



ENDLINE REPORT SUMMARY 2022
Impact Evaluation of the
Child Grant (0-2 years)
Subcomponent of the Basic Social Subsidy
Programme in Nampula Province in Mozambique
2019-2021

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Executive Summary

As part of the operationalization of the National Social Security Strategy 2016-2024 (ENSSB II), Ministry of Gender, Children and Social Action (MGCAS) revised the social assistance programs, including the Basic Social Subsidy Programme (PSSB), introducing two new components, namely the Child Grant and the Disability Grant. The Child Grant comprises three subcomponents; for children aged 0 to 2 years old, orphaned children living in poor and vulnerable households, and a grant for child-headed households.

Decree 47/2018 of August 6 approving the revision of social assistance programs provides in Article 4(1) (objectives of the PSSB) that the general objective of the PSSB is to “... **increase the consumption capacity of people in poverty and vulnerability through cash transfers.**” Specifically, paragraphs d), e) and f) state that the child grant aims to: d) Contribute to reducing the risk of chronic malnutrition in children; e) Encourage family protection of children orphaned, neglected and/or abandoned, as well as improve their living conditions and; f) Address the basic needs of child-headed households and contribute to the development of human capital.

To operationalize the new programs, MGCAS through National Institute of Social Action (INAS) and with support from partners, designed and started implementing the Child Grant 0-2 years subcomponent. As part of the design, it was decided to conduct an impact evaluation to measure implementation results and gather evidence to inform the decision making process on the expansion of the Child Grant 0-2 years.

For a better evaluation, baseline research was conducted before initiating the subcomponent implementation, so that final evaluation results could be compared with the baseline and thus assess the impact of the Child Grant implementation.

Overall, impact evaluation results allow to state that the objectives that led to the design and implementation of the Child Grant 0-2 were achieved. Data obtained from the main observed

indicators, designed to respond to PSSB objectives – **to increase the consumption capacity of people in poverty and vulnerability through cash transfers** – and of the Child Grant 0-2 subcomponent – **to contribute to the reduction of the risk of chronic malnutrition in children** – namely the impact of the Child Grant 0-2 on child well-being and the intermediate impacts on poverty and vulnerability at the household and caregiver level over a 24-month period, are consistent in showing significant improvements in the status of children, their caregivers, and their families, although variation was observed in the proportion of improvements, being higher in certain indicators and lower in others.

Thus, at the target child level, the evaluation results show that there are strong and considerable impacts on children’s birth registration (equivalent to a 150% increase over the mean at the end line of the control group), with impacts originating from the cash transfer, but also from case management. In addition, there are beneficial (and considerable) impacts on almost all variables related to diet diversity, including the number of meals per day, the minimum diversity of eating habits, the minimum frequency of meals, and the consumption of vegetables, dairy products, meat and fish, eggs, foods with vitamin A and other fruits and vegetables, which is consistent with the PSSB objective of increasing the consumption of beneficiary families.

In terms of specific nutrition outcomes, evaluation data indicate that anthropometric measures, including underweight, acute and chronic malnutrition show low progression resulting from the exclusive impact of the Child Grant 0-2. Levels of chronic malnutrition¹ remain high by endline, ranging from 51% to 54%, maintaining the level estimated for the province by the IDS 2011 (Inquérito Demográfico e de Saúde de Moçambique de 2011), indicating that more multisectoral efforts are needed to address malnutrition in this specific population. Significant reductions in chronic malnutrition may be limited due to environmental

¹ Chronic malnutrition is a long-term indicator, and is manifested by a child’s lack of growth that occurs between birth and reaching 5 years of age. In this sense, the current design of the child grant makes a partial and limited contribution to achieving the goal of reducing the risk of chronic malnutrition. It is desirable to cover the whole period of the 1,000-day window of opportunity, i.e. from 0 to 5 years..

factors, such as inadequate hygiene and sanitation, but also due to the low value of the cash transfer allocated to beneficiaries (540.00Mts, representing only 13% of monthly household expenditures). High rates of diarrhea were also found among the target children in the final survey (> 40% reporting episodes of diarrhea in the past 2 weeks). Other factors in the low impact of the grant on stunting may be attributed to the weak intervention of the case management component in monitoring the nutritional status of children, as some caregivers did not take their children for weight control on a regular basis.

Therefore, efforts need to be made to improve the anthropometric status of children, with a combination of measures, from increasing the value of the grant, better targeting of case management to monitor the target child nutritional status, strengthening the hygiene and sanitation component, among others. At the household level, impacts are also consistent and point to moderate impacts on the total per capita expenditures of 118 MZN (translating to a 13% increase from the mean at the endline for the control group). Similarly, reductions in poverty rates of similar magnitude were observed (10% reduction in the poverty rate (headcount) and 13% reduction in the poverty gap). Food insecurity also decreases, both in terms of the total food insecurity experience index (consisting of 8 questions on different aspects of food insecurity) as well as the number of meals consumed daily. Households invest in non-farm activities, increasing the probability of operating such enterprises by 16% over the mean at the endline of the control group.

At the caregiver level, caregivers have fewer depressive symptoms (11% reduction), less stress (5% reduction), higher levels of happiness, and higher life satisfaction (care component only). Caregivers are saving more money (130% increase) and report higher levels of autonomy, decision-making power, and self-assessed financial standing; however, it was observed that savings levels are very low, even among the endline treatment group (10%), a fact that may be due to the low amount of the grant that is provided. There are also notable reductions in attitudes of acceptance of intimate partner violence (IPV) and less experience of physical emotional IPV or both in

the past 12 months, the latter decreasing by 38% from the mean at the endline for the control group. Finally, no adverse impacts on pregnancy or fertility were found, with the Child Grant 0-2 reducing current or recent pregnancies and the case management component reducing child separation (assessed as any biological child <18 years old living away from home).

Finally, given the excellent results of the child grant, and the challenges faced in implementation, it is important to make recommendations to improve the intervention.

Continue the implementation of the child grant in order to reach more

children at risk of malnutrition;

Extend the duration of the children's participation in the program from 2 to 5

years, in order to maximize the impact and reach the entire 1000 days window of opportunity;

Increase the value of the transfer to

reach at least 2/3 of the poverty line

as proposed by the ENSSB..

1 Introduction



The Child Grant 0-2 subcomponent in Mozambique (Subsídio para Criança 0-2 Anos in Portuguese) is part of the Child Grant component of the Basic Social Subsidy Program (PSSB), currently in its start-up phase, which is being implemented in four selected districts in Nampula Province. The initial phase is implemented by the Ministry of Gender, Children and Social Action (MGCAS) through the National Institute for Social Action (INAS), its operational arm. The start-up phase is expected to provide important information on whether the proposed innovative model of linking cash transfers with case management for risk protection and social behaviour change communication (SBCC) – known as ‘cash plus care’ – has the potential to improve the well-being of child beneficiaries and their families. Furthermore, it is expected that the start-up phase will inform how best to scale up the intervention nationally. The American Institutes for Research® (AIR®) and its partners were contracted to conduct a 24-month longitudinal design impact evaluation and a process evaluation of the start-up phase.

The Child Grant 0-2 subcomponent provides unconditional cash transfers to primary caregivers of children with the overall objective of reducing poverty and social vulnerability, improving child well-being, and promoting access to basic social services. In addition, the care component (case management) aims to help protect targeted households from social, economic, and health risks.

This evaluation investigated the impact of the Child Grant 0-2 on child well-being and the intermediate impacts on poverty and vulnerability at the household and caregiver level over a 24-month period. Thus, it is hoped to provide the Government and its partners with solid evidence to make informed decisions for scaling up the intervention. In addition, it will increase the knowledge base on investment in similar programs at the regional level.

The main objective of the report is to present the impacts of the Child Grant 0-2 subcomponent on a wide range of outcome variables at the household, caregiver and child level. In addition, and where possible, impacts on vulnerable subgroups were examined. Finally, descriptive information on participants’ experience with the intervention is presented and the internal validity of the study is reassessed. The results and implications for

implementation should be interpreted in the context of the COVID-19 pandemic, which added to the challenges of the evaluation, the implementation of the intervention, and the overall vulnerability of the families in the study sample. The results build on the findings of the baseline report, which documented and described the study sample before the intervention began and tested for statistical equivalence between the treatment and control groups (AIR, 2020) in terms of their characteristics and outcome variables. More details about the context, the underlying motivation of the Child Grant 0-2, research-related issues, study design, data collection, sample description, and impacts can be found in the full impact evaluation report.

2 The Child Grant 0-2 Subcomponent



Supported by UNICEF Mozambique as part of a Joint United Nations Programme, MGCAS is implementing, through the National Institute of Social Action (INAS), the start-up phase of the Child Grant 0-2 Programme. The start-up phase is taking place in four districts of the Nampula province: Ilha de Moçambique, Nacala-a-Velha, Lalaua, and Mogincual. This report summarizes findings for two of the intervention districts: Ilha de Moçambique and Nacala-a-Velha, and includes Mossuril and Nacala Porto neighbouring districts for comparison. The Child Grant 0-2 includes three components:

The cash transfer: The cash component is a flat transfer of approximately 540 Mozambican meticaís (MZN)² given on a monthly basis to the primary female caregivers of all children between 0 and 2 years old. In the three districts where the impact evaluation is conducted, transfers have been geographically targeted (exclusions could be made at the community level on the basis of wealth and social status).

Nutrition and hygiene SBCC package: This component is intended for all beneficiaries of the Child Grant and consists of interventions around positive nutrition, hygiene and sanitation practices. Messages are delivered through community health workers (or Agentes Polivalentes Elementares – APE), local/traditional leaders, INAS Permanentes and social workers. SBCC is implemented in all districts that receive the cash transfer and care package of the Child Grant 0-2, except for Ilha de Moçambique.

Family support through case management:

Case management services are offered to beneficiary households classified as the most vulnerable to common protection risks following the results of a triage using a vulnerability prioritization tool implemented at enrolment³. A case plan is developed to address risks and needs of the family, based on an initial diagnostic tool, with variation in the number, frequency and duration of home visits based on the needs of the family. Case management is offered primarily through *permanentes*, and technicians from the Health, Women and Social Action District Services. Case management activities include basic psychosocial support, counselling and raising awareness on positive parenting practices, as well as information and referrals to local and legal services. All children and members of the family within selected households are supported.

The cash transfer component is hypothesized to affect a range of positive outcomes in terms of household consumption, economic standing, food security, dietary diversity and nutrition, as well as caregiver behaviour, and holistic wellbeing, including improved mental health and stress reduction. Cash transfer and case management interventions aim at integrating social services across all sectors to address multiple dimensions of poverty and vulnerability. Therefore, households that receive cash and case management are expected to demonstrate enhanced positive results as compared to the cash-only intervention. Figure 1 depicts the key programme components of the Child Grant 0-2 Programme across lifecycle stages⁴. Note that because of the non-targeted nature of the SBCC package, we are unable to attribute impacts specifically to these activities. Nonetheless, we analysed impacts related to child nutrition and caregiver nutrition knowledge, to inform some of these components. Further details on the cash and case management selection process and

² Or approximately 10 USD (30-day average pre-programme exchange rate February 2018, 0.01682 USD = 1 MZN) designed to represent one-third of the national poverty line.

