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Child Development Grant Programme Evaluation

Qualitative Midline Report

Oxford Policy Management

itad

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

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Disclaimer

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Executive summary

The programme

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

The CDGP provides a monthly cash transfer of Nigerian Naira (NGN) 3,500 (approximately £14 in 2014) for women from the time their pregnancy is confirmed until their child is two years old, targeting the critical first 1,000 days of a child's life. The cash transfer is accompanied by behavioural change communication (BCC), including nutrition education, advice and counselling to support the feeding practices of pregnant women, infants and young children. The combination of these interventions is expected to contribute to the households consuming more food, and a more nutritionally varied diet. The interventions are also expected to improve maternal and childcare practices. Ultimately, the programme is expected to lead to improvements in child nutrition within the beneficiary households and to protect children from the risks of stunting, illness and death.

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

Evaluating this programme

An independent mixed-method evaluation of the programme is being carried out by ePact, a consortium led by Oxford Policy Management. The evaluation is intended to help understand the impact of the programme on the households and communities it supports. Its findings will be communicated to the state and federal governments in order for them to see the potential impact of the programme, and in order to leverage their support for taking over the programme and expanding it across their states. The evaluation includes the following interlinked workstreams:

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

This report

This report presents the findings of the second (midline) round of qualitative fieldwork, conducted in late February and early March 2016. Building on the qualitative baseline data and report (conducted in September–October 2014)[1], the midline revisited the same seven selected communities across the five LGAs. The main purpose of the midline research was to explore any changes since the baseline, and the perceptions of beneficiaries and other community members

[1] See ePact (2015a) *CDGP Evaluation Qualitative Baseline Report.*

concerning the causes of those changes, in relation to the following six thematic areas derived from the evaluation hypotheses and theory of change:

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

The qualitative midline also explored the implementation of the CDGP in the selected communities, as viewed by beneficiaries and community members. This section of the report focuses on six key implementation processes, and will contribute to the process evaluation workstream (as well as giving essential context for understanding the perceived impacts of the programme in these communities). The first round of the process evaluation (fieldwork conducted in February 2016) [2] assessed the same processes from federal to LGA level, but did not collect any data at community level.

Methods used

The qualitative midline employed the same combination of data collection methods as the baseline: one-to-one semi-structured case study interviews; focus group discussions (FGDs); and key informant interviews (KIIs). In each of the seven communities KIIs were held with members of the Traditional Ward Committee (TWC) and Beneficiary Reference Group (BRG), a Community Health Extension Worker (CHEW), and at least two Community Volunteers (CVs). One CDGP team member (non-governmental organisation or LGA seconded staff) was interviewed in each LGA.

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

The longitudinal case studies are the core of the qualitative methodology. The sampling unit for these case studies is an individual woman (the 'focus woman'), purposively selected from the listing of potential CDGP beneficiaries conducted in preparation for the quantitative baseline in 2014. After completion of the baseline the case study sample was reviewed in consultation with DFID, and the cohort of women for follow-up in the midline and endline fieldwork was finalised. This cohort consists of the 54 women who were included in both the qualitative and quantitative baseline samples, thus enabling the evaluation to make clearer analytical links between the methods. At the time of the midline fieldwork, 40 of the case study women were current beneficiaries of CDGP and two were ex-beneficiaries.

The case study interviews, questions and analysis cover the focus woman herself and her household. For the midline, the field researchers aimed to interview the woman herself, her husband, and one other influential woman in the household (most often the focus woman's mother-in-law). In a few cases household members were not available or not willing to be interviewed, but in the majority of cases the target of three interviews per household was achieved.

[2] See ePact (2016) *CDGP Evaluation Final Process Evaluation Report: Round 1.*

Midline findings: CDGP processes and activities

Sensitisation and communication about the programme have been generally effective in these communities: all the beneficiaries and most of the non-beneficiaries interviewed had a good understanding of the purpose and rules of the programme (including eligibility). The most important sources of information seem to be the most local: village leaders, CVs, and CDGP staff when they visit the communities. Beneficiaries themselves are becoming an effective communication channel, spreading knowledge about the programme – and especially about the BCC messages – among their neighbours and relations, based on their own experience. Messages relayed by religious authorities are considered influential. Initial suspicions and false rumours about the programme's intentions have been mostly (though not completely) dispelled.

The CDGP's delivery model depends on CVs and on community institutions established specifically for the programme: TWCs involving village leadership, and BRGs which include beneficiaries, CVs and other community members. In all the qualitative evaluation sites, the **community institutions and volunteers** are established and appear to be working well. Almost all the beneficiaries interviewed knew who their CVs and the TWC leadership were, and who to go to with any questions or problems. The distinction between the TWC and the BRG within the communities was not always clear, and it seems likely that the membership and interaction of these two groups varies from place to place. All the communities had a small group of active CVs (both women and men) who were trained, knowledgeable, and generally enthusiastic about the programme.

Enrolment and registration processes, including the targeting criteria (the principle that all pregnant women who are residents of a treatment community are eligible for CDGP benefits), are widely known and understood by both beneficiaries and non-beneficiaries. The details of pregnancy testing (a key part of the enrolment process) vary from place to place. Urine tests, administered by CVs or CHEWs, are used in most of these places. Blood tests at the local health centre were used in one community. Visible evidence of advanced pregnancy was also required in some cases, and among the case study beneficiaries it was notable that most had started to receive the cash transfer in the last month or two of their pregnancy, or after giving birth. If the quantitative midline finds that late registration is widespread, it could reduce the impact of the programme (because the women are not benefitting from improved nutrition during the early months of their pregnancy). Large numbers of eligible women were said to be waiting for enrolment and registration.

The **payment system** for the cash transfers is consistent and standardised in all seven communities, according to beneficiaries' descriptions. Regular monthly payments of the correct amount are delivered to the registered beneficiary women (and only in exceptional circumstances to their registered proxies), on completion of computerised identity checks using thumb-prints, photographs and the SIM card number issued by the CDGP. Thumb-prints are sometimes not recognised by the scanner: this was the problem most often raised by beneficiaries in response to open questions about any problems they had encountered with the payment process or anything that should be improved. Respondents generally considered the payment process to be well managed and reliable.

BCC activities, providing education and counselling on nutrition, health and childcare, are being implemented in all the selected communities. Key messages are being shared and were widely known by our respondents, both beneficiaries and non-beneficiaries. Action-oriented groups (AOGs), especially cooking demonstrations, are very popular and are attended by large numbers of women, often including non-beneficiaries. Smaller group meetings of beneficiaries, led by a CV who 'steps down' what they have learned from CDGP health and nutrition training, were described in all seven communities. It was not possible to ascertain how closely these groups meet the

criteria for 'infant and young child feeding (IYCF) support groups' set out in the CDGP implementation manual. Similarly, home visits by CVs providing individual advice and follow-up were described in four of the seven communities, but it was not always clear whether these should be considered formal 'one-to-one counselling'. These home visits vary in length from a few minutes to an hour or more, and were considered very useful by the case study beneficiaries and husbands who discussed them. Based on the qualitative fieldwork, it seems likely that the intensity and effectiveness of the BCC activities varies from place to place, depending (among other factors) on the knowledge and enthusiasm of the CVs. The qualitative midline found no systematic difference in activities between the communities allocated to the two intended BCC models (the low-intensity Treatment 1 (T1) and the high-intensity Treatment 2 (T2)).

The local reporting channels and mechanisms for dealing with **complaints** are widely known in all seven communities. Most respondents said that if they had a problem with the programme they would first go to a CV. If the CV could not resolve it (or if the complaint was about the CV) they would go to the TWC, and, if necessary, they could also go to the CDGP staff or office. Very few of our respondents said they had made any formal complaint themselves or knew of anyone who had, but a number of recurrent issues were mentioned that had been referred to the CVs or TWCs – and in most cases had been resolved by them. These included problems with the payment computer not recognising thumb-prints, missed payments due to beneficiaries being absent, delays in registration, clarifications of the residence rules, and occasional disputes between husbands and wives.

Midline findings: Changes since the baseline and perceived impacts of CDGP

1. Consumption patterns and dietary practices

All the beneficiaries interviewed said that the quality and variety of the food they were eating had improved since the baseline, as a result of the cash transfer, combined with the nutrition knowledge and cooking tips they had learned from the BCC campaign. The increase in dietary diversity was expressed in terms of enjoyment and pleasure (e.g. being able to choose what to eat, and not eating the same thing at every meal), but also in nutritional terms (e.g. choosing more proteins or 'body-building foods', and including more fresh vegetables and fruits for 'balanced meals'). Many also said that the quantity of food in the household had increased, and that they were now able to eat three meals a day and snack between meals if they chose, and that their children could eat to their satisfaction (unlike before). This increase in food quantity was mainly attributed to the cash transfer, which enables beneficiaries to purchase more and different foods and also enables them to keep and consume more of their own produce. A few beneficiaries also attributed the increase in food availability in their households partly to factors such as good harvests or success in business.

2. KAP

The most striking KAP change since the baseline is the now widespread knowledge and adoption in these communities of exclusive breastfeeding, without water or animal milk, for the first six months after birth. A number of beneficiaries mentioned the pictures the CVs had shown them to explain the difference exclusive breastfeeding makes to a baby's health and development. Both beneficiaries and non-beneficiaries, including husbands, commented on how much healthier their exclusively breastfed newborns were compared to previous children. Non-beneficiary women are observing these health impacts, including less frequent episodes of diarrhoea and fever, and are also adopting the new practice of exclusive breastfeeding.

Other KAP changes frequently mentioned in the midline interviews were improvements in hygiene and sanitation, as a direct result of advice and information provided by the CVs and the group BCC sessions, and taking children for medical treatment earlier (as soon as they are ill). Mothers

attributed this earlier recourse to health care to being able to afford the costs, and/or being able to pay for treatment themselves, without waiting for their husbands.

3. Household decision-making and resource management

In these communities, beneficiary women are retaining control of the cash transfers. Almost unanimously, participants described how beneficiary women collect the monthly payment themselves, keep possession of the money, and decide how it is spent. Decision-making about the use of the money, including what kinds of food to buy, varies between households. Many women said that they consult their husband or discuss the purchases with him, especially when they are giving him money to buy foodstuffs from the market, but that the money is theirs to spend. Some consult a senior woman in the household (usually their mother-in-law or co-wife). Some women said that they alone decide how to spend the grant, without asking anyone else. No examples were found of cases where the husband alone had decided how the CDGP money should be spent.

Apart from food, the reported uses of the cash transfer include health care, clothing, school equipment, and household goods, such as cooking equipment and furniture. Many of the women and husbands interviewed are investing part of the cash transfer (or other income not spent because of the transfer) in productive assets or working capital to increase their future incomes. Some women are also saving through *adashe* (local rotating savings groups).

Many beneficiaries are giving small voluntary cash gifts out of the transfer, mainly to their husbands, mothers-in-law, and co-wives. These voluntary gifts should be clearly distinguished from enforced payments. In the midline fieldwork only one example was encountered where it was reported that compulsory deductions had been made from the women's cash payments after they were received. However, it is likely that any such problems would be under-reported to the field researchers.

4. Livelihoods and income

The most frequently mentioned changes in individual beneficiary women's livelihoods since the baseline are the expansion or diversification of their previous business activities; increased profits from existing activities; or start-up of new ones. These businesses are primarily home-based petty trading and food processing, and the beneficiaries attribute the increased investment in them primarily to the cash transfer. Some women directly invest part of the transfer in their business, while others say they keep the transfer for food purchases but are then able to re-invest the profits from their business, which were previously 'eaten'. On the other hand, some women and men said that receiving the cash transfer had enabled them to stop some types of work (such as petty trading or casual employment) and make better use of their time.

The income and food security of beneficiary households has been boosted not only by the addition of the monthly cash transfer amount, but also because husbands say they are under less pressure to provide food for the household and can therefore invest more time and money in their farming and other businesses. The regular cash transfer also reduces the need to sell the household's own production, both of staple cereals and of nutrient-dense foods such as eggs and beans, so that their stocks last longer.

Non-beneficiaries also say they are benefitting economically from the increased circulation of cash in the local economy. The increased demand for all kinds of services and products, especially food products, is partly being met by local traders opening new shops or bringing more commodities into the villages for retail sale. The snacks and sauce ingredients produced and traded among women within the community are also in higher demand, increasing the incomes of both beneficiaries and non-beneficiaries. Goods and services are paid for promptly, with less need to give credit. Even

religious teachers are said to be benefitting, because people can now afford to give them payment or alms for their lessons.

5. Risks, shocks and coping behaviour

The three main types of risk in these communities, identified during the situation analysis and baseline, are: a) seasonal fluctuations in income, food availability and health factors; b) natural hazards (mainly drought, flood and pests), which exacerbate the seasonal pattern or unpredictably affect food production and livelihoods; and c) insecurity. Participants in the midline discussions raised these same three types of problem in response to open questions about any shocks their households had faced since the baseline, and how they had coped. Coping options are limited: people borrow, ask relatives and other community members for help, look for income from other sources, and pray.

Because the CDGP cash transfer is a regular, reliable monthly income source, beneficiaries say it helps them to reduce seasonal fluctuations in their diets and enables them to sell less of their farm produce so their grain stocks last longer through the lean season. It can enable them to avoid harmful coping strategies (such as illegal firewood collection, with the risk of being caught). It can also be a safety net in times of unusual stress, whether caused by natural or man-made shocks. One of our seven communities had suffered badly from insecurity (in the form of armed bandit raids) since the baseline, causing many people to migrate from the village to safer areas. In this situation, the cash grant had helped beneficiary households to get through a difficult period after the theft of their livestock and other assets, enabling them to survive while they recovered.

6. Relational wellbeing

Nearly all our respondents, both women and men, said that receiving the cash transfer had improved relationships between beneficiary women and their husbands, and had even reduced the divorce rate at the community level, because it relieved the most common cause of marital arguments (shortage of money). Only one example was encountered where control of the cash transfer had sparked a serious domestic dispute, leading in this case to divorce. In general, beneficiary women felt that there was more harmony and understanding with their husbands because they no longer needed to constantly ask them for money, and that their status and self-esteem were enhanced by having their own money, being able to make their own spending decisions and being able to give gifts to others. The husbands interviewed were also generally supportive of their wives' participation in the programme, and were happy that the way it is implemented does not threaten their authority or undermine local culture.

Relationships among women in the household are affected in varying ways by the cash transfer and the BCC learning. In some households, relationships among co-wives, particularly when both or all are beneficiaries, have become closer because they go to meetings together and discuss what they have learned at home. In other cases, however, especially where one wife is a beneficiary and others are not, there is the potential for jealousy and conflict. The giving of cash gifts and sharing of food by beneficiaries within the household is common, and can smooth relationships with other women. Mothers-in-law, in particular, often receive cash gifts, share the improved meals, and are happy to see their sons and grandchildren benefitting, with a consequent increase in their regard for their daughters-in-law.

In the wider community, the impacts of the CDGP on relational wellbeing were mostly described in positive terms. In addition to the widely shared economic benefits mentioned above, it was said that the frequent meetings and interactions around the programme activities had increased the communities' sense of 'togetherness'. Although non-beneficiaries are certainly not happy to be excluded from the programme, they generally say they are just hoping to be included in future: there does not appear to be any major resentment towards beneficiaries. The exception to this

impression of unity is one community where the people of the separate Fulani settlements *(rugas)* have complained that they are being excluded from the programme, and there are clearly tensions between the village and the *rugas*. Discussions with key informants and others in this community suggest that there are specific factors which make it challenging for the programme to fully include migrant or transitory populations. These factors are: communications (it is harder for information to reach the outlying *rugas*); governance (the *rugas* have their own leadership structure, separate from the village leaders in charge of the TWC); language (BCC voice messages and group meetings are in Hausa, which many Fulani women do not fully understand); and residence (the CDGP requirement that beneficiaries should be resident and present every month for the cash payment does not fit with pastoralist livelihoods).

Implications of the qualitative midline findings

The qualitative midline findings have a number of implications for the programme and the evaluation, including the following.

Late registrations will reduce the impact of the cash transfer on maternal and infant health and nutrition, because beneficiaries who registered towards the end of their pregnancy or even after the baby's birth do not receive the money in time to improve their diet during pregnancy. The examples and experiences recorded in this report should be triangulated with the findings of the quantitative midline to determine the extent of this problem.

The lack of consistent differences between the BCC activities actually implemented in communities assigned to the **two intended BCC models (T1 and T2)** made it impossible to compare the intensity of the two models in the qualitative midline. If the quantitative survey finds that this lack of consistency is widespread, the overall evaluation may not be able to compare the impacts of the two models, as originally planned. The reach and effectiveness of the various BCC activities and communication channels could be assessed instead.

Nutrition and health information is being widely shared with non-beneficiaries within the treatment communities, and non-beneficiaries are adopting improved practices as a result. In terms of the CDGP's priority aim of reducing mother and child malnutrition, this effect is very much to be welcomed. From the evaluation perspective, however, it may reduce the observed difference in outcome between beneficiaries and non-beneficiaries, thus potentially leading to underestimation of the programme's impact, although the evaluation design aims to mitigate this by comparing eligible women from supported and non-supported communities, rather than comparing them within the same community that receives the programme.

Given the challenges identified in delivering the programme in **migrant or transhumant Fulani communities,** it is recommended that CDGP should look into ways of tailoring its rules and processes for pastoralist communities (perhaps with a small pilot study or a consultation exercise with the Fulani themselves). Although the Fulani are a small minority (about 7%) of the population in the programme area, ensuring their full and fair inclusion is not only desirable in principle, but could also reduce the risk of future conflict.

Table of contents

List of tables, boxes, case study examples and figures

List of abbreviations

AAH	Action Against Hunger
ABU	Ahmadu Bello University
AOG	Action-oriented group
BCC	Behavioural change communication
BRG	Beneficiary reference group
CDGP	Child Development Grant Programme
CHEW	Community Health Extension Worker
CS1, etc.	Case Study 1, Case Study 2, etc.
CV	Community Volunteer
DFID	Department for International Development (UK)
FGD	Focus group discussion
IYCF	Infant and young child feeding
KAP	Knowledge, attitudes and practices
KII	Key informant interview
LGA	Local Government Authority
NGN	Nigerian Naira
PPI	Progress out of Poverty Index
T1, T2	'Treatment' 1 and 2 (BCC approaches in the CDGP)
TBA	Traditional Birth Attendant
TFDC	Theatre for Development Centre, ABU
TWC	Traditional Ward Committee

1 Introduction

1.1 The CDGP

The CDGP is a six-year 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 NGN 3,500[3] per month for up to 70,000 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 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 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 AAH in Jigawa. In total, the programme is targeting five LGAs: Anka and Tsafe in Zamfara, and Buji, Gagarawa and Kirikasama in Jigawa.

1.2 Overview of the evaluation design

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

[3] At the time of the baseline in 2014 the transfer was worth approximately £14. Since then its value has been eroded by exchange rate movements to approximately £9 (October 2016).

Box 1: Key evaluation hypotheses

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

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

Evaluation Hypothesis III: Through nutritional advice and counselling the programme will improve the KAP of the targeted men and women in relation to nutrition and general maternal and childcare practices.

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

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

Source: CDGP Evaluation Inception Report, ePact 2014, p. iv.

The findings of this evaluation will be communicated to the state and federal government in order for them to see the potential impact of the programme and in order to leverage their support for taking over the programme and expanding it across states. The evaluation draws on a number of different methods (mixed methods) and interlinked workstreams for gathering evidence about the impact of the programme, including:

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

These different workstreams inform each other's design and analysis through a sequenced and iterative process. At the beginning of the evaluation, prior to the commencement of the

programme, the qualitative situation analysis informed the design of the programme as well as the baseline qualitative and quantitative evaluations. These two evaluation workstreams resulted in the production of two separate reports as well as an integrated summary report for the baseline. These baseline reports in turn informed the design and focus of the process evaluation and the mid-line qualitative evaluation (this report). As outlined in later sections of this report, the quantitative baseline data was drawn on in analysing the household case studies presented. During the drafting of this report, the qualitative team also provided inputs into the midline quantitative evaluation by reviewing its data collection instruments and proposed a number of questions to be incorporated. Subsequent to generation of this report, the following workstream linkages will take place:

- The midline qualitative findings and process evaluation results will support the analysis of the midline quantitative results.
- An integrated summary report will be developed, drawing on the findings from the midline qualitative and quantitative reports as well as the process evaluation results.
- Midline results will inform the design and focus of the endline qualitative and process evaluations, which are expected to take place between December 2017 and January 2018.
- Findings from the endline qualitative and process evaluation will inform the design of the endline quantitative evaluation and support the interpretation of its results.
- A final summary report will draw on all the above evidence to evaluate the impact of the programme.

1.3 Purpose and scope of the qualitative midline

This midline report presents the findings of the second round of qualitative data collection. In contrast to the quantitative survey, each round of the qualitative work is designed to be conducted at a different time of year, to maximise our understanding of seasonal variation in diets, health and livelihoods. The first (baseline) round was conducted in late September and early October 2014, at the end of the *damina* (rainy) season and the beginning of the *kaka* (harvest) season, before the programme began. The midline fieldwork took place approximately 18 months later in late February and early March 2016, towards the end of the *rani* (hot, dry) season. The timing of the third round will be decided in coordination with the quantitative endline survey, after both sets of midline findings have been reviewed and research gaps prioritised.

The three main objectives of the midline are:

- ***tracking changes***, to follow up with the same communities and case study households as in the baseline, in order to investigate what has changed and what has happened in relation to our key research themes since our previous visit. This includes, but is not limited to, any changes brought about by the CDGP. Tracking the same communities, women and households through all three rounds will enable us to build up longitudinal narratives of people's lives during the evaluation period;
- ***deepening the case studies****:* to expand our knowledge of the communities and the case study women and their households, filling any gaps in background information and adding further topics as they arise; and
- ***documenting the implementation of the CDGP****:* to explore, at community and individual level, how the CDGP is working in practice so far and how people are experiencing it in these communities. This strand of the qualitative research focuses on selected key processes and will feed into the process evaluation workstream, as envisaged in the Inception Report (epact 2014). Round 1 of the Process Evaluation (ePact 2016) assessed the same processes from national to LGA level, but did not include any primary data collection at community level.

1.4 Organisation of the report

Following this introduction, Section 2 sets out a summary of the midline methodology, including the continuity of sampling and research themes from the baseline, the data collection methods employed, the organisation and coverage of the fieldwork, and the approaches taken to data processing and analysis. This section also notes the methodological focus and limitations of the qualitative approach employed, some challenges met during its implementation, and consequent caveats about the interpretation of its findings.

