Oxford Policy Management

Child Development Grant Programme:

Key messages of the midline evaluation findings

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Child Development Grant Programme

Save the Children

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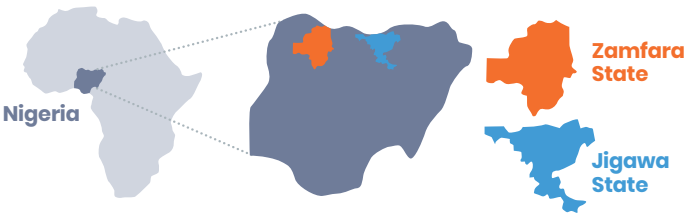
Brief overview

This note presents the summary findings of the midline evaluation of the CDGP, conducted by the e-Pact consortium and led by Oxford Policy Management. The main objective of the note is to describe the impact of the programme on the households supported by CDGP. The evidence comes from information collected through a household survey, interviews and discussions with recipients of CDGP and other community members, carried out before the commencement of the CDGP and again two years afterwards. Our findings provide a picture of how the programme has impacted maternal and child care practices, health status, food security and the nutrition status of children and mothers.[1]

Overall, the midline evaluation shows that the CDGP has had a strikingly positive impact on women's and men's *knowledge and beliefs* about healthy infant and young child feeding (IYCF) practices. The programme has also had a positive impact on improving household food security, especially during the lean season, and on reducing the stunting rate for children born after it started. The findings point to the beneficial impact on child development and maternal health of a programme combining cash transfers with behaviour change communication (BCC).

Figure 1: Where the CDGP programme operates



[1] The detailed methodology for the qualitative and quantitative evaluation can be found at the **OPM project web page**

The programme

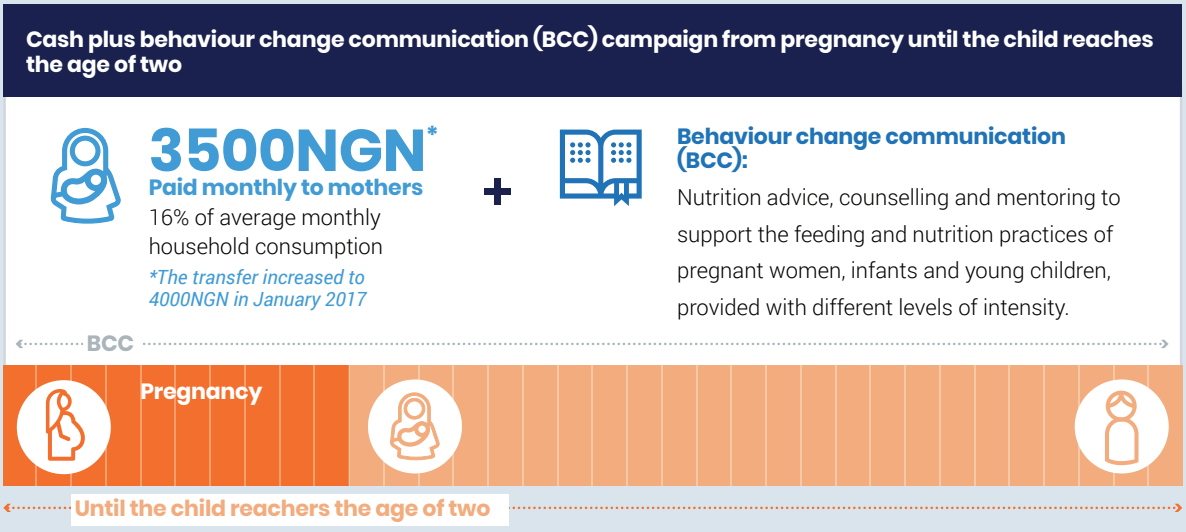
The CDGP is a six-year UK DFID-funded programme (2013–2019) implemented in the Zamfara and Jigawa states of northern Nigeria. The programme aims to address widespread poverty, hunger and malnutrition, which affects the potential for children to survive and develop.[2]