³ For the purposes of this evaluation, the percentage of households targeted for case management were increased to 50% of the Nacala-a-Velha sample to increase power to detect effects. These households did not undergo rapid assessment during programme enrollment, and instead were identified using the same screening indicators collected as part of the baseline survey.

⁴ The SBCC messages are not targeted to the evaluation sample specifically. Hence, any insight related to SBCC impact will be related to district-level activities, to which the evaluation sample may also be exposed.

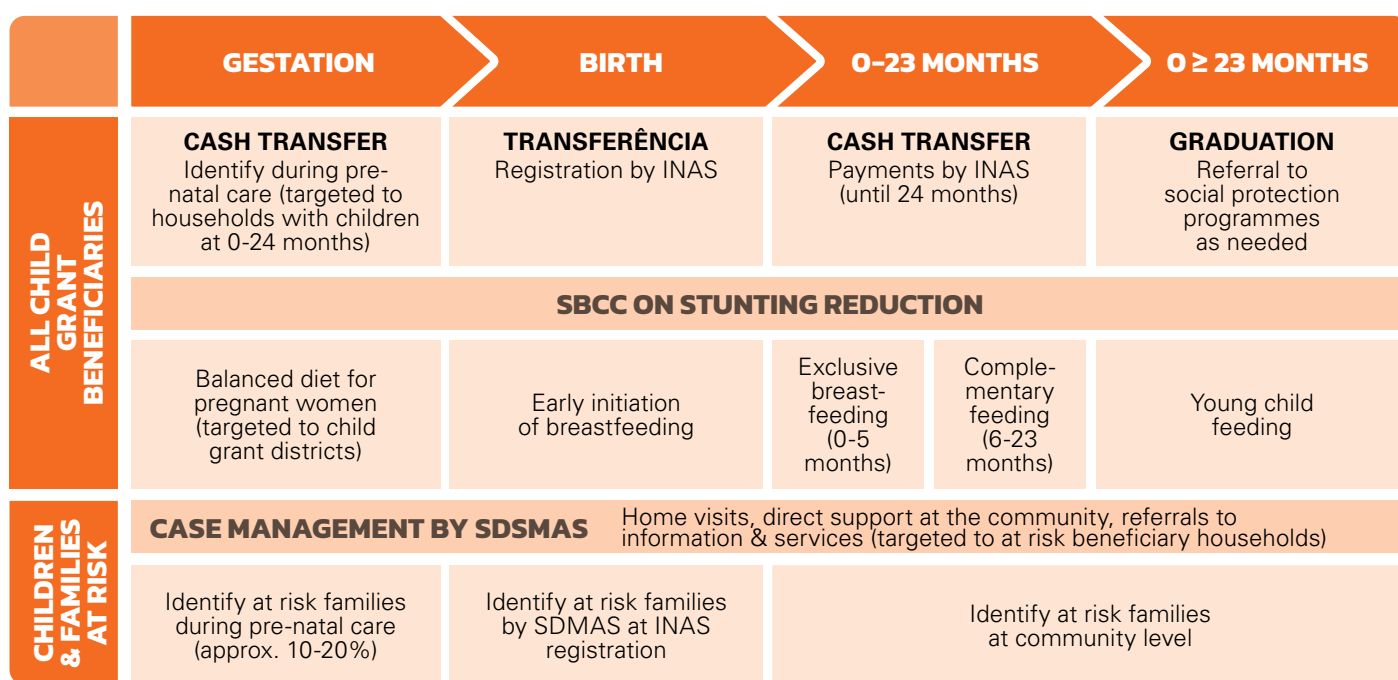
implementation are available in the baseline report and process evaluation (AIR 2020; AIR 2021b).

The evaluation builds on a programme logical framework outlining the causal chain amongst activities, inputs, outputs, outcomes and impacts, as well as the underlying assumptions (White, 2009). AIR, MGCAS and UNICEF confirmed the programme logical framework (Figure 2) during the inception meeting on 22 June 2018, and it reflects the evaluation’s goals for improving child wellbeing in the context of the Child Grant 0-2 Programme.

The logical framework reflects the evaluation’s goals for improving child well-being in the context of the Child Grant 0-2. Households receive benefits (left

column), including a monetary transfer that is given to the 0-2 child primary caregiver; community-level SBCC interventions around positive nutrition and hygiene practices; and case management, which consists of home visits, counselling, awareness of positive parenting practices, and referrals to information and services, based on identified needs. It is assumed that households use the resources for short-term benefits at the household level (increased food security, investment and savings, among others), as well as at the caregiver level (improved caregiving behaviours, improved psychosocial well-being, greater control over fertility decisions, among others).

Figure 1. Child Grant 0-2: Programme Model



Source: UNICEF Mozambique. (2018). Child Grant Communication Materials.

Once short-term outcomes are realized, there is a possibility for these beneficial outputs to impact children (right column). For example, if impacts on food security or on caregiver health and nutrition knowledge are realized at the household level, young children (between 0 and 2 years old) may have improved nutritional status and dietary intake. Note that based on previous evidence from regional evaluations, and the relatively short timeline of the evaluation, from the outset, it was understood that impacts on child anthropometry were unlikely to be realized (de Groot et al. 2017).

Similarly, through improved caregiving behaviours, these children may experience increased quality and quantity of parental stimulation. For older children (between 3 and 17 years old), expected outcomes include increased schooling and material wellbeing and reduced violent discipline and child labour.

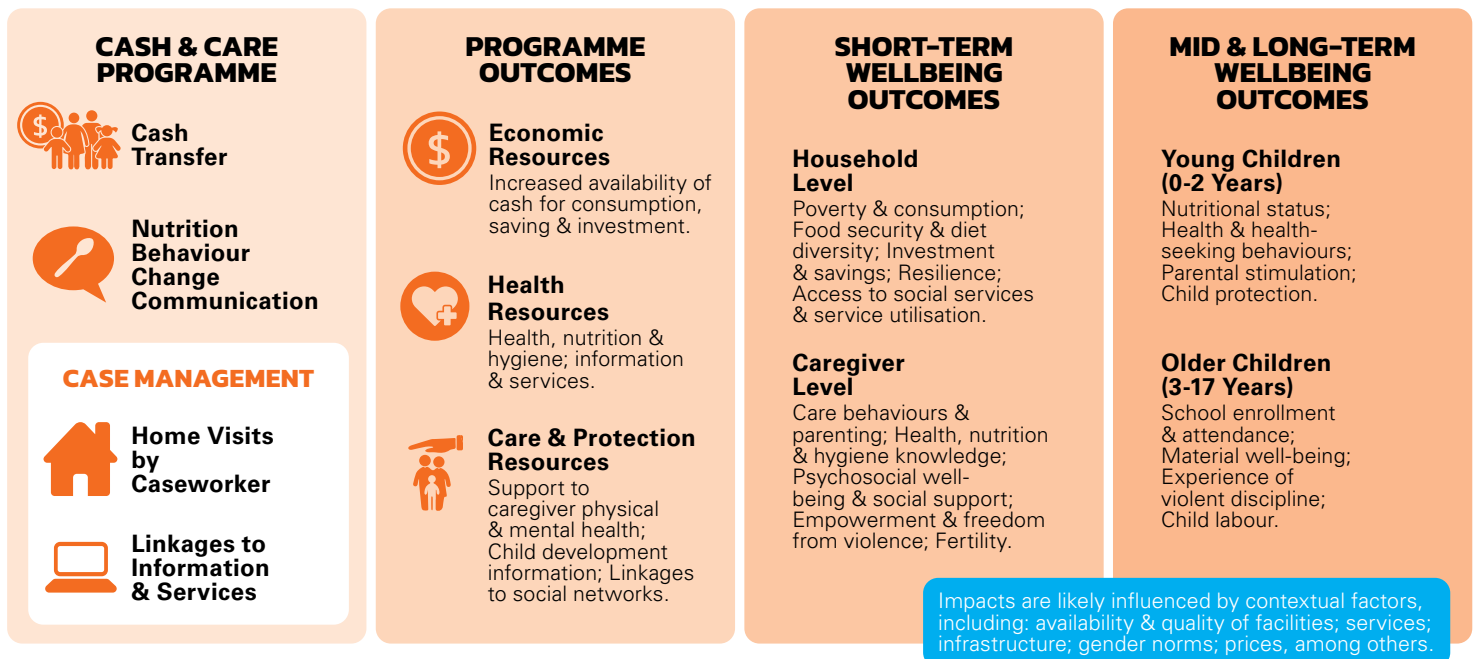
Although not explicitly indicated in the Child Grant 0-2 logic, for the majority of outcomes, it is hypothesised there may be direct effects from each programme component (cash transfer and care), as well as potential synergistic impacts across

the two components. All outcomes depend both on programme implementation factors (amount and regularity of the cash transfer, quality of case management services, exposure to SBCC, among others) and on contextual factors (distance and quality of facilities and services, food availability and affordable prices, prevailing social norms, infrastructure – including water and sanitation – among others).

The **Programme Logical Framework** (Figure 2) is important as far as it guides hypotheses for the evaluation. Many of the expected outcomes are investigated along the causal chain, focusing on causal analysis of impacts for those that are most likely to change during the 2-year study period. We

conduct gender- and age-disaggregated analysis (where applicable). Contextual and operational components are largely explored in the process evaluation; however, we also present basic descriptive results of programme beneficiaries' experience with the child grant. In addition to components mentioned directly in Figure 2, the evaluation seeks to measure some common, hypothetical and unintentional consequences of cash transfers, for example, increases in fertility or alcohol consumption. Although previous research has shown no such adverse effects, it is important to evaluate and demonstrate this in the context of the Child Grant 0-2 Programme in Mozambique (Handa et al., 2018).

Figure 2. Programme Logical Framework



The Child Grant logical framework motivates three evaluation questions for this study:

1. Does cash alone have an impact on short-term wellbeing outcomes at the household, caregiver and child levels?

2. Is the impact of the cash transfer in combination with case management intervention greater than cash alone with respect to the same outcome variables?

3. Are impacts smaller (or larger) amongst certain subgroups of beneficiaries, such as female-headed versus male-headed households, by age of the caregiver, or among male versus female children?

3 Methodology



This impact evaluation is the first rigorous evaluation of a child-focused national program of social protection through cash transfers combined with case management in Mozambique, and adds to the scarce existing regional evidence on cash-plus-care models. To date, there are few studies in the region able to distinguish the impacts of the **cash combined with care** components. Where evidence exists, including in Ethiopia, Lesotho, and Nigeria, studies generally conclude that the combined impacts exceed those of cash transfers (Carneiro et al., 2021; Park et al., 2018; Food and Agriculture Organization of the United Nations & UNICEF, 2018). However, the care components are diverse, and to date, no program in the region has looked at case management based on protection.

This is an impact evaluation that compares two **treatment groups** (the one receiving only the cash transfer and the one receiving the cash transfer and case management package) and a **control group** (which receives no intervention and serves for comparison purposes).

