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CHILD DEVELOPMENT GRANT PROGRAMME EVALUATION

Qualitative Endline Report

Oxford Policy Management

itad

ePact is a consortium led by Oxford Policy Management and co-managed with Itad

In association with:

Institute for Fiscal Studies

Acknowledgements

The evaluation team would like to thank all the community members, Child Development Grant Programme (CDGP) workers (including Local Government Authority (LGA) seconded staff) and volunteers who participated in the midline fieldwork. We are also grateful to everyone whose assistance made this study possible: colleagues from Save the Children and Action Against Hunger, community leaders, officials, and liaison people in all five LGAs.

The field research was carried out on behalf of ePact by the following team from the Theatre for Development Centre (TFDC) of Ahmadu Bello University (ABU), Zaria, Nigeria. This report, of course, draws heavily on their reports, transcripts and other contributions.

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Disclaimer

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Executive summary

The programme

The CDGP is a pilot programme funded by the UK Department for International Development (DFID) and implemented in Zamfara and Jigawa states in Northern Nigeria. The programme aims to address widespread poverty, hunger and malnutrition in Northern Nigeria, which affects children's potential to survive and develop.

The CDGP provides a monthly unconditional cash transfer for women from the time their pregnancy is confirmed until their child is two years old, targeting the critical first 1,000 days of a child's life. The cash transfer is accompanied by social and behavioural change communication (SBCC), including nutrition education, advice and counselling to support the feeding practices of pregnant women, infants and young children. The combination of these interventions is expected to contribute to the households consuming more food, and a more nutritionally varied diet. The interventions are also expected to improve maternal and childcare practices. Ultimately, the programme is expected to lead to improvements in child nutrition within the beneficiary households and to protect children from the risks of stunting, illness and death.

The programme is implemented by Save the Children in Zamfara and Action Against Hunger (AAH) in Jigawa. The pilot programme is targeting randomly-selected treatment communities in five LGAs: Anka and Tsafe in Zamfara, and Buji, Gagarawa and Kirikasama in Jigawa.

Evaluating this programme

An independent mixed-method evaluation of the programme is being carried out by ePact, a consortium led by Oxford Policy Management (OPM). The evaluation is intended to help understand the impact of the programme on the households and communities it supports. Its findings will be communicated to the state and federal governments in order for them to see the potential impact of this and similar programmes. The evaluation includes the following interlinked workstreams:

- a **household survey** conducted at baseline, midline and endline (follow-up), providing quantitative analysis, including statistical comparison between treatment (beneficiary) and control populations;
- a **process evaluation** documenting the implementation of the programme, lessons learned, and factors supporting or weakening its implementation; and
- a longitudinal **qualitative module** following a small sample of beneficiary communities and households through the evaluation period (with baseline, midline and endline fieldwork), to explore their experiences and views of the programme and its impacts, and to investigate issues that are more difficult to capture in a household survey.

This report

This report presents the findings of the third and final (endline) round of qualitative fieldwork, conducted in late November and early December 2017. Building on the previous research rounds,[1] the field teams revisited the same seven selected beneficiary communities across the five LGAs. The main purpose of the endline research was to explore any further changes and impacts since

[1] The baseline fieldwork was conducted in September–October 2014 (see ePact 2015a); and the midline in February-March 2016 (see ePact 2017a).

the midline, and the perceived causes of those changes, in relation to the following six thematic areas which the CDGP is expected to impact:

1. consumption patterns and dietary practices;
2. knowledge, attitudes and practices (KAP) relating to health, nutrition and childcare;
3. household decision-making and resource management;
4. livelihoods and income;
5. risks, shocks and coping behaviour; and
6. wellbeing.

Within these themes, the endline particularly focused on two issues highlighted by the midline findings: causal pathways underlying adoption or non-adoption of exclusive breastfeeding, and the effects of the cash transfer on the incomes and assets of beneficiary women and their husbands.

The qualitative endline also explored the implementation of the CDGP in the selected communities, focusing on beneficiaries' experience of the exit processes.

Methods used

The same combination of data collection methods was employed as in the baseline and midline:

- one-to-one semi-structured case study (CS) interviews;
- focus group discussions (FGDs); and
- key informant interviews (KIIs).

In each of the seven communities KIIs were held with members of the Traditional Ward Committee (TWC) and Beneficiary Reference Group (BRG), a Community Health Extension Worker (CHEW), and at least two Community Volunteers (CVs). CDGP team members (non-governmental organisation or LGA seconded staff) were also interviewed for each LGA.

Four FGDs were held in each community: two with non-beneficiaries (women and men); one with beneficiary women (other than the case study subjects); and one with husbands of beneficiary women. Participants for the FGDs were convened with the assistance of the TWC members and CVs.

For the endline, additional KIIs and FGDs were conducted with the Fulani community in Kokura (Kirikasama LGA, Jigawa). This module was added in response to the midline finding that the CDGP appeared less successful in reaching this pastoralist, mobile community.

One-to-one interviews were held with 51 of the 54 case-study households[2] who were identified during the baseline and followed up at midline, enabling us to trace and discuss with them any changes over the three-year evaluation period. The cohort of women who are the focus of these case studies were all potential CDGP beneficiaries at baseline: by the endline, 46 of the 51 were current or past beneficiaries. Wherever possible three case study interviews were held per household, with the focus woman, her husband, and one other woman (the focus woman's mother-in-law, co-wife or sister-in-law).

[2] The missing three households had re-located and could not be contacted.

Endline findings: expected impact areas

1. Consumption patterns and dietary practices

The endline data collection took place during the *kaka* (harvest) season, when food and money are relatively abundant. Beneficiaries still report spending the cash transfer primarily on food, but at this time of year they are more likely to buy supplementary nutritious foods (protein-rich or "body-building" foods and vitamin-rich vegetables as advised by the SBCC, as well as seasonings), while staple foods such as cereals and beans are supplied by their husbands from their own farm produce. Beneficiaries report that the cash transfer enables them to consume a more balanced and varied diet than before, especially during the leaner months of the rainy season (July to September), thus helping to smooth the marked seasonality of dietary diversity noted by the qualitative baseline.

As many of our respondents have now exited from the programme, the interviews included questions about the longer-term sustainability of these dietary improvements once the cash transfers stop. Beneficiaries say that the knowledge they have gained about nutritional needs and balanced diets, as well as the recipes and food handling tips, will enable them to continue providing more varied and nutritious diets for themselves and their children after the programme ends. Many have managed to save enough from the transfer to invest in businesses or assets that will provide future income that they can spend on maintaining their improved diets. However, nearly all agree that they will not be able to afford the same quantity and quality of food they have been purchasing with the cash transfer.

2. KAP (Knowledge, attitudes and practices)

Regarding the adoption of early and exclusive breastfeeding (EBF), the qualitative endline provides further evidence to support the midline findings: **many respondents in all our research communities say they have adopted the new breastfeeding practices** themselves, or have supported their wives to do so, or would advise other women to do so, because they believe it is better for the baby's health and nutrition. Although some people persist with traditional practices (such as giving herbs or animal milk to the newborn for the first few days before breastfeeding, and especially giving water in addition to breastmilk throughout the nursing period), there is evidence that a generational shift may be happening, with younger women more likely to adopt the "modern" practices advocated by the health services and CDGP.

Barriers to the adoption of EBF include traditional beliefs (such as that the first milk or colostrum is harmful), the religious practice of giving *rubutu* or prayer water, and the opposition of those, especially older women, who believe it is cruel to deny water to a baby.

Among the **facilitators or factors that enable and encourage women to adopt EBF**, the strongest seems to be the demonstration effect of seeing the impacts on the health and development of their own or neighbours' babies. Respondents explained that it is very difficult to be the first to adopt something new or against tradition, but it becomes easier the more other people are doing it. The new practices were said to be "snowballing" as non-beneficiaries as well as those directly involved in the SBCC activities are seeing the results and copying the new practices. Engaging husbands in the SBCC and gaining their informed support for EBF has been an important factor in the success of this message, according to beneficiaries and local key informants. The role of the CDGP's community volunteers (CVs) in providing continuous support, answering questions, and showing women the best ways to breastfeed (not only "telling us what to do") has been a deciding factor for many who had heard about EBF before but had not been persuaded to try it in practice.

The **cash transfer was said to influence beneficiaries' adoption of EBF** primarily because it enabled them to eat well enough to breastfeed successfully, although there was also some feeling of obligation to follow the CVs' advice in return for receiving the cash. The widespread adoption of EBF by non-beneficiaries, and the numerous ex-beneficiaries who are continuing to practise it with subsequent babies after their exit from the programme, are evidence that this impact may be sustained after the cash transfers stop. However, as with the general dietary impacts, some women were not sure they would be able to afford to continue eating well enough to breastfeed exclusively in future.

The SBCC advice and demonstrations about **complementary foods** that should be introduced alongside breastmilk for children from six months old appear to have been effective, with many beneficiaries explaining how they now enrich the cereal-based *kunu* (porridge) they give their infants with locally-available nutritious foods including groundnuts, palm oil, soya and milk. Affordability was again the main source of uncertainty about whether they would be able to maintain these improvements in the longer term.

Hygiene and sanitation practices advocated by CDGP (such as hand-washing, covering food, keeping cooking and feeding utensils clean, and draining stagnant water around the house) appear to be well-understood and widely adopted in the seven qualitative research sites. These findings are similar to those reported at midline. Many respondents felt that this aspect of behaviour change is the most likely to be continued after the programme ends, because it costs little or nothing: even if people cannot afford soap, they have been advised to use ash to clean their hands. Infrastructural improvements in water and sanitation, however, remain costly. We find no evidence that the CDGP has enabled people to invest in such changes, but in one of our research sites (Yankuzo) a UNICEF water project has significantly changed the context of the CDGP campaign by providing household access to piped water.

Attendance at ante-natal clinics (ANC) seems to be increased by participation in the CDGP, as found in both the quantitative and qualitative midlines. In the qualitative endline discussions, beneficiaries further explained that the cash transfer helped to cover the costs of attendance, and that the CVs' advice had influenced them to attend. While some women said they were attending ANC before the CDGP so the programme had not changed this, others said that they now understood the usefulness and importance of ANC because the programme had encouraged them to go for the first time.

The **use of health facilities in general** was said by some respondents to have increased over the three years since the baseline. This increased uptake is likely to include ANC attendance, vaccinations and de-worming treatments (which were all found by the quantitative midline to have increased in CDGP communities). In the qualitative discussions, beneficiaries report that their children who have been exclusively breastfed are much less frequently ill: husbands in particular note the reduction in medical expenses as one of the key benefits of EBF. On the other hand, health expenditure for children is among the most frequent uses of the cash transfer. Many of the qualitative respondents appreciated how the cash transfer enables mothers to take their children to a health facility straight away when they need treatment, without waiting for their husbands to provide funds. These complicated factors perhaps explain the apparently contradictory findings from the qualitative endline that children are less likely to be ill, but that their mothers are more likely to take them to a health facility.

3. Household decision-making and resource management

The qualitative endline discussions support and add detail to the midline findings that **women have a considerable degree of control over the use of the cash transfers**, which are broadly treated in the same way as the wife's own earned income. Husbands seem to have generally accepted the

message (which has been supported by local leaders) that the money is for the woman to spend, for the benefit of herself and her baby. However, this is not to say that there are no cases of friction or competition around control of these resources: TWC members regard mediation between spouses on this issue as part of their role in CDGP.

Many (perhaps most) beneficiaries give cash gifts out of their transfer to their husbands and to other women in the household. These gifts smooth relationships and increase the giver's social capital, especially strengthening mutual support networks among the women. The largest amounts (up to N 1,000) are usually given to husbands: occasionally these gifts are for the husband's "personal" use, but more often they were described as contributions to the household expenses and sometimes for investment in the man's farming or other business activities that support the whole household. Women describe how being able to make such contributions enhances their feeling of worth and status, and improves their relationship with their husband.

Beneficiaries are continuing to spend the cash transfer primarily on food: other uses include medical costs, clothes, soap, school expenses and occasionally household furniture. Most beneficiaries and ex-beneficiaries interviewed at endline had also managed to save part of their monthly cash transfer, in order to invest in starting or expanding their own income-generating activities, or to purchase durable assets (mainly small livestock) for the future. These investments appeared to be more prevalent than at midline, although this may simply be because the women had been receiving the cash for longer and had accumulated more significant savings. Overall, we find that **the increased income from the cash transfer has enhanced women's ability to make economic choices** as well as their standing and social capital in the household, and their sense of self-reliance.

4. Livelihoods and income

As found in the previous evaluation rounds, women's opportunities for income-earning work are quite constrained, not least by restrictions on their movement outside the household. Within these constraints, **beneficiaries are using the cash transfer to expand or diversify their existing businesses of petty trading, food processing and service provision**. Some have started new businesses, while others have stopped activities they were doing before and used their cash savings instead to purchase sheep, chickens or calves that they can raise within the compound. Among the many contextual factors that influence these decisions is the availability of children who can help a woman trade by taking her goods around the neighbourhood.

During the *kaka* (harvest) season, some women can earn additional income from employment in harvesting, but this is considered low-status work primarily for young girls and older or divorced women. Married women of child-bearing age (CDGP's target group) are not generally permitted to do this kind of work.

Men's livelihoods at this time of year are very much focused on farming. The endline found that most (though not all) of our communities had had a bumper harvest this year, due to favourable rains and a major shift in government policy which had made subsidised fertilizer and other inputs widely available. Some men had received cash support from their wives who were CDGP beneficiaries, to purchase fertilizer, and many mentioned (as at midline) that the cash transfer had enabled them to concentrate more of their time and money on farming because the day-to-day household needs were taken care of by their wives. However, it seems likely that **these impacts of the cash transfer on farming are quite small compared to the larger contextual factors**.

5. Risks, shocks and coping behaviour

On risks and resilience, the endline largely confirmed the findings of the midline. The three main types of covariate shock affecting these communities are seasonality (affecting income, food availability and health); natural hazards (especially drought, flood, crop pests or livestock diseases); and insecurity (especially armed raids). In addition, people face the usual range of idiosyncratic risks and shocks at household and individual level, particularly illness and unexpected medical costs, which can be a major drain on household resources. The range of options for coping with all such risks and losses (as found at baseline and midline) include liquidating assets, borrowing, asking relatives and other community members for help, or looking for income from other sources.

At endline, some respondents stated that they had sold some of the assets accrued from their time as CDGP beneficiaries in order to manage times of need, and that the cash transfer itself (while they were receiving it) helped to smooth consumption during the lean season and other periods of stress. People frequently said that one of the reasons for saving and investing (particularly in livestock) was to have something to fall back on in times of need. For CDGP beneficiaries, this use of the cash transfers to bolster household reserves can be seen as an investment in resilience, and should contribute to a reduction in negative risk-coping behaviour.

6. Wellbeing

The endline supports the findings of the midline report, that participation in the CDGP enhances beneficiaries' sense of material and relational wellbeing in a number of ways. Material wellbeing is enhanced through better health and diets, as well as through direct and indirect income effects of the cash transfer. Impacts on the relationships between married couples, and among women within households, were generally reported to be positive, enhancing relational wellbeing. Relationships among co-wives and sisters-in-law, and between beneficiary women and their mothers-in-law, were again said to be improved by sharing the knowledge and tasty recipes gained from the SBCC activities as well as by building reciprocal support through giving small cash gifts.

As noted above, beneficiary women's sense of agency and economic autonomy is enhanced by the additional income provided by the transfer. Both the midline and endline interviews also suggest that the knowledge and "enlightenment" gained from participation in the programme are in themselves a source of self-esteem for beneficiary women, and can also earn them enhanced respect from others. It is likely that all these factors contribute to enhanced subjective wellbeing.

Endline findings: CDGP implementation (exit processes)

While most respondents understood the rules for matured and premature exit in theory, there were many complaints of unfairness or lack of notice in individual cases. Many of the ex-beneficiaries interviewed felt they had been exited too early, or that others received the transfer for longer, or (most frequently) that they did not know when they would exit the programme until they turned up at the payment point to be told "zero account".

A number of factors were identified by key informants which could account in many cases for the misunderstandings and complaints about the timing and process of exits. These include:

- Beneficiaries are sometimes reluctant to believe the CVs when they are notified that they are due to exit, and may go to the payment point anyway.
- They may not attend the meeting where notice of exit was given.

- There may be confusion about the birth dates of CDGP babies (and therefore their second birthday).
- In cases where a woman has been re-registered for a second pregnancy (having lost one child), she may reach the maximum number of months allowed before the second child is two years old. In this case the system will exit her, but she may not understand why.

Beneficiaries who have exited more recently seem to be more likely to have received adequate notice, suggesting that the exit procedures have improved during the implementation of the programme. The qualitative findings on this subject will be contextualised by the broader process evaluation (phase II) report.

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List of abbreviations

AAH	Action Against Hunger
ABU	Ahmadu Bello University
AOG	Action-oriented group
BRG	Beneficiary reference group
CDG	Child Development Grant
CDGP	Child Development Grant Programme
CHEW	Community Health Extension Worker
CS	Case study
CV	Community Volunteer
DFID	Department for International Development (UK)
FGD	Focus group discussion
IYCF	Infant and young child feeding
KAP	Knowledge, attitudes and practices
KII	Key informant interview
LGA	Local Government Authority
NASSP	National Social Safety Nets Project
NGN	Nigerian Naira
NGO	Non-governmental organisation
PPI	Progress out of Poverty Index
SBCC	Social and Behavioural Change Communication
T1, T2	'Treatment' 1 and 2 (SBCC approaches in the CDGP)
TBA	Traditional Birth Attendant
TFDC	Theatre for Development Centre, ABU
TWC	Traditional Ward Committee

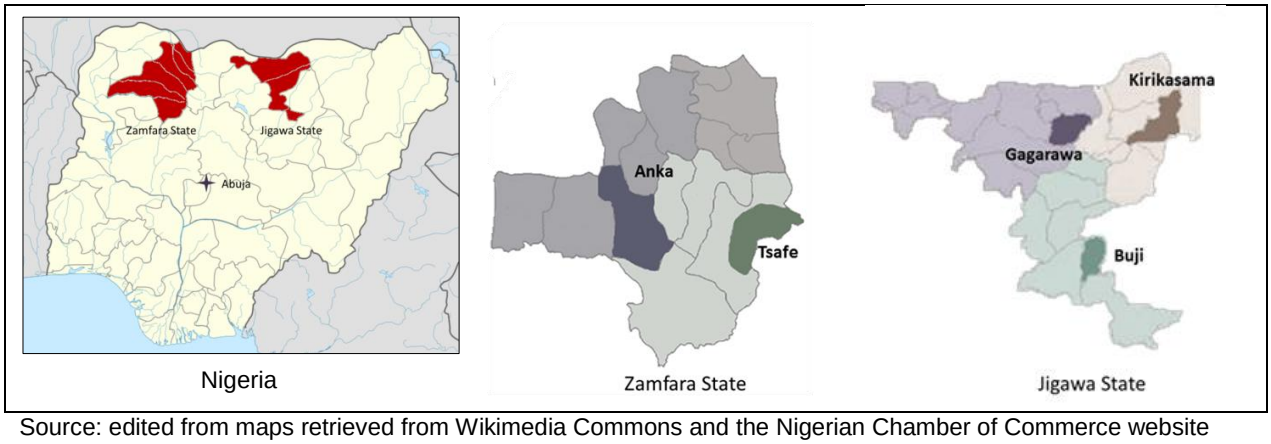
1 Introduction

1.1 The CDGP

The Child Development Grant Programme (CDGP) is a six-year, DFID-funded pilot programme (2013–2019) that is being implemented in Zamfara and Jigawa states in northern Nigeria. The programme aims to test an approach to reducing widespread poverty, hunger and malnutrition, which affect the potential for children to survive and develop. It offers an unconditional cash transfer aimed at tackling the economic causes of inadequate dietary intake, combined with a social and behaviour change communication (SBCC) campaign aimed at influencing maternal and childcare practices. This combination of cash plus SBCC is expected to contribute to the beneficiary households accessing and consuming more food that is nutritionally more varied, as well as improving maternal health and childcare practices. Ultimately, the objective is to improve child nutrition and to protect children from the risks of stunting, illness and death.

The programme is implemented by Save the Children and AAH in five local government areas (LGAs): Anka and Tsafe in Zamfara State, and Buji, Gagarawa and Kirikasama in Jigawa State (see Figure 1). Within the LGAs, the CDGP's delivery model depends on community volunteers (CVs), and on local governance structures including the Traditional Ward Committees (TWCs) and Beneficiary Reference Groups (BRGs) which are established in each community to facilitate communications and receive complaints.[3]

Figure 1 Location of the CDGP states and LGAs



Source: edited from maps retrieved from Wikimedia Commons and the Nigerian Chamber of Commerce website

The cash transfer component provides a monthly grant for over 90,000 women from the time they are pregnant until their child is two years old (a maximum period of 33 months, targeting the critical first 1,000 days of a child's life). The amount of the cash transfer was initially NGN 3,500 per month. It was increased to NGN 4,000 from January 2017 to maintain the value of the transfer.[4]

[3] CDGP (2015), Implementation Manual. See also the Qualitative Midline (ePact 2017a) and Process Evaluation Round 1 (ePact 2016) for discussion of these institutions.

[4] At the time of the baseline research in 2014 the transfer of NGN 3,500 was worth approximately £14, but by the midline its value had been eroded by exchange rate movements to approximately £9 (October 2016). At the time of writing (June 2018), NGN 4,000 was worth a little over £8.

This predictable cash transfer is expected to contribute to increased food security and improved intake of more nutritious food, leading to improvements in child nutrition.

Alongside the cash transfer, communities in the programme are provided with education and advice about nutrition and health, through the SBCC component. This campaign is intended to influence key areas of knowledge and practice, including breastfeeding and infant diets, use of health facilities, and hygiene (see Annex F for the key messages). It is designed to engage men and influential members of the community as well as the women who are the direct beneficiaries of the cash transfer. The programme was set up to test two different designs of the SBCC component:

T1 'Low-intensity' SBCC delivered through posters, radio messaging, text messaging, health talks and food demonstrations; and

T2 'High-intensity' SBCC delivered through support groups and one-to-one counselling for women receiving the transfer, in addition to all components of the 'low-intensity' BCC.

1.2 Overview of the evaluation design

The evaluation of the CDGP is expected to provide an understanding of the impact of the programme on households and communities that it supports. The evaluation's Theory of Change is included for reference in Annex A, and its key hypotheses are outlined in Box 1 below.

Box 1 Key evaluation hypotheses

Addressed primarily by the quantitative impact evaluation:

Evaluation Hypothesis I: The CDGP intervention, and in particular the provision of a regular transfer of NGN 3,500 on a monthly basis to women, will result in the consumption of larger quantities, and more varied types, of food, which in turn will result in an increase in dietary intake and consequently a reduction in child malnutrition.

Evaluation Hypothesis II: The provision of a regular predictable cash transfer will result in a reduction in negative risk-coping behaviour and, in particular, a reduction in the distress sale of assets and debt accumulation among beneficiary households.

Evaluation Hypothesis III: The nutritional advice and counselling provided by the programme will improve the knowledge, attitudes and practices of the targeted men and women in relation to nutrition and general maternal and childcare practices.

Addressed primarily by the qualitative impact evaluation:

Evaluation Hypothesis IV: The cash transfer will result in improved material wellbeing and will contribute to the relational wellbeing of households through enhanced trust and reciprocal social and economic collaborations.

Evaluation Hypothesis V: The provision of a regular cash transfer to women will enhance their ability to make economic choices and will result in improved social capital.

Addressed primarily by the process evaluation:

Hypothesis VI: Poor implementation of the programme (e.g. poor targeting, irregular payments, inadequate information dissemination, and an inappropriate SBCC campaign) will reduce the potential impacts of the programme.

Source: Adapted from e-Pact (2014) *CDGP Evaluation Inception Report*, p. iv

The findings of this evaluation will be communicated to the state and federal governments in order for them to see the potential impact of the programme and in order to provide lessons that may be applicable in the ongoing implementation of the National Social Safety Nets Project (NASSP). The evaluation draws on a number of different methods (mixed methods) and interlinked workstreams for gathering evidence about the impact of the programme, including:

1. an initial **situation analysis**, which provided us with a strong contextual understanding of the poverty situation and the social and cultural dynamics within which households and communities in the two selected states operate. This study also identified other issues that we needed to consider and include in other parts of the evaluation;
2. a quantitative **household survey** before the programme had started (baseline), a midline survey, and one towards the end (follow-up) in order to determine the effect of the programme on key impact and outcome indicators that measure child nutrition, as well as the knowledge, attitudes and wellbeing of those reached by the programme;
3. a **process evaluation** that will: i) look at how the programme was implemented and identify the factors that supported or weakened implementation of the CDGP and its potential impact; and ii) explore, towards the end of the programme, why it has or has not succeeded in achieving its outcomes; and
4. a **longitudinal qualitative analysis** that follows a small group of households receiving the programme through three rounds of data collection (baseline, midline and endline) and explores, through individual discussions, their views about the programme and its impact on issues that are more difficult to capture in a household survey. This is combined with a series of group discussions with other community members to deepen understanding of the impact of the programme and whether it has led to changes in attitudes or behaviour.

1.3 Purpose and scope of the qualitative endline

This endline report presents the findings of the third and final round of qualitative data collection (workstream 4 above). The main objectives of the qualitative endline fieldwork were:

1. **Tracking changes**: to follow up with the same communities and case study households as in the baseline and midline, in order to investigate what has changed and what has happened in relation to our key research themes. This includes, but is not limited to, any changes brought about by the CDGP.

2. **Completing the longitudinal case studies**: to expand our knowledge of the communities and the case study women and their households, filling any gaps in background information and adding further questions on topics selected after a review of the midline (qualitative and quantitative) findings.

3. **Further documenting the implementation of the CDGP**: to explore, at community and individual level, how the CDGP has been working in practice and how people have experienced it in these communities.

The endline report builds on and complements the findings of the situation analysis, baseline and midline qualitative research rounds. It also references and responds to the findings of the quantitative baseline and midline surveys (see evaluation overview above). By design, each round of the qualitative fieldwork has focused on different issues (within the broad thematic framework explained in Section 2), according to its timing in the life of the programme and in response to research gaps identified by the wider evaluation team after iterative review of the findings so far. Therefore, for a full understanding of the output of the qualitative workstream, it is recommended that this report be read together with the baseline and midline reports. However, this report can also be read as a stand-alone account of the endline findings.

1.4 Organisation of the report

Following this introduction, Section 2 sets out the methodology employed for the endline data collection and analysis, including the continuity of sampling and research themes from the baseline and midline, together with adjustments made to the methodology for this final (endline) round of research. The section then reports on the implementation of the fieldwork and the coverage achieved. It also notes the methodological strengths and limitations of the qualitative approach employed, some challenges met during its implementation, and consequent caveats about the interpretation of its findings.

Sections 3 and 4 are the core of the report and contain the main findings. Section 3 explores the experience and perceptions of beneficiaries and others in the selected CDGP-recipient communities, in relation to six key areas where the CDGP is expected to impact people's lives: food consumption and dietary practices; KAP (knowledge, attitudes and practices) in health and nutrition; household decision-making; livelihoods; risks and coping behaviour; and overall wellbeing. These thematic areas are drawn from the evaluation hypotheses and the programme theory of change (Annex A).

Section 4 focuses on the implementation of the programme, specifically on the exit processes as understood and experienced by the beneficiaries themselves and by the local CVs and committee members. As with the midline, this section is intended to complement the process evaluation (see Section 1.2).

Finally, Section 5 draws some key conclusions and observations arising from the findings, and considers their implications for the programme and the evaluation.

2 Methodology

2.1 Research themes

The qualitative component of the impact evaluation is structured around six research themes drawn from the CDGP evaluation hypotheses (Box 1 above) and Theory of Change (Annex A). These themes, which correspond to areas of life in which CDGP is intended to achieve impacts, are summarised in Box 2. The qualitative baseline report (ePact 2015a) explored how people in the selected beneficiary communities thought about and experienced these aspects of their lives before the CDG programme began. In the midline, we continued to investigate the same themes but with a focus on respondents' perceptions of any *changes* in these areas since the baseline fieldwork, and their understanding of the causes of such changes. At endline we continue to investigate and enrich our understanding of these themes with a focus on perceptions and causes of change over the past three years of CDGP operation. In line with our mixed methods approach, the endline focus was decided in coordination with the quantitative team, after both sets of midline findings had been reviewed and research gaps prioritised.

Box 2 Research themes (expected impact areas)

All three rounds of qualitative data collection have been structured around the following six thematic areas, which are drawn from the evaluation hypotheses (Box 1) and theory of change (Figure 2, Annex A):

1. **consumption patterns and dietary practices**;
2. negative **coping mechanisms** and risk-coping behaviour;
3. **household decision-making** and resource management;
4. **KAP** relating to health, nutrition, childcare and IYCF;
5. **livelihoods** (i.e. income sources and activities; assets and opportunities; how women and men make a living in different places and different seasons); and
6. overall material and relational **wellbeing**.

Gender and seasonality are treated as cross-cutting themes relating to all the above topics.

As shown in Box 2, seasonality is treated as a cross-cutting issue and is discussed wherever relevant within each theme. In contrast to the quantitative survey, each round of the qualitative work was designed to be conducted at a different time of year, to maximise our understanding of seasonal variation in diets, health and livelihoods. The first (baseline) round was conducted in late September and early October 2014, at the end of the *damina* (rainy) season, before the rollout of the programme began. The midline fieldwork took place approximately 18 months later in late February and early March 2016, towards the end of the *rani* (hot, dry) season. The third (endline) round was undertaken approximately 20 months after the midline, in late November and December 2017, during the *kaka* (harvest) season.

Within research themes 4 and 5, the endline particularly focussed on the following issues which were highlighted by the qualitative and quantitative midline findings:

1. Adoption of early and exclusive breastfeeding (i.e. giving babies only breastmilk, with no water or other liquids, for the first 6 months). Through the case study interviews, focus groups and key informant interviews, we explored in more detail whether, why and how mothers are

changing their practice in this key area for infant health and nutrition. If there is indeed a significant change, as both midlines suggest, it is important for the evaluation to understand whether this is caused by the CDGP and if so, by which component(s).

2. Effects of the cash transfer on the work activities, assets and incomes of beneficiary women and their husbands.

In addition to these areas of potential impact, both the midline and endline fieldwork included questions about the implementation of the CDGP, providing a community-level perspective to complement the Process Evaluation. At midline, information was collected about six key implementation processes (see the Qualitative Midline Report for findings on these):

1. Community sensitisation and communication about the programme;
2. Establishment and functioning of community institutions and volunteers;
3. Identification and enrolment of beneficiaries (off-line) and registration (on-line);
4. The payment system (delivery of the cash transfers);
5. SBCC about nutrition and health; and
6. Mechanisms for reporting and dealing with complaints.

At endline, since many of our respondents were either coming to the end of their cash payments or had already been exited from the programme, we focussed mainly on people's perceptions and experiences of the exit process.

2.2 Sampling

2.2.1 Community sample

Seven CDGP-recipient communities were selected for the qualitative research during preparations for the baseline data collection, and the same sites have been revisited at each round. They are distributed across all five LGAs where CDGP is being implemented, roughly in proportion to population densities. The sites were purposively selected in order to investigate the functioning of the CDGP in different contexts and to enable some contrast and comparison among the different sites, using the following criteria:

- A balance of communities assigned to T1 (low-intensity SBCC) and T2 (high-intensity SBCC);[5]
- Good and poor market access (indicator: distance to fruit and vegetable market, according to the community questionnaire);
- Good and poor access to health facilities (indicator: location/walking time to facility, according to the community questionnaire);
- Types of shocks reported in the past year, according to the community questionnaire. The questionnaire included natural shocks (drought, flood and crop damage) and man-made shocks (in-migration, curfews and violence); and

[5] This distinction was dropped from the qualitative analysis after the midline fieldwork (ePact 2017a) found that there was no systematic difference in implementation between T1 and T2 communities. The quantitative midline (ePact 2017b) also found no difference in exposure to the different high and low intensity channels reported by survey respondents, regardless of whether they were from T1 or T2.

