Oxford Policy Management

Child Development Grant Programme endline evaluation:

Key findings

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Child Development Grant Programme

Save the Children

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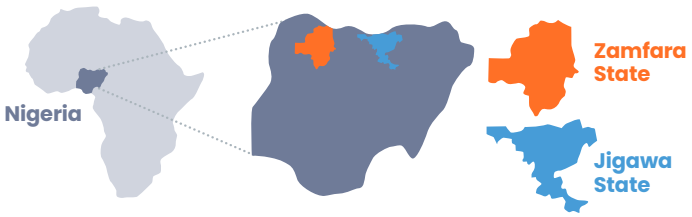
Brief overview

This note presents the summary findings of the endline evaluation of the Child Development Grant Programme (CDGP), conducted by the e-Pact consortium and led by Oxford Policy Management. The main objective of the evaluation was to describe the impact of the programme on the outcomes that it sought to achieve. The evidence comes from information collected through a household survey, interviews, and focus group discussions with recipients of the CDGP support and other community members. Data collection was carried out in 2014, before the start of the CDGP, and twice thereafter, in 2016 and 2018. Our findings examine the impact of the programme on maternal and childcare practices, health, food security, and the nutrition status of children and mothers.[1]

The evaluation found that the CDGP successfully led to a reduction in the prevalence of stunting among children. This was accompanied by a strikingly positive impact on women's and men's knowledge and beliefs about healthy infant and young child feeding (IYCF) practices, as well as the reported adoption of such practices. The evaluation also found evidence of positive impacts on household food security, especially during the lean season, dietary diversity, and household expenditure. For several of the indicators measured, the positive impacts of the CDGP were found to have continued even after households had stopped receiving transfers. Overall, the findings point to the beneficial impact on child development of a programme combining cash transfers with social behaviour change communication (SBCC) that targets the first 1,000 days of a child's life.

Figure 1: Where the CDGP programme operated



1 The detailed methodology for the qualitative and quantitative evaluation can be found on OPM CDGP project page: https://www.opml.co.uk/projects/evaluation-child-development-grant-programme-cdgp

The CDGP and its evaluation

The programme

The CDGP was a six-year UK Department for International Development-funded programme (2013–2019) that was implemented in Zamfara and Jigawa states in northern Nigeria. The programme aimed to address widespread poverty, hunger, and malnutrition, which affects the potential for children to survive and develop.[2]

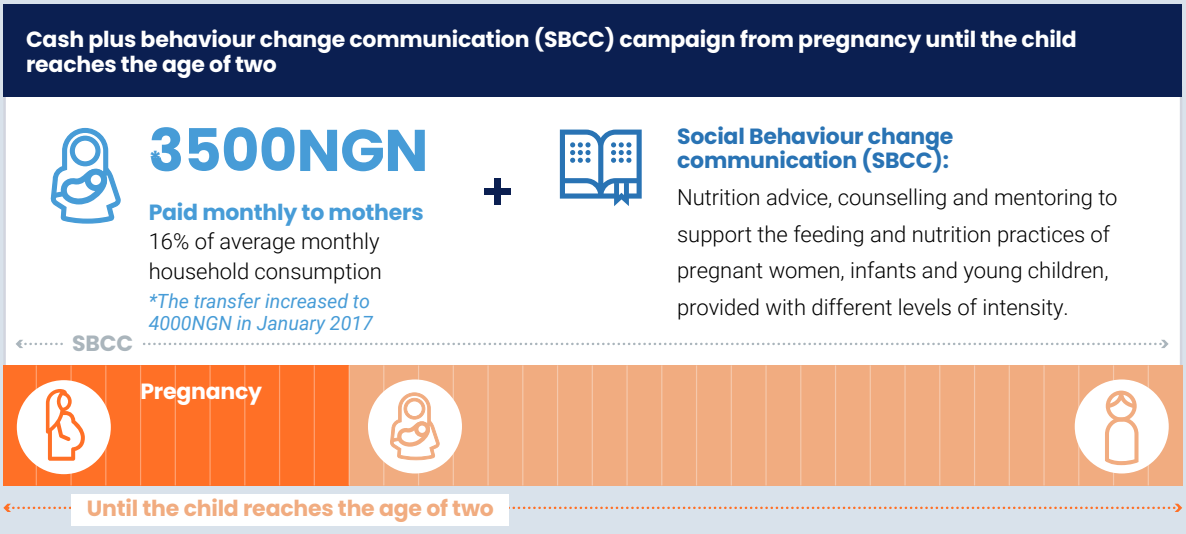
The programme provided an unconditional cash transfer of Nigerian Naira (NGN) 3,500 per month[3] (around $20)[4] to over 90,000 pregnant women. Transfers were scheduled to begin during pregnancy and last until the child turned two years old, thereby targeting the first 1,000 days of the child's life[5]. Alongside the cash transfer, communities in the programme were provided with education and advice about nutrition and health through an SBCC component (Figure 2). The combination of regular cash transfers and targeted SBCC was expected to contribute to improved food security and the adoption of beneficial practices and behaviours to support better maternal and child health.