The methodology uses a **quasi-experimental geographic Regression Discontinuity Design (RDD)** to assess the intervention impacts. RDD compares the outcome variables of households living near the border of the treatment (Nacala-Velha and Ilha de Moçambique) and control (Mossuril and Nacala Porto) districts⁵ The logic behind the geographic RDD is that those who live in the treatment area right next to the border and receive the programme are very similar in all respects to those who live just outside the border of the treatment area and therefore serve as a valid comparison group. Thus, the border between districts creates a strict discontinuity in treatment, with the northern border of Mossuril and western border of Nacala Porto serving as the discontinuity between these districts and Nacala-a-Velha, and the southern border of Mossuril serving as the discontinuity between this district and Ilha de Moçambique. RDD is combined with a difference-in-differences approach where outcome variables are measured before the intervention starts (baseline) as well as after (endline), which allows

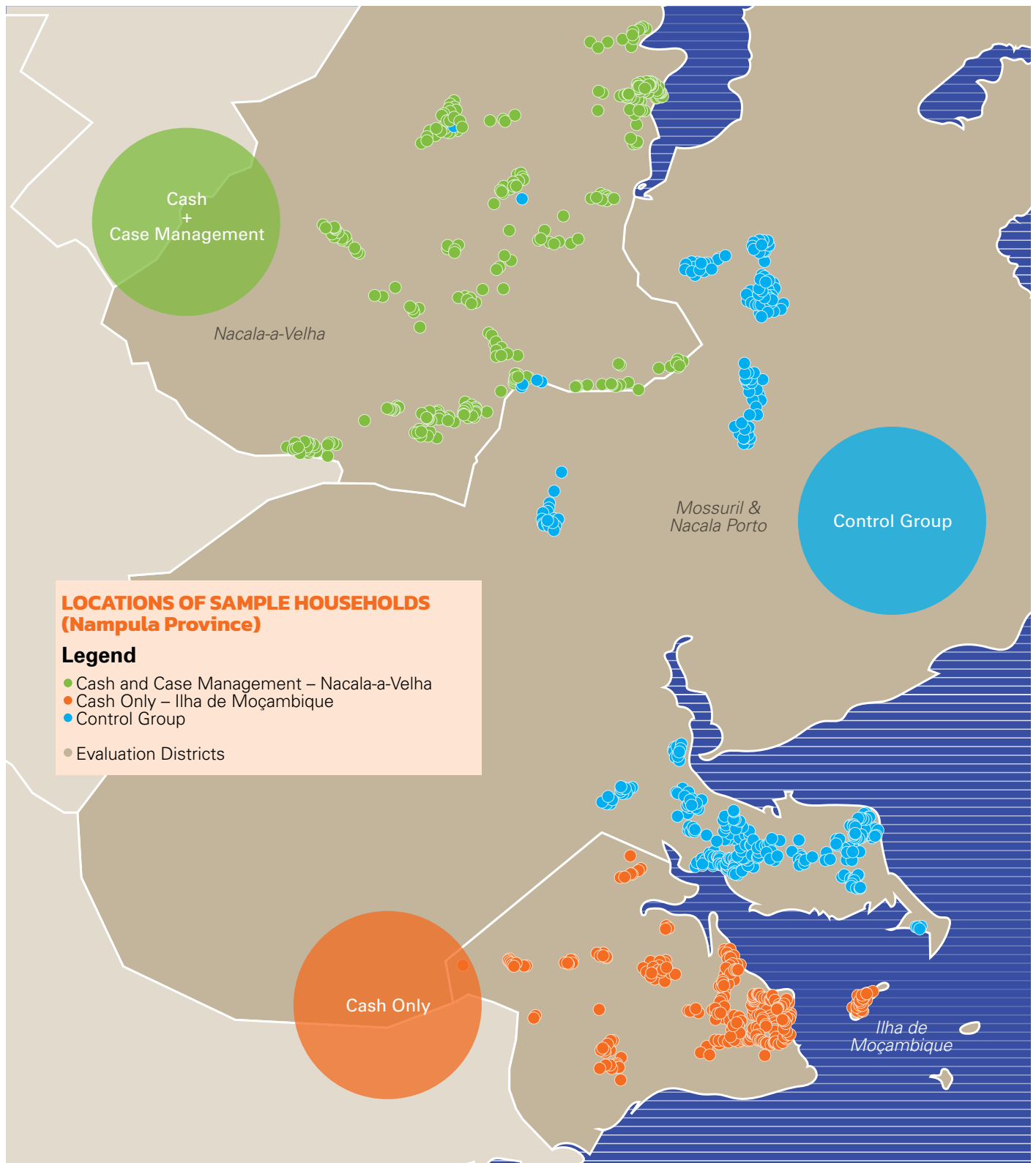
any imbalances between the treatment and control groups at the beginning of the study to be taken into account.

The sample inclusion criterion for the evaluation is that households have at least one child under 6 months old at baseline and live within 10 km from a district boarder. Figure 3 shows a visual representation of the households in the different study groups.

Baseline data collection was conducted in partnership with ELIM Serviços from February to March 2019, and endline data were collected in partnership with Dalberg Research and Arusha Ltd. from March to April 2021, using teams of female enumerators from Nampula. Interviews were conducted primarily in Makua on tablets by using SurveyCTO software and quality-checked in real time by via uploads to internet-based platforms. The study was submitted to ethical review and received approval from the AIR institutional review board and the National Bioethics Committee for Health (*Comité Nacional de Bioética Para a Saúde – Ref 704/CNBS/20*). In addition, special attention was given to administering modules of child discipline and intra-household violence, as well as referral protocols related to health and protection.

⁵ To estimate Child Grant O-2 impacts for the district of Lalaua, we rely on a difference-in-difference approach, given that Lalaua does not share boundaries with Mossuril and Nacala Porto, which rules out the implementation of an RDD design.

Figure 3. Visualisation of Study Sampling Across Study Districts



Data on approximately 2,130 households (approximately 700 per each of the three evaluation arms: the two treatment groups and the control group study arm) were collected at baseline in February/March 2019 (baseline) and approximately 1,685 were re-interviewed at endline (25-months

later). Approximately 21% of the sample was unable to be re-interviewed as they had moved, were not available at the time of the survey or could not be found. To evaluate the effects of not finding all families at the endline, we assessed the internal validity of the study by analysing baseline balance

of the panel sample (i.e., those households that were interviewed in both rounds) and differential attrition between treatment and control groups for all outcome variables. Overall, only 10 out of 284 (or approximately 4%) outcome variables at baseline show statistical differences of magnitude higher or equal to 0.25 SD, and 23 out of the 284 (or approximately 8%) showed evidence of differential attrition between those households that were found at endline versus those that were not found. It was therefore concluded that the study has high internal validity.

Using the sample panel, a difference-in-differences specification was used to estimate the intervention combined effect (i.e., combined treatment of cash transfer and case management) as well as the differential impact of case management in relation to cash transfer. In interpreting the differential impacts of cash transfer versus case management, it is noted that households eligible for case management (approximately 50% of the Nacala-a-Velha sample) present higher protection risks as compared to the remaining households. Thus, these households are not strictly comparable to the full sample. However, in the statistical estimations an index of protection risks is included in order to control for this selection bias. In addition, in all estimations, control was made of the distance to district border, by a variable indicating households located near the northern border, as well as an indicator of level of COVID-19 disruption at the community-level. In addition, a large set of background characteristics and confounders at the child, caregiver and household-levels, where appropriate, were analysed. Further details on the methodology can be found in the full report (AIR, 2021a).

Background characteristics at baseline show sample households are poor and vulnerable. They have an average of 5.2 members, are primarily Muslim (90%), and the majority (87%) are headed by men with low education levels (only 10% have some secondary school or higher and 39% have no formal schooling). Caregivers of the target child are relatively young (25.7 years old on average) and with low levels of education: over one third (34%) have no formal schooling and only 16% attended secondary school or higher. Less than a half of

the sample (only 38%) had access to safe drinking water, and only 20% treated their water to make it safe for drinking. Approximately two-thirds (66%) had access to a latrine, and about half (48%) had dirt floors—indicating generalized low levels of dwelling quality.

4 Observed Impacts of the Child Grant 0-2



Following the Child Grant 0-2 logical framework, besides baseline characteristics of the study sample, outcomes are presented in four main levels: (1) target child level, (2) household level, (3) caregiver level, and (4) older children (aged

3 to 17 years). In addition, we present some key descriptives on Child Grant 0-2 operations from a beneficiary perspective. Further results available in the full report (AIR, 2021a).

4.1 Target Children Level

Outcomes related to the wellbeing of the target child were analysed, across the following domains: (a) birth certification and registration, (b) dietary diversity and infant and young child feeding (IYCF) practices, (c) immunisations, (d) child motivation and stimulation, and (e) nutritional status (see Table 1 in Appendix).



Evaluation outcomes show beneficial (and considerable) impacts on nearly all dietary diversity, including number of daily meals, minimum dietary diversity, minimum meal frequency and consumption of vegetables, dairy, meat and fish, eggs, foods providing vitamin A and other fruits and vegetables. For example, the minimum dietary diversity increases by 100% over the mean at the end line of the control group, as well as the minimum feeding frequency (Figure 4).

There are strong and considerable impacts on children's birth registration (30 percentage points [pp] or a 150% increase over the endline comparison mean), with impacts originating from both the cash and case management components.

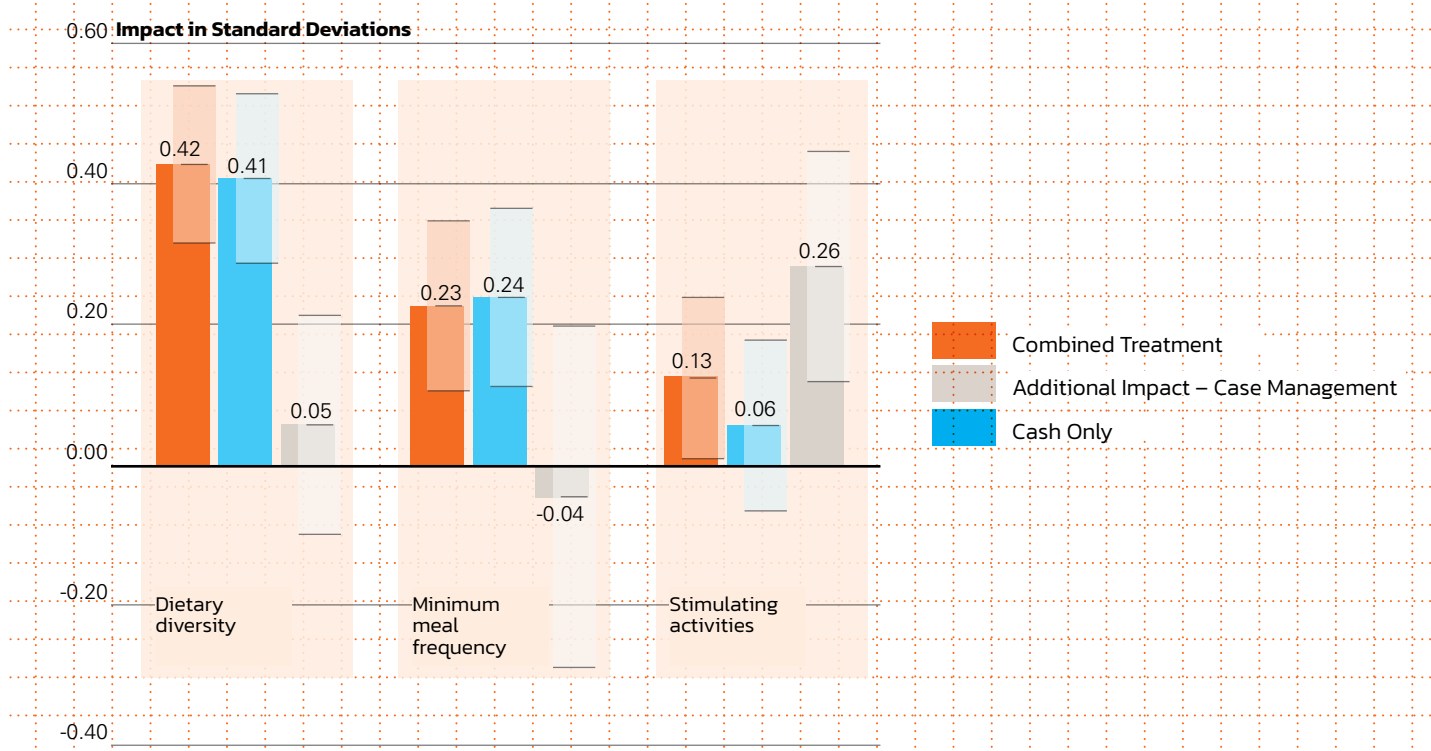
In contrast, there are fewer consistent effects on immunisations, with impacts only on having a vaccination card (resulting from the case management component) and the BCG vaccine (resulting from the cash transfer component) and no positive impacts on deworming or vitamin A doses.