Sections 3 and 4 are the core of the report and contain the main findings. Section 3 reports respondents' experience and opinions of six key CDGP implementation processes. In addition to providing community-level feedback as an input to the process evaluation workstream (as noted above), this section also gives essential context for interpreting what people say about the impacts of the programme's activities in Section 4.

Section 4 then focuses on changes since the baseline and the impacts of the CDGP as perceived by beneficiaries and other community members. These findings are organised around the six thematic areas drawn from the theory of change (Annex A) and established in the baseline (see Box 2 in Section 2.1).

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

2 Methodology

2.1 Research themes

The qualitative component of the impact evaluation is structured around six research themes drawn from the CDGP evaluation hypotheses (Box 1 above) and theory of change (Annex A). These themes are summarised in Box 2. The qualitative baseline report (ePact 2015a) explored how people in the selected beneficiary communities thought about and experienced these aspects of their lives before the CDGP began. In the midline, we continued to investigate the same themes but with a focus on respondents' perceptions of any *changes* in these areas since the baseline fieldwork, and their understanding of the causes of such changes. Discussions about the causes of change included, but were not limited to, potential impacts of the CDGP so far.

Box 2: Thematic research areas

The qualitative baseline focused on the following six thematic areas, which are drawn from the evaluation hypotheses and the theory of change in the Inception Report (ePact 2014):

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

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

In addition to these areas of potential impact, the midline interviews included a set of questions about the implementation of the CDGP in these communities so far, focusing on the following six key processes:

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

The information collected about these processes (reported in section 3 of this report) provides essential context for understanding respondents' experience of the CDGP in the selected communities. It also feeds into the broader process evaluation, adding a community-level

perspective to the first round of the process evaluation which assessed the same processes from Federal to LGA level.[4]

2.2 Sampling

2.2.1 Community sample

Seven CDGP-recipient communities were selected for the qualitative research during preparations for the baseline fieldwork, taking the ePact quantitative team's listing of 'treatment' sites as the sampling frame and drawing on information from the community questionnaire administered during the quantitative listing survey. The seven qualitative sites are distributed across all five LGAs where CDGP is being implemented, roughly in proportion to population densities. The sites were purposively selected in order to investigate the functioning of the CDGP in different contexts and to enable some contrast and comparison among the different sites, using the following criteria:

- A balance of communities assigned to T1 (low-intensity BCC) and T2 (high-intensity BCC);
- Good and poor market access (indicator: distance to fruit and vegetable market, according to the community questionnaire);
- Good and poor access to health facilities (indicator: location/walking time to facility, according to the community questionnaire);
- Types of shocks reported in the past year, according to the community questionnaire. The questionnaire included natural shocks (drought, flood and crop damage) and man-made shocks (in-migration, curfews and violence); and
- Expected diversity of livelihoods (e.g. agricultural, pastoralist, trading), based on local researchers' knowledge of terrain and location.

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

[4] See ePact (2016) *CDGP Evaluation Final Process Evaluation Report: Round 1.* Fieldwork for the process evaluation was conducted in February 2016, shortly before the impact evaluation qualitative midline.

Table 1: Qualitative research sites by sampling criteria

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

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

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

2.2.2 Case-study sample

The sampling unit for the qualitative longitudinal case studies is an individual woman (a 'focus woman'), although the data collection and analysis also includes her husband and household. At the time of the qualitative baseline, an initial sample of 84 case study women (12 in each community) was purposively selected from the listing of potential CDGP beneficiaries conducted in preparation for the quantitative baseline in 2014. Sampling criteria included the woman's age, ethnicity, experience as a mother (number of children), monogamous or polygamous marriage, spousal status (i.e. first or second wife, if polygamous), literacy, size of household, and wealth of household (as indicated by the assets and housing quality indicators in the quantitative listing survey).[5] As with the community sample, the aim was to ensure an adequate variety of cases across all these criteria in order to explore a range of individual and household-level factors that

[5] Further details of the sampling criteria and process can be found in the qualitative baseline report (ePact 2015a).

might be expected to affect the impact of the CDGP. The case study sample is not intended to be representative, and the initial sample size was determined simply as the maximum achievable with the time and resources available.

In line with good practice in mixed-methods research, the qualitative sample is designed as a sub-set of the quantitative sample. This enables clearer analytical linkages and a better 'read-through' of findings between the methodological strands, as well as a more efficient use of qualitative research time because interviewers do not need to repeat questions about basic demographics and other indicators already collected by the survey teams. However, the linking of the samples was complicated in practice by the fact that the qualitative and quantitative baseline fieldwork were conducted simultaneously, so that the final household survey sample was only decided after the qualitative data collection had started. The quantitative listing survey was used as the sampling frame for the qualitative case studies, but not all the households in the listing survey were included in the final survey sample. It was therefore decided that the qualitative case study sample would be reviewed and finalised after both baselines were complete.

Accordingly, after completion of the baselines the case study sample was reviewed in consultation with DFID and the wider ePact evaluation team. From the initial sample, 82 case studies had been successfully interviewed at baseline but only 54 of them were also included in the quantitative survey. A number of options were considered, taking account of DFID and SEQAS comments as well as feedback from the field researchers and expert advice on methodologies for the sampling and use of case studies in mixed-method evaluations. The main methodological considerations were maintaining the continuity of the sample through the three rounds of fieldwork, to enable longitudinal analysis; ensuring adequate coverage of beneficiaries; integrating the qualitative and quantitative methods; and sample size. As a result of the review it was recommended, and agreed by DFID, to take the 'Q-squared' sample of 54 women who participated in both the quantitative and qualitative baselines as the final set of longitudinal case studies to be followed up in the midline and endline data collection.

Table 2 summarises the characteristics of this revised case-study cohort. A detailed (anonymised) list of all the case study women, including selected basic data from the quantitative baseline survey, can be found in Annex B (Table 7). The baseline data was used during the qualitative midline interviews to cross-check identities and basic demographics, and as a starting point for conversations. It has also been drawn on in the analysis and write-up of case study examples in this report.

Given the focus of the qualitative research on recipient ('treatment') communities and households, it was important to ensure an adequate number of direct beneficiaries (i.e. women receiving the cash grant) among the respondents. It was not possible to check the beneficiary status of the case-study women prior to the midline fieldwork, due to technical difficulties in matching the CDGP beneficiary lists with the evaluation sample. However, during the fieldwork it was established that 40 of the case-study women were current beneficiaries of the CDGP at the time of the midline and two were past beneficiaries.[6] This number may increase, since more of the case study women may become pregnant and register as beneficiaries before the endline, but 42 is considered a reasonably large sample of beneficiary case-studies in the context of the wider mixed-method evaluation design. Meanwhile two beneficiary focus groups (one with women and one with men) were held in each community to further ensure adequate coverage of beneficiary experiences, as discussed below.

[6] The beneficiary status of each case study woman is included in the reference table in Annex B.

2.2.3 Selecting key informants and focus group members

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

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

Table 2: Case study numbers and characteristics (cohort summary)

	Zamfara				Jigawa			Total	% of total
	Anka		Tsafe		Buji	KKM	GGW		
	Matseri	Doka Gama	Keita	Yankuzo	Kafin Madaki	Kokura	Kanyu		
Total Q[2] case studies	**9**	**9**	**7**	**7**	**7**	**9**	**6**	**54**	**100%**
Marriage status									
Polygamous	2	4	3	3	4	4	3	**23**	**43%**
(first wife)	*1*	*1*	*2*	*1*	*2*	*0*	*1*	*8*	
(second wife)	*1*	*3*	*1*	*2*	*2*	*4*	*2*	*15*	
Monogamous	7	5	4	4	3	5	3	**31**	**57%**
Age group									
13–19	4	3	3	2	1	2	0	**15**	**28%**
20–29	1	5	0	3	3	3	6	**21**	**39%**
30–39	2	1	3	2	3	3	0	**14**	**26%**
40–49	2	0	1	0	0	1	0	**4**	**7%**
Pregnant at time of baseline	8	8	4	6	7	6	4	**43**	**80%**
Household size									

	Zamfara				Jigawa			Total	% of total
	Anka		Tsafe		Buji	KKM	GGW		
	Matseri	Doka Gama	Keita	Yankuzo	Kafin Madaki	Kokura	Kanyu		
large (≥ 10)	3	0	2	2	3	6	1	**17**	**31%**
medium (5 to 9)	3	6	4	3	1	2	5	**24**	**44%**
small (2 to 4)	3	3	1	2	3	1	0	**13**	**24%**
Household wealth index									
Progress out of Poverty Index (PPI) Quartile 1 (poorest)	3	3	4	0	0	1	0	**11**	**20%**
PPI Quartile 2	2	4	1	1	2	1	2	**13**	**24%**
PPI Quartile 3	2	2	0	2	4	4	2	**16**	**30%**
PPI Quartile 4 (richest)	2	0	2	4	1	3	2	**14**	**26%**
Ethnicity / main language									
Hausa	9	9	6	7	7	3	5	**46**	**85%**
Fulani	0	0	0	0	0	6	1	**7**	**13%**
Gobirawa	0	0	1	0	0	0	0	**1**	**2%**
Data source: ePact Quantitative Baseline data (collected Sep/Oct 2014)									

2.3 Data collection methods

The midline used the same basic set of data collection tools as the baseline, i.e. **KIIs, FGDs** and **case studies**. The characteristics of each interviewing method are summarised in Table 3, and the following sections outline the topics covered in each type of interview.

2.3.1 KIIs

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

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

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

3. **Member(s) of the TWC**. These local governance committees are intended to play a central role in targeting and enrolment, sensitising the community, identifying the CVs, dealing with complaints etc. The TWC is usually led by the village or Traditional Ward head (*Mai angwa*). Interviews focused on the role and establishment of the TWC itself and other community institutions, as well as on any complaints or problems they had encountered with the programme, and any good or bad effects they had observed in the community.

4. Member(s) of the **male and female BRGs** in the community. The BRGs are established by CDGP and are intended to help beneficiaries to raise any problems or complaints about the programme. The membership of the BRGs may overlap with the TWC (i.e. some individuals may be members of both). The checklist for the BRG interviews is similar to that for the TWC, covering the role and experience of the BRG itself and probing for examples of any complaints they had dealt with.

5. **Male and female CVs** recruited for the CDGP in the selected community, including CVs who have received nutrition training. According to the implementation manual (CDGP 2014) CVs may also be community leaders or elders (e.g. religious leaders, TBAs, teachers, health workers, or representatives of different groups). Interviews with the CVs mainly focused on their individual experience with the programme, including the training received and the specific activities they are involved in. Open questions were asked about any challenges encountered and their opinions on anything that should be changed or improved.

2.3.2 FGDs

The following four focus groups were held in each community:

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

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

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

Table 3: Description of data collection methods

	Case studies	KIIs	FGDs
Description	In-depth interviews and observations with individual women and their households, about their own lives and experiences	Semi-structured interviews with experts or people with an overview or special knowledge of a place or a topic	Participatory, interactive group discussions using checklists and prompts
Number of participants in each interview	One-to-one	One-to-one, or with small groups of two to four key informants	Six to 10 people
Sampling / selecting participants	Pre-selected during baseline (see section 2.2)	Individuals identified according to their role in the community or the CDGP: • CDGP staff • CHEW(s) • TWC member(s) • BRG member(s) • CVs	Participants fitting the following group criteria invited with the assistance of CVs or other key informants: FGD1: CDGP beneficiaries (women) FGD2: CDGP beneficiaries (husbands) FGD3: Non-beneficiaries (women) FGD4: Non-beneficiaries (men)

2.3.3 Case studies

For both the baseline and the midline the field researchers aimed to conduct three interviews per household, with the focus woman herself, her husband, and one other influential woman in the household (most often the focus woman's mother-in-law, or sometimes a senior co-wife), using semi-structured interview guides. Details regarding the actual number of interviews achieved can be found in the next section (2.4).

The case study interview guide contains sections on any changes in the household since the baseline interviews, structured along the lines of the key research themes (consumption patterns and dietary practices; household relationships and decision-making; health; livelihoods and income; risks and coping behaviour; and overall wellbeing). These sections include open questions about respondents' perceptions of the reasons for the changes raised. A further set of questions was then asked about the respondents' knowledge and experience of the CDGP, with a more detailed set of questions for beneficiaries on their own experience of the enrolment and registration process, the cash transfers (including control and uses of the money), the health and nutrition BCC messages and activities, and any complaints or feedback. In combination with these methods, the field researchers made maximum use of their time by carrying out systematic **observation** of the households and communities during and between interviews. These observations were noted in a separate section of interview transcripts, or reported through the debriefing workshop and team leaders' reports (see section 2.4 below).

Further details of the data collection methods, including checklists and interview guides, can be found in the Midline Fieldwork and Training Guide (Sharp and Cornelius, 2016).

2.4 Fieldwork implementation

Fieldwork was carried out between 25 February and 11 March 2016, following a two-day training workshop for all field team members held at ABU in Zaria. One team of six researchers was deployed in each state, with the two teams working simultaneously, giving an average of approximately four days for each community (including travel time). The majority of field researchers had also participated in the baseline work, which provided continuity in the methodology and understanding of the evaluation objectives, as well as familiarity with gatekeepers and leaders in the research communities. However, some adjustments were made to the team composition in light of the lessons learned during the baseline. For the midline, each team comprised four women and two men, as the majority of interviews are with women. In the Jigawa team, two of the senior female researchers were Fulfulde speakers, to facilitate interviews with the Fulani participants there.

Table 4 summarises the number of case study households, key informants and focus group members who participated in the research in each community. Overall, a total of 53 people (19 women and 34 men) were interviewed as key informants, while 270 people (132 women and 138 men) participated in the focus groups.

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

State	Zamfara				Jigawa			Total
LGA	Anka		Tsafe		Buji	Kirikasama	Gagarawa	
Community	Matseri	Doka Gama	Keita	Yankuzo	Kafin Madaki	Kokura	Kanyu	
Case studies (households)	9	5	7	7	7	8	6	49
Key informants								
CDGP staff	1 ♂		1 ♂		1 ♂	1 ♂	1♀	5 (4♂+1♀)
CHEWs	1 ♂	1 ♂	1 ♂	1 ♂	1♀	1♀	1 ♂	7 (5♂+2♀)
TWC members	1 ♂	1 ♂	1 ♂	1 ♂	1 ♂	1 ♂	1 ♂	7 ♂
BRG members	1♂ + 1♀	1♂ + 1♀	1♂ + 1♀	1♂+ 1♀	1♂ + 1♀	1 ♂	1♂ + 2♀	14 (7♂+7♀)
CVs	1♂ + 1♀	1♂ + 1♀	2♂ + 2♀	1♂ + 1♀	2♂ + 1♀	2♂ + 1♀	2♂ + 2♀	20 (11♂+9♀)
Focus groups								

State	Zamfara				Jigawa			Total
LGA	Anka		Tsafe		Buji	Kirikasama	Gagarawa	
Community	Matseri	Doka Gama	Keita	Yankuzo	Kafin Madaki	Kokura	Kanyu	
CDGP beneficiary women	1 (11 ♀)	1 (12 ♀)	1 (10 ♀)	1 (10 ♀)	1 (9 ♀)	1 (10 ♀)	1 (10 ♀)	7 groups (62 ♀)
CDGP beneficiary husbands	1 (12 ♂)	1 (10 ♂)	1 (10 ♂)	1 (10 ♂)	1 (9 ♂)	1 (10 ♂)	1 (8 ♂)	7 groups (69 ♂)
Non-beneficiary women	1 (10 ♀)	1 (10 ♀)	1 (10 ♀)	1 (10 ♂)	1 (10 ♂)	1 (10 ♀)	1 (10 ♀)	7 groups (70 ♀)
Non-beneficiary men	1 (10 ♂)	1 (11 ♂)	1 (10 ♂)	1 (10 ♂)	1 (10 ♂)	1 (9 ♂)	1 (9 ♂)	7 groups (69 ♂)

Case study interviews were carried out with members of 49 households, out of the total cohort of 54 (see Section 2.2 and Annex B). Of the 49 women who are the focus of these case studies, 40 were current beneficiaries of CDGP at the time of the midline interviews and two were former beneficiaries. As with the baseline study, the teams aimed to interview three people in each household: the focus woman, her husband and one other woman, usually her mother-in-law or a co-wife. This was achieved in 32 households (65%). In the remaining cases it was not possible to carry out all three interviews, usually because the husband or mother-in-law was unavailable. In 12 households, two interviews were conducted (11 with the focus woman and her husband, and one with the focus woman and her mother-in-law). In three of the case study households only the focus woman was available for interview, and in the remaining two (one in Kokura and one in Matseri, both non-beneficiaries) the focus woman herself declined to be interviewed but her husband agreed to talk to the research team. In total, the teams conducted 125 individual interviews for the case studies (47 focus women, 45 husbands, and 33 other women).

Of the five case study households who were not available for interview during the midline, four were from Doka Gama and had left the area because of insecurity (see Section 4.6). The fifth was a Fulani woman in Kokura who refused her consent for the interview, and no-one else from her household was willing to talk to the team. We will attempt to contact these case study households again during the endline fieldwork.

2.5 Data processing and analysis

Data analysis broadly followed the same multi-tier approach as the situation analysis and baseline report, with some adjustments reflecting learning from the two previous reporting periods. A debriefing workshop for all the field researchers was held at ABU in Zaria immediately after the end of the fieldwork, on 14–15 March. The field teams' preliminary findings, observations and impressions were captured in the workshop proceedings and in team leader reports, which were provided separately. In addition to observations on the communities these reports discuss fieldwork experiences, including reflections on the methodology and factors to note for the final (endline) round of the evaluation.

Full transcripts of all the interviews and discussions were written up by the field researchers using their own recordings and field notes. The transcripts were then uploaded into the data analysis software Dedoose, and tagged by two research assistants according to the thematic coding structure set out in Annex E. Inter-coder reliability was checked by the Itad consultant responsible for managing the coding process.

The information from these transcripts and codes was then initially reviewed for quality assurance, and to identify the main narrative threads emerging from the midline data under each of the six themes and the additional process codes, thereby expanding the narratives and identifying changes since the baseline. Using Dedoose, the data on each theme were explored based on different disaggregation criteria: location, BCC status of the community (T1 *versus* T2)[7], beneficiary status, and the case study women's age, marital status (monogamous or polygamous), relationship to the household head, and education.

These narrative threads, and the extracts linked to each code were then reviewed and compared in order to draw out a thematic summary and to highlight key points or insights, with illustrative quotations, under each topic. The full transcripts for each case study household were also read through and selected cases were compared with the baseline interviews, to achieve a contextualised and longitudinal understanding of their stories. [8]

2.6 Strengths and limitations

The strengths and limitations of the qualitative research methods used remain largely the same as for the baseline (see ePact 2015a).

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

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

[7] T1 and T2 are low-intensity and high-intensity models of BCC. See Section 3.5.1 for further details.

[8] A selection of these individual stories are summarised in Section 4 as 'Case study examples'. For anonymity, the women in these examples are identified only by the initial of their first name.

[9] See Section 2.2.

means that the qualitative findings and insights can be triangulated with those of the quantitative midline survey, to estimate the frequency and magnitude of the impacts described here.

By design, the qualitative component of the evaluation is being carried out only in beneficiary communities, and primarily with beneficiary case study households. Within the study communities, FGDs were also held with non-beneficiaries (both women and men), to capture their perspectives on the programme, and to triangulate some of the findings from beneficiaries. A minority of the case study women (7/49 or 14%) were also (as at the midline) non-beneficiaries.[10] Where appropriate and useful, statements by beneficiaries and non-beneficiaries are juxtaposed in this report. However, the sampling and methods used do not allow a systematic or generalisable comparison between treatment and control groups. The focus of the longitudinal case studies is on beneficiaries.

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

The decision to conduct each round of qualitative work in a different season (see section 1.3) maximises our exploration of seasonal differences, but it is recognised that it may also make it difficult to compare some qualitative findings between rounds. As far as possible, respondents were asked to relate any changes or impacts they described to specific seasons, and to compare their current situation to the same time last year. Seasonality will be further explored during the qualitative endline.

As with the baseline, the separation of research functions among the TFDC team (who conducted the fieldwork and wrote the interview transcripts), the research assistants (who coded the transcripts), and the UK-based researchers (who designed the data collection, analysed the coded transcripts and wrote the report) is far from ideal for a qualitative enquiry of this kind. This separation is largely dictated by the security conditions in Northern Nigeria, which make it impossible for the international team members to participate in the fieldwork. In order to mitigate these limitations as far as possible, the TFDC senior researchers were requested to provide team leaders' reports on the fieldwork in each state, and to record their own observations, interpretations and comments. All the field researchers were encouraged to make their own observations (clearly separated in the transcripts from the words and opinions of the respondents), to use the midline field guide (2016) as a framework for flexible enquiry in the field (rather than rigidly following the checklists and thematic questions), and to discuss their findings and observations during the post-fieldwork debriefing workshop. These reflections from the field were documented in the debrief minutes.

In addition to these methodological caveats, a number of challenges in the implementation of the fieldwork could potentially affect the robustness of the research. Security concerns, particularly in Anka LGA (Zamfara), continued to limit the hours the teams could spend in the communities, and therefore the depth of research. In one community (Doka Gama), ongoing violence had led to the migration of many households to other safer areas, including (as noted above) four of our case

[10] That is, these seven women were neither current nor past beneficiaries at the time of the midline. It is possible that they will become pregnant and will be enrolled in the CDGP before the endline. All the case study women were selected because they were likely to become beneficiaries (not in order to achieve a balance of treatment and control cases).

study households. This has reduced the number of case study interviews for the midline, but it is possible that these households will return by the time of the third (endline) round of data collection.

The TFDC researchers reported that it remains very difficult (despite the inclusion of two female Fulfude speakers in the research team, as recommended after the baseline) to interview the Fulani case study women in Kokura, who seemed reluctant to be interviewed or would respond with only very brief answers. The midline research gained some insights into the challenges of fully including the small minority of Fulani communities in the CDGP, which are discussed in this report. However, our understanding of their livelihoods and practices, and how these might be impacted by the CDGP, remains rather limited.

More generally, it was noted by the field research team that there was a reluctance among the households and wider communities to reveal anything negative concerning the CDGP. The TFDC researchers had the impression that things were sometimes not being said in interviews, and that participants might have been 'pre-briefed' (perhaps by the local leadership) not to say anything that they thought could jeopardise their or their community's beneficiary status. It seems likely, in other words, that negative experiences or problems were under-reported. As far as possible this was balanced during the data collection by asking the field teams to use 'probing questions' in interviews, and to follow up any complaints or negative experiences they heard about. Also, during the analysis and report writing examples of negative experiences were highlighted alongside positive reports, in order to better explore the issues raised. This does not imply any quantification of negative versus positive impacts or experiences.

