ePact
Strengthening evaluation effectiveness and impact

CHILD DEVELOPMENT GRANT PROGRAMME EVALUATION

Final Process Evaluation Report: Round I

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Oxford Policy Management

itad

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

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Disclaimer

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Executive summary

Introduction

The Child Development Grant Programme (CDGP) is a pilot programme implemented by Save the Children (SC) and Action Against Hunger (AAH) that provides monthly cash and nutritional education and counselling to 70,000 households in five Local Government Areas (LGAs) across Zamfara and Jigawa states. An independent evaluation of the programme is being carried out by ePact, a consortium led by Oxford Policy Management (OPM). The evaluation is intended to help determine the impact of the programme on the households and communities it supports, drawing on different methods and sources of data, including a quantitative household survey, qualitative research and process evaluation (PE).

This report presents the findings of the first round of PE. The evaluation aims to:

- Determine how the programme was designed and is being implemented in practice;
- Assess the scope and coverage of implementation to date; and
- Document key programme challenges and lessons learned.

Approach and methodology

Central to meeting the aims of this PE are: i) the mapping of the implementation structures and stakeholders involved in the CDGP; ii) the mapping of the core implementation processes of the programme as implemented; and iii) the assessment of the status and coverage of implementation to date. The evaluation draws on a number of methods and tools including document reviews, analysis of monitoring data, Key Informant Interviews (KIIs), stakeholder workshops and field observation.

To guide the evaluation, an analytical framework was developed around the key processes of the programme. This framework is structured around understanding how the process domains were designed, implemented in practice and at what scale, and the key challenges and lessons learned for each of the domains. A review of each process domain is followed by an analysis of emergent cross-cutting issues that together form the basis of the conclusions reached for this evaluation.

Findings

Overall, the evaluation finds that CDGP has achieved significant progress in the face of many challenges. Most of the challenges and difficulties documented in this report are well known to the programme staff, who indeed explained them to the evaluation team in key informant interviews. Some of these challenges have already been solved; some were being addressed at the time of the evaluation; and some remain to be tackled. The report aims to document all of these, together with solutions already implemented or proposed (up to February 2016), in order to maximise learning from the CDGP for future programming.

Timeline

The programme began in April 2013 with an inception phase up to December 2013. Implementation officially began in January 2014 with the initial few months spent finalising some programme modules, and entering and sensitising some communities. Contract negotiations for

payments were completed in April 2014 and the first beneficiaries were enrolled in the same month. The programme tested its operations between April and July 2014, covering 500 beneficiaries in 15 communities. The roll-out of the programme began in earnest in August 2014 and rapidly expanded immediately after the completion of the baseline surveys in October 2014.

Sensitisation and mobilisation

The programme is centred on a community-based approach with significant roles and responsibilities for Traditional Ward Communities (TWCs) established by the programme and Community Volunteers (CVs). The TWCs and CVs play a central role in the sensitisation and mobilisation of the communities; they also have other roles and responsibilities across the entire programme. However, the programme has not provided the TWCs or CVs with sufficient written guidance material around their roles and responsibilities across the entire programme that is tailored to their level of understanding and which they (or the CDGP staff delivering community-level training) can draw on as reference material. Moreover, the recruitment and provision of adequate training to CVs has been difficult at times. The programme has taken stock of this with marked increases in training activities in both states in July/August and November/December 2015.

The major challenge in this process domain has been the sheer scale of implementation in terms of the number of communities targeted, and consequently the human and logistical resources needed to reach them. The human resources needed to deliver all the activities at community level seem to have been badly underestimated at the beginning of the programme. The programme's initial target of entering 35 new traditional wards (TW) per month across the two states was ambitious and has only been achieved once (in October 2014). Entry into communities and sensitisation have been more time-consuming than envisaged, with security, road access and communication providing additional challenges.

Revisits to communities following the initial entry, sensitisation and enrolment have not happened as frequently as intended. In Zamfara, 71 TWs (about half of the total) were visited only once between October 2014 and October 2015. In Jigawa revisits were more frequent, with about a third of TWs visited more than four times and only 20 (17%) visited only once. This is likely to affect the level of understanding of the programme by TWCs and CVs and well as by the wider community.

Targeting and registration

Entry into the CDGP is conditional on only two criteria: pregnancy, and residence in a treatment (beneficiary) community. Women can register at any stage of their pregnancy, and are then entitled to monthly cash transfers and BCC services until their child’s second birthday. In practice, beneficiaries receive the cash transfer from the time they are registered. Therefore, any delay in the registration process reduces the total benefits received.

There are five steps to registration: identification of beneficiaries, residency verification, confirmation of pregnancy, enrolment (off line registration) and registration onto the payment system (online registration). Completion of the online registration requires the distribution of mobile phones to beneficiaries, as well as entering and synchronising their data (including photographs and scanned thumbprints) via an Android tablet. While enrolment and registration can take place on the same day, staff, phones and appropriately functioning tablets are not always available resulting in the final step of registration sometimes taking place a week or even a month later.

Confirmation of pregnancy is done by a urine test. Establishing a practical system for such testing has posed challenges for the CDGP. The original preference was for pregnancy tests to be carried out at health centres, with the alternative option of community-based testing where health facilities were absent or under-resourced. In practice, reliable health facilities are scarce and in most places pregnancy testing is done in the community by Community Health Extension Workers (CHEWs), CVs and seconded staff. Women can be extremely resourceful in finding ways to falsify the test, including buying or borrowing urine. Unpaid CVs and underpaid CHEWs or health staff are also sometimes tempted to falsify pregnancy test results for their own gain. Random pregnancy testing at payment points, and using supervised “instant urine” tests have been some of the responses to these challenges.

During the initial roll-out phase the registration process was slow, due to poor functionality of devices, delays in procurement of additional devices, and national and state level elections in March 2015. Registration was scaled up after April 2015 but delays in procurement of phones delayed registration in October and November 2015 once again. Despite these challenges, the total number of beneficiaries registered had reached 32,300 by the end of 2015.

Beneficiaries are expected to exit (‘graduate’) from the programme on their child’s second birthday. At the time of the process evaluation no beneficiary had yet graduated: the first graduations were due in the first quarter of 2016. However, no system has yet been established to track the birth dates of beneficiaries’ babies and thus to predict graduation dates. CDGP is aware of this problem, which is becoming urgent, and is collecting retrospective data on births.

‘Premature’ exits (before the child’s second birthday) may be due to miscarriage, stillbirth, death of the child or mother, relocation or fraud. Exit cases are reported on a monthly basis and may be investigated by field staff before the beneficiaries are ‘de-activated’ on the payment system. The total number of premature exits between November 2014 and December 2015 was 1,999.

Payments

After some initial problems the programme has established an effective payment system that has been delivering timely monthly payments to over 80% of registered beneficiaries since mid-2015. More than 32,000 women received the cash transfer in February 2016.

The original design of the CDGP envisaged a flexible e-payment system using mobile wallets, which would enable beneficiaries to accumulate balances and to withdraw cash from community-based agents as and when they needed it. Electronic transfers into beneficiaries’ ‘virtual wallets’ were expected to avoid the security risks of transporting cash. The mobile phones provided to beneficiaries were intended to enable them to access balance updates, and to foster financial inclusion. These design features have proved to be over-ambitious. The initial commissioned study (Mwamba 2013) took insufficient account of the operating environment of Northern Nigeria or the availability and penetration of existing financial services and products there. However, CDGP subsequently worked with Stanbic to develop a payment system that works within the challenging operating context. The payment system has been progressively simplified in the course of implementation.

As currently operated, the CDGP payment mechanism is a manual payment model with mobile agents delivering a fixed monthly payment, in cash, at a pre-arranged location, date and time. The mobile phones are used solely to notify beneficiaries of payments disbursed (although these notifications are apparently often not received, and information about payment dates is communicated through the CVs instead). The phone numbers act as unique ID’s (effectively account numbers), but for this purpose beneficiaries only need the number, not the phone itself.

The phones cannot be used to access financial services such as deposit-making, savings, or on-demand withdrawals. Contrary to the original intentions of the programme, beneficiaries thus have little or no choice as to where and when they can receive their payments, or how much they can withdraw.

A key factor in this significant design change has been the inability of the service provider (Stanbic) to recruit community-based agents in the CDGP areas with sufficient financial liquidity to deliver the cash transfers. Using mobile agents instead, including more recently a network of 'super-agents' with higher liquidity, has been operationally successful: since mid-2015 the system has been delivering monthly payments on time (within 10 days of disbursement to Stanbic) to about 95% of registered beneficiaries, well above the Year 3 milestone target of 80%. However, this change has raised transaction costs. Mobile agents carrying large amounts of cash incur both transport costs and higher risks. Consequently the agent's fee per beneficiary paid has been renegotiated from the NGN 55 originally planned to NGN 175.

The decision to fix the amount each beneficiary can withdraw each month (at exactly one month's payment, i.e. NGN 3,500) was also partly due to the mobile agents' need to know in advance how much money they should carry. Equally important, the fixed withdrawal amount reduces opportunities for fraud by the agent.

In establishing the current system, the programme has faced a number of challenges and delays. Contract negotiations and procurement of services have often been complex and protracted. There were significant teething problems during the first year of payments, related to delays in registration, lack of agents, faulty software and equipment, and liquidity issues. The availability and functionality of equipment has been a binding constraint for timely payments as well as for registrations. However, adjustments have been made and solutions found to mitigate most of these problems.

The programme is currently exploring alternative e-payment service providers and modalities to operate alongside the existing payment mechanism for a fixed period to assess the potential impact on resolving these challenges. This is to be encouraged, but, as the programme is aware, with any new service provider new challenges and risks are likely to arise, and costs may not necessarily be lower. Maintaining timely payments to beneficiaries, scalability and the potential for hand-over to government should be core considerations in assessing alternative payment systems.

Behaviour Change Communication (BCC)

The BCC activities are a core element of the programme design. They are intended to inform and influence beneficiary mothers and other community members to adopt beneficial behaviours relating to diet, nutrition, childcare, health and hygiene, alongside the cash transfers which are intended to provide them with the purchasing power needed to put some of these messages into practice. The programme theory of change assumes that the two components (cash and BCC) will work together to reduce malnutrition. The BCC approach is also an important factor in the design of the impact evaluation, which aims to test the difference in impact between two models of BCC (a low-intensity model labelled T1, and a high-intensity model labelled T2).

Despite their importance, implementation of the BCC activities was seriously delayed in the early phases of the programme. Although BCC interventions were introduced and tested during the pre-pilot phase, the overall strategy (including selection of key messages and communication channels to be used for T1 and T2) was not finalised until November 2014. Implementation of BCC activities was severely hampered during the main roll-out phase, from August 2014 onwards, because of the imperative to focus resources including scarce field staff on establishing the cash transfer system.

The lack of full-time nutrition and health staff meant that staff as well as CVs and CHEWs were frequently diverted from BCC work to support the registration and payment processes.

An underlying reason for this delay in focusing on the BCC design and implementation was that, at the initial proposal stage, it was expected that CDGP would be implemented alongside the established WINNN (Working to Improve Nutrition in Northern Nigeria) programme, and would be able to draw on WINNN expertise and modalities for the BCC component. In fact it was decided early in 2013 that CDGP would not operate in the same LGAs as WINNN so as to not compromise the WINNN evaluation and to enable CDGP to have its own unbiased impact evaluation, which has obviously limited the interaction of the two programmes. Although CDGP has benefited from technical assistance, materials and joint training with WINNN, CDGP was not able to rely on substantial WINNN technical support. Technical assistance in nutrition and BCC has also been provided by SC and AAH country and international offices, but CDGP has recognised that more full-time staff are needed within the programme to focus on this important domain.

During 2015, significant progress was made. A new post of full-time BCC and Nutrition Advisor in the CDGP Abuja office was filled in January 2015. Since then programme-specific Information, Education and Communication (IEC) materials have been developed, IYCF monitoring formats have been introduced, and training for nutrition CVs has been increased. Programme monitoring data show that the delivery of BCC activities at community level (in terms of the number of group and individual sessions) rose during 2015.

Nevertheless major challenges remain, particularly relating to the coverage, intensity and quality of the BCC activities. Improved monitoring and analysis of various dimensions of support is needed to enable the programme to understand better how the activities are being delivered and how effective they are likely to be. The monitoring of BCC activities so far is very much focused on counting the number of sessions and participants, with little or no information on the content, quality or effectiveness of the interventions delivered. Systematic disaggregation of monitoring and analysis (including PDM surveys) by T1 and T2 categories is needed to understand how the two models are really working and how intensive the communication is in practice, at the beneficiary level. The current monitoring system does not allow any analysis of the type or frequency of engagement with BCC activities at beneficiary level (although registering participants by their CDGP phone number would in principle make this possible).

The Nutrition and BCC strategy also relies heavily on CVs and CHEWs both for implementation and monitoring. Targets to date have been difficult to meet, and no information is available on the quality of BCC interventions. Assessing and rationalising the various components of the strategy could help to reduce the burden on CVs and support them to undertake fewer activities to a higher level of quality and intensity.

Complaints Response Mechanism (CRM)

The CRM has established a number of channels through which beneficiaries and others can seek information or assistance, ask for solutions to problems, report fraud or abuse, or seek redress for grievances. Community-based channels via the CVs, TWCs and Beneficiary Reference Groups (BRGs) are balanced by a hotline phone number direct to the local CDGP office. Complaints can also be reported in person to any CDGP staff member or partner.

However, there have been limitations on the effective use of these channels. In the absence of any full-time staff working on CRM, responsibility for answering the hotline phone has rotated among LGA team members. This has meant that the phone has not always been answered. Further barriers to the use of the hotline are that calls are not free (so mobile phone credit is needed), and as noted above the use of phones in CDGP communities is limited by patchy network coverage,

lack of electricity for charging phones, and general lack of familiarity. Key informants noted a general reluctance among beneficiaries and community members to complain. While the community-based channels probably work well for resolving some types of problem, beneficiaries reportedly prefer to approach CDGP staff members directly when they have the opportunity (for example, on payment days).

The categories created for the tracking of complaints are not refined or detailed enough to allow useful analysis of the nature of complaints or to identify areas of improvement for the programme design and implementation. Reporting of the number of complaints received and resolved is too aggregated, with all the categories counted together. In fact, the majority of 'complaints' in these aggregate figures are requests for information or assistance, most of which can be easily and quickly resolved. More nuanced analysis would enable much better use of, and learning from, the information collected. The databases used to monitor complaints also lack sufficient detail on the response to complaints, and were not up-to-date at the time of the evaluation. It is understood, however, that an improved CRM database is a work in progress.

A new post of CRM Coordinator in the CDGP Abuja office has been established and was filled in January 2016. Additional dedicated CRM positions are also being proposed at State and LGA levels. This significant expansion of human resources focused on CRM should enable CDGP to strengthen the system and address the issues noted above.

Programme monitoring

CDGP has fostered a culture of data collection, and is gathering a range of potentially useful information on various aspects of the programme. While there is an M&E Plan, it would benefit from being updated to set out in detail the rationale and purpose of the various data collection, analysis and reporting processes.

Programme monitoring is currently centred on the Monthly Dashboard, which collects data across all major programme areas from each State. Data is aggregated at the central level and used in Monthly and Quarterly Progress Reports, as well as the Indicator Performance Tracking Table which monitors logframe indicators on a monthly basis.

Narrative reports are largely summative and only contain aggregated data on key indicators. Much more could be done to improve the usefulness of such reports, such as graphical presentation of time-series analysis and disaggregating data to meaningful levels of analysis such as the State or LGA.

Data collection relies heavily on CVs, CHEWs and field staff filling in forms, and there are concerns that illiteracy (particularly among women CVs), having too many responsibilities, and insufficient training in data collection may result in poor data quality. Rationalising CV responsibilities, as well as ensuring that only data that will be analysed is collected, may decrease the burden of responsibility and improve data quality.

The Post Distribution Monitoring (PDM) survey, a useful means to gather information directly from beneficiaries, is scheduled to be implemented quarterly. However, this target may be too ambitious given that key indicators of interest do not change that quickly. The schedule puts unnecessary strain on the small M&E team to implement the next PDM survey without sufficient time to analyse the previous round and respond to any emerging issues.

The planned introduction of a new Management Information System (MIS) during 2016 presents an opportunity to review and rationalise the overall data collection, analysis and reporting system.

Cross cutting themes

The programme design significantly underestimated the level of **human resources and technical support** required to implement a programme of this scale and complexity. Central staffing (in the CDGP Abuja office) was a major bottleneck during the initial stages of implementation, resulting in little oversight or understanding of programme operations at state level. Many new positions have been created and staffed since the inception phase and during implementation to overcome this.

The programme has also struggled to access sufficient international technical assistance, although this was conceived as important in ensuring the programme is appropriately designed and implemented. This is attributed to a lack of formal agreements and plans articulating the level and timing of support required, together with the absence of counterpart staff in the Abuja office for international advisers to engage with.

Technology has posed challenges in several key process domains. Poor network coverage, lack of electricity, inadequate or delayed supplies of equipment, software problems, and frequent failure of devices due to operating conditions have affected the registration, payment, BCC, CRM and monitoring processes. Some of these problems are simply features of the challenging context of Northern Nigeria in which the programme is operating, and practical adjustments have been made to mitigate them (such as supplying power banks to extend the battery life of tablets). However, to some extent it must be questioned whether the design of the programme is too high-tech for the context. The obvious example is the role of mobile phones, which were originally conceived as essential to the e-payment system but now (with the reversion to a manual payment system) seem to serve very little purpose except to provide beneficiary ID numbers. Given the cost of the phones, and the disruption to the whole programme caused by procurement delays, their value and sustainability should be reconsidered.

Security and accessibility remain a constant challenge for the programme, and one needing continuous attention. Security arrangements for the cash transfer system, including the active support of community leaders, have been successful in preventing any incidents of robbery during the payment process. However, general insecurity in parts of the CDGP area (mainly in Zamfara), combined with poor and seasonal road infrastructure, continue to limit the programme's access to some targeted communities.

The CDGP **Implementation Manual** has evolved over time and additional operational details have been incorporated. Nevertheless this manual is not sufficiently detailed or presented with sufficient clarity or accessibility to serve as a guiding document for state and LGA level teams. The programme could also benefit from additional reference material tailored to the needs of the TWCs and CVs, utilising infographics, animation, or simple messages translated into Hausa.

Conclusions and recommendations

Overall the evaluation has found significant progress and achievements in implementing the programme but also many challenges and difficulties, most of which are known by the programme and are being addressed. At the start of the implementation in January 2014, the programme was still designing and finalising many of its processes, with limited operational details in place. Contract negotiations with payment service providers were still continuing and only concluded in April 2014, BCC interventions were still being designed, programme structures were still being formed and at the time no monitoring systems were developed or put in place.

Two years later, the programme has established a set of processes and actions that are operationally more detailed. It now has a well-established payment system that is reportedly able

to pay most beneficiaries in a timely manner, every month: an achievement eluding many other cash transfer programmes of similar and larger scale in Sub-Saharan Africa. The programme has also established a set of BCC activities, and a mechanism for community members to seek clarification and raise complaints. The M&E system collects a significant amount of information about the operations of the programme to measure progress and identify bottlenecks.

Based on the findings of this evaluation, the following recommendations are made:

1. Assess the functionality of the TWCs and CVs, and devise support and training accordingly.

2. Develop communication and sensitisation material about all aspects of the programme at community level, including reference material for TWCs and CVs about their roles and responsibilities.

3. Revise and distribute the implementation manual.

4. Consider the appropriateness of mobile phones for registration and payments, and explore alternatives.

5. Ensure a continuous supply and maintenance of technical equipment and replacement of faulty devices. Such devices include tablets, finger print scanners, mobile internet connectors and power banks.
6. Strengthen support to procurement.

7. Rationalise the various components of the BCC and monitor their quality.

8. Review and rationalise data collection and reporting.

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List of tables and figures

Abbreviations

AAH	Action Against Hunger (= Action Contre la Faim)
AOG	Action-Oriented Group
BCC	Behaviour Change Communication
BRG	Beneficiary Reference Group
CDGP	Child Development Grant Programme
CHEW	Community Health Extension Worker
CRM	Complaints Response Mechanism
CV	Community Volunteer
DFID	Department for International Development (UK)
HF	Health Facility
IM	Implementation Manual
IYCF	Infant and Young Child Feeding
KII	Key Informant Interview
LGA	Local Government Area
M&E	Monitoring and Evaluation
MIS	Management Information System
NGN	Nigerian Naira
NGO	Non-Governmental Organisation
OPM	Oxford Policy Management
PDM	Post-Distribution Survey
PE	Process Evaluation
RCT	Randomised Control Trial
RHW	Roving Health Worker
SIBTC	Stanbic Investment Banking and Trust Company
SC	Save the Children
SG	Support Group

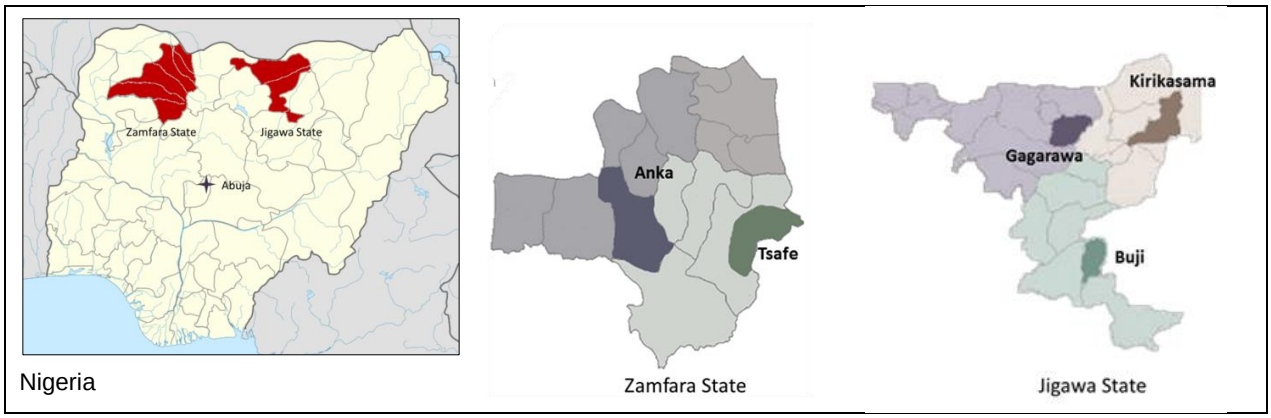
T1	Treatment 1 (= low-intensity BCC)
T2	Treatment 2 (= high-intensity BCC)
TA	Technical Assistance
TBA	Traditional Birth Attendant
TW	Traditional Ward
TWC	Traditional Ward Committee
WINNN	Working to Improve Nutrition in Northern Nigeria

1 Introduction

1.1 The CDGP

The CDGP is a five-year pilot programme (2013–2018) funded by the United Kingdom's 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 through a combination of unconditional cash transfers (aimed at tackling the economic causes of inadequate dietary intake) and a nutrition BCC component (aimed at influencing maternal and child-care practices). The CDGP is implemented by an international Non-Governmental Organisation (NGO) consortium led by SC in partnership with AAH in five LGAs: Anka and Tsafe in Zamfara state; and Buji, Gagarawa and Kiri Kasama in Jigawa state (see Figure 1).

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 programme provides an unconditional cash transfer of 3,500 Naira (about £12) per month for up to 70,000 women from the time they are pregnant until their child is two years old – a period of approximately 33 months, targeting the critical first 1,000 days of the child's life. This regular cash transfer is expected to contribute to increased food security and improved intake of more nutritious food, leading to improvement in child nutrition within households reached by the programme.

Alongside the cash transfer, communities in the programme will be provided with education and advice about nutrition and health through a BCC component. This campaign is intended to influence key areas of knowledge and practice, including breastfeeding and infant diets, and is designed to address men and influential members of the community as well as the women who are the direct beneficiaries of the cash transfer. The programme is testing two different designs of the BCC component:

1. **'Low-intensity'** BCC delivered through posters, radio messaging, text messaging and theatre/drama events.

2. **'High-intensity'** BCC delivered through SGs and one-to-one counselling for women receiving the transfer, in addition to all components of the 'low-intensity' BCC.

1.2 Evaluating the CDGP

The ePact consortium led by OPM was contracted by DFID to independently evaluate the CDGP. The evaluation is intended to help determine the impact of the programme on households and communities that are supported by it. The findings of the 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 leverage their support for taking over the programme and expanding it across their states or nationally. The evaluation comprises four components that draw on different methods and sources of data to gather evidence on the programme's operations and impact. These components are:

1. A qualitative **situation analysis**, which was carried out in September 2013 to provide a contextual understanding of poverty, hunger and the socio-cultural dynamics prevalent in the programme areas. This was carried out before the implementation of the programme and before the baseline survey and served to inform both.

2. A **quantitative impact evaluation**, employing a clustered Randomised Control Trial (RCT) design to determine the causal effect of the programme on key pre-defined impact and outcome indicators. The quantitative impact evaluation is based on a statistically representative household questionnaire survey carried out before and after the implementation of the programme. A baseline survey was carried out in August–October 2014; a follow-up survey will take place in August–October 2017.[1]

3. A **qualitative impact evaluation**, complementing the quantitative component by investigating the 'how' and 'why' questions, and providing explanations of people's attitudes and behaviour in relation to nutrition, health, food security and livelihoods, including whether and how these are changed by the CDGP. It aims to identify and explore any unexpected effects of the programme (whether positive or negative), and any unforeseen factors which may affect its success. The evaluation also helps explain the quantitative findings. The first round of the qualitative research was carried out in September and October of 2014 in seven communities across the five LGAs of the programme. The second round of the qualitative impact evaluation (and the first since implementation began) was conducted in February and March 2016.

4. A **Process evaluation**, which will investigate the programme's operations and assess successes and challenges related to the delivery of the programme as designed and implemented. The PE consists of two rounds of research: one carried out after a year of full implementation to inform implementation and programme learning (this evaluation); and another towards the end of the programme to establish the role of programme implementation on the observed outcomes of the programme (see next section).

1.3 Objectives of the PE

The rationale for the PE workstream is twofold. The first relates to the traditional role of PE in providing evidence on why the programme has succeeded as planned or not through an examination of the programme's operational mechanisms. The mapping of processes from inputs to outputs, essential to providing evidence on the programme's implementation and success, is a part of this exercise. This forms a core part of the PE workstream and is scheduled to be conducted closer to the end of the implementation period after the results of the impact evaluation

[1] The evaluation is currently in discussion with DFID to introduce a midline survey in August–October 2016 and to shift the follow-up survey to August–October 2018.

are available.[2] However, the PE workstream goes beyond this traditional role in that it takes on a 'developmental' or 'formative' approach by identifying barriers and facilitators to the implementation of the programme early in the implementation period, with the explicit intention of the findings being used by the CDGP to improve operations and ultimately enhance impact. This first in-depth PE study focuses on this second objective, and was conducted after more than a year of programme implementation in February 2016. The study aims to:

1. Establish how the programme has been designed and implemented in practice;
2. Assess the scope and coverage of implementation to date; and
3. Document key programme challenges and lessons learned.

1.4 Linkages with the qualitative impact evaluation

In parallel with the first PE study, ePact conducted the midline qualitative data collection for the CDGP impact evaluation during February 2016. As envisaged in the Inception Report (ePact 2014:50), the qualitative midline includes some questions and instruments which relate to the PE. Specifically, the qualitative team will explore, at community and individual beneficiary levels, how the CDGP is working in practice so far and how people are experiencing it. Questions about the implementation processes of the programme are included in case study interviews and focus group discussions. KIIs will also be conducted with CDGP CVs and members of the TWCs. The qualitative fieldwork will be conducted in seven communities, purposively sampled from CDGP recipient communities in all five LGAs (see the Qualitative Baseline Report, ePact 2015, for details of the communities and the sampling method). Coordinating the workstreams in this way avoids duplication and economises on resources, avoiding the need for the PE to mobilise community-level research teams.[3] Community-level analysis of processes will be written up as a separate section in the qualitative midline report (expected mid-2016) and will be synthesised in the second PE study towards the end of the programme.

1.5 Structure of this report

The remainder of this report is structured as follows:

- Section 2 describes the approach and methodology for carrying out this evaluation.
- Section 3 presents the main findings of the programme across the different key process domains: sensitisation and mobilisation; targeting, enrolment and registration; payments; BCC; CRM; programme monitoring; and other cross-cutting issues. Under each process domain the evaluation describes how it was designed, implemented in practice, and the main challenges and lessons learned through implementation.
- Section 4 concludes and provides a set of recommendations.

[2] Currently, the endline quantitative survey is planned for August–October 2017 with the results being available in February 2018. The endline PE is scheduled for March 2018.

[3] Note that because of the necessary transcription and analysis process, the findings of the qualitative (community-level) study will not be available in time to be incorporated in the report on the first PE study, but will be provided later.

The report is supplemented by a number of annexes. Annex A provides a list of people interviewed by the programme or who participated in the validation workshops at the state level. Annex B gives details and examples of the categories used in the CRM. Annex C summarises the monitoring matrix of the programme and sources of evidence for the programme logframe, Annex D lists the indicators captured by the monitoring data, and Annex E describes the organisation and staffing of the CDGP.

2 Evaluation design

2.1 Methodology

Central to meeting the aims of this PE are: i) the mapping of the implementation structures and stakeholders involved in the CDGP; ii) mapping of the core implementation processes of the programme as implemented; and iii) assessment of the status and coverage of implementation to date. The core process domains reviewed by the programme are: i) community sensitisation and mobilisation; ii) beneficiary identification, enrolment, registration and exit; iii) cash transfer payments; iv) BCC; v) CRM, and; vi) programme monitoring.

The evaluation draws on a number of data collection methods and tools to meet its intended aims, including:

- Review of programme documents and reports;
- Analysis of programme monitoring data;
- KIIs;
- Stakeholder workshops; and
- Field observation.

These are described in turn below.

Review of programme documents and reports

The evaluation reviewed all programme-related documents, including: design documents and IMs; Monthly, Quarterly and Annual Progress Reports; DFID's annual reviews; and other studies and assessments carried out by the programme and ePact.

Analysis of programme monitoring data

The evaluation analysed the data generated through the programme Management Information System (MIS) using STATA to capture the scope and coverage of implementation to date as well as to identify patterns or observations for further exploration and analysis. Preliminary analysis of key indicators was carried out before the PE data collection began to guide some topics of investigation.

KIIs

Primary data was collected through KIIs with staff from DFID, SC and AAH at several levels of implementation. In Abuja, the team spoke to CDGP staff from SC and AAH and similar interviews were carried out with state-level programme staff. Key informants were identified in consultation with CDGP. The aim was to interview all staff who were identified as primary functionaries of a process domain included in the evaluation. A full list of informants can be found in Annex A.

The interviews were guided by a set of questions (Table 1) to map the process domain under consideration in order to establish how the process domain had been implemented, how this deviated from the design, and to identify the main challenges and lessons learned.

Table 1 Key questions guiding KIIs

Questions
1. Where does the process start and where does it end? 2. What are the inputs and outputs of the process? 3. What are the individual steps involved in the process? 4. Who executes which step? 5. How long does it take? 6. Have there been any challenges with regards to this step? Could it be done differently or more efficiently? 7. How does the actual implementation compare to how things were meant to be done? Why?

Stakeholder workshops

The evaluation carried out two consultation workshops with LGA-level staff during data collection, and one validation workshop with central-level staff and state coordinators in Abuja following an initial analysis of the data.

The consultation workshops were held in each state capital – Gusau in Zamfara and Dutse in Jigawa – over two days, and involved programme staff from all five CDGP LGAs. These participatory workshops were conducted to investigate how the programme processes are being implemented at state and LGA levels, how these deviate from the implementation design, the challenges faced by programme staff, how they have dealt with these challenges, and lessons learned. From each LGA, at least one person from each of the following categories was invited to attend the workshops: LGA supervisors, payment assistants, data assistants, community mobilisation assistants, seconded government staff, Technical Working Committee members at LGA level and Stanbic staff. The participants from each state for these participatory workshops are listed in Annex A.

Following analysis of the data, the evaluation team validated initial findings with central-level programme staff and state coordinators to seek further explanations or clarifications for selected results. Lessons from this workshop were incorporated into this report.

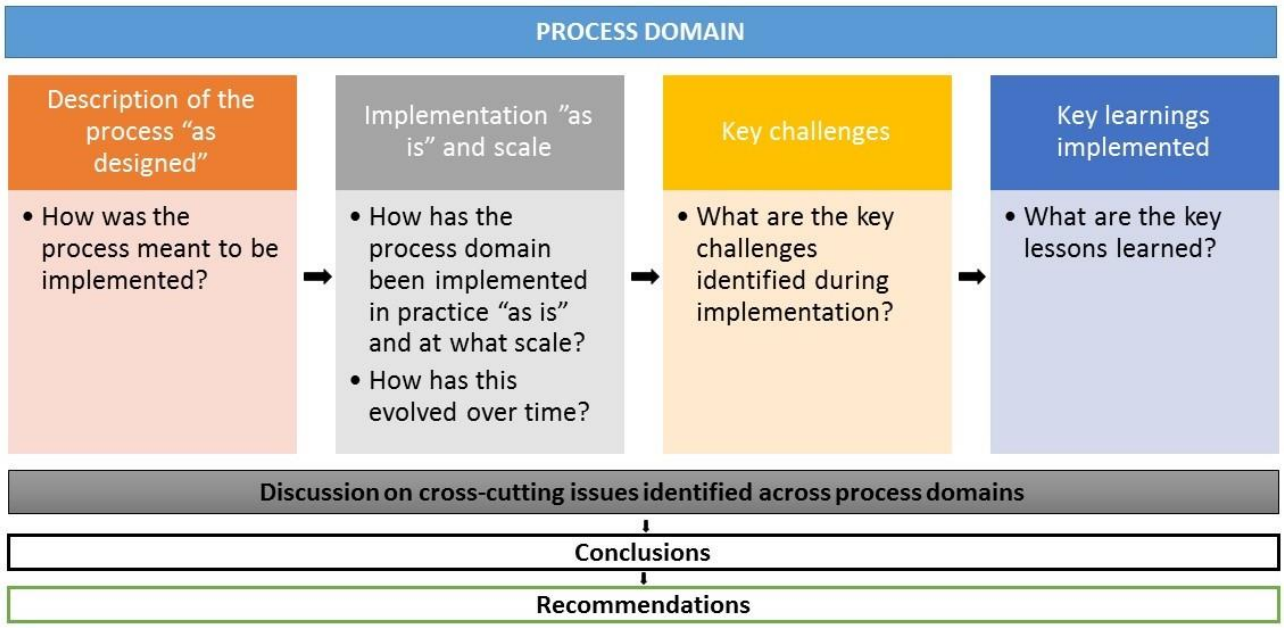
Field observation

The team visited one payment site in the community of Ahuto in Buji LGA (Jigawa state). The team observed the entire payment process from the beginning to the end and carried out some brief interviews with programme staff, payment agents, CVs and beneficiaries.

