UKaid
from the British people

Child Development Grant Programme:

Summary report of baseline evaluation findings

ePact
Strengthening evaluation effectiveness and impact

Oxford Policy Management

itad

Institute for Fiscal Studies

A brief overview of the project

This note presents the summary findings from information collected through a household survey, and interviews and discussions with households before the commencement of the Child Development Grant Programme (CDGP). The main objective of the note is to describe the situation of the communities and households covered by the CDGP before the programme began. It provides a picture of the types of services (including health and education) the communities have access to, how they earn a living and obtain food, the risks they face and how they cope with them, the use of health facilities, their knowledge of beneficial health care practices for pregnant women and children, their attitudes towards women's decision-making power in the household, practices relating to fertility and marriage, and finally the physical and cognitive development of their children.

For those interested in the full reports, these can be found at:

Part 1: http://opm.global/1TAzcDG
Part 2: http://opm.global/1TAzKd1

Annex A provides a summary of the quantitative and qualitative methods used for the baseline evaluation. The methodology for the qualitative evaluation can be found in the full report and a detailed description of the quantitative baseline survey can be found at:

www.opml.co.uk

Oxford Policy Management | Child Development Grant Programme

Contents:

4 The programme and its evaluation

6 Our baseline findings

7 Characteristics of households

17 Implications of findings

18 Annex A. Methods used

The programme and its evaluation

The programme

The CDGP is a five-year UK Department for International Development (DFID) funded programme (2013–2018) being implemented in Zamfara and Jigawa states in Northern Nigeria. The programme aims to address widespread poverty, hunger and malnutrition in Northern Nigeria, which affects the potential for children to survive and develop.

The programme provides a cash transfer of Nigerian Naira (NGN) 3,500 (£14) per month for up to 60,000 pregnant women and women with children under the age of two years (selected during pregnancy) for a period of approximately 33 months, targeting the first 1,000 days of a child's life. The cash transfer is accompanied by behaviour change communication (BCC) that includes nutritional education, advice and counselling to support the feeding practices of pregnant women, infants and young children. The combination of these interventions is expected to contribute to the households having more food and food that is nutritionally more varied. The interventions are also expected to improve maternal and childcare practices. Ultimately, the programme is expected to lead to improvements in child nutrition within the households and to protect their children from the risks of stunting, illness and death.

The programme is implemented by Save the Children in Zamfara and Action Against Hunger in Jigawa. In total, the programme is targeting five Local Government Authorities (LGAs): Anka and Tsafe in Zamfara, and Buji, Gagarawa and Kiri Kasama in Jigawa.

Programme location

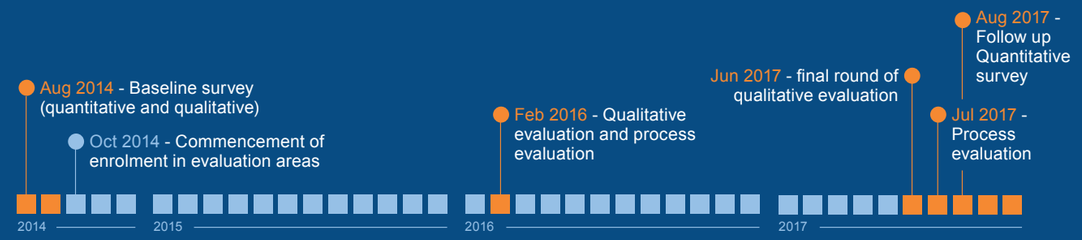
Evaluating this programme

The evaluation of the CDGP is intended to help understand the impact of the programme on households and communities that are supported by the programme. It relies on information collected using different methods that together provide the evidence for the evaluation. These methods include:

- An initial **situation analysis** that provided a strong contextual understanding of the poverty situation and the social and cultural dynamics of the households and communities in the selected areas. This was used to inform the evaluation.
- A **household survey** before the programme had started (baseline) and one towards the end (follow-up) to help us determine the effect of the programme on child nutrition, and the knowledge, attitudes and wellbeing of those reached by the programme.
- A process **evaluation of the processes of the programme** that looks at how the programme was implemented, and identifies the factors that supported or weakened the implementation of the CDGP and how these factors may affect the potential impacts of the programme.
- **A longitudinal qualitative module** that follows a small group of households receiving the programme over time and 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. This will be 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.

Programme timeline

Timeline of evaluation before & after the introduction of the cash transfer.



Our baseline findings

Characteristics of the communities

Many communities visited as part of this evaluation do not have access to important basic services.

Less than half of communities report having a **basic health facility** in their vicinity. The range of services offered is reasonable although there is some variation across LGAs. Overall, about 80% of the health facilities offer antenatal and postnatal services. Buji stands out as the only LGA with near complete availability of trained medical staff and a wider range of important maternal, new born and child health services.

Only 9%–14% of communities have a **market for fruit and vegetables** and 75% of the communities have access to **basic education services** in the form of a primary school.