3 CDGP processes and activities

3.1 Sensitisation and communication about the programme

Respondents, both beneficiaries and non-beneficiaries, were asked what they knew about the CDGP and where they gained this information. Most people had an accurate understanding of the programme's purpose (to help mothers and babies to improve their nutrition and health) and targeting (the principle that all pregnant women resident in the beneficiary communities are eligible). Beneficiaries, not surprisingly, were better informed about the details of enrolment and registration processes, the payment system, and BCC activities. However, the non-beneficiary focus groups showed a good understanding of how these components of the programme work. Many non-beneficiaries were also aware of some of the key BCC messages (particularly on exclusive breastfeeding – see Section 4.2 below), and many of the non-beneficiary women either attended the food demonstrations themselves or had learned about the advice and recipes, which were provided by neighbours and relatives who are beneficiaries. Thus, beneficiaries themselves are becoming an information source for the wider community, particularly in spreading the health and nutrition education (or 'enlightenment', as some of our respondents called it).

The most important sources of information about the programme (in terms of how frequently they are mentioned and how reliable the information seems to be) are the most local: village leaders, CVs, community meetings, and CDGP staff who visit the community (including seconded staff from the LGA). Some people had heard about the programme before it arrived in their community, from contacts living elsewhere or from general talk in nearby towns and markets, or at the hospital during ante-natal visits. Some had also heard about the programme through radio broadcasts.

Information about specific dates for payments and meetings is mostly received by word of mouth through CVs and town criers (the usual channel by which village leaders convey messages to the general population). In some cases messages supporting aspects of the programme, such as the right of beneficiary women to keep and control the cash transfer, the importance of spending the money as advised, and some BCC messages, including cleanliness, were relayed by the local mosque during Friday prayers. It is not clear from our fieldwork how frequent or widespread this practice is, but respondents who mentioned hearing such information from religious authorities considered it very authoritative and influential.

> 'You know when it is said that a thing comes from a religious leader everybody takes it seriously. That is why when something comes from them it becomes twice as important to the people.'
>
> Kokura Case Study 1 (CS1) – Husband

Men are more likely than women to hear information from some of these sources (radio, markets, towns, and mosques) because they are more mobile, more likely to own radios, more likely to be in markets and other public places, and because they attend Friday prayers. Women do not go to the mosque in these communities, although in some places the sermons can be heard from their homes. More generally, men relay the imam's teaching to the women in their household. A few older women in case study households said that they rarely go out of the compound and had heard little or nothing about the programme from any of the sources mentioned. However, this is not always the case: some mothers-in-law in the case study households, and some older women in focus groups, were well-informed and supportive of the programme.

In two of our seven qualitative evaluation sites (Kanyu and Kokura), Fulanis live in separate settlements (known as *rugas*), located on the outskirts of the village, where they have easy access

to the bush for grazing. In both these places it was noted that the Fulani were less likely to receive public communications about the programme, and that additional efforts were needed to ensure they were included. This is partly due to their location, as they are physically dispersed and further from the village centre, and therefore do not hear announcements from the mosque and those by town criers. CVs have to make a special effort to travel out to the *rugas* to inform them about meetings and payments, or to include them in counselling. Some participants mentioned language as a barrier, because the CDGP communications are in Hausa and not in Fulfulde (the Fulani language). In Kokura in particular there is also communal tension between the village population and the *rugas*, which appears to limit interaction and communication. In this community there is a perception among the Fulani that they are deliberately excluded from the CDGP: programme staff are working to counteract this but they noted some specific challenges in relation to doing so (see Section 4.6.2).

Suspicion and misunderstandings about the purpose of the CDGP were reportedly widespread at first, but have now been mostly dispelled (at least in these beneficiary communities) through people's experience of how the programme actually works, and through the sensitisation efforts of the CVs.

> 'Yes, you see when this programme commenced some women were reluctant in joining the programme because of the bad rumours that they heard.
>
> [W]hat kind of bad rumours were they hearing?
>
> That after you collect the money, they are taking your blood to somewhere that you don't know. The CVs were holding meetings with them and they became knowledgeable and that was what helped in the elimination of the rumours.'
>
> Keta KII – CHEW

However, a few people continue to mistrust the idea of people giving out free money and they continue to believe rumours that blood tests (for pregnancy confirmation) are harmful, or that beneficiaries' babies will be taken away. For example, one of our case study women in Kokura refused to be interviewed or to have anything to do with the programme, apparently for this reason. The following extract from an interview with a beneficiary's husband in Kafin Madaki illustrates how such fears are being allayed through discussion within the community, and also illustrates the importance of including men in communications:

> 'Some women were even saying that any woman that receives this support is selling her baby and they will come to snatch the baby. Sincerely, that is what we were told. I came and told my wife that anyone that says this to her again she should tell me and I will go and warn them not to ever bring such a useless talk to my house. This is useless talk, how can good thing come and it will be turned into evil? Is it because some people did not get [the cash support] or what? I said I did not believe this thing, since Allah brings you support you should collect it with your head up. ... I helped others too in this way because I enlightened my wife and she in turn enlightened other women. ... In the past people were suspicious of the programme. There was a woman who was enrolled in this community but refused to collect the money until she was gradually enlightened before she started collecting. I know that woman personally in this community. She was afraid that they would collect her baby so she refused to collect [the money].'

Kafin Madaki CS 3 – Husband

3.2 Community institutions and volunteers

In all seven communities there was an established local committee, chaired by the village or district head and including influential community figures (such as the imam), in charge of CDGP activities. This corresponds to the TWC described in the implementation manual (CDGP 2014). BRGs were also present in all the communities, though their structure and functions were less clear. The TWC leadership was male in all cases, while the BRGs included both male and female members (meeting separately or together). The BRG members interviewed as key informants included an imam, a TBA, and CVs.

There seems to be a lack of clarity in the communities regarding the distinction between the TWC and the BRGs in terms of their membership and responsibilities, and between the BRGs and the CVs. This was commented on by the field teams when trying to identify key informants in each category, and also comes out of the interview transcripts. For example, in Matseri a male BRG member gave this explanation of the BRG's role, which actually matches better the responsibilities of the CVs:

> 'Our main role is to advise women on the importance of exclusive breastfeeding, hygiene, health and nutrition within households and in the community as a whole. We are also charge[d] with the responsibility [of] teaching women on the need to wash their hands before preparing children's food.'

Matseri KII – BRG member (male)

By contrast, in Kanyu the BRG seems to be organised and active, and its local name suggests that it is composed of beneficiaries:

> 'BRG in this community signifies *Kungiyar Yan Ciki* (the 'Group of Pregnant Women'). There are 10 of us members and I am the vice chairman of the committee. Let me give you the breakdown: we have the chairman, we have the vice chairman, and we have the secretary.... [It was formed in] November 2014. ... [It meets] two to three times in a month'.

Kanyu KII – BRG member (female)

It seems likely that the exact structures and ways of working of the TWC and BRG vary from place to place, and that their membership intentionally overlaps (as found by the process evaluation, see ePact 2016). The TWC leadership were sometimes referred to as the elders, while the CVs were referred to as the youth, suggesting perhaps that the TWC are seen as the decision-makers who instruct the others on what to do. The village head traditionally arbitrates disputes (including domestic arguments), and, as expected, appears to be playing this role in the CDGP (for example, in the divorce case summarised in Case Study Example 6 below). Nearly all the beneficiaries interviewed said that if they had a complaint that could not be dealt with by their CV, they would go to the village head.

The CVs themselves may be members of the BRGs as well as being responsible for delivering or facilitating most of the activities described in the following sections (enrolment, informing women about the payments, BCC activities, and channelling complaints). Each of the seven communities has a small number (four to six) of active CVs, both male and female. Some women CVs are also beneficiaries, and some male CVs are husbands or close relatives of beneficiaries. CVs may also

be closely linked to the TWC leadership: in Matseri, for example, the wife, son and brother of the village head are CVs. This is likely to enhance their authority and to facilitate communication, although there could potentially be a conflict of interest in the event of complaints. Generally the CVs interviewed[11] were very positive about their role in the programme, the training they have received, and the impact they feel their work is having in the community. They also feel respected because of it: as one female CV in Kanyu said, '[a]ll of us the CVs feel socially elevated'.

3.3 Enrolment and registration[12]

As mentioned in Section 3.1, the CDGP eligibility criteria (pregnancy, and residence in a beneficiary community) are widely known and understood by both beneficiaries and non-beneficiaries in the communities visited. The steps in the enrolment and registration process are also widely known, as expressed by one non-beneficiary in Kanyu:

> 'When you are pregnant you will go to the Mai Garin [mayor], then he will give you paper, which you will take to the hospital and show to doctor, then the doctor will ask for your urine after which you will [be] tested by the computer and if you had lied about being pregnant they will know. And most times the women wait for four months before they say they are pregnant at least by then most people can testify to it and you know the risk of a miscarriage is less by then, you don't go and say you are pregnant after a month or two you wait until the fourth month because in the first few months one can have miscarriage so they wait until they are certain they are pregnant ... [A]fter the doctor has confirmed your pregnancy the doctor will give the woman a paper and tell her to wait .... CDGP staff will come and fill a form for you and give you a phone. When they come and you show them the form from the hospital, the CV's will fill the forms for them, then the women will be given [a] phone and ... at the end of the month the women start [to] collect money.'
>
> Kanyu FGD3 – Non-beneficiary women

The procedure for confirming a pregnancy does not appear to be standardised, but varies from place to place. In most of the communities women were required to give a urine sample for testing, and often the test was done by a CV or CHEW (rather than by a doctor, as in the Kanyu example above).

> 'In the hospital ... [t]hey gave us little bottles and asked us to urinate into it. After urinating they tested the urine. .... One woman was inserting something into the urine, she will insert it and remove it, then she will examine the thing, then throw it away. The people that were pregnant were asked to remain, while those that were not pregnant were told to go back home.'

[11] It is likely that the total of 11 male and nine female CVs interviewed as key informants (see Table 4) were to some extent a self-selecting sample of the most active and interested volunteers.

[12] In CDGP terminology 'enrolment' is the initial community-based process of identifying eligible women by verifying their residence and pregnancy, and writing their names and basic information in a hard-copy register. After this, 'registration' by CDGP staff involves entering the enrolled woman's details (including her thumb-print and photograph) into the computerised payment system, at which point she is given a phone and SIM card (see Process Evaluation, ePact 2016, for further details). In the qualitative midline interviews, women were asked about their experience of the two stages together (i.e. the whole process before they began to receive the cash transfer).

Yankuzo CS1 – Focus woman (beneficiary)

> 'The CVs and the CDGP female staff supervise the process. They come into our homes and ensure that we use the sample bottles they give us.'

Matseri CS3 – Focus woman (beneficiary)

This close supervision was introduced by CDGP to prevent women falsifying the test result by buying urine samples from other (pregnant) women. This was reportedly a problem in the early stages of implementation, but no actual examples of such fraud were encountered during the qualitative midline. Sometimes the pregnancy testing is repeated at the later stage of registration, as a further check:

> 'Yes they take urine. For example, on the day of the phone distribution, five women were disqualified... they were tested and the result showed they were not pregnant.'

Keta CS7 – Focus woman (beneficiary)

In Keta, according to the CHEW and beneficiaries, pregnancy is confirmed by blood tests rather than urine tests, also to deter fraud: [13]

> 'We will normally confirm pregnancy using blood test rather than urine because some women will bring urine from their community only because they want to be admitted into the programme. This is how we eliminate those kinds of false cases.'

Keta KII – CHEW

In some cases visible evidence of advanced pregnancy was required, apparently to make the number of applicants more manageable and perhaps also to avoid the difficulties and potential for fraud associated with the urine test:

> 'R4: Then they said it is only women whose pregnancy was glaring that will benefit.
>
> R6, R5: The pregnancy they can see visibly ...
>
> R7: They said anyone whose pregnancy was not advanced will not be given the phone even if she went there and so we did not go there, we sat in our homes, even the woman that went was told to go back because her husband had gone back home, she went three times, and then they told her [that] her pregnancy was not advanced so they will not give her.'

Yankuzo FGD3 – Non-beneficiary women

[13] Blood tests are considered more accurate, but require properly-equipped health facilities and trained medical staff. Given the scarcity of such facilities in the programme area the CDGP uses urine tests, which can be administered by CVs in the communities using simple kits (see Process Evaluation, ePact 2016). Blood tests are not funded or administered by CDGP, but in the case of Keta (according to our key informants) they are being applied by the local health centre.

> ‘They did a test and because there were lots of women they narrowed the screening to women with seven to nine months pregnancy. It was from there that I was selected...’
>
> Keta CS4 – Focus woman (beneficiary)

The time between enrolment and receiving the first cash payment varied (among our respondents) between about two weeks and two months. The beneficiary women interviewed generally considered the enrolment and registration process, including the pregnancy testing, to be fair and well managed. Asked if there was anything about this process that should be changed in their opinion, almost all said no. One beneficiary stated:

> ‘The process is transparent and good because fraudulent acts will be difficult. I was treated with respect every step of the way and that is encouraging.’
>
> Yankuzo CS3 – Focus woman (beneficiary)

A few said that the waiting time was too long, or that they would like the ante-natal care centre to be closer to their homes.

In various places the field teams heard that there were many pregnant women who had not yet been registered, and in some cases women were said to have missed their chance to be beneficiaries because they had given birth before the enrolment was done, and only women who were pregnant at the time of enrolment were included in the programme. In Yankuzo, some eligible women had been discouraged by the queues and waiting time and had not managed to enrol, as explained in this focus group extract:

> ‘R6: Honestly I went there.
>
> R5: I also went there from morning until 5pm, I spent until evening and God did not destine that we will be part.
>
> Your pregnancy was not advanced then?
>
> R5: No, we did not even get to enter the place they were. We went there, there was a crowd, people ... struggling to get the attention of the man, you know where some persons might be able to do this, some may not. So I said, honestly, I cannot do this thing, if I am destined to have it, I will.’
>
> Yankuzo FGD3 – Non-beneficiary women

From the perspective of the CDGP staff and TWC leaders interviewed, a further challenge with the enrolment process is the frequent attempts by women who are not residents of the beneficiary community to register for the programme. The CVs and TWC are responsible for policing this.

> ‘No major fraud except from women that cross over from other villages pretending to be beneficiaries. Thank God! Our CVs were able to identify such dishonest women and sent them to Bulama [village head] for serious warning.’
>
> Kanyu KII – CDGP staff

> ‘Yes, there are women from Bukolo community who came to register and we did not know when they were even given phones but we stopped the process. I have driven about 10 women who have come here wanting to be registered from other communities as well. The women from other communities are very desperate to benefit from the programme.’

Matseri KII – TWC member

3.4 Payment system

The process of cash transfer payments is consistent and standardised in all seven communities, according to beneficiaries’ descriptions. Payments are made regularly every month by agents who come to a nearby venue (usually a health centre, school, or other public building). Some women received notification of the payment date by phone, but more commonly this information is spread by the CVs and town criers. The monthly amount received was NGN 3,500 in every case among the beneficiaries we interviewed. If a beneficiary misses a monthly payment, either through failure to attend or because her thumb-print is not recognised by the computer system (see below), the amount is carried over to the next payment round so that she receives NGN 7,000 the following month. However, key informants from CDGP staff stated that accumulating balances and large lump-sum payments are discouraged because the purpose of the transfer is regular expenditure on a healthy diet throughout the month. Therefore, CDGP has introduced a rule that a maximum of three months’ payments (NGN 10,500) can be accumulated. After this the reason for the beneficiary’s absence should be investigated and, if appropriate, the account will be frozen.

At the payment point, beneficiaries’ identities are verified by their name, CDGP-issued phone number (many respondents say they present their SIM card pack rather than the phone itself), thumb-print, and photograph, as explained by this beneficiary from Yankuzo:

> ‘The three of them sit, one person collects the card, the other monitors the thumb printing and the last person does the payment...
>
> [T]hey use the town-crier to inform us……We assemble at the hospital……they call out our names, anyone that hears her name goes in then they check her SIM pack, then she goes and thumb-print on the computer, when she thumb-prints, her picture appears on the computer. After this, they give the woman her money and she goes her way.’

Yankuzo CS1 – Focus woman (beneficiary)

Two problems relating to the payment process were raised by a number of our participants. The first, which was frequently mentioned by beneficiaries, is that the thumb-print scanners sometimes fail to recognise a woman’s thumb-print at the payment point. This can apparently be caused by dirt or henna on the hands, or wear caused by physical work, or low resolution of the original scan (see Process Evaluation, ePact 2016). If the thumb-print is not recognised by the computer, the beneficiary’s account is not opened and the payment is not authorised. Three ways of dealing with this situation were described. Firstly, the woman may be asked to clean her thumb and try again:

> ‘They ask us to come with SIM packs, then they tell us to thumb-print and they capture our face, when we thumb-print, if your face appears, they will pay you the money, if it doesn’t appear, they will not pay you, they may advise that you use *Klin* [detergent] to wash your thumb.’

Doka Gama CS4 – Focus woman (beneficiary)

Secondly, the beneficiary's proxy (an individual whose thumb-print and photograph were registered at the same time as the beneficiary herself) may be identified instead:

> 'Where this happens, they call our guarantor – for me my mother in-law – when she places her thumb, if the computer accepts it, it displays my name and then I get paid.'
>
> Matseri CS5 – Focus woman (beneficiary)

If neither of these options work, the payment will be carried over to the next month while the problem is resolved.

> '...So if your hands are stained it will not recognise you?
>
> Yes.
>
> So what is the remedial measure when [this] happens?
>
> In most cases you will be paid during the next payment and in that case you get 7,000 Naira.'
>
> Keta CS7 – Focus woman (beneficiary)

The second problem raised by key informants (CDGP staff and community workers) is the frequent absence of women at the time of payments. This causes considerable additional work to investigate why the beneficiaries have not attended, and to make appropriate decisions regarding when to freeze accounts. Women may be away from the village for various reasons in any community, for example in Keta:

> 'What do you think is the reason, if the 3,500 is very useful to them and yet somebody does not come to collect the money, is it that they have some other source of income?
>
> Sometimes [the reason] is travelling, you know women go for social events, especially during the dry season when you normally will have lots of social events such as marriage or naming ceremonies. Since they do not have the payment schedule..., the [payment agents] may come to pay when they are away with nobody to contact them and by the time they are back the [agents] would have left their communities. This is my own understanding as to why they are not being paid.'
>
> Keta KII – CHEW

However, the problem of women not being present at payment time is particularly difficult to manage in the case of the Fulani women in Kokura, where seasonal migration, long absences from the village, and difficulties in distinguishing between 'residents' and people who spend only part of the year at the *ruga*, are common.

> 'We the team members get overwhelmed by many women who abscond from collecting their money. So we think it is business as usual for them not to come. Many beneficiaries absent themselves for two months…

> ...It is about migration of the Fulanis again. When we register them, that is the new beneficiary who is pregnant; and after we register her into the programme; she will start collecting her money, then they will migrate entirely to another state or LGA. Then we will not realise that she has ... migrated until her account has [accumulated]... plenty of money.
>
> ...Then we will search for her and know what is the reason that she has not collected her money. At the end we will de-activate the account.
>
> ...Well if she comes back and her reason for migration was not the normal seasonal one, we will allow her [to] continue collecting her money. But if the next migration will be for five months, we will not allow any woman like that for the CDGP programme.
>
> ...[T]o reduce this, ... we go to rugas and inspect. If among them there are transitional migrants, that usually stay for one and two months, the Fulanis will alert us and we will alert the Bulama [village head].'
>
> Kokura KII – CDGP staff

Apart from these issues, respondents generally considered the payment system to be transparent and well managed. Asked if there was anything about the system that should be improved or changed, almost all said no. The exceptions were: one request for the payments to be made at a different time of day; one suggestion that the proxy system be reviewed because it was difficult for some women to find guarantors; and one complaint about queueing outside for payments:

> 'No permanent venue for the payment. When we are on the line out[side] a payment place, some husbands complain to Bulama of exposing their wives for other men to look at them.'
>
> Kokura CS1 – Focus woman (beneficiary)

In general, people seem to be impressed with the honest management and reliable delivery of the cash, as expressed by this comment from a beneficiary's husband:

> 'Sincerely, there is something that impresses me. This money that is brought without having to go to the bank or through some dishonest middlemen. If this were from the government and NGN 3,500 is sent to you, you will be very lucky if NGN 1,500 reaches you. It will be deducted. At first I thought the money allocated was more than this until I heard on the radio that the amount is NGN 3,500 and this is the amount that is brought and given to women here. Sincerely, this impresses me a lot.'
>
> Kafin Madaki CS2 – Husband

3.5 BCC activities

3.5.1 Overview: T1 and T2 approaches

In principle, the programme and the evaluation are designed to test and compare two different models of BCC: a low-intensity model (T1) and a high-intensity model (T2). The activities planned for each model are summarised in Table 5. The qualitative evaluation sites were purposively selected to include roughly equal numbers of T1 and T2 communities. In practice, however, the

midline fieldwork found that the BCC activities implemented in each community do not consistently follow this plan, as shown in Table 6, which sets out the actual BCC activities described by key informants and beneficiaries. There seems to be some confusion as to which treatment model each community is assigned to (that is, the key informant information collected during the midline does not match the original listing). There may also be variation in the delivery of BCC activities from place to place, depending on the individual CHEWs and CVs. It is impossible to generalise from the seven communities visited for the qualitative work: the quantitative midline survey will be able to assess how consistently the T1 and T2 distinction is being implemented. In the meantime, this report finds that there was no clear distinction between T1 and T2 approaches among the qualitative sites. The following sections, therefore, rather than attempting to compare the two approaches, consider each of the BCC activity types separately.

Table 5: Summary of planned BCC activities (T1 and T2)

Activity	Description	Treatment 1	Treatment 2
Messaging/ one-way communication	Mass communication, voice messaging, radio, posters, Friday preaching and Islamic schools	✓	✓
AOGs	Food demonstrations, drama groups (20–30 persons)	✓	✓
IYCF support groups	Support groups for mothers, fathers and grandmothers (12–15 persons/group)	×	✓
One-to-one counselling	Individual counselling	×	✓
Source: CDGP Implementation Manual (2015) pp.24–25			

Table 6: Actual BCC activities in the qualitative evaluation sites

State	LGA	Community	Intended BCC intensity *	Actual BCC activities described by midline participants			
				AOGs	IYCF support groups ♀	IYCF support groups ♂	One-to-one counselling/ home visits
ZAMFARA	Anka	Matseri	T1	●	●		●
		Doka Gama	T2	●	●	●	
	Tsafe	Keita	T2	●	●	●	●
		Yankuzo	T1	●	●		
JIGAWA	Buji	Kafin Madaki	T1	●	●	●	●
	Kirikasama	Kokura	T2	●	●	●	●
	Gagarawa	Kanyu	T2	●	●		

* According to ePact randomisation list, used for purposive sampling of communities (see Qualitative Baseline Report, ePact 2015a).

