its three stages, disaggregated by specific pilot (for the first stage) or programme stream (for the second stage)

Stage 1 (2003-2010)			
Pilot or stream (year of launch)	**District level targeting**	**Household-/individual-level targeting**	**Selection process**
Kalomo (2003)	District chosen politically, with influence of donors and the goal of experimenting in different local contexts	Destitute and incapacitated/labour-constrained households	Social workers and community volunteers deliberate about those perceived to be the most destitute and incapacitated
Kazungula (2005)	District chosen politically, with influence of donors and the goal of experimenting in different local contexts	Destitute and incapacitated/labour-constrained households	Social workers and community volunteers deliberate about those perceived to be the most destitute and incapacitated
Chipata (2006)	District chosen politically, with influence of donors and the goal of experimenting in different local contexts	Destitute and incapacitated/labour-constrained households	Social workers and community volunteers deliberate about those perceived to be the most destitute and incapacitated
Monze (2006)	District chosen politically, with influence of donors and the goal of experimenting in different local contexts	Destitute and incapacitated/labour-constrained households	Social workers and community volunteers deliberate about those perceived to be the most destitute and incapacitated
Katete (2007)	District chosen politically, with influence of donors and the goal of experimenting in different local contexts	Poor elderly people	Social workers and community volunteers do the active search for poor elderly people
Stage 2 (2010-2014)			
CG	Starting with districts with the highest child mortality rate	All district households with children under 5 years old	Location by social and community workers and volunteers, and enrolment of those who match the easy-to-observe categorical criteria (i.e. having children under 5 years old)
MCTG	Starting with districts chosen among the poorest ones	Extremely poor households with elderly people and orphans, or widows and orphans, as well as those with members with disabilities	Social and community workers' perceptions of households' poverty levels defines a first list of potentially eligible households; final eligibility depends on checking whether these households satisfy the objective categorical criteria laid out by the programme
Stage 3 (2014 onwards)			
Harmonised targeting	Starting with the poorest districts	Extremely poor households considered labour-constrained due to not having any members who are fit to work, or by having dependency ratios equal to or greater than three (dependent members include those younger than 19, those older than 64 and those aged 19–64 with chronic illness or disability)	Social and community workers' perceptions of households' potential eligibility define a list of households, whose objective categorical criteria are then checked, and who are ranked in terms of their poverty levels estimated through a PMT

Source: Authors' elaboration based on Garcia and Moore (2012); MCDSW and AIR (2016a); AIR (2016a); MCDSW and AIR (2016b); AIR (2016b); and van Ufford et al. (2016).

Official estimates indicate that around 25 per cent of the Zambian population are expected to be eligible considering only the categorical criteria of the SCT's harmonised targeting format, while 20 per cent are expected to be eligible under the categorical criteria and due to being poor based on the PMT and community-based assessment (van Ufford et al. 2016). Tabulations prepared on request for this study revealed that, by December 2016, the harmonised targeting stream of the SCT reached over 239,000 households (7–8 per cent of the population, and, assuming no inclusion errors, 20 per cent of the extremely poor population of the country). A conversation with programme stakeholders indicated that the government intended to double this coverage in 2017.

TABLE 2
Coverage of the SCT over its three stages, disaggregated by specific pilot (for the first stage) or programme stream (for the second stage)

Stage 1 (2003-2010)		
Pilot	**Coverage**	**Year of reference**
Katete	4,580 *persons*	2009
Kalomo	3,573 households	2009
Monze	1,900 households	2009
Chipata	1,190 households	2009
Kazungula	674 households	2009
Stage 2 (2010–2014)		
Stream	**Coverage**	**Year of reference**
CG	28,000 households	2014
MCTG	17,700 households	2014
Stage 3 (2014 onwards)		
Current format	**Coverage**	**Year of reference**
Harmonised targeting	239,000 households	2016

Source: Author's elaboration based on: Permanent Mission of the Republic of Zambia in Geneva (2009); MCDSW and AIR (2016a); AIR (2016a); MCDSW and AIR (2016b); AIR (2016b); and tabulations received from the MCDSW at the end of 2016.

