ENDLINE REPORT

24-MONTH IMPACT EVALUATION OF THE CHILD GRANT 0-2 COMPONENT IN THE NAMPULA PROVINCE IN MOZAMBIQUE

2019-2021

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JULY 2022

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ACRONYMS

AIDS	Acquired immune deficiency syndrome
AIR	American Institutes for Research
BCG	Bacillus Calmette-Guérin
CES-D	Centre for Epidemiologic Studies Depression
CT-OVC	Cash Transfer for Orphans and Vulnerable Children
DHS	Demographic and Health Survey
DID	Difference-in-differences
ELIM	ELIM Serviços
ENSSB	National Basic Social Security Strategy
FCDO	Foreign, Commonwealth and Development Office
FIES	Food Insecurity Experience Scale
HIV	Human immunodeficiency virus
IMASIDA	Inquérito de Indicadores de Imunização, Malária e HIV/SIDA
INAS	National Institute of Social Action
IOF	Inquérito sobre Orçamento Familiar
IPV	Intimate partner violence
IYCF	Infant and Young Child Feeding
LEAP	Livelihood Empowerment Against Poverty
LMICs	Low- and middle-income countries
MDD	Minimum dietary diversity
MDES	Minimum detectable effect size
MGCAS	Ministry of Gender, Children and Social Action
MICS	Multiple Indicator Cluster Survey
MZN	Mozambique metical
NGO	Non-governmental organisation
PASD	Direct Social Assistance Programme
PASP	Productive Social Action Programme
pp	Percentage point
PSSB	Basic Social Subsidy Programme
RCT	Randomised controlled trial
RDD	Regression discontinuity design
SBCC	Social and behaviour change communication
SD	Standard deviation
SDSMAS	Health, Women and Social Action District Services
SUN	Scaling Up Nutrition
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WHO	World Health Organization

EXECUTIVE SUMMARY

I. Mozambique's Child Grant 0-2 (Subsídio para Criança 0-2 Anos in Portuguese) is a component of the Basic Social Subsidy Programme (PSSB) currently in its start-up phase, which is implemented in four selected districts of the Nampula province. The initial phase is implemented by the Ministry of Gender, Children and Social Action (MGCAS) through the National Institute of Social Action (INAS), its operational arm. The initial phase is expected to provide important insights and inform the best way to scale up the intervention at the national level. The United Nations Children's Fund (UNICEF) Mozambique, with financial support from the Netherlands, the United Kingdom and Sweden, commissioned the American Institutes for Research (AIR) and its partners to carry out an impact assessment with a longitudinal design with the duration of 24 months and an evaluation of the initial phase process.

II. The Child Grant provides unconditional cash transfers to the primary caregivers of young children with the overall aim of reducing poverty and social vulnerability, improving child wellbeing, and promoting access to basic social services. Furthermore, the care (case management plus nutrition social and behaviour change communication - SBCC) component of the Child Grant 0-2 intends to address the complex and interrelated protection, as well as social, economic, and health risks that targeted households face.

III. Purpose and Objectives. The primary purpose of this evaluation is to measure causal impacts of the intervention across a broad range of household, caregiver, and child-level outcomes, approximately 24 months after the baseline survey. In particular, the objectives are to measure impacts of both the combined intervention, as well as the additional effects of the case management components. In addition, we examine sub-group impacts on vulnerable groups when possible, for example, on female headed households or by age of the primary caregiver. Finally, we present some descriptive information on participant experience with the intervention and re-assess the internal validity of the study. The impact evaluation is the first rigorous evaluation of a national child-focused social protection intervention in Mozambique and adds to scarce regional evidence on cash plus models. The results are expected to provide solid evidence to the government and its partners to make informed decisions on scale-up. In addition, it will increase the knowledge base on investing in similar interventions at the regional level. These results and implications for implementation should be interpreted in the context of COVID-19, which added to challenges in evaluation, operations, and overall vulnerability of households in the study sample.

IV. Programme. The start-up phase of the Child Grant 0-2 is implemented in four districts of the Nampula province: Ilha de Moçambique, Nacala-a-Velha, Lalaua, and Mogincual. The care component (case management and nutrition SBCC) is implemented with the support of the National Institute of Social Action (INAS) and the Health, Women and Social Action District Services (SDSMAS) in Nacala-a-Velha, Mogincual and Lalaua. This impact evaluation studies three of the intervention districts: Ilha de Moçambique, Nacala-a-Velha, and Lalaua, and includes neighbouring Mossuril and Nacala Porto districts for comparison.