As shown in figure 2, the programme provides a cash transfer of Nigerian Naira (NGN) 4,000 (about £8.60) per month[3] for up to 70,000 pregnant women for a period of approximately 33 months, targeting the first 1,000 days of a child's life. Alongside the cash transfer, communities in the programme are provided with education and advice about nutrition and health through a BCC component. The combination of regular cash transfers and targeted BCC is expected to contribute to improved food security and the adoption of beneficial practices and behaviours to support better maternal and child health.

[2] The programme is implemented by Save the Children in Zamfara and Action Against Hunger in Jigawa. In total, the programme targets 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 from NGN 3500. The current amount is equivalent to about 25% of total household earnings reported at baseline.

Figure 2: The intervention and its objectives



The CDGP and its evaluation

How is the programme expected to reduce malnutrition?

The overall aim of CDGP is to improve child nutrition and maternal health through the pathways illustrated in Figure 3. The *monthly cash transfer* is 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 is also expected to have an impact on men's and women's time use, and on their ability to cope with seasonal risks and stresses. These effects in turn are expected to result in increased food security and an improvement in the quantity and quality of food consumed. The *BCC* is 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 BCC is 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 is intended to help understand the impact of the programme on the households and communities that it supports. The evaluation relies on information collected using different methods, which are brought together to provide our overall assessment of the programme. These methods are:

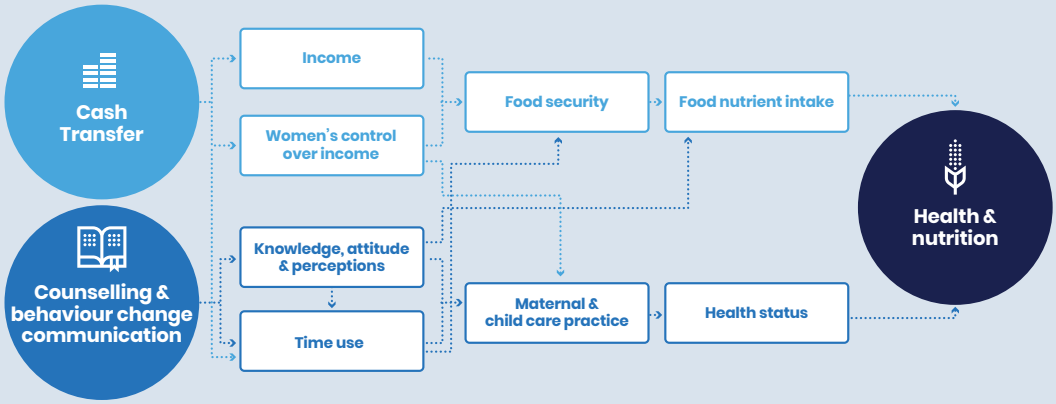
- a **household survey**[4] carried out before the programme started ('baseline'), two years later ('midline'), and towards the end ('endline', four years after it began): this survey is used to measure the effect of the programme on several key outcomes, including child nutrition, knowledge and practices regarding healthy behaviours and nutrition, and livelihoods activities;
- an **evaluation of the processes of the programme:** analysis of programme data combined with interviews with programme implementers and CDGP recipients to understand how the programme works, the challenges overcome during implementation, and the factors influencing its impact; and
- **a longitudinal qualitative component** following a small group of households receiving the programme over three rounds of data collection: it explores, through individual discussions, their views about the programme and its impact on their lives, particularly on issues that are more difficult to capture in the household survey for example culture, behaviour, power relations, etc. This is 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 attitude or behaviour.

Through a combination of these methods, the evaluation collects evidence on the pathways outlined in the programme ToC to understand whether it has been successful in meeting its aims, and why.