- Expected diversity of livelihoods (e.g. agricultural, pastoralist, trading), based on local researchers' knowledge of terrain and location.

Table 1 summarises the characteristics of each site according to the sampling criteria applied at baseline. The sample size of seven communities was based on a judgement of the maximum coverage achievable, at an acceptable depth, with the resources available. The sample is not intended to be representative, rather it aims to enable exploration of a range of local factors which might affect the implementation and impact of the CDGP.

Table 1 Qualitative research sites by sampling criteria

State	Zamfara				Jigawa		
LGA	Anka		Tsafe		Buji	Kirikasama	Gagarawa
Community	Matseri	Doka Gama	Keita	Yankuzo	Kafin Madaki	Kokura	Kanyu
SBCC approach	T1	T2	T2	T1	T1	T2	T2
Fruit/veg market in community?	No ≤ 1hr walk	No ≤ 2hr walk	Yes	No ≤ 2hr walk	Yes	No > 2hr walk	No ≤ 2hr walk
Health facility in community?	Yes	No ≤ 2hr walk	Yes	Yes	Yes	No > 2hr walk	No ≤ 1 hr walk
Reported shocks *	None**	None**	D	D, CD	F, D, CD, IM	F, D, CD	F, D, CD
Livelihoods and terrain	rocky terrain mixed farming & cash crops	flood plain farming, trading, labour migration	"grain belt", diverse crop production	irrigated farming trading	close to state capital flood plain trading, labour migration, mixed farming, partly pastoralist	wetland (fadama) partly pastoralist, fishing	mixed farming, partly pastoralist

* *CD = Crop Damage, D = Drought, F = Flood, IM = In-Migration*

** *Although the listing survey reported no shocks in these communities in Anka, participants in the qualitative baseline said that floods and cattle raids were recurrent seasonal risks.*

2.2.2 Case-study sample

Each qualitative case study focuses on an individual woman (the 'focus woman'), although the interviews and analysis also include her husband and household. The cohort of 54 case-study women was established during the baseline and revisited during each round of qualitative fieldwork. Initially 84 women (12 potential CDGP beneficiaries in each qualitative site) were purposively selected from the quantitative team's listing survey, conducted before the baseline in 2014. Sampling criteria included the woman's age, ethnicity, experience as a mother (number of children), monogamous or polygamous marriage, spousal status (i.e. first or second wife, if polygamous), literacy, size of household, and wealth of household (as indicated by the assets and

housing quality indicators in the quantitative listing survey).[6] As with the community sample, the aim was to ensure an adequate variety of cases across all these criteria in order to explore a range of individual and household-level factors that might be expected to affect the impact of the CDGP. The case study sample is not intended to be representative, and the sample size was determined simply as the maximum achievable with the time and resources available.

After completion of the qualitative and quantitative baselines, the case study sample was cross-checked with the survey sample and the intersecting 'Q-squared' sample of 54 women who participated in both the quantitative and qualitative baselines was taken as the cohort of longitudinal case studies to be followed up in the midline and endline data collection. Linking the qualitative and quantitative samples in this way enables clearer analytical linkages and a better 'read-through' of findings between the methodological strands, as well as a more efficient use of qualitative research time because interviewers do not need to repeat questions about basic demographics and other indicators already collected by the survey teams.

Table 2 summarises the characteristics of the final case-study cohort. A detailed (anonymised) list of all the case study women, including their CDGP beneficiary status and selected basic data from the quantitative baseline survey, can be found in Annex B (Table 6). The baseline and midline data were used during the qualitative endline interviews to cross-check identities and basic demographics, and as a starting point for conversations.

2.2.3 Selecting key informants and focus group members

While the community and case-study samples are longitudinal and have remained the same for all three rounds of fieldwork, the selection of key informants and focus group participants is more flexible and has varied from round to round. Key informants for the endline were identified on the basis of their position in the community and their role in the CDGP (see section 2.3.1 below) using a gatekeeper approach: the first contact point was the CDGP team member for the LGA, who then facilitated contacts with the community leaders and volunteers. It is recognised that there may be an element of self-selection bias in the sampling of key informants, particularly the community volunteers (because the most active and committed CVs are more likely to have made themselves available for interview).

Participants for the focus groups in each community were identified and invited according to the characteristics required for each group (see section 2.3.2), with the assistance of the community key informants (TWC members or CVs, and sometimes the CDGP staff member). There are likely to be unknown biases in the selection of focus group participants by community members who are themselves research participants, and who may also have vested interests in the CDGP and the outcome of the evaluation, but this was considered unavoidable given the short time the researchers were able to spend in each community. The field teams were encouraged to make the focus group invitations as open and inclusive as possible, and to follow up with any individuals who wanted to talk to them outside the organised meetings.

[6] Further details of the sampling criteria and process can be found in the qualitative baseline and midline reports (ePact 2015a and 2017a).

Table 2 Case study numbers and characteristics (cohort summary)

	Zamfara				Jigawa			Total	% of total
	Anka		Tsafe		Buji	KKM	GGW		
	Matseri	Doka Gama	Keita	Yankuzo	Kafin Madaki	Kokura	Kanyu		
Total Q[2] case studies	**9**	**9**	**7**	**7**	**7**	**9**	**6**	**54**	**100%**
Marriage status									
Polygamous	2	4	3	3	4	4	3	**23**	**43%**
(first wife)	*1*	*1*	*2*	*1*	*2*	*0*	*1*	*8*	
(second wife)	*1*	*3*	*1*	*2*	*2*	*4*	*2*	*15*	
Monogamous	7	5	4	4	3	5	3	**31**	**57%**
Age group									
13–19	4	3	3	2	1	2	0	**15**	**28%**
20–29	1	5	0	3	3	3	6	**21**	**39%**
30–39	2	1	3	2	3	3	0	**14**	**26%**
40–49	2	0	1	0	0	1	0	**4**	**7%**
Pregnant at time of baseline	8	8	4	6	7	6	4	**43**	**80%**
Household size									
large (≥ 10)	3	0	2	2	3	6	1	**17**	**31%**
medium (5 to 9)	3	6	4	3	1	2	5	**24**	**44%**
small (2 to 4)	3	3	1	2	3	1	0	**13**	**24%**
Household wealth index									
Progress out of Poverty Index (PPI) Quartile 1 (poorest)	3	3	4	0	0	1	0	**11**	**20%**
PPI Quartile 2	2	4	1	1	2	1	2	**13**	**24%**
PPI Quartile 3	2	2	0	2	4	4	2	**16**	**30%**
PPI Quartile 4 (richest)	2	0	2	4	1	3	2	**14**	**26%**
Ethnicity / main language									
Hausa	9	9	6	7	7	3	5	**46**	**85%**
Fulani	0	0	0	0	0	6	1	**7**	**13%**
Gobirawa	0	0	1	0	0	0	0	**1**	**2%**

Data source: epact Quantitative Baseline data (collected Sep/Oct 2014)

2.3 Data collection methods

The endline used the same basic set of data collection tools as the baseline and midline, i.e. Key Informant Interviews **(KIIs),** Focus Group Discussions (**FGDs)** and Case Studies **(CSs)**. The characteristics of each interviewing method are summarised in Table 3, and the following sections outline the topics covered in each type of interview.

2.3.1 KIIs

In each community, semi-structured key informant interviews were held with at least one person from each of the five categories set out below.

1. **CDGP programme staff** knowledgeable about the selected community. The CDGP office at state level was requested to assign one member of their team for each LGA, who could assist the researchers with community-level contacts and also act as a key informant. Interviews with CDGP staff focused on the implementation of the programme in the selected community.

2. **Community Health Extension Workers (CHEWs)** responsible for CDGP activities in the selected community. CHEWs are involved in training and supervising Community Volunteers (see point 5 below), and in some cases are also involved in pregnancy testing for beneficiary enrolment. The checklist for CHEW interviews focuses on their experience with CDGP and the specific activities they have been involved in, and also asks for their opinion or observations of the social, nutritional or other effects of the programme on the community.

3. **Member(s) of the Traditional Ward Committee (TWC)**. These local governance committees are intended to play a central role in targeting and enrolment, sensitising the community, identifying the CVs, dealing with complaints etc. The TWC is usually led by the village or Traditional Ward head (*Mai angwa*).

4. Member(s) of the **male and female Beneficiary Reference Groups (BRGs)** in the community. The BRGs are established by CDGP and are intended to help beneficiaries to raise any problems or complaints about the programme. The membership of the BRGs may overlap with the TWC (i.e. some individuals may be members of both). For the endline, the same checklist was used for BRG and TWC interviews, as the midline had found that the distinction between the two was not always clear on the ground.

5. **Male and female Community Volunteers (CVs)** recruited for the CDGP in the selected community, including CVs who have received nutrition training. According to the implementation manual (CDGP 2015) CVs may also be community leaders or elders (e.g. religious leaders, TBAs, teachers, health workers, or representatives of different groups).

In Kokura (Kirikasama LGA, Jigawa) additional key informant interviews were conducted with four local leaders (two female and two male) from the Fulani community, to ensure that their perspectives, and any important differences from the main (majority Hausa) settlement at Kokura, were captured.

2.3.2 FGDs

The following four focus groups were held in each community:

1. FGD1 – Currently or formerly enrolled **beneficiary women** (other than the case study subjects);
2. FGD2 – Currently or formerly enrolled **beneficiary husbands**;
3. FGD3 – **non-beneficiary women**; and
4. FGD4 – **non-beneficiary men**.

Each focus group consisted of between six and twelve individuals, convened as explained above (section 2.2.3). The topic guides for the beneficiary women focused on their experience with the CDGP, particularly the exit process. Questions were included about any changes or effects (good or bad) of the CDGP, and the participants' overall opinions of the programme. Beneficiary husbands were also asked about their knowledge and opinions of the CDGP in general, and specifically about control of the cash within their household, whether they had heard any of the SBCC messages, and their views and experience regarding the inclusion of men in the programme.

The non-beneficiary focus groups were asked a more general set of questions about any significant changes or events in the community since the baseline, and about seasonality (with a focus on food security, dietary diversity, health factors, livelihoods and incomes during the current harvest or *kaka* season in this community). They were also asked about their knowledge of CDGP and its processes, whether they had heard and/or followed any of the SBCC advice, and their opinions on any effects of the programme in their community (including social, indirect, and economic effects).

In all the focus groups, a set of questions were asked about breastfeeding and complementary feeding of infants.

Table 3 Description of data collection methods

	Case studies	KIIs	FGDs
Description	In-depth interviews and observations with individual women and their households, about their own lives and experiences	Semi-structured interviews with experts or people with an overview or special knowledge of a place or a topic	Participatory, interactive group discussions using checklists and prompts
Number of participants in each interview	One-to-one	One-to-one, or with small groups of two to four key informants	Six to 12 people
Sampling / selecting participants	Pre-selected during baseline (see section 2.2)	Individuals identified according to their role in the community or the CDGP: • CDGP staff • CHEW(s)	Participants fitting the following group criteria invited with the assistance of CVs or other key informants:

	Case studies	KIIs	FGDs
		• TWC member(s) • BRG member(s) • CVs	FGD1: CDGP beneficiaries (women) FGD2: CDGP beneficiaries (husbands) FGD3: Non-beneficiaries (women) FGD4: Non-beneficiaries (men)

Two additional focus groups were conducted in Kokura, with Fulani women and Fulani men, to ensure that their perspectives were included and to explore any relevant differences in their social and cultural context that might have affected the implementation and impacts of the CDGP.

2.3.3 Case studies

For each round of fieldwork the field researchers aimed to conduct three interviews per household, with the focus woman herself, her husband, and one other influential woman in the household (most often the focus woman's mother-in-law, sometimes a co-wife or sister-in-law), using semi-structured interview guides.

The case study interview guide contains sections on any further changes in the household since the midline interviews, structured along the lines of the key research themes (consumption patterns and dietary practices; household relationships and decision-making; health; livelihoods and income; risks and coping behaviour; and overall wellbeing).These sections include open questions about respondents' perceptions of the reasons for any changes identified. As noted above, at endline the questions on CDGP implementation focus mainly on beneficiaries' experiences of the exit process, as many of our case study women have completed their CDG programme cycle. Open questions were also asked about their overall opinion of how the programme has been implemented, with the opportunity to highlight any aspects they were dissatisfied with or wanted to comment on.

2.3.4 Citizen Report Card (CRC) tool

For the endline we introduced a new data collection tool, adapted from the CRC (Citizen Report Card) approach.[7] The tool consists of a five-point score-card inviting participants to rate the implementation of the CDGP (specifically the exit process, but also the programme overall), and then explain why they gave that score. A score of 1 represents "Very unsatisfied" and 5 means "Completely satisfied". This was included in the interview guides for key informants, focus groups and case study participants.

This tool was introduced in response to the field team's observation during the midline that respondents were reluctant to say anything negative about the CDGP, and were perhaps under-reporting problems and dissatisfactions (see *CDGP Evaluation Qualitative Midline Report*, ePact

[7] Citizen Report Cards (CRCs) are participatory surveys that solicit user feedback on the performance of public services.

2017a). Box 3 gives the suggested steps for applying the scorecard method in a focus group context. In the full CRC methodology the scorecard is applied to a representative sample and analysed quantitatively.[8] However, it is important to note that for our purposes the scorecard was used simply as a tool to elicit more nuanced feedback from participants and then to focus the follow-up discussion on the negative or dissatisfied responses. No quantitative analysis of the scores was possible or intended, given the small purposive sample and the open-ended interview techniques employed.

Box 3 Method for scorecard discussions in FGDs

Method for scorecard discussions in FGDs:

1. Give each participant 1 counter *[you could use beans, or stones, or anything else appropriate – have a bag or pocketful ready]*.

2. Explain the question and the scoring. Then ask everyone to think about the question and decide what score they will give.

3. Ask each person to place their counter on the score they have chosen *[have the score-card ready on a flip-chart paper]*.

4. Let everyone see how many "votes" were given to each score. *[remember to record the numbers in your notes and photos]*

5. Start a discussion around the scores, e.g. everyone who said it was very bad or partly bad (any score other than 5) – what are your reasons for saying that? What do you think should be done differently? etc. *[NB: The discussion is the most important part of this exercise – follow up and encourage people to explain in as much detail as possible. Notice which opinions generate a lot of agreement or disagreement. Be sure to allow enough time for the discussion.]*

Source: Sharp and Cornelius 2017, *CDGP Evaluation Qualitative Fieldwork and Training Guide: Endline*

In combination with all the above methods, the field researchers made maximum use of their time by carrying out systematic **observation** of the households and communities during and between interviews. These observations were noted in a separate section of interview transcripts, or reported through the debriefing workshop and team leaders' reports (see section 2.4 below).

Further details of the data collection methods, including checklists and interview guides, can be found in the Endline Fieldwork and Training Guide (Sharp and Cornelius, 2017).

2.4 Fieldwork implementation

Fieldwork was carried out in late November and December 2017, following a four day training workshop for all field team members held at Ahmadu Bello University (ABU) in Zaria. One team of six researchers was deployed in each state, with the two teams working simultaneously, giving an average of approximately four days for each community (including travel time). The majority of field researchers had also participated in the baseline and midline work, which provided continuity in the

[8] See, for example, World Bank (2004) *Citizen Report Card Surveys: a Note on the Concept and Methodology*. Social Development Notes No.91.

methodology and understanding of the evaluation objectives, as well as familiarity with gatekeepers and leaders in the research communities. Each team comprised four women and two men, as the majority of interviews are with women. In the Jigawa team, two of the senior female researchers were Fulfulde speakers, to facilitate interviews with the Fulani participants there.

Table 4 summarises the number of case study households, key informants and focus group members who participated in the endline research in each community. Overall, a total of 53 people (22 women and 31 men) were interviewed as key informants, while 251 people (128 women and 123 men) participated in the focus groups.

Table 4 Scope of endline data collection (number of participants by community, method and gender)

State	Zamfara				Jigawa			Total
LGA	Anka		Tsafe		Buji	Kirikasama	Gagarawa	
Community	Matseri	Doka Gama	Keita	Yankuzo	Kafin Madaki	Kokura	Kanyu	
Case studies (households)	9	7	6	7	7	9	6	51
Key informants								
CDGP staff	1m		0		1m	1	1	4
CHEWs	1m	1m	1m	1m	1f	1m	1f	7
TWC/BRG members	3 (2m:1f)	3(2m:1f)	3(2m:1f)	3(2m:1f)	2(1m:1f)	3(2m:1f)	4(2m:2f)	21
CVs	2 (1m:1f)	4(2m:2f)	4(2m:2f)	2(1m:1f)	2(1m:1f)	1f	2(0m:2f)	17
Fulani Local Leaders	n/a	n/a	n/a	n/a	n/a	4(2m: 2f)	n/a	4
Focus groups								
CDGP beneficiary women	10	10	7	10	9	7	8	61
CDGP beneficiary husbands	11	11	10	7	8	10	9	66
Non-beneficiary women	10	0	10	8	10	10	10	58
Non-beneficiary men	8	0	6	10	9	6	10	49
Fulani Men						8		8
Fulani Women						9		9

Case study interviews were carried out with members of 51 households out of the total cohort of 54 (see Section 2.2 and Annex B), although it was not possible to conduct the complete set of three interviews in all cases. Of the 51 women who are the focus of these case studies, 9 were current beneficiaries of CDGP at the time of the endline interviews while 37 were former beneficiaries, and 5 had never been registered.

Of the three case study households who could not be interviewed at endline, two had migrated from Doka Gama (Anka, Zamfara) because of security problems before the midline, and had not returned. One household from Keta (Tsafe, Zamfara) had relocated to Abuja for economic opportunities.

2.5 Data processing and analysis

Data analysis broadly followed the same multi-tier approach as the situation analysis, baseline and midline reports, with some adjustments reflecting learning from the previous rounds. A debriefing workshop for all the field researchers was held at ABU in Zaria after the end of the fieldwork. The field teams' preliminary findings, observations and impressions were captured in the workshop proceedings and in team leader reports, which were provided separately. In addition to observations on the communities these reports discuss fieldwork experiences, including reflections on the methodology and factors to note for future research.

Full transcripts of all the interviews and discussions were written up by the field researchers using their own recordings and field notes. The transcripts were then uploaded into the data analysis software Dedoose, and tagged by two Itad staff consultants according to the thematic coding structure set out in Annex E.

The information from these transcripts and codes was then initially reviewed for quality assurance, and to identify the main narrative threads emerging from the endline data under each of the six themes, process codes, and the areas of focus highlighted above. These narrative threads, and the extracts linked to each code, were then reviewed and compared in order to draw out a thematic summary and to highlight key points or insights, with illustrative quotations, under each topic.

All the case study transcripts were included in the coding and thematic analysis. In addition, the case studies were reviewed longitudinally, reading the focus women's interviews together with those of their husbands and other household members, and comparing what they said at endline with the midline and baseline data. Selected case study stories are presented in boxes throughout the report.

2.6 Strengths and limitations

The qualitative research aims to complement the quantitative survey analysis by investigating how and why people in the selected communities act or believe as they do; how social, cultural and economic contexts affect their decisions and their use of cash transfers; and whether or how the expected transmission mechanisms of the CDGP work in practice. Semi-structured interviews enable people to express their opinions and experiences in their own way, which can provide a wealth of insights into how they view the programme and how it is affecting their lives. The report makes extensive use of verbatim excerpts from the interview transcripts in order to capture as much of this as possible. However, this approach also means that different respondents are not always answering exactly the same questions or choosing all the same topics to respond to. Therefore, it is not always possible to directly compare their answers.

In reading this report it should be kept in mind that the sampling of the communities and of the case study women is purposive.[9] This approach aims to capture variations in contextual factors that are likely to affect the implementation and impact of the CDGP, but it is not intended to be representative either in a statistical or a qualitative sense. The findings therefore should not be generalised. Throughout the report, expressions such as 'most respondents' or 'a few beneficiaries' are used in a descriptive sense and always refer to 'most' or 'a few' *of the small purposive sample of respondents in this qualitative research*. The analysis highlights areas where there appears to be either unanimity or variation in the findings within or between the selected communities and groups (e.g. by location, gender or ethnicity), but it does not attempt to quantify these observations in a more general sense. The mixed-method design of the overall evaluation means that the qualitative findings and insights can be triangulated with those of the quantitative midline survey, to estimate the frequency and magnitude of the impacts described here.

By design, the qualitative component of the evaluation is being carried out only in beneficiary communities,[10] and primarily with beneficiary case study households. Within the study communities, FGDs were also held with non-beneficiaries (both women and men), to capture their perspectives on the programme, and to triangulate some of the findings from beneficiaries. A minority of the case study women (5 out of 51 households interviewed at endline) had never been beneficiaries.[11] Where appropriate and useful, statements by beneficiaries and non-beneficiaries are juxtaposed in this report. However, the sampling and methods used do not allow a systematic or generalisable comparison between treatment and control groups. The focus of the longitudinal case studies is on beneficiaries.

Attribution of any changes (e.g. in people's diets, behaviour or livelihoods) to the effects of the CDGP cannot be definitively established through qualitative methods. However, respondents in both the midline and endline fieldwork were asked what they thought had caused any such changes, in order to identify and explore causal pathways and other possible factors which may not have been anticipated in the quantitative survey.

As noted in previous rounds, the separation of research functions between the Theatre for Development Centre (TFDC) team (who conducted the fieldwork and wrote the interview transcripts) and the UK-based researchers (who designed the data collection, coded and analysed the transcripts and wrote the report) is not ideal for a qualitative enquiry of this kind. This separation is largely dictated by the security conditions in Northern Nigeria, which made it impossible for the international team members to participate in the fieldwork. In order to mitigate these limitations as far as possible during all three rounds, the TFDC senior researchers were requested to provide team leaders' reports on the fieldwork in each state, and to record their own observations, interpretations and comments. All the field researchers were encouraged to make their own observations (clearly separated in the transcripts from the words and opinions of the respondents), to use the field guide as a framework for flexible enquiry in the field (rather than rigidly following the checklists and thematic questions), and to discuss their findings and

[9] See Section 2.2.

[10] The quantitative component, by contrast, is a cluster randomised controlled trial, in which communities have been randomly selected either to receive the CDGP interventions (treatment groups) or not to receive those interventions (control group). The impacts of the interventions are estimated by comparing households in the communities where the programme interventions are applied with households in communities where they are not.

[11] All the case study women were selected at baseline because they were likely to become beneficiaries (not in order to achieve a balance of treatment and control cases).

observations during the post-fieldwork debriefing workshop. These reflections from the field were documented in the debrief minutes.

For the endline, two additional adjustments were made to mitigate this separation of research functions. The training workshop (which itself built on lessons learnt from the baseline and midline) was extended to four days, with the participation of the UK-based Itad project manager, in order to ensure all researchers understood the objectives of the endline and were familiar and comfortable with the research tools and field guide. Additionally the cleaning and coding of the transcripts was taken 'in house' and undertaken by Itad evaluators who also then contributed to the analysis and report writing.

At midline, the TFDC researchers reported that it remained very difficult to interview the Fulani case study women in Kokura, who seemed reluctant to be interviewed or would respond with only very brief answers. The midline research gained some insights into the challenges of fully including the small minority of Fulani communities in the CDGP, which are discussed in the midline report. However, our understanding of their livelihoods and practices, and how these might be impacted by the CDGP, remained rather limited. At endline, further efforts were made to fill these knowledge gaps by introducing additional key informant interviews and focus groups specifically for the Fulani community in Kokura.

The field researchers also noted at midline that there was a reluctance among the households and wider communities to reveal anything negative concerning the CDGP. The TFDC researchers had the impression that things were sometimes not being said in interviews, and that participants might have been 'pre-briefed' (perhaps by the local leadership) not to say anything that they thought could jeopardise their or their community's beneficiary status. This may be compounded by some respondents' perception that the research teams were representing CDGP (despite clear and specific explanations to the contrary). It seemed likely, in other words, that negative experiences or problems were under-reported. To counteract this as far as possible during the endline, the field teams received further training on the use of 'probing questions' in interviews, and following up any complaints or negative experiences they heard about. The addition of the CRC scorecard tool (described above, section 2.3.4) also addressed this problem by helping to elicit more details of the beneficiaries' experiences of the CDGP processes, both positive and negative. This tool proved effective in counter-balancing the suspected positive bias by encouraging respondents to explain any complaints or suggestions for improvement, in relation to specific components of the programme.

Finally, security concerns (particularly in Anka LGA, Zamfara) continued to limit the hours the teams could spend in the communities, and therefore the depth of research.

3 Thematic findings (impact areas)

3.1 Consumption patterns and dietary practices

At midline, CDGP beneficiaries reported that the quantity, quality and diversity of foods they were providing for themselves and their children had significantly improved, mainly due to the cash transfer combined with the nutrition knowledge and cooking tips they had learned from the SBCC campaign. The endline fieldwork took place during the *kaka* (harvest) season, when food is generally more abundant and varied. Therefore, our questions around this research theme at endline focused on adding to our understanding of seasonal factors in people's dietary choices.

Harvest season is generally a time of abundance, when a variety of fresh foods are available from households' own farm production as well as from the market. At the same time money is easier to come by, from farm sales, seasonal employment and effective demand for services.

> "It is normal, every harvest season people have more food to eat. So now everybody in this season eats to satisfaction because every home has enough to eat...
> You do not find anyone complaining of hunger during this season. Through the teachings our community have learnt from CDGP, you see now people add fish and meat to their food, women even fry eggs to eat because there is money and they have been told these foods are good and help prevent sickness and infant deaths."
>
> Keta FGD – Non-Beneficiary Husbands

> "During harvest, like we are now, there is increase in the diversity and quantity of what we eat and that also rubs off on the children. There is also more money from the farm produce this season so it is easy for us to purchase more food for them. Like we said earlier God has helped us and we have been having bumper harvests over the last 3 seasons."
>
> Yankuzo FDG - Non-Beneficiary Husbands

This year has been a particularly good harvest for most people in these communities (see Livelihoods section). For example in Keta:

> "people eat better and more nutritious meals because the harvest is more this year than last year, there is more money and more ingredients and the food is more nutritious".
>
> Keta FGD - Beneficiary Women

In Kafin Madaki, this group of beneficiaries listed the wide variety of foodstuffs they were able to access at this time of year:

> *What do you and other women in this community spend the cash transfer on? Has this changed since our last visit (midline)?*
>
> We spend the cash on foodstuff. We buy food such as rice, beans, fish, and fruits, and some ingredients needed to prepare them. We also buy meat, eggs and soft drinks, mostly malt drinks.
>
> *Do you spend it on different things at this time of year (kaka / harvest)? Please give examples, what are you spending the cash transfer on this season?*
>
> Before, we couldn't afford the variety of choices of food – unlike now, thanks to this programme, we can go out and buy many things.
>
> At this time of the year leafy greens like moringa and *tafasa* are available so we include them in our meals. I sometimes buy smoked fish, mutton or beef in the evenings.

> We also have good things that we cook; it is just that we could not afford such things on a daily basis. So some days and during ceremonies we do eat well.
>
> In addition to whatever my husband brings, I buy malt drinks, milk, meat, fish, beans, tofu and some other things.
>
> There is a difference now because in the past we just managed with whatever our husbands can afford but with the money we are getting we can now afford to provide our families with variety of dishes.
>
> At this *kaka* time things that are available include groundnut, millet, sorghum, beans, hibiscus and maize.
>
> From my husband's farm we got beans, sorghum, groundnut, hibiscus and maize. The rest we get from the market."
>
> Kafin Madiki FGD - Beneficiary Women

Because of the better understanding people now have about the nutritional value of different foods (particularly vegetables and "body-building" or protein foods), farmers are choosing to keep more of their own production of some high-value crops rather than selling it all. For example in Kokura:

> *"*They now eat more vegetables like lettuce, tomatoes, than before, and from the rice that is the major cash crop that they produce in the area, they process a lot of it for subsistence consumption more than before. In addition, they now also cultivate and retain beans for household consumption and do not sell all the harvest off for money which used to be the case. Then in the Kokura area, because it is wetland, they have access to fisheries, the only problem is that there was shortage of rain in the past wet season and so the wetlands around the river banks where they normally catch fish has not yielded much fish this year."
>
> Kokura KII – TWC/ BRG members (male)

Since CDGP's food and cooking demonstrations emphasize making best use of locally-available ingredients, the demonstrations are also adapted to the season, as explained by this CV in Keta:

> "When it comes to food demonstration, we consider the season first. For instance we are in *kaka* (harvest) where there is abundance of sorghum which is one thing we farm a lot, we explain to them how to make sure they remove the chaff before they grind it for any purpose they want to use it for."
>
> Keta KII – CV (Female)

The question of whether dietary improvements will be sustained after the end of the cash transfer was also discussed. By the time of the endline fieldwork (November / December 2017), although the CDGP was still running, many of the individual beneficiaries participating in our interviews had already exited the programme and stopped receiving the cash transfers. Some women noted that without the cash transfer, it would be difficult to continue purchasing the same types and quantities of food that they could buy when they were on the programme. Others, however, believe that they will be able to maintain the improvements in their families' diets. In many cases the cash transfer has enabled them to expand their businesses or invest in assets (see Livelihoods section below), from which they expect enhanced future incomes. Also, the knowledge gained about the balance of foods needed for a healthy diet, and cooking techniques to maximise the nutritional value of meals, should help to maintain some of the gains made in dietary diversity and quality, even for households on very tight budgets. However, key informants as well as beneficiaries reiterated the point made throughout this evaluation, that the main factor in poor diets is not knowledge but poverty.

> "To be honest, I was feeding as advised when I was still receiving payments but now I cannot afford them in quantities that I could afford at that time…formerly I could buy and eat

anything I wanted to but now that I am off the support I have to manage funds so that I can still operate my business. So I can only afford small amounts."

Matseri FGD - Beneficiary Women

"If there's abundance of money, one can always eat those [recommended foods]... If the man does not have money to provide this you have to be understanding…Yes, it's the money, we all know what we are supposed to be eating."

Keta FGD – Non-Beneficiary Women

"When I have money, I eat well once in a while…Money is what makes it difficult to follow the advice in the messages: to eat vegetables, beans, fish and milk."

Yankuzo FGD – Non-Beneficiary Women

"Without the cash transfers even if we advise women on what to eat, it may not make any sense to them because they lack the means to buy these kinds of food."

Yankuzo KII – CHEW (Male)

The real test of the sustainability of the CDGP's impacts on beneficiaries' diets is likely to come in the next lean season (which peaks during the *damina* rains between July and September). Respondents in both the midline and endline interviews said that the cash transfer had been particularly helpful in maintaining the quality and diversity of their diets during these difficult months, when stocks of their own production are low or finished, and market prices are high.

Case study example 1, below, includes an explanation of how the types of food item purchased with the cash transfer change according to the season.

Case study example 1: "My wife has become a pillar of support" (Doka Gama CS1)

Mrs. Z.S. – Current beneficiary

Z. was 21 at the time of the baseline and already had two children, having married at 15. She is her husband's only wife, and her household was in the 2nd PPI quartile (i.e. below average wealth) in 2014. The extended household includes her husband's mother and grandmother, as well as his younger brothers with their wives and children. One of her sisters-in-law is also a CDGP beneficiary (at endline, December 2017).