V. The Child Grant 0-2 has three components. The first component is a cash transfer of approximately 540 MZN per month (paid bi-monthly), distributed unconditionally to the primary caregivers of children between 0 and 2 years old. Eligible households are also be exposed to a SBCC package on stunting reduction rolled out at the community level, with interventions around positive nutrition and hygiene practices. Lastly, a case management

component is offered to beneficiary households classified as most vulnerable to common protection risks following the results of a rapid assessment (vulnerability prioritization triage) implemented at enrolment. Family support services are offered primarily through INAS Permanentes with technical oversight from female technicians from SDSMAS and include basic psychosocial support and counselling, awareness raising on positive parenting practices as well as information and referrals to local and statutory services. All caregivers and children within selected households are supported as part of this component, including the target child. Within the study evaluation, Ilha de Moçambique received a cash-only intervention; Nacala-a-Velha and Lalaua Sede received cash and care;1 and Mossuril and Nacala Porto, as the comparison districts, not receiving any intervention.

VI. **Methodology.** The evaluation is a 24-month, longitudinal impact evaluation of the Child Grant 0-2 that compares two treatment arms ((*1*) cash only and (*2*) cash plus case management) to a comparison group (no intervention). The methodology is a quasi-experimental geographic regression discontinuity design (RDD) to estimate impacts for the treatment districts of Nacala-a-Velha and Ilha de Moçambique by comparing households in those districts to households in the neighboring districts of Mossuril and Nacala Porto, which constitute the comparison group.[2] The logic behind the geographic RDD is that those who live in the treatment area right next to the border and receive the intervention 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. We also use a difference-in-differences specification to estimate the intent-to-treat effect of the combined Child Grant 0-2 activities (i.e., pooled treatment, cash and case management) on the outcomes of interest—as well the differential impact of cash versus case management (i.e., interaction term measuring additional impact of case management) using a household panel sample. In interpreting the differential impacts of the case management, note these households (approximately 50% of the Nacala-a-Velha sample) were assessed to have higher protection risks as compared to the remaining sample. Thus, these households are not strictly comparable to the full sample, however we control for an index of protection risks in all equations to partially account for this selection bias. In addition, we control for a large set of background characteristics and confounders at the child, caregiver, and household-levels, where appropriate. Note that because of the non-targeted nature of the SBCC package, we are unable to attribute impacts specifically to these activities.

VII. **Sample.** 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, where treatment status changes discontinuously. Data on approximately 2,130 households (700 per study arm) were collected at baseline in February/March 2019 (before the intervention started) 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,

1 It should be noted that in the Lalaua district, care services are being implemented in Lalaua Sede only (this population is part of the process evaluation), while in the Meti health catchment area, which is included in the quantitative evaluation, participants receive only the cash component.

2 The analysis for the district of Lalaua uses a different methodological approach and estimates only the impacts of receiving the cash component relative to the comparison group. We present the methodology, sampling framework, and results for Lalaua in Annex C of this report.

were not available at the time of the survey or could not be found. Analysis shows that although a higher percentage of the treatment group has left the sample (23% in the treatment group versus 17% in the comparison group), the panel generally has good internal validity, showing balance at baseline between study arms and few signs of differential attrition. Overall, households have an average of 5.2 members, are headed primarily by men (87%), with both the primary caregiver and household head having low education (only 10% and 16%, respectively have some secondary school or higher – and 39% and 34% have no formal schooling). Households are primarily Muslim (90%) and caregivers of the target child are relatively young (25.7 years old on average).

VIII. **Impact results.** Following the Child Grant 0-2 logic framework, in addition to background characteristics of the study sample, outcomes are presented in four main levels: (*a*) target child level (0 – 6 months at baseline), (*b*) household level, (*c*) caregiver level, and (*d*) older children (aged 3 to 17 years). Table 1 summarizes overall impacts on lead indicators across the four levels, including the differential impact from the care component. We discuss these and other key findings in the sections below.

- **Target children**: We examine outcomes related to the wellbeing of the target child, across the following domains: *(a)* birth certification and child registration, (*b)* dietary diversity and infant and young child feeding (IYCF) practices, (*c)* immunisations, (*d)* parental stimulation and involvement, and *(e)* nutritional status. There are strong and sizable impacts on children's birth certification and 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 addition, there are beneficial (and sizable) impacts on nearly all dietary diversity and IYCF—including number of meals, minimum dietary diversity, minimum meal frequency and consumption of legumes, dairy, meat and fish, eggs, vitamin A foods and other fruits and vegetables. For example, the minimum dietary diversity increases by 100% over the endline comparison group mean. In contrast, there are fewer consistent effects on immunisations, with impacts only on having a vaccination card (from the case management component) and the BCG vaccine (from the cash component) and no positive impacts on deworming or vitamin A doses. There are no overall impacts on parental stimulation outcomes for 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). Finally, measures of anthropometrics, including underweight, wasting, and stunting are largely unchanged due to the intervention. Levels of stunting are high at endline, ranging from 51% to 54%--indicating more is needed to address malnutrition in this population. There are few meaningful differences in impacts by gender of the target child or the household head, suggesting the intervention is equally benefiting all groups.
- **Household level**: We examine household-level domains related 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 (translating to a 13% increase over endline comparison means), driven primarily by food expenditures, as well as expenditures on housing and utilities, clothing and footwear and transportation. Likewise, there are reductions in poverty rates of similar magnitude (8 pp or 10%