Except for the primary caregivers, there are no impacts on target child motivation and stimulation by any household members (aged 15 and above); however caregivers report an increase of 11% in activities with the target child, partially driven by the case management component. (Figure 4)

Finally, measures of anthropometrics, including underweight, acute and chronic malnutrition are largely unchanged at endline. Levels of stunting are high at endline, ranging from 51% to 54%, indicating more effort is needed to address malnutrition in this population. Meaningful reductions in stunting may be limited due to environmental factors, such as inadequate hygiene and sanitation, but also due to the low value of the transfer granted to the beneficiaries (540.00Mts represents 13% of the monthly family expenses). There are also high rates of diarrhea among target children at endline (>40% reporting episodes in the last 2 weeks) – with only weakly significant impacts of the case management component.

Finally, there are few meaningful differences by gender of the target child or the household head, suggesting the Child Grant 0-2 is equally benefiting boys and girls.

Figure 4. Impacts on Dietary Diversity, Feeding Frequency, and Stimulation Activities of the Target Child



Notes: Impacts are estimated using a difference-in-differences model with robust standard errors across children in the panel sample. The orange bar presents the joint impacts of the cash transfer and the case management component. The blue bar represents the impact of the transfer relative to the control group and the grey bar represents the additional impact of the intervention for households that were eligible for the case management component. All estimates control for the linear distance to the district border (km), an indicator for the northern border, child demographics (age, gender), caregiver demographics (age, education, and marital status), household head demographics (gender, age, and education), household size, a variable for household religion, and a COVID-19 community disruption index at the bottom line. The orange and purple bar estimates also include two vulnerability indicators at baseline used to determine eligibility for case management.

4.2 Household Level



Household-level domains were examined in relation to: (a) consumption and expenditures, (b) poverty rates, (c) food security, (d) asset ownership, (e) credit and transfers, (f) non-farm enterprises, agricultural production, and livestock, (g) shocks and coping mechanisms, and (h) access to other programs.

There are moderate impacts on total per-capita expenditures of 118 MZN (translating to a 13% increase over endline comparison means). These impacts are driven primarily by food expenditures, as well as expenditures on housing and utilities, clothing and footwear and transportation (see Figure 4 and Table 1 Statistical Annex).

There are reductions in poverty rates of similar magnitude (10% decrease in poverty headcounts, and 13% decrease in the poverty gap).

Food insecurity also decreases, both in terms of the total food insecurity experience index (consisting of 8 questions regarding different aspects of food insecurity, presented in Figure 6) as well as the number of meals eaten per day.

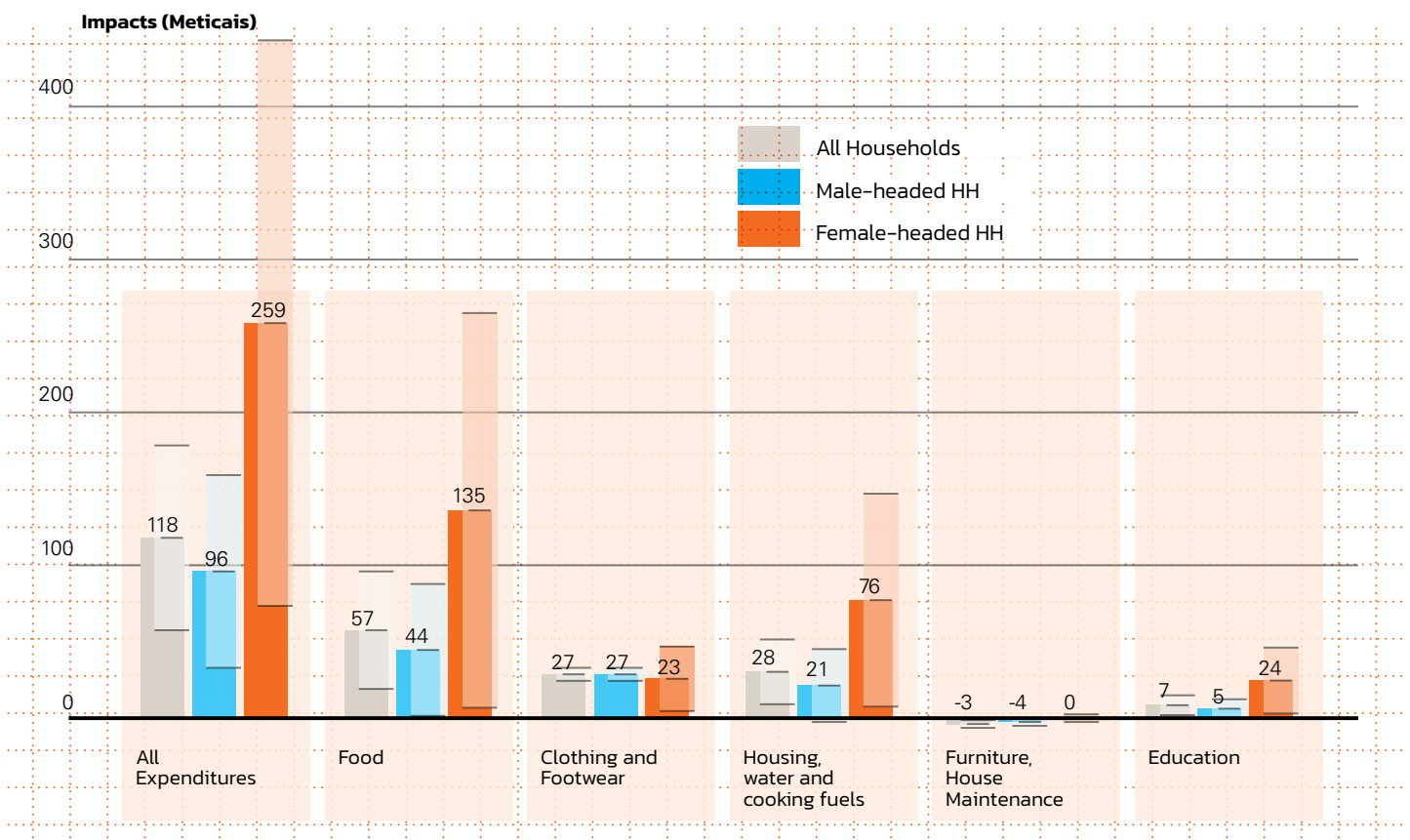
Households invest in non-farm activities, increasing operation of any enterprise (16% over endline comparison means).

While there are increases in household asset ownership, there are largely no changes in other productive indicators, including livestock ownership or agricultural activity.

Finally, households in the treatment group are less likely to report they were affected negatively by COVID-19 (54% reduction).

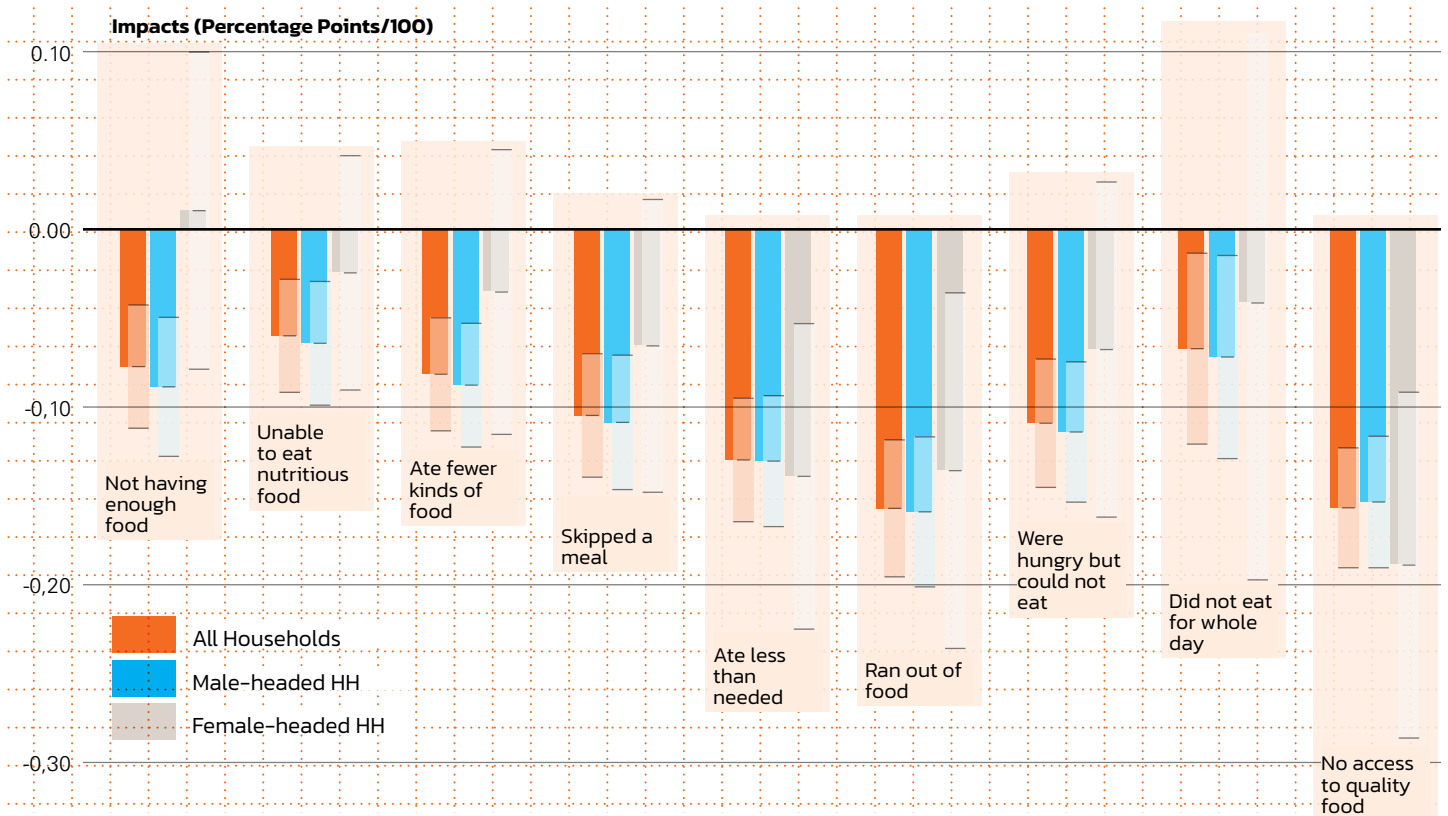
With a few exceptions (e.g., poverty gap and squared poverty gap), **the impacts on the household-level appear to accrue primarily due to the cash transfer component**. In addition, across several domains, impacts appear to be larger for female headed households – indicating the Child Grant 0-2 has been particularly beneficial for this more vulnerable demographic.