[4] Based on a randomised control trial design. Details on the methodological approach can be found in **volume II of the CDGP midline quantitative report.**

Figure 3:

The CDGP Theory of Change



Our findings after two years of programme implementation

Characteristics of the communities

The high incidence of both natural and man-made shocks can cause livelihoods activities to be negatively affected, leading to volatility in incomes and exacerbating the problems that households face.

The CDGP operates in a context of fragility and insecurity. Natural and man-made shocks are common, affecting 85% of all the communities visited as part of this evaluation. **Natural shocks,** such as drought, poor rain, flooding, or crop damage due to pests and disease, are generally more widespread than **man-made shocks**. Common man-made shocks include violence (for example cattle raids), curfews, and large migration into communities. Cattle-rustling and widespread migration are the two most common shocks.

Most communities have access to basic amenities nearby. Although only a minority have their own health facility or market where households can buy foods and other goods within the community, the majority of communities are located less than 1 km from the nearest market or health facility.

Around 40% of communities have some programme other than the CDGP operating in them.

Programme intervention: how was it implemented?

Uptake of the programme

Knowledge of the CDGP is widespread in CDGP communities and participation among eligible households is high. Almost all interviewed women who were pregnant at baseline were knowledgeable about the programme. As shown in figure 4, about 84% of women who were pregnant before the programme and living in CDGP communities ended up participating in the programme. Possible reasons why the remaining 16% of women pregnant at baseline did not end up enrolling in CDGP include: the women misreporting their pregnancy to baseline field teams, miscarrying or giving birth between the baseline and CDGP registration, or not wanting to participate. The qualitative midline also suggests that some women who wanted to participate have been unable to register due to delays in the implementation processes and/or demand outstripping the programme's capacity, both of which were manifest in the earlier stages of the implementation of the programme. A small number of pregnant women (7%) in **non CDGP areas also ended up receiving payments from the CDGP.** This could be due a number of factors, including the programme being rolled out in the wrong communities by error, or fraudulent activities.

Implementation of cash and BCC

The programme is intended to provide payments to women from the time they are pregnant until their child reaches the age of two. As shown in figure 4 **the majority of women who were initially enrolled received their first payment around the time of delivery.** The programme has put significant focus and attention on this to speed up the process of registering the women and making payments to them, and enrolment now takes place about the fifth month of pregnancy. This is a marked improvement, but there is still scope for further reducing delays.

An important feature of the CDGP evaluation is understanding the impact of different levels of intensity of the BCC component of the intervention. Under the 'low-intensity' BCC approach, messages were to be provided through posters, radio messaging, text messaging, health talks, and food demonstration; under the 'high-intensity' BCC, in addition to the same 'low-intensity' components, messages were also to be delivered through support groups and one-to-one counselling for women receiving the transfer. As shown in figure 4, **we do not find large differences between the high- and low-intensity CDGP communities in how programme participants report accessing BCC information,** indicating few on-the-ground differences in how the low- and high-intensity BCC versions of the CDGP operate in practice.

Men and women access BCC messages through different channels. The channels that women most frequently reported being exposed to were posters, followed by food demonstrations. For their husbands, the most frequent channels reported for information dissemination were the radio and posters. Messages related to exclusive breastfeeding and eating nutritious foods were found to be the most effective, as women recalled them more frequently than others.

The reach of BCC messages goes beyond communities where CDGP operates. **In non CDGP communities, it is also common to find households which report having received such messages (although the likelihood of receiving a message through any given channel is always higher in CDGP communities).** This might indicate the presence of concurring information and advice programmes in non CDGP areas.

Figure 4: How was it implemented?

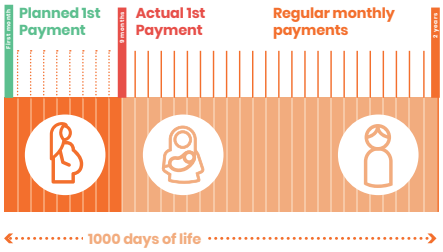
Cash transfer

Targeting
Did the cash reach the intended audience?