Benefit and payment structure

The pilots which comprised the first stage of the SCT were rolled out mostly with the purpose of experimenting with different designs to find out which model was most efficient and could, therefore, be considered for a further stage of scaling up the initiative. As such, the five pilots carried out between 2003 and 2010 differed from each other in terms of the benefit values, benefit formula, the frequency of payments and even the strategy for distributing the benefits to beneficiaries. Before presenting these features, it is important to highlight that, from 2012 onwards, the Zambian currency, the Kwacha (ZMW), underwent a reform that divided values by 1,000 (therefore, post-2012 values of, for instance, ZMW50,000 become simply ZMW50). This explain the extreme variations in terms of nominal values before and after that date. Nevertheless, all values presented here also have their equivalent in USD PPP 2011.[3]

The first SCT pilot to be rolled out, in Kalomo district, awarded beneficiaries a basic grant of ZMW40,000[4] and a ZMW10,000 bonus to households with children. Due to logistical constraints, however, the distribution of benefits did not take place every month. Instead, the accumulated value for two months was paid bimonthly. At first the programme envisaged paying the benefits via banks, for beneficiaries living 15km or closer to the bank, and organising pay-points for those living farther away. However, it soon realised that even beneficiaries living close to the bank struggled to access their benefits; therefore it started organising pay-points even for those living close to banks (Garcia and Moore 2012; Schuring, Michelo, and Boonstoppel 2007).

The Kazungula district pilot awarded a higher basic benefit, of ZMW50,000, and an additional bonus of ZMW20,000 per child in the household. The accumulated value for two months was paid bimonthly, predominantly via pay-points (Garcia and Moore 2012; Schuring, Michelo, and Boonstoppel 2007).

In Chipata district the pilot awarded a basic monthly benefit of ZMW50,000, with a ZMW10,000 additional bonus to households with two or more individuals, a ZMW10,000 additional bonus to households with children enrolled in primary school and a KZMW0,000 additional bonus for households with children enrolled in secondary school (Garcia and Moore 2012; Schuring, Michelo, and Boonstoppel 2007). Unlike all the other pilots, payments were meant to take place every month, though in practice the initiative was marked by endemic delays (Habasonda 2009). It started with a mixed payment routine, through both banks and pay-points, but shifted towards a more predominant use of pay-points later on (Garcia and Moore 2012; Schuring, Michelo, and Boonstoppel 2007; Habasonda 2009).

The Monze district pilot awarded the very same benefit as that of the Kalomo district pilot, also on a bimonthly basis and predominantly distributing benefits to beneficiaries via pay-points. A slight difference between this pilot and the Kalomo district one is that Monze's beneficiaries were supposed to commit, either in writing or orally, to keeping their children in school and following a schedule of health visits. However, households were not subjected to any sanction if they failed

to observe these commitments, and, in practice, not even this form of soft conditionality turned out to be taking place (Garcia and Moore 2012; Schuring, Michelo, and Boonstoppel 2007; Seidenfeld and Handa 2011; Handa, Seidenfeld, and Tembo 2012).

For the Kalomo, Kazungula, Chipata and Monze pilots, it is interesting to note that the value of the basic grant (originally ZMW30,000 per month, which was later increased to ZMW40,000 or ZMW50,000 depending on the pilot) was meant to cover the price of a 50kg bag of maize, which would allow a household of six individuals to consume an additional meal per day, presumably their second (Garcia and Moore 2012; Schuring 2010).

These four pilots were meant to reassess the eligibility of households every three years. For households no longer eligible for the programme, a lump sum grant of ZMW500,000 was awarded on graduation (Garcia and Moore 2012). This lump sum payment would not apply to the Katete district pilot, since it was a universal old-age pension; therefore, beneficiaries were not expected to graduate. Its benefit consisted of a flat grant of ZMW60,000 per month, with the accumulated value of two months' worth of benefits paid bimonthly, predominantly via pay-points (Garcia and Moore 2012; Schuring, Michelo, and Boonstoppel 2007).

In terms of the average benefit awarded by each pilot per household per month, the Katete pilot provides the highest value, ZMW75,000 (USD36.41 PPP 2011), followed by the Chipata pilot, at ZMW60,000 (USD29.13 PPP 2011) (Permanent Mission of the Republic of Zambia in Geneva 2009; Garcia and Moore 2012). There are no such specific figures available for the Kalomo, Monze and Kazungula pilots, but the average for these three initiatives taken together is ZMW47,500 (USD23.10 PPP 2011) (Permanent Mission of the Republic of Zambia in Geneva 2009).