Figure 5. Combined Impacts on Household Expenditures by Gender of Household Head



Notes: Impacts are estimated using a difference-in-differences model with robust standard errors using the panel sample. The estimated impacts and confidence intervals are from a model that jointly estimates the impacts of the cash transfer and case management component using the full sample (N = 3,370), the sample of male-headed households (N = 2,956) and female-headed households (N = 414). All estimates control for the linear distance to the district border (km), an indicator for the northern border, household head demographic data (sex, age, and education), a variable of the household's religion, and a COVID-19 community disruption index at the end line.

Figure 6. Pooled Impacts on Food Security Indicators by Gender of Household Head



Notes: Impacts are estimated using difference-in-differences with robust standard errors among the panel sample. Point estimates and 95% confidence intervals are from a model estimating the impact of the pooled treatment—using the full sample (N=3,370), the sample of male-headed households (N=2,956) and female-headed households (N=414). All estimations control for linear distance to district border (km), an indicator for the northern border (paired district comparison), household head demographics (gender, age, and education), household size, a dummy for household religion, and an index for COVID-19 disruption in community from follow-up.

4.3 Caregiver Level



At the caregiver-level the following domains were examined: (a) health and nutrition knowledge, (b) psychosocial wellbeing and social support, (c) empowerment and freedom from violence, and (d) fertility and reproductive health.

Across several key health and nutrition knowledge domains, including knowledge of exclusive breastfeeding, **there are no consistent or strong impacts** – demonstrating that Child Grant 0-2 components related to knowledge uptake have not been successful in changing specific knowledge assessed.

However, there were strong impacts across nearly every other domain: Caregivers have fewer depressive symptoms (11% decrease), less stress (5% decrease), higher levels of happiness and are more satisfied with life (case management component only).⁶

6. Two measures of self-rated happiness and life satisfaction were included. The first measure asks caregivers to rate their level of 'happiness' (best vs. worst life possible) on a scale ranging from 1 to 10. The second measure asks how often in the past 12 months prior to the survey the caregiver had been satisfied with her life and rated as high satisfaction those who responded 'most' or 'all the time'.

Caregivers are saving more money (130% increase), and report higher levels of autonomy, decision-making power and self-assessed financial standing – however it should be noted that levels of savings are very low, even among the treatment group at endline (10%).

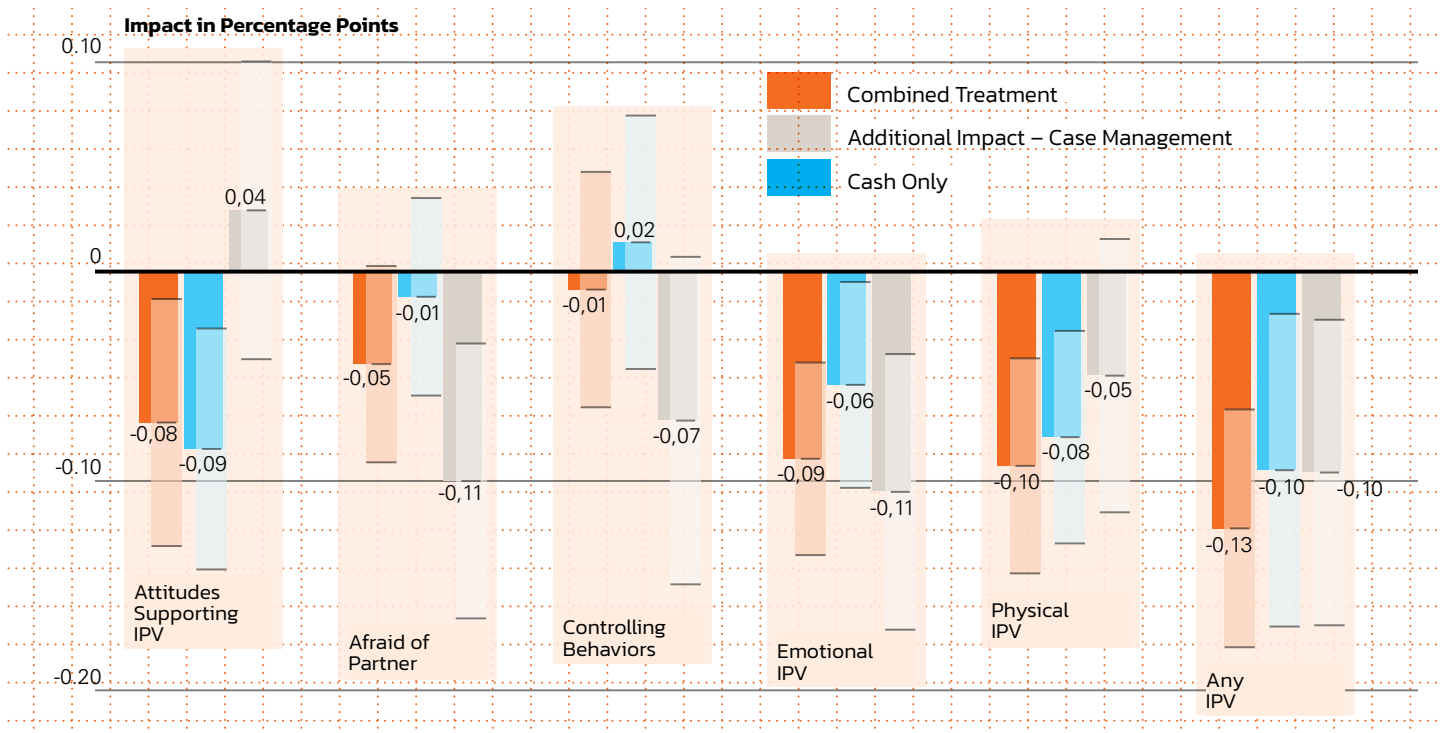
There are also notable reductions in attitudes of intimate partner violence (IPV) acceptance, and lower emotional, physical, or both, experience of IPV in the last 12 months, the latter decreasing by 38% over endline comparison means (Figure 7).

Adverse impacts on pregnancy or fertility were not found, with the Child Grant 0-2 decreasing current or recent pregnancies and the case management component reducing child separation (measured as any biological child <18 years living outside the home).

In many instances, the case management component appears to contribute substantially to additional or independent impacts – including on violence and family separation outcomes.

Finally, impacts appear to be greater across several domains for older caregivers (those >25 years at baseline), indicating more vulnerable caregivers who are adolescents or youth may need more dedicated or intensive Child Grant 0-2.

Figure 7. Impacts on Intimate Partner Violence Indicators



Notes: Impacts are estimated using a difference-in-differences model with robust standard errors across children in the panel sample. The orange bar presents the joint impacts of the cash transfer and the case management component. The blue bar represents the impact of the transfer relative to the control group and the grey bar represents the additional impact of the intervention for households that were eligible for the case management component. All estimates control for the linear distance to the district border (km), an indicator for the northern border, child demographics (age, gender), caregiver demographics (age, education, and marital status), household head demographics (gender, age, and education), household size, a variable for household religion, and a COVID-19 community disruption index at the bottom line. The orange and purple bar estimates also include two indicators of vulnerability at baseline used to determine eligibility for case management.

4.4 Older Children Level



A range of outcomes for older children (primarily those aged 3 to 17 years) were examined along four main domains: (a) material well-being, (b) education (c) time allocation, including school and work (both productive and care work) and (d) violence against children, including assessment of initiation rites among female children.

Strong impacts on material well-being of children were found, with increases of 58% over endline comparison means, in relation of children having shoes, a change of clothes and a blanket, as well as children reporting having slept under a mosquito net the night before.

In terms of education, the effects are weaker, with an 8% impact on current school enrolment and adverse impacts on school attendance (number of days per week attended).

The latter, may have to do with differences in the return to school or the conditions and procedures implemented due to the impact of COVID-19, after the schools reopen in March 2021, including the organization of classes on a rotating basis.

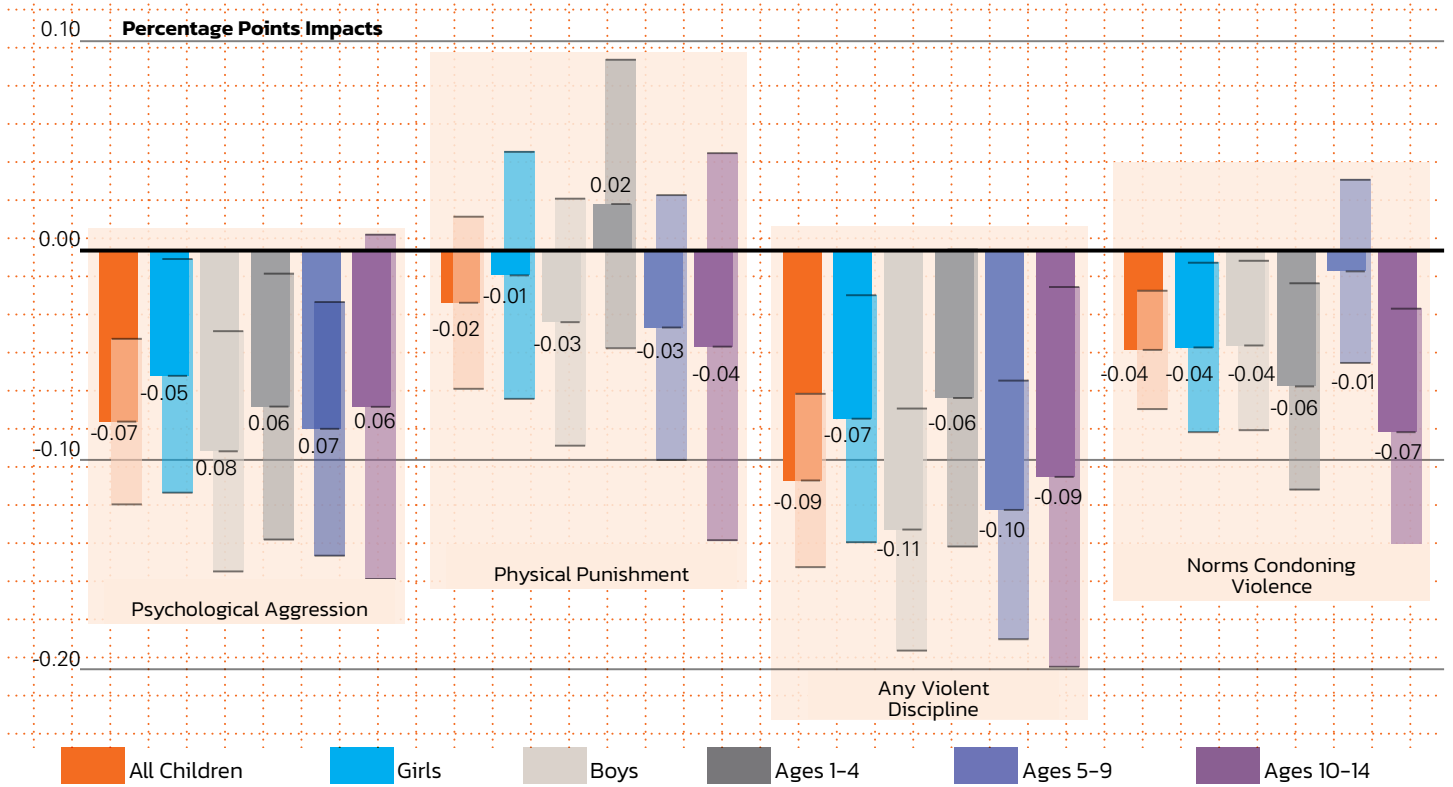
There are no observable impacts on school spending.