84%
of pregnant women in CDGP areas received the transfer

7%
of pregnant women in non CDGP areas received the transfers

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.

Amount
Was the amount given as intended?

99.7%
of respondents reported to have usually received

3500NGN
(the expected amount)

Behaviour change communication

Exposure
Did the BCC reach the intended audience?

90%
of women

83%
of husbands

Recall being exposed to at least one BCC channel

Level of BCC intensity

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

69%
High intensity

51%
Low intensity

of women were exposed to small group meetings

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

16%
High intensity

14%
Low intensity

of women were exposed to one to one counselling

Impact of CDGP on income, livelihoods and food security

By providing cash directly to women, who generally have fewer independent sources of income than their husbands, CDGP has the potential to shift existing gender norms around decision-making and the use of income within the household. Both qualitative and quantitative findings show that women retain control of the CDGP transfer and have autonomy in how they choose to spend their own income. As shown in figure 5, we find that the transfer leads to substantial increases in monthly household expenditure, with most of the transfer being spent on food.

CDGP is intended to support increased food expenditure, which in turn is 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 CDGP also has the potential to change household livelihood and work activities. On the one hand, more cash could enable households to increase their investments into livelihoods activities and household business enterprises. Alternatively, households may respond to the additional source of income provided by CDGP to shift away from some forms of work activity that are considered less desirable.

Our findings show that CDGP leads to large and positive improvements in food security. We also find that the programme leads to an increase in women's engagement in work activities and average earnings. There is no corresponding impact on men's earnings, nor is there an impact on overall household earnings (not including the CDGP).

Decision-making and use

As shown in figure 5, **women generally retain control over the transfer provided by CDGP** rather than their husbands or someone else, and they determine how it is spent. Both men and women widely accept that the primary beneficiary of CDGP are the women in the household, and that they are entitled to choose how to spend the grant.

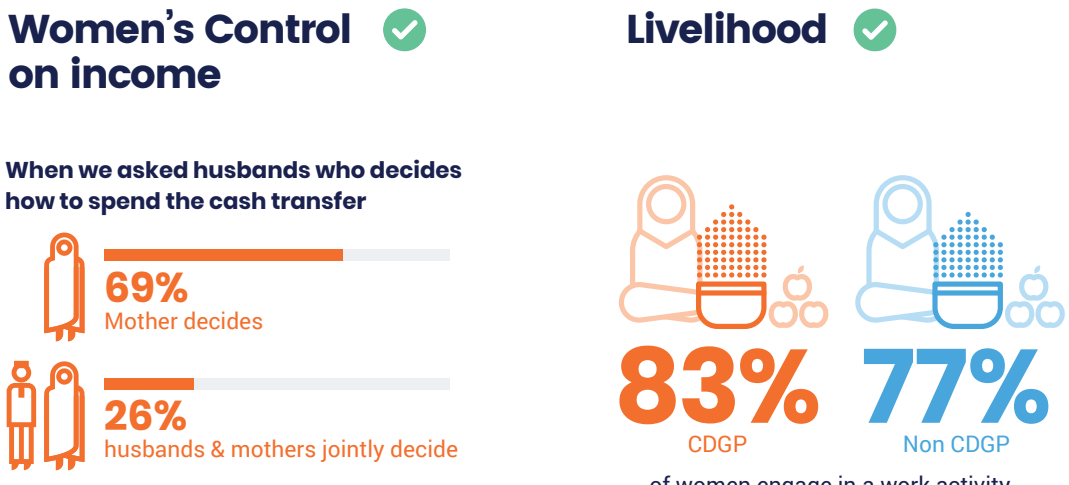
Most households report spending the majority of the additional transfer provided by the programme on food for the household, or for children in particular. As a result of the programme, women in CDGP communities spent more money on clothing for adults and children and owned more goats and chickens compared to the women in the non CDGP communities. We find that the CDGP leads to an increase in monthly household expenditure greater than the size of the CDGP transfer itself.