2.2 Analytical framework

To guide the evaluation and analysis of data gathered, an analytical framework was developed and applied to each of the six process domains mentioned above (section 2.1). The analytical framework is structured around understanding how the process domains were designed, implemented in practice and at what scale, and the key challenges and lessons learned for each of the domains (Figure 2). A review of each process domain is followed by analysis of emergent cross-cutting issues that together form the basis of the conclusions reached in this evaluation.

Figure 2 Analytical framework for the PE



2.3 Evaluation timeline

The PE was carried out between November 2015 and April 2016. The evaluation began with the design of the methodology and the development of a workplan in November 2015. A desk-based review of programme documents and collection of monitoring data was conducted in December 2015 and January 2016. Primary data collection took place in February 2016 with KIIs in Abuja and interviews and workshops at the state level. The data was analysed and written up in March 2016 and validated with programme level staff in early April. A draft report was produced in late April and the final report (this report) produced in May 2016 following incorporation of comments provided by CDGP and DFID (Table 2).

Table 2 Key timeline for the PE study

Date	Key activities conducted under the PE study
November 2015	Design of evaluation
December 2015–January 2016	Document review and data collection
01–5 February 2016	KIIs at central level – Abuja
08–16 February 2016	Visit to Zamfara and Jigawa states for KIIs and LGA-level participatory workshops
16–22 February 2016	Follow-up discussions with Central Team
05 April 2016	Second validation workshop with Central Team and state teams
19 April 2016	Draft Process Evaluation Report
04 May 2016	Comments from CDGP and DFID
23 May 2016	Final Process Evaluation Report

3 Findings

3.1 CDGP Timeline

The CDGP has been implemented in three phases over the course of the last three years from April 2013 to March 2016. These phases are described below and then graphed in a timeline in Figure 3.

1. **Inception phase (April–December 2013):** In this phase, much of the programme's staff were hired and technical elements of the cash transfer programme were designed. The procurement of the payment agent and mobile phone providers was also carried out in this phase. Engagement with federal, state and LGA governments was initiated and the five LGAs in which the programme would be implemented were selected. Halfway through the inception phase, ePact carried out a situation analysis that served to inform the design of the ePact baselines and the cash transfer programme itself.

2. **Initial implementation and pre-pilot phase (January 2014–October 2014):** The official implementation of the programme began in January 2014. The programme began some community mobilisation activities, finalised the design of some of its processes, and concluded contracts with service providers between January and April. A 'pre-pilot' was undertaken in each state to test all components of the cash transfer programme between April and July 2014. The payment portal database and some of the key M&E tools were in place to enable the programme to monitor progress during the pre-pilot and capture lessons before the programme was scaled up. During the pre-pilot, the programme registered 500 beneficiaries across 15 communities overall between April 2014 and July 2014. An external review was conducted at the end of the pre-pilot to learn lessons, refine the design and inform implementation during roll-out. Experience from the pre-pilot also determined that the most appropriate unit of intervention is the village as opposed to traditional ward because of a lack of clear boundaries between traditional wards.

3. **Roll-out phase (ongoing from August 2014):** The roll-phase began in August 2014 and intensified rapidly after the ePact quantitative and qualitative baseline surveys were completed in October 2014.

Figure 3 CDGP timeline

The remainder of this section uses the timeline presented above as a reference for the key stages in the implementation of the programme.

3.2 Sensitisation and mobilisation

Key findings

- The programme employs a community-based approach relying on TWCs established by the programme and CVs. The TWCs and CVs play a central role in the sensitisation and mobilisation of the communities; they also have other roles and responsibilities across the entire programme.
- The programme's initial target of entering 35 new TWs per month across the two states was ambitious and seldom achieved. Entry into communities and sensitisation have been more time-consuming than envisaged, with security, road access and communication presenting additional obstacles.
- Revisits to communities in which CDGP is already operating have been a challenge. In Zamfara, 71 TWs (about half of the total) were reportedly visited only once between October 2014 and 2015. In Jigawa revisits were more regular with about a third of TWs visited more than four times and only 20 (17%) visited only once. The limited frequency of revisits is likely to affect the level of understanding of the programme by TWCs and CVs and well as the wider community. CDGP have identified this as an important issue to address and plans to increase revisits are being incorporated into operational plans.
- The major challenge in this process domain has been the sheer scale of implementation in terms of the number of communities targeted, and consequently the human and logistical resources needed to reach them. The human resources needed to deliver all the activities at community level seem to have been badly underestimated at the beginning of the programme.
- Recruitment of CVs and the provision of adequate training to them have been difficult at times. The programme has taken stock of this with marked increases in training activities in both states in July/August and November/December 2015.
- CDGP has relied primarily on verbal training and has not provided the TWCs or CVs with sufficient guidance material around their roles and responsibilities across the entire programme that is tailored to their level of understanding and which they and trainers can draw on as reference material when in doubt.

3.2.1 Description of the process domain

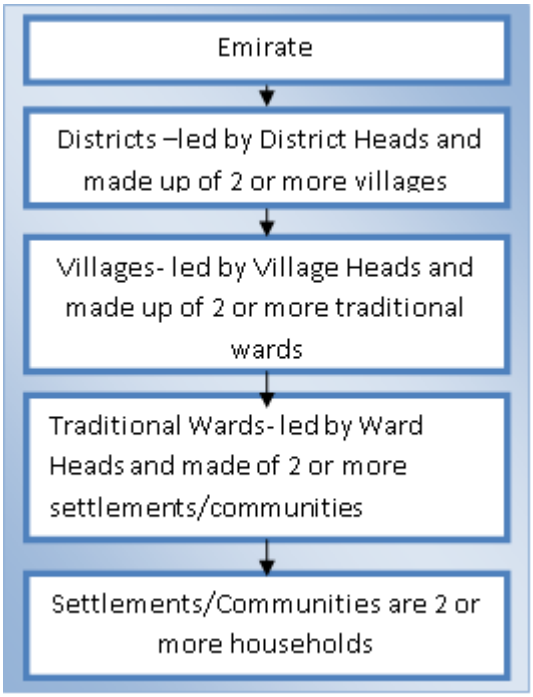
The CDGP model is largely community-based, relying heavily on the engagement and support of local leaders[4] and volunteers. The first essential stage of implementation on the ground is therefore the entry into a new community and establishing the necessary understanding, relationships and institutions. This involves communicating the purpose of the programme, its benefits, rules and processes ('sensitisation');[5] and persuading community leaders and members to

[4] By 'leaders' in this context we mean influential people at various levels of local society and governance, including, but not limited to, women and men in official or recognised positions of authority.

[5] 'Sensitisation' can be defined as a process of making people aware of **and responsive to** certain ideas, facts, events or advice. Successful sensitisation thus requires more than simply delivering information.

be active participants in the programme's activities and institutions ('mobilisation'). To do this, before arriving at the community itself, the CDGP needs to work through the hierarchy of administrative structures within each LGA, as shown in Figure 4.

Figure 4 Hierarchy of community structures within each LGA



Source: CDGP IM (2015) p.10

Traditional Ward Committees (TWCs) are established by the programme at the TW level, building on existing institutions to "complement local structures" [6] where possible. According to the Implementation Manual the TWCs should be chaired by the TW head and should include CVs, Traditional Birth Attendants (TBA), representatives of community-based organisations, officers-in-charge at the HF, community mobilisers and a security group.[7]

TWCs play several key roles in CDGP: identifying and supporting CVs; mobilising community members to take part in CDGP activities; verifying the residency of potential beneficiaries (see section 3.4); ensuring local security during payments and other CDGP activities in their ward; dealing with complaints (see section 3.6); and giving feedback on all these activities to the Village Head and the CDGP team. The TWC is intended to build on the existing community leadership and institutions: for example, disputes between husbands and wives would normally be brought to the TW head (*maiunguwa*) and his council members for resolution. The CDGP responsibilities are therefore an extension of their established role, requiring only the addition of some specialist members (particularly CVs, TBAs, and HF staff).

The recruitment of CVs is another critically important task under the process domain of community entry, sensitisation and mobilisation. The CVs are defined as 'member[s] of the community willing

[6] CDGP (2015), Implementation Manual, September, p.30.

[7] Ibid. Note that the Process Evaluation did not visit communities and was not able to verify the actual composition or functioning of the community-level institutions.

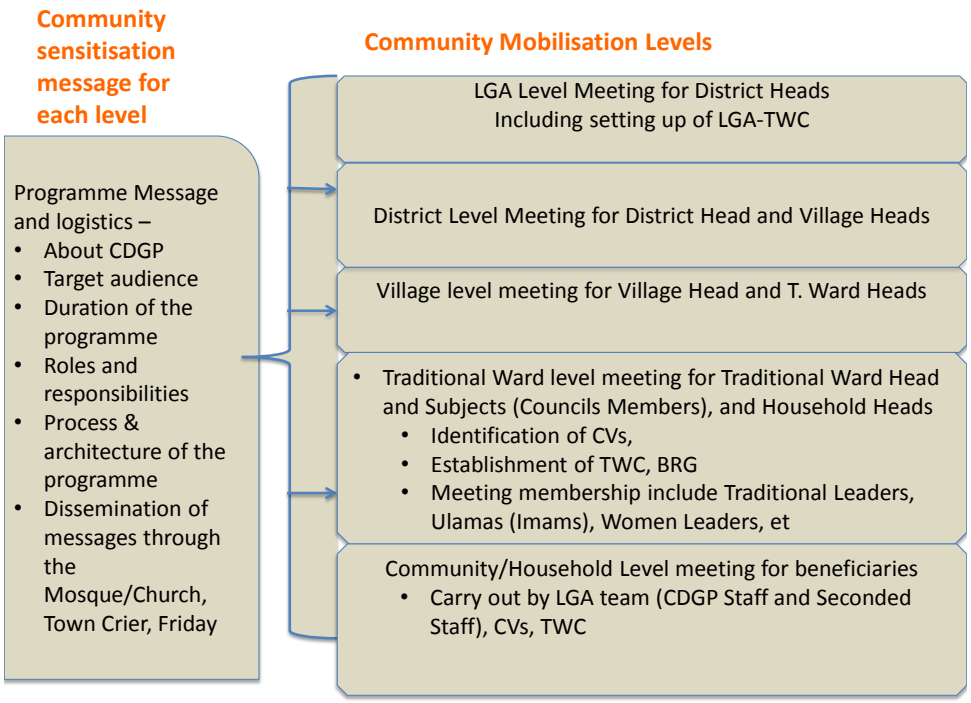
and able to work and support in activities or programmes for the community's benefit without being remunerated'.[8] The TWC is responsible for identifying suitable volunteers from their community, following the criteria given by CDGP, with at least three selected per TW.[9] The CVs play an important and elaborate role in all the key processes of the programme at the community level.[10]

3.2.2 Implementation

Community mobilisation

Figure 5 shows the sequence of meetings organised to engage the support of leaders at each level from the LGA to the community. The participants in these meetings overlap as follows. All the District Heads attend the first meeting at the LGA. Each District Head then leads a meeting in his own District, which is attended by the Village Heads. Each Village Head then convenes a meeting in his village, attended by all the Traditional Ward Heads; and each of them then leads a TW meeting attended by council members and some household heads. The final phase of meetings, at community (settlement) level, is open to all community members and is also attended by TWC members. This 'cascade' approach facilitates the communication of messages, helping to ensure that the information relayed from one meeting to the next is accurate, and reinforces the perception that leaders at each level have the backing of higher authorities to promote the CDGP.

Figure 5 'Cascade' sequence of meetings for community entry



Source: PE Workshop in Jigawa, February 2016

The meetings at TW and community level are thus a key part of the entry, sensitisation and mobilisation processes. These can be time-consuming, and may be held in stages (including visits to the same person on several days, or separate meetings for different groups) rather than as a

[8] Ibid. (p.10).

[9] Ibid. (p.11).

[10] See Annex A of IM for a full list.

single event. Table 3 sets out the estimated time needed for the entry process in each community, as presented by LGA team members in the Jigawa PE Workshop. They emphasised the importance of spending time on advocacy to ensure the support of local authority figures and opinion leaders (step 4 in the table), which is considered essential to CDGP's success. This step requires about four days, while the next phase of mass meetings with community members may take a further three days, making a total of around one week of the team's time in each community.

Table 3 Time needed for entry into one new community

Activity		Responsibility	Time needed
1	Notification (by meetings and letter)	LGA Supervisor	1 day
2	Community entry (arrival of team)	All LGA team	1 day
3	Introduction	All LGA team	1 hour
4	Advocacy with: • Traditional leaders *(bulama)* • *Ulamas* (religious leaders/imams) • Minorities • Women leaders	All LGA team	• 2 days • 2 days • 1 day • 1 day 4 days
5	Sensitisation of the community	All LGA team	3 days
6	Revisit – could be next day, or after a week or a month	All LGA team	1 day

Source: PE Workshop in Jigawa, February 2016

Added to this, the travel time necessary for the team to arrive in the community (step 2 in Table 3) needs to be taken into account. This varies considerably: logistical access is much more difficult for some CDGP communities than others, in terms of distance from the state and LGA capitals, transport infrastructure (poor roads, including some that are impassable during the rainy season), and security. Security problems are a particular challenge in parts of Zamfara: three communities in Anka and one in Tsafe were described by workshop participants as 'no-go areas' which the CDGP has not yet been able to enter.

A community mobilisation narrative report is supposed to be filled in for each community. However, the PE team was not able to access any of these reports and it is unclear what use is made of them for monitoring or management.

Other important dimensions of community sensitisation and mobilisation relate to the effective formation of TWCs and the mobilisation of CVs, and appropriate sensitisation and training. Because this PE study did not extend to the community level, we were unable to assess how far the actual establishment and operation of the TWCs follows the design set out in the IM. The Rapid Scoping Study conducted in December 2014 observed that some TWCs did not know the purpose of the cash transfer programme or other components such as BCC or CRM.[11] While the programme has evolved since then and further developed these components, the fact that revisits to communities have been limited suggests that quality issues may persist and merit further investigation.

The CDGP has not provided the TWCs or CVs, or the trainers responsible for sensitising them, with sufficient written guidance material around their roles and responsibilities across the entire programme that is tailored to their level of understanding and which they can draw on as reference material when in doubt. Much of the messaging around communication and sensitisation has been

[11] ePact (2015a), Rapid Scoping Study Report, January.

cascaded down orally with no reference documents. Moreover the current IM does not provide any instructions on how the programme should be communicated to the communities.

Coverage and performance

Given the tasks and activities involved in community entry, as described above, the scale of implementation achieved in this domain is noteworthy. Figure 6 shows the number of new TWs entered each month, in each state, since January 2014. The shape of the graph reflects the huge effort by both state teams to roll out the programme to the targeted number of communities in the second half of 2014, and continuing through 2015. In principle, the target was 35 TWs per month (across both states), but this has proven to be unrealistic to maintain in practice.

Figure 6 Monthly number of new TWs entered, by state

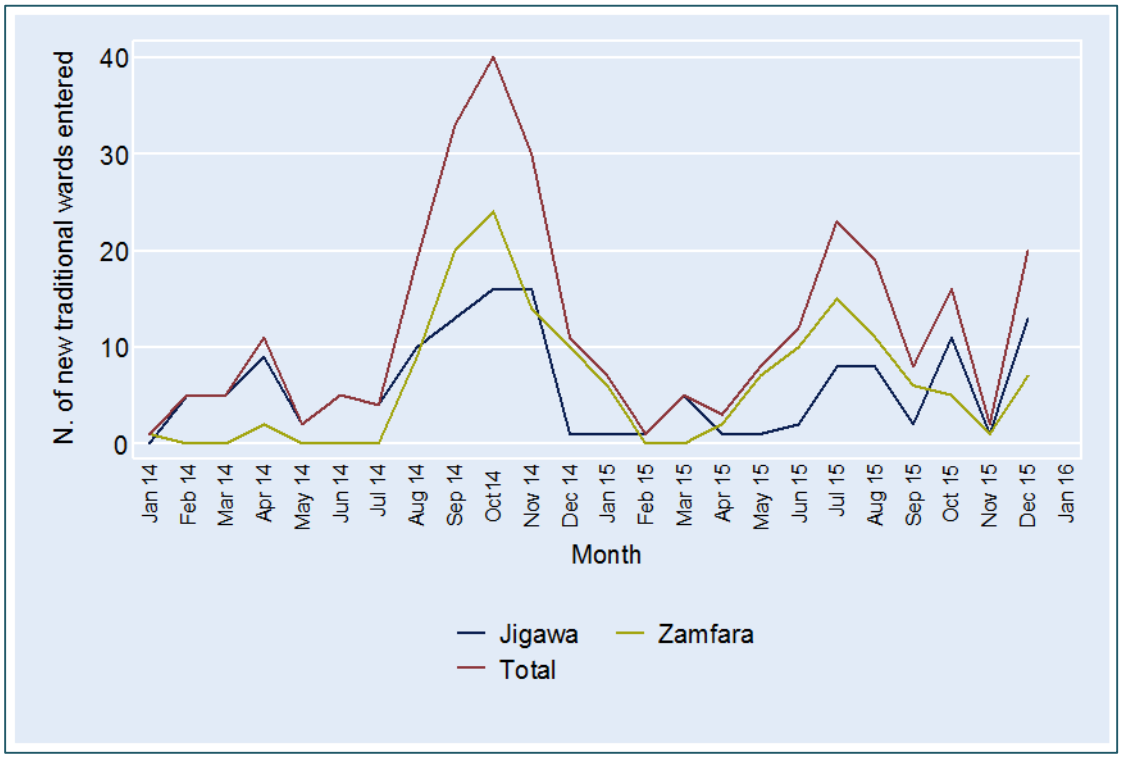


Figure 7 and Figure 8 give a cumulative view of the same data, broken down by treatment group (Treatment 1 (T1), T2 and Pilot).[12] In Figure 7, the broken red line shows the target number of 71 T1 and T2 communities for the impact evaluation (RCT).[13] If these data are complete, they show that Jigawa is covering fewer T2 communities, but was still entering new TWs in pilot villages in the latter part of 2015. In comparing the two states, it should be noted that the Jigawa team is working

[12] T1 and T2 relate to the intensity of BCC interventions (see section 3.5). T1 communities receive mass communication, voice messages and action-oriented group discussion and demonstrations. In T2 communities the programme provides IYCF support groups and one-to-one counselling in addition to T2 activities. The pilot group refers to the initial communities covered during the pre-pilot phase. The programme provides T1 and T2 interventions based on randomised allocations made by the programme evaluation. Since the randomisation is done at the village level for ease of operation the programme provides the same type of BCC support to all TWs covered, irrespective of whether they are an evaluation TW or not.

[13] For both states combined.

in three LGAs, not two – as in Zamfara – and that these three LGAs have lower population densities than those in Zamfara: it is possible that this has had an impact on the selection of communities for enrolment in order to reach their target number of beneficiaries.

Figure 7 Cumulative number of TWs entered, by state, month and treatment

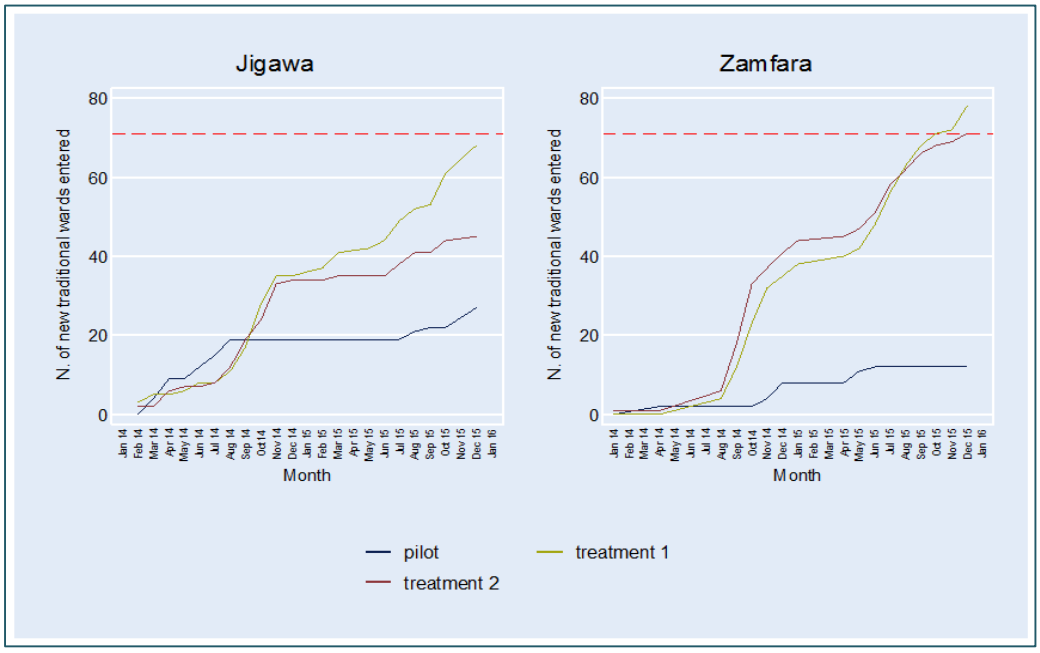
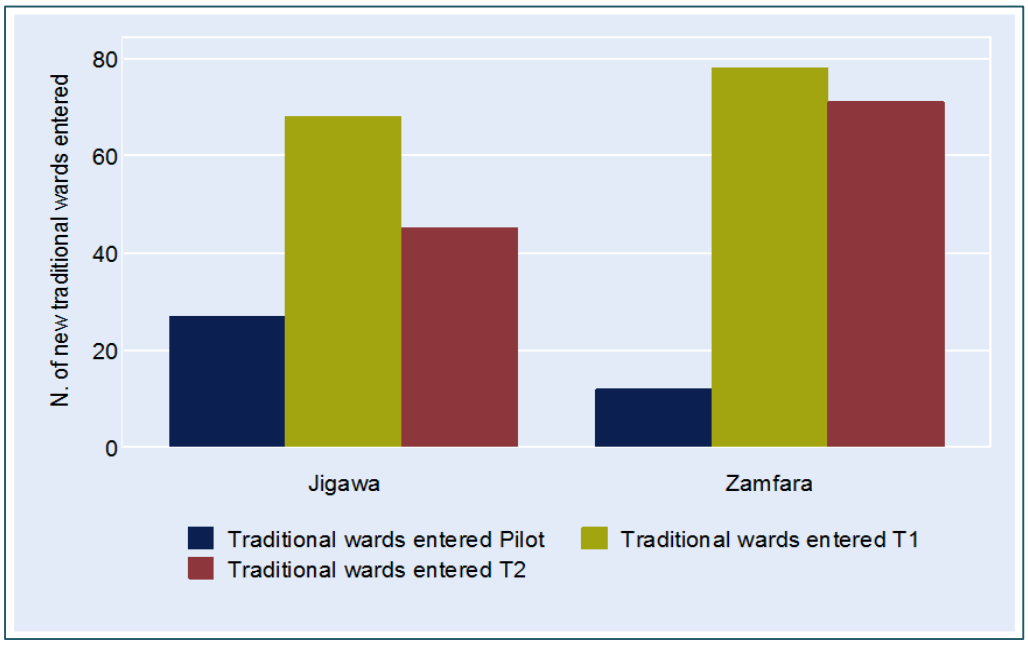


Figure 8 Total number of TWs entered since January 2014, by treatment



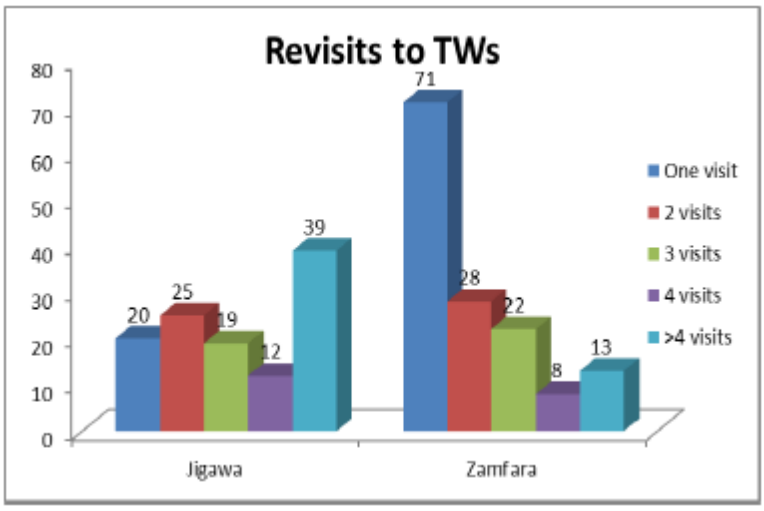
While the initial entry to a community is important, further visits by the CDGP team are obviously necessary to reinforce messages, support the CVs and TWCs, enrol and register beneficiaries as

they become pregnant (see section 3.3), deliver and supervise BCC activities (see section 3.5), and monitor the implementation of the programme (see section 3.7). Sensitisation and mobilisation activities do not stop once the CDGP is established in a community: continuing dialogue and interaction are needed to ensure effective communications about the programme (including any changes or problems arising), and to motivate volunteers and other community members to continue their active support. This requires regular meetings and occasional field visits by the CDGP LGA teams.

In Zamfara, for example, the team hold bi-monthly meetings with both the LGA Technical Working Committee and the TWCs, and a monthly feedback meeting with CVs and CHEWs. Participants in the Zamfara workshop emphasised that community sensitisation is a continuous process, and included the BCC activities – food demonstrations, health talks, IYCF SGs and 1-to-1 counselling – under this heading. In both states, additional 'sensitisation' visits or meetings are held as needed, for example if there is a dispute or a report of fraud in a particular community, or a change in CDGP rules. In both states, the government seconded staff (known as 'field assistants' in Jigawa and 'community assistants' in Zamfara) play a major role in communications between the programme and communities.

The first revisit to a community (step 6 in Table 3) may take place very quickly after the first entry in accessible areas: according to the workshop participants, some communities can be revisited the day after the first community-wide sensitisation. However, in the monitoring system 'a community is considered revisited if the next visit occurs in a different reporting week from the first visit'.[14] Using this definition, Figure 9 shows the number of revisits made to TWs in both states between October 2014[15] and October 2015. In Zamfara, 71 TWs (about half of the total) were visited only once. Jigawa seems to have achieved a better rate of revisits over the same period, with about a third of TWs visited more than four times and only 20 (17%) visited only once.

Figure 9 Revisits to TWs, October 2014–October 2015



Source: CDGP (2015), Progress Report, October.

The scale of implementation achieved in the area of CV recruitment is shown in Figure 10 and Figure 11. Note that these figures show the total number of CVs recruited and trained: the

[14] CDGP (2015), Progress Report, October.

[15] I.e. since the CDGP started using the monitoring dashboard (see Section 3.7).

identification of volunteers during the community entry process is only the first step. On the other hand, not all the CVs trained are currently active: these figures therefore give an incomplete picture of the CDGP volunteer workforce. The PE was unable to make any direct assessment of the quality, frequency (for each CV), content or effectiveness of the training. However, key informant discussions generally give the impression that the programme has found it difficult to provide enough training for the number of CVs needed. Efforts were made during 2015 to increase training for CVs, particularly in IYCF activities. The monitoring data graphed in Figure 10 is not disaggregated by type of training, but does show marked increases in training activities in both states in July/August and November/December 2015.

Figure 10 Monthly number of CVs trained, by state

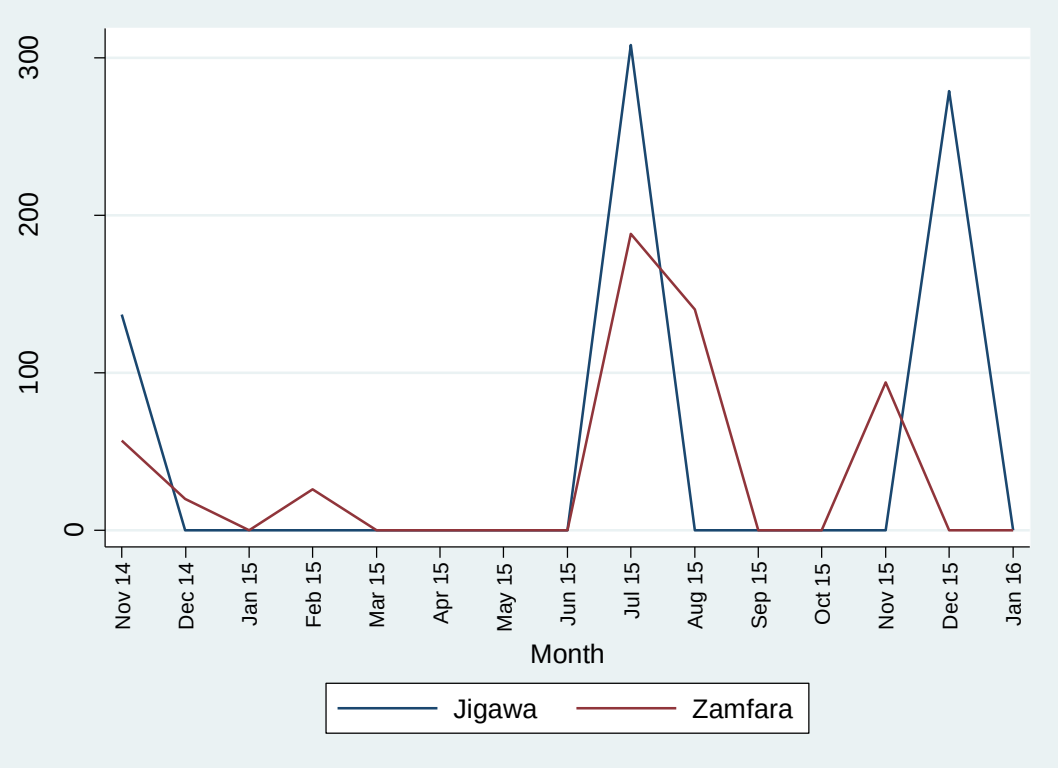
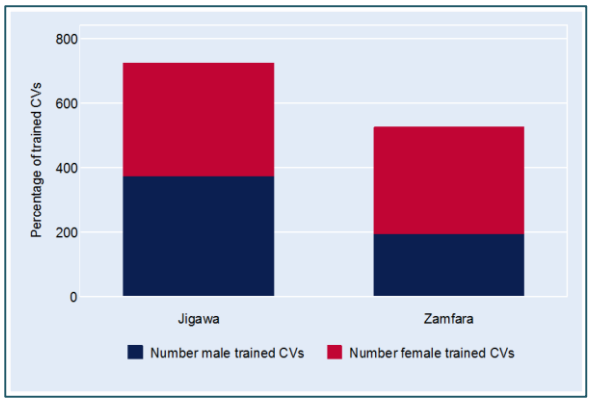


Figure 11 shows the total number of male and female CVs trained in each state since November 2014.[16] This shows that the number of female CVs is roughly the same in both states, but Zamfara has fewer male CVs (giving a lower overall total). Key informants noted that male CVs are generally more likely to be literate, and therefore more likely to be active in areas of the programme that require form-filling or the reading of materials. It is essential to have both female and male volunteers in each community, because of the general social segregation of the genders: male CVs work with beneficiaries' husbands, male IYCF SGs and BRGs, while female CVs work with women beneficiaries and groups.

[16] Monitoring data are not available for the period before that date.

Figure 11 Total number of CVs trained since November 2014, by state and gender



3.2.3 Challenges and lessons learned

The major challenge in this process domain has been the sheer scale of implementation in terms of the number of communities targeted, and consequently the human and logistical resources needed to reach them. The push to enter so many new TWs in years 2 and 3 has led to compromises in terms of full implementation and the quality of delivery, especially in the BCC activities (discussed in section 3.5). The human resources needed to deliver all the activities at community level seem to have been underestimated at the beginning of the programme.

Scale of implementation and roll-out

The target number of TWs to be reached was originally based on the target number of beneficiaries set in the business case, which estimated that about half the eligible population of the targeted LGAs would be reached by the programme,[17] and the annual targets set out in the programme's logical framework. However, early in the implementation the number of TWs to be covered and therefore the scale of the roll-out plan was greatly increased when it was decided that the village, rather than the TW, would be the unit of intervention (and therefore the unit of randomisation for the impact evaluation). This decision came about primarily because of concerns related to operational and political feasibility: defining the intervention areas by TWs, which have fairly indistinct boundaries, would have meant that some neighbours within a village would be in the programme and some would not. Politically and operationally, this was not considered feasible. A further factor was that the programme and therefore the evaluation was designed to test the difference in impact between two models of BCC (see section 3.5). Keeping the two approaches distinct and separate in different TWs within the same village would not have been possible. For the evaluation, therefore, villages were randomly assigned to one of the two treatment arms or to the control group. Within each village, one TW was randomly sampled for the evaluation survey.

This decision to use the village as the unit of implementation and randomisation meant that the programme was required to operate in 155 villages rather than 155 TWs as had been expected. The increased geographical spread had implications for the logistical demands of the roll-out (such as travel time and communications). The CGP and e-pact team had reviewed the operational feasibility of the new proposed approach and deemed it feasible, however in hindsight the programme had not fully grasped the implication of this change. Added to this, the key factor which greatly expanded the scale of the roll-out plan was the decision to aim for saturation of the villages (i.e. to enrol all TWs within each treatment village). This was not a requirement of the evaluation,

[17] DFID (2012), Child Development Grant Programme Business Case, August.

but was a commitment made to government and local leaders who did not want to see part-implementation within villages.

The commitment to saturate villages has been reconsidered during the recalibration discussions that started from mid-2015. As stated in the note on the recalibration scenarios, CDGP was "reluctant to relax this requirement as we had committed this to local leaders and communities. However, we felt that it was necessary to ensure an impactful and quality programme." (CDGP 2016, Revised Recalibration Scenarios, p.1).