3.5.2 One-way communications

Voice messaging

Very few of our participants said that they had received and understood any BCC messages via the phones provided by CDGP. Some said that the phone network coverage was poor in their area, or that the phones were often not charged (presumably due to the lack or cost of electricity), or had been lost or given away. One case study beneficiary said her phone battery had been stolen when it was sent for charging. In Kafin Madaki, beneficiaries told us they were using the CDGP phones but had swapped the SIM cards for a different network with better local coverage. They used the original SIM package as identification for the cash transfers, but were obviously not receiving any messages from CDGP as the SIM cards were not in the phones.

For those who had received the voice messages, however, the communication seemed to be clear and effective:

> 'Yes I do get voiced messages on my phone, telling us about nutrition and child care. I used to think it was a live call and try to talk back.... We get voice messages on the phone every two to three weeks. But you just listen you cannot talk back to them... They advise us on breastfeeding practices, feeding and sanitation practices for you and the children. It reinforces what the CVs are teaching us and reminds us of important things that we must uphold. The calls make me work harder because I feel encouraged.'
>
> Matseri CS3 – Focus woman (beneficiary)

> 'Have you received any voice messages through your phone about nutrition and child care?
>
> Yes.
>
> How many times?
>
> Honestly, once.
>
> And what was the message? What did you learn?
>
> They told us about exclusive breastfeeding that we should not give water, that is all I have ever heard.'
>
> Yankuzo CS1 – Focus woman (beneficiary)

There seems to be widespread confusion about the phone messages, as many people across all the communities said that they had received voice messages in English, or text messages in English or Hausa (very few beneficiaries are literate). We were not able to investigate this but it may be that these are automated messages from the network provider, or possibly credit alerts from the cash transfer provider (Stanbic). The CDGP BCC messages are sent in the form of pre-recorded voice messages, in Hausa (see Process Evaluation report).

> 'I use to get a call in English language and I don't know what it was they were saying since it wasn't in Hausa language [laughing] but some women said they got calls and it was in Hausa language... those who said they got the call in Hausa said they are told about how to breast feed their children.'

Kokura CS2, Focus woman (ex-beneficiary)

Even CVs who have been trained on the BCC and nutrition components of CDGP can be confused about the types of messages that beneficiaries should be receiving, as shown by this comment from a CV in Doka Gama:

> ‘To be sincere with you most of our women are rural women they did not go to school and as such they ... cannot read English nor the Hausa language so I cannot be so sure that the messages are effective since I have never seen my wife tell me about any of the messages.’

Doka Gama KII, CV

Radio programmes

As with the phone messages, people who had heard radio programmes about the CDGP or about health and nutrition topics had enjoyed them and often remembered the content in some detail, but many people told us that they did not have access to radios and had not heard any broadcasts. In some cases they had radios but could not afford batteries. Men seem to be more likely to own radios than women, so women’s opportunities to listen to such programmes may depend on their husbands.

> ‘R9: I have a very big radio set that my late mother gave me but I don't have money to buy batteries and am presently looking for someone who will buy it from me and get a smaller one for me so that I can listen to world news. The radio is under my bed.
>
> R3: I also have a radio set but I haven’t listen[ed] to it for a while now because of lack of money to buy batteries.’

Kanyu FGD 3 – Non-beneficiary women

> ‘I do listen to radio sometimes when my husband does not go out on time he always likes going out with the radio so that he does not miss out on the news and sports programmes....
>
> ... There are many programmes on radio that teach you better and healthier ways of doing things and they are in Hausa so we clearly understand what they are saying. There are programmes on sanitation, childcare, exclusive breast feeding and even those that teach you how to cook different dishes.’

Keta FGD 3 – Non-beneficiary women

Unlike the voice messages, which are sent only to the phone numbers provided to registered CDGP beneficiaries, the radio programmes are broadcast to the population at large. Non-beneficiaries are therefore as likely to hear the programmes as beneficiaries.

3.5.3 AOGs

Interactive group meetings, especially the food and cooking demonstrations, are very popular: in all our communities almost all the beneficiary women interviewed knew about the meetings and attended them whenever they could. Many non-beneficiary women also join these meetings, or pick up childcare and cooking tips from those who attend them.

> ‘Many, many people came to the meeting, many people. In fact they came with food to demonstrate how we will cook these foods for our children, they show you how to cook this type of food, fish , ‘awara’, jolloff taliya, ‘pate wake’, ‘alayahu’ (vegetables) food demonstration, in fact they will cook and everybody [is] given to taste the type of good food.’
>
> Kafin Madaki CS7 – Focus woman (beneficiary)

> ‘Many, many people attend the meetings, lots of people. We meet at village heads’ house for the meeting. About 50 or more people, even 100 including Fulani tribes, attend the meeting. They show us many things.’
>
> Kanyu CS3 – Focus woman (beneficiary)

One exception to this inclusiveness was in Kokura, where Fulani women felt excluded from the food demonstrations, either because information about them did not easily reach the Fulani *ruga* (hamlets) located on the outskirts of the village, or because if they did go they could not fully understand because the talks were given in Hausa.

Participants appreciate the visual aids used in the group sessions, and the opportunity to learn by doing:

> ‘The CVs step down what they learnt from the CDGP training. They bring pictures to demonstrate what they are teaching us. This gives us a better idea of what they are talking about. They also bring ingredients and teach us how to cook and prepare different things. We ask questions and they patiently explain things to us.’
>
> Matseri CS3 – Focus woman (beneficiary)

> ‘We have the meeting once in a month and we start around 12 noon sometimes and finish before 4 pm, we have the meeting in the primary school which is just close by, they teach us how to cook the meals and they also show us pictures of the meal, and allow us to cook too. I can’t say the number of women who come for the meeting, all I can say is that most of us come out anytime there is a meeting.’
>
> Kanyu CS5 – Focus woman (beneficiary)

In one community (Kanyu) an active BRG member was enthusiastic about including locally available nutritious foods in the demonstrations:

> ‘We resolve that since there is plenty of wetland vegetables CDGP committee on food demonstration should teach us how to clean and use with other grains in cooking. You see, women eat the vegetables without proper cleaning and sometimes they overcook them. But we shall still inquire on how to introduce vegetables to our babies of six months.’
>
> Kanyu KII – BRG member (female)

A number of women mentioned that they had learned not only which foods to eat for better health and nutrition, but also new recipes and cooking methods to maximise the nutritional value of the ingredients in their meals:

> ‘They taught us how to cook jollof rice, rice and beans, they taught us to parboil our rice and beans; beans first before the rice. We parboil the beans because of the chemical that might have been used to preserve it. Then we should prepare our sauce separately before adding to the rice and beans.
>
> Was this useful?
>
> Yes.’
>
> Keta CS1 – Focus woman (beneficiary)

3.5.4 IYCF support groups

In all seven communities beneficiary women attend group meetings where CVs ‘step down’ what they have learned from their training about nutrition, health, hygiene, and IYCF. Some women say these meetings happen regularly after the monthly payment process.

> ‘Every CV has about 15 women under her and we all love attending the sessions. If a woman misses a session it will be due to some very important reason.’
>
> Matseri CS3 – Focus woman (beneficiary)

> ‘Do you hold meetings where you are informed about nutrition and childcare?
>
> Yes, we the women that receive the money, we meet monthly.
>
> Have you been attending the meetings?
>
> Yes, I do not miss any.’
>
> Yankuzo CS5 – Focus woman (beneficiary)

All the women who talked about the CDGP meetings (both the AOG and support group meetings) said that the meeting places were nearby and were accessible for them, and there was no problem with getting permission from their husbands to attend such meetings once they were enrolled in the programme. It can be difficult, even so, for women to give their full attention to the BCC meetings, because of childcare and domestic responsibilities, as this beneficiary in Yankuzo explains:

> ‘I think about 19 of us attended because sometimes, some women don’t attend but for us around this area we attend. Even when some come for the meeting, little children keep coming to the venue to call them that their attention is needed at home. Some women stay back they say they are held up with chores...’

The same beneficiary was able to give details of what she had learned from the group:

> ‘...They talked about exclusive breastfeeding and complementary feeding after six months. They said we should not give a child water until after six months.
>
> What else?

They also told us that children who are still small over six months should not be given heavy meals.

What else?

The composition of water to food in the breast milk, that we should not be in a hurry to remove our babies from the breast when they are suckling, we should allow them to suckle well and for a long time on one breast so that the "food" will follow the breast milk, because until this food comes out, the child will not be satisfied, when he sucks for a long time, then we can change him to the other breast. And we should allow our babies suckle until he/she removes his mouth from the breast, that they usually wouldn't do so until they are satisfied.'

Yankuzo CS1 – Focus woman (beneficiary)

3.5.5 One-to-one counselling

From the interviews with beneficiaries it is difficult to distinguish between formal one-to-one counselling and home visits made by conscientious CVs following up on the group sessions, or simply giving extra advice in the course of neighbourly visits or while delivering information about payments or other programme business. The variation in quality and intensity of counselling received may depend to a large extent on the skills and dedication of individual CVs.

Beneficiaries who had received one-to-one counselling or home visits from the CVs generally found them to be very helpful, as expressed by this case study woman:

'The CV comes and looks around our surroundings and she stays with you to observe how you are taking care of your home. She gives advice and also corrects your mistakes. She can spend over an hour during the visit.

What do you learn from the visits?

You know when we have our monthly meeting she is teaching us in group, when she comes to my house I understand better what she is teaching me because now we are using my home for the lesson so it becomes easier for me to apply what I am learning.'

Matseri CS3 – Focus woman (beneficiary)

3.6 Complaints mechanism

Most people interviewed, and nearly all the beneficiaries, knew who to complain to locally if they had a problem with the CDGP. Some women said they would go first to their husbands, who would take it up with the leaders. Most said they would speak first to one of the CVs, or if the complaint was about the CV they would go to the TWC leadership or a member of CDGP staff when they come to the village. A few husbands said they would go directly to the LGA staff or the CDGP office in town. None of the respondents mentioned the 'hotline' phone number established by the programme to receive complaints directly, but a few mentioned that CDGP team members had given them their own phone numbers in case they had any problems.

Despite being aware of the channels, very few people said they had made any complaint themselves or knew anyone who had. The following response from a beneficiary in Matseri is fairly typical:

> 'Do you know who to contact if you have any complaints or problems about the CDGP?
>
> We have been told how to channel our complaints through the leaders.
>
> How would a complaint be made?
>
> If the problem has to do with the family, maybe your husband, you can report to the CV and if it is not something she can resolve she will forward it to the TWC. If the problem has to do with the CV then you report to the TWC and they will handle it.
>
> Have you personally had any complaints or problems?
>
> I have not had any complaint.
>
> Do you know any other people who've had complaints or problems with CDGP?
>
> I have not heard of anyone who has. The only thing you will hear is more women want to be part of the programme.'
>
> Matseri CS3 – Focus woman (beneficiary)

Across the seven communities, the types of problem or complaint dealt with by the community institutions and CVs are mainly recurrent or routine issues arising in the implementation of the programme, such as the problem of thumb-prints not being recognised by the computer (discussed in the payment section above), or women missing payments because they were absent when the payment agents came. The time lag between enrolment and receiving the first payment, and delays in re-registering women after a miscarriage and subsequent pregnancy,[14] are other concerns commonly raised with the CVs and BRGs. These problems are illustrated by the following examples:

> 'Do you know what to do if you have a complaint with CDGP?
>
> If we have problems, we report to the CV, the CV then reports to the TWC who deal with the problem or take it to the CDGP if it is beyond their power.
>
> Do you know any people in this community who've had complaints or problems with CDGP?
>
> I think the main complaint will be the fact that sometimes some women's finger prints cannot be verified for long periods and we know they are registered.'

[14] The qualitative fieldwork was not able to quantify how long or how frequent these time lags actually were: they are perceived by the beneficiaries as delays, and it is understandable that they would be anxious to know when their payments would (re)start.

Yankuzo FGD1 – Beneficiary women

‘Have you personally had any complaints?

Yes, when I was pregnant, I enrolled and my name did not show in the computer. I told them, they know, later it was resolved and I started receiving the money after the birth of my baby.

Do you know anyone else with complaint?

Yes. The same problem I had, about 15 others that I know had it. But they are being paid now.’

Matseri CS8 – Focus woman (beneficiary)

‘Some women complain that initially [they] were enrolled on the programme, then they lost their babies and they were told that when they get pregnant again, they will be enrolled back; now they are pregnant, but they have not been enrolled back.’

Keta KII – BRG member (female)

‘Yes I know who to contact. I have gone to their office of this programme over there at Gantsa behind the local government secretariat.

Have you personally had complaints or problem?

There was something that I thought was a problem but it later turned out not to be. When my wife went to collect her first payment the battery of the computer ran out and so she could not be paid. The worker begged us to come over to their office at a later time because he could not pay her until her identity was verified on the computer. We went and she was paid. The second time her finger could not be recognised by the computer and she could not be paid but when we went to their office at Gantsa it worked and she was paid. These were the things that bothered me but they were resolved. Since then we have never had any problem.’

Kafin Madaki CS7 – Husband

Some complaints arise from a misunderstanding of the programme’s rules: in these cases (such as the case discussed in the extract below) the CVs and BRG have an important role in clarifying and communicating the rules on behalf of CDGP.

‘One woman complained that she has a baby, was enrolled on the programme, received the phone and since then she has not received her money. The reason why this happened was, we discovered that she had relocated to another village, and they told us that once a person moves out of this community to another, even if she comes with her baby, she will not be given the support. ... We told her it was because she relocated to another community where the programme is not being implemented, that was why they stopped the support.’

Keta KII – BRG member (female)

Disputes within households – for example disagreements between spouses about the control or use of the cash transfer – were said to be rare but when they arise they are also referred to the BRG or TWC (arbitration and counselling in domestic disputes is part of the normal role of the community leaders). In this extract, a male BRG member explains how they deal with husband-and-wife conflicts:

> 'Whenever there is a problem [between husband and wife], the beneficiary woman informs any of the women in the BRG group (a female volunteer), the female volunteer then informs me of the challenge. And I inform the village head. I and any other man delegated by the community leader then visit the woman's husband with the hope that the problem can be resolved even before getting to the community leader...
>
> In most cases we have been successful in solving the problem, and I return to the village head telling him the issue has been resolved, ... there is usually no need to call different parties to be part of solving the issue...
>
> In instances where we are not successful, we take the issue to the district head or village head who by virtue of his position in the society, he is supposed to ensure peaceful co-existence in the community. The community leader then summons the man and his wife and both parties are allowed to air their own part of the story in the presence of the BRG members. Then with this authority, the community leader helps us to find a common ground to solve the problem. But as a result of this programme, we are held in high esteem our words carry weight in the community.'
>
> Yankuzo KII – BRG member (male)

In Kokura, the Fulani community had complained to the TWC that they were being excluded from the programme, and this complaint had been passed on to the CDGP staff, who explained that the programme is only open to settled residents. Many of the Fulani pastoralists migrate with their livestock and are only temporarily or seasonally resident in the *rugas*. The staff member interviewed raised this as a problem with the CDGP eligibility rules, and suggested that the programme may need to develop a separate model for the pastoralist communities, to enable the inclusion of women with semi-nomadic or transhumant livelihoods. Fulani respondents in Kokura continue to complain that they are unfairly excluded. This issue is discussed further in Section 4.6.2.

Two other complaints were reported only in Kokura: one was about the behaviour of a CDGP worker, which was quickly and amicably resolved. The other was a complaint, mentioned by two beneficiary husbands, that money was being deducted from the women after they were paid, reportedly NGN 200 each for a CV and a local leader, making a total deduction of NGN 400 (although it was sometimes NGN 500 in practice, because they had no change). One respondent said that this practice had now been stopped after complaints. The other said that it was continuing. The field team were unable to investigate this issue further.

4 Thematic findings: Changes since baseline and perceived impacts

4.1 Consumption patterns and dietary practices

Across the seven communities, beneficiaries reported that both the quantity and quality of the food they and their families consume had greatly improved due to the CDGP cash transfer, the cooking demonstrations and the nutrition education. There was no notable variation in this finding by location, age group, education or polygamous vs. monogamous status, although the nuances of these positive changes obviously varied from household to household.

In terms of food **quantity**, beneficiaries reported an increase in meal frequency and an increase in snacking between meals, and that they were now able to feed their children 'as many times as they want'. They talked about eating to satisfaction, having three meals a day, and being able to snack between meals when they want to.

> 'The quantities of food we eat have changed greatly because we can now buy as much food as we [want]. We cook enough and we eat enough. In fact you can decide to buy and eat something else after the family meal.'
>
> Yankuzo CS3 – Focus woman

> '...now truly, we have more food that can go round my family unlike in the past where the food may not be sufficient for us.'
>
> Matseri CS5 - Focus woman

> 'Yes, we have more food, everybody can have enough to be satisfied unlike before where sometimes the food does not go round.'
>
> Yankuzo CS1 - Focus woman

Asked about changes in the **quality** of the food they are eating, many responses related to the pleasure and enjoyment of eating tasty or different foods, being able to choose what to eat, and regularly eating dishes that were previously only served at feast days or celebrations. Because of the cash transfer, pregnant women said that they can send out to buy foods they have a craving for, instead of waiting for their husbands to bring them something. Being able to eat something different for lunch and dinner, instead of the same thing every meal, was mentioned frequently, along with eating plain staples, especially *tuwo* (a stiff porridge or paste made from pounded grain, usually millet or sorghum), less often than before. Maltina, a soft drink fortified with vitamins and minerals, is a very popular purchase.

> 'The foods we eat in our household have changed greatly. I now add many ingredients in my cooking and also serve more salads and fruits. We also have more snacks these days.'
>
> Yankuzo CS3 – Focus woman

> 'You know in the past the only food we eat was *tuwo* (pounded grain)… but now, we eat different meals… we buy our bread and milk, and we eat fish in our meals, we eat rice, milk, maltina. We have reduced consuming *tuwo*!'

Yankuzo CS1 – Focus woman

> 'During this same dry season last year, we relied more on *fura da nono* (millet with milk) as our major food.'

Doka Gama CS3 – Focus woman

Many respondents, especially beneficiary women, also talked about the nutritional quality of the foods they are eating now, and described the variety of foods and ingredients in terms of dietary diversity and nutritionally balanced meals. People said that they are eating more protein or 'body-building' foods (e.g. fish, meat, eggs and beans), as well as salads and fruits. Women who had attended or heard about the cooking demonstrations described adding extra ingredients to their sauces, and changing their cooking methods to maximise the nutritional value of their meals.

Case Study Example 1: Better diet because of the cash transfer

M is about 30 years old, and is the second of her husband's two wives. M was pregnant at baseline, and has since given birth to a baby boy, who is now 15 months old. Both wives are enrolled on the programme. M has now been receiving the cash transfer for 16 months and regularly attends the cooking and childcare training. The CV also visits her and her co-wife in their home, to talk about nutrition and childcare. She now considers herself a 'much better cook'. M uses the money the way she sees fit, which might change depending on the situation. Mostly, though, she uses it to buy nutritious foods.

'I use the money to buy what I want in terms of food with good nutrition...

Money – I get happy and eat well! I used the money to buy beans, eggs, lemon, rice ... *alale* (bean cake), fish, red oil and groundnuts with soya.'

At baseline, M was earning her own income from petty trading. She is still doing so, but now she has expanded her inventory to include processed rice and *kuka* (baobab) leaves. This has proved to be a successful venture, much to the delight of her husband (himself a farmer and a fisherman).

'My wives have been engaged in petty trading the last time you came and now their businesses ha[ve] also improved because of this cash support they are receiving...

... every month they get this cash. I calculate what I used to spend that has been lifted from my shoulders because of this cash support.'

M is very happy to be able to buy the foods she wants, in the quantities that she wants. This situation is much improved compared to that at the baseline, when she said she was only able to eat what was available, which during the scarce period between harvests (typically August) meant eating fewer meals. M and her husband attribute the improvement in their situation this year partly to the good rains, which brought a good harvest, but they say the cash transfer has helped a lot.

'It [the quantity of food in the household] cannot even be compared [to the same season last year] because everything has improved.... In the past when *rani* came, these food[s] I told you we eat now were not available. But now because of this cash support this food can be bought and eaten at any time.'

'[The quality is] [m]uch better; we can now eat fish, canned milk and more beans. *Zogale* (moringa), salad. We rear more animals and we sell ... rice and *kuka* leaves. If you had come yesterday, you would have eaten plenty of fish from my supply. We get the fish from our nearby rivers...

... Now we eat better food with eggs, ... vegetables, beans, *taliya* (locally-made spaghetti), maltina (malt drink) ... and *suya* (grilled peppered meat).' **Kokura CS1**

Some people expressed pride and a sense of enhanced social status, because they are now able to eat like well-off or urban families:

> 'You know the type of food we eat in the village, now if somebody from the city comes all the food he is eating there he will get it here because all the food they eat in the city we have them and with the help we are getting, because business people come from far with varieties of things that you can buy there, ... they eat a lot of body-building food. And if you see a pregnant woman, you will not know that she is coming from the village because she eats good food.'
>
> Kafin Madaki CS4 – Husband

The same beneficiary husband further explained that because the cash transfer enables beneficiaries to purchase more of the foods their own households and communities do not produce, it reduces the seasonal variation in dietary diversity which was noted during the baseline:

> '[I]n the past ... people ate the food they had in season ... for example beans was eaten mainly during the cold season, but with the coming of this organisation, and the way they are helping pregnant women, people eat beans and buy the beans at any time of the year even if their husbands [do] not have the money to buy the beans ... with the money they are getting they can buy it by themselves ... For example spinach in the past was only gotten during raining season but because of this organisation ... during the dry season [we] can go to the people that do the irrigation farming (because in our place here we don't farm during dry season) ... to buy foodstuffs from the irrigation farmers to bring it for women. ...So the woman here can give money when her husband is going to the market to help her buy the thing she needs.'
>
> Kafin Madaki CS4 – Husband

During the rains fresh vegetables, including nutritious wild plants, are relatively abundant and can be collected for free. In the *rani* (hot, dry) season, when the midline fieldwork was conducted, fresh vegetables are only available from irrigated farms and access to them depends on purchasing power.