Livelihoods and income

As shown in figure 5, the CDGP led to an increase in the proportion of women engaged in paid or unpaid work in the 12 months preceding the household survey. This resulted in their monthly earnings increasing by NGN 668 compared to women in non CDGP communities, representing an increase of around 20% from baseline levels. This finding mainly reflects increased engagement in petty trading, such as the preparation of snacks and cooked foods. There is no impact on whether men work, since nearly all of them do, nor is there an impact on overall household earnings (not including the CDGP transfer). This is because women's earnings make up a smaller proportion of overall household earnings than men's.

Our qualitative research did, however, find that many of the husbands of the CDGP recipients stated being able to re-invest more of their own income and time in their own farm activities, since the pressure of having to provide money to pay for the household's food was somewhat relieved.

Figure 5: Income, consumption & livelihood



Food security and coping

CDGP has had a positive impact on household food availability across all seasons, but especially during the lean season when the risk of hunger is particularly severe. The predictable source of cash has enabled households to attain more consistency in food consumption over the year, reducing seasonal variation. 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.

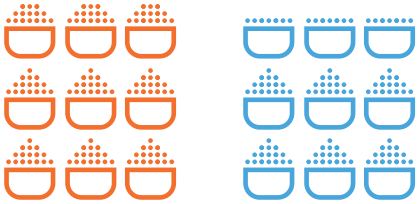
The CDGP has also had an impact on household's ability to cope with negative income shocks and seasonal variation in food availability. The proportion of households that need to resort to negative coping behaviour to meet their food requirements during periods of shock is lower for CDGP households than for non CDGP households. Reliance on external assistance, such as help from family members and friends, has also decreased due to CDGP, as has the proportion of households needing to borrow money. **Finally, the programme has also significantly decreased the instances where family members had to take on more work or move away from the community to find work to be able to cope with food shortages.**

Food security

94% CDGP

91% Non CDGP

of households experience little or no hunger.



Consumption Expenditure

The CDGP leads to an increase in monthly household expenditure that is greater than the size of the CDGP transfer itself.

37,500NGN (294 USD) CDGP

32,700NGN (256 USD) Non CDGP

Monthly household consumption

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

The combination of cash and information (known as 'cash plus' intervention) is 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 knowledge, attitudes, and practices regarding infant and child feeding, with especially large increases reported in exclusive breastfeeding rates. As shown in figure 6, the CDGP has 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. However, we do not find an increase on use of other health services beyond ANC.

Maternal health and ANC practices

There are significant increases in the use of ANC services in CDGP areas for women who were pregnant at the time of the midline survey. As shown in fiigure 6, of pregnant women in CDGP areas, 36% reported utilising ANC services, compared to 20% for pregnant women in non CDGP communities. Children born after the start of the CDGP were more likely to be born at a health facility due to CDGP, and hence to have their delivery assisted by a doctor, nurse, midwife, or community health extension worker. **Nevertheless, the situation is still very problematic: only one out of every five children born after the CDGP was born at a health facility.**