The programmes tested two approaches to SBCC:

1. 'low-intensity' SBCC, delivered through posters, radio messaging, text messaging, health talks, and food demonstrations; and
2. 'high-intensity' SBCC, delivered through support groups and one-to-one counselling for women receiving the transfer, in addition to all of the components of the 'low-intensity' SBCC.

2 The programme was implemented by Save the Children in Zamfara and Action Against Hunger in Jigawa. In total, the programme targeted five Local Government Authorities: Anka and Tsafe in Zamfara, and Buji, Gagarawa, and Kiri Kasama in Jigawa.
3 The transfer value was revised upwards in January 2017, to NGN 4,000.
4 3,500 NGN was worth $21.6 at the purchasing power parity exchange rate observed on 15 August 2014, which was at the time of the programme's inception. This was worth around 16% of the value of total monthly household consumption expenditure as estimated at baseline and more than 100% of the value of women's earnings at baseline (Carneiro, Rasul, Moore and Mason, 2015).
5 The targeting of the CDGP toward the first 1,000 days of life is in line with an established literature around the effectiveness of investments in child health and nutrition within this critical time period.

Figure 2: The intervention and its objectives



How was the programme expected to reduce malnutrition?

The overall aim of the CDGP was to improve child nutrition and maternal health through the pathways illustrated in Figure 3. The monthly cash transfer was expected to increase the income of beneficiary households and women's control over the use of that income, enabling greater spending on food and investment in household health. Indirectly, the provision of an independent source of income was also expected to have an impact on men's and women's time use, their ability to make longer-term investments, and their ability to cope with seasonal risks and stresses. These effects, in turn, were expected to result in increased food security and an improvement in the quantity and quality of food consumed. The SBCC was expected to influence women's and men's knowledge and attitudes about healthy practices to promote child development and maternal health. Taken together, the provision of cash and SBCC was anticipated to result in improved maternal and childcare practices, and ultimately in the improved health and nutrition of women and their children.

Evaluating this programme

The evaluation of the CDGP was designed to help understand the impact of the programme on the households and communities that it supported. It relied on information collected using different methods, which were brought together to provide our overall assessment of the programme. These methods were as follows:

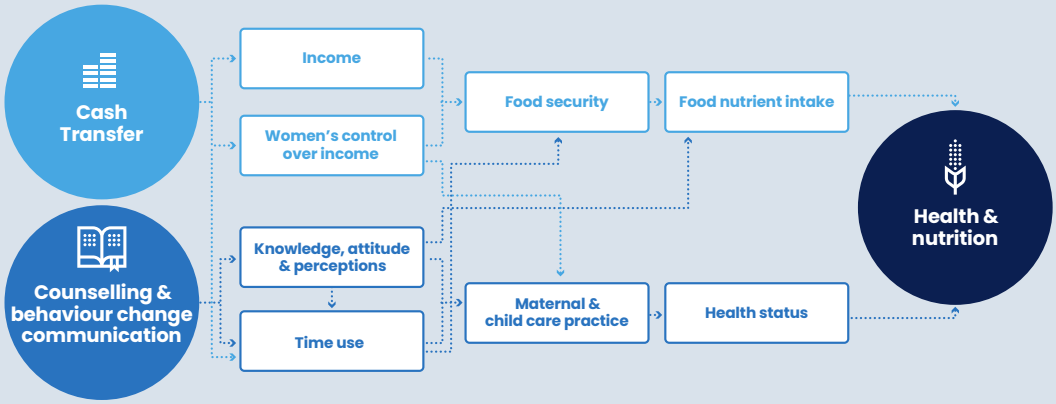
- A quantitative impact evaluation, based on a **household survey**[6] carried out before the programme started ('baseline'), two years later ('midline'), and towards the end of the programme ('endline', four years after the CDGP began). This survey was used to measure the effect of the programme on several key outcomes, including child nutrition, knowledge and practices regarding healthy behaviours and nutrition, and livelihoods activities.
- an **evaluation of the processes of the programme**, which combined analysis of programme data with interviews with programme implementers and other stakeholders, to understand how the programme worked, the challenges faced during implementation, and the factors influencing its impact.
- **a longitudinal qualitative study,** which followed a small group of households that received the programme over three rounds of data collection: it explored, through individual discussions, their views about the programme and its impact on their lives. This included exploring issues that were more difficult to capture in the household survey: for example, those relating to culture, behaviour, and power relations. Individual discussions were combined with a series of group discussions with community members, to deepen understanding of the impact of the programme and whether it has led to changes in attitudes or behaviour.