Shocks are common across all LGAs in the programme, with the majority of communities reporting being hit by some shock in the 12 months prior to the survey. Indeed, in four out of five LGAs, at least 87% of communities report being hit by some shock over this time period. **Natural shocks**, such as drought or poor rain, flooding, or crop damage due to pests and/ or diseases, are generally more widespread than **man-made shocks**. Common man-made shocks include violence (e.g. cattle raids), curfews and large migration into communities.

There is considerable variation in the availability of food items (many of which are basic food items) across LGAs and during the year. Many kinds of fruits and vegetables are not usually available in a large proportion of communities. While availability of grains, cereals (maize, millet, sorghum, and rice) and meat is quite consistent throughout the year, other items – such as eggs, peppers and tomatoes – follows a pattern of availability that is closely linked to the seasonal calendar in Northern Nigeria: food is relatively scarce from July to September (‘the lean season’) and food insecurity increases. Dairy products, such as milk and butter, are often not available between November and March.

Less than
50%
of communities report having a basic health facility in their vicinity

Only
11%
of communities have a market for fruit and vegetables

Only
75%
of the communities have access to basic education services in the form of a primary school

Characteristics of households[1]

Demographics

The surveyed households are large, with an average size of 7.4 members, and predominantly young. On average 4.5 members are less than 17 years old and 2.9 are adults (18+ years). Moreover, on average there is more than one very young child per household (under three years old) and almost two women of reproductive age.

Polygamy is widespread and women marry at an early age. 46% of the interviewed women are in a polygamous marriage and the average age at marriage is about 15 years of age. More than three-quarters of females aged 12 or older are married. Polygamous marriages are more common in the Zamfara LGAs than in the Jigawa LGAs. In the Zamfara LGAs, there are more than twice as many women in polygamous marriages as there are women in monogamous marriages. The qualitative research found polygamy to be the norm, or at least the aspiration of most, in all the communities they visited. Having more than one wife confers social status and is considered a sign of relative wealth.

A large proportion of the women we surveyed were reported to be pregnant and most had been pregnant at some stage. At the time of the survey, 68% of interviewed females were reportedly pregnant. Almost every female in the sample has been pregnant at some stage, and 89% have given birth at least once in their lives. On average, women in the sample have almost one boy and one girl below the age of seven.

Hausa is the main ethnicity and language of the surveyed respondents and only 6% of the sample are Fulani. Islam is the main religion for almost all the respondents surveyed.

The households

The average size of households is 7.4 members.

1 In interpreting the results it is important to keep in mind that, for the household survey, all the households we interviewed were those with pregnant women or with women likely to become pregnant during the next three years. This means the households may not be representative of all households in the five LGAs.

Household drinking water and sanitation

Safe drinking water is often not easily accessible, but with considerable variation across LGAs. Households in the three LGAs of Jigawa state (Buji, Gagarawa and Kiri Kasama) are more likely to source their water from a tubewell or borehole and have a far greater availability of publicly provided water, while many families in the two LGAs in Zamfara state (Anka and Tsafe) rely on unprotected dugwell surface water for drinking. This results in a marked difference across states in the percentage of households with access to an 'improved' drinking water source by World Health Organization (WHO)/ UN Children's Fund (UNICEF) standards across states and LGAs.

Most households use low-quality toilet facilities or no facilities at all. Only around 10% of families can rely on 'improved' toilets by WHO/UNICEF standards.

Work, income, and livelihoods

Crop and livestock production are the mainstay of the local and household economy in all the communities visited, but they are highly seasonal and do not provide enough food or income for the whole year for most people. Other opportunities to smooth and diversify incomes vary by location, but for men they generally include: local agricultural labour in the planting, growing and harvest seasons; urban labour migration in the dry season; trading (mostly in food commodities and livestock); and crafts and services (blacksmithing, house construction and repair, firewood collection, crafts like basketry, and so on).

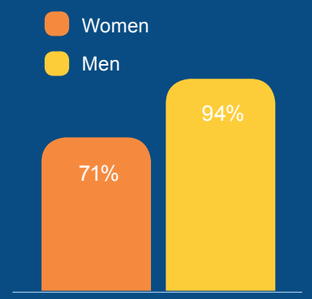
Almost 90% of men in our quantitative survey sample report working in agriculture as being their dominant type of work. 47% of men have multiple occupations, a common feature with women too. Moreover over half of men (56%) and one third of women (30%) do not report working for pay (suggesting their agricultural work is a form of self-employment). Again, agrarian households are poorer than other households.