Elaborate community involvement but limited communication and sensitisation material

The programme is heavily reliant on the TWCs and CVs in the implementation of the programme. However, during the initial sensitisation of the programme much information was communicated verbally with few guidance materials developed and tailored to the level of TWs and communities. The IM does not provide instructions on how the programme should be communicated to the community members. Moreover, the programme has not provided any guiding documents that articulate the responsibilities of the TWCs and CV across the entire programme which is tailored to their level of understanding and which they can draw on as reference material when in doubt. The current IM does not provide any instructions on how this should be done, leaving all the messaging around communication and sensitisation to be cascaded down orally with no reference documents.

CDGP and WINNN have commissioned a study on CV engagement and motivation, which should shed light on a number of issues including the effectiveness of the current sensitisation strategy. Incentives for CVs are another key issue which this study is expected to investigate. Unfortunately the report has been delayed and was therefore not available to the evaluation team.

Revisits to communities have been a challenge

There is a general consensus among key informants that revisits to communities have in many cases not been made soon enough or frequently enough, particularly during the main roll-out phase in 2014–15 when the high targets for community entry and beneficiary registration meant that there were not enough personnel and resources (let alone days in the month) to make regular revisits to communities already in the programme. This challenge was flagged in the review of the pre-pilot phase (see Tibbo and Umar 2014:11), where it was noted that using the same team members for the whole range of activities at community level (sensitisation, enrolment and registration, and monitoring and supervision) would slow the pace of implementation. The need to increase the frequency of revisits is also highlighted in the recalibration scenarios under discussion with DFID for Year 4 (see CDGP 2016), showing that this remains a challenge but one that the CDGP is well aware of and is preparing to address. All three recalibration scenarios suggest reducing the roll-out target for new TWs from the current (unachieved) level of 35 per month to 25 or preferably 15 per month, in order to allow more resources to be focused on full implementation, including continuous enrolment of newly pregnant women, BCC and monitoring, evaluation and learning activities. The findings of this evaluation support the CDGP proposal to reduce the rate of community entries in order to enhance the quality of programme implementation.

Some non-beneficiary communities were sensitised by the programme and non-saturation within villages is problematic

Some of the initial sensitisation and mobilisation activities included districts and villages which have not in fact become beneficiaries of the CDGP. This is partly because advocacy activities started during the inception and pre-pilot phases, before the ePact randomisation of treatment and control groups: at that time, it was not known which areas would fall into the control category.

There is, as a result, pressure from communities that were informed about the programme but then not included.

Another source of tension within communities comes from TWs within a village where the CDGP is operating but where enrolment has not yet begun. The level of randomisation for the programme and its evaluation is the village level, which is composed of a number of TWs. The CDGP planned its roll-out on a TW-by-TW basis, focusing initial implementation on TWs that were sampled for the evaluation. CDGP's plan was to first roll-out to all TWs that were sampled by the evaluation and then return to villages to 'saturate' them and expand the programme to the remaining TWs within the village. Field staff in the PE workshops have said that they find this situation very difficult, as they frequently have to travel through non-beneficiary areas to reach the communities where they are working, and are constantly asked why the programme has not yet come to a certain community and when the programme will be coming. It is difficult to make any helpful recommendation about the current situation except to continue advocacy for government adoption of the programme, so that eventually all TWs can be included.

Security is a challenge in some areas

Insecurity has made community entry difficult or impossible in parts of Zamfara. The problems in this area are due to banditry and inter-community violence, particularly armed cattle raids. As mentioned above, three targeted communities in Anka and one in Tsafe have not yet been entered because of insecurity.

Access and communications pose additional challenges to the programme

Although constant vigilance is needed regarding the security situation, it seems that more widespread challenges to community entry and continued sensitisation are the difficult travel conditions and the poor communication network (particularly mobile phone and internet access), which add to the isolation of many CDGP communities. Some communities are inaccessible during the rainy season: in these cases, activities need to be planned to target those areas during the dry months. Delays to community visits in the early stages of implementation have been partly addressed by providing motorbikes to field staff.

Poor network coverage for mobile phones is a barrier to communication with the TWCs and CVs, and also limits beneficiaries' access to payment notifications (see section 3.4) and the complaints hotline (see section 3.6). Even where there is network coverage, CVs apparently complain that they do not have phones. If this problem could be addressed, it might improve communications with the communities and reduce the need for in-person visits from the overstretched LGA teams.

Misconceptions and poor retention of messages

Among the challenges listed for this process domain in the workshops were that people who had already been 'sensitised' often did not remember, or could not repeat, the messages and information at the next visit. This observation underlines the need for continuous sensitisation and mobilisation, and for more frequent revisits and communication. In some places CDGP teams have been met with suspicion, and some misconceptions or unhelpful beliefs have made it difficult to convince people of the programme's motives in handing out cash, and the benefits of its BCC messages. As noted above, producing reference materials for community members may be more helpful than relying solely on verbal communication. However, it was noted that the initial entry into

a new community is much easier now than at the beginning of the programme, because everyone has now heard about CDGP.

3.3 Targeting, enrolment and registration

Key findings

- Within TWs, all pregnant women who are residents of the community are eligible for CDGP benefits and can register at any stage of pregnancy, and are entitled to benefits until the child reaches the age of two. In practice, beneficiaries receive the cash transfer from the time they are registered, thus reducing total benefits received if any of the steps leading to registration is delayed.

- There are five steps to registration: identification of beneficiaries, residency verification, confirmation of pregnancy, enrolment (offline registration), and registration onto the payment system (online registration). While enrolment and registration can take place on the same day, staff, phones and appropriately functioning tablets are not always available resulting in the final step of registration taking place a week or even a month later, as has been the case in some areas.

- Establishing a practical system for pregnancy testing has posed challenges for the CDGP. The scarcity of reliable health facilities has resulted in the responsibility for pregnancy testing being shifted to the CHEWs, CVs and seconded staff working in the communities. Women can be extremely resourceful in finding ways to falsify the test, including buying or borrowing urine and unpaid CVs and underpaid CHEWs or health staff are sometimes tempted to falsify pregnancy test results for their own gain. Random pregnancy testing at payment points, and using supervised 'instant urine' tests have been some of the responses to these challenges.

- The registration process was slow during the initial roll-out of the programme due to malfunctioning registration devices, delays in the procurement of additional devices and national and state elections in March. Registration was scaled up after April 2015 but delays in the procurement of phones delayed registration in October and November 2015 once again.

- No beneficiary had yet graduated from the programme as of February 2016, but the total number of premature exits between November 2014 and December 2015 was 1,999.

- The programme is yet to track the dates of birth of babies born, thus it does not yet allow for exit dates to be known. This is expected to be tracked once the programme MIS fully functional.

- The mobile phones have caused severe delays to registration with few tangible benefits.

3.3.1 Description of the process domain

The domain described in this section includes all the processes relating to beneficiary-level targeting: that is, how the programme ensures that its benefits reach the intended target group. This domain includes the processes by which individuals enter and exit from the programme, as well as processes for continuously updating the beneficiary register and minimising targeting errors (e.g. by detecting and deterring fraudulent registrations).

By design, the CDGP is geographically targeted at the five selected LGAs through a consultation process with the state governments, taking account of factors including malnutrition rates, security

and under-coverage by other programmes or services (see IM, p.7). As noted above, the randomisation of treatment and control villages for the impact evaluation has added a further level of *de facto* (random) geographical targeting.

Within targeted TWs, all pregnant women who are residents of the community are eligible for CDGP benefits. The programme registers individual women, not households: within a large household (e.g. a polygamous or extended-family household) any number of women can be beneficiaries if they meet the eligibility criteria. A woman can register with the CDGP at any stage of her pregnancy, and she is then entitled to benefits until her child's second birthday (unless she leaves the programme). In practice, beneficiaries receive the cash transfer from the time they are registered. Any delay in the registration process therefore shortens the period of eligibility and thus reduces the total benefits received.

Entering the programme

Once the CDGP team has sensitised and mobilised a community, the process of targeting, enrolling and registering beneficiaries into the programme follows. There are five main steps in this process, as shown in Figure 12 and described below.

Figure 12 Five main steps in targeting, enrolment and registration of beneficiaries

Step 1: Identification of beneficiaries

CVs have the lead responsibility for identifying potential beneficiaries (i.e. pregnant women) within their communities. A CV may approach a woman and invite her to apply for the CDGP, or the woman herself (or her husband) may approach the CV or TWC to request registration.[18] The CV then presents the names of new applicants to the TWC for verification of residency (Step 2).

Step 2: Residency verification

The TWC (or in practice, the ward head who chairs the TWC)[19] is responsible for verifying that the applicant meets the residency criterion. Each applicant is then given a signed residency verification slip which she takes to the HF or community centre for confirmation of pregnancy (Step 3). The TWC is expected to keep a register of residency verifications.

[18] Interestingly, many of the Category 2 calls received by the CRM hotline (see Section 3.5) are from people asking how they or their wives can be registered.

[19] The review of the pre-pilot noted that this step gives individual local leaders considerable power over who is (or is not) enrolled. In practice, it may be difficult for TWC members to challenge the leader's decisions (Tibbo and Umar 2014:27).

Step 3: Confirmation of pregnancy

Pregnancy testing is done either by clinical staff at a HF ('Plan A'), or within the community by a specially-trained CV, CHEW or Roving Health Worker (RHW) ('Plan B'). Once her pregnancy has been confirmed, the applicant is given a pregnancy outcome slip and can continue to Step 4 (enrolment). A pregnancy outcome register of all women tested should be maintained by the HF or the CV/CHEW responsible for pregnancy testing.

Step 4: Enrolment – offline registration

Having proved that she meets both eligibility criteria (residence and pregnancy), the applicant is officially enrolled as a beneficiary. Enrolment is a paper-based registration process, described in Zamfara as the responsibility of CDGP or seconded staff, and in Jigawa as the responsibility of field assistants (seconded staff), supported by the CVs. The enrolment register for each TW is kept by the CDGP at LGA level,[20] and includes basic information such as the beneficiary's name, stage of pregnancy (self-reported), and next-of-kin.

Step 5: Registration – online registration

The final step is registration of enrolled beneficiaries into the electronic database for the payment system. At this stage, new beneficiaries are given a mobile phone, a SIM card, and a 100 Naira recharge card which is needed to activate the SIM. At this time, they should also be provided with training in the use of the phone.[21]

A photograph and electronic (scanned) thumb print are taken from the beneficiary herself, and from her designated proxy or next-of-kin, who is authorised to collect cash on her behalf if she is not able to go to the payment point. In practice, the next-of-kin is almost always the beneficiary's husband.

The CDGP staff (or seconded staff) enter all these details into the database using an Android tablet: the beneficiary's name, residence, photographs and thumb prints for herself and her proxy, and the mobile phone number (which then becomes the beneficiary's unique identifier for the cash payment system). Once this step is complete and the new data has been synchronised with the payment portal, the beneficiary can collect her cash transfer starting from the next month's payment round.

Targeting, enrolment and registration of beneficiaries as they become pregnant is intended to be a continuous rolling process from the time the CDGP enters a community until the end of the pilot programme. This requires regular revisits to communities (see section 3.2).

Exiting the programme

'Graduation'

Since the CDGP is targeted at women from the time they become pregnant until their child is two years old, each beneficiary should automatically leave the programme (or 'graduate') on her child's second birthday. Evidently this requires the CDGP to know the date when each registered beneficiary gave birth, as stated in all three versions of the IM: 'birth registration will be required to allow the MIS to track children and exit them on their 2nd birthday' (IM Draft 1, July 2014).

[20] The original plan was for the TWC to maintain the enrolment register, but during implementation it was found to be more practical and reliable to keep it at the CDGP office.

[21] In practice, according to key informants, beneficiaries do not always receive adequate training on the use of the phone. Many of the women will not have used a phone before.

'Premature' exits

A beneficiary can exit from the programme prematurely (i.e. before her child turns two years old) if she loses the child, leaves the community, or is found to have been wrongly or fraudulently registered. The criteria for premature exit, along with the current rules on the beneficiary's right to cash transfers and to later re-enrolment, are set out in Table 4. The entitlement to cash transfers after premature exit due to miscarriage, stillbirth or child death has been reduced from three months to one month since the most recent (September 2015) revision of the Implementation Manual.

Table 4 Criteria for premature exit from CDGP

Reason for exit	Further information	Implications for cash benefits	Re-enrolment allowed?
Miscarriage	Woman exits the programme immediately.	Receives cash benefit for one month after exit.	Yes
Still birth	Woman exits the programme immediately.	Receives cash benefit for one month after exit.	Yes
Death of beneficiary child	Woman exits the programme immediately.	Receives cash benefit for one month after exit.	No
Death of beneficiary mother		Child continues to receive support until his/her second birthday through a female caregiver in the community, provided he/she remains in the community.	N/A
Relocation	If the beneficiary relocates to a non-treatment community, then she exits the programme immediately.	If the beneficiary relocates to another treatment community, then she continues to receive cash support.	N/A
Fraud cases	Includes false pregnancies (e.g. borrowing urine during pregnancy testing), unreported miscarriages, women registered in two communities, women who have migrated to a non-treatment community but continue to benefit, and registration of non-residents. Woman exits the programme immediately.	No cash benefits after exit.	No

Source: CDGP IM (3rd Draft, revised September 2015) and PE KIIs

Beneficiaries are expected to come forward themselves and report to their CV if they are no longer eligible for any of the reasons in Table 4. Failing this, the CVs are responsible for identifying women who have suffered a miscarriage, stillbirth or infant death, and for informing the TWC. The TWC will also identify or verify cases where women have left the community, or have been wrongly

registered. A list of exit cases from each community is provided by the lead CV to the CDGP's LGA team during their monthly meeting. CDGP staff and seconded field assistants may also collect 'exit lists', and investigate any disputed or unconfirmed cases, whenever they are present in the community for payment rounds or other activities. Once confirmed, the list of exit cases is compiled and verified by the LGA Data Assistant, and sent to the state M&E manager by the fifth of each month. The M&E manager checks the list for data consistency and then forwards it to the national Payment Manager, who de-activates the exited beneficiaries on the payment portal so that they are not included in the next payment round (see section 3.4 on the payment system).

3.3.2 Implementation

Enrolment and registration

The implementation of enrolment, registrations and exits has followed the processes as designed but with some deviations or modifications as challenges have arisen. Some of the processes of implementation have been developed in greater detail during implementation, especially around programme exits. Some of the main deviations are listed below.

Confirmation of pregnancy

As noted earlier pregnancy testing is done either by clinical staff at a health facility ('Plan A'), or within the community by a specially-trained CV, CHEW or RHW ('Plan B'). Both approaches were tested during the pre-pilot phase, using health facilities in Jigawa and community-based testing in Zamfara. Testing at health facilities is preferred, but it was recognised early in the inception phase that this would not be possible in many places, especially in Zamfara, because of the poor coverage and staffing of health facilities. While Jigawa has better coverage of health facilities in general, many CDGP communities do not have access to functioning health facilities. RHWs have been recruited from among the CHEWs in Jigawa to conduct and support community-based pregnancy testing where needed.

Initially (during the pre-pilot), applicants were asked to bring a sample of early-morning urine for testing, but it was found that this introduced an unacceptable level of fraud because many non-pregnant women were borrowing or buying urine from pregnant neighbours in order to register for the cash transfer. Consequently, the method now implemented is on-the-spot testing ('instant urine' in the phrase used by LGA team members): this means the women have to produce a urine sample in the presence of a female CV, CHEW, seconded field assistant or CDGP staff member. This raises obvious challenges in terms of privacy as well as the availability and training of appropriate female staff. In addition, the test results are likely to be less accurate (early-morning urine gives a more reliable reading because it is more concentrated). In spite of these drawbacks, the 'instant urine' approach seems to be a pragmatic compromise which, according to key informants, is working well enough.

Exiting the programme

At the design stage it was hoped that registration of births by the CDGP could be supported by the National Population Commission and linked to the provision of official birth certificates. Unfortunately, this has not been possible, and tracking delivery dates has proven to be very challenging in a context where the great majority of women give birth at home without the involvement of any medical professional. At the time of this study (February 2016), no regular system of birth tracking was yet functioning, even though the first graduations (i.e. the second birthday of children born to beneficiaries enrolled during the pre-pilot) should be taking place in the first quarter of 2016. The CDGP is well aware of this problem, and is in the process of compiling a retrospective database of estimated birth dates for the children of current beneficiaries, with the

help of CVs in each community. A template has also been developed for routine birth tracking going forward, but this is not yet operational.

'Premature' exits

Given the difficulty of distinguishing between miscarriages and false pregnancies, it is assumed that any registered beneficiary who is found not to be pregnant (and has not given birth) has committed fraud. Unreported miscarriages are also treated as fraud, in which case the woman is removed from the payment list immediately and loses her right to re-enrol if she later becomes pregnant. In a genuine (reported) case of miscarriage, she will continue to receive cash for three months and can also re-enrol for a subsequent pregnancy.

In order to assess the extent of fraud in the form of false pregnancies (i.e. women registering as beneficiaries when they were not pregnant, either by substituting urine or with the complicity of the person responsible for pregnancy testing), the CDGP introduced an additional process of random pregnancy testing of beneficiaries at payment points in September 2015. Five communities in each LGA, and 10 beneficiaries in each community, are selected each month for this check. Communities may be selected because they are remote and under-monitored, or because there is reason to suspect a problem there. Beneficiaries who do not look pregnant are selected for testing. Thus, while the testing is random in the sense that it is unexpected (like random searches by customs officers), it is not random in the sense of being statistically representative or unbiased. However, they do also seem to have a deterrent effect (in some cases women have even been observed running away from the payment queue when they realised pregnancy checks were being made).

Given the above care should therefore be taken in interpreting the number of fraud cases detected by the abovementioned checks

Coverage and performance

As with community entries, the scale of implementation is noteworthy, given the multiple challenges faced by the programme. Figure 13 shows the number of beneficiaries registered each month since November 2014.[22] The dotted line is the average total number of monthly registrations over this period. The graph shows that soon after the programme began roll-out, registrations had to be slowed down due to the national and state election period running from February to April 2015. However, soon after this, there was a massive effort to take the programme to the planned scale, especially between April and September 2015. Procurement delays led to a shortage of mobile phones in October and November 2015 (see Progress Report October 2015), causing the sharp drop in registrations in November shown in the graph. As explained in the process description above, the beneficiary registration process cannot be completed without the phones. On the ground, this meant a one-month delay in accessing the cash transfer for women who had completed the enrolment process and were waiting for Step 5 (registration). Monthly registration targets for January to March 2016 were raised to catch up with registration targets by the end of the programme year. The total number of beneficiaries registered had reached 11,939 by the end of January 2015, and 32,300 by the end of December 2015 (source: Annual Reports for 2014 and 2015). The number of active beneficiaries (net of exits) on the payment schedule for February 2016 was 32,316 (see section 3.3 for details of the payment system).

[22] November 2014 is when the Monthly Dashboard was started (see M&E section below). Data is not available for monthly registrations before that date.

Figure 13 Monthly number of registrations since November 2014

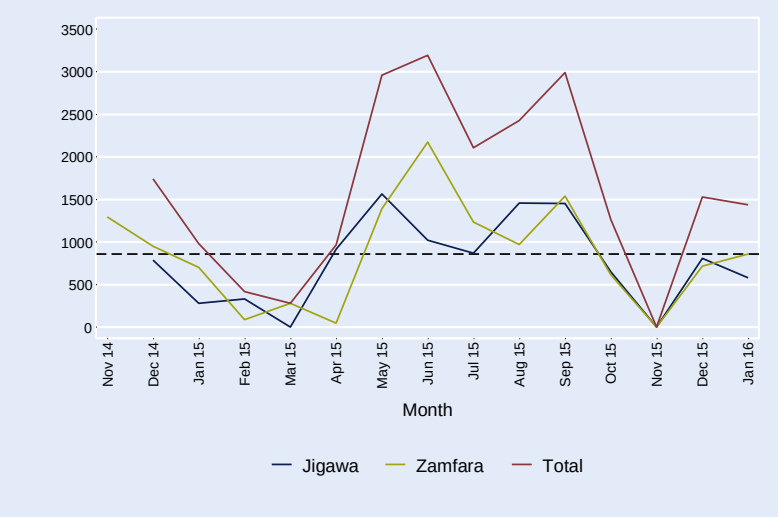
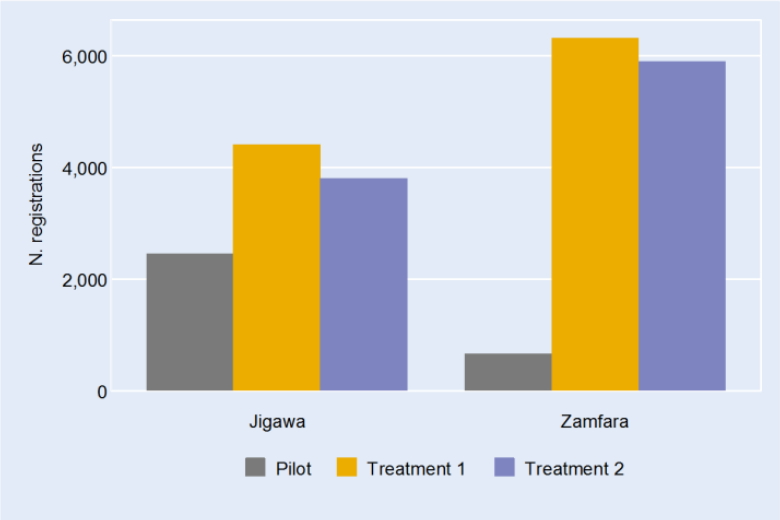


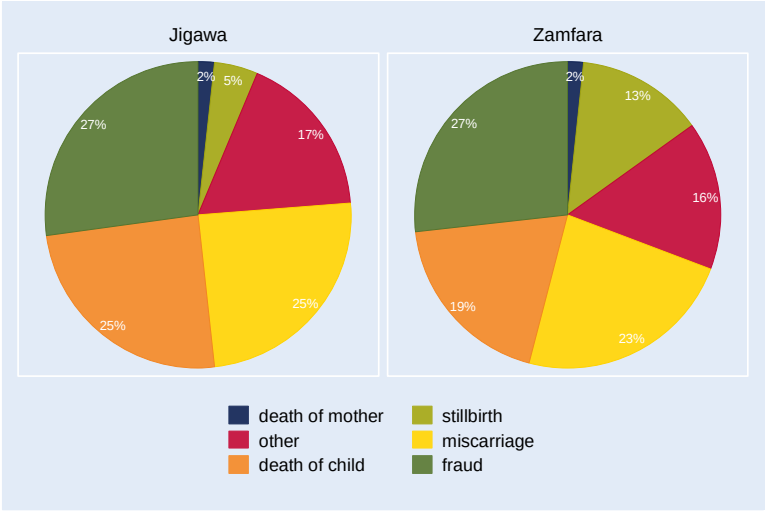
Figure 14 shows the total number of beneficiaries registered by treatment group, for each state, since November 2014. Both states show a slightly higher number of T1 than T2 beneficiaries: the reason for this is not clear. The higher proportion of 'pilot' beneficiaries in Jigawa can be partly explained by the fact that the pre-pilot was implemented in three villages in each LGA. As the CDGP is operating in three LGAs in Jigawa and two in Zamfara, the two states have nine and six pilot villages respectively.

Figure 14 Total registrations (November 2014–January 2016) by treatment



No beneficiary had yet graduated from the programme as of February 2016, but the total number of premature exits between November 2014 and December 2015 was 1,999. Figure 15 breaks this number down by reason for exit, showing that about a quarter of exits were due to miscarriage and roughly a third was due to either stillbirths or child deaths. Key informant comments suggest that the apparent difference between the two states in the relative proportion of stillbirths and child deaths is probably due to inconsistencies in the way CVs distinguish between these two categories in their reports.

Figure 15 Total exits (November 2014–December 2015), by reason



Fraud of all kinds (see Table 4 above), including cases detected by random pregnancy tests, accounts for 27% of exits in both states, or about 540 cases over the fourteen-month period. As a very rough calculation of inclusion error, this is approximately 2% of the total registrations over the same period. Of course, it is impossible to know the number of undetected frauds, but on the face of it this appears to be a low inclusion error. The CDGP has, however, adopted a zero-tolerance policy towards fraud, which is appropriate and also makes for a clear and simple message to communities and beneficiaries.

3.3.3 Challenges and lessons learned

Pregnancy testing is one of the biggest challenges in relation to targeting and enrolment

Establishing a practical system for pregnancy testing on the scale and in the context of the CDGP is probably the biggest challenge faced in relation to the targeting and enrolment process, but the programme seems to be meeting this challenge successfully. The scarcity of reliable health facilities has meant that the responsibility for pregnancy testing has rested on the CHEWs, CVs and seconded staff working in the communities in most of Zamfara and parts of Jigawa. Lessons learned include that women can be extremely resourceful in finding ways to falsify the test, including buying or borrowing urine (even finding ways to conceal borrowed urine in their clothing during on-the-spot pregnancy tests), and that unpaid CVs and underpaid CHEWs or health staff are sometimes tempted to falsify pregnancy test results for their own gain. Innovations to minimise these problems include random pregnancy testing at payment points, and using supervised 'instant urine' tests instead of the original design in which women brought samples with them for testing.

Birth tracking is currently not in place

Registering the dates of birth of beneficiaries' babies is essential in order to know when they should 'graduate' (i.e. on the child's second birthday). This has been evident since the design phase of the programme, but a system for tracking births is not yet operational.

Cross-border' registrations

One of the common categories of fraudulent registration is 'crossing borders', i.e. women from neighbouring settlements or wards being registered in a treatment community but not actually resident there. Given the random assignment of villages to treatment or control groups, and the inability of the CDGP to cover all the communities in treatment villages, field staff find it difficult to explain to these women why their community is not included and they cannot register. The borders understandably seem arbitrary and unfair. To some extent, this dilemma is common to any intervention that is targeted based on geographic boundaries; but in this case the dilemma is heightened because whether a TW is included in the programme or not is based on chance rather than any targeting criteria. If the programme is adopted and scaled up by the government in future, care should be taken to avoid these community border issues either by full coverage of villages or by applying transparent geographical targeting criteria.

Re-enrolment after graduation needs clarification

The question of whether a woman can re-enrol if she becomes pregnant again after graduating from the CDGP is noted in the IM as 'to be determined' (see also Tibbo and Umar 2014: 24–5). It is not clear whether this issue has been resolved, as the PE team were given different information by different informants. If a decision has been made, it seems that it has not been clearly communicated.

Mobile phones have caused delays in implementation with limited benefits

The distribution of mobile phones (or SIM cards) to beneficiaries is essential to the registration process, because the phone number is the beneficiary's ID number for the payment system. Without the phones the registration is stalled, as happened in October/November 2015 (see Figure 13). However, the use and benefit of the phones themselves appears limited in relation to the cost. Poor network coverage means that SIM cards sometimes cannot be activated at registration (the women or their husbands have to take the phone to a place with a signal). CDGP field staff report that many women have very little understanding of how the phones work and consequently hardly use them.

Technical challenges with registration devices (online registration)

Registration (Step 5) requires tablets and thumb-print scanners. This raises many of the same technical challenges as for the payment system, i.e. shortage and breakdown of tablets, no power source for charging in the communities, and short battery life, which limits the number of people who can be registered in one trip. Network coverage is needed for synchronising registration data with the payment portal, though not for entering the data.

Community access and revisits

Poor infrastructure and insecurity raise the same challenges for registration as for community access (see above). Regular revisits are needed to keep the beneficiary list updated by registering newly pregnant women and verifying exits.

3.4 Payments

Key findings

- An effective payment system delivering prompt payments to beneficiaries on a monthly basis constitutes a major achievement of the programme to date.
- The original design of the e-payments was ambitious and not situated within the context of Northern Nigeria or based on the availability and penetration of existing financial services or products in these areas.
- The CDGP payment mechanism is effectively a manual payment model delivering cash through agents at a specific location, date and time. The mobile phones are used solely to notify beneficiaries of payments disbursed and their numbers act as unique ID's. The phones or virtual wallets cannot be used for accessing or utilising financial services such as deposit-making, savings or payments.
- Beneficiaries have little flexibility or choice as to where, when and how much they can receive from payment agents, contrary to the original intentions of the programme.
- Contracting negotiations and procurement of services have often been complex and protracted.
- There have been significant teething problems during the first year of payments related to delays in registration, lack of agents, faulty software, and equipment and liquidity issues. Lack of community-based agents has meant that agents often have to carry large amounts of cash and travel long distances in order to pay beneficiaries, thus increasing their costs and exposure to security risks.
- The availability and functionality of equipment has been a binding constraint for prompt payments; however, adjustments have been made and solutions often found to mitigate these problems.
- The programme performance has significantly improved since August 2015 but at an increasing cost to the programme. There are fewer agents per beneficiary since the programme began and the fee per beneficiary paid has increased from NGN55 to NGN175.
- The programme is exploring alternative e-payment service providers to operate in small areas in parallel to Stanbic. It is important to recognise that with any new service provider new challenges are likely to arise and costs are not necessarily going to be substantially lower if innovative modalities are sought. There are risks to beneficiaries in terms of not receiving their payments promptly, and options selected may also suffer from a lack of scalability.

3.4.1 Description of the process domain

Overview

The CDGP originally intended to use an electronic payments (e-payment) mechanism to deliver transfers to its beneficiaries using mobile money.[23] The beneficiaries were meant to receive the e-payments through their mobile phone and able to exchange their electronic value (e-money) for cash ('cash out') with money agents based in their communities.[24] Beneficiaries were meant to be able to save or deposit money into their accounts, send money to anyone with a mobile phone, purchase airtime, and pay for goods and services.[25] Payments were meant to be made online or offline depending on availability and strength of network connection. Under the online version, beneficiaries were meant to receive a text message alert confirming disbursement of cash into their accounts, enabling them to cash out at the nearest agent using a personal identification number. With the offline version beneficiaries were meant to go to the nearest agents to cash out, using fingerprint and ID cards to enable verification by the agents using tablets.[26]

In March 2014 SC contracted Stanbic Investment Banking and Trust Company (SIBTC) Bank as the e-payment service provider and Fortis Mobile Money as the supplier of phones. SIBTC was meant to recruit and train community-based agents with a ratio of one agent to a hundred beneficiaries (1:100); the agents were meant to verify the status of beneficiaries and cash in their e-money (provide cash in exchange for their electronic value). The Stanbic agents were originally meant to receive NGN55 per beneficiary paid.

Registration

Once enrolled, beneficiaries are registered onto the e-payment mechanism (see section 3.3). According to the IM,[27] the registration process begins with beneficiaries providing their names, dates of birth and ID numbers. This information together with their profile picture and thumb prints are captured on tablets and subsequently synced with the SIBTC mobile money system (Figure 16).

[23] A mobile-based transactional service that can be transferred electronically using mobile networks. A mobile money issuer may, depending on local law and the business model, be a mobile network operator or a third party such as a bank. In Nigeria, mobile network operators are not allowed to operate mobile money.

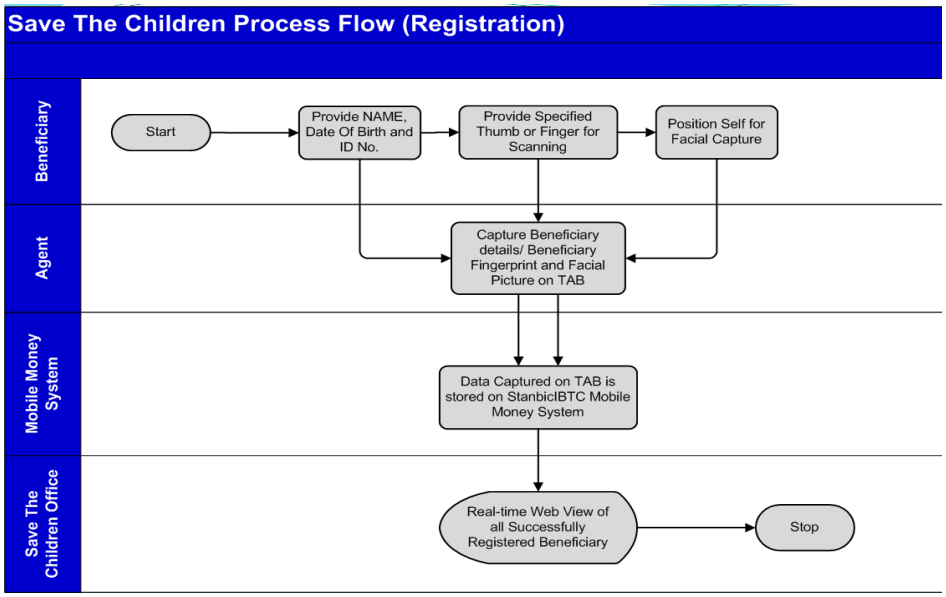
[24] CDGP (2013), Information Session for Interested Bidders, August.

[25] Stanbic IBTC Bank (2013), E-payments cash disbursement propositions, September.

[26] Ibid.

[27] CDGP IM versions: July 2014, December 2014 and June 2015.

Figure 16 Registration onto the electronic payment system



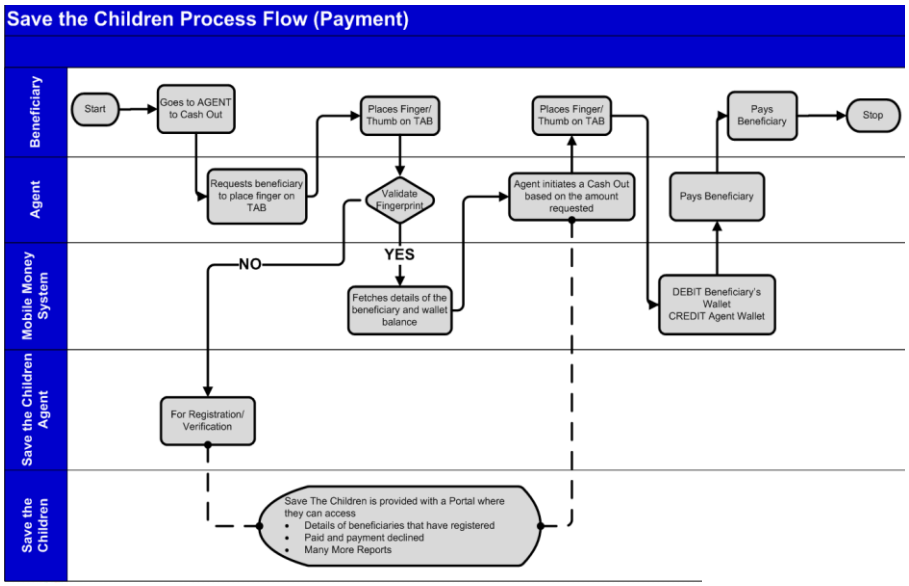
Source: SC (2013), Payment process flow submited as annex to the annual review, December and IM (all versions).