Child time spent in both in domestic activities (i.e., taking care of family members, collecting firewood, other domestic tasks), as well as productive activities (i.e., farming, fishing, harvesting) were observed across a range of outcomes, attributable jointly to cash transfer and case management.

A strong decrease in violent discipline of children was also observed (16% over endline comparison means), as well as in caregiver beliefs violence is necessary to raise children (67% decrease over endline comparison means). The latter two outcomes show strong additional impacts attributable to the case management component. These impacts occur for male and female children and children of different age groups (Figure 8).

Although not a primary outcome, self-reported initiation rites among adolescent girls (as described by caregivers) were also analysed to anticipate possible future effects regarding child marriage. However, no impacts were found on the likelihood of girls (from 10 to 18 years old) undergoing initiation rites, nor on the likelihood of planning rites in the coming years. In sum, the results presented in the figure show that while there are some differences originating from age groups in these impacts, there are fewer differences by gender of the child, suggesting that **the beneficial impacts of the Child Grant 0 – 2 are occurring for both boys and girls.** (Figure 8 and Table 4 Statistical Appendix).

Figure 8. Impacts on Violent Discipline of Children Aged 1 to 14 Years by Sex and Age Group



Notes: Impacts are estimated using difference-in-differences with robust standard errors among children who live in the household panel sample. Point estimates and 95% confidence intervals are from a model with the cash and case management treatment groups combined – using the full sample (N=8,062), girls only (N=4,003), boys only (N=4,059) and age groups (ages 1-4, N=2,999; ages 5-9, N=3,241; ages 10-14, N=1,822). All estimations control for linear distance to district border (km), an indicator for the northern border (paired district comparison), child demographics (age, sex), caregiver demographics (age, education and marital status), household head demographics (gender, age and education), household size, a dummy for household religion, an index for COVID-19 disruption in community from follow-up and enumerator fixed effects.

5 Operational performance



Operational performance among Child Grant 0-2 beneficiaries was analysed to complement information in the process evaluation.

Results show that the intervention is well-known and 91% of the sample (mainly in treatment areas) reported having received cash transfers or services.

Beneficiaries overwhelmingly identify being a caregiver with young children as **the main eligibility criteria** (93%).

Other perceived factors were: caring for orphans and vulnerable children, disability and poverty.

Despite reporting having received the equivalent of 20 months of transfers on average (10,509 MZN) over the intervention period, **transfers were lumpy** (4.6 payments on average) **and unpredictable** – with caregivers largely unable to identify when they would receive their next transfer.

At pay points, caregivers report feeling safe when picking up the transfer (90%), spending on average 74 minutes in the process, and 83% had designated someone to pick up the funds when they were not able to.

Caregivers report spending the transfer mainly on food and nutrition for the family (98%), clothing and shoes (93%) and health care (46%), with few mentioning productive investments or savings.

Finally, a lower-than-expected proportion of the eligible sample reported receiving case management component (only 27% of the case management-eligible sample and 11% of the entire treatment sample), and among those, beneficiaries reported a lower number of visits than expected (2.3 on average). This indicates possible implementation challenges for the case management implementation and should be considered when interpreting impacts presented in this report.

6 Recommendations for the Child Grant 0-2



Results of this evaluation show that the Child Grant 0-2 has wide-ranging benefits for poor and vulnerable children and their families, including impacts on household economic and food security, and ability to cope with COVID-19. It also has positive impacts on caregiver and child health, well-being and freedom from violence. Most impacts at the household level are attributable to the cash transfer component, while some specific impacts for the caregivers and the children derive both from the cash transfer and case management components. As previously mentioned, due to the untargeted nature of the SBCC and our study design, we are unable to directly attribute impacts to this component. However, it is possible that some of these beneficial impacts around IYCF, health and parenting have been generated by the SBCC component.

The Child Grant 0-2 reached a highly vulnerable segment of the population – approximately 86% of households were living in poverty before the intervention – and many struggled to meet basic needs. Nearly half of all caregivers in the study reported first being married before the age of 18, having poor mental health and inability to save money for emergencies or investments. Households that are part of the intervention experience shocks of many kinds (including COVID-19) on an ongoing basis. Therefore, safety nets such as the Child Grant provide an essential safeguard to ensure health and well-being of young children and families. **Thus, our overarching recommendation is to maintain the current design of the intervention, while planning for scale-up of the Child Grant 0-2 to other districts in Nampula and beyond.** In the immediate future, Child Grant 0-2 should be offered to the control group districts, and neighbouring areas in Nampula province.

Despite the intervention wide-ranging beneficial effects, on the different levels and domains, some are small (or modest) in comparison to similar programmes in the region, while for others, effects are null. Therefore, it appears that there are several factors related to the Child Grant 0-2 design and implementation that can be improved for it to reach

its full potential. We recommend the following actions:

Transfer value: The transfer represents 13% the monthly household expenditures at baseline – a value that has not been adjusted over time to account for inflation. Evidence from evaluations of national cash transfer programs in the Sub-Saharan African region conducted by the ‘Transfer Project’ suggests that, on average, to ensure widespread effects, the value of the transfer should equal at least 20% of total household consumption (Davis & Handa, 2015). This evaluation results show that households spent almost the total value of the transfer on regular consumption and expenditures with low or no major impacts on investing in productive activities (non-farm enterprises, agriculture, livestock) that could have a multiplier effect for the household, and help make impacts sustainable in the long run when households stop receiving the transfer. Thus, as the transfer value is an essential parameter for the effectiveness of the Children Grant 0-2, evaluation results suggest the need to readjust the transfer value, **or at a minimum establish close monitoring over time is needed to ensure the real value does not decrease further.** These considerations are particularly relevant during times of economic shocks, when households need more resources to cover their basic needs. and benefit from other transfers linked to aggregate or specific shocks.

Transfer duration: Closely related to the value of the transfer, is the duration caregivers and households are eligible to receive funds. Currently, caregivers become eligible upon the birth of a child, and this extends up to when the child turns 2 years old. Most beneficiaries reported that they did not know for how long they would continue to receive the transfers. The short duration, which can be complicated by enrolment lags and payment delays, further limits the potential of the intervention. A longer duration of the grant would allow for greater investment in children's productive activities and human capital. In many other child grant models, women become eligible during pregnancy, thus extending the period for critical investments (e.g., covering the first 1,000 days)-or children remain eligible until age 5. **In addition to reviewing benefit levels, it is recommend to assess if participation can be extended to include the pregnancy period and to cover additional years for children up to five years old.**

Payment regularity: Beneficiaries reported both irregularity in payment intervals and uncertainty about payment dates (as well as about their participation in the Child Grant 0-2). Households are more likely to invest in productive activities using the cash transfer when they have a clear understanding of timing of future payments. On the contrary, as discussed in the operational performance section, if beneficiaries cannot plan and anticipate payments, they may be unwilling to make investments or miss the critical timing of seasonality-based opportunities. It is recognized that some of these implementation challenges may have been resulted from COVID-19 constraints. Nevertheless, **current and future Child Grant 0-2 beneficiaries may benefit greatly if the intervention is able to follow a specific plan for more frequent and predictable payments.**

Operational constraints of the case management component: Our results also show that there were some challenges in terms of implementing activities for the case management component. While triage and targeting for this component was modified from standard practice to accommodate evaluation needs, only 27% of the case management-eligible sample reported receiving activities and beneficiaries reported a low number of visits. Nevertheless, our results indicate that the case management generated positive impacts for some key outcomes, in particular those around violence, child protection, and child separation. This suggests that a cash transfer plus care approach may be an effective way to address some of the key complex vulnerabilities that households with young children face. Therefore, it is recommended **continuing the joint implementation of the cash transfer and case management components and ensure that the care activities are further supported to ensure maximum synergistic benefits for participants.** The complexity and challenges inherent in delivering the care services are recognized, highlighting the wide-ranging implementation-specific recommendations made in the process evaluation report.

Bolstering activities on child nutrition: The Child Grant 0-2 did not have a measurable impact on child nutrition, an important metric of child health and development. At endline, over half of children were stunted, and 40% of children had diarrhea in the previous 2 weeks preceding the survey. The lack of impact of the intervention on long-term child nutritional status occurs despite a large increase in dietary diversity and food security among children and households, indicating that there are other factors that may be obstacles to improving child nutrition (e.g., environment and hygiene). While SBCC component of the Child Grant 0-2 may have contributed to some positive behaviours and nutrition knowledge, these were not captured through knowledge questions included in this

study. **Therefore, it is recommended that entry points for convergence between district-level nutrition interventions and the Child Grant 0-2 be explored and leveraged**, beyond SBCC model currently in operation. In particular, programming should consider the determinants of child nutrition as entry points, including ensuring a clean environment and household hygiene.

Supporting adolescent caregivers and address premature unions and early pregnancy:

While results suggest the Child Grant 0-2 had a range of beneficial impacts for caregivers, these benefits appeared to be greater for older caregivers. Younger caregivers, i.e., teenage mothers and those under 24, may need additional support to ensure the same range of beneficial impacts. Case management component already prioritizes young caregivers, and in particular those that gave birth as children (under the age of 18 years). However, this age cut off may leave out many vulnerable young mothers, many of whom were married as child brides. **Thus, it is recommended that emphasis be continued in serving adolescent mothers, and linkages be made wherever possible as part of case management with adolescent-specific health and education services.** In addition, attention to the specific barriers adolescent girls might experience (e.g., travel to pay points, transfers control) should be given across all aspects of Child Grant 0-2 implementation.