The majority of women in our quantitative survey sample are involved in some kind of work activity, usually working only for themselves or for someone else in the household and often related to agriculture. Agriculture includes both working on the land as well as animal rearing, though the majority of women are engaged in agriculture through rearing animals. Few (4.5%) women engage in crop cultivation, compared with almost all men (95.6%), with the

11%

households have access to improved sanitation facilities

Proportion of men and women engaged in any work activity



majority who do so working on a small number of plots that they generally own. **The households of women who work in agriculture tend to be poorer than other households** and not all women work for remuneration: 30% report not receiving any payment for work. Among those that receive payments, the average weekly earnings are just under NGN 1,300. Women can also earn their own income through home-based petty trade, food processing and sales, producing craft items, and services such as hairdressing and pounding grain for others

Livestock rearing is an important part of households' support. Three-quarters of households have at least one household member looking after animals. The most common animals reared by the households include both draught/working and milk-producing animals (cows, bulls, calves, goats) as well as chickens. Households own on average just under half the sheep and goats that they look after. It is very common for women to look after animals, with 67% of sampled women reporting that they look after an animal, though they generally do not look after the larger animals, such as cow, bulls, calf and camels. Many of these reared animals are owned by women themselves.

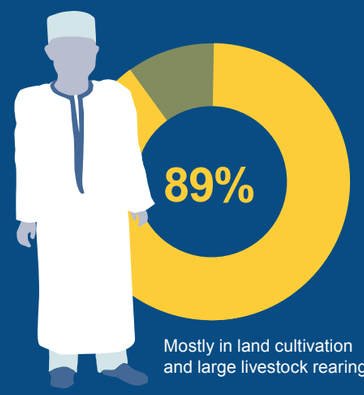
For both men and women, **very few households report actually selling livestock produce, such as milk or eggs, as a form of earnings**. This suggests that the purpose of animal rearing is mainly for home production and is an important form of savings. 28% of households report selling livestock at some point in the year (with 21% reporting having bought livestock sometime in the past 12 months). Sheep and goats are the most commonly traded animals.

Income and earnings vary a lot through the year: in some months, women report earning three to four times as much as in other months. Income volatility also exists for men, with the ratio of earned income in good to bad months being even higher, at around four to five times. In August the highest number of women and men report below-normal earnings. For women, the best month is July (at the beginning of the lean season / the end of the planting season), and for men the best months in terms of earned income are October to November (at the end of the lean season / during the harvest season).

Men's monthly earnings are around eight times higher than women's, though 13% of men still earn less per month than the value of the cash transfer. We find that around 15% of households report that at least one member temporarily migrated from the household for work in the past year.

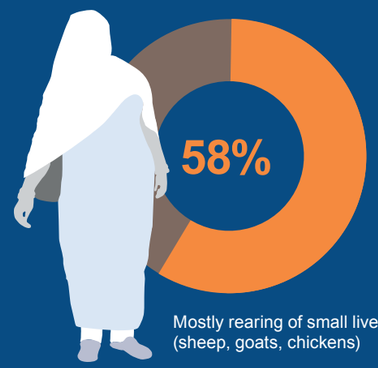
Proportion of men and women engaged in agriculture and livestock activities

For 89% of men agriculture is their dominant job



Mostly in land cultivation and large livestock rearing

58% of women were involved in agriculture



Mostly rearing of small livestock (sheep, goats, chickens)

Household saving and borrowing

Access to formal financial institutions is limited and savings are low and borrowing is rare amongst our sampled households; it often takes place through informal institutions and networks. Formal financial institutions (banks or microfinance institutions) are present in only two of the 210 communities. Fewer than 40% of households report having any cash savings. Of those with cash savings, the majority store their savings at home (77%) and about 20% report having access to savings devices through formal and informal institutions. Around 41% of households report their savings as being held in-kind, and the value of these in-kind savings is on average comparable to the value of savings held in cash (at around NGN 40,000).

Around one-in-five households report borrowing from some source. The vast majority of these are informal sources, with friends and family being the most important source of borrowing. The provision of credit from local shops also appears to be an important source of informal finance.

Household assets and expenditure

Spending on durable assets is quite uncommon, with more than half of all households not spending anything in the past 12 months. The majority of households own basic items of furniture (e.g. mattress, bed and chairs) but few households own bicycles, stoves, wheelbarrows and ploughs.

Consumption patterns and dietary practices

The main staple foods across the evaluation communities are locally-produced millet and sorghum. A range of supplementary foods in all the food groups, including pulses, animal proteins, vegetables and fruits (both cultivated and wild) are known and used in sauces to accompany the staples, and in a variety of local dishes. However, access to these foods is seasonal, depends to a large extent on household purchasing power, and varies from place to place. Very few, if any, farmers produce enough cereals to sustain their household for the whole year. In most cases household stocks run out during the bazara land preparation season (from March onwards) and the quantity and quality of the diet then depends on what people are able to buy or gather. Households with cattle or goats, particularly in the mainly pastoralist Fulani communities, may have higher consumption of milk products.