decrease in poverty headcounts, 5 pp or 13% decrease in the poverty gap). Food insecurity also decreases, both in terms of the total food insecurity experience index (made of 8 questions regarding different aspects of food insecurity) as well as the number of meals eaten per day. Households invest in non-farm activities, increasing operation of any enterprise by 7 pp (or 16% over endline comparison means). While there are increases in household asset ownership, there is no change in livestock ownership or agricultural activity. Finally, households in the treatment group are less likely to report they were affected negatively by COVID-19 (14 pp or 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 component. In addition, across several domains (e.g., total expenditures, poverty reduction, access to credit, and non-farm enterprises), impacts appear to be driven by female headed households—indicating the intervention has been particularly beneficial for this more vulnerable demographic.

- Caregiver level: At the caregiver-level we examine the following domains: (*a*) health and nutrition knowledge, (*b*) psychosocial wellbeing and social support, (*c*) empowerment and freedom from violence, and (*d*) fertility and (*e*) family separation. Across several key health and nutrition knowledge domains, including knowledge of exclusive breastfeeding, there are no consistent or strong impacts—demonstrating the intervention components related to knowledge uptake have not been successful in changing these particular outcomes. However, there were strong impacts across nearly every other domain: Caregivers have fewer depressive symptoms (-7 pp or 11% decrease), less stress (0.84 or 5% decrease), report higher levels of happiness and are more satisfied with life (case management component only). Caregivers are saving more money (4 pp or 130% increase), and report higher levels of autonomy, decision-making power, and self-assessed financial standing. There are also notable reductions in attitudes accepting intimate partner violence (IPV), and lower emotional, physical, and combined experience of IPV in the last 12 months (the latter decreasing by 13 pp or 38% over endline comparison means). Lastly, there are no adverse impacts on pregnancy or fertility found, with the intervention 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 larger 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 programming.
- Older Children: We examine a range of outcomes for older children (primarily those aged 3 to 17 years) along four main domains: (*a*) material well-being, (*b*) education outcomes, (*c*) time allocation, including on school and work (both productive and care work) and (*d*) violence against children, including assessment of initiation rites among female children. We find strong impacts on maternal well-being of children, with increases of 21 pp (58% over endline comparison means) of having shoes, a change of clothes and a blanket). We find weaker impacts on education outcomes, with a 5 pp (8%, weakly significant) impact on current school enrolment and no positive impacts on either school attendance (number of days per week attended) or

expenditures. These are likely related to school-based factors in the context of the endline data collection during COVID-19 pandemic. Schools were reopened in the same month after a year-long closure affecting the whole country. Safety concerns prompted educational district authorities to introduce limitations on the number of attendance days or vary the shift schedule. As a highly decentralized measure it led to differences at the community level that could be behind observed effects. We find reductions in 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, across a range of outcomes (i.e., farming, fishing, harvesting), with a 40% reduction relative to the endline comparison mean. Finally, we find strong decreases in violent discipline of children (9 pp decrease or 16% over endline comparison means), as well as caregiver beliefs violence is necessary to raise children (4 pp decrease or 67% over endline comparison means). The latter two outcomes show strong additional impacts attributable to the case management component. While there are some differences originating from age groups in these impacts, there are fewer differences by gender of the child—suggesting beneficial impacts are accruing to both boys and girls.

Table 1. Summary of key impact evaluation findings across domains

Target child (aged 0-6 at baseline)	Pooled treatments (coefficients) (1)	Percentage change (2)	Additional beneficial impact of case management (3)
Child has birth registration	0.30***	+150%	X
Minimum dietary diversity (MDD)	0.11***	+100	-
Has a vaccination card	0.02	NA	X
Number of activities caregiver did with child (last 3 days)	0.23*	+11	X
Wasted (weight-for-length z-score <-2)	-0.02	NA	-
Stunted (length-for-age z-score <-2)	0.03	NA	-
Household-level			
Monthly per-capita expenditures (MZN)	118.2***	+13%	-
Monthly per-capita food expenditures (MZN)	57.3**	+10%	-
Poverty headcount (all expenditure line)	-8.78***	-10%	-
Poverty gap (all expenditure line)	-4.84**	-13%	X
Food insecurity experience index (FIES)	-0.79***	-11%	-
Operates any non-farm enterprise	0.07**	+16%	-
Livestock ownership	0.01	NA	-
Affected negatively by COVID-19 shock	-0.14***	-54%	-
Caregiver-level			
Summary score of nutrition and health knowledge (0-5)	0.08	NA	-
Depressive symptoms (CES-D ≥ 10)	-0.07**	-11%	-
Stress (Cohen self-reported stress scale)	-0.84***	-5%	-
Currently saving money	0.04**	+130%	-
Self-assessed decision-making power (ladder)	0.43***	+8%	-
Emotional and/or physical IPV (12-month recall)	-0.13***	-38%	X
Currently pregnant or pregnant in the last 24 months	-0.09***	-22%	-
Any biological child <18 years lives outside the home	0.01	NA	X
Older children (primarily ages 3-17)			
Material well-being (shoes, cloths and blanket) (ages 3 to 17)	0.21***	58%	-
Currently attending school (ages 6 to 17)	0.05*	8%	-
Child time use (domestic chores, hours last 24 hours)	-0.27**	-12%	-
Child time use (productive activities, hours last week)	-0.96***	-40%	X
Any violent discipline (ages 1-14)	-0.09***	-16%	X
Caregiver believes violent discipline necessary to raise children	-0.04***	-67%	X

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 < .1. ** p < .05. *** p < .01.