By drawing together evidence from these different methods, the evaluation gathered an understanding of the programme's results against the pathways outlined in the programme theory of change, to understand whether it had been successful in meeting its aims, and why.

[6] Based on a randomised control trial design. Details on the methodological approach can be found on OPM CDGP project page: https://www.opml.co.uk/projects/evaluation-child-development-grant-programme-cdgp

Figure 3:

The CDGP Theory of Change



Source: e-Pact (2016) 'CDGP Midline Evaluation Summary Report'.

Our findings after four years of programme implementation

Context

The CDGP was implemented in a rural setting, where agricultural activities form the main source of livelihoods. The majority of households in these communities are of Hausa ethnicity[7] and are Muslims. Households are typically large (with an average household size of nine members recorded at endline), and organised around a male household head, living with one or more of his wives and their children.

Rates of poverty and deprivation are high in this context[8]. The significant burden of poverty, coupled with gaps in health service provision, have contributed to an extremely adverse undernutrition situation. Overall, around 37% of children under five years of age are classified as stunted in Nigeria[9] and this proportion is even higher in the northern states that were the setting of the CDGP[10].

Characteristics of the communities

The household survey for the evaluation was carried out in randomly selected communities, some of which were part of the CDGP intervention and some of which were not. These communities were found to exhibit high levels of **fragility and insecurity**, with natural or man-made shocks affecting four out of every five of the communities at endline. **Natural shocks**, such as drought, poor rains, flooding, or crop damage due to pests and disease, were generally more widespread than **man-made shocks**, which included violence, curfews and widespread migration into communities. Levels of insecurity, particularly in Zamfara, deteriorated over the course of the programme's implementation. The insecurity situation had significant consequences for communities in affected areas and the CDGP's operations, as well as the implementation of the evaluation itself.

In terms of infrastructure, most of the evaluation communities had access to basic amenities nearby. Although only a minority had their own health facility or market where households could buy food and other goods, the majority of communities were located less than 1 km from the nearest market or health facility.

Over the course of the CDGP implementation period, the proportion of communities with other programmes operating in them increased. At endline this was 60%, with the most commonly cited types of other programmes being related to infrastructure development.

[7] The CDGP Local Government Authorities also contain a minority of Fulani households, as well as members of other ethnic groups, including Nupe, Tiv, and Kanuri households (Leavy et al., 2014).

[8] The quantitative baseline report found that 84% of households had incomes below the global poverty line for household income ($1.25 per day at the time of the report) (Carneiro, Rasul, Moore and Mason, 2015).

[9] See the Nigeria Demographic and Health Survey (NDHS) 2018 Key Indicators Report: https://dhsprogram.com/pubs/pdf/PR118/PR118.pdf

[10] The proportion of children under five who were reported to be stunted was 68% in Jigawa, and 55% in Zamfara. (NDHS Key Indicators Report, 2018)

Programme intervention: how was it implemented?

Implementation of cash and SBCC

CDGP was successful in reaching its intended recipients. In communities where the programme operated, nine out of every 10 women who were pregnant during the baseline period reported having received cash transfers from the programme by the time of the endline (Figure 4).

According to the design of the programme, cash transfers were intended to begin from the time women were pregnant until their child reached the age of two. The evaluation showed some variation in regard to the stage of pregnancy at which beneficiaries actually received their first payments from the CDGP. **On average, women who were among the first cohort of beneficiaries to receive the support did not start to receive payments until late into their pregnancy (at around the eight month).** Over time, the efficiency of CDGP's registration processes improved, with later cohorts receiving their first payments when they were six months pregnant, on average[11].

There was also variation in regard to the point in time at which beneficiaries stopped receiving transfers. On average this occurred when the child was 24 months, as intended by the programme's design, but some beneficiaries appear to have received transfers for longer than this, and others for less time. Overall, the evidence suggests that programme implementers faced challenges in consistently ensuring that all beneficiaries received the cash transfer for the intended length of time. This was partly due to the difficulty in maintaining an accurate record of the birth dates of all children in a context where few births are formally recorded and caregivers do not know the exact birth date.

Turning to the SBCC component, the level of exposure to the SBCC channels was relatively high. The majority of men and women in CDGP communities reported having accessed at least one of the 'low'-intensity channels. **The evaluation found that there were fewer differences between the 'high-' and 'low'-intensity versions of the programme than expected.** Many men and women living in communities assigned to receive the 'low'-intensity version of the programme still reported having accessed some of the 'high'-intensity channels. This suggests that there was little differentiation in the implementation of these two versions of the programme in practice (Figure 5).