Evidence from our qualitative research suggests that no special foods are prescribed or avoided during pregnancy. Women eat the same food as other family members while pregnant and breastfeeding, which means whatever is available or what they can afford. Girls and boys are also given the same food, and when it is plentiful they eat as much as they like from the shared pot. However, **boys and older children were said to eat more because they are bigger and do more work**. At meal times, children are usually fed first, then grandparents, then the husband, and the mother last. Nutritious snacks, such as bean cakes, are often produced by women at home (for sale or consumption), and are eaten between meals to supplement the diets of children and women who can afford them.

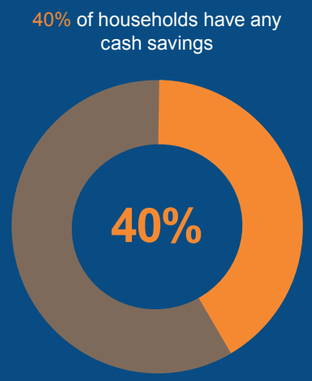
The qualitative research also found that wild foods, particularly fruits and vegetables, are a valued part of the diet, especially during the rainy season when they are abundant. Some are dried and kept as cooking ingredients for the dry season. Both the quantity and quality of food are seasonal, with the best time for diets and health being in the harvest (kaka) season between September and January. The rainy season (damina), between June and September, is the time when cereal stocks are lowest and prices are high, but it is a good time for dietary diversity because of the availability of fresh foods and the income opportunities that enable men to provide a range of foodstuffs from the market.

Food security

A relatively small share of households report food insecurity, and the reason given for those who experience it is its affordability. 10% of households report that they did not have enough food to eat during the lean season and 4%–6% of households did not have enough food to eat over the rest of the year (from October to August). The affordability of food items is given as the main cause of food shortages and richer households report slightly less food insecurity than poorer ones.

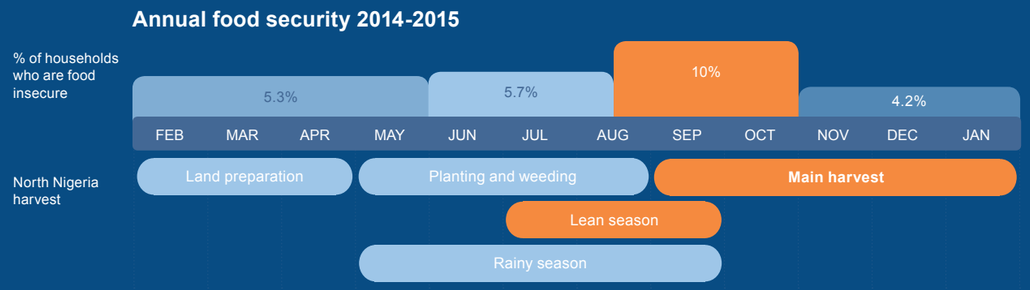
Households employ a variety of coping strategies in response to food insecurity. Seeking informal assistance through social ties and changing the amount or type of work activity that household members engage in are the most common strategies. 35% of households reported being helped by relatives or friends, 30% had members taking more work and 27% borrowed money. Strikingly, 28% of households who do not always have enough food report not using any coping strategies to manage their food insecurity.

There is no evidence that coping strategies vary over the year but there are marked differences in the coping strategies used by households in different LGAs. This applies especially to the use of informal assistance from friends and family, which is most prevalent in Anka (reported by over 60%



Nutrition and food consumption

About 10% of households report not having enough food to eat during the lean season and up to 6% of households report not having enough food to eat over the rest of the year.



of households) and least prevalent in Tsafe (reported by less than 30% of households). There is somewhat less reliance on informal assistance among wealthier households. A relatively low proportion of households report livestock sales as being a strategy to cope with insufficient food availability (fewer than 10% of households).

Household decision-making

The male head has authority over his wife or wives and children, and is responsible for providing for them. **The production and purchase of food, particularly staple grains and other major food items, are primarily the man's responsibility. Women, however, frequently have a high degree of control over how their own income from work or gifts is spent**. In roughly 50% of households, both males and females report that any significant decisions concerning major household purchases, or growing and buying food, are made exclusively by the husband. In most of the remaining cases they either report that decisions are made by husbands after consulting wives, or they are made jointly by both spouses. In 10%–12% of households women usually make decisions regarding major purchases on their own. **The husband is often reported to be the sole decision-maker in relation to health issues of women and children in the household**.

In the majority of households, men are the primary decision-makers regarding what food to grow and buy, with only approximately one-third of households involving women in this decision-making. **It is very rare to find households where women are the sole decision-makers about what food to grow and buy**. However, women are usually responsible for preparing meals and supplying the supplementary foods that accompany the staple cereal dishes, and may use their own earned income to supplement the household diet with spices, sauce ingredients, and other purchased or gathered items such as vegetables. When needed, and if they have money, woman may also 'support' their husbands by buying staples to fill gaps in the household food supply. Women also distribute snacks, and may give extra food to children in the kitchen while they are cooking.

In many households women are able to earn and retain their own (relatively small) incomes, mostly from home-based petty trade, services and food processing activities. It is from this money that women normally buy the supplementary foods, snacks and sauce ingredients to accompany or 'sweeten' the main foodstuffs: they may also re-invest in their businesses, or spend their earnings on other things, such as weddings or gifts.