Monthly payment

Once registered, the beneficiaries are paid monthly. The process of payment begins with SC giving instructions to SIBTC to transfer funds to the pool account[28] in local currency, 30 days prior to the date of disbursement. SIBTC in turn funds the beneficiary wallets and sends a notification to beneficiaries to inform them that their accounts have been credited. The withdrawal process presented in the IM is the offline payment modality described in SIBTC's proposal. Following the notification of beneficiaries through mobile alerts, the beneficiaries are meant to locate their designated agent and receive payments, once the agent has verified their identity using biometrics and phone numbers. After being paid, beneficiaries are notified of their new balance and amount debited through an alert (Figure 17).

[28] The account used by Stanbic to fund the beneficiary wallets.

Figure 17 Withdrawal of payments by beneficiaries



Source: SC (2013), Payment process flow submited as annex to the annual review, December and Manual of Operations (all versions).

In the next subsections we map and describe how the payment process happens in practice and highlight some of the challenges and lessons learned through implementation so far.

3.4.2 Implementation

Design and procurement

The design activities related to payments began in earnest in May 2013 and a study on design options for e-payments[29] was produced in June 2013. The study noted that mobile banking and phone payments had 'lower cost, greater flexibility and security with regards to large scale, regular, geographically dispersed transfers' compared to manual payments and noted that the mobile money landscape had significantly improved in Northern Nigeria, with a number of product offerings. The e-payment option was seen as offering 'considerable advantages' including reductions in cost and burden, improved transparency, enhanced security and more importantly convenience and flexibility for the beneficiaries with the potential for increased financial inclusion. The study provided a light-touch review of a number of design options and recommended a bank-led mobile payments system with multiple payment points including mobile agents, automated teller machines and point of sale devices operated by merchants. This was seen as providing the beneficiary with a choice to the select payment point closest and most convenient to them. This recommendation was based on considerations of cost, flexibility, security, coverage and financial inclusion. The report also highlighted the requirements that needed to be in place to allow for successful implementation of this model, including having payment providers with an existing product and an agent network meeting certain criteria and being capable of reaching the beneficiaries within the targeted communities.

[29] Mwamba (2013), E-payments mechanism design, June.

Further technical design work was carried out in July and August 2013 to produce a more detailed set of technical design specifications, based on which a tender was produced in August. Submissions were reviewed in September 2013, following which the contract was awarded to SIBTC.[30] There was a protracted period of negotiation over the commercial and pricing elements of the contract with SIBTC, which was finally agreed on in March 2014, although technical and operational discussions continued throughout the negotiation period. During this period, process maps for payments were developed in December 2013,[31] a payment portal was developed and tested, and agents were trained during January and February 2014. The original agreement with SIBTC required them to provide one payment agent for every 100 beneficiaries, with a payment to the agent of NGN55 per beneficiary paid.

SIBTC's original delivery model proved optimistic. It struggled to establish a network of community-based agents, because few if any traders and business people within the CDGP communities could meet the liquidity requirements. This resulted in significant delays in payments to enrolled beneficiaries immediately following the pre-pilot phase (April–July 2014), leading to an extension of the pre-pilot contract first until the end of August 2014 and subsequently to the end of December 2014.[32] The revised model relied heavily on mobile agents, often based in cities and outside the LGAs where the programme operates,[33] resulting in an additional cost burden and increased security risk to the agents due to travelling longer distances with cash.[34] The period of August–December 2014, when the programme expanded rapidly, posed particular challenges for the registration and payment of beneficiaries. The process of registration was hampered by a shortage of mobile phones (see section 3.2.2). Payments were delayed due to issues related to the unavailability of agents, malfunctioning application software, faulty tablets and scanners, and liquidity problems.[35]

Although a roll-out contract was meant to have been agreed by September 2014, with the extension of the pilot contract phase it was postponed until January 2015. Contract negotiations were again prolonged, and the contract was eventually signed in April 2015, although an interim agreement for continued delivery was in place. With the new contract a higher ratio of beneficiaries to agents were agreed upon, increasing initially to 1:200 and then, as the programme has expanded, to 1:400. With the change to mobile payment agents, who incur transport and security costs, the agents' fee has been increased first from NGN55 to NGN100 per beneficiary paid and is now currently standing at NGN175.

The current contract with Stanbic expires at the end of April 2016 and at the time of the evaluation the CDGP team was in negotiation to renew their contract while simultaneously considering alternative payment service providers.

[30] DFID (2014), Annual Review, January.

[31] Ibid.

[32] CDGP (2014), Programme Direction Team quarterly update, December.

[33] Ibid.

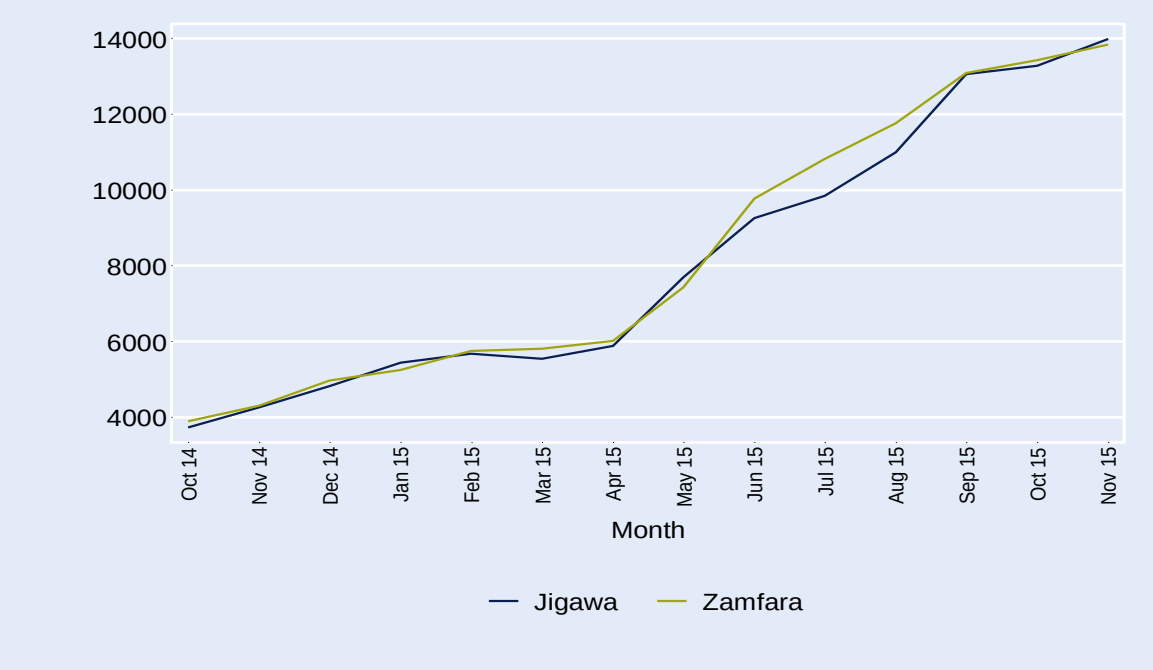
[34] ePact (2015), Rapid Scoping Study Report, January.

[35] CDGP (2014), Programme Direction Team quarterly update, December.

Coverage and performance

The first payments were made to 58 pre-pilot beneficiaries towards the end of April 2014[36] and in May, June and July close to 500 pre-pilot beneficiaries were paid by the programme.[37] By December 2014, 10,726 beneficiaries were registered and paid by the programme. The number of beneficiaries registered and paid increased rapidly from April 2015 onwards (Figure 18), reaching 26,771 by September 201538 and 32,316 by February 2016.

Figure 18 Number of beneficiaries paid per month



Source: CDGP payment data.

Prompt delivery of payments (within a designated 10-day window each month) was not always achieved in the early months of the roll-out largely due to challenges with the agent network, but has improved markedly during 2015, as shown in Figure 19 During the pre-pilot (April–July 2014), payments were made successfully to the small number of registered beneficiaries. However, in subsequent months there were significant delays in both registration and payments. In August 2014 not all beneficiaries were paid, with a backlog of payments made in September, and by early December 2014 payments for the month of October were still outstanding. Payments for November and December were expected to be paid to beneficiaries in December.[39] In fact, for the period April–December 2014, only 48% of the 10,726 beneficiaries received their payments within the 10-day payment window.[40] Although the performance of payments improved in January 2015, it declined in the subsequent few months due to malfunctioning thumb-print devices and the

[36] CDGP (2014), Monthly progress report, April.

[37] CDGP Monthly progress reports for May, June and July 2014.

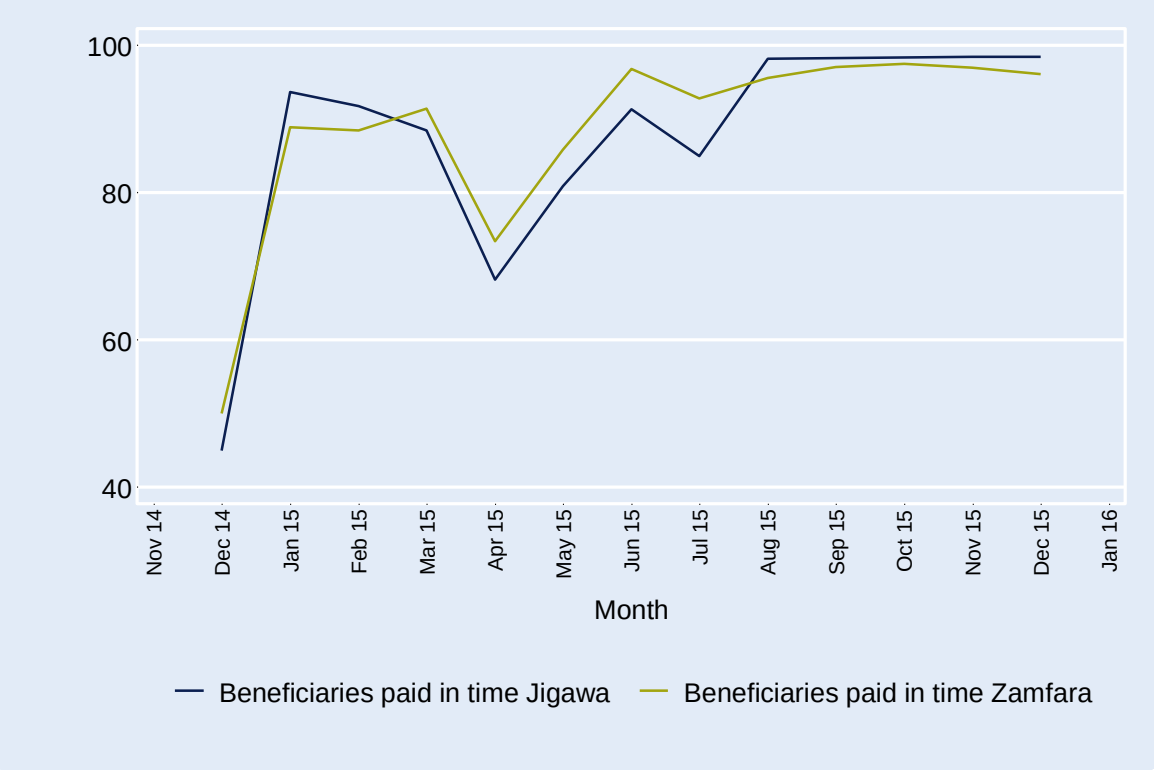
[38] CDGP (2015), Programme Direction Team quarterly update, November.

[39] CDGP (2014), Programme Direction Team quarterly update, December.

[40] DFID (2015), Annual Review, January.

elections, and in May and June 2015 only 71% of beneficiaries (13,164 out of 16,436) were successfully paid within the 10 days.[41] Since May 2015 the payments have gradually improved and between August 2015 and January 2016 most beneficiaries received their payments on time.

Figure 19 Percentage of beneficiaries paid on time



Source: CDGP Dashboard data.

The actual payment process (as of February 2016)

Section 3.4 provided a summary of the payment process as described in the IM. Here we describe and map the payment process as it is currently being implemented.

Initial registration

Once enrolled, beneficiaries are visited by LGA-level programme staff and registered into the payment system (see section 3.3). During this process the beneficiary's personal information,[42] fingerprints and photograph are captured using an Android-based tablet and software called mobile disbursement. During the same visit the beneficiaries are also provided with phones and SIM cards. Beneficiary details are usually captured offline and uploaded onto the Stanbic payment portal system when a network connection is available.

[41] CDGP (2015), Programme monitoring report, April and May.

[42] Information collected relates to the legal requirement of financial institutions to know their customers. This standard information is referred to as 'Know Your Customer' details includes the name, date and place of birthday of the individual as well as their national ID number.

Monthly payments

The monthly payment process is mapped in Figure 20. It begins with the creation of an updated payment list and schedule by SC and AAH. The payment list is updated to incorporate any newly registered beneficiaries or to remove those who have exited the programme (see exit criteria in 3.3). The lists are updated at the LGA level and sent to CDGP's National Payment Manager through the state-level M&E manager. The Payment Manager verifies the list and checks to ensure that the beneficiaries exiting the programme are converted into 'inactive' beneficiaries in the payment portal system. The manager is also responsible for flagging the following cases:

- Beneficiaries who have not collected cash for the past three months;
- Beneficiaries whose next-of-kin has collected money for the last three payments.

The Payment Manager generates an updated payment list and schedule by the 14th of every month and sends this to the Programme Manager[43] and then the Country Director (or their deputy) for approval. Once approved, the list is sent to Stanbic and funds are disbursed into its account. Stanbic credits the beneficiary accounts and sends each beneficiary a credit alert via text message notifying them of the amount they are to receive in the coming month.

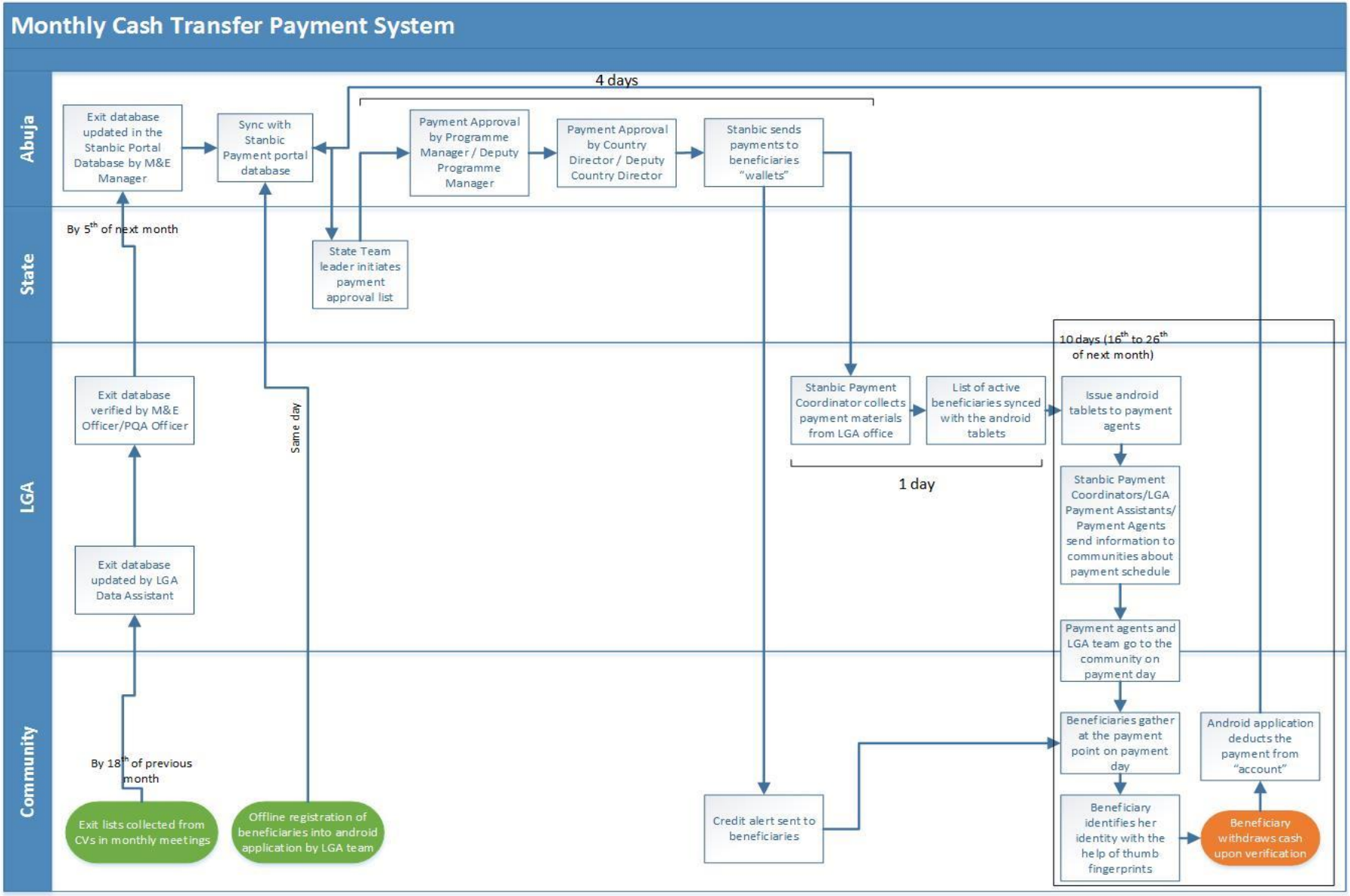
Once the beneficiaries' accounts have been credited, the Stanbic LGA coordinator collects the list of 'active' beneficiaries from Stanbic's state branch. The coordinator then goes to the CDGP LGA office to collect the necessary payment materials (tablets, thumb-print scanners and chargers) and to synchronise the 'active' beneficiary list into the tablets that are then given to the payment agents.

While the agents prepare for the payment round, the Stanbic LGA coordinator and LGA payment assistants[44] send the payment schedule to the CVs or TW leaders in the settlements so that they are aware of the date and time when their beneficiaries will be paid.

[43] This is meant to be approved by the Programme Manager and only in his/her absence approved by the Deputy Programme Manager. The Programme Manager role is currently vacant and the Deputy Programme Manager is *de facto* the Acting Programme Manager.

[44] In Jigawa it is the LGA field staff that carry out this function. These are usually government-seconded staff.

Figure 20 Monthly payment process



The payment agents and LGA staff travel to pre-arranged payment points where the beneficiaries gather (See Box 1). One by one, beneficiaries are called forward by name to collect their cash from the payment agent. The LGA staff read out their phone number and agents enter this number into their tablets. The beneficiary's identity is confirmed by scanning their thumb using biometric scanners. Once the account is verified by the tablet, the agent pays NGN3,500 to beneficiary. If the fingerprint does not match, designated LGA team members can re-scan the print and edit the file in the tablet at the payment point.[45] An amendment form must be filled in if any beneficiary detail is changed. If the beneficiary is unable to come to the payment point on the payment day, her registered next-of-kin can collect the cash in her place.

Box 1 Observations from the visit to a payment site in Buji LGA (Jigawa)

The payment site for this community was the Primary Health Centre. Approximately 100–150 beneficiaries had already gathered at the health centre and were waiting for their names to be called out by the LGA staff. Most of the beneficiaries that we asked possessed the mobile phone provided by the CDGP. Some of them had a piece of paper with the mobile number written on it. **We observed poor or no network signal on most of the mobile phones.**

Once the LGA staff called out the name of a beneficiary from a list, the beneficiary would approach the table where the payment agent was seated with a tablet, fingerprint scanner and payment money. **The LGA staff would then also read out the mobile phone number corresponding to the beneficiary from the list. The beneficiaries were not asked either to show their mobile phone or to verify the mobile phone number.** The payment agent would search for the beneficiary's account in the tablet with the help of the mobile phone number announced by the LGA staff and ask the beneficiary to scan her thumb prints. If the thumb prints matched, the payment agent was able to access the account and pay her 3,500 Naira. Once the cash was handed over to the beneficiary, the payment agent would update the tablet and the beneficiary was also asked to put an inked thumb print on the 'payment monitoring template'. **This paper template was recently introduced by AAH in Jigawa to provide an additional back-up record of payments in their state**. Once the monthly payments are concluded, the payment monitoring templates are collected from all three LGAs and kept in the state office for any future reference. This system was introduced to ensure at least one AAH staff/seconded staff/dedicated CV closely monitor and record each payment to avoid any underpayments by the agents.

The process of cash handout took three to five minutes per beneficiary.

There was **a case of thumb print mismatch due to a confusion between two beneficiaries with the same name** because the mobile phone numbers are not verified at the start with the beneficiaries. This was solved by calling out the name again, at which point the right beneficiary came forward. There were also a **few cases of thumb prints not being recognised by the scanner**, which meant the beneficiary had to wait and clean her thumb and try again.

Some of the beneficiaries looked very young (teenage) and had babies who were a few days or weeks old. We observed no prioritisation of payments. Many beneficiaries with young infants had to wait hours before their name was called out.

Following the payment and once connected to network, the agents synchronise their tablets with the Stanbic payment portal to update the beneficiaries' account balances. The agents receive a fee

[45] Not all staff are authorised to make these changes to the database (see access levels in Annex D.1). If no-one with the necessary authorisation is present when the problem arises, they have to be sent for to come and edit the thumb print files. This can delay payment to the beneficiary, and also disrupt the other work of the authorised staff member.

of NGN175 per beneficiary paid. Following reconciliation, Stanbic reimburses to the CDGP any money which a beneficiary has not collected for four consecutive months.

The programme has introduced new protocols and procedures for beneficiaries not withdrawing their cash in three consecutive payment cycles. A check on three or more months of non-withdrawal of money by beneficiaries was started because of problems related to liquidity and some beneficiaries wanting to withdraw large amounts (this was a problem for mobile payment agents as they could not predict how much money they needed to carry). Under the new protocols the state payment coordinator downloads a list of beneficiaries who have an account balance of NGN10,500 (three months' transfer) or more, and notifies the LGA field staff to conduct field visits to verify the reason for non-withdrawal by the beneficiaries. The field staff produce a case report with the reasons for non-withdrawal of cash and submit it to the MIS manager at the state level. The MIS manager at state level fills an amendment form for the beneficiary attached with proof of field visits and the MIS manager at the national level unfreezes the account if the beneficiary gives a valid reason for non-withdrawal of cash. If the beneficiary does not withdraw cash for six or more months, the account is 'closed'. If the beneficiary verifies the reason after three consecutive months of non-withdrawal of cash, she gets the payment for the next month once the account is 'unfrozen'. After each payment round, an amendment form is filled for any change in beneficiary details, which is later approved by the MIS manager. In addition to this cases where a proxy regularly collects money from beneficiaries are also investigated.

3.4.3 Challenges and lessons learned

The CDGP payment mechanism has faced a number of challenges since its design. These are summarised below.

Ambitious study design not situated in the context of Northern Nigeria

The initial design study proposed a bank-led mobile payment modality utilising a number of payment options. While the study provided a useful set of recommendations and highlighted the necessary features for the model to operate successfully, it was not set within the context of Northern Nigeria. The limitations of the study were recognised at the time: it provided an overview of technical options but had no analysis of existing e-payment products or penetration of mobile money in Nigeria and certainly not in the northern states where the programme is implemented. The ambitious design led to interest from numerous service providers who were keen to expand into the states of Zamfara and Jigawa but who did not necessarily have the presence or understanding of the context where the programme intended to operate. This led to an over-ambitious proposal that has since been significantly revised by CDGP working with Stanbic to adapt the payment process to the recognised challenges of the context.

From e-payments to manually managed payments

The programme was originally designed as an e-payment model allowing the beneficiaries to cash out their e-value at their convenience from payment agents closest to their community; however, in reality, the current payment mechanism is in effect an agent-managed, manual payment. The mobile phones have no function during the payment process other than the phone number acting as a unique ID, and effectively an account number, for the beneficiary. The identity of beneficiaries is confirmed through the scanning of thumb prints and not through the mobile phone. Therefore, under the current payment modality the account or wallet does not provide the beneficiary with access to any financial services (e.g. banking) or benefits (e.g. ability to save or make payments). The current operational policies introduced by the programme, including freezing of beneficiaries'

accounts after non-withdrawal of three consecutive payments, mean that the e-payments do not in reality provide any financial inclusion and are certainly not designed to encourage savings.[46] Concerns about possible fraud are understandably a key factor in the design and operation of the payment mechanism, as well as in the programme as a whole.

Beneficiaries have little choice or flexibility

The beneficiaries can receive their payments only when the agents are in the community and have no choice in how much to withdraw. If the beneficiaries or their proxies are not present when the agents are in their communities, they have to wait until the next month's payment. Therefore, the beneficiaries do not have any flexibility or choice as to when and how they receive payments, despite this flexibility and choice being originally envisaged by the programme.

Availability of agents in the communities and liquidity were major challenges

The payments were meant to be delivered through a network of community-based agents. However, this proved unfeasible and SIBTC reverted to using mobile agents from outside the programme communities. Not only has this resulted in additional risks to the agents who have to carry large sums of cash and travel significant distances, but it has also increased the costs to the programme: agents' commission per beneficiary served has increased from NGN55 to NGN175 since April 2014. Liquidity has also been a challenge for the agents, requiring them at times to make repeated visits to some communities. Stanbic has increased the number of 'super agents' – agents with more liquidity capacity and who often have a network of payment agents under them – to overcome these issues. Existing evidence suggests that this problem has been solved and most payments to beneficiaries have been made within the stipulated 10-day window since August 2015 to date.

The ratio of payment agents to beneficiaries was originally designed as 1:100. This was later revised through negotiation with Stanbic to 1:400. Field staff participating in the PE workshops reported that the actual ratio is much higher in some cases, but that the ratio itself is not a good indicator of whether there are enough agents, because of wide variations in the financial capacity of the agents, the population density of beneficiary communities, and the distance and difficulty of travel. Some agents are well able to manage payments for 400 beneficiaries, and some are successfully serving up to 900 each month. Stanbic commissions more agents as needed, as the beneficiary numbers increase. If the programme reduces the frequency of payments, the risk burden for agents will increase and may also affect their ability to pay beneficiaries on time.

Adequacy and functionality of technological equipment

The payment mechanism is reliant on biometric scanners, tablets, associated software and data connectivity. This has resulted in a series of delays to payments. The initial tablets procured by the programme were found to be of low quality and with a very short battery life. Given the unavailability of power in most of these communities, the number of beneficiaries an agent could pay in one visit was limited by the tablet's battery life. The programme has not been able to change the brand of the tablets used but instead initially provided two tablets per agent to enable them to execute payments faster in each settlement and to ensure payment occurred without the risk of the battery running out. However, this sometimes led to multiple withdrawals by the same beneficiary leading to negative account balances when the data was later synchronised. As a result, only one

[46] However, key informants suggest that beneficiaries are in fact using part of the cash to invest in traditional community-based savings groups.

tablet is now issued per agent. While this has reduced the incidence of fraud, it has not resolved the battery problems. The programme now provides power banks to agents to increase the longevity of the tablets.

The fingerprint scanners have also been problematic, with beneficiary fingerprints frequently not being recognised by the scanners at the payment point. This has been particularly problematic in Jigawa, where people cultivate a plant (*zoko*) which coats the fingers with a sticky sap and makes it difficult to read the fingerprint. As a response, authorised LGA staff members can now re-scan the fingerprints of the beneficiaries whose fingerprints are not recognised during payments.

Finally, payment agents need to synchronise the data captured in their tablets with the Stanbic portal in order to update the beneficiary and payment data as well as to receive their fees and reimbursement of the cash distributed. The non-availability of network or low connectivity affects agents' ability to synchronise data. The programme now provides WiFi devices to agents to synchronise data before and after payments. Nevertheless, as the number of beneficiaries increases, synchronisation of beneficiary data is likely to take an increasing amount of time, especially where there is slow connectivity.

Some of the equipment, including scanners and tablets, has broken or is in need of repair. This necessitates a continuous and speedy replacement and repair of equipment, including stocking of some reserves. In some areas there are shortages of tablets, scanners and other equipment, thus hindering the operations of the programme.

Delays in procurement and contracting

The SIBTC procurement and contract finalisation caused a major delay in the implementation of the cash transfer system. Contract negotiations with Stanbic and Fortis Mobile Money have been lengthy and complex, requiring technical support from the country office director and SC staff in London. This support and internal procurement rules have resulted in significant delays to the finalisation of contracts and the procurement of services and goods. Issues related to procurement affect the programme's ability to supply adequate equipment or replace them in a prompt manner.

The prolonged delivery challenges and contractual issues with Stanbic, including increased costs, are leading SC to explore alternative and innovative payment service providers. It is important to recognise that with any new service provider new challenges are likely to arise and costs will not necessarily be substantially lower if innovative modalities are sought. There is a potential risk of beneficiaries not receiving their payments in a prompt manner, especially at the beginning of a new system. Developing and managing the new arrangement is also likely to demand significant time from the national team and the use of other resources.

3.5 Behaviour Change Communication

Key findings

- The extent to which the CDGP could rely on WINNN to design and implement the CDGP Nutrition and BCC strategy was revised during design due to constraints in implementing in the same geographic areas.
- The vacant Nutrition Adviser post in the Central Team along with the high rate of roll-out and beneficiary registration contributed to a delayed focus on finalising the Nutrition and BCC strategy.
- AOGs are popular among community members, but given the current scale of operation and the CDGP's target of 10 AOGs per month per LGA, AOGs can be implemented in communities only twice per year at most.
- Cumbersome procurement rules for SC in Zamfara have meant that meeting AOG targets is not possible.
- The number of IYCF SGs has been increasing since July 2015, largely in Zamfara, with nearly 60% of all T2 beneficiaries having participated in an active SG in January 2015.
- One-to-one counselling has also been increasing in both states, but fewer than 20% of T2 beneficiaries had participated in a one-to-one session in January 2016.
- Progress in implementing the Nutrition and BCC strategy has been slow, due to heavy reliance on CVs and CHEWs for implementation of nutrition activities as well as in other aspects of the programme. Targets to date have been difficult to meet and data on the quality of BCC interventions is not being collected. Rationalising the various components with the ultimate aim of reducing the burden placed on CVs and supporting them to undertake fewer activities to a higher level of quality and intensity should be a priority.
- All BCC monitoring data seems to be concerned with counting the number of sessions and participants with little or no information on the content or quality of the interventions delivered.
- Tracking IYCF messages that are and are not covered may guide supportive supervisory and refresher training initiatives and ultimately improve the quality of the intervention, which may increase already low beneficiary motivation to attend SGs and one-to-one sessions.
- Voice messages are only reaching a limited number of beneficiaries due to poor network coverage and limited availability of electricity (meaning that phones are kept switched off), calling into the question the effectiveness of this modality of communication.

3.5.1 Description of the process domain

The Nutrition and BCC component of the CDGP is a core element of the programme, making this pilot cash transfer programme nutrition-sensitive. In fact, this component was a major

consideration in the design of the impact evaluation, which aims to rigorously test the difference in impact as a result of 'high' and 'low' intensity delivery of the BCC interventions.

The CDGP Nutrition and BCC strategy is based on using multiple channels to communicate key nutrition, health and IYCF messages. The idea of using multiple channels was confirmed by experience in the pre-pilot, in which community members indicated various preferences towards the different channels and indicated that having a multitude of channels could increase exposure to key messages beyond the CDGP's direct target group – such as men, elderly women in the household and influential community members. Table 5 below summarises each of the components of the BCC strategy and maps them to their respective treatment group.[47]

Table 5 Components of the BCC strategy

BCC component	Description	Low intensity (T1)	High intensity (T2)
Mass communication	This component encompasses both one-way and interactive elements which are open to everybody within and beyond the treatment communities – both beneficiaries and non-beneficiaries. Elements of this BCC component include: • Radio jingles; • Phone-in radio show; • Information, education and communication posters; • Friday preaching; and • Islamic school teachers.	✓	✓
Voice messages	Beneficiaries receive automated voice messages over their mobile phones to reinforce key IYCF messages.	✓	✓
AOGs	This BCC component comprises food demonstrations, health education/health talks, and live or filmed dramas.	✓	✓
IYCF SGs	These consist of groups formed within a community to support direct beneficiaries (mothers). SGs are also proposed for fathers and grandmothers.		✓
1:1 counselling	Trained female volunteers provide one-to-one counselling to the beneficiary upon demand.		✓

Source: CDGP (2015) IM (3rd Draft)

[47] CDGP (2015-06) IM (3rd Draft), June 2015, revised September 2015

3.5.2 Implementation

The Nutrition and BCC strategy was originally intended to piggyback on SC and AAH's existing nutrition-specific programme in Northern Nigeria – the WINNN programme. However, both WINNN and the CDGP were conceived as independent pilot programmes, each with their own objective of assessing impact as rigorously as possible. Because the WINNN programme and its impact evaluation began in 2012 – before the CDGP's inception period – it was decided that the CDGP would not be implemented in the same locations as the WINNN programme to preserve the integrity of the WINNN impact evaluation and to enable the CDGP to have a robust assessment of its own impact without any contamination or bias from the WINNN intervention. Therefore, it was decided that the CDGP would be implemented in LGAs that were not already a part of the WINNN impact evaluation.[48]

While this decision may have raised operational challenges, the CDGP was still able to learn from WINNN's experience of implementing Nutrition and BCC interventions in Northern Nigeria and, in fact, has adopted many information, education and communication materials that were originally developed for the WINNN programme.