At midline Z. had a two-month-old baby girl and had been receiving CDGP benefits for about 8 months. At that time she explained that she was practising exclusive breastfeeding with her CDGP baby, unlike her two older children who had been given cow's milk for the first two days before she began breastfeeding them and then were given water alongside the breast milk. Her husband had heard about EBF before on the radio, but they had only been persuaded to try it when the CDGP CVs and trainers had explained it directly to them and shown them the benefits. They were happy that their baby was doing well and looked healthier than her older siblings.[12]

At endline (December 2017) her daughter was 22 months old and still doing well. Z was still receiving the cash transfers (a total of 28 months support so far). Looking back, Z. says that her experience with her CDGP baby was better than with her previous children in a number of ways, starting from her pregnancy when the cash transfer enabled her to eat well. She attributes her easy delivery this time to being well-nourished and healthy:

"I was very strong through the pregnancy, and I ate a lot of beans and vegetables - spinach and zogale. In fact I was with people when the labour started yet they did not know I was in labour. I gave birth later in the evening. I gave birth in my room and my mother-in-law cut the cord....

[12] See Qualitative Midline Report, Case Study Example 2.

> ...During the previous pregnancies, I was able to eat some good foods like beans frequently only if the pregnancy was during harvest season, but once harvest is over, I cannot afford it. But with this cash transfer I was able to afford the meals we are advised to eat more regularly whether harvest period or not."

Since the birth, Z. has continued to enjoy the cash transfer and follow all the advice from the CVs and other CDGP representatives (including her husband, who is a BRG member and has been to Anka for training). She began breastfeeding the day her daughter was born ("as soon as her cord was cut, I placed her to breast") and continued with EBF until she introduced the recommended complementary foods at 6 months. Compared with her older children, her CDGP baby has been healthier and developed faster, as she explains:

> "She was a big baby and she has been healthy throughout, she does not come down with fever like her other siblings used to while they were small. In fact you know this *rubutu* that we use to give babies? We did not give her and it was very easy to wean her from breast milk unlike her other siblings....
>
> ... [M]y other children especially [her] elder sister was always ill, we had to be going to the hospital, but with [this baby], we did not have any cause to go to the hospital as we followed all the advice we were given....
>
> ... [S]he crawled and walked earlier than her other siblings, [she] walked at 1 year 2 months while her elder sister walked at 2 years."

Her husband (S.) also noted the difference in the health of his youngest daughter compared to her siblings, saying that EBF has brought "a lot of changes":

> "Less frequent visits to the hospitals is a major difference for me. The child is very healthy and we didn't have to visit the hospitals when compared to our first child. There is a great difference in the health and wellbeing of the girl we had under this project and the ones we had before CDGP."

Both of them say their decision to try EBF was influenced by the detailed information and pictures provided by the CDGP, and by the support of influential community members. Receiving the cash transfer gave an extra motivation. As Z says, "after receiving this support from them during pregnancy, it was only normal for me to try the advice they give us on breastfeeding." On the same question, her husband added:

> "It was the same information that was disseminated to every member of the community, but those who had the cash transfer had the incentive to practice EBF. Some people felt discouraged that they were not part of the cash transfer and so refused to adopt the practice."

Z herself did not find it difficult to adopt EBF, because she had the support of her husband and she already had the example of other women in the community to follow:

> "I was confident in the things I have heard and I had seen some women practice it. I was not among the first set of women to benefit from the programme, I was in the second cohort, so I had seen the outcome of exclusive breastfeeding."

At midline, Z explained how she used the cash transfer mainly to buy good food for herself and her family, sending her husband to market to buy what she wanted. At endline, buying nutritious foods was still top of her list of uses for the cash transfer, but the types of food purchased had changed because of the season:

> "... now it is harvest, my husband can bring things from the farm for us to eat, I do not have to buy food stuff except the ingredients to make the food more nutritious; palm oil, seasoning cubes, tomato, pepper, onion, fish, but during the other season, the barns are empty, I have to contribute to the purchase of [staple] food items like rice, beans, pasta and even maize. You see this way I have supported the man."

Over the three-year evaluation period, Z. has been able to expand her small home-based trading business and increase her income. At baseline, she was only doing a little trade in salt and *tuwo* (paste made from pounded grain). By the midline she had already been able to diversify her trade, adding *kuli kuli* (groundnut cakes) and Maggi seasoning, buying wholesale from the market and re-selling in her neighbourhood. At the endline, she had added tomatoes and *kuka* (baobab leaves) and said her income was higher now. She attributes this expansion in her business to the cash transfer ("When I receive the money, I am able to spare some to invest in the trade").

She has also been able to save enough through monthly contributions to a rotating savings club *(adashe)* to invest in small livestock:

> "[W]e were advised to save about N500 and we were 10 in a group. When it is my turn to collect I take N5000.... I bought a female goat and a chicken and now the chicken has hatched other children."

Through her work and savings, Z has been able to contribute financially to the household and to give small cash gifts to her husband and other household members "so that they can give blessing", enhancing her relationships and status in the household and giving her a degree of economic autonomy which she clearly takes pride in:

> "I did not think that I can have some things but see Allah has brought them to me: the goat and chicken I have, I did not know that I will be able to do anything for myself or my children, I thought I will always be dependent on my husband, but now I have money to even support him with the family responsibilities."

Looking to the future, Z. and her husband are sure they will continue to practice exclusive breastfeeding: "We have started the practice and that is how we will continue because we can all see the benefits".

Her husband (S.), alongside his farming ("you know everyone in this community farms"), is a barber and provides a laundry service. These activities and the income they generate are intermittent and highly seasonal: "[p]eople have more resources and funds ...[for these]... services during the harvest season than during the rainy or planting season". The regular cash transfer has helped to smooth gaps in his income:

> "You know for a community like this, you don't find people coming to a barber or demanding laundry services daily. But my wife has become a pillar of support, with the advent of this programme, for me especially when the business is not moving and there is low patronage. My wife has helped to fill the void, in terms of meeting daily family needs, even before they come to my attention and this has brought me great relief."

Z. is hopeful that she can also sustain her independent income from trading: "I hope that I will be able to reinvest my profits so that the business can continue." Her husband is perhaps less optimistic, saying that of course they will miss the extra income when the cash transfer stops: he does not expect Z to be able to continue the financial support she has given him over the past two years.

3.2 KAP (health and nutrition)

3.2.1 Breastfeeding

At midline (2016) both the quantitative and qualitative research streams found a marked change in knowledge and self-reported behaviour around breastfeeding, particularly the practice of exclusive breastfeeding (without giving water or any other liquids) for the baby's first six months. The quantitative midline report found that "70% of children under six months were reported as being exclusively breastfed in CDGP communities, compared to 28% of children in non-CDGP communities". At baseline (2014, before the roll-out of CDGP) the mean rate across all the surveyed communities was 10%. The qualitative midline provided independent triangulation of this apparent shift, as summarised in the box below.

Box 4 Qualitative midline findings on exclusive breastfeeding

> "During the baseline discussions few people knew about the government-backed advice on exclusive breastfeeding, and most of those who had heard it (for example, from hospital staff) were sceptical or said they were unable to practise it. By contrast, during the midline, almost everyone who talked about this issue was able to repeat the SBCC message, and a number of beneficiaries mentioned the pictures shown by CVs to explain the differences in health and development between babies who were exclusively breastfed and those who were not. Many women said they had adopted exclusive breastfeeding and had seen the difference in their babies' health and development, compared to earlier children. Husbands of beneficiaries were generally aware of this new advice and were supportive, and many commented on the better health of their children.... This change in breastfeeding KAP is not limited to direct beneficiaries: the new knowledge seems to be widely shared in the communities."
>
> Qualitative Midline Report (ePact 2017a) p.39

Given the apparent size of this effect and its potential importance for child health and nutrition, the qualitative endline aimed to dig deeper into the factors which might be helping or hindering mothers to adopt the new practices, and to understand how far the reported behaviour change is likely to reflect actual practice.

Have breastfeeding practices really changed?

The Social and Behaviour Change Communication (SBCC) component of CDGP includes three key messages on breastfeeding (see Annex F):

- Place the newborn on the breast within one hour of delivery (early initiation).
- Do not offer pre-lacteal feeds[13] to your baby.
- Practise exclusive breastfeeding (from birth to six months of age) – no water, no formula.

The discussions about breastfeeding during the qualitative endline highlighted the fact that in practice these recommendations are very closely interlinked, as delaying the start of breastfeeding almost inevitably means giving the baby something else in the meantime, and once started the practice of giving other liquids is likely to be continued. These three aspects of breastfeeding are therefore discussed together in this section, with a particular focus on the third (exclusive breastfeeding or EBF).

Overall, the endline interviews support the midline findings: many respondents in all our research communities say they have adopted the new breastfeeding practices themselves, or have supported their wives to do so, or would advise other women to do so, because they believe it is better for the baby's health and nutrition. This appears to be particularly (but not exclusively) the case among younger women, suggesting, as found in the qualitative baseline, that a generational shift in attitudes and practice may be happening. Among our focus group participants, non-beneficiaries as well as beneficiaries are aware of and practising the new advice. A number of

[13] Defined as anything (including water) given to the baby before beginning to breastfeed. This is a common practice in many countries, and Nigeria has the highest prevalence of pre-lacteal feeding in Sub-Saharan Africa (based on data from the Nigeria Demographic and Health Survey 2008, cited in K. E. Agho et al. (2016)). The 2013 DHS found that the national prevalence had risen from 56% in 2008 to 59% in 2013. Disaggregated by state, the rates in 2013 were 52% in Zamfara and 69% in Jigawa (National Population Commission 2014).

people also mentioned that they are spreading the information and showing off their healthy babies outside their communities of residence (for example, women visiting their parents' villages and men travelling for trade or work).

However, it is clear that not everyone is convinced. Some respondents said that they had not adopted EBF and did not believe it was beneficial for the baby or better than what they are accustomed to doing.

> "I gave my children water and I see them grow well, so I didn't see the need of starving them water. Besides is water a bad thing? I really don't know the use of this exclusive breastfeeding".
>
> Keta CS5 – Focus Woman (former beneficiary, mature exit)

A careful reading of the interview transcripts suggests that some people (both women and men) who say they have adopted EBF may be giving the answers they think CDGP wants to hear. In these cases the answers are hesitant or lack detail, and do not go beyond apparent rote repetition of the messages they have heard. On the other hand, many of our respondents (particularly in the beneficiary case studies) provide convincing details and discussion of how and why they have adopted the new practices, including how they dealt with doubts and opposition, and the effects they have observed in their children. Given the qualitative methods and purposive sampling employed, we do not attempt to quantify how many have genuinely adopted the new practices, but it is clear that some people have done so and that they attribute the change partly or wholly to CDGP. The following sections examine the reasons given either for adopting or rejecting EBF, and factors which persuaded, supported, or hindered those who wanted to follow the new advice.

Barriers

As discussed in the Situation Analysis and Baseline reports, there are a number of customary practices and beliefs around breastfeeding in these areas of northern Nigeria. These include not breastfeeding the baby for the first few days; discarding the colostrum (or "first milk") in the belief that it is "dirty" and harmful for the child; and giving the baby prelacteal feeds variously including water, animal milk, or herbal infusions. After initiation of breastfeeding, giving the baby water alongside the breastmilk was considered normal and an almost universal practice at baseline. Not surprisingly, at endline we found that all these practices are still followed to some extent, and that some people are resistant to changing them. However, both the Situation Analysis (2013) and the Baseline (2014) found that change was already happening before CDGP started, particularly regarding early initiation and colostrum. The qualitative midline and endline findings both suggest that this process of change is continuing, and that CDGP has contributed to an increasing number of parents deciding to adopt the "modern" practices, although we also encountered examples of potentially harmful practices persisting.

The feeling that denying water to a baby is "heartless" or "punishing the child", especially when the weather is hot, was mentioned by many respondents. At the extreme, people fear that the baby will die of thirst if not given water. Some still feel this and are continuing to give their babies water, while others were explaining their earlier fears (which had now been overcome through experience of EBF or through the explanations by CVs that breastmilk also contains water), or relaying what other people (especially older people) were saying.

> "I don't practise it [EBF].... I feel that how can you as a parent drink water and then refuse ... to give your own baby water to drink. I feel you are punishing the baby. It is not a good thing."
>
> Kokura CS2 – Co-wife (non-beneficiary)

Giving *rubutu* or “prayer water” to a baby to drink is an important ritual to welcome and protect the newborn. *Rubutu* literally means “writing” in Hausa: extracts from the Qur’an are written on slates, and washed off so that the water can be drunk. This is viewed as a religious ritual rather than a feeding practice: some of our respondents mentioned it as an afterthought having said that their babies were not given water, suggesting that it might be under-reported when mothers are asked about exclusive breastfeeding. For example:

> “...even with my first baby ..., apart from the *rubutu* that she was given at birth, she was not given water until 6 months because I told my mother not to.”
>
> Yankuzo CS5 - Focus Woman

> “[I]f I put to bed today, I give my child breast milk immediately.
>
> *Don't you give him koranic writings (rubutu) to drink?*
>
> [other participant] Of course she will give him.
>
> Very well, the father will do the *rubutu* for the baby, afterwards, I wash my breast with sponge and breastfeed him.”
>
> Keta FGD - Non-Beneficiary Women

While the qualitative research was not able to assess how much of a delay this causes to the initiation of breastfeeding, it does present two health issues in terms of the risk of direct introduction of pathogens to the infant, and the risks associated with delayed initiation. The literature suggests that breastfeeding initiation after the first hour of birth doubles the risk of neonatal mortality, while increasing the likelihood of infections, sepsis, pneumonia, diarrhoea and hypothermia (Ekubay et al, 2018). We were not able to establish how far the CDGP SBCC messages have engaged with this practice, or whether it is considered a major problem by the medical authorities in Nigeria.

Animal milk or packaged milk may be given to babies in the first few days of life, especially if breastfeeding is not initiated straight away or the mother is unable to breastfeed. Although this seems to be less frequent than the past, it is still considered necessary sometimes, as these focus group participants explained:

> *What type of milk [do women here give to babies]?*
>
> The type that is sold for N10 that is powdered...
>
> They mix it with hot water and give the child...
>
> Until breast milk begins to come...
>
> When I had my daughter last year, I gave her the N50:00 type of milk. Each day, she took like three or four ... because I did not have breast milk.....
>
> ...Some people who do not have breast milk have to give the baby packaged milk for several days until the breast milk begins to flow.”
>
> Keta FGD - Non-Beneficiary Women

> “In the past women used to start feeding their babies 3 days after [birth]. The first breast [milk] will be pressed out as a cleansing. There was no knowledge about colostrum then. The baby will be given water and some other herbs in those days. Some will feed them goat milk because it is considered closest to human milk. It is still used when a mother dies during child birth and there is no other woman to breast feed the child.”
>
> Kafin Madiki FGD - Beneficiary Women

Among our small sample of communities, giving animal milk appears to be the norm among the Fulani, who have easier access to milk from their own herds.

> "He [baby boy] drank cow's milk! We Fulani's that's how we do."
>
> Kokura CS4 - Focus Woman

> *"How are babies breastfed here? Is water given to them?*
>
> Yes, but not immediately they are born. They are given raw animal milk for three days before they start taking breast milk.
>
> *Is water given to them when they start taking breast milk?*
>
> They are given a little water.
>
> *Why are they given animal milk for three days before breast milk?*
>
> I do not know. It is a tradition that we met our elders doing. If you meet something being done you have to also do it."
>
> Kokura CS8 - Husband

A number of respondents also mentioned giving their babies bottled, boiled or sachet water, and at least one had been advised by hospital staff that if she must give water, she should give bottled water.

In relation to all these practices older people were frequently described as more resistant to change, although this was not always the case: in some households senior women and/or men have played an important role in enabling and supporting young mothers to follow the new advice, as discussed below under the heading of Facilitators.

Given the social context of extended family compounds and shared child-care, one barrier to exclusive breastfeeding is that elders and other people may give the baby water regardless of the parents' wishes:

> *"When did you start giving the baby breast milk?*
> The day I gave birth, they washed her and gave her to me to breastfeed.
>
> *Did you or anyone give the baby water?*
> No, I didn't give her water but I don't know if my mother gave her water since I always take her there but on my own I didn't give her water."
>
> Keta CS3 - Focus Woman

One of our case study women (a current beneficiary at endline) and her husband explained that they avoid this issue by not leaving the baby in the grandmothers' care:

> "Some of the elderly women still find it [EBF] difficult to accept. We actually do not allow them to take care of our babies as we used to in the past. I cannot leave my baby with either my mother or my mother-in-law because I do not trust that they will not try to give water to my baby in secret....
>
> They claim that their own parents and grandparents gave water to babies and that the fact that we survived means there is nothing wrong with it....
>
> My mother is still sceptical. I have been trying to explain things to her. She is starting to accept but it will take time."
>
> Kanyu CS3 - Focus Woman

> “You see elders are different, what we do is we give them the baby when they are sleeping or playing, so they are not aware whether you give the baby water or not.”
>
> Kanyu CS3 – Husband

Similar comments were made by a number of respondents who had decided to adopt EBF, including this case study woman (a former beneficiary who has had another child since exiting the programme):

> “... even this my second baby is exclusively breastfed and to ensure that this is the case, I do not place her in care of any other person because I do not want them to give her water.”
>
> Yankuzo CS5 - Focus Woman

In some cases, of course, mothers are unable to breastfeed adequately because of problems with their own health or nutrition. A number of women said that babies would be given packaged or powdered milk at first if the breastmilk did not come. However, others said that they had learned from the CVs how early initiation and the way they hold the baby to the breast can help their milk to flow, even if it did not do so at first. Many people also said (in response to questions about the influence of the cash transfer on breastfeeding decisions) that a mother may not be able to produce enough milk if she is not eating a nutritious diet herself.

Finally, for some people the source of the information about breastfeeding is a barrier to its acceptance, because they are suspicious of the programme’s motives and distrust the people delivering the messages. The impression from our three rounds of fieldwork is that suspicions and rumours about CDGP were quite widespread at the beginning of the programme, but have been largely dispelled in most of our communities during the implementation of the programme over the past three years. In Kokura, however (again particularly among the Fulani) some respondents were still suspicious or worried about hidden agendas, and gave this as a reason for not registering for the cash transfer and not following the breastfeeding advice.

> “The reason why I am stopping my wife [from participating in CDGP] is that there are people saying that this cash support that is being given... these children that are benefitting, someday they will be collected. Sincerely, it is because of this rumour that I stop my wife from going..... many people have rejected to be part of this programme as a result. These kinds of things we hear is the reason why we are afraid of it a little."
>
> Kokura CS9 – Husband (Fulani, non-beneficiary)

At endline only a few people mentioned such concerns, while the opposite observation was made much more frequently: that is, people were persuaded to try the new advice when they trusted the people and sources it came from (variously community and religious leaders, relatives, health professionals, CVs, or radio broadcasts). These positive influences are discussed further in the next section on Facilitators.

Facilitators and persuaders

Multiple communication channels and the role of CVs

For many people, it is the combined effect of information from CDGP and the health services that has persuaded them to try exclusive breastfeeding. As one beneficiary husband put it: “now with CDGP, doctors and hospitals, that [the old way of breastfeeding with water, herbs etc.] has changed" (Yankuzo CS2 – Husband).

"*What did you hear [about breastfeeding], and where did you hear it from?*
That a child should be breast fed while sitting properly. The breast should be put into the baby's mouth very well and not just the nipples so that the child can suck enough. Breast milk should be given to the child from birth to six months without water, only breast milk. We go for ANC and we are told these things in the hospital and the CVs also tell us. We give birth to our children in the hospital. The CVs call us and explain it to us."

Kafin Madiki CS4 – Co-wife

"...I have heard about exclusive breastfeeding at Tsafe where I use to go for Ante-natal, but I didn't adopt it until this programme came and they kept talking about it countless times that was when I decided to give it a try and of a truth it is very good."

Yankuzo CS3 - Focus Woman

"We used to hear things like that at the hospital but it was not explained with the clarity and convincing information that the programme gave us. Besides we mostly go to the hospital when our children are sick so many times the information is not even coming first hand [= at the right time?]"

Kokura CS3 – Co-wife

"The nurses and the doctors at the hospital have been telling us to adopt exclusive breastfeeding and to start feeding our babies as soon as they are born. However it is the way [the CV] taught us that convinced most women to try it out. She addressed our fears and explained the disadvantages of giving our babies water and other things in the first 6 months. She also showed us the advantage of EBF. She made us realize that breast milk was also liquid and that a baby will not even know the difference. She also uses pictures for clarity."

Kanyu CS1 – Sister-in-law

Others had heard about EBF on the radio, but were not persuaded to try it until the CDGP CVs explained it to them face-to-face and showed them the benefits in more detail.

"Once I heard more information on what I have always heard on radio, I didn't struggle to accept the practice. I also used to listen to the Exclusive Breastfeeding (EBF) on the radio with [my wife] even though we did not make too much sense of it.

Was there any difference in the information you had from the CDGP and that from the radio?

Well [for me it was a] case of seeing is believing. My direct access to the information provided and also the opportunity to ask questions and engage with the process was key to my accepting the programme."

Doka Gama CS3 - Husband

"[B]oth of us have been hearing the information for some time now on [Radio Zamfara], though we didn't adopt it then. When the CDGP, through the CVs, came and enlightened us, it was easy for us to adopt the practice. My wife didn't have any reservations. Part of the reason why men were also involved is that their understanding and accepting EBF is key to the adoption of the practice in their respective households. My wife and I agreed we should practise.....

The difference was that the Community Volunteer (CV), along with other officials of the CDGP, came with a manual, gathered us (men in the community) and explained the Exclusive Breastfeeding (EBF) to us in detail. They were explicit and exhaustive in their explanation and it was after that day that I made up my mind to adopt and practise EBF.

Keta CS7 – Husband

> "I first heard about it through some of the meetings I mentioned earlier and mentioned it to my wife. I didn't know she has also been listening to Radio Nigeria Kaduna and she has had extensive information on the programme. There is a song that she has even learnt from listening to the programme and sings it often even before she conceived. While we didn't reach a decision then, it was my neighbour's discussion with us that convinced us finally to adopt it."
>
> Yankuzo FGD - Non-Beneficiary Husbands

The key role of CVs in persuading people to try EBF was mentioned by many of our respondents, both women and men. A number of factors were mentioned that made the CVs' advice particularly effective: the fact that they are known and trusted community members; that many of the female CVs were practising EBF with their own children; that they were always present in the community to repeat the information, answer questions, and follow up with individuals; and that they engaged with all groups in the community (not only nursing mothers) all contributed to the CDGP working as a "tipping point" to persuade people who might have heard about EBF on the radio or from a doctor to actually try it in practice.

> "These CVs of yours really helped in this issue. Selecting officials in the community, such as CVs, has been very helpful sincerely because they go to every nook and cranny to meet people; males and females, old and young to discuss with them concerning this issue. Even when old people sat down to discuss on this issue when CVs come to them once, twice, and thrice by the will of Allah they will accept. If at all there are women who do not accept this advice in this community, those who do exclusive breastfeeding are the overwhelming majority. Those who reject this advice are very rare now, they are the ones not making any progress because these CVs are playing a big role in this issue. Without them the progress we have now would have been impossible."
>
> Kokura FGD - Beneficiary Husbands

The inclusion of men in the SBCC campaign, through the work of male CVs, was also frequently mentioned and appreciated:

> "You see the information on EBF was addressed to men and female. While the male CV was addressing us, the female CV also addressed the women and that has been the practice. ....
>
> .... the [male] CV who is a relative of mine, enlightened us on the advantages of breastfeeding. If it were something bad, he wouldn't volunteer or even talk to us about it.... I believed it because the person communicating the information is credible and trustworthy and is a member of our community."
>
> Doka Gama CS9 – Husband

The manuals and especially the pictures showing the effects of EBF on babies' health and growth were persuasive for many (as found in the midline).

> *So what will you say persuaded you?*
>
> The messages and pictures that I heard and saw during the enlightenment campaign and the subsequent sessions leading to the birth of my first child.
>
> *What specific message about EBF changed your mind?*

> The message for me was the health benefits and the fact that the child will not be malnourished or infected with diseases. Looking back now, I would say I am happy that I practised EBF and all the information provided has proved relevant to my family."
>
> Doka Gama CS9 – Husband

For women, the CVs' explanations and demonstrations about how to breastfeed (including the best way to hold the baby, and what they should do if they have difficulty beginning to breastfeed) were also important. This advice was given in group meetings, and in some cases was followed up in one-to-one visits to the mother's home.

> "They [CVs] also said a woman should breastfeed immediately, when we are breastfeeding, we should make sure the black part of the breast is in [the baby's] mouth and we should hold the baby well and allow him to suck the breast till he removes his mouth before placing him on the next breast."
>
> Yankuzo CS5 - Focus Woman

> "[Y]ou did not just tell us what to do, you showed how to do it and even empowered the women to be able to do it [by giving cash transfers]".
>
> Doka Gama CS2 – Focus Woman

Role of husbands

There is a clear hierarchy of authority and decision-making within households, as outlined in the Situation Analysis and Baseline reports, and discussed further in section 3.3 below. The male head of household has overall authority over household members, and senior women (first wives and mothers-in-law) have some authority over junior wives and daughters-in-law. As in all societies, the actual balance of power and the degree of consultation in decision-making varies widely according to individual character and relationships, but our endline interviews underline the role of husbands in the successful adoption of new practices such as EBF, and therefore the importance of engaging them in the behaviour change communications. The key role of husbands in allowing, supporting, or instructing their wives to follow the new breastfeeding advice (and other aspects of the CDGP programme) comes across in many of our case studies and focus group discussions, as expressed for example by this senior (65-year-old) head of a large household:

> "Nothing comes into the house and works without the consent of the head of the house. You know there are husbands that would say they do not agree, is not so? Even if the woman brings ... an advice and the man disagrees she will not be successful. But me at present if I see a woman attempting to give my child water before 6 months she will be in trouble, because the burden of taking the child to the hospital is mine. I have seen something beneficial if you say you will not do it there will be trouble for you. It is only when a man agrees that this thing can be done. I accepted it. It does not stop on me, all my grandchildren are not given water. I accepted and everybody under me I have shown them the benefit of the thing."
>
> Kokura CS3 - Husband

In some cases the husband is the first person to introduce the idea of EBF into his household, as men are more likely to listen to the radio and to hear about new initiatives and programmes in the area.

> "My husband was the first person that explained it to me. He told me that there is an initiative that supports women to take care of their children, having to give them only breast

> milk from birth to 6 months without water and asked me if I can be part of such initiative... I told him that ... all I need is his permission and since he is supporting it then why not. From pictures that are being shown to us, you could see the difference in the growth of children that are exclusively breastfed."
>
> Kanyu CS4 – Focus Woman

Having her husband's support can also strengthen a wife's position when criticised by other women, or feeling unsure about the right thing to do:

> "[W]hen this programme started and they talked about exclusive breastfeeding a lot of women felt it was completely heartless to deny the child water until after six [months]. Some of us had to say that our husbands have given us the approval not to give the child water just so we can stop people from talking."
>
> Yankuzo CS7 - Focus Woman

> "...when I was told the first time to breastfeed my child exclusively without water, I asked, will it be possible for me to do so? I was tempted to give the child water I even asked them to give me water at some point but I have people around me who encouraged based on what we were advised in the hospital and when I did it I loved the result I saw. My husband was very encouraging because I told him about this new information and he said if this a good thing that will help in the growth of the child then we should all embrace it and everyone around me is doing that."
>
> Matseri CS3 - Focus Woman

In the small number of Fulani households among our case studies, the husbands appear to be less involved in decisions about breastfeeding. In contrast to the men quoted above, our Fulani case study husbands had not heard any messages about breastfeeding and did not expect to be involved in such matters.

> "[T]he decision [about EBF] is mainly that of the woman because she is the one breastfeeding."
>
> Kokura CS7 – Husband (Fulani, ex-beneficiary).

> "Breastfeeding a baby? (laughs) what is my business with breastfeeding? When a baby is born we are simply asked for the materials for naming ceremony, that is our role".
>
> Kokura CS9 – Husband (Fulani, non-beneficiary).

Although we cannot generalise from this very small sample, it is plausible to hypothesise that this relative lack of engagement with child-care decisions may be linked with their pastoralist and migratory livelihoods, as they are often away from the home tending their animals:

> "When does he have time to sit down for me to even tell him this?"
>
> Kokura CS4 – Focus Woman (Fulani, ex-beneficiary)

Our case study interviews also suggest that Fulani women are more isolated from neighbours and relatives outside their immediate household, because of the scattered physical layout of *ruga* settlements: they may therefore be less likely to be influenced by other women's breastfeeding advice or example.

Influence of other women in the household

Because the CDGP is targeted to individual women rather than households, we met many examples where two or more women within a household had been beneficiaries. When this happens the women will often go to meetings together and discuss what they have learned and how to spend the cash transfer, sharing their new knowledge and supporting each other to apply it in their home. In this case study, for example, all five women in the household had been CDGP beneficiaries:

> "[W]hen they receive the transfers they all cook and share with one another and their children also eat from the food.... they all sit together and discuss what they would buy with the money, then they give their husbands the money to help them buy it from the market".
>
> Doka Gama CS4 – Sister-in-law

Even when only one household member is a beneficiary, if she is on good terms with her co-wives and sisters-in-law she is likely to pass on what she is learning (along with a share of the "good food" she is cooking and often a small share of the cash). One early adopter within a household may influence other women to follow suit. For example:

> "My sister-in-law sees ... and learn[s] from me, she asks questions about whatever she sees me doing. She believes that I won't do anything that will harm my own child that's why she follows whatever I do."
>
> Yankuzo CS7 - Focus Woman

> "The respondent said that in his household, his first wife was the first to accept it and that his other wife ... also accepted it and that they always talked about EBF whenever they sit down to eat together or when they are in a group talking."
>
> Yankuzo CS3 – Husband

> "In our house it is K. [who first tried EBF]. She was not giving her child water and when other women in the house saw how her child was healthy, they gave birth and also didn't give their children water. ... She used to tell them about it and they also saw the benefits and decided to practise it."
>
> Kanyu FGD - Non-Beneficiary Women

> "*Who was the first to adopt exclusive breastfeeding in your household?*
> It's the CV I told you about earlier in our house that first started. She's the oldest wife in the house and when we saw her do it we all followed suit."
>
> Doka Gama CS6 - Focus Woman

Senior wives and mothers-in-law, being higher in the household hierarchy, can have a strong influence on what young mothers do, although like all relationships this varies. Some of the mothers-in-law we interviewed said they did not intervene in their sons' marriages or childcare decisions, while others actively supported or opposed their daughter-in-law's choices. Many of the mothers-in-law and other older people we spoke to accepted that things have changed for the current generation of mothers:

> "During our time, we didn't give babies breast milk for the first three days – they were fed with only water. Now we understand, and see our mistakes.... I support my daughter-in-law in following this advice."
>
> Kafin Madiki CS6 – Mother-in-law

Some of our case study husbands also explained how they intervened with their own mothers, persuading them not to sabotage their wives' decision to try exclusive breastfeeding. This adds another dimension to the importance of the husband's support within the household:

> "My mother felt it was not known to our culture and so she wasn't going to fold her arms and watch us (my wife and I) kill our baby. We told her there is no way we would also want to kill a child we gave birth to. If EBF was a problem or harmful there is no way it will be introduced into the community so please kindly endure and observe the process for the next 6 months. While she agreed then, she came back 3 months after that [saying] the child must be given water. I told her if the child didn't die from lack of water in the last 3 months, then I don't think she will in the next 3 months. It was a problem then but she finally agreed and allowed the process to run its full course for 6 months."
>
> Keta CS7 - Husband

> "As expected my mum, who was alive, when we first introduced EBF vehemently opposed the practice. She felt it was wrong to deny an infant water for six months. I had to talk with her daily for about a week before we overcame her, this was important because we didn't want her introducing the newborn to water when she is alone with my wife or with the baby."
>
> Yankuzo CS1 - Husband

Religious and community leaders

Beyond the household, other influential people in the community also played a role in persuading parents to adopt the CDGP's breastfeeding advice. Village and District Heads and their wives are trusted authorities, and are likely to be actively involved in the local promotion of CDGP either through their membership of the TWC and BRG committees or as CVs (see the Qualitative Midline Report, Section 3.2. on the CDGP institutions and volunteers in these communities).