Some informants in the qualitative research suggest that unearned income (e.g. gifts) is treated differently to earned income and may be more likely to be given to the husband and/or shared with other household members. However, household respondents in the quantitative survey did not note a difference between how earned income or gifts to wives would be used. About 50% of both husbands and wives agree that the wife should have full control over the use of these resources, with the vast majority of the remaining individuals suggesting that some joint decision-making is preferable. The proportion of those who argue that the husband should have sole control of these resources is around 10%.

The quantitative survey findings suggests that if the CDGP cash transfer is viewed as either income or a gift to women, then in about half the households it is likely that the women will decide on how the money is used, in about 8% of households the man will decide, and in the remainder they will decide in consultation with one another. However, it remains to be seen if the cash transfer will be perceived in this way.

Education

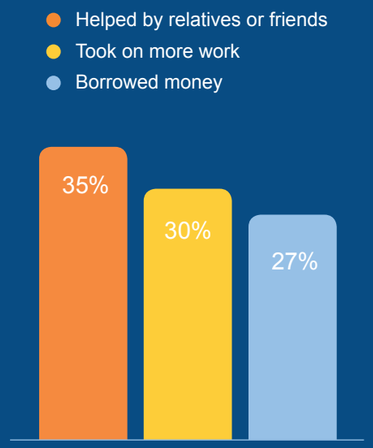
Across all age groups, only around one-in-five women report being literate, with younger women being more likely to be literate than older women. This has important implications for the materials that can be used for the delivery of the BCC messaging

Among children aged four to eight, enrolment rates are below 40% for both genders, and among older children (aged 9–18), half of boys and a quarter of girls are currently attending school (this includes integrated Islamic education but does not include non-integrated Quranic education). This is surprising given the finding that around 75% of communities in each LGA contain a primary school. Only a slightly higher fraction of children report ever having attended school, suggesting low enrolment rates are due to the majority of children never making it into school (rather than high drop-out rates during primary school years).

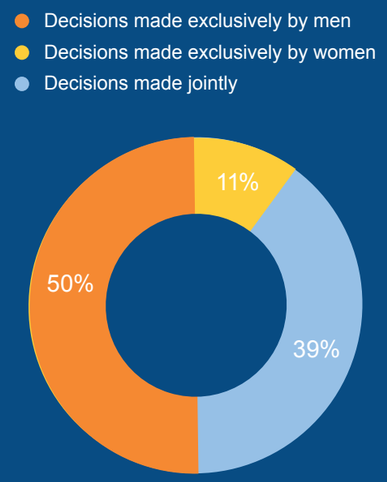
Women's and men's knowledge and beliefs about health

There are important misconceptions about adequate breastfeeding practices among both men and women. The quantitative survey found that very few people believe that the baby should be breastfed immediately after birth, half believe the baby should not be exclusively breastfed during the first days of life, and almost half believe that colostrum is not good for the baby. This was confirmed through our qualitative research, which found that it is the customary practice to not breastfeed immediately or exclusively. New-borns are often given cow milk, goat milk, or powdered milk for the first two days of life before being put to the breast: in the case of first babies, this period is extended to a week. The mother's first milk (colostrum) is traditionally considered 'dirty' and harmful to the baby, so it is believed that the new mother needs to go through cleansing treatments before starting to nurse. The research also found that almost all babies were given water, and sometimes animal milk or other liquids,

Households employ a variety of coping strategies in response to food insecurity

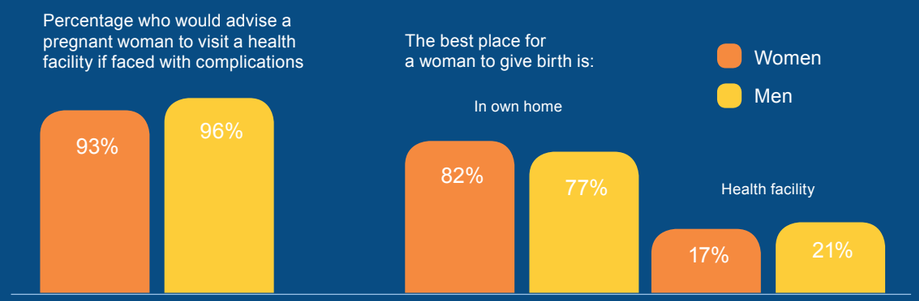


Household decision-making



Husbands' and wives' beliefs about pregnancy and infant health

There are misconceptions about appropriate health practices among men and women.



alongside the mother's milk. Respondents were adamant that it is essential to give babies water in this climate, because they will otherwise suffer from thirst and cry. Some younger women said they had been told by clinic staff not to give water, but even if they wanted to follow this advice other household members would over-ride them and give the baby water.