These considerations should be complemented with further efforts focused on prevention of child marriage within communities and participant families in order to curb the cycle of early marriages and childbirth. This may include engaging with specific services and programmes aimed at reducing early, forced and child marriage across legal, health and education services, as well as engagement with community actors and groups.

7 Conclusion



This impact evaluation provides concrete evidence of the beneficial impacts of the Child Grant 0-2 implementation, applying an approach of cash plus case management for children, caregivers and families.

The results found at all levels assessed (target child level, household level, caregiver level, and other child levels) are solid in demonstrating that the Child Grant 0-2 has achieved its objectives and these are aligned with the objectives of the PSSB and even more aligned with the objectives set out in the ENSSB II.

These recommendations result not only from findings verified in the field, but also from the analysis of the circumstances involved in the implementation of this subcomponent, which interfered in some way with the results obtained. The materialization of these recommendations is crucial for raising the quality of the intervention and, consequently, for raising its results and impact.

The research shows a clear rationale for scale-up of the child grant, however points to several ways the programme could be strengthened. There are also several limitations worth keeping in mind. First, because of the low number of households that received the case management component, results may not reflect the full scope of potential impacts and associated benefits. Similarly, as previously mentioned, the study did not test the impacts of the nutrition SBCC component. Finally, the implementation and evaluation were disrupted by the ongoing COVID-19 pandemic, which resulted in challenges to all aspects of implementation, and may have affected both regularity of payments, as well as frequency and quality of case management component. Results also do not address the cost-effectiveness of different Child Grant 0-2 components, nor do they make explicit recommendations on the

fiscal sustainability or institutional arrangements, including systems building recommendations. Despite these limitations, this research shows that MGCAS, INAS and partners have laid the framework for improvements in multi-dimensional wellbeing for populations at need and for children in particular, and provided an essential safety net in the face of ongoing shocks in Mozambique.

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9 Annexes



FICHA DE SAÚDE DA CRIANÇA

Nome da Criança: Benifago
Mãe: Benedita Contando

Sexo: M F

Idade: 19

Local de parto: Em casa A caminho Na maternidade

Tipos de Parto: Normal Ventrosa Cesariana Pelvico

Idade	Altura (cm)	Peso (kg)
19	150	45
20	155	50
21	160	55

9.1 Annex A: Summary of Evaluation Results

Table A1. Summary of Impacts on Key Outcomes from Target Child

Dependent	Impact Estimates			Endline Mean	
	DD Pooled Treatments (1)	DD Cash (2)	Additional Impact CM (3)	Comparison Group (4)	N (5)
Birth registered	0.30*** (0.02)	0.27*** (0.03)	0.09** (0.04)	0.20	1637
Minimum dietary diversity (MDD)	0.11*** (0.02)	0.11*** (0.02)	0.02 (0.03)	0.11	3338
Number of activities caregiver did with child (last 3 days)	0.23* (0.12)	0.12 (0.13)	0.46*** (0.16)	2.18	3338
Stunted (length-for-age z-score < -2)	0.03 (0.03)	0.02 (0.03)	0.04 (0.04)	0.51	3338
Wasted (weight-for-length z-score < -2)	-0.02 (0.02)	-0.02 (0.02)	-0.00 (0.03)	0.08	3311
Had diarrhea in the last 2 weeks	0.01 (0.03)	0.02 (0.03)	-0.07* (0.04)	0.40	3299

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors using the panel sample, with the exception of birth registration, which is a single-difference estimate using the endline only. Column (1) presents programme estimates from a model with the cash and case management treatment groups combined. Columns (2) and (3) present programme estimates from a model with an additional interaction term for households eligible for the case management component. The coefficient in Column (2) represents the impact of the cash transfer relative to the comparison group, and Column (3) represents the additional programme impact for households eligible for the case management component. All estimations control for linear distance to district border (km), an indicator for the northern border (paired district comparison), caregiver demographics (age, education and marital status), household head demographics (gender, age and education), household size, a dummy for household religion, an index for COVID-19 disruption in community from follow-up, child age and gender. The model presented in Columns (2) and (3) also includes two indicators of protection vulnerability at baseline used to determine eligibility for the case management component. * $p < 0.1$. ** $p < 0.05$. *** $p < 0.01$.

Table A2. Summary Impacts on Key Outcomes at the Household Level

Dependent	Impact Estimates			Endline Mean	
	DD Pooled Treatments (1)	DD Cash (2)	Additional Impact CM (3)	Comparison Group (4)	N (5)
Monthly per-capita expenditures (MZN)	118.2*** (36.1)	112.8*** (38.1)	24.0 (49.7)	878.8	3370
Monthly per-capita food expenditures (MZN)	57.3** (25.3)	54.2** (26.8)	13.6 (34.9)	587.3	3370
Poverty headcount (all expenditure line)	-8.78*** (2.65)	-9.46*** (2.81)	2.53 (3.66)	83.99	3370
Poverty gap (all expenditure line)	-4.84** (1.88)	-3.63* (1.98)	-4.94* (2.58)	37.11	3370
Food insecurity experience index (FIES)	-0.79*** (0.14)	-0.70*** (0.15)	-0.34 (0.21)	6.99	3370
Operates any non-farm enterprise	0.07** (0.03)	0.07** (0.04)	0.01 (0.05)	0.44	3370
Livestock ownership index	0.01 (0.05)	0.00 (0.05)	0.04 (0.07)	0.06	3370
Affected negatively by COVID-19 shock	0.01 (0.05)	0.00 (0.05)	0.04 (0.07)	0.06	3370

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the panel sample. Column (1) presents programme estimates from a model with the cash and case management treatment groups combined. Columns (2) and (3) present programme estimates from a model with an additional interaction term for households eligible for the case management component. The coefficient in Column (2) represents the impact of the cash transfer relative to the comparison group, and Column (3) represents the additional programme impact for households who were eligible for the case management component. All estimations control for linear distance to district border (km), an indicator for the northern border (paired district comparison), household head demographics (gender, age and education), a dummy for household religion, and an index for COVID-19 disruption in community from follow-up. The model presented in Columns (2) and (3) also includes two indicators of protection vulnerability at baseline used to determine eligibility for the case management component. * $p < 0.1$. ** $p < 0.05$. *** $p < 0.01$.

Table A3. Summary Impacts on Key Outcomes for Caregivers

Dependent	Impact Estimates			Endline Mean	
	DD Pooled Treatments (1)	DD Cash (2)	Additional Impact CM (3)	Comparison Group (4)	N (5)
Knows baby should be breastfed exclusively for 6-months	0.01 (0.02)	0.01 (0.02)	-0.03 (0.03)	0.83	3342
Depressive symptoms (CES-D \geq 10)	-0.07** (0.03)	-0.06** (0.03)	-0.03 (0.03)	0.63	3342
Stress (Cohen self-reported stress scale)	-0.84*** (0.30)	-0.69** (0.32)	-0.54 (0.39)	17.84	3342
Currently saving money	0.04** (0.02)	0.04* (0.02)	0.01 (0.02)	0.03	3342
Self-assessed decision-making power (ladder)	0.43*** (0.15)	0.45*** (0.16)	-0.04 (0.20)	5.72	3342
Participates in at least one community group	0.03 (0.03)	0.01 (0.03)	0.08** (0.04)	0.41	3342
Emotional and/or physical IPV (12-month recall)	-0.13*** (0.03)	-0.10*** (0.04)	-0.10** (0.05)	0.34	2814
Currently pregnant or pregnant in the last 24 months	-0.09*** (0.03)	-0.09*** (0.03)	-0.02 (0.04)	0.41	1624
Any biological child <18 years lives outside the home	0.01 (0.03)	0.03 (0.03)	-0.08** (0.04)	0.31	1627

Notes: CES-D stands for Centre for Epidemiologic Studies Depression scale; CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the panel sample, with the exception of pregnancy and biological children living outside the home, which are estimated using single differences at endline. Column (1) presents programme estimates from a model with the cash and case management treatment groups combined. Columns (2) and (3) present programme estimates from a model with an additional interaction term for households eligible for the case management component. The coefficient in Column (2) represents the impact of the cash transfer relative to the comparison group, and Column (3) represents the additional programme impact for households eligible for the case management component. All estimations control for linear distance to district border (km), an indicator for the northern border (paired district comparison), caregiver demographics (age, education and marital status), household head demographics (gender, age and education), household size, a dummy for household religion, an index for COVID-19 disruption in community from follow-up and enumerator fixed effects. The model presented in Columns (2) and (3) also includes two indicators of protection vulnerability at baseline used to determine eligibility for the case management component. * $p < 0.1$. ** $p < 0.05$. *** $p < 0.01$.

Table A4. Summary Impacts on Key Outcomes for Older Children

Dependent	Impact Estimates			Endline Mean	
	DD Pooled Treatments (1)	DD Cash (2)	Additional Impact CM (3)	Comparison Group (4)	N (5)
Material well-being (shoes, cloths and blanket) (ages 3-17)	0.21*** (0.02)	0.22*** (0.03)	-0.01 (0.03)	0.36	6822
Currently attending school (ages 6-17)	0.05* (0.03)	0.07** (0.03)	-0.05 (0.04)	0.64	4466
Child time use (domestic chores, hours last 24 hours)	-0.27*** (0.12)	-0.22 (0.13)	-0.10 (0.16)	2.30	5773
Child time use (productive activities, hours last week)	-0.96*** (0.25)	-0.89** (0.25)	-0.35** (0.33)	2.37	5773
Any violent discipline (ages 1-14)	-0.09*** (0.02)	-0.07*** (0.02)	-0.07** (0.03)	0.58	8062
Caregiver believes violent discipline necessary to raise children	-0.04*** (0.01)	-0.01 (0.01)	-0.10*** (0.02)	0.06	8062

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among children living in the household panel sample. Column (1) presents impact estimates from a model with the treatment groups combined. Columns (2) and (3) present impact estimates from a model with an additional interaction term for households eligible for the case management component. The coefficient in Column (2) represents the impact of the cash transfer relative to the comparison group, and Column (3) represents the additional impact for households eligible for the case management component. All estimations control for linear distance to district border (km), an indicator for the northern border (paired district comparison), child demographics (age, sex), caregiver demographics (age, education, and marital status), household head demographics (gender, age, and education), household size, a dummy for household religion, an index for COVID-19 disruption in community from follow-up and enumerator fixed effects. The model presented in Columns (2) and (3) also includes two indicators of protection vulnerability at baseline used to determine eligibility for the case management component. * $p < 0.1$. ** $p < 0.05$. *** $p < 0.01$.

9.2 Annex B: Lalaua Complementary Analysis

Through INAS, MGCAS also implemented the start-up phase of the Child Grant 0 to 2 in the district of Lalaua. Households that were included in the assessment in this district received the cash component for having a young child as part of the household.