IX. **Operational performance.** We examine operational performance among intervention participants to complement information in the dedicated process evaluation. Results show that the intervention is well-known and approximately 91% of the sample (entirely in treatment areas) report ever receiving cash transfers or services. Participants overwhelmingly identify caregivers with young children as the main eligibility criteria (93%), with other perceived factors being caring for orphans and vulnerable children, disability, and poverty. Despite reporting receiving the equivalent of 20 months of transfers on average (10,509 MZN) over the intervention period, the transfers were lumpy (on average over 4.6 payments) and unpredictable—with caregivers largely unable to identify when they would receive their next transfer. At pay points, caregivers report feeling safe (90%), spending on average 74 minutes picking up money, and 83% had designated someone to pick up the funds when they were not able to. Caregivers primarily report spending the transfer on food and nutrition for the family (98%), clothing and shoes (93%) and health care (46%), with few mentioning productive investments or being able to save the money. Finally, a lower-than-expected proportion of the eligible sample reported receiving the case management component (only 27% of the case management-eligible sample and 11% of the entire treatment sample), and among those, participants reported a lower number of visits than expected (2.3 on average). This indicates possible implementation constraints for the case management component and should be considered when interpreting impacts presented in this report.

X. **Programme and policy recommendations.** 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, as well as caregiver and child health, well-being, and freedom from violence. Most impacts at the household level are attributable to the cash component only. However, numerous impacts for the caregivers and older children specifically derive both from the cash and case management components. With ongoing experience of shocks (including COVID-19) locally and nationally, safety nets such as the Child Grant 0-2 provide an essential safeguard to ensure health and well-being of young children and families. **Thus, our overarching recommendation is to maintain the current unconditional design, while planning for scale-up of the intervention to other districts in Nampula and beyond.** In the immediate future, the intervention should be offered to the comparison group districts, and neighbouring areas in the Nampula province.

XI. Despite the wide-ranging beneficial effects, when assessing the impacts on the different levels and domains, some are small (or modest) in comparison to similar programmes in the region—while for others, there are null effects. Therefore, we conclude there are several factors related to intervention design and implementation that may have prevented it from realizing its full potential. We recommend the following implications for policy and programming:

- **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—and that is lower than the recommended regional average of 20%. Our 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 lead to longer-run sustainable impacts. These findings raise an opportunity to **revisit benefit levels, or at a minimum suggest close monitoring over time is needed to ensure the real value does not decrease further.**

- **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. The short duration, which can be complicated by enrolment lags and payment delays, further limits the potential for sustainability of impacts. A longer duration of eligibility would allow increased investment in productive activities and human capital of children. Similar to other Child Grant models, **we recommend assessing if participation can be extended to include the pregnancy period or additional years for children.**

- **Payment regularity:** Beneficiaries reported both irregularity in payment intervals (lumpy payments) and uncertainty about payment dates. Households are more likely to invest in productive activities using the cash transfer when they have a clear understanding of timing of future payments. We recognize that some of these implementation challenges may have been resulted from COVID-19 constraints. Nevertheless, current and future **participants will benefit greatly if the intervention is able to follow a specific plan for 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—suggesting a cash plus approach may be an effective way to address some of the key complex vulnerabilities that households face. We therefore recommend **continuing the joint implementation of the cash and case management components and ensure that the care activities are further supported to ensure maximum synergistic benefits for participants.** We recognize the complexity and challenges inherent in delivering the care services and underscore the wide-ranging implementation-specific recommendations made in the process evaluation report.

- **Bolstering activities on child nutrition**: The intervention did not have a measurable impact on child nutrition, a key intervention target and important child health and development. At endline, over half of children were stunted, and 40% of children had diarrhoea in the previous 2 weeks preceding the survey. While the SBCC component of the intervention may have contributed to some positive behaviors and nutrition knowledge, these were not captured through knowledge questions included in this study. In addition, it is possible that a delay in the full initiation of SBCC activities may have contributed to a reduced probability of favorable synergistic impacts on child nutrition and related outcomes. **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 the light-touch 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: While our results suggest the intervention had a range of beneficial impacts for caregivers, across several categories, these benefits appeared to be driven largely by older caregivers (e.g., those aged 24 and older). Case management 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 and young mothers, and linkages be made wherever possible as part of case management with adolescent-specific or friendly services. In addition, attention to the specific barriers adolescent girls might experience across different intervention components (e.g., travel to pay points, control, and decision-making over transfers) should be given across all aspects of implementation. These considerations should be complimented 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.