There were differences between men and women in regard to the exposure to different types of SBCC channel. For women, the channels most frequently reported were posters, followed by food demonstrations. For their husbands, the channels most frequently reported were the radio and posters.

[11] There were some initial teething problems in the implementation of the CDGP, partly due to staffing bottlenecks. See baseline process evauluation report

Figure 4: How was the cash transfer implemented?

Targeting

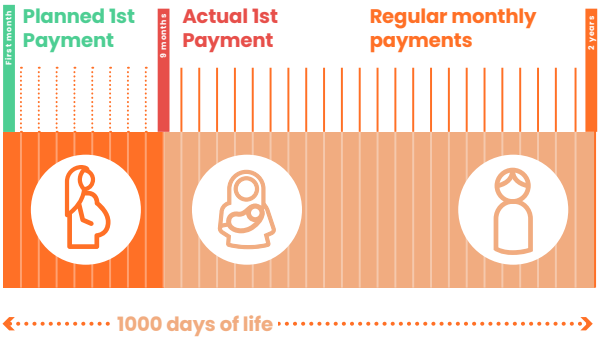
Did the cash reach the intended audience?

90%
of pregnant women in CDGP areas received the transfer

11%
of pregnant women in non CDGP areas received the transfer

Timing & frequency

Was the cash given when intended?



The majority of women received their first payment around the time of delivery.

Once started, the payments have been regular.

Figure 5: Social Behaviour change communication

Exposure

Did the SBCC reach the intended audience?

94%
of women

94%
of husbands

Recall being exposed to at least one SBCC channel

Level of SBCC intensity

In high intensity SBCC areas, small group meetings and one to one counseling did not happen to the degree expected.

47%
High intensity

39%
Low intensity

of women were exposed to small group meetings

Little differences in how the low-and high-intensity SBCC versions of the CDGP operated in practice.

35%
High intensity

25%
Low intensity

of women were exposed to one to one counselling

Impact of the CDGP on income, livelihoods and food security

By providing cash directly to women, who generally have fewer independent sources of income than their husbands, the CDGP had the potential to shift existing gender norms around decision-making and the use of income within the household. The CDGP was intended to support increased food expenditure, which in turn was expected to help households improve their food security throughout the year (particularly during the lean season when food shortages pose a greater threat). The predictable source of income provided by the CDGP also had the potential to change household livelihood and work activities. On the one hand, more cash could have enabled households to increase their investments in livelihood activities and household business enterprises. Alternatively, households may have responded to the additional source of income provided by the CDGP by shifting away from some forms of work activity that are considered less desirable.

Decision-making and use

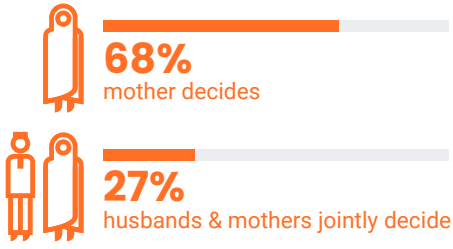
Women generally retained control over the transfer provided by the CDGP, and were able to determine how it was spent. Both men and women who were interviewed widely accepted that women were the primary beneficiaries of the CDGP cash transfers, and that they were entitled to choose how the money was spent.

Most households reported spending the majority of the transfer on food for the household or for their children. Due to the cash transfer, there was an increase in overall household expenditure, primarily driven by increases in food expenditure (Figure 6).

Figure 6: Income, consumption & livelihoods

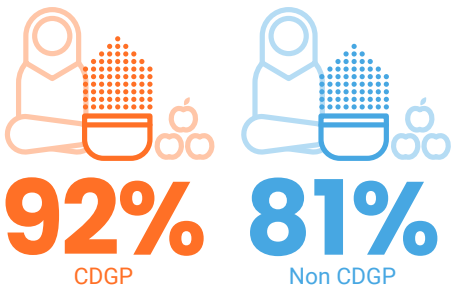
Women's control of income

When we asked husbands who decides how to spend the cash transfer



They spend it on food for the household and for children in particular.

Livelihoods



of women engage in a work activity.

CDGP women had more livestock and savings, and borrowed less.

Livelihoods and income

The CDGP had an impact on the proportion of women engaged in any work activities. Access to the programme also stimulated greater investment in their business activities, leading to increases in women's revenues from their businesses and their business expenditures. The evaluation did not find a similar story for their husbands, which is not surprising given that most men most were already working.