> "I heard it is good to breast feed a child without giving anything else like water and I heard [it] from the community leader's wife. ... I think it is good advice and I practise it. Other women in the community also practise it."
>
> Matseri CS8 - Focus Woman

> "There was no resistance because once the Hakimi [District Head] and the head of the household endorsed the practice, there is no other authority within the household that can resist or have any influence in adopting and practising it."
>
> Doka Gama FGD - Beneficiary Husbands

For others, the approval of the local religious authorities (who may also be committee members) was key:

> "It's my wife [who first introduced the idea of EBF in my household] but I only gave approval when I [heard the] Imam and Village head speak on its importance."
>
> Keta FGD - Non-beneficiary husbands

> "Well for me, once I checked with my Mallam (religious leader) and he confirmed to me that there is nothing in the Hadith or Suna that the changes my wife is introducing to the house ... contradict in any way, then I did not need any further verification."

Yankuzo CS1 - Husband

One of our beneficiary case study husbands, who also happens to be a local leader and committee member, noted that traditional birth attendants were another key influencing group whose inclusion had helped to make the CDGP campaign effective. This is particularly important given that our endline interviews suggest that most women in these communities still give birth at home, even if they are regularly attending ANC, partly because of the distance and the scarcity or expense of transport to hospitals.

> "The involvement of Traditional Birth Attendants (TBAs) in the sensitization and awareness on EBF proved to be a masterstroke in overcoming this fear. Their presence and participation re-assured households that EBF is not harmful and also dispelled all the fears people had about EBF..... Because people trust them, we always ensure their participation and voice during each of the meetings we hold. They encouraged more women to visit the hospital regularly and to practise EBF."
>
> Yankuzo CS4 – Husband - *Maiangwa* (Village head) and TWC member

"Seeing is believing"

A common factor in all our interviews with people who had adopted EBF, regardless of the other factors and information sources that had persuaded them to try it, was the demonstration effect of seeing the positive impacts on the health and development of their own or their neighbours' babies. Faster growth, fewer illnesses (especially diarrhoea), and less frequent expenditure on hospitals and drugs were frequently mentioned.

> "I have now realised that the main reason why they were falling ill was because I was giving them water in the tender months. .... With this experience both I and my baby did not have any challenges!"
>
> Kanyu FGD - Beneficiary Women

> "There is difference between children that are not given water and those [whose] parents give them water: children that take water are always having frequent watery stool and don't look as healthy as those that do not take water."
>
> Kanyu CS4 - Focus Woman

> "When we first heard about EBF, it was from the CV and we were mad with her for even suggesting it. It was really hard at first because I thought the baby will die from thirst. To my surprise my baby was doing better without water. There were none of the health challenges that my first child experienced. My second child with whom I benefitted [from the cash transfer] and my youngest child who I also EBF are healthier and hardly fall ill."
>
> Kanyu FGD - Beneficiary Women

> "It [EBF] is a common practice now in this community because we have seen the benefit. There is no family, whether beneficiary or non-beneficiary, who feeds her baby with goat or cow milk anymore as was the practice in the past. Everyone has noticed the changes, in terms of health and wellbeing for children who are EBF....
>
> ...The reason why the practice has snowballed is because beneficiary women often share the messages and information they receive on the project with their colleagues who [do not have the opportunity] to be on the project."
>
> Doka Gama FGD - Beneficiary Husbands

> “...the babies are healthier – they hardly fall sick, and they do not vomit or defecate incessantly. Seeing the benefits from the women who started practising it has led to others accepting and following the advice.”
>
> Kafin Madaki CS7 – Mother-in-law

> "My child of just 21 months looks like a child of 3 years. All those who were not breastfed for 6 months immediately after birth cannot compare with those breastfed in area of physical growth, skin nourishment and intelligence".
>
> Yankuzo CS2 – Husband

> “The reason why I said it [EBF advice] is useful is that the children that were not given water except breastmilk for six months based on this instruction have proven the benefits of this thing on their bodies. You see it is what I have seen and not what I only heard.”
>
> Kokura CS1 - Husband

> "I have never had a child that was less affected by illness than this one that was given exclusive breastfeeding. ... You see, they have planted something that even without the programme it will be continued."
>
> Kanyu CS1 – Husband (beneficiary)

Older people and non-beneficiaries also say they have been persuaded to adopt the new practices because they have observed the benefits:

> “[M]y husband is fifty seven years old and he asks me to EBF without giving water. This is because he has seen some other people practise it and their children are smart and strong. The way they crawl and walk is different.”
>
> Matseri FGD - Non-Beneficiary Women

> “Things are changing all the time .... During our time there was nothing like this.... when we give birth we used to give goat milk to the child but things have changed now. I am happy with this new way of giving breast milk without water, because I see the benefits and I will advise any young girl to practise it. ... I see my grandchildren healthy, so it is a thing to be happy with".
>
> Kokura CS7 – Mother-in-law (Fulani)

Several participants commented that it was very difficult to be one of the first people to do something new or against traditions in the community, but that once some people had done it and the results could be seen, it became easier to follow their example.

> “It is not easy, because it is against the norms that the community is used to. At first, a lot of people refused to accept it. It was opposed. The norm was to feed the baby with water after it’s born, and babies ... begin to get breast milk only after the first three days. After the spread of information – and the talks about it, people felt pressure and gradually adopted the policy, until it became widely accepted. The unexpected improvements with the babies that were exclusively breastfed was the turning point for many women. We actually want the best for our children.”
>
> Kafin Madaki CS6 - Focus Woman

The new breastfeeding practices (and other innovations promoted by CDGP) were often described as “modern” in a context where “many things are changing”, and associated with language such as “a new era” and “progress”. This perception that EBF is modern may be further weakening the influence of the older generation (particularly grandmothers) in this area.

“Do you think some ... grandmothers still believe that it is wicked to deny the child water?

Like my grandmother, I tell her she's old fashioned and we have new ways of doing things, I tell her that in such a manner that won't upset her. I also told her about the importance of exclusive breastfeeding and we even listen to the radio together whenever the programme comes on air, so she no longer disturbs me nor insists I have to give some water to the child.”

Yankuzo CS7 - Focus Woman

“I don’t think grandmothers should determine whether a couple should practise EBF or not.”

Yankuzo FGD - Beneficiary Husbands

“[I]n any case most of the older women do not influence the decision about child care in this community, it is between her and her husband.”

Doka Gama CS2 – Focus Woman

Effects of the cash transfer on EBF adoption

One of the questions asked of both women and men in the case study interviews and focus groups was whether the cash transfer had affected their decision to adopt exclusive breastfeeding, and if so how. Although the CDGP cash transfer is unconditional, it seems likely that beneficiaries would feel some pressure or obligation to follow the recommended practices while receiving the money. One of the CVs we interviewed admitted having threatened women with removal from the programme if they did not go for ANC (adding “we do that to protect their health” – Keta KII, female CV), and it would be surprising if similar hints had not been dropped about following the breastfeeding advice. However, only a few of our respondents said that the cash transfer had “motivated” them in this way, and none of the beneficiaries said they thought they would be exited from the cash transfer if they did not follow the SBCC advice.

"[I]t was because she was on the programme that she heard this advice and you know the money motivated her to follow the advice because the people were concerned that she eats well to have the strength to breastfeed.”

Yankuzo CS5 - Husband

“After receiving this support from them during pregnancy, it was only normal for me to try the advice they give us on breastfeeding.”

Doka Gama CS1 – Focus Woman

"[S]ome people in town believe that we are practising this EBF only because we are receiving a grant."

Yankuzo CS4 – Focus Woman

By contrast, a much more frequent response to the question was that the cash transfer enabled women to try exclusive breastfeeding because they could afford to eat well enough to do so.

“Did the cash transfer affect your decision to try exclusive breastfeeding?

Sure it did, because we eat healthy food, the breast milk remains fresh, thick and undiluted.”

Matseri CS9 - Focus Woman

“Did the cash transfer affect your wives’ decision to try EBF? Why? How?

> Very much, very much indeed. This money that is given to them is what helps them to eat good food for the breasts to have adequate milk. You see it is the major cause of this thing. When the milk is adequate the babies will feed and not bother about the water."
>
> Kokura CS1 - Husband

> "Because you need money to buy and eat those healthy food[s] we were advised to eat so that the child can grow well."
>
> Keta CS3 – Focus Woman

> "... If she did not have access to such money, I am not sure we would be able to be consistent with the advice".
>
> Yankuzo CS5 - Husband

> "[L]ots of women ... may not be able to afford the meals and nutrients the CDGP advises them to feed on to be able to sustain EBF.... without the means how will they sustain the practice?"
>
> Doka Gama CS3 – Husband

In spite of this caveat about affordability, all the beneficiaries and ex-beneficiaries we interviewed who had adopted EBF themselves said that they would continue to practise it with future children. Some were already doing so, with new babies born since their cash transfers ended. One of our case study husbands (Doka Gama CS9) commented that he thought the cash transfer had motivated people to try EBF in the beginning, but that now they were continuing because they had seen and experienced the health benefits for their children. The fact that non-beneficiaries are also adopting the practice further supports the hope that the change will be sustainable. Following are a few examples of the many ways people expressed their intention to continue with EBF and other new practices in the absence of the cash transfer.

> "[M]y family's health and hygiene has improved and is [being] sustained even without my wife receiving support from the programme or from any source. You know we do not need money to sustain these changes because we have had great awareness and understanding around the issues of hygiene, dietary practices, and infant and [young] child feeding and nutrition".
>
> Yankuzo CS1 – Husband

> "[EBF is] very good advice and if God blesses me with another child I will practise it again.... children that take water are always having frequent watery stool and don't look as healthy as those that do not take water".
>
> Kanyu CS4 – Focus Woman

> "It is not really about the money, it's more about the knowledge we are getting..... These practices will be passed from generation to generation."
>
> Kokura CS3 – Focus Woman

Case study example 2 is an example of how non-beneficiaries are also being influenced by the SBCC messages on breastfeeding.

Case study example 2: "They did not come to our house" (Kokura CS8)

Mrs. H.B. – Non-beneficiary

H. was 23 years old at baseline and had four children, having married at 14. Her household, which is part of the Fulani *ruga* at Kokura, was above average wealth (PPI Quartile 3) at baseline. She is the second wife, but since the midline her senior co-wife was divorced by their husband and has moved away with her children, so H. is now the only wife. Also her husband's parents, who were living with them, died in the year before the endline interviews (2017), so the household is now smaller and has faced some major stresses in the past three years.

H. has never been registered with the CDGP. Her youngest child (a daughter) is now four years old and was born before the CDGP started. She was pregnant in 2016 and would potentially have been eligible as a beneficiary then, but she was not enrolled and unfortunately lost the baby.

Although H. has not directly participated in any CDGP activities, she knows her local CV and has heard about exclusive breastfeeding and other SBCC messages from the CV and other women in the community:

> "I have my neighbours who are beneficiaries and any time they go and learn they give us feedback. I hear the explanation from them but I have never attended".

She has not tried EBF herself because she did not know about it when she was nursing her youngest child, but says she would do so in future because she has now learned about it and seen the benefits:

> "We didn't have such education before but if God blesses me with another child I will definitely practise exclusive breastfeeding..... The children don't fall sick. They grow very healthy. We hear about it and we see the children. They don't have frequent stooling [diarrhoea] like those that drink water".

She says that some women still think it is wrong to deny water to a baby but she herself trusts that the people bringing this new information are knowledgeable and well-intentioned. While some older people in particular are resistant to change, others are open to it:

> "Anything new they bring to Nigeria, we don't get to know it because we are in the bush but once we hear people coming to educate us from the city, we will understand it and accept it. Since they work with the doctors, they are better informed than us that are in the bush. For me, I believed it from the moment I heard about it because they will not just come here and tell us what is not true. And I see it in the children that this was practised... It [this attitude of fear] will reduce since there is more awareness now. Women are practising it, and other people are seeing the successes and are desiring to also practise it."

Like many Fulani women H. used to earn income from buying and selling *nono* (cow's milk), but in 2017 she had been unable to do anything because of the illness and subsequent death of three family members (her husband's parents and sister): "I didn't have enough time since we were caring for them when they were sick."

> "I used to buy and sell "nono" before. By this time of the day, I would have been back from buying it, and once I finish cooking food I go out to sell it. It is only this year that I didn't do any trading."

Because of this, she felt worse-off at endline than she was 3 years before ("No money is coming now"), and she had not been able to make any investments or asset purchases.

H's husband (B) makes his living from crops and livestock. Over the last few years he has seen changes in farming with the spread of *rani* (dry season, irrigated) farming and the increased use of purchased inputs ("now you have to buy sprayers, buy herbicides, buy pesticides and buy fertilizer"). However, his harvest has been poor this year (2017) because the rains stopped before the grain crops were ripe. The rice harvest in Kokura was particularly badly hit by the lack of water:

> "In the past you used to get five or six bags but this year even a single bag you did not get."

He has also lost some animals that fell sick and died, but he says there is no help from the government or elsewhere: "you have to use your own money to buy drugs in the market".

B. has had no involvement with CDGP, and says (at endline) that no-one in his household or wider family has been registered. He has seen posters showing pictures of a woman and baby, but has not talked to anyone about them and has not heard any of the SBCC messages. He is dissatisfied with the programme (giving it an overall score of 3/5) because he feels his household has been excluded:

> "This year they came and enrolled new women recently but they did not come to our house, they did not inform my wife... I have a daughter whose mates [co-wives] were all enrolled but she is not enrolled... She gave birth just recently."

3.2.2 Complementary foods

Along with the advice on breastfeeding, CDGP's key SBCC messages include: "Introduce complementary foods at six months of age (180 days) while continuing to breastfeed" (Annex F, message 6). This is in line with the guiding principles for complementary feeding (Dewey et al 2003), which add that the consistency of complementary foods should start from puree, and become more solid between 6 months and 12 months when the child has developed enough to eat 'normal' foods. The frequency of feeding should be 2-3 times daily at 6 months, and gradually increase to 3-4 times daily after 9 months. Feeding should follow the principles of responsive feeding, and appropriate psycho-social care. All complementary feeding practices should ensure good hygiene and proper food handling.

In our communities, respondents explained that in the past most women would give their babies a simple *kunu* or "pap" (semi-liquid porridge or gruel) made with ground cereal grains and water, from as early as 3 months of age. Through the CVs' mentoring and cooking demonstrations, CDGP has been introducing recipes for more nutritious complementary foods as well as advising women to start them later, after 6 months of exclusive breastfeeding.

The evidence from the qualitative endline suggests that women in these communities now have a good knowledge of complementary feeding, particularly regarding the timing of complementary foods, and the phasing in of different types and consistencies of food from semi-solid through to solid foods between the ages of 6 and 12 months. The new recipes for *kunun lafiya* or "healthy kunu" (which add protein-rich and nutritious locally available foods to the cereal-based pap) seem to be very popular and widely known among non-beneficiaries as well as among women who directly participated in the demonstrations and counselling. The following excerpts are examples of very similar responses given by mothers in all our communities to the question, *When did you start to give your baby other foods, and what did you give her/him?*

> "When she was six months. I gave her *kunun lafiya*. I made it with groundnut, soya beans, millet and guinea corn and added sugar to it and was giving her. As she was growing I also gave her rice, spaghetti. I used to prepare semi-solid meals for her and give her to eat. I also gave her meat, *awara* [soya cakes], oranges and other nutritious food. These foods are nutritious food and we are encouraged to feed our children with it. When the child is fed with healthy food, the child will grow well and healthy too."
>
> Kokura CS7 - Focus Woman

> "At six months. I gave him *kunun lafiya*. I made it adding soya beans, and I also add moringa before giving him. I also buy milk and Maltina drink and give him. When he started eating very well, during the rainy season I buy egg and boil it and give it to him to eat. It is his money so let him eat it, just the way I also ate when I was carrying his pregnancy."
>
> Kokura CS2 - Focus Woman

"*Kunun lafiya* is the first food they are being fed with...

They are given semi-solid meals. In the past mothers will grind grains and mix it with water and give their children to drink. The child is not even breast fed immediately after delivery until two days after, the baby will cry and cry and will not be given anything. There is now awareness. This programme has supported women; they are educated and know the importance of giving their children healthy foods."

Kanyu FGD - Non-Beneficiary Women

*"*I gave him liquid peak milk, and I gave him pap, the kind that was recommended comprising maize, soya beans and groundnut.

Why did you choose pap?
Because it was recommended to us and this has been our practice all along except that the pap we give is different from the one recommended, our own pap is made from millet."

Matseri CS2 - Focus Woman

"I give my eight month old baby pap made from groundnuts, tiger nuts and millet...

Before now what did you feed your baby with after the age of six months?
Pap made from corn, guinea corn [sorghum] or millet. ...but now I give the baby pap from soyabeans, bambara nuts and groundnuts along with corn, millet and/or guinea corn"

Matseri FGD - Beneficiary Women.

"I started giving him pap, made from maize, sorghum and groundnuts, when I prepare it, I add some sugar to it to taste and give him….that is what we have around here but I try to make it properly that will be good for the child. I also use groundnut because we were told it is good for the child."

Doka Gama CS6 - Focus Woman

"We usually start with pap [b]ut we were taught how to make turn brown ["Tom Brown porridge" [14]]. It contains many grains and vitamins. We make the cereal with millet, soy beans, groundnut and other grains. When we cook it we can add milk, moringa leaf powder and palm oil. ...
...In the past we introduced babies to pap from mixed or different grains even before 6 months. Now we add milk and also make turn brown for them. It is filling and makes them strong and healthy. Older children can take it too."

Kanyu FGD - Beneficiary Women

As with breastfeeding, CDGP is not the only source of information and advice about complementary feeding. While most of our respondents who discussed this topic said that they had learned about it from CVs or from other women who were CDGP beneficiaries, some (like this case study participant) had heard the advice from doctors or health facility staff:

"The respondent stated that when the child was about 6 months old, she began to blend together maize, groundnut, and soya bean and made them into pap, which she started to feed her baby with, along with potable water. The respondent said that she made this choice of food because the doctor told them so and that they had been taught during pregnancy of what healthy foods to feed their children."

[14] A popular recipe across Northern Nigeria and Ghana, which combines corn, soya beans and groundnuts.

Doka Gama CS4 - Focus Woman

While the health benefits of these better quality and more diverse complementary foods are widely understood, and all the direct beneficiaries interviewed said that they have changed their practice as a result of the new knowledge gained from the CDGP, some worry that they will not be able to afford to continue this without the cash transfer.

> *"Is there anything you did differently with this child that you didn't do with your previous children?*
> Yes, before now we didn't care about complementary food for the child, we gave them what we eat like *fura* (drink made from sorghum or millet) and *tuwo* (ground maize paste, served with soup). There is difference, you see we usually cook our food plain without fish, meat or oil ... the cash transfer really helped us to buy those things we could [not] afford before."
>
> Doka Gama CS6 - Focus Woman

> "I started giving him groundnuts and soya beans milk, but I couldn't sustain it because it is expensive to make, I give him palm oil as well. When I stopped giving him the soya and groundnut milk, I started giving him pap that is made from sorghum."
>
> Yankuzo CS7 - Focus Woman

Regarding hygiene and food handling, both the midline and endline interviews found widespread improved understanding and practice, largely attributed by respondents to CDGP SBCC activities, around the importance of keeping a child's feeding utensils and the immediate environment clean in order to reduce the risk of exposure to pathogens. This is explored further under the heading of sanitation and hygiene.

3.2.3 Sanitation and hygiene

The CDGP SBCC component promotes improved hygiene and sanitation habits, particularly emphasizing handwashing before food preparation; before and after feeding a baby or child, and after using the toilet or cleaning the baby's bottom (Annex F, message 7). CVs and CDGP staff, through action-oriented group meetings and counselling, are also promoting hygienic food handling (such as cleaning utensils and covering food to keep flies away) as well as general cleanliness and sanitation around the home, explaining the links between these and children's health.

Both the midline and endline found that these improved sanitation and hygiene practices had been widely and enthusiastically adopted by beneficiaries and non-beneficiaries alike. At endline, these practices appear to have really gained traction in all our communities. Care is taken to ensure a clean environment, especially in terms of limiting the exposure of infants to pathogens. Husbands generally support these efforts and many expressed their pride and pleasure in the improvements their wives are making to the home environment. Many of our respondents, key informants as well as beneficiaries and community members, thought that the hygiene and sanitation improvements were the changes most likely to be continued after the CDGP has ended.

However this finding should be interpreted within the context of relatively poor water and sanitation infrastructure. The midline quantitative findings for example suggested that household drinking water sources, and toilet facilities were not substantially more likely to be 'improved' in CDGP communities compared to non CDGP communities, which remains a constraint to improvements in sanitation.

The links between sanitation and health are now generally understood in all our communities. The advice to keep infants' and young children's hands and utensils clean appears to be well understood, and widely practised by beneficiaries and non-beneficiaries alike:

> "Even poor hygiene can make someone ill but now there's more sensitization about hygiene."
>
> Matseri FGD - Non-Beneficiary Women

> "They tell us to always clean our environment and make sure we prepare our food in healthy environment and we should always wash our children's eating plates and keep it in clean place. Keeping the children clean will also make them healthy....
>
> In the past, a child will go to the toilet in the morning and you don't care to wash his hands but now we use soap or ashes to wash our children's hands."
>
> Kokura FGD – Beneficiary Women

Keeping a clean environment – including maintaining the cleanliness of the toilet, and always having access to soap or ash for handwashing - was mentioned in all our communities as important.

> "In the area of hygiene, they have been taught and are practising it, when they use the toilet, they should wash their hands with soap and water, if there is no soap, they can use any detergent, if that is not available too, they can get ash from their fireplace and use it to wash their hands."
>
> Keta KII - BRG Member (Female)

> "Back then [before the CDGP] when you enter a compound, you will see that the child's feaces is left there in the middle of the compound where flies and chicken play with it while they are busy cooking by the side. We are happy with this new information to stop open defecation and leaving toilet open."
>
> Keta KII - CV (Female)

> "The environment should be kept clean. That you should wash your children's hands after going to the toilet. The children should be bath[ed] and ensure they are clean, wash their clothes, clean where you cook and always keep your cooking utensils clean for the health of your family and the children."
>
> Kanyu FGD - Non-Beneficiary Women

Minimising the risk of children putting unclean items in their mouths, and keeping food preparation areas and utensils clean, were also frequently mentioned as important new habits adopted because of the CDGP activities.

> "His eating utensils are separate and I don't allow anyone to use. I washed it after each use and kept it clean."
>
> Kafin Madiki CS5 - Focus Woman

> "There are special utensils for the feeding of our baby which she constantly leaves in water and she also doesn't use bottles, what she uses is a bowl."
>
> Matseri FGD - Beneficiary Husbands

> "We bath them regularly, make sure we feed them in a clean plate and always wash their hands before they eat. Keep the house clean so that when they play around they won't pick [up] dirt and put in their mouth."

Doka Gama CS6 - Focus Woman

The hygiene advice seems to have been taken on board by husbands (both beneficiaries and non-beneficiaries), who are also doing their part, for example by removing drainage channels around the house which used to harbour stagnant water and mosquitoes. Wives are also said to be driving changes within the household, reminding husbands to wash their hands before interacting with the children.

> "When a child wants to defecate he should be taken to the toilet and not allowed to squat anywhere else, and when he is done his hands and body should be washed. Dumping of refuse carelessly is another issue they [CDGP CV] talked to us about and we have changed that…..
> This kind of enlightenment is good ... I also do not allow them to leave our drinking pot uncovered. [We] even use polythene sheets to cover it as added protection against this cholera…. in the past people made gutters by their doors but we were told that this would bring mosquitoes which caused malaria. Secondly, leaving food uncovered could open way for cholera to affect people. We heard these and have accepted and are careful about them."
>
> Kafin Madiki FGD - Non-Beneficiary Husbands

> "Women have been taught from their gatherings to maintain good hygiene and sanitation in and around the house, cooking area, toilets, how to prevent mosquitoes and proper disposal of waste. In the area of choice and preparation of food, they have learnt a lot and are now comparable to other women in the urban area or city….
>
> Before now, I didn't wash my hands before eating or after using the toilet. This has changed, the reason is that I have been told what the benefits are and the negative effects it can have on my health. I also ensure that there is either soap or ash in my toilet for washing of hands after making use of the convenience. The drainage in my house is also taken care of, I don't allow still water to gather there anymore. All these we have learnt as a result of this programme."
>
> Doka Gama FGD - Beneficiary Husbands

> "I keep seeing improvement in the housekeeping habits of my wife. She has become meticulous, she washes her clothes, no more indiscriminate disposal of waste or refuse around the house and she uses her money to buy toiletries in the household. She even tells me to wash my hands before carrying our baby whenever I come back from the farm or other work (laughter)....
>
> When you come into our toilet you would see there is always soap or at least ashes for washing the hands just after leaving the toilet. It has become a habit in my household and I am happy about it."
>
> Matseri FGD - Beneficiary Husbands

> "We now have learnt to wash our hands at all times after use; these were not common practices. CDGP brought all of this to our community....
>
> People now generally take care of their environment by sweeping and cleaning regularly. It started with those women who were registered but over time after seeing how important it has become for them, everyone in the community gradually began to follow and now we have our community cleaned."
>
> Matseri FGD - Non-beneficiary Husbands

In Yankuzo there has been a clean water initiative implemented by UNICEF and the state government, which has clearly been a factor in enabling better sanitary practices. Various

respondents said that this has made it easy to maintain good hygiene standards, highlighting the importance of infrastructure development and service delivery for the effectiveness of SBCC.

> "The majority of households have adopted washing of hands before eating, washing of hands before feeding a baby and even after using the toilets. All these are easy to practise because we have water in virtually every household in this community."
>
> Yankuzo FGD - Non-Beneficiary Husbands

As with breastfeeding practices, a number of respondents noted how the face-to-face practical demonstrations and follow-up by CVs in beneficiaries' own homes had helped them to integrate the recommended habits into their daily routines:

> "The CV takes us through how to take care of our environment and to keep ourselves and our children clean and healthy. Each CV has about 20 women under her. Each set of women is a mix of pregnant and breast feeding women. So we all learn everything we need to know. The CV comes into my home to observe how I am implementing what she has taught us. She also gives me guidance which helps a lot because we are now using my home for practice."
>
> Kanyu CS1 – Sister-in-law (beneficiary)

As noted above, the hygiene and sanitation practices are often cited as those most likely to be sustained. There is a perception that these hygiene practices are easy to continue, as they cost the household little or nothing (compared with maintaining a healthy diet for example), and that they have a notable effect on health.

> "Yes, there are changes. Because some of these are associated with hygiene, the households have integrated these practices into their daily activities and I doubt very much if it can be reversed. This is because the husbands have commended the programme and I am sure they wouldn't want to do anything that would jeopardize the health of their families."
>
> Yankuzo KII - CHEW (male)

> "Yes ... they will all be sustained. Hygiene has already become a part of us and we don't require so much to practise it."
>
> Matseri KII - TWC member (male)

> "I know practices such as hygiene and sanitation, attending ANC and use of health facility will be sustained. There is no woman or man that has been washing his or her hands during this programme that will suddenly stop. These are practices that cost little or nothing to continue, we have even been told that when we cannot afford soap we should use ash to wash our hands."
>
> Keta FGD - Beneficiary Husbands

> "Truthfully, I think the changes relating to cleanliness can be continued but the aspect [of] buying nutritious food when this cash support is not available will be difficult to continue."
>
> Kanyu FGD - Beneficiary Husbands

3.2.4 Accessing health services

Ante-Natal Care

Ante-natal care (ANC) attendance is one of the priority SBCC messages. Most of the participants who talked about this issue were aware of the advice that women should attend regular ante-natal care sessions while pregnant. At midline, attendance at ANC clinics was said by some key informants to have increased since the start of the CDGP, and the quantitative midline also found that the CDGP had been responsible for a 16% increase in ANC usage in CDGP communities (36% ANC attendance) compared to the control communities (20% ANC attendance).

In the qualitative endline, key informants and community members again observed a general increase in the number of women attending ANC. Direct beneficiaries of CDGP almost unanimously say they attended ANC during their pregnancy. As described in the focus group excerpt below, non-beneficiaries have also been motivated to attend ANC by the possibility of registering for the cash transfer:

> "Every week the place is filled, all the chairs will be occupied, with some women sitting on the floor.
>
> *Is that how it was before?*
> No. It wasn't like that before, people are more enlightened now.
>
> *How did they get to understand the value of antenatal?*
> When one goes to the hospital and one is tested and they identify the illness you have, they are able to help better.
>
> Some people did not use to come for antenatal, but because of the chances of receiving the phones, they started to attend the antenatal clinic.
>
> In the past only few persons attend antenatal clinic...
>
> But now from early morning on the clinic day, all the chairs will be occupied.
>
> If a woman develops some challenge during delivery and is brought to the hospital, the health workers request for her antenatal card, if she has it, it helps them to attend to her but if she doesn't have the card, they usually express dissatisfaction with the woman."
>
> Keta FGD – Non-Beneficiary Women

In all the qualitative evaluation sites it seems that many, though not all, women have now been convinced that ANC is good for them and their baby, and try to go if they can. Those women who have attended ANC say they found the advice and check-ups useful, and many say CDGP influenced their decision to go:

> "For my first 3 pregnancies I did not go for ANC because I did not have anyone that really encouraged and explained things properly to me. I used to see some women going but I did not know it was this useful and important until I joined this programme."
>
> Kanyu FGD – Beneficiary Women

> "Honestly, Alhamdullihi, my two previous pregnancies honestly had complications because I wasn't going for ante natal, but when I was pregnant [with my CDGP baby son] no week passes me by without going for ante natal, if [I] must miss ante natal, there must be a reason why I didn't go. You can ask the other women in this house and they will testify that I go for my ante natal regularly."
>
> Matseri CS3 - Focus Woman

For women who do go to ANC, the support of husbands is important, not only in terms of having their permission to travel outside the home:

> "I also started going to the hospital for ANC on the advice of my CV. My husband also always reminds me when it is time."
>
> Kanyu CS3 – Focus Woman

> "I used to attend ANC at the hospital regularly. My husband insists that I do not miss any clinic."
>
> Kokura CS- Focus Woman - Rakiya Isubu

Having enough money for transport and other expenses (and for a woman, having her own money) is an important factor in the decision to go for ANC, and the CDGP cash transfer has therefore influenced their ability to attend. Once the programme comes to an end, it remains to be seen whether the higher attendance will be maintained.