1 INTRODUCTION

1. This report provides the endline results of the evaluation of Mozambique's Child Grant 0-2 (Subsidio para Criança 0-2 Anos in Portuguese). The Child Grant 0-2 is a sub-component of the Basic Social Subsidy Programme (PSSB)'s Child Grant Programme, a national programme led by the Ministry of Gender, Children and Social Action (MGCAS). The evaluation coincides with the intervention's start-up phase, which is scheduled to run through 2021 in four selected districts of the Nampula province. The intervention follows a 'cash and care' methodology and includes three components—namely, (1) cash transfers, (2) social behaviour change communication (SBCC) on stunting reduction and (3) protection case management for the most vulnerable. The Child Grant 0-2 aims to reduce poverty and social vulnerability by providing cash transfers to the primary caregivers of young children with the overall aim of reducing poverty, improving child wellbeing, and promoting access to basic social services. Furthermore, the care component of the intervention intends to address the complex and interrelated protection, as well as the social, economic and health risks, that targeted households face. The intervention commenced implementation in September 2018, and this evaluation provides critical evidence on its effectiveness to inform how best to scale up on a national level.

2. On behalf of MGCAS, the United Nations Children's Fund (UNICEF) Mozambique contracted the American Institutes for Research® (AIR®) and its partners to conduct a 24-month, longitudinal impact evaluation and process evaluation of the start-up phase of the Child Grant 0-2. The impact evaluation investigates the intervention's effects on child wellbeing and intermediate impacts on poverty and vulnerability at the household and caregiver levels in three pilot districts (i.e., Lalaua, Ilha de Moçambique and Nacala-a-Velha, the latter two districts being discussed in this report, while the results for Lalaua are presented in Annex C). The evaluation conceptual framework, analysis and conclusions follow a gender- and child-sensitive approach, informed by the role of social protection in reaching the most vulnerable populations and achieving the Sustainable Development Goals (SDGs). The impact evaluation is the first rigorous evaluation of a national child-focused social protection intervention in Mozambique and adds to scarce regional evidence on cash plus models. Thus, primary users of the impact evaluation include national and provincial policy makers, including MGCAS and government partners, as well as key stakeholders, including UNICEF and donors. The evaluation aims to provide these stakeholders with the information needed to make informed decisions on scale-up and investment in similar interventions regionally. In total, the start-up phase has a projected budget of 3.5 million USD and has reached 15,345 beneficiaries to date.

1.1 Evaluation Objectives

3. The primary purpose of this evaluation is to measure causal impacts of the intervention across a broad range of household, caregiver, and child-level outcomes, approximately 24 months after the baseline survey. In particular, the objectives are to measure impacts of both the combined intervention, as well as the additional effects of the case management components. In addition, we examine sub-group impacts on vulnerable groups when possible, for example, on female headed households or by age of the primary caregiver. Finally, we present some descriptive information on participant experience with the intervention and re-assess the internal validity of the study. These results build on findings from the baseline report, which documented and described the study sample prior to the start of the intervention and tested for equivalence at baseline between the treatment and comparison groups (AIR, 2020). The full TOR for the evaluation are included in Annex D (Figure D.1) which have largely

remain unchanged since the inception.[3] This report first explains the context, details, and motivation behind the Child Grant 0-2. Subsequently, it explains the theory of change, research questions, study design, data collection, sample description and impacts of the intervention across key outcomes, and it concludes with policy recommendations.

4. AIR and partners conducted a complementary process evaluation to investigate the Child Grant 0-2 against the Organisation for Economic Co-operation and Development evaluation criteria (i.e., relevance, effectiveness, impact, coverage, coordination, and equity) by using, primarily qualitative methods. The process evaluation focuses on complementary questions regarding the intervention fidelity, challenges and strengths of implementation, potential supply- and demand-side barriers to accessing cash grants and care services and beneficiary experience. The process evaluation is intended to help the same group of policy makers and key stakeholders redesign the intervention to improve its operation and delivery and is disseminated in parallel with the impact evaluation. Paired with the impact evaluation results, the research comprises a full suite of information needed for policy makers to take decisions on the future of the Child Grant. The process evaluation was implemented in all four start-up districts in 2021 with inputs and in collaboration with the impact evaluation team, and findings are presented in a separate report (AIR, 2021). Where relevant, we cross reference the process evaluation report to show key areas of agreement and divergence in results.