The CDGP led to significantly higher levels of investment. Households in CDGP communities **owned more livestock and engaged in more purchases and sales of livestock than those in non-CDGP communities.** These impacts were larger in magnitude compared to the midline. This suggests that investment in larger assets like livestock becomes more feasible for households after the accumulation of successive cash transfers, once their more immediate needs have been secured. The CDGP also had an impact on the proportion of women owning any animals themselves, independently from the rest of the household.

The programme significantly reduced the proportion of households borrowing money, as well as the amounts borrowed. It also increased the proportion of households with savings, as well as the total value of savings (including both cash and in-kind savings).

Despite the increases in women's livelihoods activities, there was no impact on overall household income at endline. This is partly because men's income did not increase, and men's income is typically a much larger proportion of overall household income than women's.

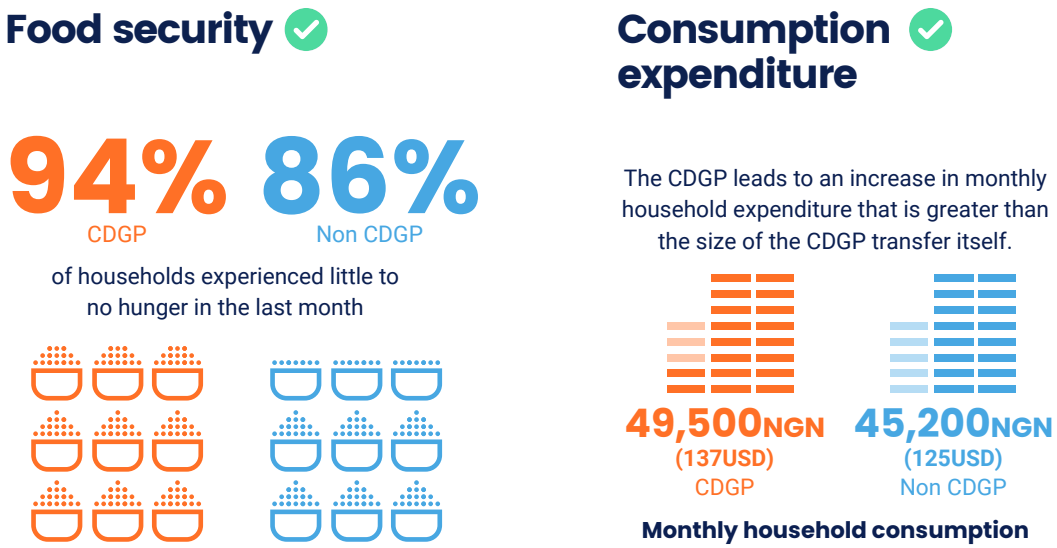
Food security and coping

The CDGP had a positive impact on household food availability across all seasons, especially during the lean season, when the risk of hunger is particularly severe. Households in CDGP communities were 12 percentage points less likely to suffer a food shortage at some point in the last 12 months. The grant allowed recipients to purchase more foods that are not produced in their community, thereby reducing both the seasonal variation in the diversity of foods eaten, as well as food availability throughout the year.

Households in CDGP communities were also more likely to report experiencing 'little or no household hunger' in the 30 days prior to the survey (as measured by the 'Household Hunger Scale'), indicating increased access to sufficient food. At endline, there were almost no households in a situation of severe household hunger in CDGP communities (Figure 7).

The CDGP improved households' ability to cope with negative income shocks, reducing their need to resort to negative coping behaviours in order to manage. There was a reduction of 5.5 percentage points in the proportion of households that sought external assistance from friends and relatives. The CDGP also reduced the incidence of family members needing to take on more work, or move away from the community to find work, in order to cope during times of need.

Figure 7: Food security and consumption expenditure



Impact of the CDGP on knowledge, attitudes, and practices related to maternal health and IYCF

The combination of cash and information was expected to provide households with the means, capacity, and information to support improved child nutrition and adopt healthy behaviours to promote maternal and child health. Our findings show large impacts of the programme on improving knowledge, attitudes, and practices regarding IYCF, with especially large increases reported in exclusive breastfeeding rates. The CDGP also had an impact on promoting increased dietary diversity of infants over six months, as well as increased use of antenatal care (ANC) services for pregnant mothers.

Maternal health and ANC practices

The CDGP led to significant increases in the use of ANC services in CDGP communities for women who were pregnant at the time of the endline survey. Of women who were pregnant when interviewed in CDGP communities, 51% reported utilising ANC services, compared with 36% of pregnant women in non-CDGP communities (Figure 8).

At endline, children born in CDGP communities were 11 percentage points more likely to have been delivered at health facilities compared with children in non-CDGP communities. This is similar to the findings at midline, indicating a continuation of these positive impacts over time.