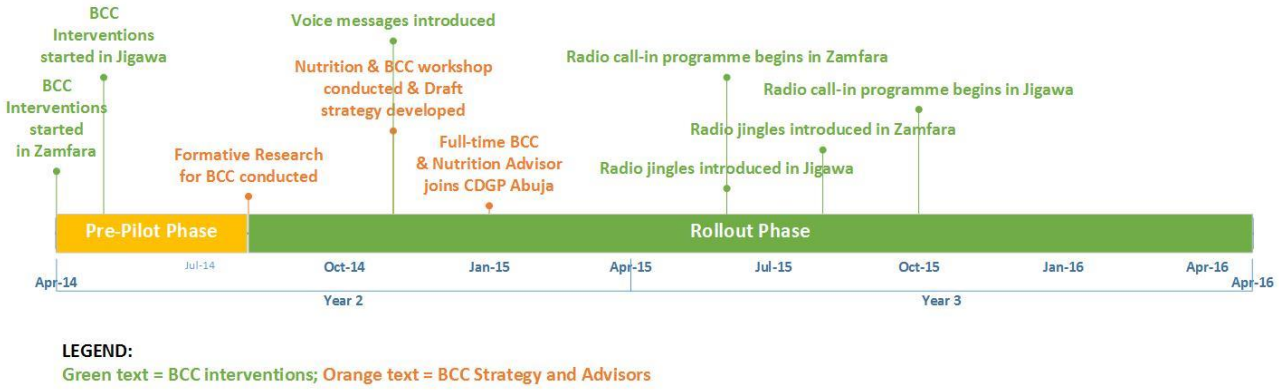
As the initial design of the CDGP assumed complementarity with WINNN, very little attention was paid to the design of the BCC component in the design phase of the programme. It is worth noting that this assumption may have been misplaced as WINNN's BCC component does not overlap with either of CDGP's BCC models. WINNN's BCC component consists of health facility- and community-based IYCF counselling and community-level meetings with fathers and grandmothers indicating that many of CDGP's BCC strategy would need to be newly developed for CDGP.

The CDGP also envisioned making use of WINNN's nutrition adviser to develop and oversee the implementation of its BCC strategy, even though it soon became apparent that it was not feasible for one adviser to support two large nutrition programmes. Therefore, progress in the development of the BCC approach was delayed and the CDGP rolled out the programme in December 2014 while the post of Nutrition Adviser in the Central Team was vacant (discussed further in section 3.8.1). The development of the BCC approach was further delayed by the high rate of roll-out across both states and the big push for beneficiary registration and delivery of cash transfers (see sections 3.2 and 3.3 above).

It was only in mid-2015, well into Year 3, that the implementation of the BCC activities really started to take off, as described below and illustrated by the graphs which follow. The timeline in Figure 21 presents a summary of key events and activities in the BCC process domain, which are also discussed in the following pages.

[48] ePact (2015) Child Development Grant Quantitative Baseline Report, March 2015.

Figure 21 Timeline for BCC interventions



Mass communication

Posters have reportedly been distributed across CDGP villages and HFs where pregnancy verification and payments are often carried out. Radio jingles have been recorded and are played regularly on local radio channels in each state. Generic jingles were broadcast in Jigawa from 2014, but these were revised with more specific CDGP messages in October 2015. In Zamfara, jingles were launched in August 2015.

A weekly **phone-in radio programme** was launched in Zamfara in July 2015. This is a one-hour show in which CDGP staff and invited experts talk about one selected topic, and listeners can call in with questions. A similar programme was piloted in Jigawa in November 2015, and has been established as a regular weekly show from January 2016. The Zamfara programme has even received calls from other states. The CDGP estimates that about 30% of the callers are beneficiaries: however, the last PDM survey found that only 8% of respondents had listened to the programme.[49]

Information, education and communication cards were introduced in November 2015. These are based on the National IYCF Counselling Cards, but focus more specifically on the CDGP key messages and use culturally appropriate images of women in local Islamic dress combined with messages in the Hausa language. These are used by CVs to deliver health and nutrition messages across all CDGP communities.

Voice messages are pre-recorded messages on nutrition, health and IYCF which are sent automatically via the mobile phones issued to all CDGP beneficiaries at registration. Voice messaging was not tested during the pre-pilot phase, but was introduced during the roll-out phase towards the end of 2014.

Action Oriented Groups

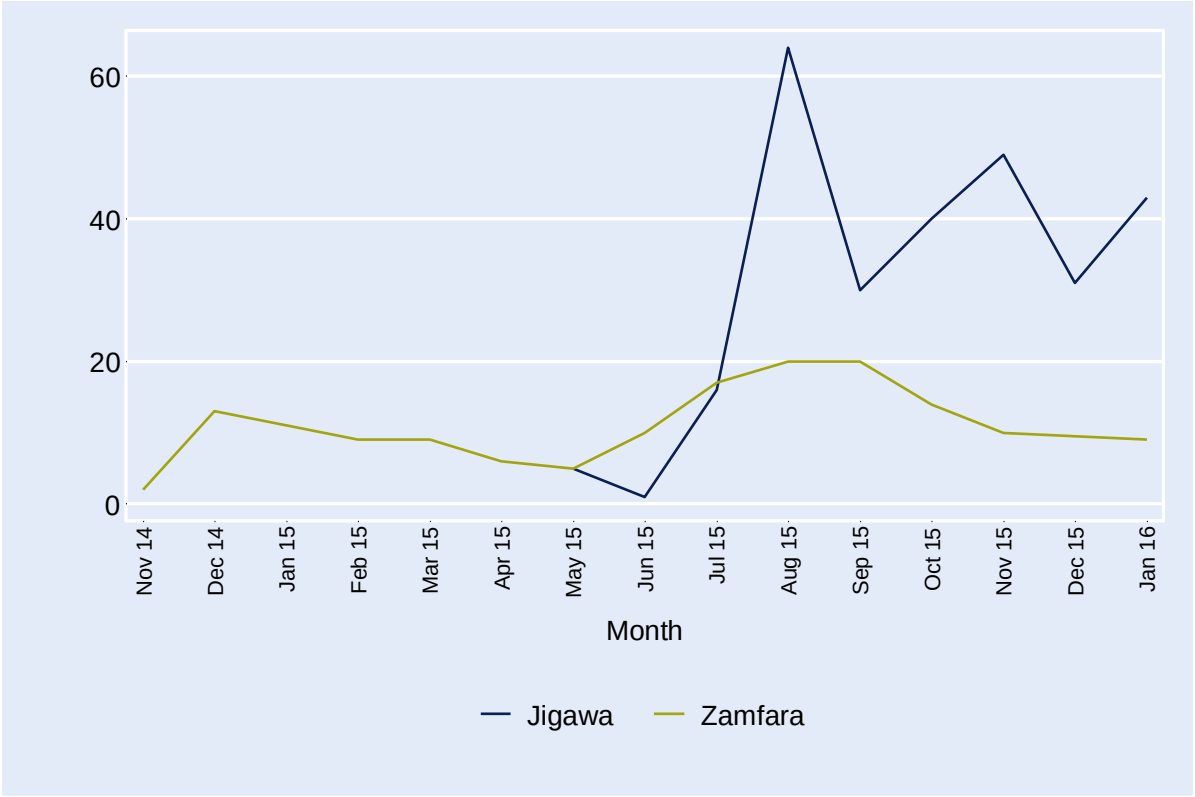
AOGs have been implemented across all CDGP communities. The main activities at these sessions are cooking demonstrations along with nutrition education on the benefits of different foods, and health talks. Live drama was originally part of this BCC component; however, early experience in implementation revealed that too much effort and resources were required to deliver live drama across a large number of communities and it has since been dropped from the AOG strategy. Instead, the CDGP in collaboration with WINNN is planning to produce videos featuring

[49] CDGP (2015-03) Post Distribution Monitoring Strategy Document, March 2015.

drama and songs, which can be shown at group meetings and are expected to be more motivating for beneficiaries and much easier for field staff to deliver.

Figure 22 shows the trend in the number of AOG sessions (predominantly food demonstrations and health talks)[50] throughout the period of implementation to date.[51] This figure clearly displays the delay in start-up of BCC activities in Jigawa. The target for AOGs is currently set at 10 AOGs per month per LGA, but the data clearly indicates that in recent months the Jigawa team (responsible for three LGAs) has been exceeding this target, while the Zamfara team (responsible for two LGAs) has not been able to reach its target.

Figure 22 Monthly number of AOG sessions (food demonstrations and health talks)



[50] The IYCF dataset (see section 3.7) records the number of food demonstrations and the number of health talks as separate indicators. However, in practice, these are often carried out in the same session. In the analysis presented here, we have assumed that food demonstrations and health talks held in the same month and same location (and in most cases with the same number of participants recorded) were delivered at one session, and we have counted this as one AOG meeting. The problem of potential double-counting in these monitoring data was noted in the CDGP's October 2015 Progress Report.

[51] For all the graphs in this section, it should be noted that BCC monitoring data for Jigawa is not available before May 2015. This is partly attributed to the vacant Deputy Programme Manager for Health and Nutrition post in the Jigawa State team from January 2015 to May 2015 but also because of late start in carrying out this activities in this State.

Workshops with state and LGA teams reveal that there are two reasons driving this differential between state teams. The first is related to the team size and capacity to deliver this intervention. Because AOGs are led by CDGP staff, the Deputy Programme Manager of Health and Nutrition in Jigawa has more LGA-level staff to achieve this target, as compared to her counterpart in Zamfara.

A second reason for this differential is related to the fact that there are different implementing partners leading operations in each state. Preparing for AOGs, particularly food demonstrations, requires a significant amount of money to purchase food in local markets, cooking equipment and utensils. LGA teams therefore need to make a requisition for money to their respective organisations to enable them to make such purchases in advance of the AOGs; this requisition is then reconciled after the AOGs are complete. While this system of requisition and reconciliation works well for AAH in Jigawa, the SC procurement rules do not allow LGA teams to make requisitions over a certain monetary amount. LGA teams are only able to make a requisition to cover the cost of four AOGs before having to reconcile the advance and submit a second requisition. These procurement rules greatly restrict the Zamfara team's ability to meet AOG monthly targets. Furthermore, such administrative barriers have also been found to be demotivating and a cause of significant frustration among staff, thus risking this BCC component being neglected.

A further issue related to the AOGs concerns the rationale of the targets themselves. It appears the target of 10 AOGs per LGA per month was initially outlined for practical operational reasons which are already proving to be difficult to achieve. Assuming that the CDGP is able to implement AOGs at the set target in both Jigawa and Zamfara, each month 50 TWs could be covered. As of January 2016, CDGP data reveals that they are implementing across nearly 300 TWs (294 TWs), which indicates that at the current scale of implementation with the proposed target an AOG could be implemented in a TW on average every six months – or twice per year. However, this assumes the scale of implementation remains constant, but we know that the CDGP will continue to expand into new communities, reducing the frequency of possible AOGs per community per year.

This raises the question of the impact of AOGs: are the messages that are conveyed at food demonstrations powerful enough to make an impact with such a low intensity of exposure? It is also understood that AOGs are often attended by more than 50 members of the community, which might dilute any messages conveyed.

IYCF SGs

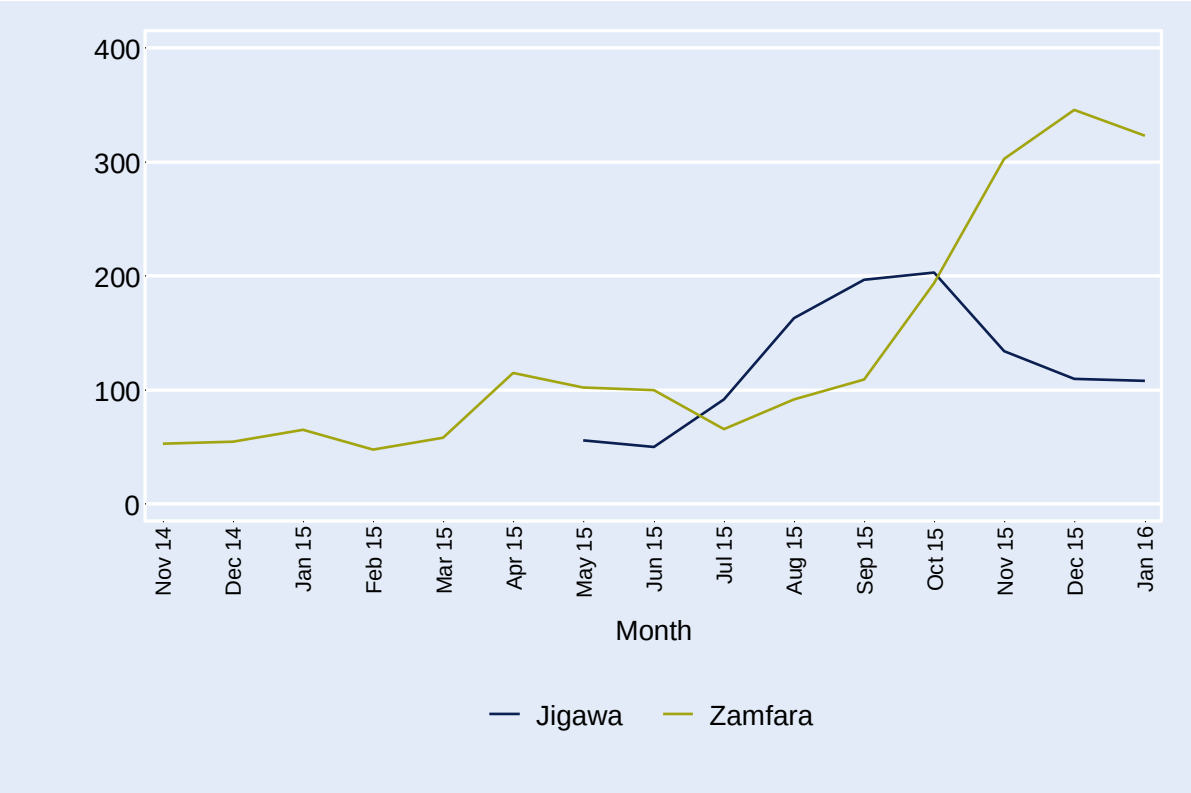
IYCF SGs have been set up in 139 TWs to date. The recommended size of each group is 12–15 people, but the actual size of groups cannot be confirmed from the current monitoring data. Group meetings are facilitated by CVs with supportive supervision provided by CHEWs. While the logframe target is for 60% of T2 beneficiaries to be enrolled in a SG, the CDGP is in theory aiming to have every registered beneficiary in a T2 community attend an IYCF SG every month. In addition to SGs for beneficiaries, the CDGP has outlined a strategy to implement male SGs because men play an important role in decision-making in the household, including decisions about nutrition and attendance at antenatal clinics. To date, efforts to set up male SGs have faced considerable difficulty with relatively few active male SGs recorded. This may be due to the general lack of motivation of male participants to meet regularly in the form of a SG. But it is also clear that CDGP's focus has been on other components of the BCC strategy as guidelines for the male SGs have not yet been developed.

The IM recommends that SGs should meet every month, but in practice CDGP classifies a group as 'active' if it has met at least once in the previous three consecutive months. Facilitating meetings of all support groups every month may be too demanding on the time of community volunteers: this is one of many issues that could helpfully be investigated by the delayed CV engagement study

noted earlier. The monitoring data graphed in Figure 23 shows that the number of active SGs is rising, especially in Zamfara, with over 300 in January 2016. While it is unclear why the number of SGs has declined in Jigawa in recent months, this is a significant achievement of the CDGP and a direct result of renewed efforts to promote BCC interventions from mid-2015 onwards.

The analysis of this data must be considered carefully. In the process of validating our results with CDGP, it was revealed that each state had a different definition of an 'active' IYCF SG. In Jigawa, the team was using the definition as outlined above, whereas the team in Zamfara were classifying a group as 'active' if they had met at least twice in the last quarter. While the definition of this has been inconsistently used between states, the emerging pattern remains interesting in that we can see a scaling-up of SG in both states in the recent months. Inconsistencies in such indicators could be resolved by means of a systematic documentation of the M&E system in the form of an M&E Plan, as further discussed in section 3.7 below.

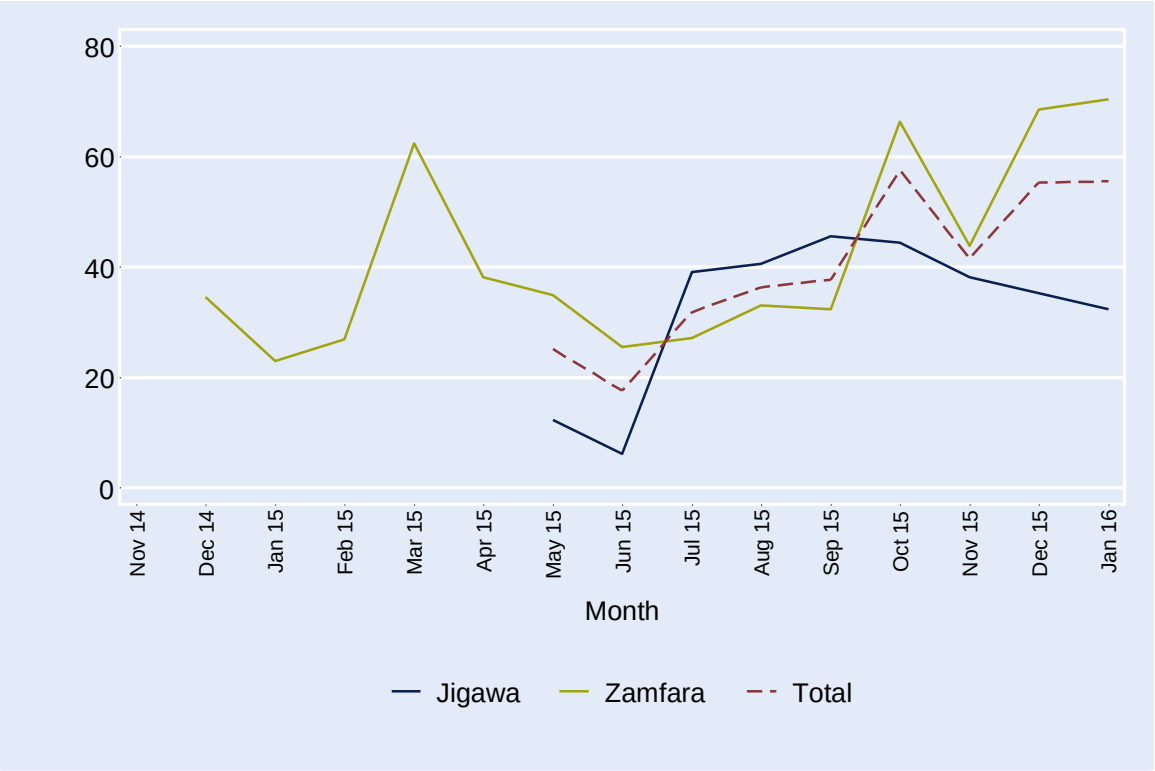
Figure 23 Monthly number of active IYCF SGs, by state



The next graph attempts to use programme data to assess the percentage of T2 beneficiaries participating in an active SG, as this data is not readily available. To do this, we assume each SG is composed of 15 beneficiaries and that each beneficiary does not attend more than one SG in a single month. By multiplying the number of active SGs conducted in each month by the assumed size of the SG (15 beneficiaries), we can approximate the number of T2 beneficiaries who participate in active SGs in a given month.

Looking at the dashed red line, which represents the total proportion of T2 beneficiaries participating in an active SG (igure 24), we see that just under 60% of T2 beneficiaries have participated in an active SG in January. Much of this is driven by progress made in Zamfara.

igure 24 Percentage of beneficiaries participating in an active SG, by state[52]



One-to-one counselling

One-to-one counselling is provided by CVs to beneficiaries who request it on an 'as-needed' basis. In this model, beneficiaries are able to request one-to-one counselling from female CVs operating in their community (for example, during SG meetings). The husbands of beneficiaries are also able to request one-to-one counselling from male CVs, but the extent to which this happens is unclear.

As shown in Figure 25, the number of T2 beneficiaries in one-to-one counselling sessions has steadily increased since mid-2015. However, when we look at the proportion of T2 beneficiaries in a given month who have participated in a one-to-one counselling session (Figure 26), we see a relatively stable trend, with about 10% of T2 beneficiaries participating in a one-to-one session in January 2016, indicating that the CDGP has scaled up the number of sessions in line with the increase in the number of registered beneficiaries, but is falling short of achieving its target to have 30% of T2 beneficiaries participating in one-to-one sessions.

Unfortunately, it is not possible from the monitoring data collected to assess how frequently any individual beneficiary is counselled. The cumulative number of new participants in one-to-one counselling sessions between November 2014 and January 2016 (that is, the number of individuals who have received at least one counselling session) is 1,547 in Jigawa and 2,751 in Zamfara.

It is striking that all the monitoring data on BCC is concerned with counting sessions and participants, while little or no information is available on the content or quality of the interventions delivered, or on the frequency or intensity of activities at beneficiary level. Supervisory visits are made by CHEWs and CDGP staff to observe and support the CVs delivering the BCC services, but

[52] Only T2 beneficiaries have been included in the denominator for this graph.

the only information available on this is the number of visits made and not the findings of the supervisory visits.

Figure 25 Monthly number of beneficiaries receiving one-to-one counselling

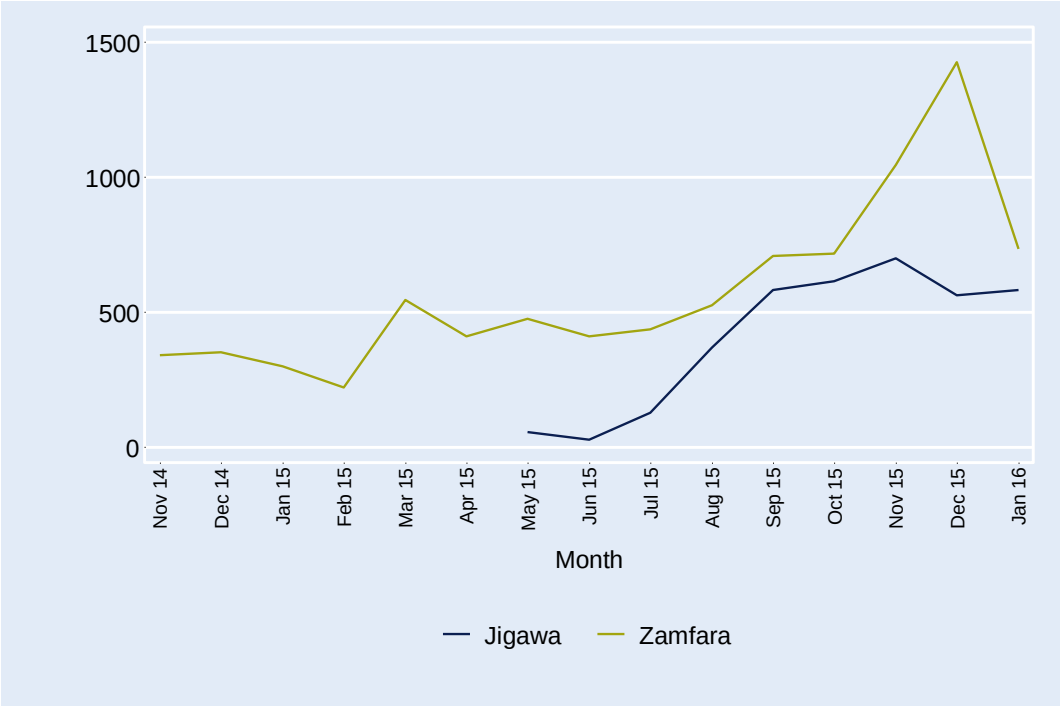
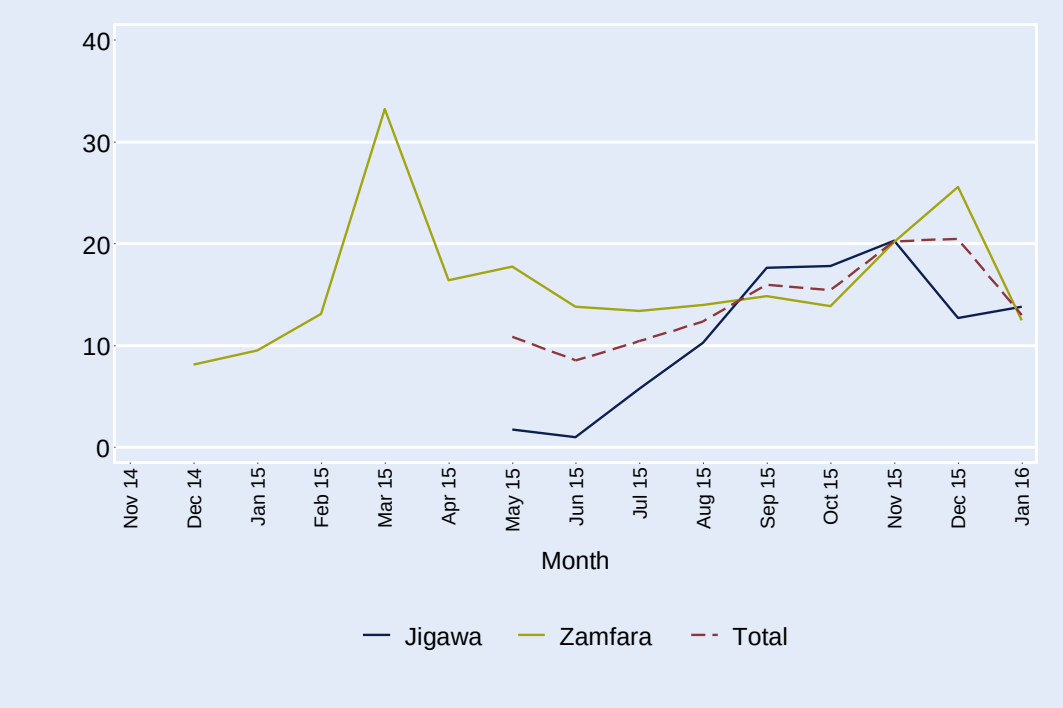


Figure 26 Percentage of beneficiaries receiving one-to-one counselling by month and by state[53]



3.5.3 Challenges and lessons learned

Staff capacity to lead the BCC component of the CDGP was limited

A major cause of delay to BCC activities, especially during the main roll-out phase (from mid-2014 to mid-2015), was the perhaps unavoidable decision to focus resources, including scarce human resources, on all the processes enabling the delivery of the cash transfer component (including the community entry and registration processes described above). The general shortage of field staff and the lack of full-time posts dedicated to Nutrition and BCC activities meant that all LGA team members and CVs were frequently focused on the support for registration and cash transfer payments rather than the BCC component.

At the central level, there was no full-time Nutrition and BCC Adviser post in the CDGP Abuja office until January 2015 (near the end of Year 2). Prior to that, the programme relied on technical assistance in nutrition from the SC and AAH country offices and headquarters, and the SC regional office in Dakar. A BCC consultant was also engaged from late 2013 to early 2014. The original design assumed that the CDGP would be implemented alongside WINNN, and would therefore make use of the technical and field capacity in nutrition. However, it was decided as early as May 2013 that the CDGP would work in different LGAs, so no overlap was possible. The CDGP has benefited from a close relationship with WINNN, including shared training opportunities, interactions with WINNN advisers, and drawing on their experience and findings. However, the extent of WINNN's capacity to support the CDGP was limited.

[53] Only T2 beneficiaries have been included in the denominator for this graph.

Now that the full-time Nutrition and BCC Adviser has been in post for a year, the pace of BCC activities is picking up and more attention is being paid to the challenges of ensuring and assessing their quality. A new post of full-time Nutrition Assistant in each LGA is also being proposed for Year 4, which should further increase the programme's capacity for BCC in the communities.

A further challenge the CDGP faces as it increases the scale of its operations is the capacity of a fixed-sized team at state and LGA level to implement BCC activities over an increasing number of communities. To date, the CDGP has increased the scale of its BCC activities but falls short of meeting its targets. Meeting BCC targets will continue to be a challenge as the programme is rolled out – particularly for BCC components that require staff support.

The original design was over-ambitious and relies heavily on CVs

It is well understood that a multi-modal approach is necessary for the BCC component to influence behaviour change. Not only does this approach accommodate the varying preferences of beneficiaries, it enables messages to reach beyond beneficiaries and influence the understanding of community members and leaders, which may in turn create a supportive environment for behaviour change.[54] However, given the scale of operations, the targets of the various components in the BCC strategy need to be re-assessed, balancing effort and effectiveness. The concern here is that most of the BCC activities rely on CVs and that rationalising their efforts and reducing the burden placed upon them could yield significant gains in quality.

It is our understanding that supportive supervision is carried out by CHEWs who do fill in a quality assessment check-list; this data is limited and it is not possible to reach any conclusions on the quality of BCC implementation (see section 3.7 where quality monitoring is discussed in more detail). However, we can use operational data to estimate coverage. Taking AOGs for example, at the current scale of operations, the CDGP is set to deliver two AOGs per community per year. Given the significant resources and administrative barriers that need to be overcome to implement this component, is this BCC component likely to have an impact at this scale of implementation?

Another BCC component that has proved difficult to launch is male SGs. While it is clearly important to reach fathers and other influential members of the community, perhaps other mass media strategies are more appropriate. Operational data and experience over the last 18 months of implementation should be used to rationalise the various components of the BCC strategy, with the ultimate aim of reducing the burden placed on CVs and supporting them to undertake fewer activities to a higher level of quality and intensity. This will involve re-assessing the extent of CVs' responsibilities for other programme functions, such as mobilising beneficiaries for payments, participating in BRGs and responding to any complaints. It is well understood that CVs play a pivotal role in various process domains of the programme and the BCC strategy should be tailored to what is feasible given their other functions.

[54] Tibbo, K. and Umar, C. (2014) Review of the Child Development Grant Programme, Nigeria: Pilot Strategies and Processes. Final Report, September 2014.

Improving BCC monitoring data

As outlined in section 3.7, the CDGP monitoring system collects a wealth of data across the programme. While much of the analysis presented in this section relies on programme data, a number of challenges remain to be addressed.

Data should only be collected with a view to analysis and ultimately to enabling the programme to take management actions and to learn. At present, CHEWs collect data on supportive supervision, register beneficiary attendance at SGs and one-to-one counselling, and track topics that are covered. However, none of this data is analysed at the programme level. Rather, the data seems to only be collected to track activity implementation. Much better use could be made of these existing registers and forms.

For example, collecting and analysing data on the topics covered in SG and one-to-one sessions would reveal which of the IYCF messages are discussed and which ones are missed. This, in turn, could inform supervisory and refresher training efforts to improve CV delivery of IYCF messages. The risk here is that messages delivered through CVs become repetitive, leading to audience fatigue and ultimately reducing any incentive to participate in these sessions. Actively monitoring content could mitigate this risk.

With regards to SGs, much more could be done in the monitoring of this BCC component. Currently, the number of SG sessions and the number of active SGs are monitored on a monthly basis. However, if SGs could be tracked at the community level, this would enable the CDGP to assess how many SGs transitioned from 'active' to 'inactive' status in a month and vice versa. This information would not only be able to direct supervisory efforts, but could also elicit lessons about the determinants of maintaining active SGs, which would be useful for broader programme learning.

Beneficiaries' incentives and motivation to participate in BCC activities

In the PE workshops in both states, LGA team members commented on the problem of poor attendance and the lack of motivation for beneficiaries to attend BCC activities – in contrast to the cash payment, which everyone is keen to attend. Illiteracy and the low level of general education among beneficiaries – most women registered in the CDGP have never been in a formal learning environment – can also make communication and learning challenging. As noted in section 3.2, traditional beliefs and misconceptions about CDGP's objectives in communities could be a barrier to effective BCC.

Improving the quality of the BCC interventions delivered by CVs could be an important factor in increasing beneficiaries' motivation to participate in BCC activities. Other opportunities to increase beneficiary motivation include integrating BCC activities with monthly payments and creating links to other nutrition services, such as distribution of multiple-micronutrient powders, which is currently being piloted by the United Nations Children's Emergency Fund in Nigeria.

Low coverage of voice messages

Voice messages are a key component of the mass media communications approach. However, this component faces particular challenges of gaining coverage among beneficiaries given the difficulties of operating in Northern Nigeria. Workshop participants indicated that network coverage

is patchy, and beneficiary mobile phones are often not charged so they are not able to receive voice messages. Beneficiaries also often give or sell the phones to other people, so even when a voice message call is picked up there is no way to know who has received it. The PDM data from December 2015 reveals that fewer than 10% of beneficiaries reported hearing IYCF messages via voice messages.[55]

Operational data from the voice messaging service provider was not informative. Given the dearth of data from the service provider, it is impossible to tell which messages were sent out, how frequently they were communicated and how many beneficiaries picked up the phone or heard them. Additional data would be useful to better understand the performance of this BCC component, but the challenges presented above and data on coverage from the PDM call into question the effectiveness of this modality.

Low coverage of radio jingles and radio shows

Radio programmes also face similar challenges to voice messages in that coverage is dependent on radio signal, access to radios and electricity. However, the purpose of the radio shows is to reach beyond the beneficiary target group and it is difficult to assess its coverage as the only data we have is via the PDM, which samples only beneficiaries.

Workshop participants did reveal that the radio jingles and radio shows served to sensitise communities and the general public about CDGP's activities, but the PDM data suggests that coverage among beneficiaries is low and the CDGP is currently thinking about asking CVs to organise listening groups in communities so that radios can be shared and the programme can be discussed. While this may be a good idea to increase coverage, making further requests of CVs' limited time should be considered carefully.

[55] CDGP (2015-08) Bi-Annual Post Distribution Monitoring Report, August 2015.

3.6 Complaints Response Mechanism

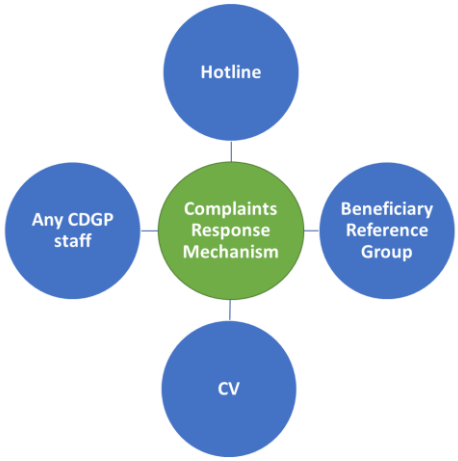
Key findings

- The CRM for the CDGP has managed to create sufficient channels for reporting and monitoring of grievances and complaints – the hotline, BRGs, CVs and any CDGP staff.
- However, there are limitations in terms of effective utilisation of the channels, lack of dedicated human resources for complaints response and redressal, and effective reporting and monitoring of the complaints through programme monitoring system.
- The databases used to monitor complaints lack sufficient details on complaints response and are not up-to-date.
- The categories of complaints created for the tracking of complaints are not refined and detailed enough to capture the theme of complaints and suggest areas of improvement for the programme design and implementation.