Knowledge of healthy breastfeeding and IYCF practices

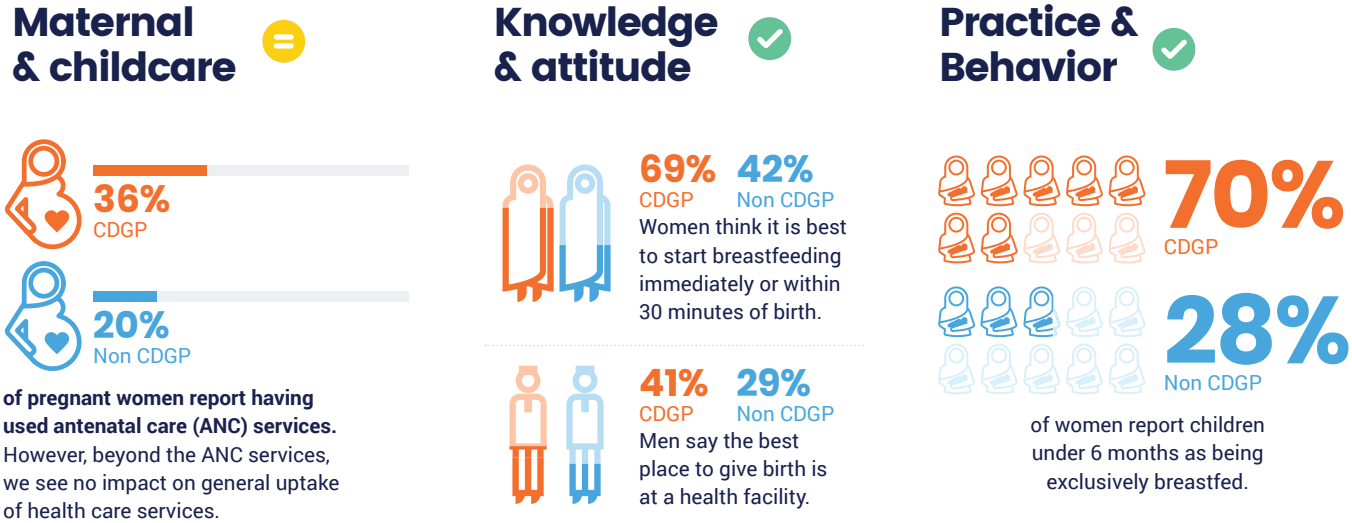
To gather evidence on the impact of the CDGP on health and nutrition, we asked respondents to tell us about their views on different health practices and what they do.

The CDGP has had a strikingly positive impact on women's and men's *knowledge and beliefs* about healthy breastfeeding and IYCF practices. The evaluation finds improvements in reported beliefs and knowledge of participating households on numerous health issues, including early initiation of breastfeeding, exclusive breastfeeding, attitudes towards the benefits of colostrum, and that it is not advisable to give water to a baby under six months. The fact that these improvements are observed for both men and women is important, as it indicates a positive shift across all household members.

As well as improving knowledge of IYCF practices, CDGP has also had an impact on actual reported behaviours. We find significant increases in the proportion of infants under six months of age who are fed exclusively with breast milk. As shown in figure 6, at midline 70% of children under six months are reported by the women as being exclusively breastfed in CDGP communities, compared to 28% of children in non CDGP communities. There are also **improvements in practices related to older children in terms of dietary diversity measures.** As shown in figure 6, a higher proportion of children aged between 6–23 months receive the recommended number of food groups in CDGP communities relative to non CDGP communities due to the programme. There remains significant room for improvement, because the figure is still low (21% of CDGP children).

The qualitative research supports these findings. Women cited the CDGP's role in enabling them to make more autonomous choices in terms of what and when to eat and feed their children, instead of having to rely solely on their husbands. This has resulted in a shift from consumption of simple cereal staples to more meat, nuts, fruit, and in particular more dairy products. Altogether, these results indicate remarkable changes due to CDGP.

Figure 6: Health practice & behavior



Maternal and child nutritional status and health

The ultimate goal of CDGP is to improve maternal and child health and nutrition. We find that the programme has had an impact on raising the proportion of vaccinated children. It also leads to a reduction in stunting (low height-for-age) for children born after the CDGP started, but an increase in their wasting (low weight-for-height). There is no impact on these nutritional outcomes on children born before the CDGP started. There are few differences in anthropometric indicators of nutrition between mothers in CDGP and non CDGP communities.