> 'We don't eat as well as we eat in the raining season but there are varieties because of the dry season farming. Now you find onions, tomatoes, carrots, cabbage, lettuce, moringa, watermelon and many other things fresh from the farms to the market. Some families are really hard up so they have to manage.'
>
> Keta FGD3 – Non-beneficiary women

4.2 KAP (health and nutrition)

The CDGP BCC component (see Section 3.5) aims to change people's understanding and behaviour in key areas affecting the health and nutrition of women, their children and the wider household. The priority BCC messages promoted by the programme are given for reference in Annex F. During the qualitative midline fieldwork we did not ask specifically about each of these messages but instead posed open questions about what the respondents had learned and what (if anything) they had changed as a result. The contents of this section therefore reflect the areas of

learning and change raised by the respondents (in addition to the changes in diet and cooking practices, which also relate to the impacts of the BCC messages, discussed in Section 4.1. above).

4.2.1 Breastfeeding

The most striking change in these communities since the baseline, in terms of KAP relating to childcare, health and nutrition, is the now widespread understanding and adoption of exclusive breastfeeding (giving the baby nothing but breast milk, and specifically no water, until the age of six months). During the baseline discussions few people knew about the government-backed advice on exclusive breastfeeding, and most of those who had heard it (for example, from hospital staff) were sceptical or said they were unable to practise it. By contrast, during the midline, almost everyone who talked about this issue was able to repeat the BCC message, and a number of beneficiaries mentioned the pictures shown by CVs to explain the differences in health and development between babies who were exclusively breastfed and those who were not. Many women said they had adopted exclusive breastfeeding and had seen the difference in their babies' health and development, compared to earlier children. Husbands of beneficiaries were generally aware of this new advice and were supportive, and many commented on the better health of their children.

> 'My wife and I have learnt about the usefulness of exclusive breastfeeding, this she has done with the last child. When you see him, he looks much healthier compare[d] to other of our children who were born earlier. Before, our wives breastfeed and equally feed newborns with food that adults do eat, but now that has stopped. Our wives give only breast milk to new born and they do that for the length of six months.'
>
> Matseri CS6 – Husband

This change in breastfeeding KAP is not limited to direct beneficiaries: the new knowledge seems to be widely shared in the communities.

> 'Another aspect that we have experience[d] change as a community is people['s] attitude towards exclusive breastfeeding, the programme has reoriented and created awareness among household about the significance of good diet in the lives of children and women.'
>
> Keta CS4 – Husband

Case Study Example 2: Adoption of exclusive breastfeeding

Z is in her twenties and is the only wife of the household head, who is a farmer and a trader. Two months before the midline data collection, Z gave birth to her third child, a baby girl. She has been receiving the cash transfer for about eight months.

Z uses the money so that she and her husband and children are able to eat well. She often sends her husband to the market to buy the foods that she wants.

'Now we eat various things because we are getting that money. When we get the money, I buy yam, rice, beans, spaghetti, vegetables and fruits, we combine them in different forms and eat; like rice and beans, spaghetti and beans, yam and vegetables and others like that.'

She typically gives about NGN 500 to her husband, and gives some small gifts of NGN 50 or NGN 100 to other women in the household. She also contributes about NGN 1,000 monthly to a savings group *(adashe)*. Z had a small home-based business at the time of the baseline, but since then she has expanded and diversified her business:

'I have been able to expand my business, you know the last time I told you I sold *tuwo* (paste from pounded grain), now I sell *kuli kuli* (groundnut cakes), I buy it wholesale from the market and re-sell here. I also sell spices (Maggi).'

During the *Damina* (rainy season), both Z and her eldest daughter contracted malaria, which is quite common in Doka Gama due to the bush and areas of stagnant water. However, she was able to buy drugs from the health centre in Wuya, and both have fully recovered. Other than this incident, Z is happy that her family is healthy. She and her husband are particularly happy with the health of their youngest child. They both believe that the more nutritious foods they are able to buy as a result of the grant have contributed to the health of their baby. As she says, 'You know if someone does not eat to satisfaction, the breast milk will not flow.'

Z regularly attends the CDGP group sessions, where she enjoys the cooking demonstrations, learning about nutritious foods, breastfeeding and complementary feeding practices, hygiene and other childcare considerations.

In the baseline interview in 2014, Z said that she gave her babies cow's milk for the first two days before starting to breastfeed, and that she also gave them water in addition to her breastmilk in the first six months. Now, as a result of what she learned from the CDGP sessions, Z is practising exclusive breastfeeding with her newest baby. Both Z and her husband believe that the new baby is healthier than their two previous children because of this new practice. Her husband commented:

'Yes, she started exclusive breastfeeding with our new born child, you need to see how strong and healthy she looks...

...[M]y newborn child who my wife gave birth to as a beneficiary is better than the other children who did not enjoy this opportunity, if not because she is sleeping at the moment I would have ask[ed] them to bring her here for you to see how healthy she is looking.'

Doka Gama CS1

Non-beneficiaries also said that they have observed a reduced incidence of diarrhoea and fever among babies who are exclusively breastfed, which is causing them to appreciate and in some cases copy the practices of the beneficiary women. For example, in Yankuzo the women in our non-beneficiary focus group said that the beneficiary women pass on what they learned from the BCC activities. They stated: 'We change! Even though we do not receive the money, we have

changed our behaviour.' Within this group, knowledge and adoption of the breastfeeding practices promoted by CDGP varied, as the following extract from the discussion shows:

> 'R4: No you do not have to wait to wash him, you must not wash him before placing him to suckle, once you deliver your baby, you put him to suck and then breastfeed exclusively for six months before you begin to give water and other food.
>
> Interviewer: Yes, but are [you] practising this?
>
> R5: Honestly, we have not started.
>
> R6: I have started, I breastfed my son exclusively for six months.
>
> R4: Me too and I saw the difference because those frequent diarrhoea and fevers – he did not suffer them.'
>
> Yankuzo FGD3 – Non-beneficiary women

4.2.2 Accessing health services

A number of beneficiaries said whenever they or their children need health care they now go early, because they can pay for it themselves.

> '[My health and my children's health] has improved a lot honestly... Because once my children are ill, I am able to take them to the hospital promptly, I do not even wait for him [my husband] and so we tackle ailments before they become severe.'
>
> Keta CS4 – Focus woman (beneficiary)

> '[I]n the past if they are ill because of the cost implication at the hospital, we keep trying to remedy the illnesses in our homes. Because of our financial status, we will keep these children in the house and hope that they will get better someday. A child will suffer an illness from childhood and we will not take him to the hospital, then we watch them grow up with this illness, when he is grown up we will start seeing the effect of that ailment that did not receive medical attention, which could have been treated easily in the hospital. But now, as soon as a child becomes ill, you can take him to the hospital immediately to receive medical attention before the situation worsens, because we can afford the cost.'
>
> Keta CS5 – Focus woman (beneficiary)

On the other hand, some respondents (particularly husbands, e.g. in Kafin Madaki) commented that their expenditure on health care has gone down because the beneficiary women and their babies are healthier, so there is less need to go to hospital especially during pregnancy.

Attendance at ante-natal care clinics was said by some key informants to have increased since the start of the CDGP. It is not clear how far this is attributable to the programme, although ante-natal care attendance is one of the priority BCC messages. Most of the participants who talked about this issue were aware of the advice that women should attend regular ante-natal care sessions while pregnant (see Annex F).

4.2.3 Sanitation and hygiene

Respondents across all the sites stated that hygiene practices (such as handwashing, washing utensils and keeping flies away from food) have improved because of the BCC messages, group sessions and home visits. Women are said to take more pride in the cleanliness of their children, their homes and themselves. For example, this beneficiary in Matseri explained how the hygiene lessons, together with the nutrition education, had changed her housekeeping practices:

> 'Everywhere is always clean and I am now very conscious of areas where dirt can accumulate. I wash my cooking utensils as soon as I am done with them. We don't overlook muddy areas now if we see that water is accumulating anywhere my husband clears it and fills up the hole. We dress better and our clothes are always clean...
>
> ...I have learnt so many things. I am a better and more creative cook now. I am a better wife and a mother now because I have learnt better housekeeping practices. I have also learnt how to take care of myself as a care giver....
>
> ...In the past I thought a full belly meant one has eaten well but now I know that for one to get the right nourishment meals have to be balanced. I also know the implication of ... hygiene practices like rinsing plates before serving in them even though they have been washed the previous night. Sanitising what and where our children eat. Keeping my environment clean actually makes me feel proud of my home.'
>
> Matseri CS9 – Focus woman (beneficiary)

> 'They also tell us that if a child defecates, we should wash our hands with soap before feeding him, whether breast or food.'
>
> Keta CS3 – Focus woman (beneficiary)

> 'We were taught how to bath children, wash their clothes, cleanliness and hygiene.'
>
> Kanyu CS3 – Focus woman (beneficiary)

Some men mentioned that the local imam had preached in support of the new hygiene practices, and many beneficiary husbands expressed appreciation of the improved cleanliness of their homes and children. For example, the husband of the beneficiary just quoted said:

> 'I learned many things [from the CV's home visits]. Every morning I ensure that the baby is bathed with warm water, the compound is swept and food is prepared for the house in a hygienic manner... Because of th[is] enlightenment we get there is an improvement in the cleanliness of our home. The house is swept as a[nd] when due, the toilet is cleaned well because the toilet can breed germs, food is not exposed to flies, the children are bathed and dressed well.'
>
> Kanyu CS3 – Husband

4.2.4 Impacts on health and nutrition

Various respondents, when asked open questions about changes, commented that the health of beneficiary women and their babies was visibly better than before, and better than non-beneficiaries. They observed that the women were a healthier weight and their skin looked better; that their babies were bigger and developed earlier than previous children; and that women who were well-nourished during their pregnancy had easier births. These changes were attributed by the respondents to the improved diets and changes in breastfeeding practices brought by CDGP.

> '[A]s a result of the programme you will see the behaviour and energy of the children is different from the days of the past because of improved health. Even now, if you compare the children of women benefitting from this programme and those of the women not benefitting you will see a clear difference in behaviour; the benefitting children play with energy while the non-benefitting children do not.....
>
> ... Before this programme started, when a woman is pregnant from the early stage she would continue having problems because there was nothing to eat that would build her body and make the child healthy. But in this programme she eats and drinks good food that will build her body such that even when she gives birth it will be safe. In fact some women give birth without anyone knowing unless she tells them after. As against the past, even though it is fate, when some women were giving birth they had to be taken to the hospital and additional blood and other things must be sought for. But as a result of this programme they give birth with no problem.'
>
> Kanyu FGD2 – Beneficiary husbands

Some of the respondents showed a recognition of the link between 'body-building' or 'blood-building' foods and anaemia in pregnant and lactating women. The CDGP has enabled women to purchase such foods, and there appears to be a better understanding of the health benefits associated with the intake of these body-building foods, particularly during pregnancy.

> 'In the past, without the CDGP support, there were a lot of occurrences of pregnant women running into difficulties like anaemia, partly because we had been unable to afford blood-building food for them as a result of our poverty. However, with the commencement of this programme in our community through the help of almighty Allah some of these problems have been mitigated. We are happy with the new turn of events because as a result of the grants that the pregnant women receive, the women are able to buy body-building and nutritious supplementary feeding that would help them to go through pregnancy and child birth with less of the problems that we used to encounter.'
>
> Kanyu CS1 – Husband (non-beneficiary)

On the same subject, a CHEW in Keta expressed the view that the knowledge brought by the CDGP has been as important as the money in reducing anaemia and the need for blood transfusions:

> '[T]he knowledge they acquire in knowing protein as a body-building food and carbohydrate as energy giving food is more than money and it is a good knowledge because a woman can now combine food to achieve balanced

> diet. This knowledge wasn't there before and that is why you cannot compare the beneficiaries with the non-beneficiaries if you look at the nature of their bodies. With the knowledge they are now able to combine little things and get a balanced diet. [Before] the programme you see if a woman goes for haemoglobin test, she will have 40%, 50%, instead of 100%, and so before this can be balanced or sufficient you must have to give three to four pints of blood to that woman.'
>
> Keta KII – CHEW

4.3 Household decision-making and resource management

4.3.1 Control over, and sharing of, the cash transfers

Across all the communities and the different categories of respondent there was general agreement that the CDGP cash transfer is for the woman and she should decide how to spend it. Everyone interviewed on this subject said that if a husband were to try to take the money from his wife she should complain to the CVs or TWC, who would intervene.

> 'Our pregnant and nursing mothers were told that if they have any problems they should speak out.... they should report to the CV, for instance when after the woman collects her 3,500 and her husband threatens or tries to bully her to collect the money, she can go back to the CV's and ask "who was this money given to?" and the CVs will say the money is for you don't give him, after which the CVs will call the husband and tell him that the money is not meant for him. [W]e are grateful that in this community we have never experienced such a thing as the husband trying to bully his wife and collect the money from her.'
>
> Kanyu FGD3 – Non-beneficiary women

The men are also generally supportive of this principle, recognising that even though the money does not come into the husband's hands it benefits his children and the household as a whole, and also benefits him individually because it reduces the pressure on him to provide money for food:

> '[T]his cash support does not come into the hands of men, it comes into the hands of women and they do not give their husbands the money but they use it to buy what to eat.'
>
> Kafin Madaki CS2 – Husband

Within the beneficiary households, decision-making about what to spend the money on (including what foods to buy) is varied and nuanced, as expected. No systematic patterns were found in the qualitative data, but factors such as the size of the household, the age and status of the wife, the personal relationships among the women, and between the woman and her husband, and the significance of the cash transfer amount (in relation to the previous income of the individual woman and of the household) are likely to affect how much discussion or consultation there is about the use of the money. Some of our beneficiary respondents said they decided alone, without asking anyone else. Many said they consulted their husband or discussed the purchases with him, but that the money was theirs to spend. As it is usually the husband who goes to the market for major food purchases (apart from the snacks and condiments traded among women in the community), most women said they would tell him what they wanted him to bring, but some added that he might also exercise discretion, depending on what he found for sale. Some beneficiaries took advice from

their mother-in-law or senior co-wife on what they should buy. In households where the husband was temporarily absent (for example, on seasonal labour migration or trading), his mother or senior wife might take over his role as decision-maker. No examples were found of cases where the husband alone had decided how the CDGP money should be spent.

Many of the beneficiaries said that they voluntarily give a small share of their cash transfer (most often NGN 500, in some cases up to NGN 1,000) to their husbands. They also give small amounts to other women in the household (especially mothers-in-law and co-wives), and sometimes to their own parents or other people in the community. Sharing of the food purchased and prepared by the beneficiaries, both within the household and with neighbours, is common-place and seems to be an expected social norm. Such voluntary gift-giving can help to smooth relationships, enhancing the beneficiary woman's social capital and status (see the section below on relational wellbeing): this should be clearly distinguished from enforced levies or requirements for the beneficiaries to pay for any of the services provided through CDGP. Very few of our participants mentioned any such payments. The notable exception was the complaint in Kokura that NGN 400 had been compulsorily deducted from the women's money after they received it (this example is detailed in Section 3.6). However, as noted in the methodology section, it is likely that any problems of this kind would be under-reported to the field team.

Case Study Example 3: Household relationships and decision-making

U is in her early twenties and is the only wife of the household head, who is a farmer. She was pregnant at baseline, and has since given birth to a healthy baby boy, who is now 12 months old. During the midline interview she revealed that she is expecting once again, and although she is experiencing stomach pain intermittently, is visiting the hospital regularly and is generally feeling happy and healthy.

U has been a beneficiary of the CDGP for about 14 months, and is also a CV. In this role she holds monthly meetings for the beneficiary women on nutrition, care and hygiene, and visits beneficiary households in the area. She enjoys being a CV, and it is a source of pride in her household.

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

She says she does not share any of the money with anyone else, and does not save any. She does consult with her husband regarding what the household needs, but '[n]o one but myself make[s] use of my money'. Her husband agrees, saying: 'I make the decisions in the house but she decides what to do with this cash support when it comes in.'

She believes that the household eats much better now, partly because of a better harvest, but also because the money allows her to buy foods she wants. U regularly shares the food she makes with the other members of her household, including her mother-in-law, who says:

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

Both U and her husband are happy that the extra income is controlled by U, and believe this has reduced the pressure on her husband to provide for the family, and improved their relationship. As he puts it:

'there is more understanding… in the past a woman expected the husband to take care of her needs and it could be that the husband did not have resources at that time. Now [with] this cash support,

when the husband does not have, she has [and] would not bother him. In this area there is understanding of each other greatly.'

His mother (U's mother-in-law) feels the whole household has benefitted:

'I tell you, sincerely we are living happily. The wife, the husband, the mother-law, and the father-in-law, everybody is happy. Where the husband or father cannot provide, this programme has bridged that gap and that's the end!'

Kafin Madaki CS2

4.3.2 Uses of the cash

The qualitative interviews did not attempt to quantify the frequency or amount of expenditure on different types of item, but they did explore the range of things beneficiaries said they spent the cash transfer on. Food was the first item mentioned by all respondents, specifically the types of food mentioned in Section 4.1 under dietary quantity and quality. Health care was also often mentioned: many women said they took their children to the clinic earlier, or without needing to wait for their husbands, because they could afford to cover the costs themselves. Clothes for themselves and their children, school equipment for older children, and household goods, such as cooking equipment and mattresses, were also bought by some beneficiaries.

Spending on productive assets or working capital, with an eye to securing their future income after the programme ends, was important for many of the women interviewed. In some cases part of the cash transfer itself was used for this purpose, in others it enabled beneficiaries to re-invest business profits, which were previously spent on feeding the family. This is discussed further in Section 4.4 on livelihoods and income.

Some beneficiaries were also saving part of their cash transfer through regular monthly contributions to local rotating savings associations *(adashe)*. With this type of association, the members take it in turn to receive the whole pot and are thus able to make major purchases without taking on interest-bearing loans.

In the Jigawa communities, participants (key informants, focus group participants and case study individuals) consistently said that the CDGP had instructed beneficiaries that the cash transfers were to be spent only on food, and not for other purposes (specifically not for saving or investing in businesses or assets). Given this clear instruction, it is not surprising that very few beneficiaries in the Jigawa sites mentioned spending any of the money on anything other than food. It is impossible to tell from the data collected whether the women in Jigawa had indeed used the money only for food (unlike many of their counterparts in Zamfara), or whether they simply, and understandably, did not want to say they had used it for anything else.

4.4 Livelihoods and income

4.4.1 Women's livelihoods

In Zamfara, many of the women beneficiaries among our participants are investing part of the cash transfer in their own businesses and future income sources. The types of productive investment mentioned include livestock (particularly goats), commodities for trading (such as seasonings and higher-value ingredients like groundnuts for processing), and, in the following example, a knitting machine:

> 'I ... invest part of the money I am getting ... I am making a lot more now and I am saving more too. I was able to buy a knitting machine with my savings. I hope to start making adult and children's wears with the machine and that will be very profitable as it is not very common here...'
>
> Keta CS3 – Focus woman (beneficiary)

Even if all the transfer amount is spent on food and health (as is apparently instructed by CDGP, particularly in Jigawa), the increase in the beneficiary women's income is fungible and frees up money they would otherwise have been spent on food. Without the transfer, the small income women make from home-based food processing and sales is often spent mainly on supplementing the household food supply. With the additional income from the cash transfer beneficiaries say they are able to re-invest some of their profits and expand their businesses, boosting their future potential income, as in this example:

> 'I make and sell *hoche* (sorghum cakes) and before the cash grant, we would eat a lot from what I make for sale and therefore [I] would not get any cash profit. And that's how the cycle was. But now with the cash grant ... I can take some of it and buy food for the house when my husband does not have and that way I am able to sell and make profit from the *hoche*. I now make better income from the sales that I make and with the additional cash in circulation I also sell *gala* (meat roll) now.'
>
> Doka Gama CS3 – Focus woman (beneficiary)

This beneficiary similarly explained how the profits from her small home-based business selling *danwake* (bean dumplings), *awara* (soya cake) and *koko* (millet balls) were previously 'going back to our mouths', but now she is able to increase her capital:

> 'Before ... I [would] use part of my profit to feed my children but with this money all I have to do is to use some for feeding while I use some part of the money for capital for my business, so the income of the household and mine, I'll say is better compared to the years before [when] the little I made was going back to our mouths again.'
>
> Kokura CS2 – Focus woman (beneficiary)

In some cases, by contrast, women who were previously spending time on income-generating activities said that they had stopped their business activities since receiving the cash transfer, because they can now manage without the money they were making. This reduces physical stress on the woman (depending on what type of work she was doing), and potentially frees up more of her time for childcare. Some husbands similarly said that the reduced pressure on them to provide food for the household means that they are able to reduce or stop some types of work. This effect has the potential to change women's and men's time use, as envisaged in the theory of change (Annex A).

Case Study Example 4: Effects of the cash transfer on household income and wealth

H is about 40 years old, and is the second of two wives of the household head, who is a trader and farmer. H was pregnant at baseline, and has since given birth to her 10th child (a baby boy). Since the baseline, three women within the household (H, her co-wife and her daughter-in-law) have become beneficiaries of the CDGP. H herself started receiving the cash transfer just after she gave birth, and has now been a beneficiary for about a year.

H uses most of the money she receives to buy food. She also saves some, buys clothes for the baby, and gives small gifts of NGN 100 or NGN 200 to other household members. She does not give any of the money to her husband. Recently, using some of the cash transfer and some money from her husband, H has started her own business producing local spaghetti. Previously, she only did small paid jobs, like grinding corn. She believes that the cash transfer has had positive effects on the whole household:

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

The two wives take turns to cook for the household, and they go together to the CDGP meetings. Relations within the household are harmonious. H says the quality of their meals has improved, though the quantity they eat has not really changed. Decisions about what food to buy are made jointly by her and her husband, who is the one who goes to the market:

'My husband does the purchases, I tell him what we need and sometimes he decides on his own... I specifically give him the money for that, or I send my son.'

H's husband explained that the additional regular income from the programme is a significant amount for his household, and it has also enabled him to invest more in his farming and trading activities.

'[F]or us having NGN 3,500 come into the house monthly is an improvement, it is a remarkable change by our standard. Everybody in the family is happy, better than before. You know money solves a whole lot of problems...

Honestly I use[d] to be under pressure, pressure of providing for the family as the head of the family, but now the pressure is less I invest more into my farm ...

[Household income] has ... increased. We do business and also from my trading and selling of livestock, it has increased adding the cash transfer to it which is more of something constant. Formerly it was just on me [the responsibility of providing for the household], but now there is alternative source and as such, reduced pressure [laughing].'

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

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

Matseri CS7

4.4.2 Household income and food security

Many of the case study husbands stated that they are able to re-invest more of their own income and time in their activities – or towards new livelihood activities – now that the pressure of having to provide money to pay for food for the household is somewhat relieved. Additionally, some of the beneficiary women will give a proportion of their income to their husband for this purpose. In some

cases the additional income has allowed husbands who rely on agriculture to rent more land, hire workers if necessary and afford fertiliser. Some said that they were able to spend more time on their own farms because they did not have to engage in stop-gap activities or labour migration to meet the short-term income needs of the household, and that this had led to increased farm production and more food stocks for the year.