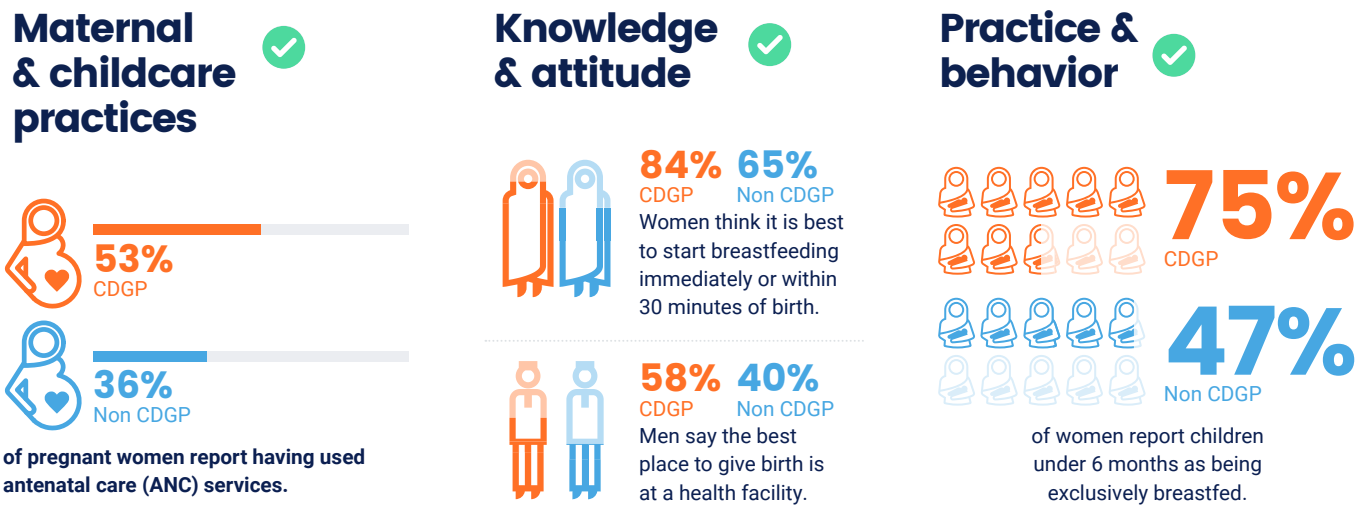
Nevertheless, the situation remains very problematic, with only one out of every four children who were born after the CDGP midline survey being delivered at a health facility. This may be due to limited availability of skilled staff at health facilities in the evaluation communities, only around 60% of which were reported to be places where the delivery of children was possible. The qualitative study also found that the costs of accessing health facilities (for example, the cost of transport) were a key consideration for some households in deciding whether to visit a health facility.

Knowledge of healthy breastfeeding and IYCF practices

The evaluation found improvements in beliefs and attitudes regarding a range of health issues, including early initiation of breastfeeding, exclusive breastfeeding, the benefits of colostrum, and the fact that it is not advisable to give water to a baby under six months of age. The fact that these improvements were observed for both men and women is important, as it indicates a positive shift across all household members. These positive impacts were observed at midline as well as endline, indicating that changes in behaviour caused by the programme have persisted throughout the evaluation period.

As well as improving knowledge of IYCF practices, the CDGP also had an impact on actual reported practice. This included improvements in healthy breastfeeding practices in relation to young children, and improved dietary diversity for older children. Improvements were particularly notable for immediate, exclusive, and appropriate breastfeeding. This is consistent with the considerable improvements in knowledge and beliefs documented, indicating that these changes in knowledge effectively translated into changed practices too (Figure 9).

Figure 8: Health practice & behaviour



The CDGP led to significant increases in the proportion of infants under six months of age who were fed exclusively with breast milk. The impact of the CDGP on the proportion of children under six months of age reported to have been exclusively breastfed was around 30 percentage points at endline.

Our qualitative research explored the enablers and barriers to exclusive breastfeeding. It found that one major factor facilitating increased uptake of exclusive breastfeeding was the effect of seeing other women and members of the community adopting these practices. Our respondents explained that it is very difficult to be the first one to adopt something new or something that goes against tradition, but that it becomes easier to do so the more other people are doing it. The adoption of new practices was therefore described as 'snowballing', as non-beneficiaries of the CDGP, as well as those directly involved in the SBCC activities, saw the results and copied the new practices. Additionally, the engagement of husbands in the SBCC was also found to be an important factor in the success of these message, according to beneficiaries and local key informants. The role of the CDGP's Community Volunteers in providing continuous support, answering questions, and showing women the best ways to breastfeed (not only 'telling us what to do') was also found to be a deciding factor for many, who had in some cases heard about exclusive breastfeeding before but had not been persuaded to try it themselves.