Women and children's health and nutrition status

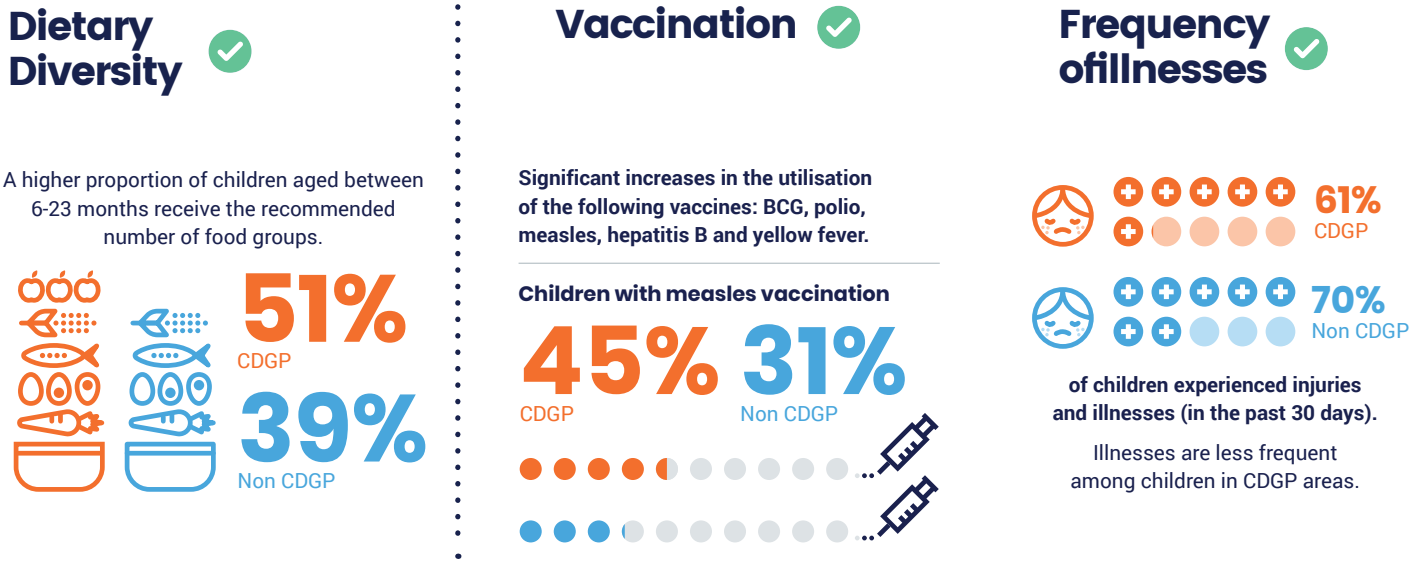
As shown in figure 7, the CDGP has led to improvements in infant and child health that go beyond nutrition. Specifically, the programme has led to increases in the utilisation of several vaccines, including polio and measles. Children in CDGP communities are also are more likely to receive deworming treatment, less likely to suffer from injury and illnesses, less prone to diarrhoea, and more likely to receive adequate care when they do have diarrhoea. These factors are important, as they are known to be associated with malnutrition. The reduction in the incidence of illness and diarrhoea may be the result of improved IYCF practices, such as early initiation of breastfeeding and exclusive breastfeeding and dietary diversity. This link was raised by respondents in our qualitative midline investigation, who reported noticing significant reductions in fever and diarrhoeal episodes among their children after introducing exclusive breastfeeding. That said, the incidence of diarrhoea is still very high: around one-third of children born after the start of the CDGP and one-fifth of children born before the CDGP were reported to have had diarrhoea in the two weeks prior to being interviewed.