> "They all unanimously agreed that the cash transfers have also gone a long way in affecting their decisions to go for ANC visits, stating that before they had nothing to do with ANC visits ... But now the programme has helped to educate us about the benefit of ANC visits, and we are better able to care for ourselves when we are told what our bodies require during these visits."
>
> Yankuzo FGD – Beneficiary Women

> *"In this community, does the cash transfer affect women's decisions to go for ANC in hospitals when pregnant?*
>
> This is beyond doubt. First, when a woman is two months pregnant, some even start going from one month pregnancy, and she does not stop going until she gives birth. The result is that giving birth becomes easier, you will hear people saying that woman gave birth whether at night, in the evening, or in the morning; without anyone knowing….In the past women sometimes had to be transported in a car or cattle carts to the tarred road no matter the intensity of the *damina* [rains]. You see, there has been change indeed…. Instead of having to go to your neighbours to borrow money to enable your wife to go to the hospital [for ANC], this cash support has created a means for her to go to the hospital. You see, there have been great changes."
>
> Kokura FGD – Non-Beneficiary Husbands

> "The cash transfer helped women to eat good food and also feed their children well. With the money, they are able to save and expand their businesses. And when they need to take their child to the hospital they can use their money to treat the child. They transport their selves to the hospital for ANC and also eat what they feel like eating when they go for the ANC. When you ask your husband for money to do these things and he doesn't have, then you will tell him that you have it and he will permit you to go".
>
> Kokura FGD - Non-Beneficiary Women

> "They save part of this money [the CDGP cash transfer] and when their husbands do not have money to give them, they use it to go to the hospital for their ANC.
>
> Yes. Their husbands don't even stop them.
>
> All they need is to ask for permission and the men don't refuse them."
>
> Kanyu FGD - Non Beneficiary Women

However, money is not a constraint for everyone. For example in Kafin Madaki, participants in the beneficiary women's focus group said:

> "We've been doing this since before the programme, so the cash does not influence us on ANC visits."
>
> Kafin Madiki FGD – Beneficiary Women

Use of health facilities for children

At midline, both the qualitative and quantitative reports found that children had fewer episodes of illness as a result of CDGP. In the qualitative discussions, respondents said they had observed that babies who were exclusively breastfed were less likely to get diarrhoea and fevers: this was repeated by many of our participants at endline, as reported above. The quantitative midline analysis showed that children in CDGP communities were less likely to suffer illness or injury than children in the control communities. At the same time, it found that children who did suffer from diarrhoea were more likely to receive adequate treatment, and that there was a significant increase in take-up of vaccinations and de-worming treatments for children in CDGP communities (ePact 2017b, p.30-33). The latter finding is consistent with beneficiaries' statements in both the midline and endline rounds of qualitative interviews that the cash transfer enables them to take their children to a health facility sooner, without waiting for funds from their husbands or other sources, when needed. These complicated factors perhaps explain the apparently contradictory findings from the qualitative endline that children are less likely to be ill, but that their mothers are more likely to take them to a health facility.

The use of health facilities in general was said by some respondents to have increased over the three years since the baseline. An example of this is the following comment from an experienced health worker in Yankuzo (note that he does not specify the mothers' reasons for attending the clinic: the increased attendance he describes may include ANC visits and vaccinations, as well as seeking treatment for sick children).

> "There is an increase in the number of households who now access health services. In my 7 years of working at this health facility, before the coming of CDGP, I sometimes don't have more than 20 women coming to this health facility weekly. Since the coming of CDGP, I now have a minimum of 20 patients daily at the health facility, sometimes we get as much as 50 people. The increase in the use of the health facility by women and their children, the kinds of informed questions we receive when we interact or consult with the women are all indications that they understand the messages about health and nutrition."
>
> Yankuzo KII - CHEW (Male)

As found in the midline, many people said that lack of money was a common reason to delay taking a sick child to a health facility. For beneficiaries the cash transfer has eased this, and they are more likely to seek prompt treatment from medical staff (rather than traditional healers or home treatments).

> "Its [CDGP's] effect is beyond measure because if you observe the illnesses are not as in the past. In the past people left their ill children for three or four days without treatment but now treatment is sought in the first or second day because there is the money to pay for it and you will see there is successes. But in the past they could be without treatment for a week because there was no money to take them to the hospital. You see, what would you do? You did not have money and your neighbour did not have money; they could not help each other."
>
> Kokura FGD – Non-Beneficiary Husbands

> "It's a must that I take him to the hospital for treatment, even if I am not the one I encourage others to do same when their children are ill, why? Because you as a mother cannot know exactly what is wrong with the child except doctors because that is their area of specialization and they can know what is wrong with the child better."
>
> Matseri CS3 - Focus Woman

> "When their [beneficiaries'] children are sick and the husband does not have money, they use the money to take the child to the hospital for treatment."
>
> Kanyu FGD - Non Beneficiary Women

Some respondents associated their increased use of health facilities with the knowledge and understanding they had gained from the CDGP, while others suggested that there may be a wider trend towards more use of health facilities in some places, independent of the CDGP.

> "Though my wife is not on the programme, she has benefitted from the knowledge her friends and neighbours share with her on antenatal, taking children to hospital and how to manage her pregnancy when she was pregnant last year."
>
> Yankuzo FGD - Non-Beneficiary Husbands

> "We take our families to the hospital but that was not the practice in the past. Now our people frequent the hospitals".
>
> Kokura FGD - Fulani Men

3.3 Household decision-making and resource management

The qualitative endline interviews add further detail to the finding from the midline, baseline and situation analysis that women in these communities have a considerable degree of autonomy in the spending of their own earned income. However, women's earning opportunities are limited (not least by social and cultural norms which restrict their movement outside the home), and the income they control is therefore relatively small and in some cases non-existent. The cash transfer is a significant addition for many individual women, even when it is a small proportion of the household's total income. Impacts of the cash transfer on women's livelihoods and income are discussed further in Section 3.4: meanwhile this section focuses on decision-making within the household, particularly on decision-making about the use of the cash transfers and the effects on women's status and autonomy. This topic relates to evaluation hypotheses IV and V (see Box 1 in the Introduction).

Husbands have overall authority over the running of the household, including major expenditure decisions and the activities of their wives. Senior wives and mothers-in-law have some authority over women who are lower in the household hierarchy, and will sometimes take on the responsibilities of the household head in his absence, but ultimately defer to the judgement of the male head of the household. As described in the baseline report, husbands are responsible for providing staple foods and other major items for the household, while wives will "support" them by covering minor expenses and supplementary foods from their own money when they are able to.

> "I provide all of my family's needs. My wife uses the money she makes from her business to take care of her needs that are personal to her. She does things for her family and other relations. She also can get gifts for friends that are celebrating one thing or the other."

Kokura FGD - Fulani Men

> "[T]he most senior wife in the household is the one who advises them on how to spend their money but she does not enforce it on them, but their husbands have the final say. If he does not agree with what they want to do with the money then they do not go ahead with it."
>
> Doka Gama CS4 – Sister-in-law

3.3.1 Control and sharing of cash transfers

At the beginning of the programme there were concerns that the CDGP cash transfer might be regarded as an unearned windfall rather than earned income, and was therefore more likely to be appropriated by husbands (see Baseline and Situation Analysis reports). This does not seem to have happened: the cash transfer was described by all our research participants as the beneficiary woman's money, for her to spend on good food and care for herself and her children. Naturally households vary in the degree of consultation or influence by husbands regarding how the CDGP money is spent, and beneficiary women differ in how far they share the cash transfer with their husbands and other family members, as illustrated by the examples in this section. However, the programme's sensitisation campaign seems to have been effective in communicating the purpose of the cash transfer, as explained for example by these focus group participants:

> "Participant A opined that the money was meant for the nursing or expectant mother, for her upkeep to purchase whatever she needs to ensure the wellbeing of the child. In addition to that, another participant added that no one eyed the sum given to the mothers as it was for the betterment of the lives of both mother and baby. ... Another participant reiterated that the money was not for any other person but the mother and baby for their upkeep."
>
> Kafin Madiki FGD - Beneficiary Husbands

This is not to say that there is no friction or competition around control of these resources. For example, non-beneficiary men in Kokura discussed how women "cannot all be the same" in these matters:

> "You see, when this problem arose because some women were not willing to share the cash with their husbands, there were some of your women [i.e. CDGP staff] that came to advise them and they are now taking this advice. This problem started and then stopped. You know village life. Some of them started this problem but others assisted their husbands with the cash. They cannot all be the same.
>
> Now the moment they receive the cash they give their husbands what they normally give them. Some give them like 500 Naira, 400 Naira or even 1,000 Naira can be given to them. Sometimes when she buys the things and cooks in the house everybody gets to eat a little."
>
> Kokura FGD – Non-Beneficiary Husbands

Beneficiary husbands in Matseri shared their personal experiences of this:

> "You see the situation varies, there are women who will always submit every income they have to their husbands without the latter asking, while there are those that will not give a penny even where their husbands insist. My wife has given me money out of the cash transfers twice. While on the first occasion I spent it on myself, on the second, it was for the treatment of our son who had a fever. I hadn't money then and she provided the cash for his treatment then....
>
> For me, while I don't spend the cash on myself, I am responsible for shopping for all the foodstuff my wife needs in the household. We divide the money into two, use half for food

items and the other half for non-food related expenditure. The reason why the cash comes to me is because our culture and religion don't permit women to go the market to shop for what they need."

Matseri FGD – Beneficiary Husbands

Meanwhile, a local leader from the same community (Matseri) gave his perspective on the challenges for those responsible for the governance of the CDGP within the community, suggesting that there may always be friction about these issues within some marriages, but that on the whole the programme had been successful in persuading men and that impacts on relationships and social wellbeing were mostly positive.

"[No] matter how much we try some men would still bully their wives to collect their money and it may never come to our attention. ...

From the outset of the programme, we had instances where men would insist on their women to part with the fund from the cash transfers. We did awareness and sensitize the men and we no longer have those instances anymore. That said, we cannot rule out the possibility of some women agreeing to hand over the funds to their husbands without notifying us, in that instance, we cannot interfere. At the community level, we have not observed any [negative] social effects. On the contrary, we have had improved household relationships in the community."

Matseri KII – TWC member

Gifts and sharing

While some beneficiary women say that they do not share their cash transfer with anyone, many others (as we found in the midline) give small amounts to their husbands and to other women in their household (especially senior wives and mothers-in-law). Some also give occasional cash gifts to their parents. "Gifts" to the husband are usually higher value (most often N 500, or up to N 1,000): sometimes these are for his own "personal reasons", but more often they seem to be a contribution to the household expenses or the husband's business. Sometimes beneficiary women pay directly from their own money for items that would normally be considered the husband's responsibility (such as staple food purchases, medical expenses, or school expenses for the children). As was found in the Qualitative Midline, all of these types of contribution seem to enhance the giver's social capital and standing in the household.

"I give my husband N500 and my mother in law N100 for their blessings. Sometimes, I send my parent N500."

Keta CS2 – Focus Woman

"I [give] my co-wife a bit of the money and my husband too but not always."

Yankuzo CS4 – Focus Woman

"I do not give any amount to anyone. I use it to buy what I need to give my family balanced meals. If my husband wants to buy the food items for the day I complement whatever he is buying with the things we have been taught to add to our dishes. I do not have to give my husband anything; after all he is also enjoying the nice meals that I cook now."

Kanyu CS3 – Focus Woman

> "You will only give it to somebody close to you like a person you live with. You will give the person like N10 or N20."
>
> Kafin Madiki CS4 – Focus Woman

> "*Whenever you receive your cash transfer, do you usually give some of it to some people?*
>
> Yes, my husband.
>
> *How much and why?*
>
> I give five hundred naira out of it, sometimes he refuses it, except I insist he collects out of it, he will always tell me to use it for the purpose [it] is meant for.
>
> *Why do you give him?*
>
> Because he is the father of the child and he deserves it too. The child is our responsibility and we cater for the child's welfare together."
>
> Doka Gama CS6 – Focus Woman

In the endline interviews, a number of beneficiary husbands said that they had declined cash gifts from their wives: however, the impression is that it was important that the gifts were offered.

> "Let me speak for my household, my wife always likes to give me N1,000 out of the cash transfers that come to her and I often decline. This is because I have come to understand that the money is meant to help her and our unborn child so I would rather encourage her rather than take from her. The money has brought relief [for] me so it would be wrong for me to take from her, I rather look for ways to support her."
>
> Matseri FGD – Beneficiary Husbands

> *"Did you give your husband any from what you bought?*
>
> I did but he declined, [saying] that it is for me and my child."
>
> Keta FGD – Beneficiary Women

Participants in one men's focus group in Kafin Madiki explained how the giving of gifts among women in the household ("for their blessings" as one case study beneficiary put it) helps to build a reciprocal support network: whoever has good fortune shares it with her housemates, in the expectation that they will do the same when they in turn have good luck.

> "After they have taken care of their children and something remains she can give some to either the other wife or her mother-in-law and when Allah also gives [to] these ones they will also help her. They do these kinds of assistance to each other. "
>
> Kafin Madiki FGD – Non-Beneficiary Husbands

Uses of the cash transfer

Both the quantitative and qualitative midlines found that food purchases were by far the most frequently reported use of the cash transfers. The quantitative analysis showed that this was followed in order of frequency by savings, health expenditure for children, shoes and clothing for children, gifts to other household members, assets (including tools), and health expenditure for adults (ePact 2017b p.22-24). While the qualitative research did not attempt to quantify the frequency or amount of expenditure on different items, focusing instead on exploring the range of things beneficiaries spent the cash on and how and why they made these decisions, the qualitative midline findings match closely with this list of expenditure items.

At endline, food (especially the types of nutritious food recommended by the CVs) was again the purchase most commonly reported by beneficiaries. Other expenditure items for themselves and

their children included clothes, soap, and school expenses, while household purchases such as mattresses were mentioned occasionally. The women's ability to contribute to the general household expenses, which are usually considered the husband's responsibility, was frequently mentioned.

> "*What do you spend the cash transfer on?*
>
> I use it to take care of the home, our well-being, feeding and health, when any of my children fall sick I use out of the money for treatment. I also use it for what it is meant for which is to feed well."
>
> Doka Gama CS6 – Focus Woman

> "All agreed that the cash transfers have gone a long way to affect women's decisions on how they care for themselves, their children, and their families generally, especially in the area of feeding and clothing for the members of their family. They added that before the cash transfers started coming in, they could not go out into the public in confidence because they did not have good clothes to wear."
>
> Yankuzo FGD - Beneficiary Women

> "I am now able to give my children school lunch money whenever their father is down financially. There was a time my children's school uniform was torn and their father did not have enough money so I gave him some money and he was able to complete it and get them new school uniform. I am really happy with the progress I am making under this programme."
>
> Kanyu FGD – Beneficiary Women

> "With the cash transfer given to them, when the father doesn't have money they take their children to the hospital with it. The mothers were able to use part of the money to buy school uniform, books and pencils for their children to go to school. They buy soap and wash their children's clothes with it, making their children appear clean. ... When women are given this money, they don't give it to us and they don't give their husbands but they use it to buy ... foods for their children."
>
> Kanyu FGD – Non-Beneficiary Women

Medical treatment again featured as an important category of expenditure (see also section 3.2.4 above), with many people saying (as at midline) that the cash transfer enabled women to take sick children to health centres earlier, and without waiting for their husbands to find money for the costs.[15]

> "[W]hen your child is sick and your husband is not at home you can use the money to rush your child to the hospital, therefore it has helped us."
>
> Kanyu CS5 – Focus Woman

> "Women save part of this money and they also use it to do little trading, so when their children are sick and the husband does not have money, they use the money to take the child to the hospital for treatment."
>
> Kanyu FGD - Non Beneficiary Women

[15] The quantitative midline found that 9% of women interviewed had spent part of the cash transfer on health costs for their children (ePact 2017b p.24). While this is much less frequent than expenditure on food (89% say most of the cash is spent on food, ibid. p.23), the qualitative discussions suggest that being able to pay for medical treatment when needed is important to the beneficiaries.

"...when their husbands are low on cash, they usually help out with feeding the household, and if any of their children falls ill, they use part of the money to see to his/her welfare."

Yankuzo FGD - Beneficiary Women

The reliability of the cash transfer means that it can also be used to obtain loans. For example, non-beneficiary women in this focus group in Keta discussed the effect of the cash transfer on beneficiaries' ability to access medical care when needed, adding the fact that they can even receive treatment on credit, using their future cash transfer as a guarantee of payment.

"R3: [P]eople that have money are able to come to the hospital when they or their children are sick and now more women attend ANC because of the programme, they are hoping that the people that give phones will come and enrol them on the programme.

R4: Women always took their children to the hospitals even before the programme, but now the visits have increased. There is progress. When we come for antenatal, they are always telling us to bring children to the hospital if they are sick.

R2: And they give drugs free without one paying any money.

Did the cash transfer affect the beneficiary women's decision in taking their children to the hospital?

R's: Yes

R1: If the husband has no money and the wife is compassionate, she will give the money so they can seek healthcare for their child.

R2: If she isn't well also, she doesn't have to wait for her husband, if he's at the market, she has money to do what she needs to do.

R3: Sometimes, beneficiary families can go to the hospital and receive treatment without money. As soon the cash transfer comes, they are able to offset their bill; they give [the health care provider] the money."

Keta FGD – Non-Beneficiary Women

Lastly, many women said that the cash transfer had helped them directly or indirectly to build up their savings, to invest in businesses that would provide income into the future, or to purchase assets (particularly livestock) that they could either sell on at a profit or keep as a longer-term investment for their child's future or in case of emergencies. These uses of the cash and potential impacts are discussed further in the section on Livelihoods. Interestingly, some women had also given their husbands part of the cash transfer to invest in farming, as noted by these non-beneficiaries (with perhaps a touch of envy):

"[S]ome of our friends got monies from their wives to farm so they farm larger farmlands [than] before."

Matseri FGD – Non-Beneficiary Husbands

"It has been easy for many of us particularly those ones who have their wives registered for the cash transfer, they get support financially from their wives to buy fertilizers and with that you see all the increase."

Keta FGD – Non-Beneficiary Husbands

3.3.2 Women's economic choices and status

It is clear from many of the excerpts above, and from our endline interviews overall, that for women beneficiaries the increased income from the cash transfer has enhanced their ability to make

economic choices as well as their standing and social capital in the household, and their sense of self-reliance. Some case study participants expressed this directly, for example:

> "It also gave me some right to decide sometimes on what the family eats which used to be my mother-in-law alone that used to decide, the reason being that I also make some contribution on the purchase of food items. It also gave me the power to eat what was solely beneficial to me and my baby. And before the cash transfer I was trading which was on and off, but now my trade is steady and I am making some good returns to support myself and my little girls."
>
> Matseri CS4 – Focus Woman

> "I must talk about my wife [who] has been empowered also financially by CDGP and she now has her own income generating activity which is helping me a great deal as household head, because sometimes she completely pays for food without having to wait for me."
>
> Yankuzo CS6 - Husband

Engaging husbands in all aspects of the programme including the SBCC and sensitisation; ensuring they are persuaded of the benefits to them and their children, and that their position as household heads is enhanced rather than threatened by their wives' participation; appears to have been a key element in CDGP's success in this regard. Male household heads retain overall authority over their wives, including whether or not they are allowed to register for such programmes or attend SBCC meetings, as some of our respondents underlined:

> "It is extremely important sir, if not for our taking part in these meetings, we will not have been able to allow our wives to implement most of the things they are taught by the CVs."
>
> Yankuzo FGD - Beneficiary Husbands

> "Participant A started off by saying his wife would not even go out in the first place without his permission! Availing herself to be taught was entirely up to him and as such, it is very important that he as the head of the family is enlightened. Another believed that since the programme are new to the area; it is pertinent for men to be knowledgeable about them too."
>
> Kafin Madiki FGD - Beneficiary Husbands

> "*Is she receiving this cash support given to women?*
>
> No. Is [it] not when I allow her to go that she would collect?
>
> *You stopped her then?*
>
> Sincerely I stopped her."
>
> Kokura CS9 – Husband

Case study example 3 illustrates how the cash transfer can empower women, and enable the household to plan for the future.

Case study example 3: "The grant has brought a lot of changes" (Yankuzo CS2)

Mrs. B.Y. – Current beneficiary

B was 18 years old at baseline, and is the second of two wives of the household head, who is a farmer and a trader. Her co-wife has eight children, and at baseline B had two children, however she tragically lost both at early ages. Three weeks before midline B gave birth without complication to a strong and healthy baby girl. B was enrolled about a month before she gave birth, and by endline had been enjoying the cash transfers for about 23 months. She is aware she must be coming to the end of her time as a recipient, but she does not know when she will be exited.

B says the cash transfer has empowered her and the two other beneficiaries in the household. She mainly uses the money to buy the 'special foods' they learn about from the CVs, and sometimes to make other purchases. B has also managed to put a little aside as savings. The women enjoy the fact that they can make these decisions by themselves and are not completely reliant on what their husband is able to provide.

> "The grant obviously has brought a lot of changes to this household. All 3 of us receiving the grant have been empowered, we now afford to buy what we need by ourselves without waiting for our husbands. We buy our special food and even sometimes buy a few dresses for our babies and sometimes for ourselves."

B says she doesn't share the transfer with her husband, or other family members, but when she has cooked a nutritious meal using the ingredients she bought with her *'talafi'* she will typically share some with other household members: "When I cook my special meals I give them to taste."

B's husband says that although B and her co-wife (also a beneficiary) do not share the cash with him directly, he does not have to worry so much about providing for them, and this makes his life considerably easier.

> "the burden used to be much on me but now with this financial help to them? It has made it easy for me…They use from their purse all the time. So I am able to concentrate the ones (money) on the farm." Husband-EL

He says that now he does not have to spend so much money at home, he can refocus his attention on his farm, and has made some investments that have paid off.

> "Yes, my income has improved. I spend less at home so I have a little more compared to before, when I supported the family alone. [Now] I hire cattle to help me farm, I equally apply fertilizer, and my farmland has increased to 2 hectares from 1 and half before." Husband- EL

B has also been able to make some small investments in her business trading palm oil, Maggi, salt and firewood, and has recently purchased some goats that she plans to breed.

B's husband says he is particularly grateful that the financial burdens usually placed on him by his wives are alleviated by the cash transfer, and that he can now invest more of his money in his children's future:

> "I now pay attention to paying my children's school fees but for other domestic cares, my wives sort them out. I have 5 children in school of which I pay their fees alone. 1 in Federal college of Education, 1 in secondary and I have 3 in primary schools." Husband- EL

As a Traditional ward committee (TWC) member, B's husband is very supportive of the idea that the grant is exclusively for the benefit of the beneficiary women and children, and a large part of his role on the TWC is informing the other men in the community about the reasoning behind this, and where necessary settling disputes.

> "We insist on men in the community whose wives are beneficiaries not to collect such monies from their wives and we also assist to settle disputes especially the ones involving husbands insisting that wives share the cash transfer with them." Husband- EL

Regarding her interaction with the programme, B says she has learnt a lot from the SBCC activities. While she enjoyed the food demonstrations, the biggest change she has made was to try exclusive breastfeeding, which she says she would not have done without the programme.

> "I did EBF for 6 months…. [before] I did not know about EBF and did not practise. I would have found it hard to believe if it was mere enlightening campaign, because it would have been difficult to accept that a baby can survive for 6 months without drinking water. But the trainings and of course the cash backing went a long way in convincing me to give it a try."

B was also keen to highlight that she had learned about complementary foods and that she had used the 'pap' formula that she learned from the CV's for her most recent child

> "After that I commenced giving her pap made from corn and soya beans.
> *Did you know about this pap formula before this programme?*
> No I did not know this pap recipe before now. The CV taught us how to make it." B Endline

Both B and her husband are delighted with the results of EBF that they see in their own child, and more generally that it is noticeable who in the community has been practising.

> "My child of just 21 months looks like a child of 3 years. All those who were not breastfed for 6 months immediately after birth cannot compare with those breastfed in area of physical growth, skin nourishment and intelligence". Husband EL

B's husband believes EBF is becoming more widely accepted, and that they are breaking away from the more traditional practices.

> "Water, herbs among others [used to be given]. But now with CDGP, doctors and hospitals, that has changed". Husband EL

This opinion is echoed by B's mother in law, who with 20 grandchildren is open-minded about EBF and says she is not opposed to it: "There is a lot of change".

Looking ahead, B and her husband are sad that the programme will soon come to an end, however they are content that they have used their money wisely and believe their investments should allow them to continue to prosper in the future.

> "I think that I would be able to cope due the fact I make some proceeds from my trade and I have also bought a few goats that will multiply and I can begin to sell some of them." B Endline

> "I hire cattle to help me farm and I equally apply fertilizer and my farmland has increased to 2 hectares from 1 and half before…. My wives have been buying goats and chicken, training them which afterwards they will give birth and they will have more, this is the investments they do…. all those investment will certainly help once CDGP is over." Husband EL

3.4 Livelihoods and income

3.4.1 Women's livelihoods

The endline fieldwork confirmed the finding of the qualitative midline that many women who received the CDGP cash transfer have used part of it to invest in various types of income-generating activities and assets. The quantitative midline (based on data collected in 2016) estimated that CDGP had so far increased the number of women engaging in economic activity by 6%, raised women's average income by 20%, and increased the likelihood of a woman owning any animals by about 7% of baseline values.[16] At endline, since many of our respondents had already exited from the programme and were no longer receiving the cash transfers, the qualitative

[16] ePact (2017b) *CDGP Evaluation Quantitative Midline Report*, p.viii.

discussions focused on their perceptions and expectations of whether and how they could sustain the gains they had made.

The types of economic activity open to women have not changed since the Situation Analysis and Baseline reports. Married women of child-bearing age are very restricted in their movements outside the home, and therefore most often earn their income through home-based activities (petty trade, food processing and sales, small livestock rearing, and services to other women such as hairdressing and pounding grain). Fulani women have more freedom of movement, and frequently travel around the local area selling milk and yogurt.

In the *kaka* season, some women earn extra income by participating in harvesting, although farming is generally a male domain. It is mostly young girls, older women and divorcees who work on farms: married women generally are not permitted to do so, except in cases of poverty (when their husband "doesn't have anything to give" them): our respondents quoted below suggest that this is considered shameful.

> "Some women go to the farms, others don't, depending on if their husbands allow them. Some go to glean millet, others go to harvest maize or beniseed [sesame]. Mostly divorced and older women go to farm but women like us don't go out to farms, we do petty trading at home. The one who has capital starts a trade and the ones who don't have capital sit at home. Most women are locked up *'kulle'* in their houses and don't go out."
>
> Matseri FGD - Non-Beneficiary Women

> "Even young girls work on other people's farm… Any woman who is not married can go and do this work. Some men allow their wives to do the work… Yes, if he doesn't have anything to give the woman, he tells her to go and work so she can get something for the family… A man who doesn't have anything to give his wife will allow her to go… In fact some women will leave this community to another and go and work on another person's farm for pay… Yes some men are not able to stand watching their wives doing this, so they permit them to go elsewhere, get the money and return back to the home. He would even tell them where to go."
>
> Keta FGD - Non-Beneficiary Women

Within these constraints, many of our respondents explained how CDGP beneficiaries had used part of the cash transfer to expand or diversify their existing businesses, or establish new ones (see the midline report for more detailed discussion of this). Many also invested in productive assets, primarily livestock but occasionally major items such as land.

> "I bought a goat, I took care of it and it grew, then I sold it and bought another goat and used the remaining profit for something else. I was part of the programme and have been exited already but I still do well with the business I have on ground."
>
> Doka Gama CS7 - Focus Woman

> "My wives have been graduated 4 months now but still have money because they saved up capital for business. My first wife has goats and has purchased a house and has bought a plot of land from the sale of her goats."
>
> Keta CS3 - Husband

> "I have since been exited from the programme already, but I can boast of something I have for future use, if this sheep gives birth and I run into trouble I will sell it. I am really happy."
>
> Yankuzo CS7 - Focus Woman

For ex-beneficiaries like these, such investments are a strategy to sustain the higher incomes they experienced while receiving the transfer, and an inflation-proof means of saving for their children's future or for possible emergencies. These factors and the perceived longer-term impacts of the cash transfer on livelihoods and resilience are discussed further in sections 3.4.4 and 3.5.2.

3.4.2 Men's livelihoods and farming

The qualitative midline report found that the cash transfer was having positive impacts on beneficiary husbands' businesses and overall household food security, most often because they were able to invest more of their own time and money in trading or farming since the burden of covering day-to-day food and household expenses had been reduced. In some cases wives were directly contributing part of their grant to their husbands to invest in their farms or other businesses. This continued to be the case at endline, although as many women have now exited from the programme it was not clear whether this effect would be sustainable.

As the endline fieldwork took place at harvest time, much of the discussion about men's livelihoods and income centred on farming, which is the primary mode of livelihood and source of household income in all our communities. In most of our communities, this season's harvest was reported to be better than the last few years, with some farmers reporting a "bumper" crop.[17] The most frequently cited reason for this, apart from favourable rains, was the increased availability of fertilizers at subsidised prices and often on credit, attributed to the current government's renewed focus on agriculture. This increased use of fertilizer was mentioned by numerous respondents, in all the evaluation sites. Some also said that crop production practices had improved over the last few years, and that they had made greater investments in factors such as ox-ploughing and hired labour. In Kokura, which borders on the wetlands and has *fadama* farmlands, the government had also distributed water pumps, dug irrigation wells, and provided loans to establish irrigated farming in the dry *(rani)* season.

> "Allah brought us a government that has farming in its agenda... last year they distributed fertilizer, seeds, water pumps, they also dug irrigation wells..."
>
> Kokura CS2 – Husband

Husbands of CDGP beneficiaries were in many cases supported by their wives to make these investments in farming, either directly through a contribution from the cash transfer or indirectly because their own funds were freed up by their wives taking care of household expenses so they "spend less at home".

> "Yes, my income has improved. I spend less at home so I have a little more compared to before sir, when I support the family alone.
>
> *What did you do differently from previous years?*
>
> I hire cattle to help me farm and I equally apply fertilizer and my farmland has increased to 2 hectares from 1 and half before."
>
> Yankuzo CS2 - Husband

[17] The exceptions are Kokura and parts of Kafin Madaki, where the harvest was less good. These are discussed in Section 3.5. under natural risks.

The following focus group excerpt expresses well how a number of factors combine to determine the harvest outcome for different people, making it difficult to separate the potential impact of the CDGP support:

> "The truth is simply that the fertilizer and rain this farming season is what really brought increase to our farm produce…Government brought fertilizers to us at subsidized rates so people were able to [buy] but not all of us….Our friends whose wives are beneficiaries get support from their wives with monies to buy fertilizers. I have lots of friends who tell us about their wives' support to them in the area of finance to buy fertilizers and apply on their farms."
>
> Matseri FGD - Non-Beneficiary Husbands

Overall, therefore, the qualitative evidence suggests that the good rains and fertilizer subsidies have played a major role in enhancing household incomes in the current season, although the cash transfer has helped. This and other contextual factors discussed in the next section should be taken into account when assessing the impact of CDGP on livelihoods and incomes.

3.4.3 Economic context: price rises

At midline, the economic multiplier and market effects of the cash transfer (due to the injection of cash into the local economy and the increased demand for goods and services) was a frequent topic of discussion (see ePact 2017a p.50-52). At endline, these positive effects were again described by a number of respondents, expressing concern that they would soon disappear when the programme ends. For example, one shopkeeper explained:

> "Honestly, should the cash transfer end today, there will be a downturn. Majority of my customers are beneficiary women under the CDGP and once the funds no longer come in, their purchasing power will plummet and this will affect my turnover. The thing about business is that it is the turnover that matters ... and once these women can't patronise me then there will be problems."
>
> Keta CS7 - Husband

More frequently, participants in the endline discussions raised the issue of price rises which had affected their livelihood choices and the value of their income over the past three years. As illustrated in the excerpts below, price rises have had mixed effects, some positive and some negative. Clearly the purchasing power of the transfer itself has eroded since the beginning of the programme (see Introduction). The qualitative work was not able to investigate market prices or to establish the likely net effects on CDGP beneficiaries: this may be something the quantitative endline survey could investigate.

Many respondents (both women and men) noted that price rises had significantly affected the profitability of some activities, and had led some people to change the type of business they do. In Kafin Madiki, several women said they had switched to selling rice instead of other commodities, because it was more profitable. It was not clear from the interviews whether this was a temporary situation connected with the harvest:

> "I sell rice, in small quantities. I used to just sell sugar in small quantities before, but not anymore. Now I have enough money to invest in something bigger. I sell rice because it is more profitable. I plan to continue trading in rice and then diversifying as my finances grow stronger."
>
> Kafin Madiki CS6 - Focus Woman

> "I used to sell kola nut before, but it got too expensive and the profit wasn't good enough, so I dropped it. A bag of rice goes for about 10-11,000 Naira. We buy half of that for resale. We also plant sesame and hibiscus *(zobo)*. The kola nut was not very profitable, compared to the rice – which is much more. So I decide to switch to selling rice."
>
> Kafin Madiki CS7 - Focus Woman

Some women and men had been negatively affected by price rises. Even if their incomes had gone up, their input costs and general expenses had also risen, leaving them feeling worse off.