There is strong reliance on informal family networks for advice on important health issues, and not much reliance on trained health workers. This is worrisome given the misconceptions about best health practices noted above. A striking 80% of all females would go to their husband for advice on pregnancy and children, 30% would consult their mothers, and only 22% would seek the advice of a trained health worker. The propensity to seek advice on food and nutrition issues from health workers is even lower, at only 9% for women and 14% for men.

Men and women are both relatively likely to advise others to seek health care at a health facility. However, around 7% of men and women would not advise a woman to visit a facility even if she faced complications in pregnancy, and 19% would not advise a woman to give birth in a health facility if she faced costs of NGN 2,000. It is also striking that only 70% of women would advise another woman to give birth in a health facility that does not have any female staff. Interestingly, across all these different hypothetical cases, men are more likely than women to recommend visits to the health facility to pregnant women.

Both men and women overwhelmingly state that the best place to give birth is at home, and men are more likely than women to mention the health facility as a desirable place to deliver a baby. We find that males and females who are better off are more than twice as likely to advise a woman to give birth in a health facility than those who are poorer. Most (91%) of all women in our survey gave birth at home. Furthermore, it is very worrying that 13% of all women report that they received no assistance during their delivery. Only two-thirds of the sample of women has ever heard of contraceptive methods.

Maternal and child health

There is a very severe problem of chronic child and mother malnutrition. The nutritional status of children was very critical in the areas surveyed. More than half of the children surveyed (66%) were classified as stunted, significantly above the WHO cut-off for a critical situation (40%). Some 35% of the children were considered underweight, again higher than the WHO cut-off for severe levels of malnutrition (30%). 7% of the children were wasted. These statistics indicate a very severe problem of chronic child malnutrition.

Dietary diversity among children under five is poor. Only 16% of children 6–23 months of age receive the recommended number of food groups and this figure does not improve much as children get older. Across age groups, the main components of children's diets are staples, fruits and vegetables. **Only about a quarter of the children of all ages also report consuming meat, fish and dairy**.

Children also commonly suffer from diarrhoea. Diarrhoea is found to be very common: 29% of the children in the sample suffered an episode of diarrhoea within the two weeks that preceded the survey. This is important because diarrhoea can severely affect nutrition in young children, and it is fatal in many cases. Furthermore, it is not clear that parents understand how best to look after children with diarrhoea as only 19% of parents recognise the need to provide extra fluids and only 7% recognise the need for extra food. Failure to adopt appropriate care practices in response to diarrhoea puts children at risk of severe dehydration, malnutrition, and death.

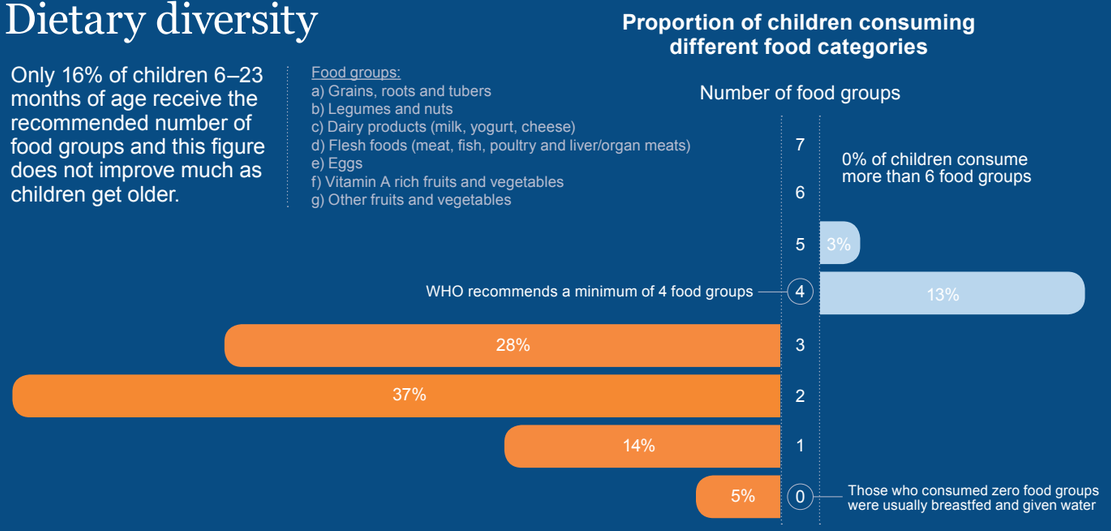
Only 4% of children under five had had all the basic vaccinations. Almost one-quarter of all children under five in the sample had not received any polio vaccinations, and only 19% received one at birth, presumably due to low rate of deliveries in a health facility (9%). The situation is similar for other vaccinations

Malnourishment is also severe amongst women. 26% of non-pregnant woman in the sample have a body mass index (BMI)2 below 18.5, which is the threshold for undernourishment. We find that women's malnutrition does not depend on household resources. It is possible that women in rich households have low access to nutritious foods, even when this food is available, because they lack control over what food they themselves and the household consumes, or alternatively that they lack knowledge about what constitutes a healthy, balanced diet.