From 2010 to 2014, when the SCT evolved from several pilots into a unified, single programme operating through two streams (the CG and the MCTG), the benefit formula became a flat grant of ZMW60 per month (USD22.74 PPP 2011) per household, increasing to ZMW70 in 2014 (USD23.00 PPP 2011), paid bimonthly. Payments were delivered via pay-points. Although from 2014 onwards the SCT underwent major design changes with the introduction of harmonised targeting, its benefit remained the same at ZMW70 per household per month (van Ufford et al. 2016).

TABLE 3

Summary of benefit and payment structure across the stages of the SCT, disaggregated by kind of pilot (for the first stage) and programme stream (for the second stage)

Pilot (year of launch)	Benefit formula/structure (nominal values as of 2009)	Household-/ individual-level targeting	Selection process
Stage 1 (2003–2010)			
Kalomo (2003)	**ZMW40,000/USD19.42 PPP 2011** (basic benefit) + **ZMW10,000/USD4.85 PPP 2011** (bonus for households with children)	Bimonthly	Banks, and pay-points for those farther than 15km from a bank; but soon even those close to banks began receiving the benefit via pay-points
Kazungula (2005)	**ZMW50,000/USD24.28 PPP 2011** (basic benefit) + **ZMW20,000/USD9.71 PPP 2011** (for each child)	Bimonthly	Predominantly pay-points
Chipata (2006)	**ZMW50,000/USD24.28 PPP 2011** (basic benefit) + **ZMW10,000/USD4.85 PPP 2011** (bonus for households with two or more individuals) + **ZMW10,000/USD4.85 PPP 2011** (bonus for households with children enrolled in primary school) + **ZMW20,000/USD9.71 PPP 2011** (bonus for households with children enrolled in secondary school)	Monthly (but marked by endemic delays)	Only changed to pay-points later (when it started being subjected to an assessment)
Monze (2006)	**ZMW40,000/USD19.42 PPP 2011** (basic benefit) + **ZMW10,000/USD4.85 PPP 2011** (bonus for households with children); soft conditionalities never rolled out	Bimonthly	Predominantly pay-points
Katete (2007)	**ZMW60,000/USD29.13 PPP 2011** per elderly person	Bimonthly	Predominantly pay-points
Stage 2 (2010–2014)			
CG	**ZMW70/USD23.94 PPP 2011** (flat)	Bimonthly	Predominantly pay-points
MCTG	**ZMW70/USD23.94 PPP 2011** (flat)	Bimonthly	Predominantly pay-points
Stage 3 (2014 onwards) (nominal values as of 2015)			
Harmonised targeting	**ZMW70/USD23.94 PPP 2011** (flat)	Bimonthly	Predominantly pay-points

Source: Authors' elaboration based on Garcia and Moore (2012); MCDSW and AIR (2016a); AIR (2016a); MCDSW and AIR (2016b); AIR (2016b); and van Ufford et al. (2016).

3 Governance

Throughout its three stages, the SCT has always been an unconditional cash transfer programme, managed by the MCDSW. The institutions responsible for each aspect of enrolment, selection and payment, however, have changed and evolved alongside the three phases of the programme. Up until 2007-2008 these roles were mostly performed by local partners contracted by donors, such as the UK Department for International Development (DFID), the German Technical Cooperation Agency (GTZ) and CARE. From 2007-2008 onwards, and especially from 2010 onwards, these responsibilities were transferred to the local government, more specifically to local Community Welfare Assistance Committees (CWACs). At the subnational level,

the Public Welfare Assistance Scheme (PWAS) designates District Welfare Assistance Committees (DWACs) responsible for establishing, supporting and monitoring Area Coordinating Committees (ACCs) that oversee the CWACs (Chiwele 2010).

The CWACs perform case management not only for the grants and in-kind support they deliver on their own (which are actually of very limited reach and budget), but also for the SCT. However, given that the Public Welfare Assistance Committee's (PWAC) entire ground staff consists of volunteers, there are severe limitations to its operation, especially when considering that the volunteers of the PWAS, CWACs and ACCs are often almost as vulnerable as the people who benefit from the programme.