3.6.1 Description of the process domain

The CRM component of the programme, as described in the IM, is intended to encourage and enable beneficiaries to communicate complaints, provide feedback and make requests for information to the programme, and for the programme to provide responses or solutions. There are currently four points of entry to contact the CDGP – the hotline, BRGs, CVs and CDGP staff. These are represented in Figure 27 and described in more detail below.

Figure 27 Four entry points of CRM



The hotline

The hotline is a dedicated phone number that beneficiaries or any other person can call to seek information, provide feedback or make a complaint related to CDGP. The hotline number should be displayed on posters or notice boards at the payment points and other public places, and provided

to beneficiaries at the registration and during phone training, community consultations and BCC sessions.[56]

The hotline phone is in each LGA office and is answered by any of the LGA staff, decided on a rotation basis.[57] The calls on the hotline are not free – callers require call credit to make the call.[58] When a call is received on the hotline number, the staff member either resolves the request at that time or escalates it, as appropriate, depending on the complaint category (described below). If the call cannot be resolved at that time or the caller does not have call credit, the CDGP staff member takes the caller's details and number and calls them back.

BRG

According to the IM, a BRG should be formed in each TW and should complement the TWC. The BRG should include one woman leader, two beneficiaries, one TBA, one imam, one traditional leader, two beneficiary husbands, and a CV. Separate men's and women's BRGs should be formed and these BRGs should meet monthly.[59] In practice, the membership of a BRG is likely to overlap with that of the TWC.

The BRG/TWC can resolve minor complaints themselves (for example, disputes between husbands and wives are likely to be referred to the TWC). CDGP staff sometimes attend TWC meetings to explain the programme rules or discuss difficult cases.

CVs

A CV may resolve the complaint immediately (especially requests for information) or pass it on to the TWC or a CDGP team member (this could be a CHEW, a seconded staff member or an SC/AAH staff member).

CDGP staff

A complaint can be made directly to a CDGP staff member, whenever they are present in the community (for example, during payments, registration, BCC activities or community meetings). It was suggested by key informants that community members prefer to talk directly to programme staff when they have the opportunity to do so.

There are also informal channels through which the CDGP receives information, including tip-offs about suspected fraud or issues with CVs, for example from Stanbic coordinators supervising the payment agents. CDGP's good working relationship with the payment provider has enabled such informal channels to exist, ensuring the quick and direct communication of problems.

[56] A proposal to add the hotline number to the end of CDGP radio jingles was being considered at the time of the PE interviews.

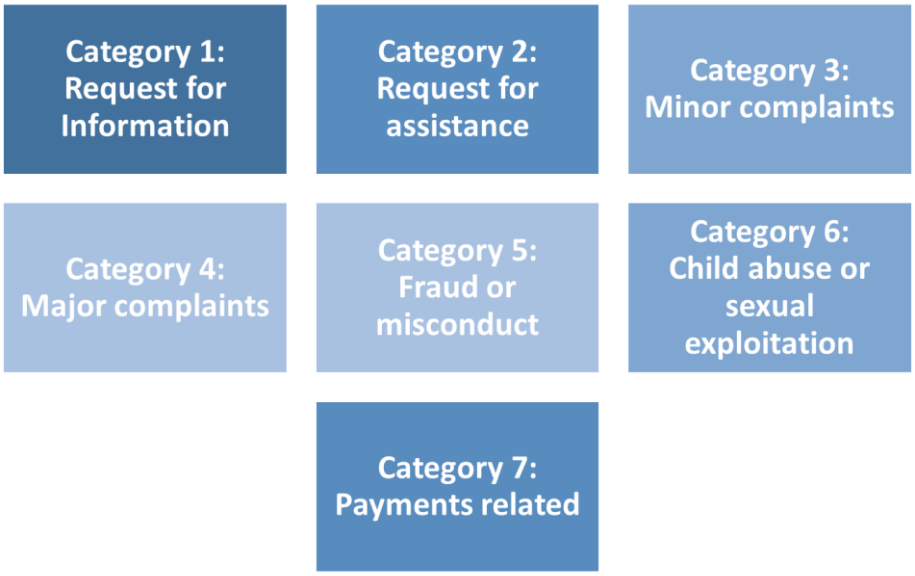
[57] A proposal to have dedicated CRM staff at both LGA and state level was being considered at the time of the PE interviews.

[58] A proposal to provide a toll-free number for the hotline was being considered at the time of the PE interviews (February 2016).

[59] As the PE team did not go to community level, we were not able to observe directly how these community-level structures are working or how far their membership and functions match the IM.

When a 'complaint' is received through any of the entry points above, it is logged under one of seven complaint categories. These are presented in Figure 28. Further details and examples of the categories can be found in Annex B.

Figure 28 Seven categories of complaints



The LGAs can usually handle complaints in Categories 1 to 4. Categories 5 and 6 are escalated to national level and Category 7 is handled by the payment provider, Stanbic. Each complaint received by any of the entry points or channels is recorded on a Complaints Response and Feedback Form, which is later entered into the CRM database. Setting up the CRM at the LGA level involves a one-day training of CDGP staff, payment agents and LGA steering committee on CRM, then a three-day step-down training for CVs, CHEWs, TWCs and beneficiaries.

3.6.2 Implementation

Timeline and evolution of the CRM

The new position of CRM Coordinator at the central level was created and filled in January 2016. Before this position was created, LGA supervisors and the M&E coordinator at state and central level used to monitor complaints – there was no dedicated staff at the central level for this process. This position now creates a direct link between LGAs and the central level for quick responses to complaints.

While the CRM form was introduced during the roll-out phase, the CRM database was introduced later in February 2015. This enabled a central repository of complaints received and their tracking and responses by the LGA supervisors and M&E coordinators.

The BRGs were established at different times in different states, and in each community during the sensitisation and mobilisation processes. The first BRGs were formed in April 2014 in Zamfara state, and in June 2014 in Jigawa (during the pre-pilot).

Coverage and implementation

The CRM database has not yet been fully populated and updated. The analysis of coverage and implementation of CRM below, which is based on the CRM database, is only representative of the data already entered in the system, and therefore may not be complete. As shown in Figure 29, the number of complaints received was very low at the beginning of the programme but has increased since then (as expected, because the number of beneficiaries has also risen). The number of complaints received has been higher in Zamfara than in Jigawa: this could be due to the channels being more effectively used by the beneficiaries, or reporting on complaints being more efficiently done; or it could be that there is a higher number of implementation issues in Zamfara.

Figure 29 Monthly number of complaints received, by state

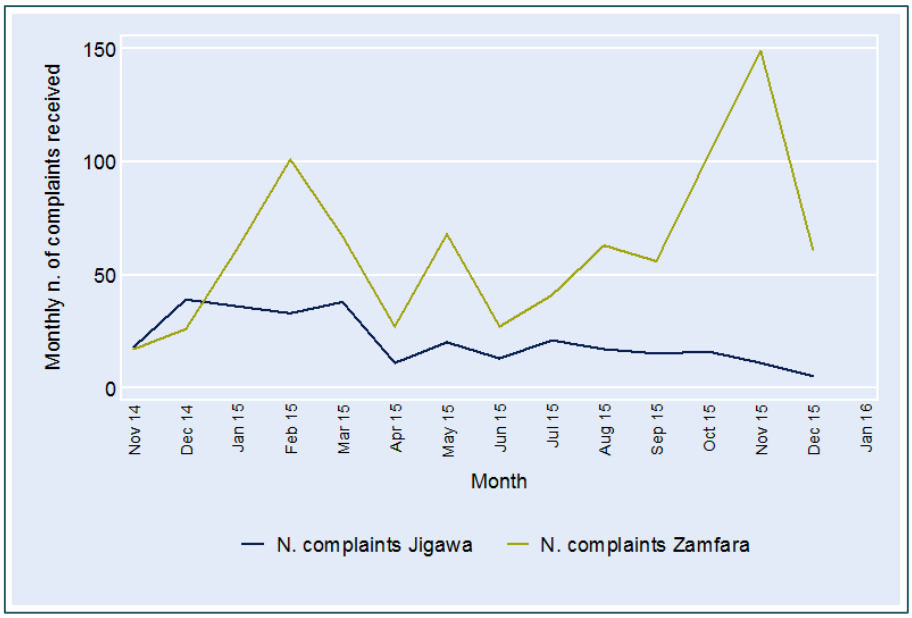


Figure 30 gives a breakdown by category of complaints received each month between November 2014 and December 2015. In most months, most complaints received have been in Categories 1 and 2 – requests for information and assistance. These categories are essentially not complaints, skewing the total complaints figures reported in the dashboard. For complaints in Categories 3 and 4, the current CRM system shows variable data and relatively low numbers: this may be because the CRM system is not capturing these complaints effectively. The number of complaints logged in Category 5 has also been low. This could be partly due to the measures already implemented to reduce fraud (such as random pregnancy testing – see section 3.3), but probably a bigger factor according to key informants is the general reluctance among beneficiaries and CVs to complain or to report potential fraud. There has been no case of complaint in Category 6 so far. There was an increase in the number of payment-related complaints received (Category 7) in the last quarter of 2015. Complaints in this category are usually received during the payment days by the staff in the field, and the majority are routine problems with the payment process (especially with the thumb-print scanners).

Figure 30 Monthly number of complaints received (both states), by category

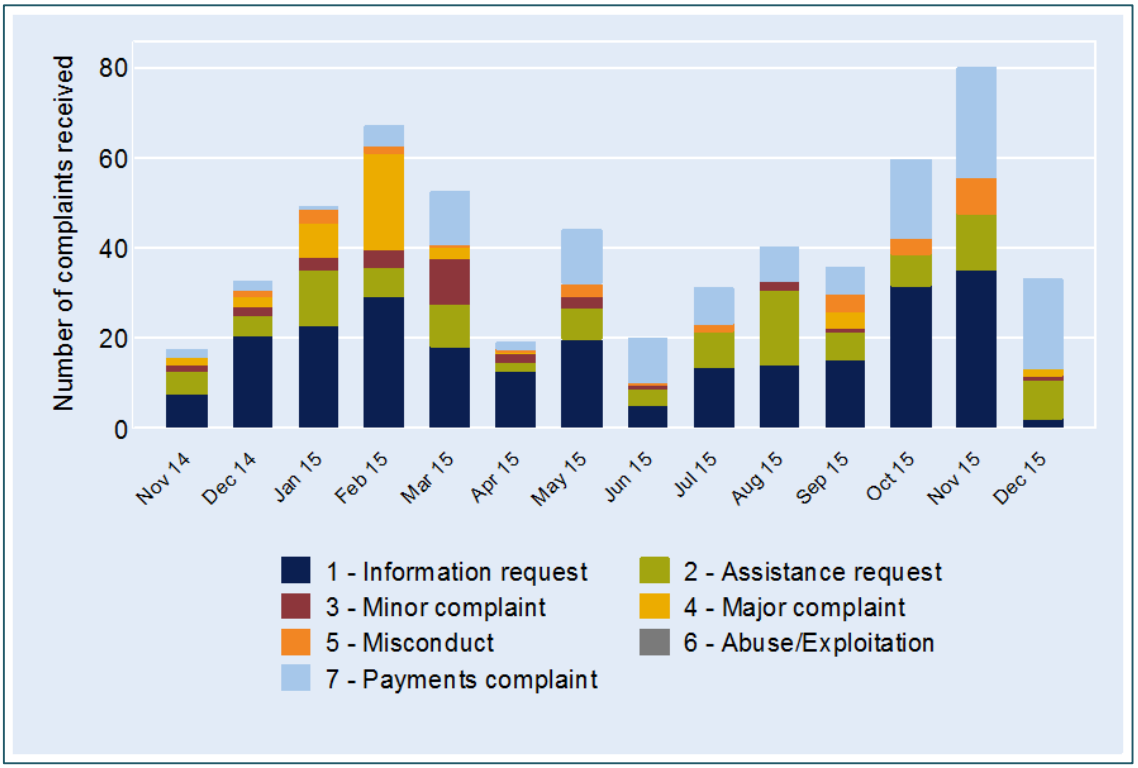
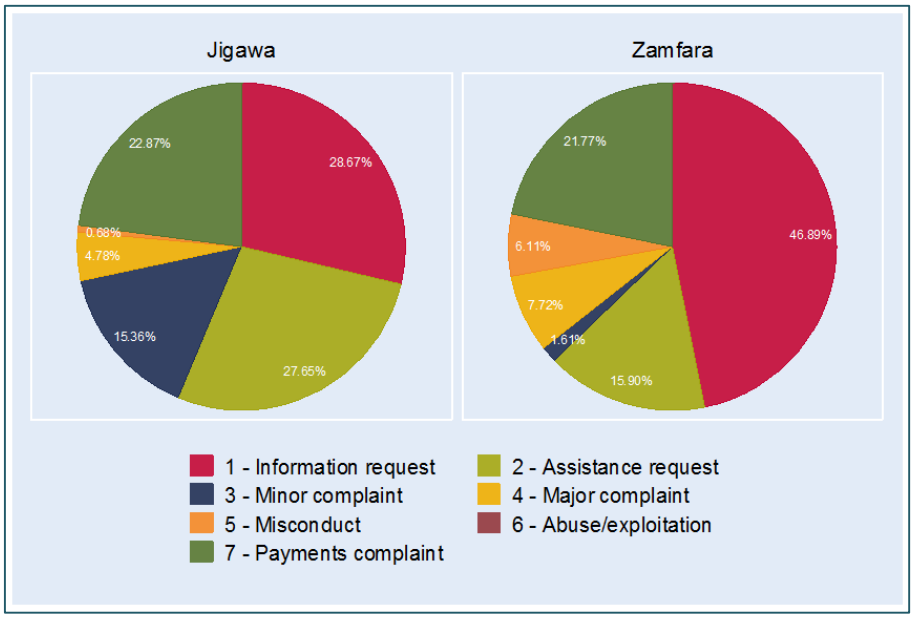


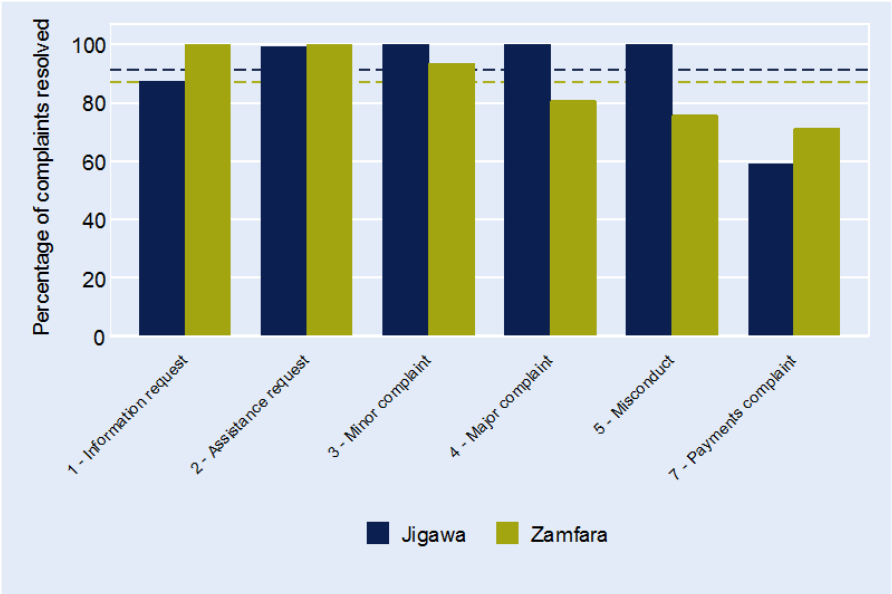
Figure 31 below presents the percentage of all complaints received between November 2014 and December 2015, by category and state. The graph confirms that the majority of the communications are information and assistance requests (Categories 1 and 2). The next most frequent category is complaints related to payments, Category 7. The total percentage of minor and major complaints (Categories 3 and 4) was higher for Jigawa than for Zamfara. The proportion of complaints received under Category 5 was higher for Zamfara than for Jigawa. The figures above show a marked rise in Category 5 complaints in November 2015, but there is no information in the monitoring system to explain the nature or cause of these complaints.

Figure 31 Total complaints received (November 2014 to December 2015), by category



The average resolution rate of complaints (i.e. number of total complaints resolved out of total number of complaints received) was higher for Jigawa than for Zamfara, as shown in Figure 32. The resolution rate for complaints under Categories 4 and 5 is lower than for other complaints. This can be explained by the nature of these complaints, which requires them to be escalated to the Central Team and requires detailed investigation and stricter actions to be taken for them to be resolved. It should be noted that how a complaint is categorised as 'resolved' remains unclear.

Figure 32 Percentage of complaints resolved, by category



3.6.3 Challenges and lessons learned

TWCs play an important role in dealing with complaints

The TWCs are the traditional local structures for resolving disputes within a community. The CDGP has been able to leverage the existing position of the TWCs within the community and in theory extended this to include beneficiaries, CVs and husbands of beneficiaries and to form the BRGs. Therefore in reality there is a high degree of overlap between the TWCs and BRGs and in many instances they may in effect be the one and same thing. Traditionally the TWCs have more power and influence than a community structure created exclusively for CRM would have.

Issues with the hotline

As mentioned earlier in section 3.6.1, the responsibility for answering the hotline phone currently rotates among LGA staff: there is no dedicated staff to respond to the hotline. These LGA staff members have a huge existing workload in terms of the programme implementation and hence are not always available to answer the phone. Responding to the hotline during the payment period, the last half of each month, is especially difficult as most of the LGA staff are in the field monitoring the payment process. However, this means that some complaints can be directly communicated to the LGA staff when they are in the field. The current system of rotation of responsibilities seems to be working but as the number of beneficiaries increases, the complaints will become more frequent and the system unsustainable. The hotline requires a dedicated team at the LGA level which the programme is currently addressing.

During the observation visit to a payment site for the PE study, it was noticed that there were no posters or information displayed on the hotline available at the site. This may reflect the fact that the hotline number is not being effectively communicated to the beneficiaries or community members.[60]

At present, hotline calls have to be paid for (by mobile phone credit). This may well be limiting the number of complaints received from beneficiaries or community members. The programme provides a call credit of NGN100 to beneficiaries at registration, but this is a very small amount of credit, enough to allow the SIM to be activated. A proposal is being discussed at the central level to make the hotline toll-free in future. However, this could mean outsourcing the hotline to an external provider, and may limit the possibility of calling people back if sufficient details are not noted. Poor coverage of phone networks in many of the programme communities also limits the use of the hotline.

Reliance on community structures may create a 'closed loop'

While complaints being received and resolved at the community level shows a great success, there are challenges in terms of beneficiaries overcoming existing community social and power structures. If a beneficiary or CV is facing an issue related to the programme, or wants to report a case of fraud or abuse within the community itself or a complaint against a CV, then it is difficult for them to do this within the community structure. Complaints received and resolved by the community structures may suffer from a 'closed loop' problem, meaning that the people being complained about may be the same people receiving the complaint. In such cases, the monitoring system is unlikely to detect whether the complaint was resolved to the satisfaction of the beneficiary, or whether any follow-up action was taken. Alternative channels (such as the hotline

[60] Whether the beneficiaries or community members know the hotline number could not be assessed in the PE study but could be assessed either in the PDM or as part of the ePact qualitative study.

and direct access to CDGP staff) are needed alongside the community-based structures to act as checks and balances and enable complainants to bypass local power structures when necessary.

Reluctance to complain

It was suggested by several key informants that beneficiaries are generally reluctant to complain, either due to a lack of awareness of different channels for lodging complaints or the process of CRM as a whole, or a lack of understanding of their rights, or fear of being exited from the programme if they complain.

The majority of literate CVs are male and hence they do not always receive complaints from female beneficiaries or members. There is a great reliance on the reporting of complaints by the CVs but given their limited abilities, illiteracy and the huge burden of responsibilities related to the programme implementation, they are not effectively incentivised to report problems to the CDGP.

Insufficient monitoring of complaints and their resolution

Currently the primary responsibility of monitoring the complaints database at LGA level is with the LGA supervisor, while at the state level, the responsibility lies with the M&E officer. At the LGA level, given the existing responsibilities of LGA supervisor, monitoring is often not possible. Lack of monitoring may result in poor follow-up and a low level of resolution of complaints.

There is a proposal to create new posts for CRM monitoring and management both at the LGA and state level. If these posts are confirmed, this will ensure more effective monitoring of the complaints and their resolution, and also allow for regular visits to the communities to hear from the beneficiaries and community members directly. There was also a proposal to include helpdesks at the food demonstration sessions or at the payment days to enable increased reporting of complaints by the beneficiaries or community members.

A new CRM Coordinator position was created at the central level in January 2016; this is expected to streamline the process of monitoring of complaints and their resolution as well as to bring accountability. Before this position was created, there was no dedicated staff member monitoring complaints and any monitoring was done by the M&E Adviser at the central level.

Incomplete database

In terms of reporting and monitoring of the complaints through the CRM database, the database is still being updated. The CRM database is not up-to-date, either due to delay in data entry by the LGA Data Assistant or incomplete collection of data from the community, or non-completion of complaints received by CDGP staff through the Complaints Response and Feedback Form. When the databases were reviewed during the PE study, it was found that the CRM database had not been updated for Zamfara state for the period after February 2015 and for Jigawa state for the period before November 2015.

While the database tracks the category of the complaint and the complainant details, the form and database do not effectively track whether the complaint was resolved satisfactorily. The database also does not report on what action was finally taken to resolve the complaint. The difference between 'date communicated' and 'date closed' is not clear, as these are either the same date or within a few days' range. There are also no columns in the database for state and LGA to ensure effective tracking. It was suggested during the PE study that many of the complaints are received and resolved by the community-level structures of the BRGs/TWCs, which implies that these complaints do not get reported or monitored unless escalated. Hence, the CRM database may not

provide a complete picture of the programme grievances. There were also issues related to poor access to communities and security risks, which limit investigations to the more serious complaints.

Lack of clear categorisation of complaints

The current categorisation of complaints does not fully capture the complexity of the programme in delivering both cash transfers and BCC interventions. The categories are very broad and hence information on how to improve the programme gets lost in these categories. Categories 3, 4 and 5 in particular encompass a very wide range of potential issues: aggregating complaints into these categories means that the monitoring system does not give full information on the nature and cause of complaints or issues which could be used to better document, analyse and improve programme implementation.

Adding more detail to these categories, and refining the recording of issues and problems being identified for both the cash transfer and BCC component, would help to ensure the CRM data feeds back into the programme design and learning. Additionally, Categories 1 and 2 are not complaints at all but requests for information or assistance. These categories comprise the majority of the reporting and hence could be diverting resources away from reporting of complaints of other categories which are more pertinent to effective implementation of the programme.

Category 6 (allegations of child abuse or sexual exploitation by anyone other than programme staff) could be treated separately, in order to streamline the CRM categories and to focus more attention on types of feedback and problems relating to the programme implementation. This does not, of course, imply that cases of abuse should not be reported and taken with the utmost seriousness: simply that they could be separated from CDGP implementation issues. Aggregating figures for all these categories together limits the use of the data for programme monitoring and skews the output indicator reported against the logframe. Given the pilot nature of the CDGP, it would be very helpful to refine both the definitions and sub-categories of complaints, and the monitoring system for documenting and learning from them.

3.7 Programme monitoring

Key findings

- Programme monitoring is centred on the Monthly Dashboard, which collects data across all major programme areas from each state.
- Data is aggregated at the central level and used in Monthly and Quarterly Progress Reports as well as the Indicator Performance Tracking Table, which monitors logframe indicators on a monthly basis.
- The current M&E Plan would benefit from going beyond simply defining indicators to rationalising and outlining useful types of analysis relevant to implementation stakeholders.
- The current narrative reports are largely summative and report only aggregated data on key indicators. Much more could be done to improve the usefulness of such reports, such as using graphical time-series analysis and disaggregating data to meaningful levels of analysis – such as the state or LGA.
- Data collection relies heavily on CVs filling in forms and there are concerns that illiteracy and having too many responsibilities may result in poor data quality.
- Rationalising CV responsibilities as well as ensuring that only data that is ultimately used and analysed is collected may decrease the burden of responsibility and improve data quality.
- The PDM is a useful means to gather information directly from beneficiaries and is scheduled to be implemented quarterly. However, this target may be too ambitious given that key indicators of interest do not change that quickly and this puts unnecessary strain on the team to implement the PDM without sufficient time to analyse and respond to any emerging issues.

3.7.1 Description of the process domain

The M&E system of the CDGP is an essential component of the programme. The M&E system is led by an M&E and Value-for-Money Adviser in the Abuja Central Team who is supported in each state by an M&E Officer in Zamfara and a Programme Quality and Accountability Officer in Jigawa (see section 3.8.1 for a more detailed discussion on the staffing and organogram of CDGP). In each LGA, there is one data assistant, who is responsible for the verification and compilation of all data within the LGA. The data underpinning the M&E system is collected by the people responsible for implementing a particular process, who in many cases are non-programme staff such as CVs and CHEWs.

The M&E system has been designed for the collection, compilation and analysis of data across each of the process domains to track the scale of implementation activities and ultimately progress against logframe indicators.

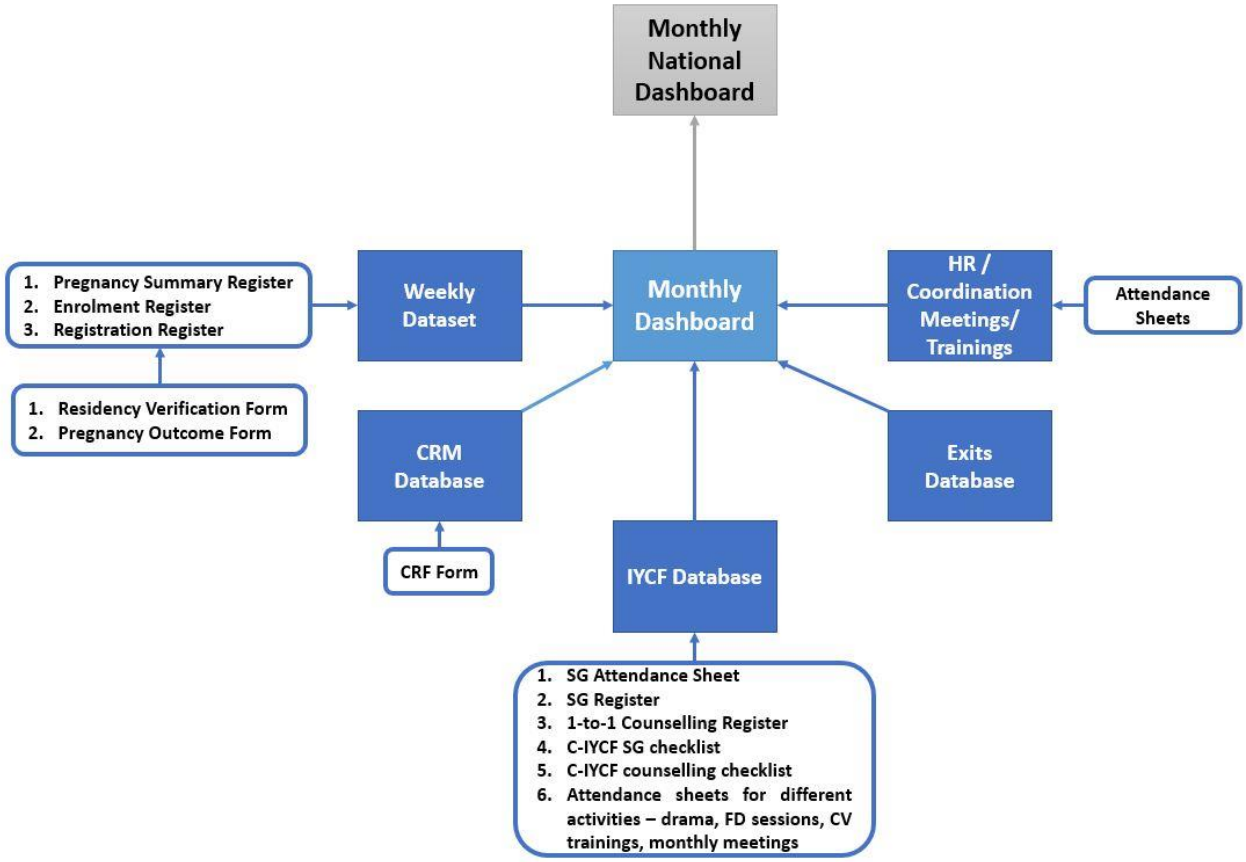
In addition, the M&E system also conducts quarterly surveys of beneficiaries by means of a PDM to monitor satisfaction, understand cash transfer utilisation patterns and generate programme learning.

The M&E system is centred on the Monthly Dashboard, which compiles data from the following sources of data:

1) The weekly dataset (for payments)
2) The IYCF dataset
3) The complaints response and feedback dataset
4) The exits dataset
5) The seconded staff and training dataset

This is summarised in Figure 33 below, which displays the various sources of data that feed into the Monthly National Dashboard. Further details of each component are described in Annex D.

Figure 33 Representation of the programme monitoring system and the Monthly Dashboard



The Monthly Dashboard from each state is compiled in Abuja to produce the Monthly National Dashboard, which is the single source of aggregated operational data for the programme. This data is then used to feed into various management reports, including: Monthly Progress Reports, Quarterly Progress Reports, and the Indicator Performance Tracking Table which monitors

logframe indicators. Each of these management reports also draws on data from beyond the M&E system.

In addition to the operational data summarised in the Monthly Dashboard, the M&E system also regularly collects data from beneficiaries by means of a PDM survey. The objectives of this survey are to re-enforce accountability to beneficiaries and improve programme learning. The CDGP has designed two versions of the PDM questionnaire: a light-touch survey to be conducted every quarter, which collects data on the cash transfer process, what beneficiaries are purchasing with the cash transfer and awareness of BCC interventions and messages; and an expanded version to be conducted every six months, which captures data on dietary diversity, food security and coping strategies, in addition to the set of questions in the quarterly survey. TWs in which the programme operates are randomly selected for the survey and beneficiaries are sampled through a process that is not specified in the technical documents. The sample size for each PDM survey is approximately 379 beneficiaries; for the bi-annual PDM the survey sample is stratified to collect data from beneficiaries who have been registered in the programme for less than six months, and beneficiaries who have been registered for longer to assess any differences between the two groups.[61]

3.7.2 Implementation

The M&E system for the CDGP is directly linked to its implementation. The CDGP has managed to foster a culture of regular data collection and compilation at all levels of implementation to ensure the Monthly Dashboard, the basis for programme monitoring, is kept up-to-date. The exits database needs to be up-to-date to ensure an updated list of beneficiaries is available for generating the payments list on a monthly basis. However, the Monthly Dashboard was introduced in November 2014 when the full roll-out of the programme started. Given the late introduction of the Monthly Dashboard, monitoring data from the pilot communities for April–October 2014 has not been compiled and is unavailable.

The PDM has been successfully carried out three times throughout the course of implementation. Interestingly, the CDGP has deliberately chosen to have the Jigawa team oversee PDM activities in Zamfara and vice versa to limit any bias in data collection and to allow the two state teams to interact, learn from each other and provide feedback.

Two data quality assessments of the CDGP's existing monitoring system have so far been conducted by SC in April 2015 and December 2015. The findings from the data quality assessment conducted in April 2015 were available for review and are discussed below.

3.7.3 Challenges and lessons learned

Despite CDGP's success in setting up and implementing an M&E system to cover the wide-ranging complexity of the programme, there remain some important challenges that, if addressed, could unlock the usefulness of the M&E system. These challenges are outlined below.

Documentation, analysis and use of M&E data is largely for programme accountability

The CDGP has an extensive M&E system that comprehensively mirrors each component of implementation. While the broad components of the M&E system is outlined in an M&E plan, it is yet to be fully documented such that it clearly describes and rationalise all aspects of the M&E

[61] CDGP (2015-03) Post Distribution Monitoring Strategy Document, March 2015.

system from the point of data collection to the point of analysis and the reports which it would feed into.

A review of the Monthly Progress Reports indicates that M&E data could be better used in monthly reporting. The current Monthly Progress Report is structured as a narrative report that systematically reports on registrations, revisits, payment, BCC activities, exits and the CRM.[62] [63] [64] [65] While this template covers all of the major process domains of the programme, only a limited number of indicators related to each process domain are analysed. Further, the analysis is not standardised and the indicators presented vary from month to month. Much of the report is summative in that it reports the aggregate value of key indicators at the national level, as opposed to presenting analysis at the level of implementation such as the state and LGA. Finally, the analysis focuses on incremental achievements, presenting only the analysis for the particular month of reporting against the overall target and the cumulative achievement, as opposed to tracking progress over time.

It is clear that the Monthly Progress Reports are an important source of reporting 'upwards' – where data is compiled and aggregated to produce a summative narrative of CDGP's performance as a whole. This type of analysis is largely useful for accountability purposes and logframe reporting. What is unclear is how data from BCC and CRM is analysed beyond the few indicators that are included in the Monthly Progress Reports. However, much more can be done to highlight operational trends and produce analysis that is actionable to improve implementation.

Given the high burden of data collection (explored further below), data should only be collected if it is to be used. Updating the M&E plan would benefit the CDGP by rationalising the data that is collected, and optimising how it can be used for programme monitoring, learning and management actions. Monthly and quarterly reports should be presented with a standard set of analysis for each process domain. All analysis should be broken down to meaningful levels of operation, which could be the LGA or the state, depending on the indicators in question. This will enable the analysis to assess operational performance and make a comparison between different levels of the programme to highlight relative strengths and weaknesses. Finally, all analysis should be done with the historical performance context in view. Such a time-series analysis will illustrate progress over time and could identify persistent gaps and temporary shifts in performance.

For example, a graphical time-series analysis of the National Monthly Dashboard data of the cumulative number of TWs entered by state reveals that the Jigawa team has consistently been entering more T1 TWs than T2 TWs since February 2015, whereas the Zamfara team has rolled out the programme about equally between T1 and T2 TWs (see Figure 8). There appears to be a systematic bias in the roll-out planning in Jigawa that was not caught because simply looking at the monthly number of TWs entered in the current progress report format would not reveal the emerging divergent pattern.

Revising the reports and analysis that come out of the M&E system and making the best use of the rich and comprehensive data that is regularly collected will enable better management decisions to

[62] CDGP (2015) Quarterly narrative report, July–September.

[63] CDGP (2015) Quarterly narrative report, October–December.

[64] CDGP (2015) Monthly progress report, August.

[65] CDGP (2015) Monthly progress report, October.

be made; also, if meaningful operational analysis is shared with state, LGA and even CHEWs and CVs, programme learning at all levels could be enabled.