Dietary diversity

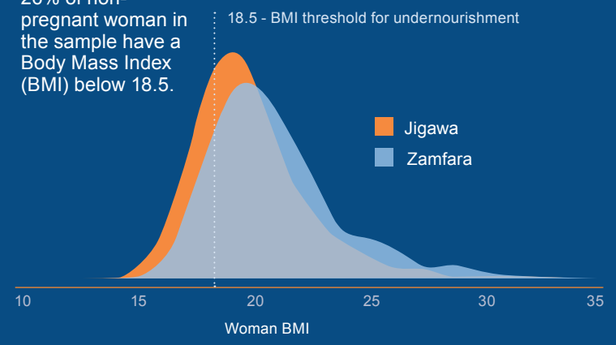
Only 16% of children 6–23 months of age receive the recommended number of food groups and this figure does not improve much as children get older.

Food groups:
a) Grains, roots and tubers
b) Legumes and nuts
c) Dairy products (milk, yogurt, cheese)
d) Flesh foods (meat, fish, poultry and liver/organ meats)
e) Eggs
f) Vitamin A rich fruits and vegetables
g) Other fruits and vegetables



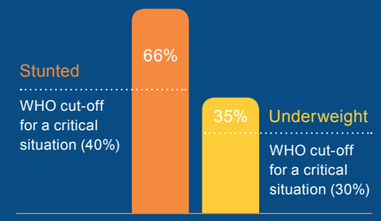
Maternal Health BMI

26% of non-pregnant woman in the sample have a Body Mass Index (BMI) below 18.5.



Child Malnutrition

66% of children under 5 were classified as stunted. 35% of the children were considered underweight.

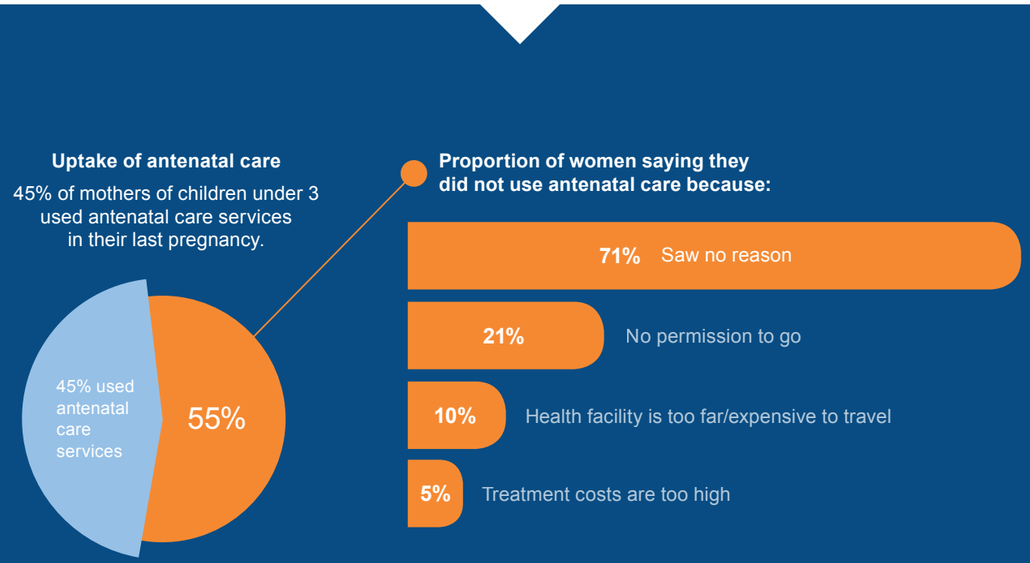


Access to health and antenatal care

Access to health services varies by location. Not surprisingly, women appear more likely to attend antenatal and postnatal care, and to take sick children to a health facility, if there are functioning facilities nearby. If not, the cost and difficulty of transport can add significantly to the total cost of medical care. Due to the practice of female seclusion, some women need permission from their husbands to attend health facilities. Although cost may not be the only reason for permission being refused, it is more likely to be given if the husband (or sometimes the woman herself) can afford to pay for transport and treatment.

Just under 40% of all women had visited the health facility at least once in the past six months, excluding visits for antenatal care. These proportions are much higher in Jigawa than in Zamfara, where the figure in Anka LGA is only 24%. There is a substantial difference in use of health facilities between the poorest quarter of women and the remaining three-quarters. Richer women are much more likely to have visited the health facility at least once in the past six months.