1.2 Context

5. Mozambique experienced sustained economic growth following its struggle for independence and civil war, but obstacles to attaining child wellbeing endure, and large disparities between provinces of Mozambique persist. Poverty rates remain stagnant, at approximately 55%, since 2003 because of high levels of foreign investment in extractive industries that had little trickle-down effect on the local economy and job creation and little investment in smallholder agriculture, which sustains most of the country's population (Cunha et al., 2013). Between 2003 and 2011, chronic undernutrition of children under age 5 slightly increased from 41.0% to 42.6% (UNICEF, 2014). The central and northern provinces of Mozambique face larger hurdles in achieving child wellbeing than do the southern provinces. For example, in 2014, 23% of children under age 5 in Maputo City and Province suffered from chronic undernutrition, whereas in Nampula (the location for this study), 55% of children were affected (UNICEF, 2014).

6. Mozambique has made child wellbeing a policy priority, and, as a result, the country has already demonstrated signs of improvement. In 2011, Mozambique joined the Scaling Up Nutrition (SUN) movement to address hunger and malnutrition and signed the Comprehensive Africa Agriculture Development Programme to promote food security and economic prosperity. Targeted nutritional policies led to reductions in overall rates of chronic food insecurity, from 61% in 1997 to 24% in 2018 (United States Agency for International Development [USAID], n.d.). Survival rates for children under age 5 have greatly improved, with mortality rates dropping from 20% in 1997 to 10% in 2011 (UNICEF, 2014). The reduction in mortality amongst children under age 5 can be attributed to increased government funding for health programmes, higher health workforce density, and institutional birth coverage to prevent or treat malaria, diarrhoea, and mother-to-child transmission of human immunodeficiency virus (HIV)/acquired immune deficiency syndrome (AIDS) (Fernandes et al., 2014).

3 At the time of drafting, numerous aspects of the impact evaluation were yet to be determined, including the exact location of the evaluation, the timeline and the methodology. Therefore, while many details of the original TOR have evolved, the main research objectives and activities remain largely unchanged.

7. Despite these improvements, many challenges remain. From 1990 to 2003, maternal mortality declined from 1,000 maternal deaths per 100,000 live births to 408 maternal deaths per 100,000; however, from 2003 to 2011, those rates remained stagnant (UNICEF, 2014). In a recent measure from 2017, the maternal mortality ratio in Mozambique was estimated at 452 per 100,000 live births (UNICEF, 2021) In addition, 42.3% of children under age 5 are stunted due to poor maternal nutrition, poor child feeding practices, poor food quality and frequent infections (World Food Programme, 2018). The repercussions of early childhood stunting can reverberate throughout a child's life, resulting in lower learning achievement and lowered wages and productivity as an adult (Aguayo & Menon, 2016). In addition, safety is a pre-requisite for early childhood development. Adequate nutrition combined with consistent, responsive adult caregiving is the best way to offset the effects of multiple adversities (UNICEF, 2011). The pregnancy and postpartum periods can be stressful for mothers and families, and additional health and economic vulnerabilities are experienced which compromise their wellbeing. According to the most recent nationally representative data, nearly half (49%) of women 20 to 59 years old were married at age 18 in Mozambique, and 16% were married by age 16 (Ministério da Saúde et al., 2015). The average total fertility rate is 5.3 children per woman, and this figure is higher in rural areas and among women with no education and low household wealth. Finally, 36% of ever-partnered women report experiencing controlling behaviours, 18% report physical violence, 13% report emotional violence and 3% report sexual violence perpetrated by an intimate partner in their lifetimes. Moreover, according to the 2011 Mozambique Demographic and Health Survey (DHS), 18% of children do not live with either of their biological parents, in many cases because of HIV/AIDS adult mortality, migration due to economic and climatic factors, informal fostering, disability and child marriage. Children who are deprived of a family environment are less likely to have positive physical or psychosocial support and are more vulnerable to mistreatment and deprivation. For example, orphaned children under age 5 have the highest probability (51%) of being stunted, and orphaned children between the ages of 10 and 14 are 7% less likely to be in school (UNICEF, 2014).

8. Education in Mozambique is characterized by low literacy and numeracy levels and high school dropout among adolescent boys and girls. Less than 5% of students in grade 4 are proficient in Portuguese and less than 8% have sufficient math skills (Ministry of Education and Human Development, 2016). Official statistics does not fully reflect the dynamics of child's participation in school. While primary school enrolment continues to be high according to the Ministry of Education and Human Development (MINEDH) administrative records (over 90%, primarily due to children of secondary-school ages enrolled in primary school), almost half of primary school-aged children are out of school (43%) as they never finish the academic year. Opportunities for school-age children are limited beyond primary school (UNICEF Mozambique 2021a). Official age entering the school in Mozambique is 6, but it is not uncommon to find children as young as 4 or 5 to be enrolled as caregivers use the school as a method of providing childcare. A two-tier system allows for a primary school structure of 5 or 7 grades. However, over-age of primary school students poses real challenges. The national longitudinal study (ALDE) reports that 17% of adolescents aged 13 to 18 are still in primary school (UNICEF Mozambique 2021b).