Data quality is an issue

As outlined above, much of the data collected in the current monitoring system relies on data collection by CVs. This is particularly the case for data collected during the BCC interventions as outlined in section 3.5.2. One of the themes emerging from the state and LGA-level workshops of the PE is that CVs are often illiterate, find filling in data entry forms challenging, and lack sufficient training on data collection and management. Further complicating this issue is the wide-ranging responsibilities placed on CVs for all dimensions of the programme – from mobilisation on payment days, participating in BRGs, receiving questions and complaints on the programme, and implementing community-level components of the BCC strategy. Given this context, the quality of the data feeding into the M&E system is an important consideration.

It is worth noting that the CDGP has made significant efforts to maintain data quality by simplifying data entry forms, and recruiting CHEWs to oversee the work of CVs, including the filling in of forms and instituting weekly and monthly meetings with CVs to review their activities and validate data entry forms. However, insights gained from the PE workshops reveal that concerns about data quality persist. There are a number of additional steps that the CDGP could consider to improve data quality from CVs. These are outlined below:

1. Rationalise the data that is being collected. Only data that is analysed needs to be collected. Updating the M&E plan as outlined above could guide this process.

2. Institute regular refresher trainings specifically on filling in forms and data collection.

3. Use meaningful graphical analysis of the data that is collected to 'feedback' display performance, understand trends, and agree plans to foster an appreciation of 'why' the data is collected.

4. Conduct annual data quality assessments.

Using the PDM to assess the quality of implementation and programme learning

A detailed analysis of the PDM methodology and data is beyond the scope of this exercise. However, a review of the PDM questionnaire and three PDM survey reports – December 2015, August 2015 and January 2015 – reveal some important considerations.

With regards to the questionnaire, the CDGP has designed it in such a way so that it covers all process domains of the programme. It is particularly good to see the PDM asking about the knowledge, attitudes and practices of key IYCF messages as well as beneficiaries' satisfaction with the conduct of CDGP staff, CVs and TWC members. However, there are two components that could be added very simply and yield informative findings. The first is re-structuring the questionnaire to explicitly ask the respondent about exposure to each of the BCC interventions. Currently, the questionnaire is able to determine exposure by first asking the respondent if they have heard any of a number of key messages, followed by asking them where they heard the message. Re-structuring the questionnaire to ask explicitly about exposure to each component of the BBC will enable the questionnaire to then ask subsequent questions on the quality of that intervention. For example, asking the respondent 'Did you participate in any food demonstrations in the last month?' could be followed by a series of questions related to the quality of that exposure – 'How many other people participated in the food demonstration with you?'; 'Did you find the food

demonstration useful?'; 'Have you tried some of the recipes yourself?'; 'Why or why not?' – to better understand the beneficiary's point of view and contribute to programme learning.

With regards to the PDM report, the analysis is comprehensive of all of the indicators in the questionnaire. However, it is interesting to note that the stratified sampling intended for the bi-annual PDM which draws a sample of beneficiaries enrolled in the programme for less than six months and beneficiaries enrolled for more is not analysed in any meaningful way. The PDM's objective of identifying strengths and weaknesses to encourage programme learning could be improved by conducting a time-series analysis. This would entail presenting a comparison of key indicators of the current PDM with estimates from previous PDMs to determine trends and identify progress or persisting challenges. Such a time-series analysis would inform the CDGP of the indicators which shift significantly within the three months between PDM surveys. If indicators do not shift within this period of time, this would call into question the need for conducting the PDM at such a high frequency.

It is understood that an important component of the PDM is to assess beneficiary satisfaction with the programme and monitor how the cash transfer is used. But these indicators do not necessarily have to come from a survey instrument such as the PDM. A simple 'exit-interview' – similar to 'client exit interviews' conducted in the health sector to assess patient satisfaction after receiving health services – could be implemented at the payment point to track key 'short-horizon' indicators such as beneficiary satisfaction and use of funds. Indicators that shift over a longer horizon could remain within the PDM instrument that is conducted at a lower frequency, such as once or twice a year.

Reducing the frequency and shifting to an 'exit-interview' would significantly simplify the PDM surveys for the CDGP M&E team. Currently, by the time the PDM data collection is conducted, data is entered, analysed and written up in a report for a presentation, there is little time left for the CDGP to take action before the next PDM cycle begins. Furthermore, reduction in frequency of data collection would also make the M&E system more cost-efficient as survey teams would no longer be required to randomly select beneficiaries and visit them in their households to collect data as 'short-horizon' indicators could be tracked at a natural point when beneficiaries gather.

3.8 Cross-cutting themes

Key findings

- The programme significantly underestimated the level of support required to implement a programme of this scale and complexity. Many new positions have been created and staffed since the inception phase and during implementation to overcome this.
- Central staffing was a major bottleneck during the initial stages of implementation and resulted in little oversight and understanding of programme operations at state level, which has over time been rectified.
- The programme has struggled to draw sufficiently on international technical assistance, which was conceived as important in ensuring the programme was appropriately designed and operationalised. This is explained by the lack of formal agreements and plans articulating the level of support required and its timing, together with absence of counterpart staff to engage with. CDGP has recently put in place a 'TA planner' which outlines support required well in advance to better coordinate international support.
- The use of technology and related equipment has posed major challenges to the programme and their benefits are not immediately clear.
- Security and accessibility remain a constant challenge for the programme and one needing continuous attention.
- The IM of the programme has evolved over time and additional details of operations incorporated. Nevertheless, this manual is not sufficiently detailed or presented with sufficient clarity or accessibility to serve as guiding documents for state- and LGA-level teams. The programme could also benefit from additional reference material tailored to the needs of the TWCs and CVs utilising infographics or animation, or simply through the use of simple messages translated into Hausa.

3.8.1 Organisation and staffing

The staffing structure and size of the team have gone through a number of iterations since first conceived in the DFID's Business Case. Overall the programme is led and managed by a Central Team based in SC in Abuja and supported by two implementation teams led by AAH in Jigawa and by SC in Zamfara. In this section we highlight the evolution of the team and challenges faced. A full description of staffing structure and its evolution are provided in Annex E.

The Central Team – current structure and its evolution

The Central Team was originally designed to consist of only two members – a National Programme Coordinator and a Procurement Expert.[66] The National Programme Coordinator was to have overall responsibility for the programme with support from Programme Managers in each state to implement the programme (see Figure 35 in Annex E). The Team was expanded during the inception phase to include a Deputy National Programme Manager to oversee the operations at the state level and a Social Protection Adviser to oversee the technical components of the

[66] DFID (2012), CDGP Business Case, August.

programmes (see Figure 36 in Annex E). Following the inception phase and during the pre-pilot phase, a Payment Manager and Monitoring Officer were also added to the Central Team. Despite these additions, central support for implementation was still deemed inadequate and six additional posts have been created to cover BCC, CRM, finance, knowledge management, advocacy and communication as well as a General Programme Officer (see Figure 34 in Annex E). The fact that these positions have been created and filled during the implementation of the programme suggests that the level of support required to implement a programme of this scale was significantly underestimated. The limited staffing at the central level was a bottleneck for the programme implementation in the initial stages, resulting in limited oversight and knowledge of how the programme was being implemented at the state level, on what scale and with what quality.

State-level teams

The state teams broadly follow the same staffing structures and similar roles and functions but sometimes with different job titles, and are not always fully dedicated to the programme. This is borne out by the difference in the organisational structures of the two NGOs operating autonomously at the state level; these had limited coordination at the central level in the early stages of the programme, which was exacerbated by the very high turnover of staff at AAH and limited capacity at SC. See Figure 37, Figure 38, Figure 39 and Figure 40 in Annex E.

Government seconded staff at LGA level

To enable government buy-in and participation in the programme and enhance their capacity to implement such a programme, government staff were seconded to the CDGP at the LGA level by the LGA government bodies. In Jigawa state, there are a total of 22 seconded staff at present. However, only 10 out of these are actually government staff seconded to CDGP – the remainder are non-government staff – suggesting perhaps the difficulty in mobilising sufficient number of government staff. Moreover, the programme initially provided NGN 60,000 as top-up to these staff in Jigawa and NGN 75,000 in Zamfara state. These top-ups were an initiative from the CDGP to get government buy-in at the stage of implementation when the number of seconded staff sought by the programme was lower; however, as the number of seconded staff deployed to the programme has increased, this has led to concerns with sustainability. Consequently, the top-up amount was reduced significantly to NGN 25,000 in early 2015. The reduction in top-ups has led to some resignations across the two states.

In Jigawa state, the government has recently created a budget line for future top-up payments to the seconded staff. However, there are concerns from the government with regard to the high administrative burden of executing such payments and the creation of a double salary structure for these seconded staff.

International technical assistance

Short- and long-term international technical assistance was seen as necessary in ensuring appropriate resources and skills to design, launch and monitor the cash transfer programme.[67] Despite its importance this does not formally feature on the organograms of the programme and until recently there was no formal agreement or elaboration on the level of international technical assistance to be provided, for what purpose and by when. This resulted in ad hoc requests for technical assistance (TA) when problems arose, which were largely viewed as 'peer review' inputs

[67] Save the Children (2012), Technical Proposal, December.

by staff in SC London and in the regional office and not as the substantive design inputs that were required by the programme. The prompt availability of technical staff to provide support was also problematic, resulting in delays in the programme implementation and development of important process domains. When TA was available, the expert had no counterparts to work with and, in the absence of staff dedicated to specific functions of the programme (e.g. BCC, CRM, etc.), progress was often slow. The clearest illustration of this point appears when the 'BCC and Nutrition Adviser' function is considered. Prior to January 2015, when this role was filled, the only counterpart to international TA on nutrition existed within each of the state teams, which was not sufficient to lead the development of the nutrition-sensitive component of the cash transfer programme. The Central Team is now trying a new approach where it is requesting specific inputs and timeframe for the support it requires from SC London. The team expects this to improve the level of TA support it receives.

3.8.2 Technology

The original concept of the CDGP was quite hi-tech, especially in the domain of the payment process, which was expected to use mobile wallets and e-payments. This has proved to be impractical in the current context of Northern Nigeria, and the payment process has been progressively simplified. Nevertheless, ongoing technology challenges were identified as a problem in all the process domains.

Tablets and thumb-print scanners are necessary for both the registration and payment processes. Frequently-mentioned challenges with these are the insufficient number of tablets and wireless internet connectors; hardware failures and maintenance problems; short (and reducing) battery life combined with no electricity supply in most of the beneficiary communities; and low resolution on the scanners (contributing to the frequency of thumb prints not being recognised by the scanners at payment points). Some power banks have been provided in response to the battery problems, but field staff say they are not powerful enough. Given the reliance on these technology resources, the CDGP should review whether sufficient investment has been made in them to ensure adequate and reliable equipment.

Poor and patchy network coverage for mobile phones, internet (for synchronisation of registration and payment data), and radio broadcasts is compromising the effectiveness and coverage of several processes including BCC.

Mobile phones were originally seen as essential to the payment and BCC processes. However, in practice they seem to be little used and not essential. Voice messaging appears to have very low coverage. Credit alerts are not received and perhaps not necessary now that the amount a beneficiary can withdraw each month has been fixed at one month's transfer (NGN 3,500). Notification of payment dates is communicated through CVs. For identification at the payment point, beneficiaries only need the number, not the phone or even the SIM card itself. Given all these factors, combined with the cost of the phones and the bottleneck caused when procurement was delayed, the CDGP should consider whether the phones are necessary to the operation of the programme. It is not suggested that this key element should be changed at this point in the pilot programme, but alternatives should be investigated for any future scale-up or government adoption of the programme model.

3.8.3 Security and access

Limitations on the programme staff's ability to work closely and frequently with communities because of security concerns, poor road infrastructure (including routes which are impassable

during the rainy season), and remoteness affect all the process domains. These concerns underline the challenging context in which this programme is being implemented.

At the time of the PE study, security was a greater concern in Zamfara (particularly Anka LGA) than in Jigawa. Payment rounds have sometimes been postponed, and some targeted communities have not been reached at all, because of general insecurity and banditry. It is, however, remarkable that no incidents of robbery have happened during the payment rounds since the beginning of the programme. Key informants attributed this partly to the payment agents' local knowledge and skill in travelling incognito between communities without making it known that they were carrying large quantities of cash, and also to good communications with community leaders who keep the CDGP advised of the fluctuating local security situation and alert them when a planned visit is considered unsafe.

3.8.4 Implementation Manual

Three drafts of the CDGP IM have been produced so far, in July 2014, December 2014 and June 2015 (revised in September 2015). Although there are no fundamental differences in the programme components from one draft to the next, each is more detailed than the previous version and contains updates to the programme rules where relevant (for example, on exits and the payment MIS system). The next update was in preparation at the time of this study and is expected to be completed early in 2016.

With a programme of this scale and complexity it is appropriate for the manual to be a 'living document', with successive versions incorporating changes and improvements as the programme itself evolves and lessons are learned about the best way to get things done. With the CDGP specifically, it was noted by several key informants that much of the detail of implementation was not set out at the design stage and could be developed only once the programme was operational. It is very important that the manual captures these details, not only for CDGP use but also as a record and resource for other programmes.

It is therefore suggested that the next version of the IM should be as detailed as possible (perhaps drawing on some of the process mapping in this report, if helpful); that the word 'draft' should be removed, even though it is unlikely to be a final, definitive version; and that the manual should then be shared more widely. Given the very heavy workloads of all the CDGP staff, it might be advisable to engage a consultant to complete the manual. Style and accessibility of information provided as well as availability of physical copies at the state and LGA level are some of the things that the programme could consider.

The programme may also want to consider development of additional material describing the roles and responsibilities of the TWCs and CVs and how the programme is meant to operate at the community level and serve as reference documents. Use of infographics, animation or translation into Hausa may be some of the ways in which these could be made accessible.

4 Conclusions and recommendations

4.1 Conclusions

This PE was carried out almost two years since the programme began its implementation, with the aim of understanding how the programme was designed and implemented in practice, with what scope and coverage and with what results. The evaluation also intended to highlight the challenges faced and lessons learned, and to provide an opportunity for programme reflection and learning that ultimately helps improve the programme's operations and thus its impact. It did so by mapping the organisational structure and stakeholders involved in the programme, mapping the key processes of the programme and assessing the scale and coverage of implementation, drawing on data collected and analysed through a variety of sources.

Overall, CDGP has made significant progress in implementing the programme but has also faced many challenges and difficulties, most of which are known by the programme and are being addressed. At the start of the implementation in January 2014, the programme was still designing and finalising many of its processes, with limited operational details in place. Contract negotiation with payment service providers was still continuing and was only concluded in April 2014, BCC interventions were still being designed, programme structures still being formed, and at the time no monitoring systems had been developed or put in place. Two years later, the programme has established a set of processes and actions that are operationally more detailed. It now has a well-established payment system that is reportedly able to pay most beneficiaries in a prompt manner every month – an achievement eluding many other cash transfer programmes of similar and larger scale in Sub-Saharan Africa. The programme has also established a set of BCC activities, a mechanism for communities to seek clarification and complain, and collects a significant amount of information about the operations of the programme to measure progress and identify bottlenecks. Inevitably, some processes have been more successful than others and there remain gaps and areas for improvement:

- Initial entry into communities and **sensitisation and mobilisation** into the community has been more time-consuming than envisaged with fewer communities visited on a monthly basis than was originally planned. The programme has established committees at the ward level (TWC) and mobilised CVs, but the level of support and sensitisation has likely been inadequate given the programmes' inability to revisit many of its communities since initial mobilisation, especially given the limited guidance material developed and provided to these structures.

- **Enrolment and registration** of beneficiaries was very slow during the initial roll-out due to delays in procurement of devices, and problems with the functionality of devices used for registration. The national elections also led to slowdown and in many areas a pause in activities of the programme. Establishing a practical system for pregnancy testing has posed challenges; randomised pregnancy testing and supervised instant urine tests have been introduced to respond to possible fraud by community members. Tracking the births of born babies also remains to be done.

- The **payment process** is effectively manual and managed through a network of agents. The design of the e-payments was ambitious and not situated within the context of Northern Nigeria or based on the availability and penetration of existing financial services or products in these areas. The payments were often delayed during the initial roll-out period due to a

lack of agents, faulty software, and equipment and liquidity issues. These problems have now been rectified and performance is much improved.

- It has taken a long time for the programme to be able to establish the **BCC components** of the programme. The extent to which the CDGP could rely on WINNN to design and implement the CDGP Nutrition and BCC strategy was overestimated. The BCC strategy is heavily reliant on CVs and CHEWs for delivery. The programme has been behind schedule in achieving its intended targets, especially on one-to-one counselling; currently there is little or no information on the content or quality of interventions delivered.

- There are sufficient channels for reporting and monitoring of **grievances and complaints**. However, there are limitations in terms of effective utilisation of the channels, lack of dedicated human resources for complaints response and redressal, and effective reporting and monitoring of the complaints through the programme monitoring system.

- **Programme monitoring** is currently centred on a Monthly Dashboard which collects data across all major areas of the programme. While a culture of data collection has been fostered, the analysis of data gathered is limited to a few staff at the central level and information is largely summative and produced mainly for tracking progress against logframe targets.

Underpinning many of the challenges identified above has been the significant underestimation of the number of people and the full-time expertise in key technical areas required for designing and implementing a programme of this scale and complexity in an operationally challenging environment.

The programme had envisaged only two staff members at the federal level to design the programme and coordinate the operations of the two states. This created a significant bottleneck in getting the programme off the ground during the earlier phases of inception and initial implementation. As a result, many processes took longer to be designed and completed and when operationalised there was limited oversight and control on how things were actually being implemented, on what scale and with what quality. The programme was also unable to draw on the much needed support and international TA available from the headquarters adequately, systematically or promptly.

Finally, accessibility and security pose particular challenges to the programme and need constant monitoring and incorporation in the operations of the programme.

4.2 Recommendations

Based on the findings of this evaluation, the following recommendations are made:

Recommendation 1: Assess the functionality of the TWCs and CVs and devise support and training accordingly

TWCs and CVs have a major role in the implementation of this programme. While there is some information on the number of traditional wards entered and number of CVs recruited and trained, there is little information on the effective formation of TWCs, their operations or the number of active CVs. Given the importance of these structures, the programme may benefit from assessing how well these structures are operating and what support is required to ensure their continued operation.

Recommendation 2: Develop communication and sensitisation material about the programme at community level

Although the programme has delivered verbal instructions and training to CVs and TWC members, and has reportedly produced some pictorial materials for this purpose, it has not developed sufficient detailed material that describes the programme and its operations specifically targeted at the level of the community. This information should include manuals and reference documents for the trainers and the TWCs and CVs about their roles and responsibilities and how the programme works in detail and at different stages. This information should be tailored to the community, taking account of language and cultural context as well as low literacy levels by using infographics, animation or the development of simple messages translated in Hausa.

Recommendation 3: Revise the Implementation Manual

The IM is the main reference document describing how the programme should operate. As such it should have as much detail and clarity as possible. It should be written in an accessible manner and copies should be made available at the state and LGA level.

Recommendation 4: Consider the appropriateness of mobile phones for registration and payments and explore alternatives

The mobile phones are necessary for enrolment and registration of beneficiaries, with the mobile phone numbers serving as unique IDs. However, given the limited role of the phones during payment process (other than for the sending of message alerts) and their limited use and function in BCC activities, the programme should consider whether they should continue to be used, especially as they are thinking about scalability. In the absence of mobile phones, the programme could utilise other means of capturing unique IDs, such as use of official registration documents or unique codes or numbers generated by the programme.

Recommendation 5: Continuous supply of technical equipment and replacement of faulty devices.

The programme needs to ensure that there is sufficient technical equipment to ensure the smooth operation of the programme, especially as it continues to expand. Malfunction or breakage of tablets, finger print scanners and power banks, and a shortage of mobile internet connectors, have reportedly led to frequent delays in operations. There is a need for the continuous and speedy replacement and repair of equipment when it breaks down as well as stocking of adequate reserves. This will require regular checking and reporting on the status of equipment available to the Central Team to ensure sufficient lead times to follow procurement processes.

Recommendation 6: Strengthen support for procurement

Procurement and contract negotiations have created major delays in the implementation of the programme. The CDGP currently relies on SC in Abuja and in London for technical and administrative support for procurement. However, given the size of the programme and its supply requirements the programme may benefit from dedicated staff supporting procurement.

Recommendation 7: Rationalise the various components of the BCC and monitor quality

The BCC is heavily reliant on CVs and CHEWs for implementation and has struggled to date to achieve its intended targets. There is a need to rationalise the various components of the BCC with

the ultimate aim of reducing the burden placed on CVs and supporting them to undertake fewer activities to a higher level of quality and intensity.

Programme monitoring should also allow for monitoring the content or quality of the interventions delivered to establish where supplementary training could be provided or what elements of the BCC intervention could be improved.

Recommendation 8: Review and rationalise data collection and reporting

A clearly outlined and detailed M&E plan would help rationalise all aspects of the M&E system from data collection to analysis and report production. This recommendation is particularly important as the CDGP will soon be implementing a new MIS that should be guided by a comprehensive document such as an M&E plan.

The Monthly Progress Reports need to be standardised to include the same set of indicators for each process domain every month and should also facilitate a trend analysis of these indicators. This will enable analysis to assess operational performance and make a comparison between different levels of the programme to highlight relative strengths and weaknesses. The reports should also facilitate analysis at all levels of implementation – both at state and LGA level, not just national level. The reports should also maximise the utilisation of monitoring data by incorporating additional indicators, especially for BCC and CRM, from its present scope.

A further rationalisation of CDGP data collection efforts should be the frequency of the PDM. At present, one PDM is scheduled to be conducted every quarter. Alternative sources of data should be explored (such as a pay-point exit survey) to reduce the frequency of the PDM exercise as it is currently a major burden on a very small M&E team. The current high frequency does not allow for full analysis of the data that is collected nor management actions to be implemented before attention turns to the next one.

Recommendation 9: Seriously consider what components of the CDGP pilot are scalable

The CDGP pilot experience thus far has yielded some important insights into how such a complex cash transfer programme should be set up and implemented. We also learn how many components of the CDGP were over-ambitious in their original design. While CDGP has made impressive progress in rolling out the programme despite these challenges, the PE team recommend that the CDGP should consider expanding the pilot to test alternative payment modalities very carefully.

As outlined in this report, the CDGP team (at central, state and LGA levels) are working at full capacity and have much work to do to improve the quality of the existing programme. Expanding the pilot to include an alternative payment modality should be considered only if it will not compromise the already strained delivery of the existing programme.

Further, the PE team encourage the CDGP to explore alternative payment modalities that are scalable or that can be easily handed over to government. As tempting as new technologies may be, a focus on sustainability should be emphasised in the selection of alternative payment modalities.

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Annex A People interviewed

A.1 List of key informants

Name of interviewee	Job title	Organisation
CDGP Abuja		
Solomon Bahiru	Deputy Programme Manager	Save The Children
Kerina Zvogbo	Senior Social Protection Advisor	Save The Children
Ramatu Aliyu	Advocacy and Communication Advisor	Save The Children
David Akpan	Knowledge Management Coordinator	Save The Children
Mercy Jibrin	BCC & Nutrition Advisor	Save The Children
Osunnuyi Oluwatosin	MIS / Payments Manager	Save The Children
Ayowumi Ogunjobi	M&E and VFM Advisor	Save The Children
Eunice Victor	CRM Coordinator	Save The Children
Comfort Ocheje	Finance Manager	Save The Children
Paul Xavier Thangarasa	Social Protection Programme Manager	AAH, Abuja / Jigawa
AAH		
Melanie Roberts	Deputy Country Director/ Programs	AAH, Abuja
Simon Narbeth	Senior Social Development Adviser	DFID, Abuja
SC UK		
Nicola Hypher	Senior Social Protection Adviser	SC UK, London
CGDP Zamfara State Team		
Tanko Langaya	State Team Leader	Save The Children
Ese Awharitoma	Health & Nutrition Advisor	Save The Children
Abdulrashid Abdulwahib	Cash Transfer Coordinator & Acting M&E Officer	Save The Children
Fatimah Musa	Advocacy, Community Mobilisation & BCC Officer	Save The Children
CDGP Jigawa State Team		
Stella Esedunme	Programme Manager (State Team Leader)	AAH
Zulaikha Abdulmalik	Deputy Programme Manager, Nutrition & Health	AAH
Fatima Adamu	Communications Officer	AAH
Hassan Ibrahim Khalil	MIS Officer	AAH
Elmina Maina	Nutrition & Health Officer	AAH
Murtala Bello	M&E Officer	AAH

A.2 List of participants in LGA workshops

Participants in Zamfara workshop

#	Name	Designation	Sex	Day 1	Day 2	Month and Year of joining CDGP
ANKA LGA						
1.	Rashida Lawal	Community Mobilisation Assistant	F	Y	Y	Nov 2013
2.	Mansur Zubaim	Seconded staff	M	Y	Y	Jun 2015
3.	Lawal A Banaga	Stanbic Coordinator	M	Y	Y	Jun 2013
4.	Abdul Karim Ahmed	LGA payment assistant	M	Y	Y	Sep 2015
5.	Nura Nahuche	LGA supervisor	M	Y	Y	Aug 2015
6.	Abdullah Mohammed	NGO, Technical Working Committee	M	Y	Y	Nov 2013
TSAFE LGA						
7.	Zainab A Sabo	Community Mobilisation Assistant	F	Y	Y	Nov 2013
8.	Bature Labaran	Stanbic coordinator	M	Y	Y	Feb 2013
9.	Lawali Halilu	Seconded staff	M	Y	Y	Jun 2015
10.	Nasiru Musa	LGA payment assistant	M	Y	Y	Oct 2015
11.	Lawal Rabiu	LGA data assistant	M	Y	Y	Nov 2014
12.	Shehu Liman	Educator, Technical Working Committee	M	Y	Y	Nov 2015

Participants in Jigawa workshop

#	Name	Designation	Sex	Day 1	Day 2	Month and Year of joining CDGP
BUJI LGA						
1.	Kabiru Muhammed Tukur	LGA Field Assistant/ Seconded staff	M	Y	Y	Feb. 2014
2.	Mustapha Abdullah	LGA Technical Working Committee Member	M	Y	Y	Jun. 2014
3.	Aminu Garba	LGA Technical Working Committee Member	M	Y	N	
4.	Ode Ode	LGA Data Assistant	M	Y	Y	Nov. 2015
5.	Abdullah M.	LGA Supervisor	M	Y	Y	Oct. 2013
6.	Iliya Waziri	LGA Field Assistant/ Seconded staff	M	Y	Y	Apr. 2013
7.	Ado Habibu	LGA Stanbic Payment Coordinator	M	Y	Y	Apr. 2013
GAGARAWA LGA						
8.	Auwalu Ahmed Muhammed	LGA Stanbic Payment Coordinator	M	Y	Y	Apr. 2013
9.	Sadiq Baba Bukar	LGA Data Assistant	M	Y	Y	Nov. 2015

10	Kabiru A. Yusuf	LGA Field Assistant/ Seconded staff	M	Y	Y	Oct. 2014
11	Abu Bakar Hassan	LGA Supervisor	M	Y	Y	Jan. 2016
12	Maryam Lawan Abubakar	LGA Field Assistant/ Seconded staff	F	Y	Y	Feb. 2014
13	Bashir U. Galadima	Vice Chairman	M	Y	Y	Apr. 2013
14	Imamu Sabo Kiliman	LGA Technical Working Committee Member	M	Y	Y	Apr. 2013
KIRIKASAMA LGA						
15	Halidu Muhammed Kabir	LGA Stanbic Payment Coordinator	M	Y	Y	Apr. 2013
16	Almu Muhammed Almu	LGA Data Assistant	M	Y	Y	Nov. 2015
17	Mohammed Lawan	LGA Field Assistant/ Seconded staff	M	Y	Y	Mar. 2014
18	Ibrahim U. Uman	LGA Supervisor	M	Y	Y	Oct. 2015
19	Fatima Adamu	LGA Field Assistant/ Seconded staff	F	Y	Y	Oct. 2014
20	Suleiman Khalil	LGA Technical Working Committee Member	M	Y	Y	Apr. 2013
21	Mansur A Tijjani	LGA Technical Working Committee Member	M	Y	Y	Apr. 2013

Annex B CRM Complaints Categories

	Explanation of Category [68]	Examples (from CRM database)[69]
1	**Request for information** about CDGP	• When is the payment agent coming? • What's the importance of exclusive breastfeeding?
2	**Request for assistance** (i.e. to become a beneficiary)	• When will CDGP come to my community to register newly pregnant women? • How do I become eligible for the cash? • Former beneficiary who was exited because she left the community – calling to ask for re-activation because she's returned. • Call from non-beneficiary community, asking for community to be included • Caller wanting to know more about nutritious food
3	**Minor complaints** (e.g. lack of follow-up, community volunteers and staff not arriving on-time for scheduled activities, complaints about the quality of activities in the community).	*No examples in database*
4	**Major complaints** (e.g. long queues for payment, forced collection of funds by husbands / community members/ leaders; payment agents soliciting for tips).	• (via BRG): husband wanting to remove his two wives from the programme because they won't give him a share of the money
5	**Misconduct or fraud.** Breaches of Save the Children's Code of Conduct and/or Child Safeguarding Policy, e.g. allegations of inappropriate behaviour or misconduct *by SC/AAH or partner staff or representatives* including fraud, theft, corruption, or abuse.	*No examples in database.*
6	**Abuse / exploitation**. Allegations of child abuse or sexual exploitation of beneficiaries *by non-SC/AAH staff or representatives*, i.e. a member of the community, staff of other NGOs or the UN.	*No complaints logged in this category.*
7	**Payments complaint**. Complaints about the payment mechanism, for referral to Stanbic. Allegations of fraud by payment agents should be logged as category 5 (and also referred on to Stanbic).	• Payment not received because of fingerprint problems (frequent complaint) • (via hotline) Agent would not pay next of kin because beneficiary herself had not come for 3 months. • (via CV) Zero account problem

[68] Source: CDGP Implementation Manual (3rd draft, 2015).

[69] The CRM database has been recently established by the new CRM Coordinator. The database is not yet fully populated, but it is expected to be an extremely useful tool for management and evaluation. All the examples in this table are from Jigawa, only because the description of the complaints has not been entered in the Zamfara database.

Annex C CDGP Monitoring Matrix

INDICATOR	DATA SOURCE Where is the information collected from?	FREQUENCY How often will it be measured?	PRIMARY PERSON RESPONSIBLE Who will measure it?	OTHER STAKEHOLDERS INVOLVED IN DATA COLLECTION Who are the other personnel involved?
Output Indicator 1: Secure payments mechanism providing regular, timely cash transfers to 70,000 pregnant women and women with under-2s				
1.1 Cumulative number of beneficiaries registered in the programme	Programme Dashboard	Monthly/weekly	M&E and PQA	MIS, PQA and LGA Data Assistant
1.2 % of registered beneficiaries receiving correct cash transfer amounts within 10 days of approve date of a monthly basis.	Stanbic Portal	Monthly	MIS	M&E
1.3 % of traditional ward covered in targeted villages	Programme Dashboard	Monthly	M&E &PQA	M&E,MIS, LGA Supervisors and data assistant
1.4 % of community members satisfy with transparency of CDGP targeting and enrolment mechanisms.	PDM	Quarterly	M&E&PQA	M&E,PQA and LGA team and enumerators
1.5 % of beneficiaries with transparency of easy payment mechanisms	PDM	Quarterly	DPM	STL and M&E and finance officers
1.6 operational cost of cash transfer per beneficiaries	Annual work plan (review meeting)	Quarterly	Finance &DPM	STL, FSL PM, M&E
1.7 Cash transfer as % of total program cost	Aggreso	Quarterly	Finance &DPM	STL, FSL PM, M&E
1.8 Cost delivery as % of cash transfer	Aggreso	Quarterly	Finance &DPM	STL, FSL PM, M&E
Output 2: Effective system for mobilisation, targeting & complementary interventions				
2.1 Resolved complaint as % of total reporting complaint in all category	Programme Dashboard	Monthly	M&E Coordinator	M&E & LGA team
2.2 % of beneficiaries participating in IYCF group sessions and 1:1(Treatment 2 communities only)	Programme Dashboard	Monthly	Nutrition Advisor/DPM	State Nutrition Advisor FSL Nut.
2.3 Number of beneficiaries participating in 1:1 counselling	Programme Dashboard	Monthly	Social Protection Advisor	Programme Officer, Nutrition Advisor, SHNO, FSL Nut and M&E?PQA
2.3 % of beneficiaries participating in 1:1 counselling in T2 community	Programme Dashboard	Monthly	Nutrition advisor/DPM	M&E

2.4 Cumulative number of people engaged in action oriented groups, nutrition awareness session and mass media	Programme Dashboard and PDM Estimated Number from the Campaign (Mass media)	Monthly (PDM-Quarterly) Quarterly	Nutrition Advisor	Programme Officer, Nutrition Advisor, SHNO, FSL Nut M&E/PQA
2.5 % of pregnant and lactated mothers with improved their knowledge on key health and nutrition messages **(T1 & T2)**	PDM	Quarterly	M&E coordinator	M&E , PQA, LGA supervisors & enumerators
2.6 % of pregnant and lactated mother with improve with improved health and nutrition practices **(T1 & T2)**	PDM	Quarterly	M&E coordinator	M&E, PQA LGA supervisors and enumerators
2.7 % of community volunteers trained on IYCF who obtain > 70% in post training evaluation test	Training report	Quarterly	Nutrition adviser and DPM	Nutrition Adviser ,DPM and nutrition and health officer
Output 3: Enhanced government capacities for managing cash transfers in focus states				
3.1 Number of social protection plans approved by the stakeholders	Program report	Annually	HR/Logistics	STL,PM
3.2 Number of government staff seconded to the project team	Employee records	Quarterly	STL and FSL PM	NPM, STL, FSL PM
3.3 % of government staff trained on social protection who obtain > 60 % in post-test evaluation	Training report	Quarterly	Social Protection Advisor	NPM, STL, FSL PM and Finance Coordinator
3.4 State government contribution as % of program implementation cost.	Program report	Annually	Social Protection Advisor	NPM, STL, FSL PM
Output 4: Evidence of cash transfer modalities and impacts provided to policymakers and practitioners at State and Federal levels				
4.1 Action plans implemented based on the lessons from the process and impact monitoring analytical report	Program Report	Bi-Annually	DPM	NPM, STL, FSL PM
4.2 Status of the program MIS	Progress Report	Bi-Annually	M&E	DPM, STL, FSL PM
4.3 number of dissemination with federal and state level audience	Progress Report	Bi-Annually	DPM	DPM, STL, FSL PM
4.4 Number of cases studies , technical and policy briefs document	Progress Report	Quarterly	DPM	DPM, STL, FSL Pm
Non-Logframe Indicators – Process Indicators				
% of pre-mature exits in the program	Programme Dashboard	Monthly	M&E	PQA, M&E & MIS
Number of beneficiaries re-enrolled into the program	Weekly dashboard	Weekly	M&E	MIS, M&E &PQA
Number beneficiaries graduated in the program	Stanbic Portal	Quarterly	MIS	M&E, PQA, STL & FSL PM

Number of child birth in the program	Programme Dashboard	Monthly	Nutrition Adviser/DPM	M&E , PQA LGA supervisors & LGA Data Assistant
Number of children with NPOC birth certificate	NPoC Certificate	Quarterly	Nutrition Adviser/DPM	M&E, PQA, LGA supervisors & Data Assistant

Annex D Access levels and Indicators captured by the M&E System

D.1 Access levels of the Stanbic Payment Portal Database

Table 6 below gives an overview of the different access levels of the Stanbic Payment Portal Database for different users to edit beneficiary details and payment authorisation process.