The use of antenatal services is low. The proportion of women who used antenatal care services in their last pregnancy is about 45% and the proportion of currently pregnant women who have seen anyone for antenatal care is 31%. On a positive note, those who do use it appear to be receiving an acceptable standard of service, though there is room to improve. **Richer women are much more likely to receive antenatal care**, which could reflect both increased knowledge about the importance of antenatal care, and greater ability to pay for access to this type of care. 71% of women who did not use antenatal care services in their last pregnancy said they did not need it (despite the fact that 70% of men and women interviewed said that they would advise a pregnant woman to visit a health facility for a check-up if she was healthy and nothing was wrong). 21% said that they did not have permission to travel to a health facility. Husbands may not allow women to travel either because they do not have the necessary funds available, or simply because they do not wish the woman to go to the health facility. Only 10% reported not attending antenatal care sessions because the health facility was too far and it was too costly to travel.



Implications of the findings

Our findings highlight a number of important considerations for the programme during its implementation. If the CDGP increases household resources, then it could well improve food security. However, as the evaluation findings show, this is contingent on a number of factors, including:

- considerable variability in the availability of food throughout the year and between LGAs. This may affect households' abilities to obtain a more balanced diet through the additional grant;
- decisions regarding how to spend the resources. It is very rare to find households where women are the sole decision-makers regarding what food to grow and buy. This decision is often conferred to the man; and
- being a wealthy household is no guarantee of more and better spending on food and improved nutrition of children, but those who do spend more on food have better nutrition outcomes.

To improve household-level health and nutritional outcomes will require continued sensitisation. There are important misconceptions about adequate breastfeeding practices, with only 40% of children appropriately breastfed, and only 27% breastfed immediately after birth, therefore BCC interventions are needed and, if delivered appropriately, hold promise in terms of improving child nutrition.

The BCC interventions should be targeted beyond pregnant women and should also include males and older female relatives. Their design also needs to take account of the fact that very few women are literate.

The CDGP implementers should also note that there is strong reliance on informal family networks for advice on important health issues, and not much reliance on trained health workers. This should be taken into account in determining how the BCC messages are delivered.

Annex A. Methods used

Quantitative impact evaluation

The quantitative impact evaluation is a cluster randomised controlled trial, in which communities are randomly selected either to receive support from the programme or not to receive support. The effects of the intervention are found by comparing households in the communities where the programme is operating with households in communities where it is not. Households that are randomly chosen to receive the CDGP are called ‘treated households’ and are in the ‘treatment group’. Households that are randomly chosen to not receive the CDGP are called ‘control households’ and are in the ‘control group’. Randomisation is considered the most rigorous way to measure the effect of the CDGP on beneficiary households because it ensures that treatment and control groups have similar characteristics at the start of the evaluation. Thus, any differences observed at the end of the programme can be attributed to the intervention.

This evaluation has two treatment groups and one control group. The first treatment group (henceforth known as Treatment 1) is offered the cash transfer and ‘low intensity’ BCC. The second treatment group (henceforth known as Treatment 2) is offered the cash transfer and ‘high intensity’ BCC. The control group receives no intervention for the duration of the evaluation, but may receive the intervention after the second household survey is completed (currently planned for 2017), depending on availability of funding. Having two separate treatment groups and one control group will enable us to measure the impact of the unconditional cash transfer and ‘low intensity’ BCC as well as the additional effect of providing ‘high intensity’ BCC. The unit of randomisation is the village. This means that we randomly chose which villages would be in Treatment 1, Treatment 2 and the control group.

Oxford Policy Management | Child Development Grant Programme

Qualitative impact evaluation

The qualitative evaluation employed a combination of case study interviews, focus group discussions (FGDs) and key informant interviews (KIIs). Each case study focused on an individual woman who was a potential direct beneficiary of the CDGP: interviews were held with the woman herself and with two other members of her household, one woman and one man (usually the husband), to understand the dynamics of the household. The study aimed to enrol 12 case study households in each community (making a total of 84), and succeeded in interviewing 82. Four FGDs (with older and younger women, and older and younger men) were held in each community, using flexible semi-structured checklists based around six research areas The key informants in most cases included a traditional birth attendant (TBA), a local leader and a religious authority. Participatory and visual tools (maps, transects, calendars and diagrams) were used in the focus groups and KIIs.

At community and household (case study) levels, the qualitative evaluation sample was selected from the sampling frame of the quantitative survey: this intersection of samples enables us to link the analysis at later stages of the evaluation. At both levels, the qualitative sampling is purposive. It aims to capture variation in factors that might be expected to affect the implementation and outcome of the CDGP, so that the qualitative research can investigate and compare different contexts and experiences of the programme. The qualitative sample is not designed to be representative of the CDGP area as a whole, and care should be exercised in drawing generalisations or wider inferences from it.

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). The programme is funded by UK aid.

For further information visit www.opml.co.uk or contact:
Andrew Kardan - Andrew.kardan@opml.co.uk

Graphics were designed by Pete Duncan - pete@collectedpixels.co.uk
with support from Marta Moratti - marta.moratti@opml.co.uk
and Giada Nuzzo - giada.nuzzo@opml.co.uk

Child Development Grant Programme

Save the Children

ACTION AGAINST HUNGER
ACF INTERNATIONAL