FIGURE 1
The PWAS structure
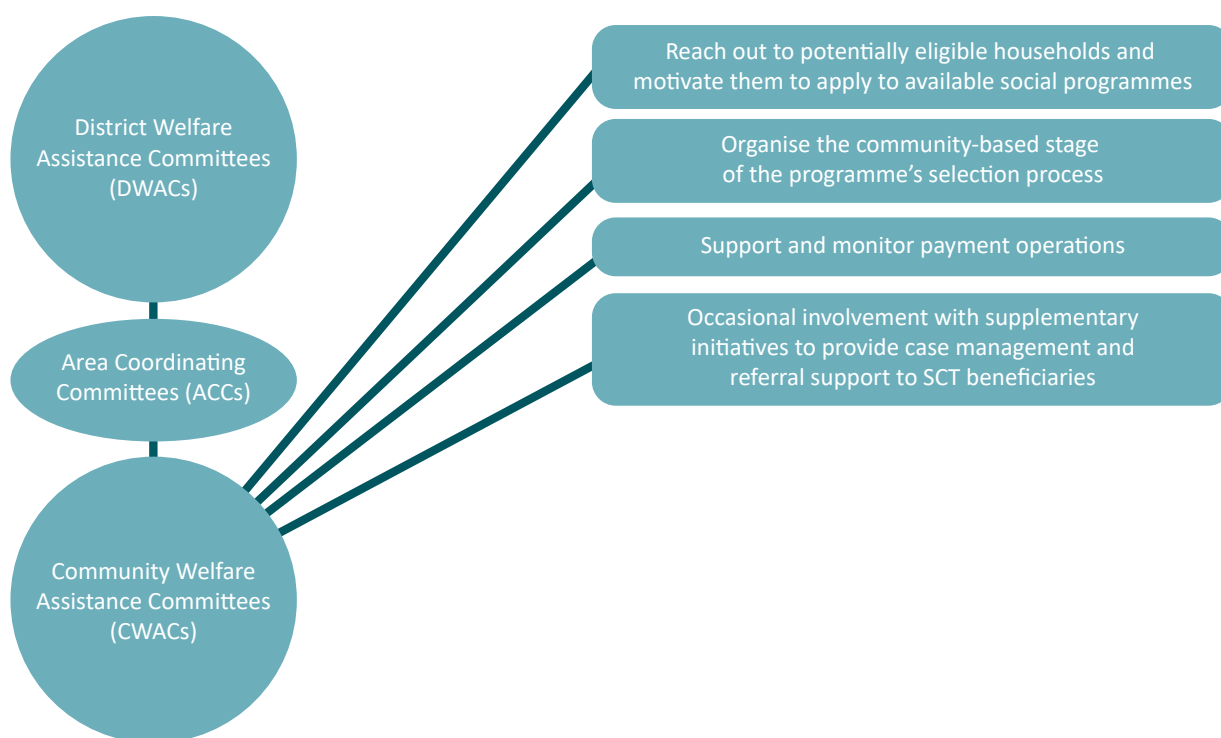
Source: Authors' elaboration based on Chiwele (2010).

Baseline reports from impact evaluations of the CG and MCTG programmes indicate that targeting of these initiatives is good (AIR 2016a; 2016b). However, another targeting assessment suggests that CWACs tend to prioritise identifying their relatives and neighbours in contexts where a limited budget prevents coverage of all eligible households in a district (Beazley and Carraro 2013). Since 2014, data collection and validation have become the task of enumerators, who are teachers designated to enrol and validate the information declared by households identified by the CWACs as potentially eligible for the SCT (van Ufford et al. 2016).

In terms of funding, there has been a significant expansion, as well as a gain of financial ownership by the government. The original pilots were mostly funded by donors (DFID, GTZ and CARE), but, starting mostly in 2010, the government has been expanding its share. Interviews with MCDSW stakeholders revealed that in 2016 the government contributed 85 per cent

of the programme's budget. For 2017 the government planned to double its social protection budget (a 108 per cent increase) and to further scale up the SCT (UNICEF and ZIPAR 2016).