9. Until the adoption of the Social Protection Law in 2007, the Social Action Programme (Programa de Subsídio de Alimentos) established in 1990 was the main social protection programme in Mozambique to support the elderly, people with disability and people with chronic disease. The Social Protection Law updated the terms of assistance, including conditions and eligibility criteria and further extended Mozambique's government effort to build a basic and non-contributory social security system that protects the most vulnerable members of its society—but predominantly exclude children. From 2010 to 2014, the National

Basic Social Security Strategy [ENSSB] I implemented the PSSB, the Direct Social Action Programme (PASD) and the Productive Social Action Programme (PASP) to provide cash transfers to labour-constrained households and short-term employment to food-insecure households in rural areas with increased but insufficient government funding and donor contributions (UNICEF, 2014). An evaluation of ENSSB I found low coverage amongst eligible populations and lack of social protection for children; only a small fraction of vulnerable children received indirect benefits (International Labour Organization, 2015). In 2016, the government adopted ENSSB II for 2016–24 with the aim of providing significantly increased social protection for children through a child grant implemented on a national scale (Falange & Pellerano, 2016; Republic of Mozambique, 2016). The ENSSB II contributes to 'reducing poverty and vulnerability, ensuring that the results of the growth of the Mozambican economy benefit all citizens, particularly those living in situations of poverty and vulnerability'. It aims to (*a*) boost the level of consumption and the resilience of the poor and vulnerable strata of the population; (*b*) contribute to the development of human capital through improving nutrition and access to basic health and education services for the poor and vulnerable strata of the population; (*c*) prevent and respond to risks of violence, abuse, exploitation, discrimination and social exclusion through social welfare services; and (*d*) develop the institutional capacity to implement and coordinate the basic social security sub-system (Republic of Mozambique, 2016). The ENSSB II expands the existing PSSB to include a child grant component that targets (*a*) children in early childhood, (*b*) child-headed households, and (*c*) orphaned children in poor and vulnerable households. The Child Grant 0-2 is therefore a new sub-component of the child-sensitive grant introduced within the PSSB, following the Decree N 47/2018 (6-Aug-2018) that operationalizes the ENSSB II. It is anticipated that by 2024, one-half of all Mozambican children (ages 0–17) will live in households that receive social transfers (Falange & Pellerano, 2016) and 28% of the population living below the poverty line should be covered by basic social protection programmes (GoM, 2020).

10. Most recently, devastation and lost livelihoods caused by natural disasters and the social and economic fallout due to the COVID-19 pandemic have exposed the vulnerability of poor populations. Cyclones Idai and Kenneth, which hit Mozambique in March and April 2019, and subsequent related floods, affected millions of people across Mozambique, Zimbabwe and Malawi and was the worst natural disaster to hit southern Africa in decades.[4] With the number of children in Mozambique in need of humanitarian assistance totalling nearly 1.4 million, there is an increasing role for social protection to respond to the multi-sectoral needs of affected populations. Consequently, the Child Grant 0-2 planned to expand to affected populations in Cabo Delgado (starting in November 2020). The COVID-19 pandemic has resulted in numerous adverse indirect impacts on the Mozambican population, with a predicted drop in consumption of 7% to 14% in 2020, or a 4 to 10 percentage point (pp) increase in poverty. This equates to approximately 2 million additional people entering poverty and a reversal of gains made in the previous decade (Barletta et al., 2021). In addition to household-level impacts, the COVID-19 pandemic has also had a severe impact on children's schooling and protection outcomes—effects which are still unfolding and being documented at the time of writing (Azevedo et al., 2021; Bhatia et al., 2021). Improving children's wellbeing in the context of exposure to natural disasters and public health emergencies represents an acute challenge in Mozambique.

1.3 Child Grant 0-2 Description

11. Supported by UNICEF Mozambique, the MGCAS is implementing, through the National Institute of Social Action (INAS), the start-up phase of the Child Grant 0-2 in four

4 https://www.unicef.org/mozambique/en/cyclone-idai-and-kenneth (accessed August 26, 2019).

districts of the Nampula province: Ilha de Moçambique, Nacala-a-Velha, Lalaua and Mogincual. The Nampula province was selected for the start-up phase because of the high and increasing trends in poverty, despite overall reductions in national poverty levels (MGCAS, 2019). All geographic areas across these locations are expected to receive the Child Grant 0-2 (including both rural and urban locations). As determined during the inception meeting (June 2018), AIR's impact evaluation studies three of the intervention districts—namely, Ilha de Moçambique, Nacala-a-Velha and Lalaua—and includes neighbouring Mossuril and Nacala Porto districts for comparison.

12. The Child Grant 0-2 encompasses the following design characteristics:

- The cash transfer: The cash component is a flat transfer of approximately 540 Mozambique meticals (MZN) (representing one-third of the national poverty line) given to the primary female caregivers of all children between 0 and 2 years old monthly. In the three districts in which the impact evaluation is conducted, transfers were be distributed nearly universally with (exclusions could be made at the community level on the basis of wealth and social status) and unconditionally for households with children aged between 0 and 6 months old at enrolment. Transfers were not capped at the household-level, meaning a household could receive double or triple the transfer value if they had two or three children in the appropriate age range. The cash component is implemented on a graduation basis (i.e., until enrolled children reach age 2).