> ‘Looking for money takes me to different places outside this town. But since this support came I can afford to stay at home to concentrate instead on my farm without having to worry about what my family will eat.’
>
> Kanyu CS3, Husband

> ‘In the past, as a farmer, in order to earn some money to meet some domestic needs, one may have to go and labour on the farm of a wealthier person in order to be paid some money. The change that has now occurred with the coming of the CDGP is that since God has assisted us with the grants to support the feeding of the family, the man now concentrates on working full time on his own farm, which has now increased the volume of harvest that our land yields. The man is now relieved from having to work on another person’s farm for a small fee, instead he puts his energy and attention into tending his own farm better and yielding a better harvest. With a better harvest, the storage of food stuff in the house is also increased.
>
> ... the men are freed to some extent from looking for daily bread and therefore have more time to tend the farms in the morning, then come back to take the animals grazing in the evening, with the assurance that the women have something little to facilitate processing the feeding of the family, which otherwise would have been the added responsibility for the men to hustle for. As such, the yield from the farm and the livestock has improved compared to previous years.’
>
> Kanyu CS1, Husband

Households’ grain stocks from their own production last longer, because of reduced pressure to sell the harvest to meet monetary needs, and because they have the purchasing power to buy other foods to diversify their diet and thus consume less of their own sorghum and millet. This means that the household is able to provide for itself for more months of the year, and is therefore less exposed to rising market prices for staples during the lean (rainy) season before the next harvest.

This effect applies to other foods produced by the household, not only grain stocks. Beneficiaries also comment that, because of the extra cash in the household, they are able to sell less and eat more of their own production of high-value nutritious foods, such as eggs, fish, meat and beans. As this nutrition-trained CV from Kokura explained:

> ‘Our people are farmers, in dried products and raw produce, water melon, banana, we sell them in the market, but when this CDGP arrived, we now eat half of the nutritious food and are happy. ... We used to sell our chicken we rear and guinea fowl and the eggs we sell them off, then with the coming of the *kungiya* (association, i.e. CDGP), we sell half and eat the rest, so we get good food. We catch fish, we slaughter animal[s] and sell them. [I]n fact the offal, kidney, liver etc., we [used to] sell off, but when this *kungiya* came ... now we eat them.’ Kokura KII – CV (male)

Other husbands of beneficiary women, like the women themselves, have been able to invest more in their trading and other businesses, thus increasing the overall household income:

> '[Our household income] has indeed improved, I usually sell furniture and this has improved, I have earned more compared to the time there was no such money coming from CDGP. It has helped because I am able to put in my profit into expanding the business. Before it is not possible because it is the profit that one uses to feed the family but now with the 3,500, I have less of the weight of providing for the house.'
>
> Yankuzo CS4 – Husband

Non-beneficiary men and women have also seen their businesses and incomes boosted by the influx of cash into the community, as summarised in the next section.

4.4.3 Economic multipliers and market effects

Beyond the beneficiary households, community members said that they are benefitting from the increased economic activity, the influx of traders and commodities for sale, and the general increased circulation of cash brought by the CDGP. The field teams observed new shops in the villages, and greater availability of purchased treats, such as maltina, compared to their previous visit during the baseline fieldwork. As this beneficiary husband put it:

> '[B]efore ... you will have to go to the middle of town before you can buy anything .... but now ... all the things you know from canned malt, to peak milk, to juice, to yoghurt, all the things you know to enjoy life, you will get them in shops in this village.'
>
> Kafin Madaki CS4 – Husband

Our interviews suggest that many, if not most, of the businesses and individuals supplying these foods to retail customers, as well as other commodities and services, are local. Thus, one effect of the increased demand for goods and the general circulation of money is to raise the incomes of non-beneficiaries, spreading the benefits of the CDGP within the community. This includes women, many of whom are engaged in home-based food processing and trading activities, buying and selling among themselves. Children are commonly employed to 'hawk' women's goods from household to household, so this type of economic activity may not be very visible in formal market places.

> '...[I]ncomes are better now because the beneficiary women buy more things from us. Whatever we produce or buy now is sold faster and that way we are now able to save and do more things for ourselves.'
>
> 'We are also eating more and better now.'
>
> Doka Gama FGD3 – Non-beneficiary women

Women-to-women services and casual employment are also boosted, as this extract illustrates:

> 'They [beneficiaries] help us in many ways. They can give us money to work for them or tasks to do for them and pay us. Like they can give us groundnuts to extract oil and make cakes for them, or rice to process. This helps us to develop capital.' Matseri FGD3 – Non-beneficiary women

In the following extract, a group of non-beneficiary women in Yankuzo give several examples of how their own and their husbands' incomes are increased by the circulation of cash and the greater demand for goods and services when the beneficiaries receive their monthly transfers:

> 'R9: Our business has grown ... Because whenever they collect their money, they come and buy commodities from us, we also have increased through such means.
>
> R10: ... [T]he day they said they were coming to give the money, I made two pots of spaghetti, I always wish that the day they will come to pay will be Saturdays so that there is no school, so that my children can keep coming to carry the foods for sale...
>
> ... R5: For me when they give the money, there is more money in the community, my husband can carry people on his bike and return home with money to fend for the family, we too enjoy the situation; we can have different meals for lunch and dinner respectively ...
>
> ... R3: The programme is good, like for me and others that our husbands teach (Arabic teacher) every Saturday, they give them money, but when they did not used to pay them, we did not used to get this money and especially during the periods they receive this money, they even give alms to the teachers, we are able to buy food, buy those that nourish us, eat and be satisfied, we are grateful...
>
> .... R9: We have experienced progress because my husband is a businessman, he goes to [another state], buys wares and brings them to this community to sell, we make profit from this and are able to move on with our lives, and as a housewife I do my own petty trading, when they get their monies they come to buy things from me which they eat and I am also able to make my own money.'
>
> Yankuzo FGD3 – Non-beneficiary women

Non-beneficiary men also benefit from the increased demand, and this group noted that beneficiaries among their customers are able to pay them immediately, without asking for credit:

> '[W]e have more sales now compared to the time you came. Business thrives more especially during the periods when these women receive their money, whatever you are selling in relation to food will have high patronage....'
>
> 'You will sell your commodities and receive your money immediately, not give them out on credit. They will not be coming to tell you "*please give me some time to do so and so and get money"*, but immediately you give your goods, you get your money.'
>
> Matseri FGD4 – Non-beneficiary men

Concerning credit and debt, some participants (e.g. Yankuzo FGD3) commented that the regular predictable income from the cash transfer makes it easier for beneficiary women both to obtain a loan and to repay it:

> 'When you don't have money to buy something you can always collect what you want in credit and by the time you are paid the 3,500 Naira you can always pay back.'
>
> Kokura CS2 – Focus woman (ex-beneficiary)

On the other hand, others say that because of the cash transfer there is less need to borrow to provide for the family. As one beneficiary husband (Kafin Madaki CS5) put it, because he does not need to borrow he can 'cover his secrets' (avoid exposing his financial problems to others). This view of borrowing as something potentially shameful was expressed by a number of participants, for example in this FGD:

> 'During *rani* money is difficult to get. You may be able to get what to feed your family but nothing more. Sometimes you are even ashamed of borrowing because the person gets to know that you do not have anything.'
>
> Kokura FGD4 – Non-beneficiary men

4.5 Risks, shocks and coping

Three main types of risk were identified in these communities during the baseline and situation analysis:

- seasonal variations in income, food availability and health problems;
- natural hazards, especially drought, flood, crop pests or livestock diseases, which exacerbate seasonal shortages in a bad year or unpredictably affect food production and other income sources; and
- insecurity (man-made hazards, mainly theft and violence).

Because the CDGP cash transfer is a regular, reliable monthly income source across the seasons, beneficiaries say it helps them to reduce the seasonal fluctuations in diet and to sell less of their farm produce so their grain stocks last longer through the lean season (see Section 4.1). It can also be a safety net for times of stress, as some of the examples in this section show.

4.5.1 Seasonal and natural hazards

In the period between the baseline and midline data collection a number of natural stressors affected the communities to differing degrees. Matseri, Keta, Yankuzo and Kafin Madiki communities reported some instances of flooding, which destroyed crops or led to poor harvests. In Kokura and Kanyu a shortage of rainfall in the 2015 *damina* (rainy season) period led to a reduced harvest for some households in this year (the impact appears to vary depending on the type of crops grown, field location, timing, luck etc.). This type of problem seems to be regarded as part of the normal risk and unpredictability of farming.

In a number of communities (Matseri, Keta, Yankuzo and Kokura) pests have caused additional stress on farming. Both insects and birds are cited by many as a real problem affecting crop production and food security. Birds were particularly problematic in Kokura during the *kaka* (harvest) and *damina* (rainy) seasons, damaging sorghum and rice crops:

> 'R2: What I will say is that during *damina* there were birds that came to bother us, both the well-off and the poor that farmed were affected. At first

the birds invaded sorghum and there were farms that even a single ear was not harvested.

R3: And you see this sorghum is our food.

R4: Sincerely, this sorghum, there are some farmers that did not harvest anything. Before he finished the early morning prayer and go they have finished with the farm.

R5: After the sorghum they descended on rice which was beginning to become ripe until towards the end of the rice harvest that Allah scattered them away and people had some relief.

What did you do to cope with this? Was there any outside help?

R1: ... What we do is to go to religious teachers for prayers. They gather to pray for us and by the will of Allah we are having respite....

R4: Sincerely, there is no help....

... R1: The help you get is one. If Allah has it that you have a brother he can help you, is it not true? If you have a relative that is able he can help you.

R2: Even the one you are depending on may be affected. Let us say the truth. It is not possible to get any donation.

R3: If you say you will depend on Zakka (Islamic tax meant for charity) you may not see anything.

R4: If you have the strength you have to stand up and look for what to eat.'

Kokura FGD4 – Non-beneficiary men

The range of options for coping with such risks and losses can be seen as an extension of the usual seasonal strategies: people borrow, ask relatives and other community members for help, and look for income from other sources.

'This problem of *damina* that you talked about, every household head that is affected tries to find solution for himself, there will always be a way out, because shortage of rainfall is what brought the problem, some harvested food some did not.'

Kanyu FGD4 – Non-beneficiary men

'...this Fadama (Baturiya Wetland) has been flooding our husband's small farm; but thank God his brothers at Hadejia and Nguru do help him.'

Kokura CS6 – Focus woman (non-beneficiary)

Income diversification options vary from place to place, and are not necessarily negative. However, men do sometimes resort to harmful strategies, such as illegal firewood collection, as explained during this FGD:

> 'When these birds eat our crops we all have to go in the government forest to look for food. Some do not have what to eat today until they go, cut this firewood and come and sell before buying food. There are many farms that were invaded by birds and after this farming is over we have no other means of livelihood except this hard labour, either you cut *kaba* (palm leaf) or you go into the government forest to cut firewood. And you are afraid because when forest officers see you it is a problem. Even without these birds, it is not every farmer's harvest that can last up to 10 months and farming is what majority depend on here.'
>
> Kokura FGD4 – Non-beneficiary men

4.5.2 Insecurity

The third main type of risk, insecurity, severely affected Doka Gama (in Anka LGA, Zamfara) in the months before the midline. After a series of violent cattle raids many people (including four of our nine case study households) had in fact left the village to stay with relatives in other towns or villages, because they felt unsafe in their own homes.

> 'We are living under fear every day, we are always under attack from cattle rustlers. They attack us in the night and now the whole community is in fear.'
>
> Doka Gama CS3 – Husband

In addition to the livestock losses, crop production has also been affected by the insecurity, as explained by one of our case study participants:

> 'My household food production would have been better if not for the insecurity we are experiencing now. Most people cannot go to the farm due to the fear of bandits' attacks. Many people ha[ve] been killed in their farms...'
>
> Doka Gama CS1 – Husband

To a lesser degree, Matseri (Anka) and Yankuzo (Tsafe) have also been affected by banditry and livestock theft since the baseline, as the following extracts explain:

> 'After you left, bandits came in and stole our camels, cattle, sheep, and goats. They tied our shepherds and beat them up. None of the animals has been retrieved up till now.'
>
> Matseri FGD3 – Non-beneficiary women

> '[W]e have been attacked several times in this community from cattle rustlers; we have not had help from the government about the killings and stealing going on in our community.'
>
> Yankuzo CS2 – Husband

In response to these attacks, the men in Yankuzo and Doka Gama have formed a community watch group (Yan' banga). Other than this, the only coping strategy available (apart from leaving the village) is to ask the government and security forces for help. Most of our participants who

discussed this felt that little or nothing had been done to help them, but some action has reportedly been taken more recently:

> '[T]he public reported the case to the government, those that are closer to the place, because they have been coming and seeing the situation we are faced with. So now we are enjoying their efforts.'
>
> Doka Gama KII, BRG member (male)

For a household, even if all the people escape unhurt, such thefts of livestock (particularly of large and valuable animals, like cattle and camels) represent a sudden and potentially catastrophic loss of assets. For CDGP beneficiaries, the income from the cash transfer may help the household to cope with day-to-day needs while they try to recover from such a blow (as in the case study example below), but it is unlikely to be enough to make a significant contribution to restocking.

Case Study Example 5: Coping with insecurity

Z is about 17 years old and is the only wife of the household head, who is primarily a farmer but also occasionally works as a motorbike taxi driver during the off season. Z became pregnant soon after the baseline period and was enrolled into the CDGP. She gave birth to a baby girl, who contracted a viral illness before her first birthday. Z immediately took the child to the hospital in Wuya when she recognised the symptoms, but tragically she passed away. At the time of the midline data collection Z is pregnant again, and feels happy and healthy. She is now re-enrolled on the programme.

Z is one of four CDGP recipients in the household, and they enjoy going to the group sessions together and discussing the things they learn.

'Across the household the relationships have improved. I and the wives of my husband's elder brothers are all beneficiaries so we are always exchanging ideas and consulting each other.'

Z uses most of the money she receives from the CDGP to buy nutritious foods. She also shares a portion of it with her family, while also investing a little every month.

'Whenever I collect the NGN 3,500 I give my husband NGN 1,000, my father-in-law and my mother-in-law get NGN 100 each. I usually give my husband NGN 1,000 or NGN 500, depending on my needs for that month. I give my mother and father-in-law NGN 100 each and I also give my mum and dad NGN 100 each and then I contribute NGN 500 in a thrift organised by beneficiary women. The rest of the money I spend on food stuff and other things that will enable me to cook balanced meals to meet our nutritional needs.'

Z also now runs a small business, which, combined with the CDGP allowance and a successful yield from the past year's farming activities, means she feels the household is currently doing well.

However, it has not always been so easy during this period. Doka Gama has been subject to a number of raids and attacks, which have caused much distress, and many people have fled to the safety of Wuya town. Z and her family have been personally affected by this banditry, losing many of the assets and stocks they had worked to accumulate.

'Last dry season we did not have enough because bandits stole our animals and farm produce. It was a huge loss. This year they came too and even invaded our homes and took away our valuables. They came in with guns thank God they did not shoot anybody. When the bandits came into the community, I and my husband hid under the bed but three of the bandits found us and ordered us out at gun point. It was very scary. They asked my husband for money but he did not have any in the house. They took ... [what] they found and then left with the rest of the animals.'

Z reflects that the CDGP money helped her family to cope after the raids, enabling them to get by until they could regroup and begin to thrive again.

'During those difficult times the family solely depended on the money I was getting…. We just survived on my allowance for a while.'

Since the raids, Z is happy that she and her family are doing well again, although there is a constant fear that the bandits will return.

Doka Gama CS7

4.6 Relational wellbeing

4.6.1 Household relationships

Husbands and wives

Nearly all our respondents, both women and men, said that receiving the cash transfer had improved relationships between beneficiary women and their husbands, and had even reduced the divorce rate at community level, because shortage of money and the pressure on husbands to provide for the needs of their wives and children were the most common cause of tension and arguments between spouses.

> '[I]n the past before they began to give us this money, the situation was that whatever I wanted to do, I had to burden him with it, he had to provide. But now, he sees things sometimes he is not even aware of the challenge or the need, he just sees that I have been able to handle some of the needs, he is not burdened with the responsibility of providing. So now, if I ask him to do something, he is not reluctant to do it, he does with pleasure, because he knows the many other things I do not ask him to do for me.'
>
> Yankuzo CS5 – Focus woman (beneficiary)

Husbands are generally supportive of their wives' involvement in the programme, including their right to keep the cash and to decide how it should be spent. They appreciate that the additional income is for the needs of the beneficiary woman and their children, and that the household will also benefit from the overall increase in income. Many of the men interviewed also said they were enjoying the new recipes and greater variety of food that the women were sharing with the household because of the extra money and the cooking and nutrition tips learned from the BCC activities.

The husbands interviewed did not feel threatened by their wives' participation in the programme or by the relative economic autonomy it gives them. Husbands clearly retain overall authority over the household, and have to give permission for their wives to be registered and to attend meetings. Some commented that the way CDGP is implemented is good because it does not undermine their local culture.

> 'I had to give my consent before she was enrolled and I did not stop her. This makes her respect me the more, sincerely.'
>
> Kanyu CS2 – Husband

Only one example was encountered of a case where the cash had led to serious domestic conflict: this was in one of our case study households, and is summarised in Case Study Example 6. A notable feature of this story is that the village head and the community supported the wife and ostracised the husband for trying to forcibly take the phone and the cash from her.

Case Study Example 6: Conflict over control of the cash transfer leads to divorce

A. is in her early 20s. She was pregnant at the time of the baseline study, and has since given birth to a baby boy (her third child). She is a CDGP beneficiary, and has been receiving the cash transfers for about 13 months, starting from the eight month of her pregnancy. At the time of our baseline visit in October 2014 she was living in a relatively well-off household, married to a man from the village head's compound. She was the second of his two wives.

When she first received the cash from CDGP, she used to give NGN 1,000 to her husband and NGN 50 to her co-wife. However, her husband demanded more and took the phone away from her. The resulting violent argument led to divorce, as A. explained to our researchers:

'When they gave us the phones, he asked me to give him, and so I told him I wasn't going to give him... Then he began to hit me and I insisted I was not going to give him; he began beating me, I asked my little girl to go into the compound and [call] people, when they came, they carried him away to a separate room away from our room. After a while, he told me the village head asked him to collect the phone, I told him he was lying against the village head so I asked the village head and he said he doesn't know anything about what I am saying, that he [my husband] was lying against him. After that experience, we divorced.'

After the intervention of the village head, who ruled that the cash was intended for A. and that her husband had no right to it, the phone was returned to her. Her husband later left the village with his other wife and their child.

'[H]e could not stay in this village because there was no support from anywhere. He could not even farm well ..... He waited till all the harvest was over, when he saw he did not have any harvest he had to leave with his family.'

A. is still benefitting from the CDGP. She is staying in her parents' house, and now that she has no husband to go to the market for her, her brother has taken over this role. Out of the monthly transfer she now gives NGN 100 each to her mother and brother, and spends the rest of the money on healthy food for herself and her children.

Doka Gama CS4

Relationships among women in the household

Because eligibility for the CDGP is defined at the individual level (that is, the registered beneficiary is a woman and not a household or household head), there are many households where more than one woman is a beneficiary. Equally, in other cases there may be a number of women of child-bearing age within a household (sisters-in-law or mothers-in-law, as well as co-wives), but only one is a beneficiary. In our discussions this was mostly described as a matter of luck and in the gift of Allah: it was frequently said that non-beneficiaries simply hoped that it would be their turn soon. In polygamous households where all the wives are beneficiaries, participating in the BCC meetings together and sharing the benefits of the cash transfer can improve relational wellbeing among co-wives. In some cases where only one woman is benefitting, relationships with co-wives and sisters-in-law can be smoothed by sharing food and small gifts from the cash transfer, and the benefits, although unequally distributed, were said to have improved harmony among the women of the

household, rather than causing any friction. However, there are cases of jealousy or conflict among co-wives, as in the following example:

> ‘[My relationship is] worse with my co-wives because of this programme I am benefitting from, but with my husband, my relationship is better.
>
> They [co-wives] are envious of the support I am getting ... I see them unhappy about the fact that I am able to meet my needs at the appropriate time and they are not. ...They express their jealousy and annoyance on my children; they shout on them, curse them and maltreat them even though each time I receive the allowance ... I give each of them NGN 100 or NGN 50.’
>
> Keta CS1 – Focus woman (beneficiary)

Mothers-in-law generally have a positive view of their sons’ wives participating in the CDGP. Unlike the relationship among co-wives, mothers-in-law have authority over their daughters-in-law and do not see them as potential rivals. Many, though not all, are past child-rearing age (‘retirees’ as they were described in one FGD), and so are not aspiring to register as CDGP beneficiaries themselves. Generally, they are happy to see the improvement in the health and wellbeing of their grandchildren, and the reduced burden on their sons (the beneficiary husbands) as breadwinners. It is common for mothers-in-law to be given small cash gifts from the transfer, and to benefit by sharing the meals provided for the household by beneficiary women (with the improved ingredients purchased, and new nutritious recipes learned from the AOGs). Some mothers-in-law take an active interest in the new knowledge and practices learned from the CVs, and advise the beneficiaries on what to do in terms of childcare and what food to buy. Some young wives said that their relationship with their mother-in-law was improved by their new knowledge and by the income from the cash transfer.

Women’s empowerment and status

Many of the beneficiary women interviewed said that their inclusion in the CDGP had improved their status within the household and the community. As indicated in the previous sections, the money enables them to provide for the household, invest in petty trade or other businesses, and solve problems without making additional demands on their husbands. Sharing their good fortune through small cash gifts to household and community members can also enhance women’s social standing and respect, and build their social capital, as the following extracts illustrate:

> ‘I used to solely depend on my husband and so we had to make do with whatever he brings and now I am in a position to take care of my home and to support my husband. This has earned me more respect. I can also take [care] of my parents’ needs without having to wait for my husband. It is really liberating and I think many women will like to be in my shoes.’
>
> Doka Gama CS7 – Focus woman (beneficiary)

> ‘People respect and admire me more because I am in a better position now to help them. Whenever I can I do, and I do not act disrespectfully to anyone in the house.’
>
> Doka Gama CS6 – Focus woman (beneficiary)

> ‘Relationships within the household have changed, I now have economic power which has earned me more respect.’

Doka Gama CS3 – Focus woman (beneficiary)

Case Study Example 7: Enhanced status within the household

Z is about 27 years old and is the only wife of the household head, who is a farmer and a motorcycle taxi driver. Z was pregnant at the baseline period and has since given birth to a healthy baby boy, now 12 months old. She has been a CDGP beneficiary for 13 months. She uses all the money she receives from the programme to buy nutritious foods, and does not share any of it with her husband or any other community members. She decides how to spend it. She says, 'I assist my husband with [the] change of menu. But he does not ask what I do with the money I collect.'