Barriers to the adoption of exclusive breastfeeding in CDGP communities included traditional beliefs (such as the view that the first milk, or colostrum, is harmful), the religious practice of giving rubutu (prayer water) to the baby after birth, and the opposition of other influential people, especially older women, who can believe that it is cruel to deny water to a baby.

Overall, our qualitative research found many respondents in all its research communities reporting that they had adopted the new breastfeeding practices themselves, had supported their wives to do so, or would advise other women to do so, because they believed it was better for the baby's health and nutrition.

Maternal and child nutritional status and health

The ultimate goal of the CDGP was to improve maternal and child health and nutrition.

The CDGP led to investments in child health that went above and beyond nutrition, corresponding to the broad set of SBCC messages delivered. This included an impact on the uptake of vaccinations, as well as on a range of other positive health indicators, such as a reduction in the incidence of diarrhoea, the proportion of children who had recently suffered an illness or injury, and the proportion of children given deworming medication in the last six months prior to the endline survey (Figure 10).

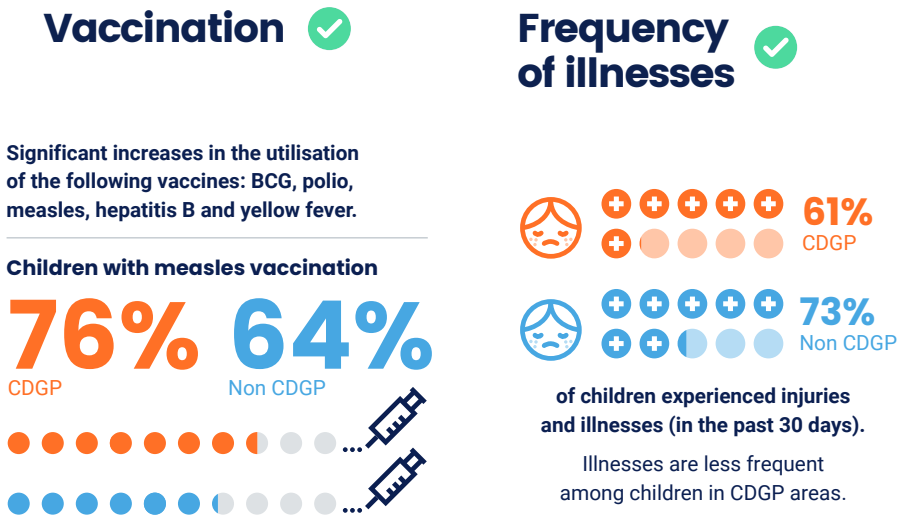
The ultimate objective of the CDGP was to improve maternal and child nutrition, and we find that the programme did have a positive impact on reducing stunting (low height-for-age) among children who were of an age range to be directly exposed to it. This is an important achievement, since stunting is an indicator of long-term nutrition that does not shift easily. There was no corresponding impact on children's weight-for-height or weight-for-age, although the rate of wasting (low weight-for-height) was considerably lower to begin with in our setting than the rate of stunting.

Turning to children who were born after the midline survey, who were generally the younger siblings of those directly exposed to the CDGP after the baseline, the evaluation found similarly positive impacts on the uptake of vaccinations and other positive health outcomes. **This is an important finding as it shows that investments in health were sustained for the younger siblings of initially-exposed children, even once the transfers ended. This may point to an effect of the SBCC component of the CDGP in promoting changed practices regarding child health, even after cash transfers ceased.** That said, there was no impact on anthropometric outcomes for these younger siblings, in either stunting, wasting, or underweight measures. This suggests that it is important for children to be directly exposed to cash transfers in order for impacts on anthropometric measures to occur.

On the whole, there was little evidence of any effect of the CDGP on women's nutritional status, as measured by height, weight, body mass index, and mid–upper arm circumference.

Figure 9: Dietary diversity

Figure 10: Health & nutrition



Conclusions and lessons about the CDGP and its impact

Based on the findings of the impact evaluation, there are several lessons to be learned about this programme and its impact:

Conclusions about the implementation of the programme

- Coverage of the cash component of the CDGP was high overall, despite some initial teething problems in its roll-out.
- It was difficult for the CDGP to reliably enrol beneficiaries early in their pregnancy, as intended by the programme's design. The programme made some improvements in the efficiency of its registration processes, but by the time of the endline some delays still remained. There was also some evidence of variation in the timing of exit from the cash transfers.
- There do not appear to have been substantial differences in the implementation of the two versions of the CDGP intervention that this evaluation sought to test. In practice, the two SBCC components appear to have been experienced fairly similarly by respondents.
- It is important to deliver SBCC through multiple channels, because men and women access messages through different channels. Women were substantially more likely to attend health talks and food demonstrations in the community, while men were more likely to recall messages from radio announcements.