Impact evaluations

Of the five pilots that formed the SCT from 2003 to 2010, only the Kalomo and Monze pilots were subjected to impact evaluations, and the Kalomo impact evaluation was actually a comparison of beneficiaries' conditions before and after receiving the grant, since the study had no control group. Once the SCT shifted its format to that prevailing from 2010 to 2014, it underwent another impact evaluation exercise. But since its latest design change, from 2014 onwards, it has not undergone any impact evaluation.

The main findings of the Kalomo impact evaluation (a comparison of beneficiaries' conditions before and after the intervention)

included desirable improvements in terms of school enrolment, access to more than one meal a day, more satisfaction with the meals eaten, access to a more varied diet, less reported illness, a decrease in the number of households depending on external sources of income (such as relatives and neighbours), a reduction in household debts and increased asset ownership, investment and consumption. There was a decrease in the practice of begging among the communities covered, and there was no significant evidence of misuse of the SCT benefit money. The sole aspect that did not cause the expected impacts was that of school absenteeism, which increased in the short term (even though there were signs of improvement in the long term) (Schuring, Michelo, and Boonstoppel 2007).

Regarding the Monze district pilot, the main findings of its impact evaluation include improvements in terms of livestock ownership, access to fertilisers and a greater amount of cash crops. There have also been positive impacts such as increased enrolment and on-time school entry. Beneficiaries were also found to experience positive impacts on their expectations of quality of life and willingness to delay gratification. Worryingly, there were no impacts on food expenditure or food composition, nor on any health outcomes. Besides sampling limitations, the authors of the impact evaluation study also noted that the lack of positive impacts on health and nutrition might be a result of the systematic delays in payment delivery, such that beneficiaries would often receive a large amount of money covering many months when they were not paid, which would stimulate them to invest the money (or pay debts with it), instead of using it for routine consumption related to health and nutrition. Another important shortcoming identified by the impact evaluation had to do with severe delays in the support meant to be given to CWAC members to enable them to conduct their tasks (Seidenfeld and Handa 2011).

The main findings of the impact evaluation of the CG and the MCTG streams of the SCT include positive effects on income, depth of poverty, food security, housing and living conditions. Furthermore, positive impacts were found on children's access to clothes and other basic material needs, productivity and asset ownership, as well as on the likelihood of children to be enrolled in school while also reducing their probability of dropping out of school. The CG stream also revealed positive impacts on reducing diarrhoea incidence among children under 5 years old and improving infant and young child feeding in beneficiary households.

The MCTG impact evaluation included a module on adolescents aimed at assessing impacts on knowledge, attitudes and practices (KAP) related to HIV. This measured impacts on age of sexual debut, age-disparate sexual partnerships, condom use and mental health. None of them, however, revealed any benefit from the SCT (MCDSW and AIR 2016a; AIR 2016a; MCDSW and AIR 2016b; AIR 2016b).

Maybe more important than the impact evaluation studies *per se* were some coverage and process evaluation studies that took place and led to alterations to the programme's operations and overall design (mostly on its targeting and selection process). The targeting assessment of the CG and the MCTG by Beazley and Carraro (2013), for instance, revealed that the categories used did not

have the highest correlation with extreme poverty. According to van Ufford et al. (2016), this study was fundamental to motivating the shift towards the harmonised targeting approach, including the introduction of a PMT to rank people in terms of their poverty level, and the introduction of enumerators to collect data for the PMT among households identified by CWAC members.

4 Conclusions

The trajectory of Zambia's SCT from a set of pilots to its current, uniform design reveals improvements following a process of experimentation regarding the best selection criteria and processes *vis-à-vis* the available state capacity to handle the SCT's core operations. Back in 2003, the pilots that would later turn into the SCT were delegating many crucial roles to associations and non-state actors. Furthermore, the selection criteria were largely based on community-based mechanisms without even a clear and objective benchmark. Over time, the State seems to have gained the capacity to assume control of the SCT's core operational functions, and has been able to gradually standardise the SCT and make the selection process more transparent and progressive.