Z is very happy to list the variety of new nutritious foods she is able to buy:

'I used the money to buy beans, eggs and canned milk for me and the children. I also bought more fish….. [it's] much better; we can now eat fish, canned milk and more beans. *Zogale* (moringa), salad. We rear more animals now and they are more than when you c[a]me ... two years back, I even have plenty chickens.'

'You see we now make *alale* (steamed bean paste) with ingredients, we eat moringa with onions and fresh tomato, we eat pounded yam with good food. When we can afford it, we add meat to our food. Sometimes we go to Medu to buy maltina and put a little in everybody's cup to drink.'

Z enjoys going to the group sessions, and feels she has learnt a lot from them regarding how to cook nutritious and healthy meals, and about the importance of hygiene in her household.

'Yes I learn more on how I should cook, take care of the children's health and my own health also…. I am now a good cook and hygiene expert, [it's] very useful.'

Her husband also appreciates these changes:

'[T]here is a general improvement in the way my wife takes care of herself and the children. She ensures that the children wash their hands whenever they use the toilet and she also take[s] care of the food that they eat to prevent any germs from contaminating it. I also advise her on these things and she takes my advice seriously.'

Between the baseline and the midline, Z's mother-in-law passed away. This has brought a major change to Z's status, as she is now the senior woman in the household. As her husband puts it:

'there is a change since now there is no longer any elder in house. We are the family now and as a result we became closer with my wife and people say I am a rag and she is a louse, you see, there is no separating a louse from a rag. There are no quarrels or serious disagreements. We advise each other, she listens to me and I listen to her and things are going fine.'

Receiving the cash transfer has also contributed to Z's status and self-esteem. Both Z and her husband report that there is an environment of mutual respect within the household.

'Yes it is better. I now have power because of the money. He (husband) respects me for that. I am now his queen. You can see how I look!' – Z.

'Sincerely, the welfare and happiness of my family is not the same...[as] when you came. It has improved a lot. My wife is doing much better now and you can see it even on her skin. It is clear that she now eats and drinks good food because of this support she is receiving. Whenever she receives the support you see her very happy in the house.' – Husband. **Kanyu CS2**

4.6.2 Community cohesion

The effects of CDGP on the wider community (outside the household) are generally described in very positive terms. In addition to the economic impacts for non-beneficiaries discussed in Section 4.4.3 above, some respondents commented that the frequent gatherings for AOGs and other meetings about the programme have increased social interaction and generated a stronger sense of community 'togetherness'. Spreading and sharing the 'enlightenment' from the BCC messages was also described in focus groups as benefitting the whole community. However, complaints from neighbouring communities that are not currently included in the CDGP, and attempts by non-resident women to register for the programme (see Section 3.3), are common. Within the beneficiary communities, however, non-beneficiaries (including pregnant women who are eligible but not yet registered) were generally said not to resent the beneficiaries, rather they simply hope for their turn to come, as expressed in this focus group in Yankuzo:

> '[W]e are happy for the beneficiaries because they tell us that they gave them money and told them to eat nutritious foods; drink maltina, milk and eggs, so while rejoicing with them you are praying to God to count you among those that will benefit.'
>
> Yankuzo FGD3 – Non-beneficiary women

It is likely, however, that any resentment or stresses within the communities were under-reported to the field teams (as flagged in Section 2.6. on the methodology). It is certainly not true that all non-beneficiaries are happy to be excluded (see, for example, the extracts from the same Yankuzo focus group in Section 3.3). The clear exception to the generally positive presentation of community unity was in Kokura, where the people of the Fulani *rugas* complained of exclusion. This issue is discussed in the following section.

Perceived exclusion of Fulani settlements

Kokura is the only place where people answered 'yes' to the question, 'Has the money caused any problems or arguments among different people in this community?'. Here there are tensions between the villagers and the Fulani settlements *(rugas)* around the outskirts, and a perception that the Fulani are excluded or marginalised from the programme. One of our case study women, a Fulani who is not a beneficiary, despite apparently being eligible (she was pregnant at baseline and now has a 16-month old child), said:

> 'I hear that Kokura women are getting money every month, but we here in *ruga* are not part of it... you see we are Fulanis. Nobody likes us here. We only see things happening in Kokura [for] people that are with *Bulama* [the village head], but not with us at *ruga* in Kokura.'
>
> Kokura CS 6 – Focus woman (non-beneficiary)

A number of people in the main village also commented that their Fulani neighbours are complaining about exclusion, for example:

> 'The Fulani at *ruga* complain when they come for their hair to [be] braid[ed] in this house. Many of them were not included.'
>
> Kokura CS1 – Focus woman (beneficiary)

Key informants interviewed from the programme side (staff member, CVs and CHEW) are aware of this perception and agree that there have been problems, but say that the number of Fulani

participants is now gradually increasing. In explaining the challenges they have met in fully engaging the separate Fulani settlements[15] in the programme they highlighted the following factors, some of which have been touched on in earlier sections of this report.

a) Communications. Because of the physical location of the *rugas*, being far from the village centre, messages sent by town-crier, announced from the mosque, or passed by word of mouth around the community are less likely to reach them. CVs also need to make a special journey out to the *rugas* to carry out their various responsibilities (including enrolment, counselling visits, and informing beneficiaries of payment or meeting dates).

b) Governance. The *rugas* have their own leaders, known as *hardo*, who are apparently not included in the TWC. The one Fulani beneficiary among our case studies (Kokura CS4) was the only household interviewed who did not know the local leaders responsible for the programme.

c) Language. Many Fulani do not understand Hausa well, and, conversely, not all CDGP staff speak Fulfulde. Fulani women are less likely to understand BCC voice messages sent by phone (in Hausa), or to attend cooking demonstrations and other meetings, because of the language barrier. The CDGP staff member interviewed stressed the importance of recruiting Fulfulde-speaking CVs:

> 'We have only one CV in charge of one-to-one counselling who is literate. He is Fulbe from *rugar Isa* (hamlet of Isa) and he reads and translates information to them in Fulfulde fluently with no problem and they trust him. If we have a BRG with CVs like that, even if they are few, it will help the programme a lot in breaking the barrier of *harshe* (language).'
>
> Kokura KII, CDGP staff member

d) Residence. Perhaps the most fundamental issue is that the CDGP rules require beneficiaries to be residents of the community and to be present every month to collect their payment. In the case of the *ruga* Fulanis, it has been challenging for the programme to distinguish residents from migrants (or temporary, seasonal residents). Indeed, this distinction may not seem fair or reasonable to the Fulani themselves. A further problem arises when registered beneficiaries who have passed the residence test then migrate for several months and cannot access their cash payments: under the CDGP rules their accounts are then frozen (see Section 3.4). Our key informant suggested, 'CDGP should devise different structures that will take care of migrant Fulanis, like the programme for Migrant School...' (Kokura KII – CDGP staff).

In Kanyu, the only other place among the qualitative evaluation sites that includes separate Fulani settlements, community relations seem to be more harmonious, but the challenges are similar. The following extracts from KIIs highlight the additional efforts needed to include the Fulani in the general dissemination of information about the programme, and in its direct benefits.

> 'The elders in Kanyu communities have been very helpful. The imam teaches with a microphone every Friday on important issues like this one [mobilising women to come to AOG meetings]. The women can hear from their houses except at the *ruga* (Fulani hamlet).'
>
> Kanyu KII – CDGP staff member

[15] Most communities in the programme area are reported to be ethnically mixed, with people from Hausa, Fulani and other backgrounds living closely together. The issues discussed in this section were only raised in the two communities where the Fulani live separately and pursue different (pastoralist, semi-nomadic) livelihoods.

‘Yes we go to their [beneficiaries’] homes to enlighten them and after that we take them to the house of *Wakili* (assistant community head). We say every woman that is in this programme should ensure that she goes to the house of *Wakili* and we gather them to enlighten them on what we were trained. We also take a motorcycle to go to the Fulani settlements to gather the women in the house of their *hardo* (leader) and tell them everything.....

...They [payment agents] sometimes come when I am not around. You see when they come to this community everyone will know that they have come but the Fulani settlements may not be able to know and so the payment will be made without the knowledge of some women. When I return ... after some days when a woman did not get the money she comes to inform me and I call to ask why it is so and they will say she was absent. Or they will call me to say I should bring a certain woman to a certain community to be paid her money. This is the problem. You see I will burn the fuel on my motorcycle to go to these Fulani settlements to tell the beneficiaries to come and receive their money. The same thing happens during enrolment and when they come to give them telephones. I go to call them to come and be given.’

Kanyu KII – CV (male)

5 Conclusions

In all of the qualitative evaluation sites the midline field visits found that implementation of the CDGP is proceeding broadly as planned, with some variation in terms of detailed processes among communities (as might be expected). Institutional arrangements for community participation in, and management of, the programme (TWCs, BRCs and CVs) are in place and seem to be functioning in all seven sites. Registered beneficiaries are receiving regular monthly cash transfers, along with advice on health, nutrition and IYCF.

The enrolment process, particularly the key stage of confirming a woman's pregnancy, varies from place to place. Pregnancy testing is done by urine testing in most places, and by blood test in one of our seven sites. However, visible signs of advanced pregnancy are also used as a screening check: in at least one place this was described as a way of reducing the unmanageable number of women wanting to register. Although this is practical and reliable, where this test is applied it does mean that women will not be enrolled early in their pregnancy. It is notable that **most of our case study beneficiaries had started receiving the cash transfer late in their pregnancy** (in their eighth or ninth month), or even after giving birth.[16] The practical challenges of confirming pregnancy earlier, together with the understandable tendency for women not to tell people they are pregnant until the second trimester (see Section 3.3), probably partly explains these late registrations. The time needed for CDGP to complete the whole enrolment and registration process before disbursing payments to a new beneficiary may also be a factor. However, late registrations may reduce the impact of the cash transfer on maternal and infant health and nutrition, because the beneficiaries do not receive it in time to improve their diet during the earlier months of their pregnancy.[17]

The payment mechanism, including identity checks at the payment point, is regarded by beneficiaries as transparent and fraud-proof, and monthly payments of the correct amount are received regularly (in these seven communities). The process for payments is consistent and standardised across all the selected sites. Occasional non-recognition of thumb-prints by the computer was the most common problem raised by beneficiaries in response to open questions about their opinion of the payment process. Payments are collected by the beneficiary women themselves in all these communities.

Regarding the BCC component of the programme, in terms of the activities on the ground and the intensity of education and counselling received by the beneficiaries, **there does not appear to be any consistent or systematic difference between communities allocated to the two intended BCC models (T1 and T2)**. Based on the qualitative research, it is hypothesised that this outcome may be affected by various factors, including variations in the skills and dedication of individual CVs; availability of CHEWs; variations in network coverage of phones and radios; remoteness or accessibility; and density of settlement (in communities where people live close together it was suggested that there was more communication and interaction, including sharing of BCC messages and frequent home visits by CVs). If the quantitative survey finds that this lack of consistency is widespread, it will not be possible for the evaluation to compare the impacts of the

[16] As with all findings in this report, this statement applies only to our small purposive sample and cannot be generalised. The quantitative midline survey should be able to quantify the timing of registration and receipt of the cash.

[17] 'Enrolment at an early stage of pregnancy will maximize impact on nutrition for children and during the first "1000" days of the child's life.' (CDGP 2014:7, Implementation Manual).

two models as originally planned. The reach and effectiveness of the various BCC activities and communication channels could be assessed instead.

Nutrition and health information, including breastfeeding advice and improved cooking methods to retain the nutritional value of foods, is being widely shared with non-beneficiaries within the treatment communities. The qualitative work suggests that many non-beneficiaries are attending the AOGs, which are attracting large numbers of women (up to 100 in some reported cases). Even where this is not the case, beneficiaries are sharing what they learn with others in their household and the wider community, and non-beneficiaries are changing their behaviour as a result. In terms of the CDGP's overall aim of reducing mother and child malnutrition, this effect is very positive and very much to be welcomed. From the evaluation perspective, however, it may reduce the observed difference in outcome between beneficiaries and non-beneficiaries, thus potentially leading to underestimation of the programme's impact, although the evaluation design is expected to mitigate this, given its comparison of eligible women between supported and non-supported communities rather than between recipient and non-recipient members within the same community where CDGP is operating.

According to the beneficiaries and other community members, the **impacts of the programme on short-term material wellbeing are already evident**. All the beneficiaries interviewed said that the quality and variety of foods they were eating had improved as a result of the cash transfer, combined with the knowledge acquired from the BCC campaign; many also said that the quantity of food in the household had increased. Impacts on the nutrition and health of children and mothers, including easier childbirth, bigger babies, and more active children, were observed by husbands and key informants, as well as by the mothers themselves. As noted in the methodology, the qualitative research does not attempt to quantify the frequency or magnitude of these impacts: however, the beneficiaries' own perception that the NGN 3,500 per month is enough to have a significant effect on their diet is consistent with the findings of the recent cost of the diet analysis for the programme area (Save the Children 2015).[18] Many of the foods listed by beneficiaries in our interviews are produced locally (but consumption had previously been limited by affordability). Other foodstuffs are reportedly being brought into the villages for retail sale by local traders in response to the increased effective demand, thus reducing the importance of access to formal market places by bringing the market to the village. There seems to be a general increase in economic activity in the beneficiary communities, stimulated by the cash transfer.

Longer-term impacts on beneficiaries' livelihoods, food security, and capacity to cope with shocks are less clear. However, beneficiaries in the qualitative consultations are very aware that the cash transfer is for a limited period only and many are saving or investing part of the money to improve their future income prospects. The cash transfer represents a regular, reliable (though small) supplement to the overall household income, which some beneficiaries say has been important in helping them to cope with lean seasons and shocks (such as poor harvests and livestock thefts). Whether this income is enough to enable people to fully recover from such shocks or to build their resilience for the period after the cash transfer ends, has not yet been investigated.

Perceived impacts on relational wellbeing, both within the household and in the wider community, are generally positive. Very few cases were encountered where the cash had caused a conflict between husbands and wives: on the whole, domestic relationships were said to have improved because the stresses of poverty were relieved. The cash transfer may, however,

[18] This report finds that the transfer amount alone, assuming no other income, is enough to meet 105%, 96% or 75% (in each of the three livelihood zones, respectively) of the nutrient requirements of a pregnant woman plus one child under two years old. This calculation is based on locally available foods consistent with local food habits (the 'food habits nutritious diet'). Save the Children 2015, executive summary.

cause friction among women within the household (co-wives and sisters-in-law), in cases where one is a beneficiary and others are not.

In all the qualitative sites the message from CDGP that the money is for the beneficiary woman to keep and spend is very clearly understood and people seem to be following it. Earlier concerns raised by local key informants that the money might be appropriated by husbands (see ePact 2015a) have not been borne out by the evidence collected so far. Almost unanimously, participants in the qualitative midline described how the **beneficiary women collect the money from the payment agents themselves, keep possession of the cash, and decide how it is spent** (with varying degrees of consultation with their husbands and other household members).

The findings that men are more likely to have access to some key information sources (including radio programmes, mosques and public gatherings such as markets and community meetings), and that they play an important role in relaying information as well as advice to the women of their households, confirms the suggestion from the baseline that **it is important for CDGP to ensure men are included in the BCC campaigns and in the sensitisation about the programme**. Our household case studies and focus groups suggest that many fathers are interested in learning how to improve the health of their children, and when they are well-informed they can help and encourage their wives to make positive changes.

Finally, the midline research found that **there are specific challenges in delivering the CDGP equitably to women in migrant or transhumant Fulani communities** (see Section 4.6.2). The Fulani are a small minority in the programme area (about 7% according to the quantitative baseline, ePact 2015b). However, looking ahead to the possible adoption of the CDGP model by the state governments, it is recommended that the programme should look into ways of tailoring its rules and processes for migrant communities (perhaps with a small pilot study or a consultation exercise with the Fulani themselves). Ensuring the full inclusion of this minority is not only desirable in principle, but could also reduce the risk of future conflict.

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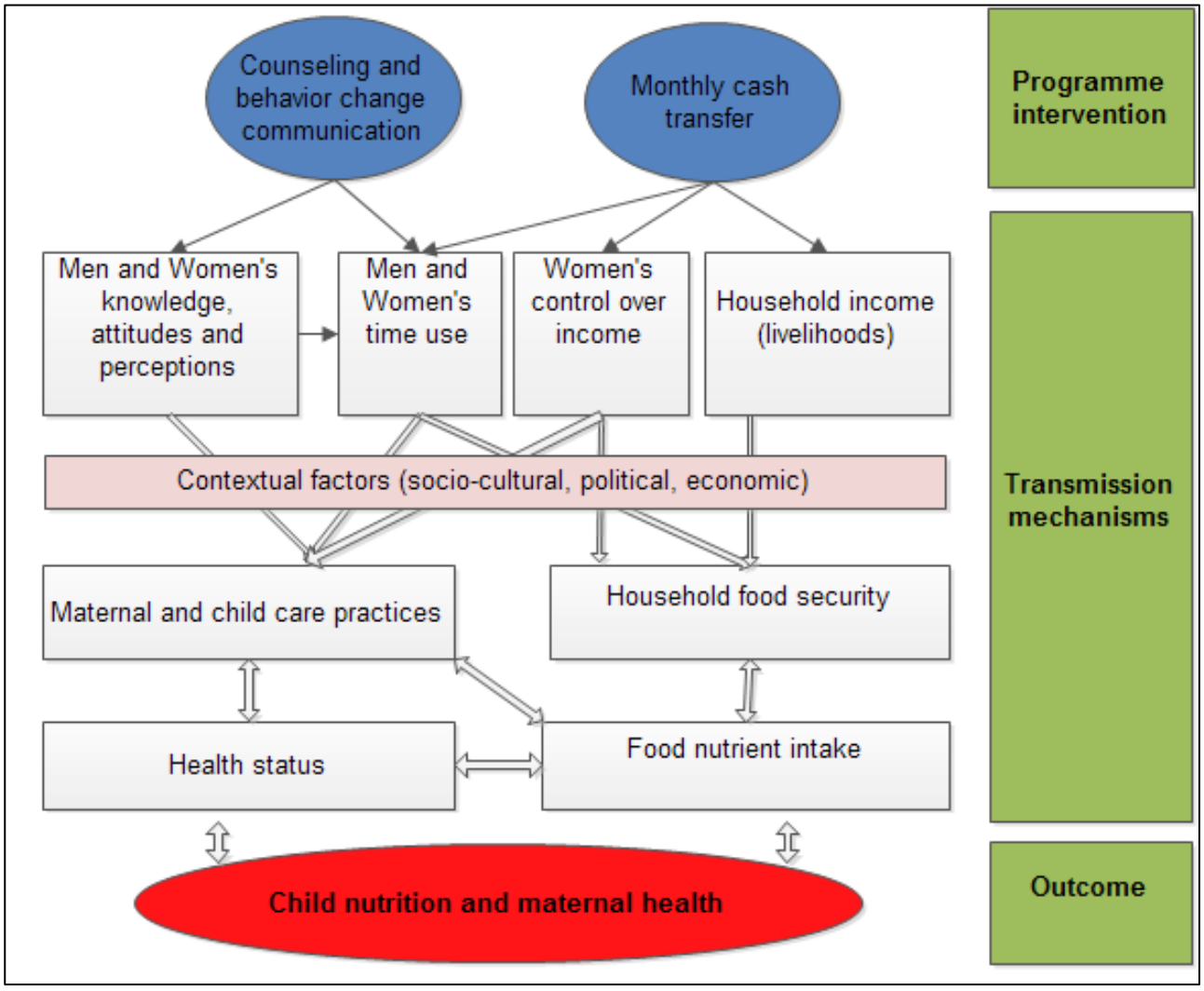
Annex A CDGP theory of change

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

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

Figure 1: CDGP Evaluation theory of change



Source: CDGP Evaluation Inception Report, ePact 2014:8

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

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

Annex B Case study characteristics

Table 7: Case study characteristics (reference list)

	Case study woman							Household characteristics at baseline		
Case study no.	CDGP beneficiary? (at midline, Feb 2016)	Woman's age at baseline (Sep 2014)	Monogamous / polygamous	Number of living children at baseline	Age at first marriage	Literate?	Ever attended School?	Household size	Wealth group (PPI quartile)	Ethnicity / main language
Matseri 1	Yes	33	M	9	15	No	No	11	2nd	Hausa
Matseri 2	Yes	15	M	0	14	No	No	14	2nd	Hausa
Matseri 3	Yes	18	M	2	11	No	No	4	4th	Hausa
Matseri 4	Yes	15	M	0	14	Yes	Yes	9	3rd	Hausa
Matseri 5	Yes	30	M	6	12	No	No	8	1st	Hausa
Matseri 6	No	45	M	0	15	No	No	4	1st	Hausa
Matseri 7	Yes	40	P (2/2)	5	12	No	No	12	1st	Hausa
Matseri 8	Yes	17	M	0	16	No	No	3	4th	Hausa
Matseri 9	Yes	27	P (1/2)	3	14	No	n/a	6	3rd	Hausa
Doka Gama 1	Yes	21	M	2	15	No	No	4	2nd	Hausa
Doka Gama 2	*Migrated*	*35*	*M*	*7*	*15*	*Yes*	*Yes*	*9*	*2nd*	*Hausa*
Doka Gama 3	Yes	26	M	4	13	No	No	6	1st	Hausa
Doka Gama 4	Yes	20	P (2/2)	2	13	No	No	7	3rd	Hausa
Doka Gama 5	*Migrated*	*13*	*P (2/2)*	*0*	*12*	*No*	*No*	*8*	*1st*	*Hausa*
Doka Gama 6	Yes	25	P (1/2)	4	12	No	No	8	2nd	Hausa
Doka Gama 7	Yes	15	M	0	13	No	No	2	2nd	Hausa
Doka Gama 8	*Migrated*	*20*	*P (2/2)*	*0*	*13*	*No*	*No*	*6*	*1st*	*Hausa*
Doka Gama 9	*Travelled*	*16*	*M*	*0*	*12*	*No*	*No*	*2*	*3rd*	*Hausa*
Keta 1	Yes	49	M	8	14	No	No	7	1st	Hausa
Keta 2	Yes	35	M	7	15	No	No	8	1st	Hausa
Keta 3	Yes	18	M	1	15	Yes	Yes	4	4th	Hausa
Keta 4	Yes	30	P (1/2)	1	15	No	No	9	1st	Hausa

	Case study woman							Household characteristics at baseline		
Keta 5	Yes	30	P (1/2)	7	15	Yes	Yes	11	4th	Hausa
Keta 6	Yes	14	M	0	14	Yes	n/a	15	2nd	Gobirawa
Keta 7	Yes	19	P (2/2)	0	14	Yes	Yes	7	1st	Hausa
Yankuzo 1	Yes	31	M	6	17	Yes	Yes	7	4th	Hausa
Yankuzo 2	Yes	18	P (2/2)	2	15	No	No	11	3rd	Hausa
Yankuzo 3	Yes	35	P (1/4)	10	15	No	Yes	23	4th	Hausa
Yankuzo 4	Yes	20	P (2/2)	1	16	No	No	6	2nd	Hausa
Yankuzo 5	Yes	20	M	0	17	No	No	2	4th	Hausa
Yankuzo 6	Yes	20	M	1	17	No	Yes	5	3rd	Hausa
Yankuzo 7	Yes	18	M	0	18	Yes	Yes	2	4th	Hausa
Kafin Madaki 1	Yes	20	M	0	14	No	No	2	4th	Hausa
Kafin Madaki 2	Yes	20	M	1	17	No	No	3	3rd	Hausa
Kafin Madaki 3	Yes	35	P (1/2)	4	17	Yes	Yes	11	3rd	Hausa
Kafin Madaki 4	Yes	30	P (1/2)	6	17	No	Yes	13	3rd	Hausa
Kafin Madaki 5	Yes	35	P (2/2)	9	14	No	No	21	2nd	Hausa
Kafin Madaki 6	Yes	16	M	0	15	No	No	2	3rd	Hausa
Kafin Madaki 7	Yes	27	P (2/2)	4	15	No	No	6	2nd	Hausa
Kokura 1	Yes	28	P (2/2)	5	13	No	No	13	3rd	Hausa
Kokura 2	No (past ben) *	30	M	5	15	Yes	Yes	7	4th	Hausa
Kokura 3	Yes	39	P (2/2)	10	14	No	No	18	3rd	Hausa
Kokura 4	Yes	41	M	1	13	No	No	15	3rd	Fulani
Kokura 5	*No consent*	*15*	*M*	*0*	*12*	*No*	*No*	*14*	*4th*	*Fulani*
Kokura 6	No	31	P (2/2)	7	14	No	No	16	1st	Fulani
Kokura 7	No	18	M	1	14	No	No	10	4th	Fulani
Kokura 8	No	23	M	2	14	No	No	4	3rd	Fulani

	Case study woman							Household characteristics at baseline		
Kokura 9	No	22	P (2/2)	2	14	No	No	9	2nd	Fulani
Kanyu 1	No	22	M	3	15	Yes	No	5	4th	Hausa
Kanyu 2	Yes	25	M	5	13	No	No	7	3rd	Hausa
Kanyu 3	Yes	25	P (2/2)	2	14	Yes	No	12	2nd	Hausa
Kanyu 4	No (past ben) *	20	P (2/2)	2	14	No	No	7	2nd	Hausa
Kanyu 5	Yes	21	M	2	14	No	Yes	5	4th	Hausa
Kanyu 6	No	22	P (1/2)	2	15	Yes	No	5	3rd	Fulani

Notes:
Italics / grey text = not interviewed at midline
* The two case study women listed as past beneficiaries were registered while pregnant, but they were 'prematurely exited' because their babies were stillborn.