> "I made more profit in the past compared to now because then, prices of things were not as high as it is now. For me, I am doing less now in terms of even making profit… The prices of things have now gone high; you will have to buy polythene bag for N 100 which was N 30 in the past, 1 bowl of tiger nuts for N 500, two cups of sugar for N 150. How much will you then make? There is no more profit in it."
>
> Kanyu CS4 - Focus Woman

> "It is difficult to say that there is any significant change because the cost of everything has gone up and the value of the profit I am making now is less as compared to value of what I was making then."
>
> Yankuzo CS4 - Focus Woman

> "We have had changes in our farm output in the last 2 years. The availability and access to fertilizer has significantly boosted farm output. Unfortunately, the rise in prices tend to have eroded the gains we have made from farming. Things have become so expensive that we cannot even make sense of the gains we have had from farming."
>
> Yankuzo FGD - Non-Beneficiary Husbands

> "There is more income although one doesn't enjoy its durability like before. Things are more expensive unlike before."
>
> Kafin Madiki CS2 - Husband

On the other hand, some (male) farmers, especially those who have had a particularly good harvest this year, felt they had gained from the rising market value of their produce:

> "We have more money! Prices of things have gone high in the market so we have more money. Things we sold previously for N 6,000 now we sell at N 10,000. Our income is way better simply because we have harvest which is greater than the previous years."
>
> Keta FGD - Non-Beneficiary Husbands

> "We are doing more because the price of food has increased, we had bountiful harvest this year and the market value is better than last year. We suffered setback last year, coupled with lack of fertilizer. But this year's yield was quite good, we had more harvest and the market value appreciated, we get our desired gain when we sell our goods."
>
> Yankuzo CS7 - Husband

3.4.4 Savings, investments and sustainability of impacts

At midline, we found that some beneficiaries were already saving part of their cash transfer through regular monthly contributions to local rotating savings associations *(adashe)*. At endline, many more beneficiary and ex-beneficiary women described how they had saved through these groups

or individually to invest in the purchase of livestock and other assets which could provide them with future income and something to fall back on in case of need. Women said they had planned these investments explicitly to ensure some continuity of the income gains they had experienced from the cash transfer.

> *"Apart from CDGP cash transfer, do you have other sources of income?*
>
> No I don't have any business, I don't do buying and selling. But when I got married newly I was given a knitting machine, I was knitting but I stopped because I didn't have any one who could market it for me.
>
> *Even when this programme started, you didn't start any business?*
> No, except the Adashi I did.
>
> *What did you do with the Adashi?*
>
> I bought sheep as you can see over there.
>
> *What plans do you have for it?*
>
> If my girl grows I will show her that the sheep is a sign of the good fortune she brought to the family.
>
> *Do you intend to sell it or keep rearing it?*
>
> Unless a pressing need occurs, I just want to rear it - as you can see [there are] two, the one I bought gave birth to the second one, that is my long term investment since I don't have any business for now, but I intend to start up a business later in the future."
>
> Keta CS3 - Focus Woman

> "Those of us that are running business are still into it. But it is now stronger than before – we are doing more of it.
>
> I was also making oil and cookies, but my income is bigger now as a result of the savings I make from the cash transfer. I save N 500 per month with a group of women and I collect about N 4,000 when it is my turn. I put all this in my business.
>
> This change is because we are buying more of goods and raw materials and selling more. I am able to save some money from the cash transfer...
>
> *If your income is higher now, do you think you will be able to continue this after the CDGP programme ends? Why / why not?*
>
> Of course we will be able to continue, don't forget that we were already doing our own small businesses before the cash transfer. Our businesses are bigger now and I for one will continue to diversify so that I can continue to properly take care of my family."
>
> Kafin Madiki FGD - Beneficiary Women

Some other people were less optimistic but still had hopes for the future after the end of the programme. Whilst many had saved in anticipation for the future they were aware that this may not be able to maintain the quality of life they could afford while receiving the cash transfer.

> "I started a business with the money and each day I made a profit of up to N200. Now that the cash transfer has stopped, I have less to buy with so I make N40 or N50 daily."
>
> Matseri CS8 - Focus Woman

Insecurity was another reason for a less optimistic future in some places (see also Section 3.5). For example, in Yankuzo:

> "My wife envisaged that the financial support was not going to be forever, so she joined a savings group some months after she was enrolled into the CDGP. As a result, she bought

2 female sheep and 1 male sheep and a cow which she was rearing for over two years before cattle rustlers raided our community and stole them away."

Yankuzo CS1 - Husband

More generally, women noted that without the cash transfer they were likely to notice a drop in disposable income even if their businesses were thriving, as they would again need to spend their profits on household needs:

"Do you think this increase [in income] will continue after the CDGP programme ends?

I hope that my business will continue to thrive, as at now, I am still doing very well, but I cannot say for sure that it will continue to increase after the programme. However, our animals will continue to increase by the grace of God.

Why are you not certain?

You know we used to have the transfer to support some of the family responsibilities, but now it will be strictly our businesses that can be used to support the family."

Matseri CS5 - Focus Woman

Some beneficiaries have made no investments and feel that when the cash transfer ends, they will be back where they started.

"It is obvious, no one can deny that it is the money from CDGP that has brought this remarkable change for us and we are thankful....
Honestly I do not have any investments for the future except for my farm produce, that's why we [are] praying CDGP should not cease from doing this cash transfer if not poverty will return to all of us."

Keta CS1 - Husband

"*If your income is higher now, do you think this will continue after the CDGP programme ends?*

It can't be the same, there are going to be changes.... You see I don't make sufficient income from my business. The cash transfers from CDGP has empowered my wife and she, in turn, has helped to cater for needs at home. This has brought me great relief and when the CDGP programme ends I will be without any form of support and we can only look up to God for the best."

Doka Gama CS1 - Husband

The story of **Case study example 4**, an ex-beneficiary of CDGP who feels her household is much better off than at baseline, illustrates the complex contextual and other factors that combine with the impact of CDGP to determine the outcome for a family's livelihoods, income and wellbeing.

Case study example 4: "We have really gone forward" (Kanyu CS2)

Mrs. Z.B. – Ex-beneficiary (matured exit)

Z. was about 25 years old at baseline, and already had five children. She was (and still is) her husband's only wife. Their household is relatively well-off (PPI 3rd Quartile at baseline). She was pregnant at the time of the baseline interviews, and was one of the first cohort of women registered with CDGP. She started receiving the cash transfers about a month before the birth of her baby boy, and says she was exited from the programme when she weaned him, after receiving a total of 20 months' transfers. By the time of the endline interviews, she had been out of the programme for about a year.

At midline (2016), Z. was enjoying the cash transfers and using them to buy nutritious foods, applying the new knowledge she was acquiring from the food demonstrations and hygiene talks. She explained how her status within the household had risen since the baseline, partly because of her increased income ("I now have power because of the money") but also because her mother-in-law had passed away in the meantime so she had moved up the hierarchy. Both she and her husband appreciated the improvements in their household environment and their diet which they attributed to the CDGP.

Z. practised exclusive breastfeeding for the first time with her talafi baby, with the well-informed support of her husband (B.) who is a BRG member and has been for training sessions with AAH in Gagarawa. Both are very happy with the resultant health and growth of their son: her husband joked that the baby (now 3 years old) is "bigger than me his father." Regarding the decision to adopt EBF, B. says he was the first person to bring the idea into his household: he passed on the information to Z. and advised her to try it. He says:

> "When I do things in my home there is no resistance because I and my wife have a very good understanding... Our baby was among the first babies to be exclusively breastfed and other women saw the way the baby was healthy and decided to try.... This practice has become part of us until we stop having children. Even our children will be advised to do this."

At endline, Z. was heavily pregnant and was intending to exclusively breastfeed the new baby, even though she would not get CDGP cash support this time ("they explained to us that once a woman has benefited and exited once she is no longer eligible for the programme again").

Looking back over the 3-year evaluation period, Z. and her husband both say they are doing much better now. She says:

> "we have really gone forward, ...things are better - we are proud owners of a big cow, goats, ram, new wall... new roofs... new pipe-borne water..., healthy-looking children, neat environment and another new baby on the way, then the talafi!"

This rise in their fortunes is partly attributed to the effects of the cash transfer *(talafi)*, but they have also received an inheritance and had a "bumper harvest" this year "as a result of the present government's directive for everyone to go back to farming", and the consequent availability of subsidised fertilizer. B was able to buy fertilizer without taking out a loan, so his farm profits are higher. He has invested in livestock and a new motorbike for his transport business, having abandoned his previous less profitable line of work selling sacks:

> "In the past we had only sheep which were owned by someone else but now there are two cows tied in my house. At that time [baseline, 2014] I had a Jincheng motorcycle but now I have a Boxer motorcycle which is still new."

Looking to the future, he explains this dual investment strategy as a means of building his ability to cope with future shocks:

> "The reason why we do this is because no one knows tomorrow. It is a means of saving against the unknown future. Your income may cease in the future, you or a member of your family may fall ill, and ceremonies may come at a time when you do not have money. You can ... sell these assets [livestock] and solve your problems without going to someone else to beg".....
>
> "...You see this commercial motorcycling that I do provides me with money for lunch every day. Even when I wake up with no money but in good health and with fuel in the motorcycle I will be able to provide what will be eaten for lunch and sometimes even for dinner... You know if you have a means of raising income every day whatever you save will be safe but if you do not have a means of livelihood what you save may not be safe because that is what you will take and use when something comes up."

Z. herself earns her own income from petty trading, selling beans, Maggi and pepper. She was doing this before participating in CDGP and has not changed her livelihood activities during the evaluation period.

Overall, their feedback about the way the programme has been implemented is very positive. The only aspect they are dissatisfied with is the exit process. Z. feels she was removed from the cash transfer too soon, before her child's second

birthday: she says this also happened to some of her neighbours. Also, she was not told in advance that her cash was stopping:

> "In fact we went to where they collect *talafi*. In fact, I even lost my slippers, they asked for my name and I told them... They checked and said I have been exited. In fact I [borrowed] N400 ... to go to Gagarawa ... but they saw nothing was in my account."

3.5 Risks, shocks and coping

3.5.1 Risks and shocks

Three main categories of risk experienced by the case study communities were identified in previous rounds of the evaluation: seasonality (affecting income, food availability and health); natural hazards (especially drought, flood, crop pests or livestock diseases); and insecurity (especially armed raids).

Insecurity has continued to affect Doka Gama, Keta and Yankuzo (Anka and Tsafe LGAs in Zamfara) where there have been cases of armed banditry and cattle theft. Men in Doka Gama explained how this affects their ability to accumulate assets or to invest for future needs:

> “R8: You see the problem of insecurity has affected our pattern of assets and investment. The ones we have had over the years were stolen from us, so everyone is now cautious about what they invest in.
>
> R2: That’s the biggest challenge, you don’t want to buy motorcycle or livestock and someone will just raid you and take it away from you. Sometimes you can even be killed for owning assets.
>
> *Has anyone been a victim of such raids in the past?*
>
> R2: Yes, my son ... was raided and his motorcycle was taken away from him. Thank God, the community quickly mobilized and recovered the motorcycle. Other victims were not lucky....
>
> R9: It is a very precarious situation we are in, for me they came right into my house and made away with my livestock. If you keep money and they also get wind of it, you may also be killed, so there is just no solution to these problems.
>
> R1: The only investment now is by buying grains such as beans, groundnut or millet to store.
>
> R3: In investing, you have to be shrewd and discreet because once you expose yourself and it is known that you have assets or have made certain investments you can be raided and also pay the supreme price in extreme cases.”
>
> Doka Gama FGD - Beneficiary Husbands

In Keta, there were complaints that the security forces were too slow to respond:

> “There is insecurity here in our community. We do not have police or army to guard us; cattle rustlers have taken great advantage of us. ..
> The major challenge is when you resist these thieves, you end up dead, so they cart away our herds every now and then...
> Most times when we have tips that the thieves are coming, we will inform the security outfits, guess what? They will only arrive after the harm has been hatched. Security is our major challenge here.”

Keta FGD - Non-beneficiary husbands

In Kokura however, the local men had managed to form an effective vigilante group and stop the raids:

> "We used to have bandits that come to steal from us but we formed a vigilante group and that put a stop to it. We rotate in patrolling and keeping an eye on the routes where they are most active. We were able to capture some of them and have handed them over to the authorities. We no longer have such cases anymore."
>
> Kokura KII - TWC Member

Natural risks, including crop pests, droughts and flood, are a frequent feature of farming life. As noted in the Livelihoods section, most of our respondents had a good harvest this year. However, in the wetlands *(fadama)* around Kokura and Kafin Madaki there was a shortage of rain and ground water which was said to have severely reduced the rice harvest, while bean production was also hit by poor timing of rains in Kafin Madaki. Farmers there wished they had irrigation to reduce their dependence on rainfed production:

> "R6: The farming this year has been backward because people getting a bag of beans now got 10 or twenty measures. Those who got two bags are those said to have gotten the most beans this year.
> R7: Last year I got 50 measures of beans but this year I got only 2 which we have already eaten.
> R8: There was no rain in *kaka*. Just when the crops shot up and were ready to produce the rain suddenly stopped in *kaka*.
> R9: You see, if we had irrigation wells we would have watered our rice farms when the rain stopped".
>
> Kafin Madaki FGD - Non Beneficiary Husbands

> *"What about those that lost their crops during the last farming season?*
>
> R3: There are many who lost.
> R4: There are those who lost. You see, some sorghum had not finished growing, some millet farms too were not fully ripe, and rice in some places did not survive at all.
> R5: It was the river which did not produce as much water. Some are lucky to get something.
> R6: Those who got, got. Some of us lost.
>
> *How did you cope? Was there any help from someone, such as the government?*
>
> R1: (general response) No, None."
>
> Kokura FGD - Non Beneficiary Husbands

For the Fulani community in Kokura, natural risks include landslides, floods and exposure:

> "We have indeed had many challenges. We had landslides and this resulted in less farm produce for many of us. We had less millet and sorghum and that affected us a lot. We have been experiencing that for the past 3 years. This has also affected the quality of the soil.
>
> The sudden cessation of the rains this year also affected our crops.
>
> This was initially due to heavy rains and then the after effect of the naturally created gorges set in. This year it was the cessation of rains so it's not always the same. We can go long years without experiencing any problems. We also had bandits coming in to steal our animals but we were able to take charge of the situation."
>
> Kokura FGD - Fulani Men

"The biggest risk to both adults and the children is ... exposure (cold gusty winds, high temperatures, excess aridity). Excess water from Baturiya wetland forces some *rugas* to move to higher adjacent plains much closer to main Kokura community to avoid risk of flood. ..Some *rugas* use hand dug wells to supplement for water needs obtained from an isolated bore hole closer to Kokura. The women and children limit movement in extreme weather conditions."

Kokura KII – CV (Fulani Female)

3.5.2 Resilience and coping strategies

Even when there are no major covariate shocks affecting whole communities, people face the usual range of risks and shocks at household and individual level, particularly illness and unexpected medical costs, which can be a major drain on household resources. The range of options for coping with all such risks and losses (as found at baseline and midline) include liquidating assets, borrowing, asking relatives and other community members for help, or looking for income from other sources. At endline, some respondents stated that they had sold some of the assets accrued from their time as CDGP beneficiaries in order to manage times of need, and that the cash transfer itself (while they were receiving it) helped to smooth consumption during the lean season and other periods of stress. People frequently said that one of the reasons for saving and investing (particularly in livestock) was to have something to fall back on in times of need (see also section 3.4.4. on savings under Livelihoods). For CDGP beneficiaries, this use of the cash transfers to bolster household reserves can be seen as an investment in resilience, and should contribute to a reduction in negative risk-coping behaviour (Evaluation Hypothesis II, Box 1).

"I think the default coping strategy is to borrow from neighbours and friends. However, for those whose wives are beneficiary under this project, they do not worry about such shocks as their wives will be there to cover their backs.

Is there any family that you know of who had shocks, and how were they able to cope?

Well some people lose their valuables to either fire incidence in the house or poor farm yield and whenever such happens, they go borrowing as a means of coping with the shock. That is the ... coping measure I know of. Also, people may also render help to such a person as a sign of sympathy."

Keta CS7 - Husband

"Last year I bought a sheep and a goat from the savings I had from selling my farm produce. I sold what I had from the farm to make the investment and we fed daily from the wages I made from freighting of goods within and outside the community. The reason for the investment is to guard against future shocks or uncertainties that may arise in the family....

...Yes I experienced a few shocks over the last one year ...: Aside from the loss of our investments in cattle and sheep [to armed robbers], I lost my mum, who was living with us during your last visit. Also, a part of my house collapsed during the last rainy season

What did you do? How did you cope with this misfortune? Who helped you (if anyone)?
When these events happened, my wife was no longer under the project and we just took it as an act of God. We lived within what we had left and I worked harder to sustain the family. We didn't go to beg or ask for help from any source....

The cash transfers also served as a cushion to the perennial food shortages we usually face in August (at the peak of the rainy and farming season) where most of us are unable to go out to work."

Yankuzo CS1 - Husband

In **Case study example 5,** recurrent bandit raids seem to be almost a part of life for this ex-beneficiary, who explains how the cash transfer helped her manage the effects of an attack two years ago, but after another more recent raid she had to rely on neighbours who were themselves affected.

Case study example 5: "Some people helped us" (Doka Gama CS7)

Mrs. Z.S. – Ex-beneficiary (premature exit)

Z. was about 15 years old at baseline, having married at 13, and was the only wife of the household head. They live together with her husband's three brothers and their wives, and the household was in the 2nd PPI Quartile (below average wealth) in 2014. Z. was pregnant with her first child at baseline. She was one of the first cohort of women registered with CDGP having given birth shortly after the baseline period, and received her first cash payment about three weeks after the birth of her baby.

Despite reporting that she experienced an 'easy' pregnancy and no complications at birth, the baby girl sadly contracted a viral illness before her first birthday. Z immediately took the child to the hospital in Wuya when she recognised the symptoms, and the baby was treated with various different drugs but she never recovered and tragically passed away. Two months later (after 14 months of cash payments) Z was exited from the CDGP. Z stated that the exit process was peaceful, and she appreciated that a CV had come to inform her about the process.

> "I was exited peacefully and I didn't have any problems."

At the time of the midline data collection Z was pregnant again, but had not been re-registered onto the programme. She continued to attend food and hygiene demonstrations, and further discussion of SBCC messages within the household among her mother and sisters in law continues to be a frequent occurrence.

Z has since had another baby girl who was 13 months old at the time of the endline interviews, and she still tries to adhere to the lessons she learnt from the programme about nutritious 'body building' foods:

> "I have stopped receiving cash transfer because my child died, but I try to still eat those foods I eat before."

During her time as a beneficiary, Z used most of the money she received to buy nutritious foods enabling her to cook the 'balanced meals' that she learnt about from the CV's in order to meet her families nutritional needs, while also finding a little extra to invest every month in 'adashe'.

Z felt that by being in a position to help with the family income, she had earned more respect within her household. This combined with the new knowledge she and her husband have acquired through interactions with the SBCC and the CV's, has helped them to make decisions for the future.

> "We always discuss these things and how they are affecting our lives and that of the community. We also make better plans for the future. My husband is happy and excited [about] the changes he is seeing in our home. He loves the way I am cooking our meals and together we spend more time taking care of our surroundings." Z Midline

Z had successfully practised exclusive breastfeeding with her first child before she passed away, and was continuing to practise what she had learnt with her second child. Z has the full support of her mother-in-law, who was in fact the first person in the household to advocate for trying exclusive breastfeeding. Now she has seen the results, she insists that all the women in her household practise exclusive breastfeeding, something she believes is both beneficial to children's health, and easier than the old traditional practices.

> "Truth be told, this advice is a good one, we tried it and we saw positive results, we are happy, at least we have been relieved from the difficult task of going to the bush or forest to get trees. All that is required of a woman is to breastfeed her child as soon as she delivers. And that we shouldn't give them water until after six months, we

followed these instructions diligently and we are holding onto it because our children no longer fall ill as often as before." Mother in Law

Z's mother-in-law also participates in the CDGP activities and is well versed in the SBCC messaging. She strongly advocates that the other women in her household follow the suggested practices, and happily discusses the benefits and difficulties encountered.

> "They also told us that when a woman gives birth and there is no breast milk flowing yet, that we should still place the child on the breast it will flow, when we tried it to our greatest surprise it worked, they also told us that the breast milk alone is very good for the child. We have taken this new practices and adopted it." Mother in Law

At baseline Z was not engaged in any business activities, and relied solely on what her husband was able to bring in to support her. With the cash she received from the programme, she started to invest in a small business selling groundnut cookies and *hoche* (sorghum cakes), which at midline was making her a small profit. At endline she was very busy making *hoche* because of the abundance of sorghum at harvest season. Through her *adashe* savings group, she was also able to purchase a goat, which she fattened and then sold for profit.

> "I took care of it and it grew, then I sold it and bought a she goat and used the remaining profit for something else."

The profit from her business, and the CDGP allowance she and the other beneficiaries in her household bring in each month has allowed her husband to purchase a motorcycle which he uses for commercial purposes after the farming season. Z states that the family is much better off now as a result of all this additional business activity.

Doka Gama is subject to frequent raids from armed and violent bandits and cattle rustlers. Z's family has been victim to such raids more than once. Before the midline, their cattle and household valuables were stolen. During this period Z's family had to survive on the CDGP allowance.[18] Since the midline, and having been exited from CDGP, misfortune struck again, and this time Z lost her cattle, and tragically her father. This time she had to rely on kindness from the community, but many were in the same boat.

> "Some people helped us, but it was the entire village that was involved so no one can help the other".

Looking back over the past three years Z believes that despite the insecurity and many challenges they have faced, she and her husband are doing more business and have increased their income. She attributes some of this to the cash transfer, but Z points out that she was exited some time ago, and her business has continued to grow.

> "Of course it will continue. [I] have been exited already but I still do well with the business I have on ground."

3.6 Wellbeing

One of the expected impacts of CDGP is that "the cash transfer will result in improved material wellbeing and will contribute to the relational wellbeing of households through enhanced trust and reciprocal social and economic collaborations" (Evaluation Hypothesis IV, Box 1). This theme has been explored through each round of the qualitative fieldwork.

The situation analysis and qualitative baseline discussions on wellbeing centred on what it meant to people in the CDGP communities to live well, and what they aspire to for their children and families. These discussions underlined the perception that poverty and wealth are about more than just money, and emphasised the importance of interaction and capabilities within families and communities. Social harmony and family life were emphasised as very important factors of what

[18] See Qualitative Midline Report, Case Study Example 5.

wellbeing means. Having “no-one to help” was described as a feature of the “worst form of poverty”. Money or ownership of key assets such as houses, land and livestock, are of course a key means of accessing not only goods, but also social standing and resilience in terms of assets and claims to fall back on. The quantity, quality, and reliability of food supplies in the household were also seen as a key element of wellbeing. Suggested pathways out of poverty and towards wellbeing *(wadata)* included jobs and other economic opportunities, education, community support, cash, farm inputs, access to markets, and health services.

At midline, the quantitative survey found that women in CDGP communities reported a higher level of subjective wellbeing compared to women in non-CDGP communities, based on where they placed themselves on a ‘ladder of life’ picture (ePact 2017b p.97-8). This finding is supported by the results of the qualitative midline, which investigated the factors that contribute to the feeling of increased wellbeing. It found strong evidence that the short-term material wellbeing of beneficiaries was improved through better health and diets, as well as direct and indirect income effects of the cash transfer. Impacts of the cash transfer on relational wellbeing were reported to be mainly positive, with most married couples enjoying more harmonious relationships due to the easing of financial stresses (although in a few cases, control of the cash had been a source of conflict). Relationships with other women in the household and compound are very important in these patrilocal, multi-generational and often polygamous family units. In most cases, the midline found that these relationships had been improved, and the status of beneficiary women raised, by the cash transfer (although again, there were some cases of jealousy and conflict). In the wider community, the impact of the CDGP on relationships and social cohesion was mostly positive, with increased interaction due to the SBCC meetings as well as greater economic activity.

The qualitative endline research found further examples and very similar statements about all these effects, for example regarding marital harmony:

> “The cash transfer has had good effects ... it has improved the relationship between couples in most of the households. Thanks to the cash transfers, women are now playing influential roles in household food expenditure and diets.”
>
> Matseri FGD - Beneficiary Husbands

> “There has been improvement in the relationship between husbands and wives. Having this money has improved the unity and peace in homes. In the past when she asked and you do not have there may be a problem but now she has her own so there is no reason to bother you to the extent of quarrelling.”
>
> Kanyu FGD - Beneficiary Husbands

> “It improved the relationship between my husband and me because I was no longer a burden to him, through this money, we were able to eat good food, I expanded my business, I bought a goat for rearing and many good things.”
>
> Yankuzo CS5 – Focus woman

> “More women now live peacefully with their husbands, they are more enlightened on nutrition, hygiene and care of their children.”
>
> Matseri KII – TWC member

> “[W]omen who have benefitted from this programme have been able to take up some responsibilities and are also better home makers now. Every man does better when there is peace and contentment in his home.”
>
> Kafin Madiki CS1 - Husband

Relationships among co-wives and sisters-in-law, and between beneficiary women and their mothers-in-law, were again said to be improved by sharing the knowledge and tasty recipes gained from the SBCC activities as well as by building reciprocal support through giving small cash gifts (see section 3.3.1).

> "Even among women in large compounds, their relationship has improved because the beneficiary women among them assist the rest with the food they cook and show them what they learnt from the demonstration lessons."
>
> Kanyu KII - TWC Member

> "Our relationship has also improved. As the [mother-in-law] I also benefit from this cash transfer when [my daughter-in-law] receives this cash…. she buys accessories for the house, she also buys clothes for herself and her children, and food for herself and her family!"
>
> Yankuzo CS6 - Mother-in-law

The sister-in-law of one case-study woman recounted how the five beneficiary women within the household had become closer after they started receiving the cash transfers:

> "They ... began to relate better, started cooking and sharing information, and they also began agreeing with one another more than before. ... [W]hen they receive the transfers they all cook and share with one another and their children also eat from the food. ... [W]henever they receive their transfers, they all sit together and discuss what they would buy with the money, then they give their husbands the money to help them buy it from the market."
>
> Doka Gama CS4 – Sister-in-law

Some respondents observed improved relationships and more interactions not only within households but even between different communities, as explained by this key informant in Yankuzo:

> "There is also more interaction amongst neighbouring communities because the programme has created new bonds. The people have much more to share now, be it regarding health or business issues. The relations between couples have also changed. They make decisions together and have more issues to discuss now. You find that men spend more time at home. Their responsibilities have reduced so now they are achieving more in their businesses. There is also less tension in the homes because all needs are being met."
>
> Kokura KII - CHEW (Male)

Impacts on material wellbeing have been largely covered in sections 3.1. (improved diets), 3.2. (better health), 3.3. (spending of the cash transfer by women, on items to improve their daily lives and homes), and 3.4. (incomes and livelihoods, including savings). In sum, the qualitative endline finds that participation in the CDGP has had positive impacts on all these aspects of material wellbeing for beneficiary women and their households. As described by the beneficiaries themselves, these effects are largely attributable to the cash transfer, but the knowledge gained from the SBCC component also has an impact on material wellbeing in terms of pleasanter home surroundings (because of behaviour changes in response to hygiene lessons), healthier and more enjoyable meals (partly due to the food demonstrations and nutrition lessons), and perhaps most importantly better health outcomes for themselves and their children (which they attribute to behaviour changes including EBF, in combination with the cash transfer).

Both the midline and endline interviews also suggest that the knowledge and "enlightenment" gained from participation in the programme are in themselves a source of self-esteem for

beneficiary women, and can also earn them enhanced respect from others. In addition, the greater economic agency and choice gained from receiving and using the cash transfer (as discussed in section 3.3.2.) is a source of pride and pleasure. It is likely that all these factors contribute to enhanced subjective wellbeing.

Case study example 6 expresses the multi-dimensional nature of wellbeing, and the combination of factors (including the CDGP) that have contributed to this woman and her family feeling better off than they were three years ago.

Case study example 6: "We are more comfortable than many" (Matseri CS7)

Mrs. H.H. - Ex-beneficiary (matured exit)

H is about 40 years old, and is the second of two wives of the household head, who is a trader and farmer. H was pregnant at baseline, and her 'CDGP baby' was her 11th child (a baby boy). Over the course of the CDGP, three women within the household (H, her co-wife and her daughter-in-law) become beneficiaries. H herself started receiving the cash transfer just after she gave birth, and enjoyed the cash transfers for about 24 months before being exited.

H said that while she was enrolled in CDGP she used most of the money she received to buy food, while putting a little aside in savings groups, and using the rest to buy necessities or give small gifts to other household members. Using some of the cash transfer and some money from her husband, H started her own business producing local spaghetti. Previously, she had only done small paid jobs, like grinding corn. She believes that the cash transfer has had positive effects on the whole household:

> 'We now eat balanced meals, I have better kitchen utensils, my room is more comfortable ... and I can also support my son periodically in his trading business.' H Midline.

H says that she practised EBF for the first time with her CDGP baby, as it was not something that she knew about before her involvement with the CDGP. H says she doesn't know if other people in her community will continue to practise EBF when CDGP is over, and that perhaps it would be hard to do without the money needed to buy body building foods, but she says she would continue the practice if she has more children in the future.

> "Knowledge is more powerful, like now I have exited the programme the knowledge acquired would stay with me and if I have another baby I would do EBF."

H knew from the start that the CDGP was not forever. She enjoyed about 24 months of cash transfers before she went to receive her monthly payment, and was informed on the same day that she no longer had money on her account and was exited.

> "I was told that the cash transfer was just for a period but I was not informed when the time for my exiting the programme came close. So I had no knowledge of it until I went to collect my money on pay day only to be told that I have exited the programme."

H was philosophical about the exit process, she admits it would have been nice to have some prior notice about her final payment, but overall she is happy that she was able to enjoy two years of payments.

> "I would have preferred to be told like 1 month before the exit date…but I was grateful, because we were told that you will exit the process on 3 accounts, either because you had miscarriage, or your baby died or finally when your baby reaches 2 years, at least for me it was because my baby had reached 2 years."

Looking back over the past three years, H and her husband agree that they feel they have made progress. The CDGP has allowed them to make some investments over time that have helped the family to grow prosperous.

At midline H's husband had explained that the additional regular income from the programme relieved the pressure on him to provide for the family, and had enabled him to invest more resources into his farming and trading activities.

> "Formerly it was just on me [the responsibility of providing for the household], but now there is alternative source and as such, reduced pressure….. now the pressure is less I invest more into my farm" Midline

In the baseline survey, H's household was in the poorest quartile. Asked how the household's income compares to others now, her husband's response at midline suggested that this may have changed:

> 'My income and assets have increased, there is some envy by members of the community, and we are more comfortable than many.' Midline

The midline quantitative survey confirmed that this was in fact the case, H's household having moved from the poorest quartile to the wealthiest quartile. At endline, despite no longer receiving the CDGP income, the household continues to prosper. H's husband was enjoying the benefits of a particularly good harvest, which he was able to take full advantage of due to the investments he made in his farm, particularly with regards to fertilizer.

> "Yes I have more money this farming season than before you came, I have more income now. I was able to buy and apply more fertilizer in my farm."

H herself also used her *adashe* payout to boost her business, which is turning over a tidy profit.

> "*Adashe* was to prepare for a rainy day, now that I have exited the programme, I used the money to boost my trade and I am reaping better income from it now. This income is helping me sustain myself and my family…. I make and sell ground nut oil and kuli kuli and I make a profit of about N1000 -N2000 on a weekly basis."

While both H and her husband are pleased with how things have gone over the past three years, H is most grateful for her healthy baby boy. She believes that he is noticeably the healthiest baby she has raised, and credits the programme fully for this:

> "I will give a score of 10 if allowed, because none of my children came out as healthy as [this boy], the programme has been very beneficial."