From its second to its current, third phase, the many categorical criteria that mediate eligibility were simplified by adopting one single categorical selection criterion capable of encompassing many of the vulnerable groups previously listed as eligible according to the CG and, especially, the MCTG. In many respects, one can think of the current SCT selection criterion as a revamped and easier-to-manage version of the MCTG, which, instead of listing all eligible family types, uses a broader category (the dependency ratio) likely to reach out to previously covered families and many others also found to be in a situation of vulnerability. The progressivity of this new approach also benefits from a complementary PMT that has been used since 2014.

Zambia's SCT also holds the distinction of having implemented these institutional and design improvements without compromising the expansion of its coverage, and while increasing the government's financial ownership of the initiative. Currently, the SCT is one of the cash transfers in the subregion with the largest coverage and greatest government ownership.

Though relatively little time has passed since the SCT was last subjected to an impact evaluation study, it seems strategic to undertake another such study, as the design of the programme has been significantly altered since 2014. The impact evaluation could benefit from the programme's plan to expand its coverage in the near future, including the expansion towards districts that are not yet being covered. This could make it easier to build a counterfactual group.

Certain studies and assessments have proven crucial to many of the SCT's design changes, most notably that taking place from 2014 onwards. To a large extent, this was influenced by targeting assessments of the CG and the MCTG. Not only was the targeting of the programme altered as a result of this study, but even its selection process changed, as poverty assessments shifted from community impressions to a PMT-based ranking. The very collection of information by enumerators to run this PMT emerged as a way to avoid selection biases found by the study to be introduced by CWAC members.

More such relations between programme assessments and its operational features should be encouraged, to avoid the trap of running studies whose results are only considered by programme managers as long as they attest to the good quality of the initiative. Assessments and impact evaluations are not pieces of propaganda, and their findings should be given political relevance even (and specially) when they imply the need for adjustments to the programme. In the past, impact evaluation studies of the Kalomo and Monze district pilots, for instance, led to no programme adaptation whatsoever, even though the studies suggested that the programme was not capable of fostering positive health outcomes. Similarly, the impact evaluation of the MCTG that revealed no impacts on HIV-related KAP has not led to any significant restructuring of the programme to make it more effective at promoting such outcomes.[5]

The need for institutional plans to incorporate evidence-based critiques of the programme's design can be illustrated by the SCT pilots taking place between 2003 and 2010. Even though they were carried out with the explicit purpose of experimenting and learning so as to decide on the best design for a national programme, it turned out that only two of them were subjected to impact evaluations. And none of them really contributed to the decisions about how to scale up the initiative from 2010 onwards. The Chipata pilot, which adopted one of the most creative payment structures, was not evaluated nor considered adequately in this process. It is plausible that, had all the pilots been subjected to evaluation and their findings taken seriously, the SCT could probably have started to operate, back in 2010, in the format it assumed in 2014, instead of operating for four years in formats that were later found to be undesirable.

1. International Policy Centre for Inclusive Growth (IPC-IG).

2. These illustrative conditions often included, but were not limited to: households headed by elderly people, households with people with disabilities, households caring for people with chronic illness, households with a high dependency ratio, households that experience persistent hunger (Garcia and Moore 2012; Hamonga 2006), households with inadequate shelter, households whose members do not have clothes to wear, households without a regular source of substantive income, and households without assets that can help them cope with crisis (Permanent Mission of the Republic of Zambia in Geneva 2009).

3. All values presented in USD PPP 2011 derive from the following methodology. The amount of benefits in USD PPP 2011 is the value of the benefits converted to international dollars using the Purchasing Power Parity conversion factor (PPP). Calculated by the World Bank and available on the World Development Indicators (WDI) database, the PPP for private consumption is "the number of units of a country's currency required to buy the same amounts of goods and services in the domestic market as a US dollar would buy in the United States," thus measured in Local Currency Units (LCUs) per international dollar. The last PPP has 31 December 2011 as the reference date; therefore, the annual Consumer Price Index (CPI) series of the WDI database was used to deflate the nominal benefit values to their real value at the price levels at the end of 2011, before the conversion to international dollar:

Benefit in International $ = Benefit_ LCU * CPI_2011 * 1/ (CPI_REF_YEAR * PPP)

All the values in USD PPP 2011 were calculated using the last year for which data in LCUs were available. This means that all the pilots had their values converted to USD PPP 2011 based on LCU benefit values as of 2009, even though benefit values were determined back in 2007. The second stage of the SCT was converted based on LCU benefit values as of 2014, which had increased nominally compared to what used to be paid up to that year. And the third (current) stage of the programme was converted based on LCU benefit values as of 2015, even though its benefit value was determined in 2014. For this third stage of the SCT we could have used 2016 as the year of reference for the values in LCUs, since the nominal value has not changed. But we preferred to make the conversion to USD PPP 2011 based on the 2015 LCU value because 2016 experienced atypically high inflation.