Table 6 User access levels of the Stanbic payment portal database

Access Levels of Stanbic payment portal database			
Level	CDGP team	Roles in the payment system	Payment portal access
Central	Country director	Approve the payment amount to be paid by Stanbic to the beneficiaries every month	L6 access (final approval of payment amount to Stanbic)
Central	Programme manager	Approve the payment amount to be paid by Stanbic to the beneficiaries every month	L5 access (approval of payment amount to be paid to the beneficiaries)
Central	Deputy programme manager	Authorise payment lists and sends it to the programme manager for approval. Sends the payment list to the Finance Manager for review.	L4 access (authorise payment lists for review by finance manager)
State	State team leader	Authorise payment lists and sends it to the Deputy Programme Manager for approval.	L3 access (authorise payment lists, edit beneficiary level data)
State	Cash transfer coordinator/ PQA officer		L2 access (edit/validate and upload data upon documentation and approval)
LGA	LGA staff		L1 access (enter and view data; cannot edit/amend details)

D.2 Indicators captured in the Monthly Dashboard

Table 7 below provides an overview of the indicators monitored in the Monthly Dashboard.

Table 7 Indicators captured in the Monthly Dashboard

Indicators reported in the Monthly Dashboard		
Indicator category	Indicator as specified in the database	What the indicator means
Registration	Number of registered beneficiaries in T2	Number of “new” pregnant women registered in T2 communities in that month
Cash transfer payments	Number of beneficiaries paid	Number of beneficiaries paid for that month
	Number of beneficiaries paid on time (between 16th and 26th of the month)	Number of beneficiaries paid on time for that month

Exits	Exits per type of premature exit (miscarriage, still birth, death of child, death of mother, fraud, other reasons)	
Complaints Response and Feedback	Complaints received per category	Number of "new" complaints received from beneficiaries that month (for each category)
	Complaints resolved per category	Number of complaints resolved that month (for each category)
BCC interventions	Number of women receiving voice messages	Number of beneficiaries receiving voice messages that month
	Number of women receiving text messages	Number of beneficiaries receiving text messages that month
	Action group: Estimated number reached through radio jingles	
	Action group: Number of beneficiaries at drama events	Number of beneficiaries who attended drama events that month
	Action group: Number of beneficiaries at food demonstration sessions	Number of beneficiaries who attended food demonstration sessions that month
	Number of beneficiaries participating in support group meetings (T2)	Number of beneficiaries participating in support group meetings in T2 communities
	Number of beneficiaries in 1 to 1 counselling (T2)	Number of beneficiaries who attended 1-to-1 counselling sessions in T2 communities
	Number of IYCF trained CVs (female and male)	Number of CVs trained on IYCF
Government engagement	Number of government seconded staff (male and female)	
	Number of government staff trained on social protection	
	Number of coordination meetings on social protection	
	Total number of CVs trained (male and female)	Number of CVs trained on (what?)
Births tracking	Number of deliveries	Number of children born to beneficiaries that month
	Number of certified deliveries	Number of children who received birth certificate that month
Health Education	Health education	Number of beneficiaries who attended health education sessions
Source: Monthly Dashboard reporting template		

D.3 Indicators captured in the Weekly Dataset

Table 8 below provides an overview of the indicators monitored in the Weekly Dataset.

Table 8 Indicators captured in the Weekly Dataset

Indicators reported in the Weekly Dataset		
Indicator category	Indicator as specified in the database	What the indicator means

Pregnancy outcome confirmation	Number of women confirmed pregnant	Number of women with confirmed pregnancy for a community along with the method of conducting pregnancy testing
	Method of pregnancy testing	
Enrolment	Number of women enrolled	Number of women enrolled i.e. “offline registration” for a community
Registration	Number of women registered	Number of women registered i.e. “online registration” for a community along with date of registration in that community
Source: Weekly dataset reporting template		

D.4 Indicators captured in the IYCF Database

Table 9 below provides an overview of the indicators monitored in the IYCF Database.

Table 9 Indicators captured in the IYCF Database

Indicators reported in the IYCF database		
Indicator category	Indicator as specified in the database	What the indicator means
Support groups (SGs)	Number of active SGs	
	Number of newly formed SGs for that month	
	Number of SGs that met every month	
	Number of women’s SGs that met every month	
	Total participants in women’s SGs	
	New participants in women’s SGs	
	Number of men’s SGs that met every month	
	Total participants in men’s SGs	
	New participants in men’s SGs	
Counselling	Number of beneficiaries who received one-to-one counselling	
	Number of beneficiaries who received one-to-one counselling for the first time	
	Number of CVs trained in IYCF	
	Number of active IYCF CVs	
Supportive supervision	Number of supportive supervision carried out by the CHEW	
Action Oriented Groups	Number of food demonstration sessions	
	Number of participants in these food demonstration sessions	
	Number of health education sessions	
	Number of participants in the health education sessions	
	Number of drama events	
	Number of participants in the drama events	
Active CVs	Number of active CVs	
Source: IYCF database reporting template		

D.5 PDM Survey

Table 10 below provides an overview of the indicators monitored in the PDM and their frequency of assessment.

Table 10 PDM Survey – sections, frequency and indicators assessed

PDM Survey			
PDM Section	Frequency	Sub-category of indicators assessed	Indicators assessed
Cash transfer monitoring	Quarterly	Timely cash payment	% of beneficiaries who received cash regularly on a monthly basis
		Cash transfer amount	Amount of cash received
		Process and costs of receiving cash	Costs of transportation to and from agent
			Other fees paid in order to access the cash transfer
			Distance travelled to access cash
			% of beneficiaries who feel safe when travelling to collect and spend their cash payment
		Clear information about payments	% of beneficiaries who get clear information on: date of payment, location of payment and amount to be paid
		Satisfaction with CGDP staff and processes	% of beneficiaries satisfied with the staff members, CVs, payment agents, TWC members, payment process, CRM
Monitoring purchases made with the cash transfer	Quarterly		Items purchased with the cash
Complementary services monitoring	Quarterly	Access to complementary services	% of beneficiaries hear any radio jingles on CDGP
			% of beneficiaries receive voice messages
			Type of voice message heard
			% of beneficiaries attend food demonstration
		Knowledge and practice of key health and nutrition messages	% of beneficiaries with knowledge on early initiation of breastfeeding, exclusive breastfeeding and complementary feeding
			% of beneficiaries with appropriate breastfeeding practices
			% of beneficiaries with knowledge of appropriate hand washing practices
			% of beneficiaries with appropriate hand washing practices
Changes in beneficiaries' household	Bi-annually	Food security	% of beneficiaries who worry that their household would not have enough food to eat in the past 4 weeks
			% of beneficiaries who were not able to eat the kind of foods they

			preferred because of lack of resources in the past 4 weeks
			Frequency at which beneficiaries went a whole day and night without eating anything because there was not enough food
		Dietary diversity	% of beneficiaries who ate different kinds of food the day preceding the survey
		Coping strategies	% of beneficiaries who purchased food on credit or borrowed money to buy food in the past 4 weeks
			% of beneficiaries who reduced or stopped someone's health bill payment to pay for food in the past 4 weeks
			% of beneficiaries who sold items (such as clothes, etcetera) in the household to pay for food in the past 4 weeks
			% of beneficiaries who have eaten seed stock meant for the next planting season in the past 4 weeks
		Gender roles and power issues	% of beneficiaries who make decision about what to buy with the cash transferred
Source: Post Distribution Monitoring Strategy Document, March 2015			

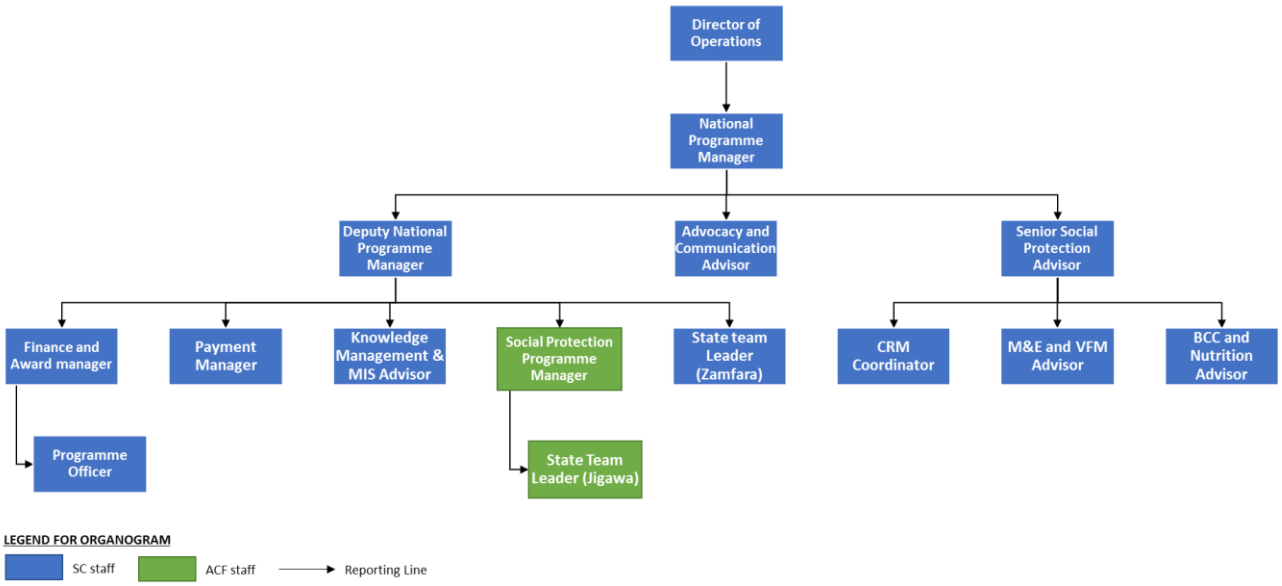
Annex E Organisation and staffing

This section presents an overview of the way in which CDGP's staff are structured. CDGP is organised with a central team based in Abuja and implementation teams led by AAH in Jigawa and by SC in Zamfara. In this section, each 'level' of the staffing structure is discussed in turn starting with the central team and then the state-level and LGA-level teams.
The organograms for each 'level' of the CDGP (central level, state-level and LGA-level) have been reproduced by the team to reflect the current staffing structure and their inter-relationships. Each of the roles in the organogram are shaded according to the role's organisational affiliation including SC (highlighted in dark blue), AAH (highlighted in green), the LGA Government (highlighted in yellow), the community (highlighted in orange) and the payment agent Stanbic (highlighted in light blue). Each organogram is accompanied with a legend to clarify the colour shading.

E.1 The central team - current structure and evolution

The Central Team is organised as follows:

Figure 34 CDGP Organogram – Current (February 2016)

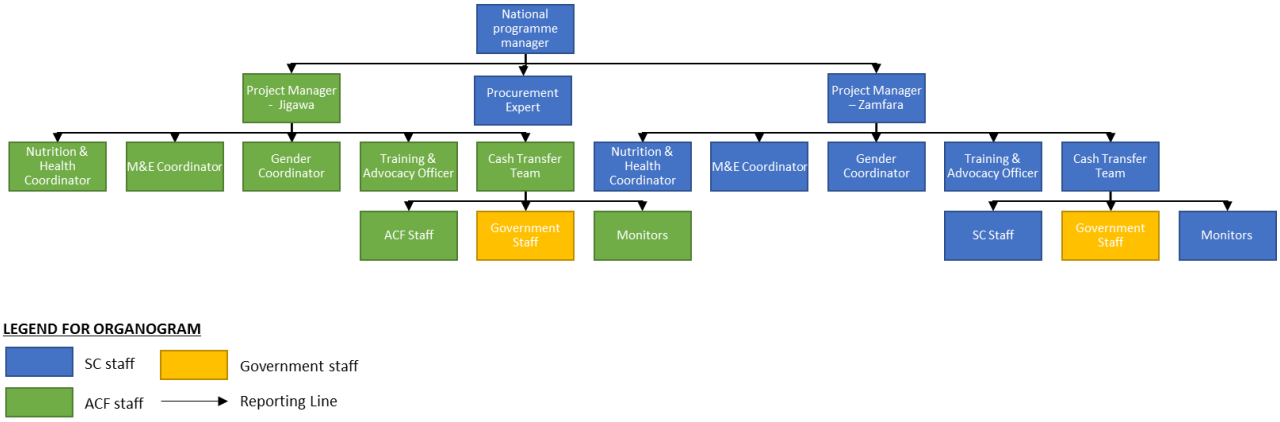


As is clear in Figure 34, the central team of CDGP is located in SC as the leader of the consortium for this pilot project. AAH links into the CDGP central team by means of an Abuja-based Social Protection Programme Manager to whom the Jijawa State Team Leader reports to, whereas the Zamfara State Team Leader reports directly to the Deputy National Programme Manager.

The organisation of each of the State teams is discussed in the sections below. At the time of writing of this report, all positions in this organogram were filled except for the National Programme Manager position which has been vacant since June 2015. However, it is important to note that many of the positions in this organogram have only recently been created and filled.

The central team was originally conceptualised in the Business Case[70] to consist of only two members – the National Programme Coordinator and the Procurement Expert. The National Programme Coordinator was to have overall responsibility of the programme and would rely on Program Managers in each State to implement the programme. The teams in each state would consist of a full complement of technical staff including expertise in nutrition, gender, M&E, cash transfer specialist and training and advocacy (see Figure 35).

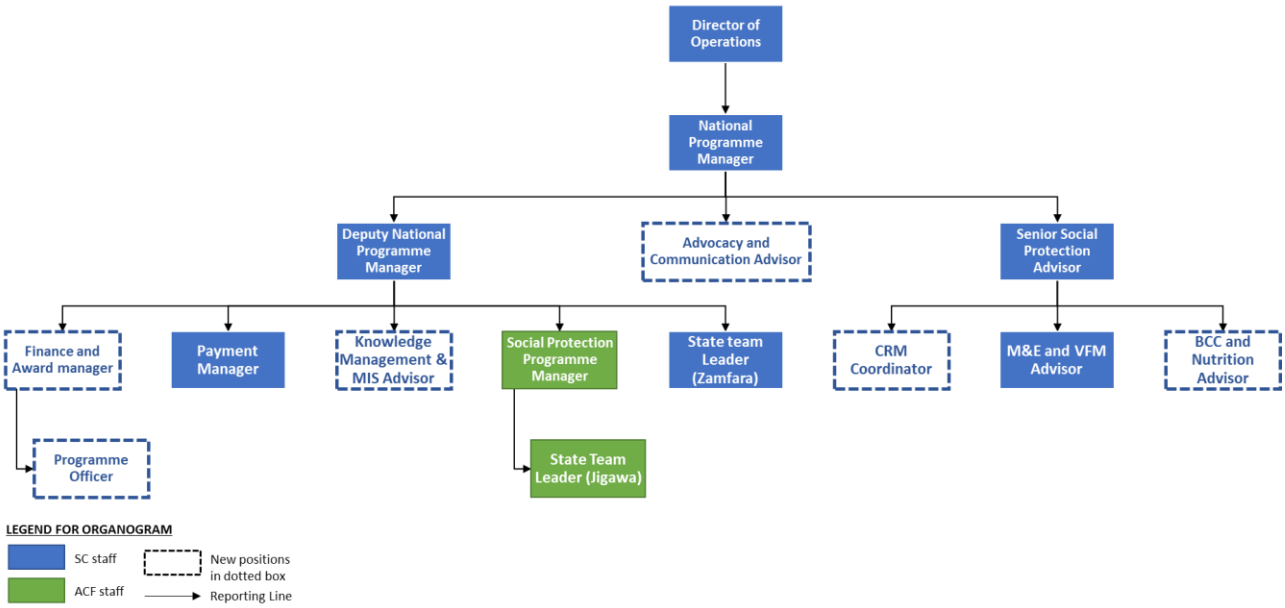
Figure 35 CDGP Organogram - Business Case (August 2012)



From this original conceptualisation of the organogram, CDGP expanded the central team during the inception phase to include a Deputy National Programme Manager who would oversee operations including oversight of each State-level team and a Senior Social Protection Advisor who would oversee technical components of the programme. A representation of the organogram at the end of the inception phase (April 2014) is presented in Figure 36 in which the dashed boxes indicate positions that were not yet created.

[70] DFID (2012), CDGP Business Case, August.

Figure 36 CDGP Organogram – Central Team at the end of inception phase (April 2014)



Despite the expansion of the central team as compared to the Business Case organogram, a comparison of the organogram at the end of inception phase (Figure 36) to the current organogram (Figure 34), reveals the full extent of the staff requirement to implement such a programme. All of the posts represented in 'dashed boxes' have been created since the after the inception phase to fill critical gaps in the central level team. What follows is a brief overview of the rationale of some of these newly created posts to illustrate how and why the central team organogram has evolved since the end of the inception phase.

Prior to the creation of the 'Finance and Award Manager' position, CDGP relied on data entry clerks and SC-Nigeria's finance department to fulfil this function. This was not practical due to the high number of monthly transactions including payments to suppliers such as Stanbic and managing monthly reconciliations so a dedicated position within the central team was created and filled in August 2015.

A similar story emerges for the 'BCC and Nutrition Advisor' where this function was originally conceived to draw on the Senior Nutrition Advisor supporting SC-Nigeria's nutrition-specific WINNN Programme. This Programme is also implemented in Northern Nigeria and started before CDGP so expanding the role of the WINNN Senior Nutrition Advisor to cover CDGP was seen to be a potential efficiency to be realised. However, in practice, the demands of the WINNN Programme proved to be too great to allow sufficient time to support CDGP in the design, implementation and monitoring of its nutrition-sensitive activities. As such, the 'BCC and Nutrition Advisor' role in the CDGP Central Team was created and filled in January 2015.

Whereas these two positions were created as consequence of the original set-up not being practical, the 'CRM coordinator' and 'Advocacy and communications advisor' roles were new functions not originally conceived in the design of CDGP. During the inception phase, an external consultant was used to set up CRM protocols after which the State-level teams were meant to implement them. However, throughout the course of implementation, it became clear that some

issues arising through the CRM mechanism required a member of the central team to coordinate follow-up actions and ensure consistency in responses across both States. As such the 'CRM coordinator' role was created and filled in January 2016.

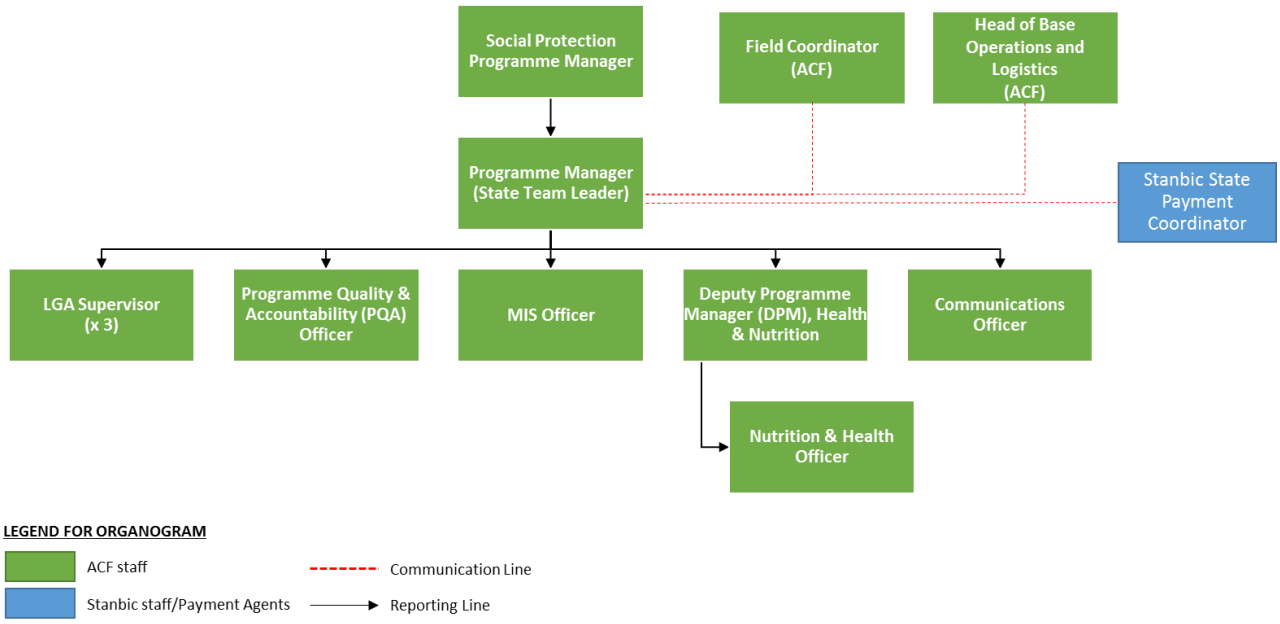
With regards to the 'Advocacy and communications advisor' role, this function was originally conceived to be undertaken by the National Programme Manager who ultimately did not have the time to design, prepare and coordinate advocacy activities alone. As such, a new position was created to support the National Programme Manager with these tasks and was created and filled in June 2015.

E.2 The Jigawa team - current structure and evolution

In Jigawa state, managed by AAH, there is a State Team Leader (also called "Programme Manager"). The Programme Manager apart from reporting to the Social Protection Programme Manager based in Abuja, also reports to the Field Coordinator and Head of Base Operations and Logistics of AAH based in Jigawa.

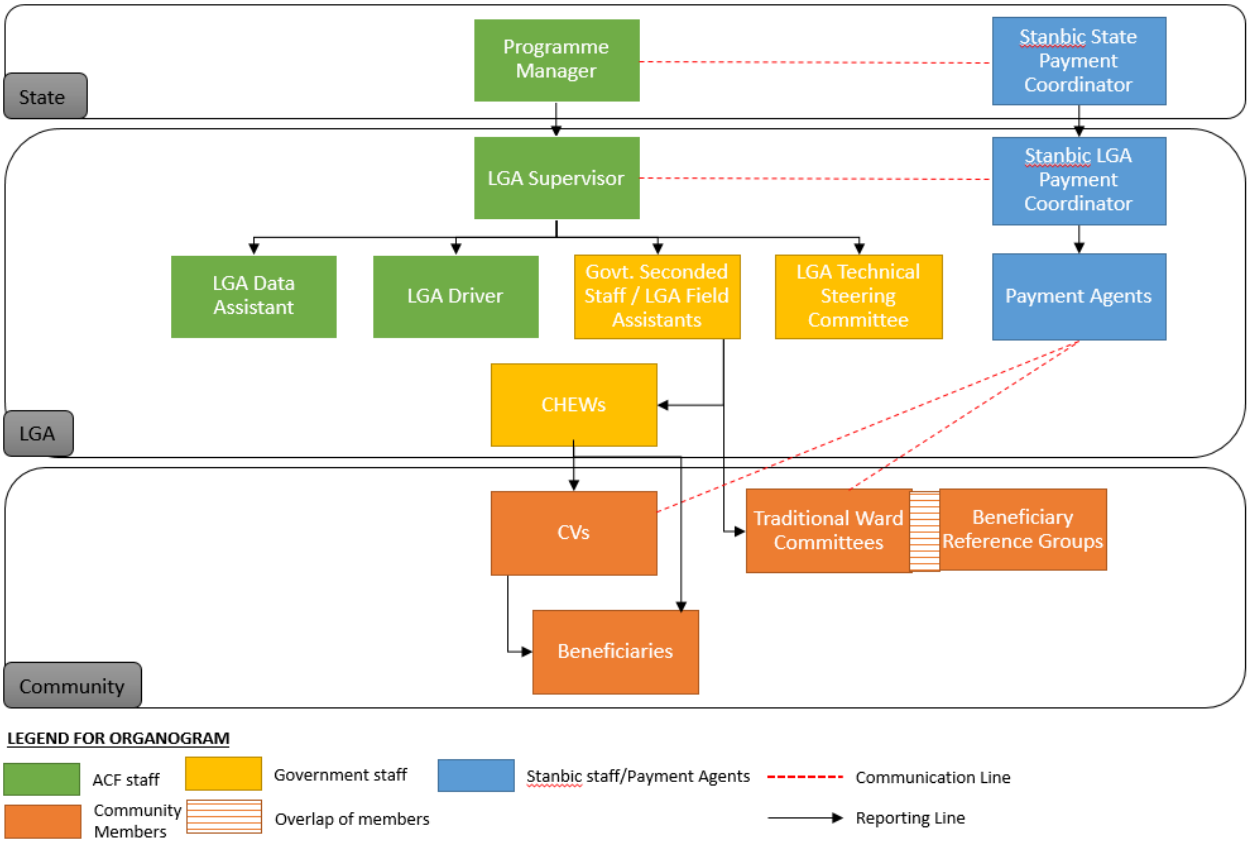
The state team has five key positions: LGA Supervisor (one for each LGA); Programme Quality and Accountability Officer (similar to M&E Coordinator in Zamfara state); MIS Officer (similar to Cash Transfer Coordinator in Zamfara state), Deputy Programme Manager (DPM) (Health and Nutrition) (similar to Nutrition Coordinator in Zamfara state) and Communications Officer. There is an additional Health and Nutrition Officer reporting into the DPM.

Figure 37 CDGP Organogram – Jigawa State team



The organogram for an LGA in the Jigawa state is represented in Figure 38 below.

Figure 38 CDGP Organogram - Jigawa State, LGA and Community teams



An LGA Supervisor has the following key positions under him at the LGA level: LGA Data Assistant, LGA Driver and LGA Field Assistants. The LGA Field Assistants are the seconded government staff who are responsible for all aspects of CDGP – community mobilisation, enrolment, registration, payments and BCC interventions. There is no dedicated staff for either of these processes in the Jigawa state at the LGA level. There are proposals to introduce dedicated CRM Assistants at the LGA level to deal with CRM.

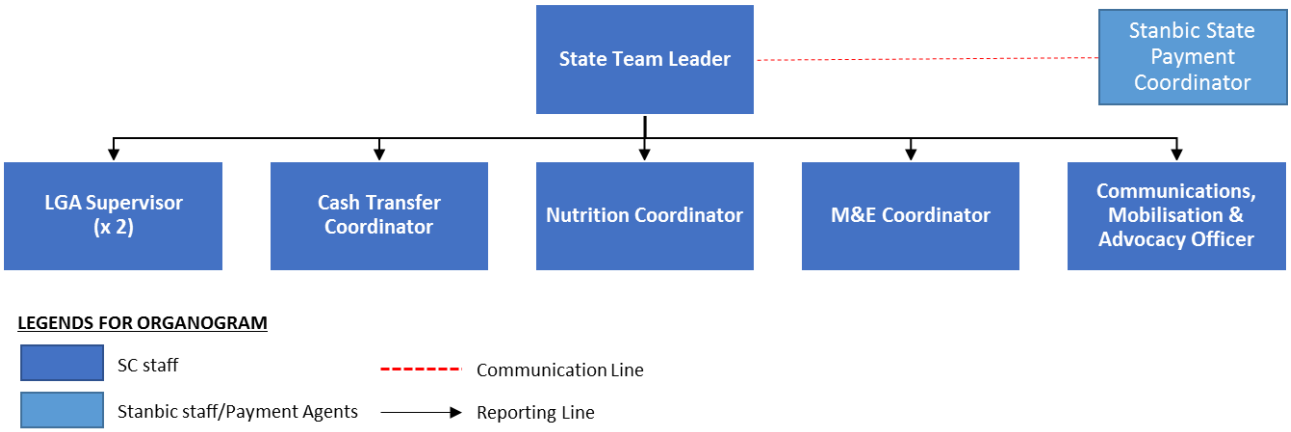
The LGA Field Assistants work with Community Health Extension Workers (CHEWs), CVs and Traditional Ward Committees (TWCs) to roll out the programme and ensure its coverage. The Beneficiary Reference Groups (BRGs) used for grievances redressal are formed out of the TWCs with the addition of more members such as beneficiaries and their husbands.

LGA Supervisor also reports to an LGA Technical Steering Committee which supervises the programme. For the payments process, Stanbic has a Payment Coordinator at both state and LGA level. Payment process is executed with the help of the network of payment agents/superagents.

E.3 The Zamfara team - current structure and evolution

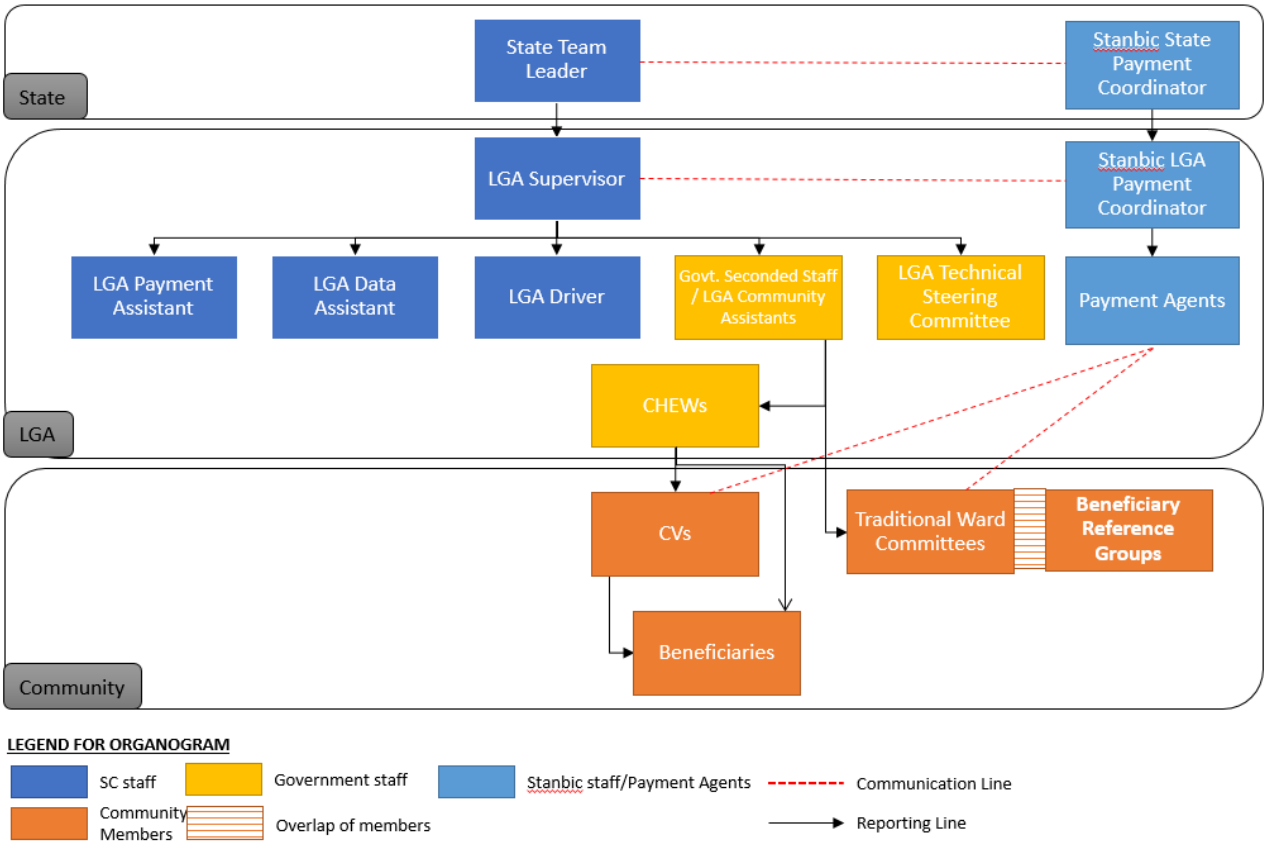
In the Zamfara state, managed by SCI, there is a State Team Leader. The state team has five key positions: LGA Supervisor (one for each LGA); M&E Coordinator; Payment Coordinator, Nutrition Coordinator and Communications, Mobilisation and Advocacy Officer. The position of M&E Coordinator has been vacant since 2015.

Figure 39 CDGP Organogram - Zamfara State team



The organogram for an LGA in the Zamfara state is presented in Figure 40 below.

Figure 40 CDGP Organogram - Zamfara State, LGA and Community teams



An LGA Supervisor has the following key positions under him at the LGA level: LGA Data Assistant, LGA Payment Assistant, LGA Driver and LGA Community Assistants. The LGA Community Assistants are the seconded government staff who are responsible for all aspects of CDGP – community mobilisation, enrolment, and registration and BCC interventions. There is dedicated staff for payments process in the Zamfara state at the LGA level.

There are proposals to introduce dedicated CRM Assistants to deal with CRM and nutrition assistants to supervise BCC interventions at the LGA level. There are also proposals to have full-time CDGP staff as Community Assistants who will in turn manage and supervise the government seconded staff.

The LGA Community Assistants work with Community Health Extension Workers (CHEWs), CVs and Traditional Ward Committees (TWCs) to roll out the programme and ensure its coverage. The Beneficiary Reference Groups (BRGs) used for grievances redressal are formed out of the TWCs with the addition of more members such as beneficiaries and their husbands.

LGA Supervisor also reports to an LGA Technical Steering Committee which supervises the programme.

For the payments process, Stanbic has a Payment Coordinator at both state and LGA level. Payment process is executed with the help of the network of payment agents/superagents.