4 CDGP Implementation

4.1 Exit processes

The distribution of cash transfers started during 2014 in all our sampled communities except Kokura, where the date of the first transfer was recorded as July 2015 (see Table 5). At midline, therefore, the programme had been running for at least six months and the focus of the qualitative process questions was on the enrolment, registration and payment systems. At endline, the CDGP had been in implementation for more than two years in Kokura, and three years or more in all the other sites. This provided an opportune moment to understand beneficiaries' experience and perceptions of the exit processes, since many of our respondents were either coming to the end of their cash payments, or had already been exited from the programme.

Table 5 CDGP implementation start dates in the qualitative evaluation sites

State	LGA	Community	Date of first registration	Date of first cash transfer
ZAMFARA	Anka	Matseri	October 2014	October 2014
		Doka Gama	October 2014	November 2014
	Tsafe	Keita	October 2014	November 2014
		Yankuzo	November 2014	November 2014
JIGAWA	Buji	Kafin Madaki	June 2014	July 2014
	Kirikasama	Kokura	July 2015	July 2015
	Gagarawa	Kanyu	August 2014	October 2014

Source: *CDGP Evaluation Qualitative Fieldwork and Training Guide: Midline* (Sharp & Cornelius 2016:2). Information from CDGP Abuja.

4.1.1 Understanding of the exit rules

The CDGP's Implementation Manual (2015) and Standard Operating Procedures (2017) set out two modalities of 'exit' from the programme, which they term 'matured' and 'premature' exit:

- *Matured exit* is the exit of beneficiaries who have reached their maximum time of eligibility. This is premised on the fact that the intervention targets the first 1,000 days of a child's life, and therefore covers the period from conception to when the child reaches the age of 2 years (24 months). Because the actual date of registration varies based on when the pregnancy was verified by the CDGP, there is a high level of variance in the total number of months (and therefore cash payments) that will have been received by each beneficiary. Once a beneficiary has reached matured exit, they cannot then be re-enrolled into the CDGP.

- *Premature exit* refers to exit from CDGP ahead of the intended Matured exit dates, and can be due to: miscarriage, stillbirth, death of a beneficiary child, death of a pregnant beneficiary, voluntary exit, or fraud. Beneficiaries can be re-enrolled in the CDGP in the event of miscarriage, stillbirth, or in the event of death of the beneficiary child if still under one year old. In all other cases re-enrolment is not possible.

Most of our endline respondents were aware of the exit rules in theory, although as shown in section 4.1.4. many felt they were not adequately informed about when their own exit date would be. For “matured exit” beneficiaries, most respondents knew that the cash transfers were due to end “in line with the weaning period”, or “when the child reaches 2 years”.

> “We were told that once a child is weaned at two years, then in few months you will be exited. And if you give birth again, you will not be enrolled again. You will collect only once, for one birth. Had it been I got pregnant again after I weaned my child I would have not been enrolled, that was what we were told. When your child dies or you have miscarriage you will be exited, and it has happened to people.”
>
> Kafin Madiki CS5 – Focus Woman

> "The reason I was exited was because it was exactly my time. My child reached two years.
>
> ...My child reached two years old so I was told and then exited. There was no problem because I knew about the process. They usually inform us on it.
>
> ...There is no problem. We know about the process. They inform us before the exit.”
>
> Kokura FGD - Beneficiary Women

> “We were told before that when our children are up to twenty-four months we will be exited. So when I went to collect the money I was told that my child has reached twenty-four months and I was then exited. I was not paid any money and I returned home.”
>
> Kanyu CS5 - Focus Woman

The conditions for premature exit were also widely understood and accepted as fair, as long as the rules were applied to everyone:

> “[T]he reason I was exited was because I had a miscarriage. We were informed from the beginning on the process for exiting a person. So when I had miscarriage I told them so I was paid the cash transfer for two more months and then exited. ... To me it is very well. It is okay, they followed the rule.”
>
> Kokura FGD - Beneficiary Women

> “After the death of my child I went to collect the money and I was asked about my baby which I told them that the baby died. So I was told that from next month I will no longer be collecting the money, I will be exited. I said, alhamdudillahi (I am grateful).
>
> They use to also sensitize us that once your baby dies, reach the age of 2 years, or you have miscarriage, you will be exited. They also have record and details of your baby; when you deliver the baby is all recorded…. Whether you like it or not, they have to adhere to the process when your time has reached for the exit, and there is no how you will be happy to be exited. The process for my exit is okay because if I say I should not be exited then I am not being fair to the set out process.”
>
> Kanyu CS4 - Focus Woman

4.1.2 Duration of assistance

As the total duration of enrolment varied between women based on the timing of the registration of their pregnancy[19], there were a number of cases of complaint or confusion around why some

[19] The intervention theoretically targets the first 1,000 days from conception until 24 months. However, actual registration was based on confirmation of pregnancy, which varied quite widely in timing. Some beneficiaries

women appeared to be receiving the grant for longer or shorter time periods than others. In some cases this is likely to be the result of the differences in registration dates, although many respondents also said that the child's age at exit was not consistent. Following are some examples of how people expressed this issue of some women benefitting for longer than others, which many considered unfair.

> "She said that some of the women that are exited have children of less than 2 years, some of them are actually 19 months old, she explained that they exit because other women need to be registered and start receiving the cash transfers."
>
> Doka Gama KII - BRG Member / TBA (Female)

> "... the other women whom I started with were still receiving cash transfer for about ten months after mine stopped. I was not happy with the exit process, when I was exited from the programme, other women I started receiving this cash transfer with were still collecting. I was not happy that I and my co wife took the case to the village head so that it will be sorted out, but we were told that I was removed from the top, although some of the women who were removed from the programme like myself were registered back except a few of us."
>
> Yankuzo CS3 – Focus Woman

> "The respondent explained that when she was exited, the other people who were registered at the same time with her continued to receive cash transfers for about 4 months after she had been exited. She explained that then she was not happy because their children are about the same age, but now she is okay because not so many months after she had been exited, the other women were exited one after the other, only that they got more money than she did."
>
> Yankuzo CS6 – Focus Woman

> "I was exited when my daughter clocked 2 years. ... Some women that were with me, had babies that had not even completed 2 years, but they were told the same thing – that their time too was up."
>
> Kafin Madiki CS7 – Focus Woman

In Kafin Madiki and Kanyu, a number of women flagged that the total period of enrolment has been significantly shorter than they expected:

> "We know the reasons to remove people from receiving the cash such as; - miscarriage, death of the child or when the child reaches the age of 2. But ... there are some women in this community that were removed without meeting all these exit conditions – they were told their money was finished, so they are removed. Usually when a woman goes to sign for her money, she is told that her money has finished and she is therefore off the programme.
>
> ... I do not understand when they say your money is finished and your child is not dead and not yet two years.

therefore started receiving the cash transfer early in their pregnancy and others much later or after the child's birth (see the Qualitative Midline report for further discussion of this). This variance can represent a number of months' worth of cash transfers and significantly affects the total value of assistance received.

... I will give it 1/5.[20] I believe there is a problem somewhere and I don't know who is misunderstanding who. So we need to understand how long a woman is supposed to be a beneficiary for."

Kafin Madiki FGD - Beneficiary Women

"The problem concerns the CVs carrying out the work. These CVs come to say to us that our women are exited. Some of our women benefitted for 15 months, 16 months, and some for only 10 months and they would say she was exited."

Kanyu FGD - Beneficiary Husbands

4.1.3 Re-registration after premature exit

As noted above, *premature exit* refers to exit from CDGP before the child's second birthday, and can be due to: miscarriage, stillbirth, death of a beneficiary child, death of a pregnant beneficiary, voluntary exit, or fraud. Beneficiaries may be re-enrolled in the CDGP in the event of miscarriage, stillbirth, or in the event of death of the beneficiary child if still under the age of 1 year old, where this event is reported within one month of the event. In all other cases re-enrolment is not allowed.

The endline interviews suggest that the application of the re-registration rules has been inconsistent, varying from case to case and perhaps from place to place. It was not possible for the field teams to investigate the details of each case or to check with CDGP about why decisions had been made about particular individuals. Clearly the process of exit and re-registration is complex, and the CDGP operating procedures were still being developed and improved while the programme was implemented. The problem may be partly one of communication and misunderstandings. Whatever the facts and reasons of each case, we find that there is some confusion, and for some people a perception of unfairness, in the application of the re-registration rules.

"When my baby passed away, I informed them about it – because they told us beforehand, that it is one of the reasons to take people off the list. So they duly took me off it…. The problem is getting back on the list. Some of us, after the death of our babies, we reported to them – like they asked us to, and they told us we will get back on the list whenever we got pregnant again. But it never happened. When we got pregnant again, we went back to them – but they refused to put us back on the list, till this moment – I've given birth again, and my baby is now 8 months old, yet they are yet to put me back on the list…they broke their promise to us, to put us back on the list if we got pregnant again."

Kafin Madiki CS6 - Focus Woman

"I have a wife [benefitting from this cash support] who gave birth but the baby later died [and she was exited] and she became pregnant again. She carried that pregnancy, gave birth and her baby is now 6 months but she has not been re-enrolled. They finally said five days ago that a message was sent from Abuja that she should not be re-enrolled. I asked for the reason and they said she had benefitted for up to 10 months so she is no longer eligible."

Kanyu FGD - Beneficiary Husbands

[20] All references to scores are in response to a "scorecard" question which asks people to rate the process from 1 (very unsatisfied) to 5 (completely satisfied). See Section 2.3.4 for further explanation of this tool.

> "We were informed that if a woman loses her pregnancy, she should be identified and exited from the programme and where she gets pregnant again, she should be enrolled back. We were also told that if a woman has a still birth or abortion, we should get three witnesses to this; the religious leader, district head and a CV. We are implementing this, but the challenge is when these women are pregnant again, they are not enrolled back into the programme. I have a case like that currently; my sister in law had a still birth, after collecting money for 3 months as we were told, I asked her not to return. Now she is pregnant and almost due for delivery, but she has not been enrolled back into the programme."
>
> Doka Gama KII - Nutrition CV (Female)

By contrast, some of our research participants had been exited and re-registered according to the rules as they understood them, and were happy with the fairness of the process, as in the example of this case study participant in Kokura:

> "I was once exited when I had my previous baby, and the baby died after delivery. I started collecting when I was three months pregnant and when I delivered the baby, the baby died. So I was paid for two more months and then exited....
>
> ...As God will have it, I got pregnant again for this my son and I was returned back to benefit. For me there is no problem with it because we are informed right from the beginning so when it happened it was not new to us. And as God will have it, I returned back to benefitting from the initiative again because I got pregnant after the exit. The exit is very well."
>
> Kokura CS2 - Focus Woman

4.1.4 Notification of exit

By far the most frequent complaint about the exit process was a lack of prior notice regarding the exact date when cash transfers would stop, many of our case study women reporting that they were only informed at the payment point on the day they had expected to collect, that they had a 'zero account'.

> *"Did you have prior notice that you were going to be exited from the programme?*
>
> No we didn't, we just went to receive our money and were told we had zero account."
>
> Matseri CS2 - Focus Woman

> "Well I was told that the cash transfer was just for a period but I was not informed when the time for my exiting the programme came close. So I had no knowledge of it until I went to collect my money on pay day only to be told that I have exited the programme… I would have preferred to be told like 1 month before the exit date."
>
> Matseri CS7 - Focus Woman

> *"Did you know you were going to be exited from the programme?*
> No I didn't, when we went to collect money, we placed our thumbs on the machine and then they told us we did not have any money in our account….after I had placed my finger on the machine, my name and face had come out when they now said I had been "weaned" from the programme. The man then asked me to return next month to confirm if I had actually been weaned from the programme. I did and when I placed my thumb on the machine, I was told that I had been weaned off the programme and that was how I stopped."
>
> Matseri CS5 - Focus Woman

"I feel that [you are] supposed to be given at least 2 months notice before [you are] exited from the programme so that you can plan towards this, not that you come prepared to receive money and you are disappointed.

What score will you give the exit process?

1, Very badly."

Yankuzo CS5 - Focus Woman

"I had gone to collect money and was told that my time had ended. I was aware that I will be exited at some point but I did not know when. It was so sudden. I heard that in some places you get paid the month you are notified....
...Well, I am grateful for the cash I received throughout the duration, it helped a lot, but I wasn't quite happy about the exit process – no one was. They should do better in terms of informing women about the duration, so they won't wake up one morning, expecting to receive the cash, only to get turned down. It's demoralizing."

Kafin Madiki CS7 - Focus Woman

"I did not know until ... I went to collect [my] money. I gave them my card, thumb printed and was shocked to be told there was no money, that I have exited from the programme. I wish they did not say that to me in front of so many people!"

Kokura CS1 - Focus Woman

In addition to the embarrassment and wasted time, some women who had this experience complained of having spent money on transport or in some cases having incurred debts in anticipation of receiving the cash, only to return with nothing.

"In my opinion I think that if a woman is close to being exited from the programme, she should be told a few months [before] that time so that she wouldn't leave home and other duties, waste money on transportation only to be disappointed. I think if they do it this way it will save us a lot of stress of travelling all the way and queueing up for the whole day and then be told that you have nothing."

Keta CS5 - Focus Woman

"No I was not told. When I heard the announcement that payment day had come, I went over also as usual. After going through the process of finger print identification, I was then informed that I had zero account.

So how did you feel?

I was very unhappy, most especially because I was expecting a payment and I had even made my budget of the items to buy, I was indeed very unhappy."

Yankuzo CS4 - Focus Woman

"In fact, we went to where they collect *'talafi'* (money). ... I even lost my slippers, they asked for my name and I told them.... They checked and said I have been exited. ... I [borrowed] the sum of N400 to go to Gagarawa (collection centre) but they saw nothing was in my account."

Kanyu CS2 - Focus Woman

"CVs should get a list so as to inform those graduating (exiting) on time. One incident happened; the woman queued up and on reaching her turn she was told she had been graduated - there she fainted. She had already piled up debts waiting to make refunds."

Keta CS3 - Husband

By contrast, some other respondents gave the exit process a high score said it was well handled: the key difference was that these beneficiaries felt they had been given adequate notice and could plan for the end of the cash transfers.

> "Well I was already aware that I will exit when my baby reaches 24 months so I was keeping that in mind and when the time came close I was informed by the CV.
>
> *So how did you take it?*
>
> I had already prepared myself, because I had saved some money and started a little business of selling Samira (fancy plastic dishes), babies clothes and some other small things, so I make some profit which I use to keep supporting my healthy diet."
>
> Matseri CS4 - Focus Woman

> "I was told a month before. When I went to collect the money they told me that after the next month I will no longer benefit from the programme because my child was already two. I believe we should have been told at the beginning of the programme. However I am also happy I got a month's warning, at least that prepared my mind."
>
> Kokura CS3 - Focus Woman

According to some beneficiaries and key informants, women who have exited more recently are more likely to have been given notice, as the CDGP implementers have taken note of the problem and are improving the procedures. For example, key informants in Doka Gama and Keta explained how they are now handling this issue:

> "One of the major complaints we receive is the women's dissatisfaction with the way they exit them from the programme. The issue featured prominently during our last meeting at Anka and it was agreed we should go back and sensitize the beneficiaries that they will be informed months before they are due to exit the programme. We receive information and disseminate information in the community."
>
> Doka Gama KII - BRG member (Male)

> "We inform them when they have about two months left. I call out their names from the list at the venue of the periodic meetings held and inform them of the remaining months they have under the support programme."
>
> Keta KII - CV (Male)

In Yankuzo, a former beneficiary who had exited from the programme about 18 months before the endline interviews had heard that the procedure had now changed to give women more notice:

> "I was told that women are supposed to be given prior notice before the month they will be exited from the programme - a month or two months before…. During our time you know you have been exited from the programme once you don't hear your name called out from the list."
>
> Yankuzo CS5 - Focus Woman

Various key informants raised the following factors which could account in many cases for the misunderstandings and complaints about the timing and process of exits. These include:

- Beneficiaries are sometimes reluctant to believe the CVs when they are notified that they are due to exit, and may go to the payment point anyway.
- They may not attend the meeting where notice of exit was given.

- There may be confusion about the birth dates of CDGP babies (and therefore their second birthday). [21]
- In cases where a woman has been re-registered for a second pregnancy (having lost one child), she may reach the maximum number of months allowed before the second child is two years old. In this case the system will exit her, but she may not understand why.

Some women admitted that they had been notified they were due to exit, but went to the payment point anyway, for example:

> "I was told by my CV that I had three months more to enjoy but I forgot the timing and went to collect thus I was not paid."
>
> Doka Gama FGD - Beneficiary Women

As the frontline representatives of the programme, CVs are sometimes the bearers of bad news and say that they are often blamed by beneficiaries for decisions that are out of their hands.

> "Beneficiaries are not happy with me when they have to exit. Some get pregnant hoping to be enrolled and they blame me when they are not. Even those whose babies reach 24 months are blaming me."
>
> Kanyu KII - Female CV

> "... there is also the problem of insults and backlash we faced from the outset. As a result of lack of understanding, most of the women felt we are responsible for their exit or non-payment from the programme. Thank God, they now understand that it is the computer that is responsible for that."
>
> Matseri KII - Nutrition CV (Male)

Case study example 7 tells the story of a former CV, who is happy about every aspect of the programme except the exit process.

Case study example 7: "If CDGP ends, we too end" (Kafin Madaki CS2)

Mrs. U.I. – Ex-beneficiary (matured exit)

U. was about 20 years old at baseline, and had one child prior to the beginning of the CDGP. She was and still is her husband's only wife. Her extended household now consists of her husband and their three children, her parents-in-law, her husband's three brothers and their respective wives and children.

U's husband I. is a farmer, and their household is relatively well off (PPI 3rd Quartile at baseline). However this year has not been the easiest harvest period, the success of the farm is subject to the whims of the weather. I. and his brothers plant a variety of crops, and are familiar with changeable yields year on year.

> "There are different crops being produced here. I got more beans in the last harvest than in the previous harvest but I got more grains in the previous harvest than in the last harvest. It is the same with groundnuts, the quantity we got in the last harvest we did not get in the previous harvest. That is the truth."

U lamented that at endline 'the weather conditions contributed to this less income and scarcity', and consequently many men in the community have had to leave to seek work in the cities. The women who remain in Kafin Madiki have little in the way of income generating options, and have to rely on the food stocks from the barns, and what they can afford from the markets.

[21] There may be lessons to learn here about the birth monitoring tool, which was developed late during CDGP implementation.

> "There is no work. We women work on 'zobo' and we help in removing husks from ... food stuffs (rice, maize, *gero*, etc), that's what we do now. If our husbands travel out during 'raining' season, you look after the children (the kids and yourself) – [there's] nothing unless they look for money… and there's no available job to be done."

U was pregnant at the time of the baseline interviews and despite some complications at birth, by midline was accompanied by a happy, strong and healthy baby boy (of 12 months at midline) and was once again expecting. U was a beneficiary of the CDGP for about 31 months during which time she spent the majority of the money on 'body building' foods (as instructed), and she enjoyed sharing the nutritious meals she cooked with the other members of her household, including her mother-in-law, who said:

> "This girl, when she collects her money, she cooks nice meals with her fish, and chicken. When those people with vegetables come, is it salad you call it, she'll cook her rice and her stew and garnish it with this salad."

The cash transfer, combined with the household's harvest allowed U to purchase livestock, which she recognised could help in the future:

> "We have invested in buying livestock [so] when CDGP programme ends you will be able to survive."

U is completely convinced about the benefits of EBF. She has continued the practice with her youngest (non-CDGP) baby, and expects to do so with any more children she might have in the future.

> "My *waya* baby is looking healthier and stronger….I will continue with this EBF forever until I stop having all my babies."

Whilst participating in the programme U was also trained as a CV. In this role she held monthly meetings for the beneficiary women on nutrition, care and hygiene, and visited beneficiary households in the area. She very much enjoyed being a CV, and it was a source of pride in her household. In the midline interview, she said:

> "I am trying my best as a CV. I am good at informing women (awareness) on what to eat and how they should breast feed their babies. ... I am good in demonstrating on the way to eat good food with their children after collecting their money." U Midline

After 31 months of enjoying the CDGP transfer, U was exited from the programme when the CDGP staff realised that her child had reached 2 years of age. U (alongside many women in Kafin Madiki) was very dissatisfied with the exit process. She feels aggrieved by the manner in which she was exited, and reported that many women in Kafin Madiki felt they had been removed from the programme with no warning.

> "They just stopped. They saw my child reached the age of 2 years. I really am not happy, the way women were forcefully exited. This money we are being given it is really helpful in feeding with our children and now it's been removed from under our feet all of a sudden!"

Coinciding with U's exit from the programme, and to her great disappointment, she was additionally told that she was no longer required as a CV. U cannot understand this decision, and is greatly upset, she believes she was a good CV, and suspects a mistake has been made.

> "Honestly we are not happy on this at all, am not happy. I put all my energy and strength at my job and I was brutally removed. I was really happy then but all of a sudden am not happy."

U and her husband believe that their lives were improved by the cash transfer, however now it has ended, they are not sure they are any better off than before. As she put it at endline,

> "[O]ur income has increased [since] 3 years ago ... but now ....it has gone down... because before we were collecting cash transfer *(talafi)* and getting money but now nothing!...
>
> [M]y income will decrease when and if the CDGP programme finally ends. If CDGP ends, we too end.'"

Despite her disappointment at having been removed from both the programme and her responsibilities as a CV, U is grateful for the enlightenment she received about body building foods, hygiene and exclusive breastfeeding. Overall she rates the programme 4 out of 5, but is keen to point out that the exit process receives a 0.

5 Conclusions

The qualitative research finds that the CDGP has had positive impacts in all six of the thematic areas investigated. The size and frequency of these impacts will be assessed by the quantitative component of the evaluation: the qualitative work focuses on understanding how and why the transmission mechanisms of the programme work, and how beneficiaries themselves perceive the programme and its impacts. From this perspective, the endline provides further insights into how people experience the effects of the CDGP on various aspects of their lives.

Regarding consumption patterns and diets, **the cash transfer has enabled beneficiaries to purchase the ingredients for a more nutritionally varied diet** than the qualitative work found at baseline, for themselves and their children. Better maternal nutrition has contributed to easier pregnancies and births, according to beneficiaries, and also enables mothers to breastfeed successfully. The nutritional information about the types of locally-available foods to include in a balanced diet, and the cooking tips and recipes provided through the SBCC demonstrations, have contributed to the cash being spent on the recommended nutritious foods. These recommended foodstuffs, including the recipes for improved complementary foods for infants, are widely known. As the endline fieldwork took place during the harvest season, staple foods were relatively abundant and women were more likely to spend the cash transfer on nutritious additions to their meals and sauce ingredients. Respondents noted that the transfer had been particularly important during the rainy season when it is more difficult and expensive to maintain a varied diet. At that time of year the transfer was also more likely to be spent partly on basic foodstuffs for the household.

On knowledge, attitudes and practices (KAP), the endline focussed particularly on investigating the factors and pathways influencing the significant rise in the rate of exclusive breastfeeding (EBF) which was found by the midline reports. We find that **the strongest and most persuasive factor is the demonstration effect for parents of seeing the results of EBF on the health and development of their own or their neighbours' babies**. Once some people in the community (including CDGP beneficiaries, CVs and local leaders) were practising EBF with good results there was a "snowballing" effect as other people, including non-beneficiaries, followed suit. Respondents explained that it was much more difficult to be among the first to try something new and against tradition, and in this regard **CDGP does seem to have had an impact in persuading and enabling mothers to try EBF for the first time**. In many cases people had heard about EBF from the health services or radio programmes, but were only convinced to try it by the face-to-face explanations and the frequent encouragement, mentoring and practical advice from the CVs. While the qualitative research does not attempt to generalise about the effectiveness of the CDGP's volunteer-based model (and it is clear that there remain problems around incentives), our case studies provide strong examples of success where the CVs' ongoing support within the community has acted as a "tipping point" in parents' decision to try EBF. This finding supports the midline conclusion that using multiple channels for SBCC messages is an effective strategy. Not only do different people access different channels, but there seems to be a cumulative persuasive effect when the same information has been heard from several trusted sources.

The involvement of husbands in the SBCC messaging and mentoring was found to be very important, not only in the general sense of allowing wives to participate in the programme without (in most cases) generating conflict, but also specifically in influencing the uptake of EBF. We find that the support of husbands who have been persuaded of the benefits of EBF makes it easier for wives to persist with the practice and protects them from criticism or opposition by other people in the community or household (including their mothers-in-law).

We find that **the main effect of the cash transfer on successful uptake of EBF is through enabling nursing mothers to consume a nutritionally adequate diet**, which in turn enables them to produce enough rich breastmilk to satisfy the baby. This finding raises uncertainty about the degree of sustainability of this impact after the end of the programme, as some mothers may not be able to afford the improved diet in future. However, since we also found widespread uptake of EBF by non-beneficiaries and continued practice by ex-beneficiaries, we conclude that many people are continuing to practice EBF in the absence of the cash transfer.

We also find that **the programme has influenced the increased attendance at ANC by helping women meet the costs of attendance as well as by persuading them of its importance** (through the SBCC campaign and especially through the encouragement of the CVs). **The SBCC campaign has also influenced people to improve their hygiene and sanitation practices** around the home, and this impact seems likely to be sustainable as its effects are popular and the behaviour change is virtually cost-free.

On the theme of decision-making and resource control within beneficiary households, this report further confirms the midline findings that **women beneficiaries have largely retained control of the cash transfer and have spent it primarily on the items promoted by CDGP** (improved diets for themselves and their children, including nutritionally-diverse complementary foods for infants). Other uses of the cash include health costs for children, clothing, soap and school expenses. The impacts of this increased decision-making power on women's economic agency and wellbeing are addressed below in response to Evaluation Hypotheses IV and V.

We also find that **many women who receive the cash transfer are able to save enough to invest in income-earning activities and assets**. The range of livelihood opportunities for women remains very limited, but we find that beneficiaries have variously used their savings from the transfer to start, expand, or diversify their activities in home-based petty trading and food processing businesses. Investment in small livestock is also a popular use of savings, because they are an inflation-proof store of value for the future as well as a source of nutritious and saleable food products, and offspring for sale or accumulation.

Livestock are also seen by beneficiaries and their husbands as a "rainy day" investment which can be liquidated in times of stress or unexpected expenditure, thus increasing the household's coping capacity and resilience in the face of shocks. Coping options for the types of risk faced in these communities (seasonal, natural and man-made) remain quite limited, but we find that **the CDGP cash transfer has helped beneficiaries cope with seasonal stresses and income gaps, and with various household-level shocks such as illness and loss of family members**.

Among our case study communities and households, **the most destructive shocks experienced during the evaluation period (particularly in Zamfara) have been man-made** shocks in the form of armed robbery involving livestock theft, destruction of crops, and sometimes murder. The qualitative work cannot quantify the frequency of such experiences, but when they happen they are very damaging. In communities vulnerable to recurrent attacks, people are no longer investing in livestock or other assets because they may be targeted. The impact of CDGP in enabling people to cope with and recover from this kind of shock is clearly limited. However, we do find case study examples where **the regular monthly cash transfer has helped people get through the period after a major shock**, for example by supporting the basic consumption needs of the wife and children while the husband travels elsewhere to seek income.

With reference to the key hypotheses addressed primarily by the qualitative impact evaluation (see Box 1 in the Introduction), the report finds the following.

Evaluation Hypothesis IV: *The cash transfer will result in improved material wellbeing and will contribute to the relational wellbeing of households through enhanced trust and reciprocal social and economic collaborations.*

Participation in the CDGP enhances beneficiaries' wellbeing, both material and relational, in a number of ways. Drawing on earlier rounds of qualitative research which explored the meaning of wellbeing for people in these communities, the endline finds that people's material wellbeing has been positively affected by the improvements in child health, more nutritious diets (including the pleasure of eating tasty and varied foods), cleaner home environments, and the ability to purchase items such as clothing. Relationships between beneficiaries and their husbands were generally said to be improved by the cash transfer (as found in the midline), because the wife's ability to pay for food, medical treatment and other day-to-day expenses herself relieved the stress on the man to provide for the family, reduced the frequency of demands made by the wife, and thus reduced the grounds for tension or arguments between them. Relationships among women within the household (an important aspect of wellbeing for married women living in their husband's family and with limited freedom of movement outside the home) were also generally said to be improved by the cash transfer and the interactions promoted by the SBCC activities. Most beneficiaries interviewed gave small cash gifts from their transfer to other household members (their mother-in-law, co-wives or sisters-in-law), as well as larger gifts to their husbands. These gifts were described in ways that suggest they build reciprocal support bonds and help to smooth any resentment from housemates who had not received the cash transfer. "Gifts" to husbands were more often considered as contributions to household expenditure or investments in the husband's activities as main breadwinner (usually farming, or sometimes trading and other businesses). Being able to make such gifts and contributions was described as raising the giver's status in the household and was clearly a source of self-esteem, which contributes to the individual's sense of wellbeing.

While most of these effects can be attributed (at least partly) to the cash transfer, the endline interviews found that the SBCC component of the programme also impacted on both material and relational wellbeing. Some of the material improvements in health, environment and diets mentioned above are directly attributable to changes in people's knowledge and practices, either in combination with the cash transfer or (for non-beneficiaries) independently of it. Examples are the improved hygiene practices and exclusive breastfeeding (which many respondents believed to be a key factor in the better health of their children), both of which were reported to have been widely adopted by people who are not receiving the cash transfer as well as by direct CDGP beneficiaries.

For women and men who had learned about health and nutrition from the SBCC activities, the knowledge gained was in itself a source of pride and pleasure, which was frequently described as something that would stay with them in future and be passed on to their children. Relational wellbeing was said to be improved by the increased social interaction for women attending SBCC meetings, and by the sharing of information and meals (as well as cash) among women, both within the household and in the wider community.

Evaluation Hypothesis V: *The provision of a regular cash transfer to women will enhance their ability to make economic choices and will result in improved social capital.*

During the period of two years or more (for “matured exit” beneficiaries) when women are receiving the cash transfer, the qualitative evidence strongly supports the hypothesis that it enables them to make more decisions for themselves and their children (including the types of expenditure discussed above in relation to hypothesis IV), and that this enhanced agency improves their social standing and the networks they can call on for reciprocal support when needed (social capital). A further finding that emerges strongly from the endline discussions is that when women have this degree of economic choice they are very likely to use it, if they can, to invest in business capital or assets for the future. The regularity and reliability of the transfer enables beneficiaries to obtain credit when needed, and to participate in rotating savings associations *(adashe)*, thus accumulating relatively large sums for investment. Although the sustainability of such gains cannot be predicted, and will certainly vary widely among the women involved, there are some grounds to suggest that this impact on enhancing economic choices for women may last beyond the end of the cash transfer itself.

While the qualitative work finds that the CDGP has had positive impacts, the programme is not the only cause of change. The case studies in particular highlight the many contextual and other factors which determine outcomes for people’s health, prosperity and wellbeing. These include other programmes and campaigns such as the government health service messages about breastfeeding and IYCF, and infrastructure projects such as the UNICEF water programme which has dramatically changed the ability of people in one of our study sites (Yankuzo) to follow hygiene advice, by providing piped water. A bumper harvest season for most of our study sites this year (2017/18 farming season) has contributed to a general feeling of prosperity and wellbeing. At household level, many other factors were found to affect outcomes in all the impact areas, including inheritance, illness, success in business, and theft. The quantitative analysis at endline will be better able to gauge the relative significance of CDGP’s impacts by comparing treatment and control communities.