Annex C Glossary of local foods and other terms

Foods

Agino	Monosodium glutamate
Alale	Seasoned and steamed bean paste
Alayehu	Spinach
Alkaki	Sweet wheat cakes
Awara	Cake made from fried soya bean paste
Baba dogo	Brand name for spice/seasoning for soup
Bambara nut	Nutritious legume widely grown in West Africa (*vigna subterranea L.*)
Beniseed	Pumpkin seeds
Bula	Balls made from maize flour and stored in water for weeks
Chin-chin	Fried doughnuts made with wheat and sometimes cow-pea flour
Daddawa	Soup condiment made from locust bean seeds
Dagedage	Tomato stew
Danbu	Couscous
Dankali	Sweet potatoes
Danwake	Bean-flour dumplings
Dawa	Sorghum
Dinya	Fruit of the black cherry birch tree (*vitex doniana*)
Doya	Yam
Fete	Porridge made from grains and vegetables
Fura da nono	Drink made from millet meal with milk/yoghurt
Fura	Drink made from sorghum or millet
Ganye	Vegetables (general term)
Gari	Corn flour
Garri	Flakes made of ground and fried cassava
Gero	Millet
Girido	Wild food, leaves
Goji	Pumpkin
Goruba	Doum palm fruit (*hyphaene thebaica*)
Guinea corn	Sorghum
Gurasa	Bread
Gwate	Porridge made from ground maize and vegetables
Hatsi	Grains (general term)
Hoche	Cake or bread baked from sorghum (more often eaten during *bazara* season/food scarcity)
Indomie	Instant noodles (brand name)
Kabewa	Pumpkin
Kakan wara	Made from maize and beans
Kantu	Sweet sesame cake
Kanwa	Potash
Kanya	Wild fruit (*diospyros mespiliformis*)
Kanzo	Edible burnt part of food; remnant of millet paste soaked and scraped from the pot, dried as food

Kawuri	Wild grass/leaves
Kenaf	*Hibiscus cannabinus*
Kifi	Fish
Kindirmo	Yoghurt
Kirinya	Pickles; *bridelia spp.*
Koko	Pounded millet, moistened and moulded into balls
Kosai	Deep-fried bean cake
Kosan rogo	Deep-fried cassava cake
Kubewa	Okra
Kudaku	*Traditional food in Doka Gama* (*Anka*)
Kuka	Baobab-leaf
Kuli kuli	Groundnut cakes
Kunu	Gruel made from maize or millet
Kunun kanwa	Gruel made of millet and potash
Kunungyeda	Pap made from groundnut paste and rice
Kwado	Salad made of moringa, kenaf (hibiscus) and peanut cake
Locust bean	Seeds of the locust bean tree or néré (*parkia biglobosa*)
Maggi	Seasoning/stock cube (brand name)
Maiwa	Red sorghum
Maltina	A malted soft drink/soda, fortified with B vitamins and calcium (brand name)
Man shanu	Locally-made butter (from cow's milk)
Masa	Corn (maize) cake
Miyan kuka	Soup/sauce made from baobab leaves
Moi moi	Steamed bean pudding made with cow peas
Nakiya	Sweet rice cakes
Nama	Meat
Namam kaza	Chicken
Namam shanu	Cow meat (beef)
Nono	Cow milk
Okro	Okra/ladies' fingers
Onga	Brand name for seasoning (monosodium glutamate)
Pate	Porridge made from ground maize and vegetables
Peak milk	Powdered milk (brand name)
Rake	Sugar cane
Rama	Kenaf leaves (*hibiscus cannabinus*)
Riddi	Sesame
Rogo	Cassava
Sakwara	Pounded yam
Shasshaka	Grits eaten with oil and pepper
Shinkafa da kaza	Rice and chicken (celebration food)
Shinkafa da miya	Rice and stew (celebration food)
Shinkafa	Rice
Shuwaka	Bitter leaf
Star	Brand name for spice/seasoning
Suya	Grilled meat/kebabs
Tafasa	Edible green leaves of a shrub

Taliya	Local spaghetti made from wheat flour
Taushe	Vegetable soup enriched with pumpkin and groundnut or sesame seeds
Tiger nut	Nutritious tuber, member of the sedge family (*cyperus esculentus*)
Tsaba	Grains (generic name)
Tsamiya	Tamarind
Tsire	Roasted skewered meat
Tubani	Maize and bean paste mixed with potash
Tuwo	Pounded grain served as a paste
Tuwon dawa	Sorghum (guinea corn) paste
Tuwon gero	Millet paste
Tuwon masara	Maize paste
Tuwon shinkafa	Rice paste
Waina	Rice or maize cake
Wake	Beans (cowpeas)
Yadiya	Wild creeper, 'leaves from the bush'; gathered in *bazara* season and dried
Yakuwa	*Hibiscus sabdariffa* leaves
Zobo / zoborodo	*Hibiscus sabdariffa* flowers
Zogale	Leaves of the moringa tree (*moringa oleifera*)

Seasons

Note: *Correspondence to the European months is approximate: the actual timing of the seasons varies from year to year and from place to place.*

Rani	Hot, dry season/harmattan (Jan/Feb/Mar)
Bazara	Land preparation/early rainy season, hot and humid (Apr/May/Jun)
Damina	Rainy season (Jul/Aug/Sep)
Kaka	Harvest/early dry season, cold and windy (Oct/Nov/Dec)

Other local terms

Ambaliyan ruwa	Flood
Bulama	Village head
Burtsatse	Borehole
Cirani	Temporary male labour migration
Fadama	Wetland or irrigable land – usually low-lying plains underlaid by shallow aquifers found along major river systems, which also provide water for livestock during the dry season[19]
Hakimi	District head
Hardo	Leader of Fulani *ruga* (settlement)
Inna wuro	'Mother of the house'
Kaba	A type of palm leaf used in basket-making
Karamin karfi	Someone with little power
Kungiya	Committee / TWC
Mai angwa	Village head

[19] Information source: www.worldbank.org/en/news/feature/2010/07/28/fadama-iii-rural-agriculture-project-fast-becoming-a-household-name-in-nigeria.

Mai garin	Mayor
Mai gida	Owner or head of compound
Ngozoma	Traditional birth attendant (TBA)
Okada	Commercial motorcycle/motorcycle taxi
Randa	Clay water-storage pot
Rigiya	Well
Rubutu	Extracts from the Qur'an written on slates, and sometimes washed off and drunk for healing ('prayer water')
Ruga	Fulani hamlet
Rumbu	Grain store or silo
Talafi	Money / cash transfer
Tamowa	Thinness, not growing
Tsinka-tsinka	Eclampsia (illness affecting pregnant women and babies, associated with the cold of the rainy season)
Wadata	Wellbeing or wealth
Wahala	Problem, hardship or distress
Wakili	Aide to the village head
Waya	Phone

Table 8: Locally available foods by type (reference table)

Food type	Locally available foods
Cereals	Millet, sorghum, rice, maize
Roots and tubers	Cassava, sweet potato, yam, tiger nuts
Pulses, legumes, nuts, seeds	Cowpeas, groundnuts, bambara nuts, sesame, locust bean, soya beans
Vegetables	Pumpkin, hibiscus (kenaf), moringa, baobab leaves, okra, tomatoes, peppers
Fruits	Wild berries, dates, doum palm berries, tamarind, orange, banana
Meat/poultry, offal	Cows, goats, chickens, guinea fowl
Eggs	Chicken and guinea fowl eggs
Fish, seafood	Freshwater fish (including dried fish)
Milk and milk products	Cow's milk and goat's milk, yoghurt, butter
Oil/fat	Groundnut oil, butter
Sugar/honey	Sugar cane, dates, honey

Annex D Qualitative evaluation sites by LGA, district, village and traditional ward

	LGA	District	Village	Traditional ward	Name used in qualitative reports	Quantitative survey site
ZAMFARA	Anka	Matseri	Matseri	Katun Bare	**Matseri**	**119**
	Anka	Wuya	Sardauna	Doka Gama	**Doka Gama**	**136**
	Tsafe	Keta	Mayana Keta	Sabon Gari	**Keta**	**231**
	Tsafe	Yankuzo	Marafan Yankuzo	Sabon Garin Hayin Kasuwa	**Yankuzo**	**260**
JIGAWA	Buji	Yayari	Kafin Madaki	Kafin Madaki	**Kafin Madaki**	**324**
	Kirikasama	Baturiya	Baturiya	Kokura	**Kokura**	**401**
	Gagarawa	Yalawa	Kanyu	Kanyu	**Kanyu**	**533**

Annex E Data processing codes (guidance for coders)

Theme codes

Coding
Any references in the transcripts to the six themes and sub-categories should be coded to the relevant mother code, and, if there is a change, whether it is positive or negative. If there is no discernible mention of change, it is perfectly fine to just code the mother codes. If there is some jumping around between codes in the text (I noticed quite a lot regarding consumption patterns and livelihoods for instance) do your best to identify and code both, overlapping if necessary.

T1. Consumption patterns and dietary practices

Quantity of food consumed or available

Quality or variety of food consumed or available

Actual diet
Men – actual diet
Women – actual diet
Pregnant or breastfeeding women – actual diet
Infants and children – actual diet
(*If text specifies gender, i.e. boys or girls, include this in the excerpt*)

Preferred foods
Men – preferred foods
Women – preferred foods
Pregnant or breastfeeding women – preferred foods
Infants and children – preferred foods
(*If text specifies gender, i.e. boys or girls, include this in the excerpt*)

Celebration foods
What foods are eaten on special occasions? Include any information on the type of celebration (*religious holiday? wedding? funeral? etc.*)*, any comments or descriptions of the food eaten, anything about the seasonality of these events* (*do they happen at specific times of year?*)

Constraints on eating preferred foods
If the preferred diet is different from the actual diet – why? What prevents the respondents eating the food they prefer?

Forbidden or avoided foods

Pregnant or breastfeeding women – forbidden or avoided foods
Include any information on things women either actually avoid, or believe should be avoided, during pregnancy or breastfeeding. Include any comments on why these foods should be avoided, any previous beliefs that are no longer practised.
For any other groups (*i.e. foods avoided by everyone or by people other than pregnant or breastfeeding women*)*, code at level 2* (*forbidden or avoided foods*)*.*

Seasonality of diet

Include any information on seasonal changes in composition, quantity, quality, variety, or frequency of diet/consumption.

Portion sizes
Include here any text giving information on portion sizes consumed by different groups or household members (*e.g. men, women, boys, girls, pregnant women – who eats more or less, and why*). *Include also any information on the order or priority of consumption* (*who eats first or last, and why*).

T2. Risks, resilience and coping

Types of risk, stress or shock
Include any information about the types of event or hazard that can threaten people's access to food, income or wellbeing (*e.g. drought, flood, price rises, health risks*). *Include here any information about the effects of such events.*

Seasonality of risk, stress or shock
What time of year do these things happen? When is the period of food shortage or hungry season? Include here any information describing these periods (*months/season name, what happens at that time, etc.*)

Responses to risk, stress or shock
What do people do when faced with food shortages? Include all coping responses here, e.g. sell productive assets, borrow money, withdraw children from school, migrate, reduce consumption, changes in behaviour or household structure.

Sources of assistance
When people are under stress, or short of food or money, who do they turn to and what sort of assistance do they receive?

T3. Household decision-making and resource management

Decisions about food
Who decides or controls the distribution of food in the household (*e.g. decisions about who eats what, portion size, timing and frequency of meals, distribution of household stocks to wives or other household members*)*? Who controls any stocks of food within the family or household? Include any information on why or how these decisions are made.*

Decisions about money

Decisions about food purchase
Include here any information on: Who decides what food is bought? Are women allowed to go and buy food, or to directly commission what is bought through someone else (*perhaps an older child, or their husband*)*?*

Decisions about other expenditure
Who decides about non-food expenditure? Include any information about types of expense (*what is money spent on, why, when, how much etc.*).

Distribution of income or gifts
Include any information about who receives or controls money coming into the household. E.g. if a mother receives a cash transfer, does she keep it or share it? Who decides? Include any text explaining attitudes or practices about this.

Women's control over cash
Include any information about women's ability/opportunities to earn, save, invest or spend money. Is earned income seen as different to unearned income (*e.g. gifts or welfare payments*)*? Include any information on other people* (*e.g. husbands or senior women*) *influencing or deciding how women's money is used. Include any comments or perceptions on how these things should be managed.*

Decisions about mother and child health care
If a woman or child needs medical care, who decides whether/where/when they can go? Include any information about women's autonomy here, i.e. can a mother decide about health care for herself and her children or does she need permission to go to a clinic or healer? If so who from? Why? Include any text expressing attitudes to this issue.

T4. KAP relating to health and nutrition

Breastfeeding

IYCF

Care of sick and malnourished children

Nutritional needs of pregnant and breastfeeding women
Include here any information about people's attitudes, beliefs or knowledge about the types or quantity of food that women should eat (*or not eat*) *whilst pregnant and/or breastfeeding. Include any text on why they think this and where they learned it/who from.*

Health-seeking behaviour
When babies, children, women or other household members are ill, what do they do/where do they go, and why? Include any information on constraints to using medical facilities, e.g. distance or cost, and any comments or attitudes about the treatment received from different providers.

WASH (water, sanitation and hygiene)
Water sources
Sanitation
Hygiene

KAP of advice givers
Include: who do women go to for advice about health, nutrition, pregnancy or breastfeeding (*e.g. TBAs, clinic staff, ante-natal classes, their mothers or mothers-in-law, elders*)*? Whose advice do they trust or rely on? What advice have they received from these sources?*

T5. Livelihoods

Livelihood activities
This refers to everything that people do to make a living, i.e. to generate income (*in the form of cash, food, or other in-kind payments*)*. Include here any information on how people in this community make a living* (*e.g. farming, fishing, trading, labour migration, casual labour, weaving or other home industry – whatever they mention*)*. Include any text explaining which activities are preferred and why, which provide better or more reliable income, which are less risky, which require capital or connections to pursue. Include any information on who does what* (*e.g. some types of work may be done mainly by poorer people, or by a particular ethnic or social group, etc.*).

Income
Include here any information about how much income is earned from specific activities, or from an individual's or household's work in general. If the text specifies gender (*women's income or men's income*)*, please include that text in the excerpt.*

Assets
Include any information on things that people own, which are either needed for their livelihood activities (*e.g. land for farming, capital for trading*)*, or are invested in as household wealth or savings* (*e.g. livestock, buildings, furniture, jewellery*)*.*

Seasonality of activities and income
Include here any information about how people's work or income changes according to months or seasons.

T6. Wellbeing

In this section, if the text distinguishes between the attitudes of men vs. women, older vs. younger people etc., please include that text in the excerpt. Otherwise, we can analyse this dimension using descriptors, as most of this information will come from men's or women's focus groups.

General changes in welfare and happiness.

Process codes

Documenting the implementation of the CDGP: to explore, at community and individual level, how the CDGP is working in practice so far and how people are experiencing it. This strand of the qualitative research will feed into the Process Evaluation, as envisaged in the Inception Report (epact 2014). The focus of the current phase of the Process Evaluation is to identify barriers and facilitators to the effective implementation of the CDGP, in order to improve the programme's impact. We will focus on the implementation of the **cash transfers** and the **BCC/nutrition advice** campaign. Information collected during the midline will be fed back to CDGP to inform the programme in the short term (as well as contributing to the final evaluation report).

P1. Community sensitisation

The CDGP is centred on a community-based approach, with significant roles (in terms of sensitisation) and responsibilities for TWCs established by the programme and CVs.

This Code refers to the perceptions and knowledge gained by the beneficiaries as a result of this community-based approach. This would include the beneficiaries' general knowledge and awareness of the programme and any information from the beneficiaries regarding the CVs and TWCs' responsibilities in relation to the project.

P2. Beneficiary identification and Enrolment

Entry into the CDGP is conditional on only two criteria: pregnancy, and residence in a treatment (beneficiary) community. Women can register at any stage of their pregnancy, and are then entitled to monthly cash transfers and BCC services until their child's second birthday. There are five steps to registration: identification of beneficiaries, residency verification, confirmation of pregnancy, enrolment (off line registration) and registration onto the payment system (online registration). Although each of the five steps can be carried out in a matter of minutes per beneficiary there can be delays between the steps, especially between enrolment and registration. Completion of the

online registration requires the distribution of mobile phones to beneficiaries, as well as entering and synchronising their data (including photographs and scanned thumb-prints) via an Android tablet. Confirmation of pregnancy is carried out by a urine test.

This code refers to the beneficiaries' experience of the above. This would include: knowledge of who is eligible to receive benefits; how beneficiaries are selected; explanations of the process of identification and enrolment (who contacted them, where did they have to go, what did they have to do, how long did it take, did they have a pregnancy test etc.?); explanations of the pregnancy test. Experiences, problems or feedback specific to the identification process.

P3. Cash transfer payments

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

This code therefore refers to the actual payment process, which might include references to the following: have they received the money, how much? When? How frequently? Who makes the payment? Who is the payment made to?

Any explanations of the process (e.g. did they receive a mobile phone message? ID checks? Where did they have to go? Who did they receive the cash from?).

P4. BCC

The BCC component is intended to inform and influence beneficiary mothers and other community members to adopt beneficial behaviours relating to diet, nutrition, childcare, health and hygiene, alongside the cash transfers, which are intended to provide them with the purchasing power needed to put some of these messages into practice. This is comprised of:

1. mass communication (radio jingles; phone-in radio shows; information, education and communication posters; Friday preaching and Islamic school teachers);
2. voice messages directly to their mobiles;
3. AOGs: food demonstrations, health education/health talks, and live or filmed dramas (these consist of groups formed within a community to support direct beneficiaries (mothers)); and
4. one-to-one counselling.

This code therefore refers to the beneficiaries' experiences of the BCC component and would include the following: Have they heard the communication messages? Which ones? What did they hear? What did they learn? What did they think about them? Were they useful? Did they go to the group sessions? Which ones? What did they hear? What did they learn? What did they think about them? Were they useful? Etc.

P5. Complaints response mechanisms

There are a number of channels through which beneficiaries and others can seek information or assistance, ask for solutions to problems, report fraud or abuse, or seek redress for grievances. Community-based channels via the CVs, TWCs and BRGs are balanced by a hotline phone

number direct to the local CDGP office. Complaints can also be reported in person to any CDGP staff member or partner.

This code therefore refers to any experiences of the complaints response channels and would include the following: Are they aware of the complaints response mechanisms? Do they know who to go to with complaints? Have they made any complaints? What were they? What was the process by which they made them? Have they heard of anyone who has made a complaint? What was the complaint? What was the process they went through?

Annex F CDGP BCC messages

Box 3: Key BCC messages – priority nutrition practices for CDGP

1. Eat one additional meal for mother each day during pregnancy.
2. Attend ante-natal care at least four times during pregnancy.
3. Place the newborn on the breast within one hour of delivery (early initiation).
4. Do not offer pre-lacteal feeds to your baby.
5. Practice exclusive breastfeeding (from birth to six months of age) – no water, no formula (BMS).
6. Introduce complementary foods at six months of age (180 days) while continuing to breastfeed.
7. Use good hygiene practices (three practices – wash hands with soap before food preparation, wash your hands and the child's before and after feeding baby/child, wash hands each time after using toilet or cleaning baby's bottom).
8. Purchase healthy/nutritious foods for your family.
9. Feed your child a variety of foods and increase that variety as the child gets older.
10. Never feed the baby or young child using a bottle.
11. Do not use or purchase infant formula.

Source: CDGP Implementation Manual (2015) p.26