4. This value was originally K30,000, but it was increased to K40,000 from 2007 onwards (Garcia and Moore 2012).

5. The response to those failures to have the desired impacts on HIV-related KAP has been taking the form of case management pilots with very limited coverage.

References

AIR. 2016a. *Zambia's Child Grant Program: 48-Month Impact Report*. Washington, DC: American Institutes for Research. <http://www.air.org/system/files/downloads/report/CGP_48month_Final_Jan2016.pdf>. Accessed 8 December 2017.

AIR. 2016b. *Zambia's Multiple Category Targeting Grant: 36-Month Impact Report*. Washington, DC: American Institutes for Research. <http://www.air.org/system/files/downloads/report/MCTG_36Month_Final_Feb2016.pdf>. Accessed 8 December 2017.

Beazley, R., and L. Carraro. 2013. *Assessment of the Zambia Social Protection Expansion Programme Targeting Mechanisms*. Oxford: Oxford Policy Management and Rural Net Associates. <http://www.opml.co.uk/sites/default/files/Assessment%20of%20the%20Zambia%20Social%20Protection%20Programme%20Targeting_Final%20Report.pdf>. Accessed 8 December 2017.

CSO. 2015. *2015 Living Conditions Monitoring Survey Key Findings*. Lusaka: Republic of Zambia Central Statistical Office. <http://www.zamstats.gov.zm/index.php/publications/category/27-living-conditions>. Accessed 8 December 2017.

Chimai, B., and B.P. Mulenga. 2014. "Welfare Effects of Social Cash Transfers in Chipata and Kazungula Districts of Zambia." *Business and Economic Research* 4(1). <https://goo.gl/DNSvCT>. Accessed 5 March 2018.

Chiwele, D.K. 2010. "Assessing administrative capacity and costs of cash transfer schemes in Zambia: Implications for rollout." *IPC-IG Country Study*, No. 20. Brasília: International Policy Centre for Inclusive Growth. <http://www.ipc-undp.org/pub/IPCCountryStudy20.pdf>. Accessed 5 March 2018.

Garcia, M., and C.M.T. Moore. 2012. *The Cash Dividend: The rise of cash transfer programs in Sub-Saharan Africa*. Washington, DC: World Bank. <http://www.cashdividend.net/wp-content/uploads/2013/06/eBook-Cash-Dividend-Cash-Transfers-Programs-in-SSA-Garcia-and-Moore-2012.pdf>. Accessed 5 March 2018.

Habasonda, L.M. 2009. *Political Economy of Cash Transfer in Zambia: A report prepared for the Overseas Development Institute*. London: Overseas Development Institute. <https://www.odi.org/sites/odi.org.uk/files/odi-assets/publications-opinion-files/5751.pdf>. Accessed 5 March 2018.

Hamonga, J. 2006. "Community-Based Targeting Case Study: Zambia" Presented at the Third International Conference on Conditional Cash Transfers, Istanbul, 29 June.

Handa, S., D. Seidenfeld, and G. Tembo. 2012. *The Impact of a Large Scale National Cash Transfer Program on Household Time Preference*. Chapel Hill, NC: Carolina Population Center, University of North Carolina. <https://editorialexpress.com/cgi-bin/conference/download.cgi?db_name=CSAE2013&paper_id=431>. Accessed 5 March 2018.

Michelo, S. 2015. "Social Cash Transfer Scale-Up For Zambia." *One Pager*, No. 287. Brasília: International Policy Centre for Inclusive Growth. <http://www.ipc-undp.org/pub/eng/OP287_Social_Cash_Transfer_Scale_Up_for_Zambia.pdf>. Accessed 8 December 2017.