Finally, regarding the implementation of the programme, the qualitative endline focussed on understanding beneficiaries’ experience of the exit processes. On this subject we found a wide range of good and bad experiences. **While most respondents understood the exit rules in theory, there were many complaints** about unfairness (because some women were exited before others, or received fewer months’ support in total); failure to re-register women who had followed the rules on reporting an earlier miscarriage or death but had not been re-registered for a subsequent pregnancy; and lack of notice before the cash transfer payments stopped. We find that **the application of the rules appears quite variable** from place to place and over time. However, there is some evidence that the procedures including notice periods have improved for more recent exits, which triangulates with key informants’ information that CDGP has been working on developing these procedures during implementation. Some features of the programme make the management of exits quite complex, particularly the variation in total duration of benefits due to the registration date depending on confirmation of pregnancy, and the difficulty of accurately monitoring birth dates in order to pinpoint the child’s second birthday. In terms of lessons to be learned for future programmes, we recommend a thorough review and documentation of these aspects of CDGP design and implementation. These findings have been provided to the process evaluation team and have contributed to the broader Process Evaluation Report (ePact, forthcoming).

References

Agho, K.E., P.Ogeleka, F. A. Ogbo, O. K. Ezeh, J. Eastwood and A. Page (2016) *Trends and Predictors of Prelacteal Feeding Practices in Nigeria (2003–2013)*, **Nutrients** 2016, 8 (8), 462. https://doi.org/10.3390/nu8080462

CDGP (2015) *Implementation Manual (Revised)*, September.

CDGP (2017) *Standard Operating Procedures*

Dewey, K.G. and Brown, K.H. (2003) *Update on technical issues concerning complementary feeding of young children in developing countries and implications for intervention programs*. **Food and Nutrition Bulletin**. 2003;24:5–28

Ekubay M, Berhe A, and Yisma E. (2018) *Initiation of breastfeeding within one hour of birth among mothers with infants younger than or equal to 6 months of age attending public health institutions in Addis Ababa, Ethiopia*. **International Breastfeeding Journal**. 2018;13:4. doi:10.1186/s13006-018-0146-0.

ePact (2014a) *CDGP Evaluation Final Inception Report.*

ePact (2014b) *CDGP Evaluation Situation Analysis Report.*

ePact (2015a) *CDGP Evaluation Qualitative Baseline Report.*

ePact (2015b) *CDGP Evaluation Quantitative Baseline Report Part 1: Baseline findings.*

ePact (2016) *CDGP Evaluation Final Process Evaluation Report: Round 1.*

ePact (2017a) *CDGP Evaluation Qualitative Midline Report.*

ePact (2017b) *CDGP Evaluation Quantitative Midline Report.*

ePact (forthcoming) *CDGP Evaluation Process Evaluation Report: Study 2.*

National Population Commission (2014) *Nigeria Demographic and Health Survey 2013*, NPC Abuja and IFC International, Rockville, Maryland, USA

Save the Children (2015) *Cost of the Diet Analysis Report for Three Livelihood Zones in the Child Development Grant Programme (CDGP) areas in Northern Nigeria.*

Sharp, K and A. Cornelius (2016) *CDGP Evaluation Qualitative Fieldwork and Training Guide: Midline*, ePact

Sharp, K and A. Cornelius (2017) *CDGP Evaluation Qualitative Fieldwork and Training Guide: Endline*, ePact

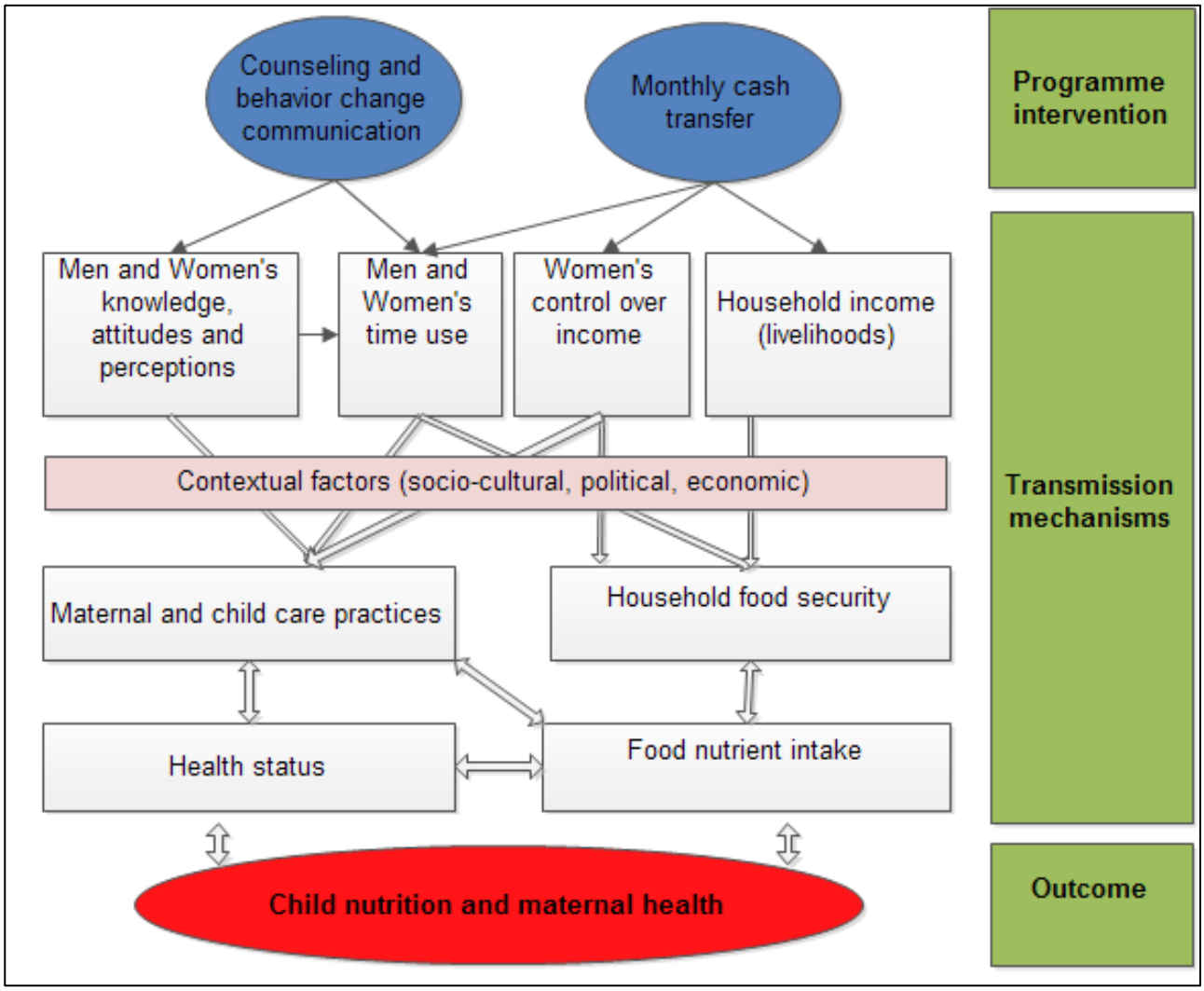
World Bank (2004) *Citizen Report Card Surveys: a Note on the Concept and Methodology*. Social Development Notes No.91

Annex A: CDGP theory of change

The theory of change diagram, shown below, summarises *how* the CDG programme interventions are expected to achieve the outcomes of improved child nutrition and maternal health. Between the interventions (in blue) and the outcome (in red), there are a number of expected intermediate effects and connections ('transmission mechanisms'):

- The *monthly cash transfer* is expected to increase beneficiary households' income and women's control over the use of income (for example, for food purchases). Indirectly, it is also expected to have an impact on men's and women's time use, and on their responses to seasonal risks and stresses. These effects in turn are expected to result in increased food security, and an increase in the quantity and quality of food consumed.
- The *counselling and SBCC* are expected to influence women's and men's knowledge, attitudes, perceptions and time use, resulting in improved maternal and childcare practices and ultimately improved health and nutrition of women and children.

Figure 2 CDGP Evaluation theory of change



Source: *CDGP Evaluation Inception Report, ePact 2014:8*

A core purpose of the qualitative research is to explore how these transmission mechanisms actually work. All of the intended causal chains may be helped or hindered, or mediated in various ways, by the socio-cultural, political and economic context in which the programme is implemented. Also, the assumptions about how one element affects another may prove to be wrong or incomplete, and other factors outside the programme's control might affect its success in changing behaviour and improving food security.

The definition of household food security assumed here – 'physical and economic access … at all times to sufficient safe and nutritious food for an active and healthy life' – relates to both the quantity and quality of the diet people are able to consume. Maternal and childcare practices affect what people choose to consume or provide for their families, and how they prepare it, from the range of foods that they can access.

Annex B: Case study characteristics

Table 6 Case study characteristics (reference list)

	Case study woman							*Household characteristics at baseline*		
Case study no.	CDGP beneficiary status (at endline, Nov/Dec 2017)	Woman's age at baseline (Sep 2014)	Monogamous / polygamous	Number of living children at baseline	Age at first marriage	Literate?	Ever attended School?	Household size	Wealth group (PPI quartile)	Ethnicity / main language
Matseri 1	Ex-ben (M)	33	M	9	15	No	No	11	2nd	Hausa
Matseri 2	Ex-ben (M)	15	M	0	14	No	No	14	2nd	Hausa
Matseri 3	Ex-ben (M)	18	M	2	11	No	No	4	4th	Hausa
Matseri 4	Ex-ben (M)	15	M	0	14	Yes	Yes	9	3rd	Hausa
Matseri 5	Ex-ben (M)	30	M	6	12	No	No	8	1st	Hausa
Matseri 6	Non-ben	45	M	0	15	No	No	4	1st	Hausa
Matseri 7	Ex-ben (M)	40	P (2/2)	5	12	No	No	12	1st	Hausa
Matseri 8	Ex-ben (M)	17	M	0	16	No	No	3	4th	Hausa
Matseri 9	Ex-ben (M)	27	P (1/2)	3	14	No	n/a	6	3rd	Hausa
Doka Gama 1	Ben	21	M	2	15	No	No	4	2nd	Hausa
Doka Gama 2	Non-ben	35	M	7	15	Yes	Yes	9	2nd	Hausa
Doka Gama 3	Ben	26	M	4	13	No	No	6	1st	Hausa
Doka Gama 4	Ex-ben (M)	20	P (2/2)	2	13	No	No	7	3rd	Hausa
Doka Gama 5	*Migrated*	*13*	*P (2/2)*	*0*	*12*	*No*	*No*	*8*	*1st*	*Hausa*
Doka Gama 6	Ex-ben (P)	25	P (1/2)	4	12	No	No	8	2nd	Hausa
Doka Gama 7	Ex-ben (P)	15	M	0	13	No	No	2	2nd	Hausa
Doka Gama 8	*Migrated*	*20*	*P (2/2)*	*0*	*13*	*No*	*No*	*6*	*1st*	*Hausa*
Doka Gama 9	Ex-ben (M)?	16	M	0	12	No	No	2	3rd	Hausa
Keta 1	Ben	49	M	8	14	No	No	7	1st	Hausa
Keta 2	Ex-ben (P)	35	M	7	15	No	No	8	1st	Hausa
Keta 3	Ex-ben (M)	18	M	1	15	Yes	Yes	4	4th	Hausa
Keta 4	Ex-ben (M)	30	P (1/2)	1	15	No	No	9	1st	Hausa
Keta 5	Ex-ben (M)	30	P (1/2)	7	15	Yes	Yes	11	4th	Hausa
Keta 6	*Migrated*	*14*	*M*	*0*	*14*	*Yes*	*n/a*	*15*	*2nd*	*Gobirawa*
Keta 7	Ex-ben (M)	19	P (2/2)	0	14	Yes	Yes	7	1st	Hausa
Yankuzo 1	Ex-ben (M)?	31	M	6	17	Yes	Yes	7	4th	Hausa

Yankuzo 2	Ben	18	P (2/2)	2	15	No	No	11	3rd	Hausa
Yankuzo 3	Ex-ben (M)	35	P (1/4)	10	15	No	Yes	23	4th	Hausa
Yankuzo 4	Ex-ben (M)	20	P (2/2)	1	16	No	No	6	2nd	Hausa
Yankuzo 5	Ex-ben (M)	20	M	0	17	No	No	2	4th	Hausa
Yankuzo 6	Ex-ben (M)	20	M	1	17	No	Yes	5	3rd	Hausa
Yankuzo 7	Ex-ben (M)	18	M	0	18	Yes	Yes	2	4th	Hausa
Kafin Madaki 1	Ex-ben (M)	20	M	0	14	No	No	2	4th	Hausa
Kafin Madaki 2	Ex-ben (M)	20	M	1	17	No	No	3	3rd	Hausa
Kafin Madaki 3	Ex-ben (M)	35	P (1/2)	4	17	Yes	Yes	11	3rd	Hausa
Kafin Madaki 4	Ex-ben (P)	30	P (1/2)	6	17	No	Yes	13	3rd	Hausa
Kafin Madaki 5	Ex-ben (M)	35	P (2/2)	9	14	No	No	21	2nd	Hausa
Kafin Madaki 6	Ex-ben (P)	16	M	0	15	No	No	2	3rd	Hausa
Kafin Madaki 7	Ex-ben (M)	27	P (2/2)	4	15	No	No	6	2nd	Hausa
Kokura 1	Ex-ben (M)	28	P (2/2)	5	13	No	No	13	3rd	Hausa
Kokura 2	Ben	30	M	5	15	Yes	Yes	7	4th	Hausa
Kokura 3	Ex-ben (M)	39	P (2/2)	10	14	No	No	18	3rd	Hausa
Kokura 4	Ex-ben (M)	41	M	1	13	No	No	15	3rd	Fulani
Kokura 5	Non-ben	15	M	0	12	No	No	14	4th	Fulani
Kokura 6	Ben	31	P (2/2)	7	14	No	No	16	1st	Fulani
Kokura 7	Ex-ben (M)	18	M	1	14	No	No	10	4th	Fulani
Kokura 8	Non-ben	23	M	2	14	No	No	4	3rd	Fulani
Kokura 9	Non-ben	22	P (2/2)	2	14	No	No	9	2nd	Fulani
Kanyu 1	Ben	22	M	3	15	Yes	No	5	4th	Hausa
Kanyu 2	Ex-ben (M)	25	M	5	13	No	No	7	3rd	Hausa
Kanyu 3	Ben	25	P (2/2)	2	14	Yes	No	12	2nd	Hausa
Kanyu 4	Ex-ben (P)	20	P (2/2)	2	14	No	No	7	2nd	Hausa
Kanyu 5	Ex-ben (M)	21	M	2	14	No	Yes	5	4th	Hausa
Kanyu 6	Ben	22	P (1/2)	2	15	Yes	No	5	3rd	Fulani

Notes:

Italics / grey text = no household member available for interview at endline

Ben = current beneficiary; **Ex-ben (M)** = ex-beneficiary, matured exit; **Ex-ben (P)** = ex-beneficiary, premature exit; **Non-ben** = non-beneficiary

Annex C: Glossary of local foods and other terms

Foods

Agino	Monosodium glutamate
Alale	Seasoned and steamed bean paste
Alayehu	Spinach
Alkaki	Sweet wheat cakes
Awara	Cake made from fried soya bean paste
Baba dogo	Brand name for spice/seasoning for soup
Bambara nut	Nutritious legume widely grown in West Africa (*vigna subterranea L.*)
Beniseed	Sesame
Bula	Balls made from maize flour and stored in water for weeks
Chin-chin	Fried doughnuts made with wheat and sometimes cow-pea flour
Daddawa	Soup condiment made from locust bean seeds
Dagedage	Tomato stew
Danbu	Couscous
Dankali	Sweet potatoes
Danwake	Bean-flour dumplings
Dawa	Sorghum
Dinya	Fruit of the black cherry birch tree (*vitex doniana*)
Doya	Yam
Fete	Porridge made from grains and vegetables
Fura da nono	Drink made from millet meal with milk/yoghurt
Fura	Drink made from sorghum or millet
Ganye	Vegetables (general term)
Gari	Corn flour
Garri	Flakes made of ground and fried cassava
Gero	Millet
Girido	Wild food, leaves
Goji	Pumpkin
Goro	Nut
Goruba	Doum palm fruit (*hyphaene thebaica*)
Guinea corn	Sorghum
Gurasa	Bread
Gwate	Porridge made from ground maize and vegetables
Hatsi	Grains (general term)
Hoche	Cake or bread baked from sorghum (more often eaten during *bazara* season/food scarcity)
Indomie	Instant noodles (brand name)
Kabewa	Pumpkin
Kakan wara	Made from maize and beans
Kantu	Sweet sesame cake
Kanwa	Potash
Kanya	Wild fruit (*diospyros mespiliformis*)

Kanzo	Edible burnt part of food; remnant of millet paste soaked and scraped from the pot, dried as food
Kawuri	Wild grass/leaves
Kenaf	*Hibiscus cannabinus*
Kifi	Fish
Kindirmo	Yoghurt
Kirinya	Pickles; *bridelia spp.*
Koko	Pounded millet, moistened and moulded into balls
Kosai	Deep-fried bean cake
Kosan rogo	Deep-fried cassava cake
Kubewa	Okra
Kudaku	*Traditional food in Doka Gama* (*Anka*)
Kuka	Baobab-leaf
Kuli kuli	Groundnut cakes
Kunu	“Pap” or semi-liquid porridge made from made from various cereals (often millet)
Kunun kanwa	“Pap” or semi-liquid porridge made of millet and potash
Kunungyeda	“Pap” or semi-liquid porridge made from groundnut paste and rice
Kunun lafiya	“Healthy kunu” – recipes introduced by CDGP combining cereal with protein-rich and nutritious local foods including groundnut, soya, milk, moringa\
Kwado	Salad made of moringa, kenaf (hibiscus) and peanut cake
Locust bean	Seeds of the locust bean tree or néré (*parkia biglobosa*)
Maggi	Seasoning/stock cube (brand name)
Maiwa	Red sorghum
Maltina	A malted soft drink/soda, fortified with B vitamins and calcium (brand name)
Man shanu	Locally-made butter (from cow’s milk)
Masa	Corn (maize) cake
Miyan kuka	Soup/sauce made from baobab leaves
Moi moi	Steamed bean pudding made with cow peas
Nakiya	Sweet rice cakes
Nama	Meat
Namam kaza	Chicken
Namam shanu	Cow meat (beef)
Nono	Milk / fermented milk
Okro	Okra/ ladies’ fingers
Onga	Brand name for seasoning (monosodium glutamate)
Pate	Porridge made from ground maize and vegetables
Peak milk	Powdered milk (brand name)
Rake	Sugar cane
Rama	Kenaf leaves (*hibiscus cannabinus*)
Riddi	Sesame
Rogo	Cassava
Sakwara	Pounded yam
Shasshaka	Grits eaten with oil and pepper
Shinkafa da kaza	Rice and chicken (celebration food)
Shinkafa da miya	Rice and stew (celebration food)
Shinkafa	Rice

Shuwaka	Bitter leaf
Star	Brand name for spice/seasoning
Suya	Grilled meat/kebabs
Tafasa	Edible green leaves of a shrub
Taliya	Local spaghetti made from wheat flour
Taushe	Vegetable soup enriched with pumpkin and groundnut or sesame seeds
Tiger nut	Nutritious tuber, member of the sedge family (*cyperus esculentus*)
Tsaba	Grains (generic name)
Tsamiya	Tamarind
Tsire	Roasted skewered meat
Tubani	Maize and bean paste mixed with potash
Tuwo	Pounded grain served as a paste
Tuwon dawa	Sorghum (guinea corn) paste
Tuwon gero	Millet paste
Tuwon masara	Maize paste
Tuwon shinkafa	Rice paste
Waina	Rice or maize cake
Wake	Beans (cowpeas)
Yadiya	Wild creeper, 'leaves from the bush'; gathered in *bazara* season and dried
Yakuwa	*Hibiscus sabdariffa* leaves
Zobo / zoborodo	*Hibiscus sabdariffa* flowers
Zogale	Leaves of the moringa tree (*moringa oleifera*)

Seasons

Note: *Correspondence to the European months is approximate: the actual timing of the seasons varies from year to year and from place to place.*

Rani	Hot, dry season/harmattan (Jan/Feb/Mar)
Bazara	Land preparation/early rainy season, hot and humid (Apr/May/Jun)
Damina	Rainy season (Jul/Aug/Sep)
Kaka	Harvest/early dry season, cold and windy (Oct/Nov/Dec)

Other local terms

Adashe	Rotating savings association
Ambaliyan ruwa	Flood
Bulama	Village head
Burtsatse	Borehole
Cirani	Temporary male labour migration
Fadama	Wetland or irrigable land – usually low-lying plains underlaid by shallow aquifers found along major river systems, which also provide water for livestock during the dry season[22]

[22] Information source: www.worldbank.org/en/news/feature/2010/07/28/fadama-iii-rural-agriculture-project-fast-becoming-a-household-name-in-nigeria.

Hakimi	District head
Hardo	Leader of Fulani *ruga* (settlement)
Inna wuro	'Mother of the house'
Kaba	A type of palm leaf used in basket-making
Karamin karfi	Someone with little power
Kulle	Female seclusion
Kungiya	Committee (TWC / CDGP)
Mai angwa	Village head
Mai garin	Mayor
Mai gida	Owner or head of compound
Ngozoma	Traditional birth attendant (TBA)
Okada	Commercial motorcycle/motorcycle taxi
Randa	Clay water-storage pot
Rigiya	Well
Rubutu	Extracts from the Qur'an written on slates, and sometimes washed off and drunk for healing ('prayer water')
Ruga	Fulani hamlet
Rumbu	Grain store or silo
Talafi	Money / cash transfer
Tamowa	Thinness, not growing
Tsinka-tsinka	Eclampsia (illness affecting pregnant women and babies, associated with the cold of the rainy season)
Wadata	Wellbeing or wealth
Wahala	Problem, hardship or distress
Wakili	Aide to the village head
Waya	Phone

Table 7 Locally available foods by type (reference table)

Food type	Locally available foods
Cereals	Millet, sorghum, rice, maize
Roots and tubers	Cassava, sweet potato, yam, tiger nuts
Pulses, legumes, nuts, seeds	Cowpeas, groundnuts, bambara nuts, sesame, locust bean, soya beans
Vegetables	Pumpkin, hibiscus (kenaf), moringa, baobab leaves, okra, tomatoes, peppers
Fruits	Wild berries, dates, doum palm berries, tamarind, orange, banana
Meat/poultry, offal	Cows, goats, chickens, guinea fowl
Eggs	Chicken and guinea fowl eggs
Fish, seafood	Freshwater fish (including dried fish)
Milk and milk products	Cow's milk and goat's milk, yoghurt, butter
Oil/fat	Groundnut oil, butter
Sugar/honey	Sugar cane, dates, honey

Annex D: Qualitative evaluation sites by LGA, district, village and traditional ward

	LGA	District	Village	Traditional ward	Name used in qualitative reports	Quantitative survey site
ZAMFARA	Anka	Matseri	Matseri	Katun Bare	**Matseri**	**119**
	Anka	Wuya	Sardauna	Doka Gama	**Doka Gama**	**136**
	Tsafe	Keta	Mayana Keta	Sabon Gari	**Keta**	**231**
	Tsafe	Yankuzo	Marafan Yankuzo	Sabon Garin Hayin Kasuwa	**Yankuzo**	**260**
JIGAWA	Buji	Yayari	Kafin Madaki	Kafin Madaki	**Kafin Madaki**	**324**
	Kirikasama	Baturiya	Baturiya	Kokura	**Kokura**	**401**
	Gagarawa	Yalawa	Kanyu	Kanyu	**Kanyu**	**533**

Annex E: Data processing codes (guidance for coders)

Part 1 – Research themes / impact pathways

T1. CONSUMPTION PATTERNS AND DIETARY PRACTICES

- Quantity of food consumed or available
    - positive change (+ explanation /reasons)
    - negative change (+ explanation /reasons)
- Quality or variety of food consumed or available
    - positive change (+ explanation /reasons)
    - negative change (+ explanation /reasons)

T2. RISKS, RESILIENCE AND COPING

- Types of risk, stress or shock
    - Insecurity / displacement
    - Natural hazards (drought, flood, crop & livestock diseases etc.)
    - Other
- Responses to risk, stress or shock (coping behaviour)
    - Sources of assistance
    - Use of CDGP transfers to cope with/ recover from shocks

T3. HOUSEHOLD DECISION-MAKING AND RESOURCE MANAGEMENT

- Decisions about food distribution within the household
- Decisions about food purchase
- Decisions about other expenditure
- Women's control over cash (including CDGP transfer)
- Decisions about mother and child health care
- Perceived changes in women's roles / status / decision-making power

T4. KAP (HEALTH AND NUTRITION)

- Exclusive breastfeeding (only mother's milk for 6 months – no water)
    - understanding/ knowledge / opinions
    - adoption (practice) of EBF (+ explanation / reasons)
    - barriers / non-adoption of EBF (+ explanation / reasons)
    - expected future practice

- Early initiation of breastfeeding (within 1 hr of birth)
    - understanding/ knowledge / opinions
    - adoption (practice) of early breastfeeding (+ explanation / reasons)
    - barriers / non-adoption of early breastfeeding (+ explanation / reasons)
    - expected future practice

- Complementary foods

- Care of sick and malnourished children
- ANC (antenatal care)
- Use of health facilities (other than ANC)
- WASH (water, sanitation and hygiene)

- Changes in health or nutrition over the evaluation period

T5. LIVELIHOODS

- Livelihood activities (including any changes and perceived impacts of CDGP)
    - Men's livelihood activities
    - Women's livelihood activities
- Income (including any changes and perceived impacts of CDGP)
    - Men's income
    - Women's income
- Assets/ investments/ savings (including any changes and perceived impacts of CDGP)
    - Men's assets
    - Women's assets

T6. WELLBEING

- Overall wellbeing / happiness
- Relational wellbeing
    - between spouses
    - within the household
    - within the community

T7. SEASONALITY

- Seasonality of **diet** (including seasonal changes in composition, quantity, quality, variety, or frequency of diet/consumption).
- Seasonality of **food availability** (stocks & markets)
- Seasonality of **risk, stress or shock**
- Seasonality of **health and illness**
- Seasonality of **livelihood activities**
- Seasonality of **income**
- Seasonality of **expenditure / cash needs**

- *Rani* (dry season / harmattan)
- *Bazara* (early rains / land preparation)
- *Damina* (rainy season)
- *Kaka* (harvest season)

- This year's harvest (compared to previous years)

Part 2 - Programme implementation / processes (community & beneficiary perceptions)

P1. COMMUNITY GOVERNANCE / LEADERSHIP

- TWC (Traditional Ward Committee) & BRG (Beneficiary Reference Group)
  - Score 1 (very poor/ not satisfied) + explanation / reasons
  - Score 2 + explanation / reasons
  - Score 3 + explanation / reasons
  - Score 4 + explanation / reasons
  - Score 5 (very good / completely satisfied) + explanation / reasons

- Local leaders (roles/ involvement with CDGP)

- Health workers (CHEWs, clinic staff etc - roles/ involvement with CDGP)

P2. COMMUNITY VOLUNTEERS (CVs)

- Score 1 (very poor/ not satisfied) + explanation / reasons
- Score 2 + explanation / reasons
- Score 3 + explanation / reasons
- Score 4 + explanation / reasons
- Score 5 (very good / completely satisfied) + explanation / reasons

P3. ENROLMENT / REGISTRATION / TARGETING

- Score 1 (very poor/ not satisfied) + explanation / reasons
- Score 2 + explanation / reasons
- Score 3 + explanation / reasons
- Score 4 + explanation / reasons
- Score 5 (very good / completely satisfied) + explanation / reasons

P4. CASH TRANSFER PAYMENTS

- Score 1 (very poor/ not satisfied) + explanation / reasons
- Score 2 + explanation / reasons
- Score 3 + explanation / reasons
- Score 4 + explanation / reasons
- Score 5 (very good / completely satisfied) + explanation / reasons

- Uses of cash transfers
  - buying food
  - paying medical costs
  - payments to other people (voluntary or forced)
  - investment in livelihood activities or assets
  - savings
  - other

- Control of cash transfers (who collects & keeps the cash, who decides on its use)
- Perceived impacts of cash transfers

P5. SBCC ACTIVITIES

- SBCC & nutrition advice component overall
    - Score 1 (very poor/ not satisfied) + explanation / reasons
    - Score 2 + explanation / reasons
    - Score 3 + explanation / reasons
    - Score 4 + explanation / reasons
    - Score 5 (very good / completely satisfied) + explanation / reasons

- Action-oriented groups (AOGs) - food demonstrations, health talks etc.
    - Score 1 (very poor/ not satisfied) + explanation / reasons
    - Score 2 + explanation / reasons
    - Score 3 + explanation / reasons
    - Score 4 + explanation / reasons
    - Score 5 (very good / completely satisfied) + explanation / reasons

- IYCF support groups for women
    - Score 1 (very poor/ not satisfied) + explanation / reasons
    - Score 2 + explanation / reasons
    - Score 3 + explanation / reasons
    - Score 4 + explanation / reasons
    - Score 5 (very good / completely satisfied) + explanation / reasons

- IYCF support groups for men
    - Score 1 (very poor/ not satisfied) + explanation / reasons
    - Score 2 + explanation / reasons
    - Score 3 + explanation / reasons
    - Score 4 + explanation / reasons
    - Score 5 (very good / completely satisfied) + explanation / reasons

- One-to-one counselling
    - Score 1 (very poor/ not satisfied) + explanation / reasons
    - Score 2 + explanation / reasons
    - Score 3 + explanation / reasons
    - Score 4 + explanation / reasons
    - Score 5 (very good / completely satisfied) + explanation / reasons

- Radio broadcasts
- Posters
- Phone messages

- Other sources of advice / influence (e.g. religious leaders, doctors, husbands, other women etc)

P6. COMPLAINTS & PROBLEMS

- Official complaints (i.e. people who used the CDGP complaints mechanisms - examples / narratives)
- Fraud
- Forced payments or deductions from the cash transfer
- Manipulation of enrolment lists (nepotism, bribery etc)
- Other problems / complaints

P7. EXIT PROCESS

- Score 1 (very poor/ not satisfied) + explanation / reasons
- Score 2 + explanation / reasons
- Score 3 + explanation / reasons
- Score 4 + explanation / reasons
- Score 5 (very good / completely satisfied) + explanation / reasons

P8. OVERALL SATISFACTION WITH CDGP

- Score 1 (very poor/ not satisfied) + explanation / reasons
- Score 2 + explanation / reasons
- Score 3 + explanation / reasons
- Score 4 + explanation / reasons
- Score 5 (very good / completely satisfied) + explanation / reasons

P9. PERCEIVED IMPACTS OF CDGP

Impacts on:

- diet & consumption practices
- child care practices
- children's health / nutrition
- women's health / nutrition
- health-seeking behaviour
- women's livelihoods & income
- men's livelihoods & income
- women's time use
- men's time use
- women's status & decision-making power
- household relationships
- community cohesion & relationships
- coping behaviour & resilience
- other

- Negative impacts

Future expectations (sustainability of impacts)

Annex F: CDGP SBCC messages

Box 5 Key SBCC messages – priority nutrition practices for CDGP

1. Eat one additional meal for mother each day during pregnancy.
2. Attend ante-natal care at least four times during pregnancy.
3. Place the newborn on the breast within one hour of delivery (early initiation).
4. Do not offer pre-lacteal feeds to your baby.
5. Practice exclusive breastfeeding (from birth to six months of age) – no water, no formula (BMS).
6. Introduce complementary foods at six months of age (180 days) while continuing to breastfeed.
7. Use good hygiene practices (three practices – wash hands with soap before food preparation, wash your hands and the child's before and after feeding baby/child, wash hands each time after using toilet or cleaning baby's bottom).
8. Purchase healthy/nutritious foods for your family.
9. Feed your child a variety of foods and increase that variety as the child gets older.
10. Never feed the baby or young child using a bottle.
11. Do not use or purchase infant formula.

Source: CDGP Implementation Manual (2015) p.26