Sample

At baseline, AIR and partners collected data from 456 households in Lalaua in June 2019, and 728 control households in February/March 2019 in Mossuril and Nacala Porto – the comparison districts. In the final assessment, data were collected from 417 households in July 2021 for Lalaua, and 711 households in March/April 2021 in the comparison districts. The evaluation team collected data in different months for the treatment and comparison households, as Lalaua was included in the evaluation after data were collected in comparison districts in 2019.⁷

Approximately 22% of the sample could not be interviewed at endline because they had changed their place of residence, were not available at the time of the survey, or could not be located. To assess the implications of not locating all baseline households, two different models were estimated. First, impacts were assessed using only the panel observations (i.e., the observations of the households that were interviewed in both cycles: baseline and endline). Second, impacts were assessed using all observations, even if they were not part of the panel. The estimated results of these two specifications are very similar, which means that the results are not driven by attrition bias. Some additional analyzes were also performed and it was confirmed that the panel sample has good

internal validity; that is. that the statistical balance for the baseline outcome variables did not change significantly for those in the panel sample.

Overall, baseline households in Lalaua comprise 4.33 members per household, compared to 4.96 members per household in the comparison districts. In both groups, 87% of households are male-headed. In terms of education level, the primary caregiver and the head of the household in Lalaua have low levels of education (only 5% and 17%, respectively, have secondary or higher education and 37% and 42% have no formal education). These levels of education are very similar to those of household heads and caregivers in the comparison districts. The caregivers of the target children are relatively young (the average age is 26.0 years in the treatment and comparison areas). However, there are some important differences in the two populations. First, in terms of religious affiliation, 81% of households in Lalaua are Christians and 13% Muslim. This clearly contrasts with the households in the comparison districts, where 93% of the households are Muslim. Second, in terms of agricultural production, 45% of households in Lalaua reported producing at least one crop versus only 32% in comparison districts.

Methodology

The evaluation team carried out an impact assessment of the intervention, which lasted 24 months. This evaluation compared the results of the treatment group in Lalaua, which received the cash transfer, with the comparison districts. To assess impacts, we used a difference-in-differences approach, which compares the change (i.e., difference) of a particular outcome variable (e.g., expenses) between the treatment group and the comparison group at

7. As addressed in the baseline report (AIR, 2020c), this difference in the timing of data collection may have resulted in some significant imbalances in the baseline between Lalaua and the comparison districts in key effects, including consumption and expenditure levels, as well as anthropometric variables for the target child. In fact, data collection in Lalaua occurred in July, when households have more access to food and resources, in contrast to the data collected in the comparison districts, which were collected at the end of the lean season. For the final data collection Lalaua data were collected a few months after the data from the comparison districts in order to account for some of the seasonal differences in the seasonality of the data explain some of the seasonal differences between treatment and control households through the empirical methodology. However, as explained in more detail in this section, some estimated impacts may still be affected by the differences in the timing of data collection.

baseline to the change (i.e., difference) of the same outcome between the treatment group and the comparison group at **endline**. This approach facilitates the assessment of impacts in the final assessment after readjusting those impacts for any baseline imbalances between the treatment and control groups. The main assumption underlying the differences-in-differences strategy is that, in the absence of the intervention, the outcomes for the treatment and control groups would have had a similar progression over time (i.e., the outcomes would have evolved in parallel over time).

It should be noted that for the assessment of impacts for the Lalaua sample, a different methodology was used than that used to estimate the impacts for Nacala-a-Velha and Ilha de Moçambique, which uses the discontinuous geographic regression method given that these latter districts they share a common border with the control districts of Mossuril and Nacala Porto and can be considered to have the same characteristics. However, it was not possible to use the same empirical strategy for Lalaua as the control districts of Mossuril and Nacala Porto do not share district boundaries with Lalaua. But for most outcome variables, the empirical difference-in-differences strategy also provides a robust methodology for assessing impacts.

Results

The impacts of the cash component in Lalaua are analyzed at four main levels: (a) target child level, (b) household level, (c) caregiver level, and (d) oldest child level (those who are 3 to 17 years old). Table 1 summarizes the impacts on the key indicators at the four levels. All the results analyzed below use the panel observations, that is, the observations for which baseline and endline data are available.

1. Target Child: Results related to the well-being of the target child are analyzed in the same domains evaluated for the districts of Nacala-a-Velha and Ilha de Moçambique. There are strong impacts on children's birth registration (20 percentage points [pp], or a 100% increase over the final assessment comparison average). In terms of immunizations, we found some mixed results. On the one hand, we found positive impacts on having a vaccination card (11 pp, or an increase of 11%), receiving the BCG and Polio vaccines (11 pp, or an increase of 11%) and a decrease in the probability of having diarrhea in the last fortnight before the survey (-15 pp, or a 39% reduction compared to the comparison group). On the other hand, we did not find positive impacts on other vaccines, deworming, or provision of vitamin A. Regarding the nutritional status, the results indicate that the intervention had no impact on dietary diversity and chronic malnutrition. However, there was a 4-percentage point reduction in the propensity of being wasted, a short-term nutritional measure. However, this positive result must be interpreted with caution. While lower levels of wasting in Lalaua may have benefited from a lower incidence of diarrhea, differences in data collection dates between treatment and comparison groups may have also influenced this outcome. That is, children in Lalaua are not only three months older than children in the comparison districts at the time of the interview, but they may also show weight gains due to the increased availability of food in Lalaua in July, when the data were collected relative to food availability in Mossuril and Nacala Porto where data were collected in April.⁸

⁸ The sample inclusion criterion for the evaluation in the districts of Lalaua (treatment) and of Mossuril and Nacala Porto (comparison) is for households to have a child born after 15 August 2019. The differential timing in data collection at baseline for Lalaua and the comparison districts may have important implications for some outcomes. In control districts, data were collected in February and March 2019, and as a result, children were less than 6 months old at the time of the baseline survey. In contrast, data in Lalaua were collected in June 2019, which means that eligible children were between 3 and 9 months. This age difference at the time of baseline data collection produced relevant differences in some outcomes between the treatment and comparison groups, including infant nutritional status. The evaluation team decided to collect data in Lalaua for children born at the same time of year, rather than the same age at the time of data collection, because evidence shows that seasonal fluctuations in food consumption in rural Mozambique are high (Handa and Mlay, 2007) and these fluctuations in access to food and economic resources can also have large variations in child development (e.g. height and nutritional status) for children born at different times of the year (Arsenault et al, 2014; Fentahun et al 2018). Thus, while it is true that age differences at the time of the survey create disparities in some outcomes between the treatment and control groups, differences generated by births at different times of the year were considered more problematic for estimating impacts.

2. Household level: In terms of household-level impacts, we found moderate impacts in total expenditure per capita (119 MZN, which indicates an increase of 14% compared to the endline average for the comparison group), mainly driven by expenditures on clothing and footwear (88 MZN). Interestingly, there are no impacts on food expenditures, which is to be expected as the data in Lalaua were collected at a time when more food is available, and households can use the cash transfer on other types of products. Higher spending results in a 9pp reduction in the poverty index (or 10% compared to the comparison group) and a 7pp reduction in the poverty gap. While no impacts were observed on food expenditures (which were assessed in the last seven days prior to the survey), we found an 11% reduction on the food insecurity scale (which is measured over a time period longer than 7 days as in the food expenditures). The results also provide evidence that households in Lalaua use cash transfers in some productive activities, such as investing in livestock (an 8pp increase in goat ownership and a 25 pp increase in chicken ownership, which translates into a positive increase of 0.21 in the livestock ownership index).

3. Caregiver: At the caregiver level, providing a transfer to households in Lalaua resulted in some positive impacts. First, caregivers in the treatment group are significantly more likely to save (24 pp increase, or 600%, over the control group). This result can be partially explained by the timing of data collection in Lalaua because in July households in this district need less resources to buy food and, as such, may be able to save part of the transfer. Caregivers also reported having more decision-making power than caregivers in the comparison group (a 23% increase), lower levels of physical spousal violence (45% reduction), and a 29% reduction in the likelihood of young biological children living outside the household. Results on caregivers' psychological well-being are more mixed, which is not surprising given that in Lalaua the intervention did not provide the case management subcomponent. For example, there are no impacts on reducing depressive symptoms and or stress levels.

4. Older Children: We found strong impacts on child well-being, with a 26pp increase (72% above the final assessment comparison average) in the probability of having shoes, a change of clothes, and a blanket. We also found positive impacts on education, with an 11pp (17%) increase in school enrollment. Finally, we observed strong reductions in child violent discipline (19 pp reduction, or 24% above the comparison average at endline), as well as a reduction in caregiver's conviction that violence is necessary to discipline children (a 7pp decrease, or 140%, relative to the mean of the comparison group at endline).

Table B1. Summary of key impact evaluation findings across domains

	Estimated Impact (1)	Percentage Change (2)
Target child (aged 0–6 at baseline)		
Child has birth registration	0.20***	100%
Has a vaccination card	0.11***	11%
Received BCG vaccine	0.11***	11%
Received Polio Vaccine	0.11**	12%
Had diarrhea in the last two weeks	-0.15***	-39%
Minimum dietary diversity (MDD)	0.04	NA
Wasted (weight-for-length z-score <-2)	-0.04**	-50%
Stunted (length-for-age z-score <-2)	0.01	NA
Household-level		
Monthly per-capita expenditures (MZN)	119.5***	14%
Monthly per-capita food expenditures (MZN)	2.4	NA
Monthly per-capita clothing expenditures (MZN)	88.0***	463%
Poverty rate	-9.15***	-10%
Poverty gap	-6.99**	-18%
Food insecurity experience index (FIES)	-1.80***	-11%
Livestock ownership index	0.21***	NA
Affected negatively by COVID-19	-0.01	0%
Caregiver-level		
Currently saving	0.24**	600%
Self-assessed decision-making power (ladder)	1.32***	23%
Emotional and/or physical IPV (12-month recall)	-0.10***	-45%
Any biological child <18 years lives outside the home	-0.09*	-29%
Depressive symptoms (CES-D ≥ 10)	-0.04	NA
Stress (Cohen self-reported stress scale)	1.87***	10%
Older children (primarily ages 3–17)		
Material well-being (shoes, cloths and blanket) (ages 3 to 17)anos)	0.26***	72%
Currently attending school (ages 6 to 17)	0.11**	17%
Any violent discipline (ages 1-14)	-0.19***	-24%
Caregiver believes violent discipline necessary to raise children	-0.07***	-140%

Notes: Pooled treatment impacts are coefficients from difference-in-differences estimations with control variables at the child, caregiver and household-levels and robust standard errors among the household panel sample. Percentage changes are calculated only when effects are significant and are in relation to the endline comparison group mean. Additional impacts of the case management component are calculated using a model with an additional interaction term for households who were eligible for this component. * $p < 0.1$. ** $p < 0.05$. *** $p < 0.01$.

Operational Performance

We also assessed operational performance among beneficiaries in Lalaua. The results indicate that the intervention is well known, with over 88% of the sample reporting that they received the cash transfer. Beneficiaries also identified caregivers with young children as the main eligibility criterion (86%) to be part of the intervention. Other criteria identified are care for orphans and vulnerable children, disability, and poverty. Despite reporting that they received 13,880 MZN on average during the intervention period, transfers were also reported to be irregular (on average, 4.7 payments) and unpredictable. Thus, caregivers were unable to estimate when they would receive their next transfer. Caregivers mentioned the used the transfer in food and nutrition to the household (97%), clothes and shoes (88%) and health care (57%).

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