Conclusions about the impact of the programme

- The CDGP was extremely effective in promoting improvements in caregivers' knowledge of beneficial child health and nutrition practices, across a wide range of domains that span the range of messages provided through the programme's SBCC campaign.
- The CDGP had impacts on households' economic status and security that persisted after the transfers themselves ended. These findings provide some encouragement that some positive impacts from this programme on household livelihoods and resilience to shocks may continue in the longer term.
- The impact of the CDGP in promoting positive practices for healthy child feeding was sustained for new children born in the household. The CDGP had a positive impact on health and nutrition practices adopted for new children born in the household, after the original, older child for whom the transfers were received.
- The positive impact of the CDGP on reducing stunting for children who were of an age range to be directly exposed to the transfers is an important result. Stunting reflects long-term, chronic, malnutrition, and improvements are typically slow to materialise. However, the proportion of children who are stunted remains very high in this context. This indicates that in spite of the beneficial effect of the CDGP, the malnutrition situation remains very grave and further intervention is needed.

The findings of the evaluation demonstrate that the CDGP was a viable social protection instrument, which had important effects on the health and nutritional wellbeing of children in the first 1,000 days of their lives. Although a social assistance programme combining cash with SBCC (sometimes referred to

Figure 11: What was its impact?

as 'cash plus') can, as demonstrated here, reduce malnutrition and improve child health outcomes, the challenges that remain in substantially improving anthropometric outcomes must be recognised. Anthropometric measures of child nutritional status, such as stunting, have multiple, complex determinants that a single programme may not be able to jointly address in isolation. The inclusion of a broader set of complementary interventions, including supply-side support, may therefore be necessary. Comparisons of the cost-effectiveness of various nutrition-focused interventions are also required to shed further light on the appropriateness of different modalities.

By targeting the vulnerabilities faced by children in the first 1,000 days of their lives, the CDGP took an approach to social protection that is sometimes known as a 'life-cycle approach'. This means that it was based on the premise that individuals and households face different risks and vulnerabilities at different stages of their lives. If the vulnerabilities faced by children during this period are deemed a priority focus for the Federal Government, a decision is required regarding whether to reach them through a similar approach targeted to their stage of life, or instead to offer social protection to all households living in poverty. This evaluation suggests that the 'life-cycle' approach can be successful. The evaluation found evidence that uptake of positive health behaviours was linked to the role of early 'influencers' in the community, who demonstrated the benefits of behaviour change to others. It would be a valuable avenue for future research to explore whether similar mechanisms enabling behaviour change on this scale would arise through a poverty-targeted programme that does not explicitly target the first 1,000 days of life.

Recommendations for related programmes in the future

The CDGP was very successful overall and through its six years of implementation much has been learned about a cash and SBCC intervention focused on pregnant women until their child reaches the age of two, especially in the fragile context of northern Nigeria. Future programmes exploring similar design features may want to take the following into consideration:

- **The 'first 1,000 days of life' is indeed the most important phase for impacting the future wellbeing of infants and toddlers, but the practicality of implementing a programme focusing on this period to the letter is operationally complex.** This requires an accurate database of children's birthdays, which is difficult in many contexts where civil registration data are not widely available. In these situations a more practical approach is to adhere to the spirit of the 'first 1,000 days' by applying a fixed number of payments from the time of enrolment.
- **Delivering SBCC through a 'low-intensity' strategy may be sufficient to attain impacts in improved knowledge and beliefs.** Our evaluation demonstrated the striking impacts of the CDGP in shifting knowledge and beliefs among women and men about healthy child nutrition practices. However, our findings also show little difference in high- and low-intensity SBCC locations. This suggests that implementing the 'low-intensity' version of the programme may be sufficient to achieve these impacts, with lower additional value of the high-intensity component.
- **Programmes focused on nutritional outcomes need to consider the circumstances in which stunting is an appropriate high-level indicator to use.** The evaluation's results reveal strong impacts of the CDGP across many dimensions of its theory of change. However, there were mixed impacts on the anthropometric indicators that were intended to capture the programme's overall success in relation to its ultimate impact objectives. This may partially reflect some characteristics of these indicators themselves, which may have more underlying and complex determinants than those which this programme aimed to target. There may therefore be a case for broadening the toolbox of measures used to draw conclusions about the final impacts of programmes of this type.

The Child Development Grant Programme was implemented by Save the Children and Action Against Hunger. The evaluation was conducted by the e-Pact consortium (Oxford Policy Management, Itad and Institute for Fiscal Studies) and funded by UK aid.

Visit the OPM CDGP project page or contact:

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