For children born after the start of the CDGP, we find that the programme has had a moderate impact on increasing height-for-age (measure of stunting) and on reducing the proportion of children who are stunted (i.e., have low height-for-age) and severely stunted. However, the incidence of stunting remains high. For this same group, the CDGP has also led to a decrease in weight-for-height (measure of acute malnutrition). In other words, at any given age, children born after the start of the CDGP are taller in CDGP communities than in non CDGP communities, but they are relatively thinner. This is not driven by a decrease in weight-for-age, but rather by an increase in height-for-age as a result of the programme. It is possible that early improvements in nutrition contribute to an increase in a child's height, but a chronic lack of access to adequate nutrition in this area, even in CDGP areas (coupled with lack of access to complementary water, sanitation, and hygiene services) prevents children's weight gain from keeping up with their height gain.

When we consider children born before the start of the CDGP (i.e., those aged 0–5 at baseline), we no longer see any impacts of participation in the CDGP on stunting. This may provide support for the claim that the first 1,000 days of life (from conception to age two) offer a critical and unique opportunity window of opportunity for investing in child health.

The CDGP has had little impact on the nutritional status of women as measured by various anthropometric measures (height, weight and Body Mass Index).

Figure 7: Health & nutrition



Lessons about the CDGP and its impact

Based on the findings of the impact evaluation, we draw several lessons learned about this programme and its impact:

- **in terms of targeting, the CDGP is reaching extremely vulnerable populations with a high incidence of serious health and nutrition problems;**
- **the timing of the first payment varies widely across women, but women mainly receive their first payment only around the time of delivery.** Although the programme is designed to start the payment of transfers as soon as the woman is pregnant, for many of the mothers who were already pregnant at baseline, the first payment did not come until around the time of delivery. The timing of enrolment has, however, improved since then;
- **women generally retain control of the cash transfer, and it is mostly spent on food;**
- **it is important to provide BCC through multiple channels, since husbands and wives access messages from different sources;**
- **there are no significant differences in implementation between high- and low-intensity BCC communities.** In practice, BCC appears to be implemented similarly across all programme communities, regardless of their assigned intensity;
- As summarised in figure 8, **the CDGP has positive impacts on the health, nutrition and development of young children in these communities.** This shows that a combination of cash transfers and information can generate important changes in the lives of children at very young ages;
- **the CDGP leads to increases in the height of children, but not in proportional increases in weight.** It is plausible that children are receiving more nutritious foods that enable growth, or that the benefits of better breastfeeding practices enable growth—or even that children are born less stunted to start with, to better nourished mothers—but then children do not receive enough calories to enable them to gain sufficient weight for their height;
- **the CDGP leads to improvements in the stunting rates of young children born during the implementation of the CDGP, but not in the stunting rates of older children born before the beginning of the programme.** It is possible that the impact of cash transfers and BCC on stunting only occurs if the child is exposed in utero and slightly after; and
- **despite the positive impacts of the CDGP, the population in CDGP communities remains malnourished and subject to substantial food insecurity.**

Figure 8: What was its impact?

Based on these findings, it is clear that the CDGP is a viable social protection instrument that can have important effects on the health and nutritional wellbeing of children in the first 1,000 days of their lives. The programme nevertheless requires further review and adjustments to lend itself to a less resource intensive scalable national programme. A review of the community voluntary approach, the intensity of BCC, the payment modalities, and its link to a broader institutional setting would be the first steps in this direction.

While a social assistance programme combining cash with BCC (sometimes referred to as 'cash plus') can, as demonstrated here, reduce malnutrition and improve child health outcomes, its limitation in significantly improving child nutritional outcomes given its multi-determinant nature needs to be recognised. Placing a 'cash plus' programme within a broader set of complementary interventions focused on supply-side issues is necessary. Comparisons of the cost effectiveness of various nutrition focused interventions will also shed further light on the appropriateness of each.

Taking a life cycle approach to social protection (i.e., the recognition that individuals and households face different risks and vulnerabilities at different stages of their lives), the CDGP aims to address the vulnerabilities associated with the first 1,000 days of children. If this group is deemed important for the Federal Government, it needs to decide whether it will take a rights-based approach to reach them (i.e., all children under the age of two) or one that will be more focused on reaching households living in poverty.

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

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