MCDSW. 2014. *Social Cash Transfer (SCT) Overview*. Lusaka: Ministry of Community Development and Social Welfare. <http://41.72.99.155/mcdmch/sites/default/files/downloads/Social%20Cash%20Transfer%20Fact%20sheets.pdf>. Accessed 8 December 2017.

MCDSW and AIR. 2016a. *The Child Grant Programme: A Comprehensive Summary of Impacts (2010–2014)*. Lusaka: Ministry of Community Development and Social Welfare. <https://www.unicef.org/zambia/Policy_Brief_CG_final.pdf>. Accessed 8 December 2017.

MCDSW and AIR. 2016b. *The Multiple Categorical Targeting Grant: A Comprehensive Summary of Impacts (2011–2014)*. Lusaka: Ministry of Community Development and Social Welfare. <https://www.unicef.org/zambia/Policy_Brief_MCTG_final__May_2016.pdf>. Accessed 8 December 2017.

Monteiro Costa, A.B., M. Gyoeri, and F. Veras Soares. 2016. "Scaling Up Cash Transfer Programmes: Good Practices and Lessons Learned from Kenya, Tanzania and Zambia." *Community of Practice on Cash Transfers in Africa, Policy Brief*, No. 1. Brasília: International Policy Centre for Inclusive Growth. <http://www.ipc-undp.org/pub/eng/PRB_CoP01_Scaling_up_cash_transfer_programmes_good_practices_and_lessons.pdf>. Accessed 8 December 2017.

Permanent Mission of the Republic of Zambia in Geneva. 2009. *Note No. 16/09. Response to the questionnaire on cash transfers addressed to governments by the independent expert on the question of human rights and extreme poverty*. Geneva: Permanent Mission of the Republic of Zambia in Geneva. <http://www.ohchr.org/Documents/Issues/EPoverty/casher/Zambia.pdf>. Accessed 8 December 2017.

Schuring, E. 2010. *Strings Attached or Loose Ends? The Role of Conditionality in Zambia's Social Cash Transfer Scheme*. Maastricht, Netherlands: Maastricht Graduate School of Governance.

Schuring, E., S. Michelo, and E. Boonstoppel. 2007. *Final Evaluation Report: Kalomo Social Cash Transfer Scheme*. Lusaka: Ministry of Community Development and Social Services. <https://health.bmz.de/ghpc/case-studies/Cashing_in/Toolset_2_Evaluations_and_data/Final_evaluation_report_for_Kalomo_2007.pdf>. Accessed 8 December 2017.

Seidenfeld, D., and S. Handa. 2011. Results of the Three Year Impact Evaluation of Zambia's Cash Transfer Program in Monze District. Final Report. Lusaka and Washington, DC: American Institutes for Research. <https://transfer.cpc.unc.edu/wp-content/uploads/2015/09/Zambia-Monze-Followup-Report.pdf>. Accessed 8 December 2017.

Tembo, G., N. Freeland, B. Chimai, and E. Schuring. 2014. "Social Cash Transfers and Household Welfare: Evidence from Zambia's Oldest Scheme." *Applied Economics and Finance* 1(1), May. <http://redfame.com/journal/index.php/aef/article/view/354>. Accessed 8 December 2017.

UNICEF and ZIPAR. 2016. *Analytical Brief of the Social Sector Budget 2017: "Leaving No One Behind"*. New York: United Nations Children's Fund, and Lusaka: Zambia Institute for Policy Analysis and Research. <https://www.unicef.org/zambia/ANALYTICAL_BRIEF_OF_THE_SOCIAL_SECTOR_BUDGET_2017.pdf>. Accessed 8 December 2017.

van Ufford, P.Q., C. Harland, S. Michelo, G. Tembo, K. Tool, and D. Wood. 2016. "The Role of Impact Evaluation in the Evolution of Zambia's Cash Transfer Programme." In *From Evidence to Action: The Story of Cash Transfers and Impact Evaluation in Sub-Saharan Africa*, 1st edition, edited by B. Davis, S. Handa, N. Hypher, N. Winder Rossi, P. Winters, and J. Yablonski. Oxford: Oxford University Press. <http://www.fao.org/3/a-i5157e.pdf>. Accessed 8 December 2017.