- Nutrition and hygiene information package: This package consists of SBCC interventions around positive nutrition and hygiene practices. Originally, the intervention and accompanying messages were planned to be disseminated by APEs, community leaders, theatre, or radio. However, in the pilot, INAS *Permanentes* were trained to deliver the messages. SBCC is implemented across the Child Grant 0-2 cash and care districts except for Ilha de Mozambique but will not exclusively target beneficiaries of the Child Grant 0-2.

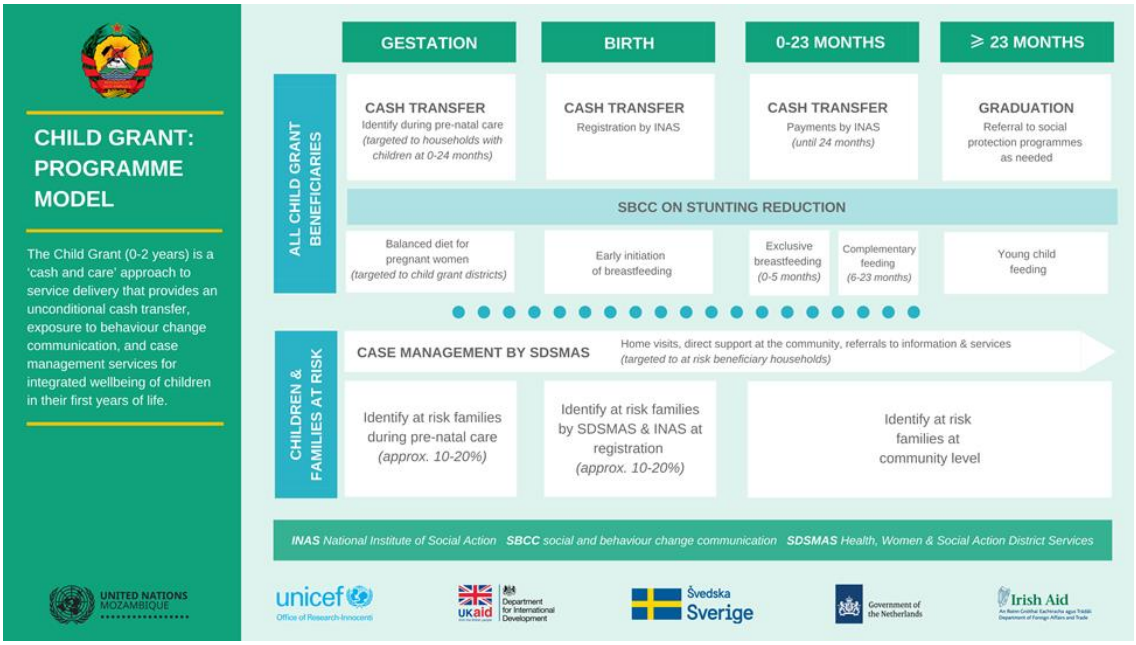
- Family support through case management: Case management services are offered to beneficiary households classified as the most vulnerable to common protection risks following the results of a triage using a vulnerability prioritization tool implemented at enrolment. While original implementation targets set the proportion of case management eligible participants at 10-15% of the cash transfer caseload, in practice approximately 20% of participants were targeted for case management.[5] 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* with technical support, oversight, and engagement in high-risk cases by female technicians from the Health, Women and Social Action District Services (SDSMAS). Case management activities include basic psychosocial support, counselling, and awareness on positive parenting practices, as well as information and referrals to local and statutory services. All children and their caregivers within selected households are supported.

5 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 program enrollment, and instead were identified using the same triage indicators collected as part of the baseline survey.

13. Among districts targeted for the quantitative evaluation, Ilha de Moçambique received a cash-only intervention; Nacala-a-Velha and Lalaua received the full intervention, so both the cash and case management components (although the Meti health catchment area in Lalaua receives only cash); and Mossuril and Nacala Porto, as the comparison districts, did not receive any intervention. According to official payment distribution dates, the first transfers took place during the April to June period of 2019, approximately 2 to 5 months after the baseline survey. At the time of writing, the implementation is ongoing in all intervention districts.

14. The cash transfer component could potentially affect a range of outcomes for households, including household consumption, economic standing, food security, dietary diversity, and nutrition, as well as caregiver behaviour, and holistic wellbeing, including improved mental health and reduced stress. The cash component addresses SDG 1, to end poverty in all its forms, and implement social protection systems (Target 1.3). The full package of cash and care aims to integrate social services across sectors to address multiple dimensions of poverty and vulnerability. In particular, the nutrition SBCC component works towards addressing SDG 3, Good Health and Wellbeing, as well as SDG 6, Clean Water and Sanitation. The case management component works towards SDG 16 (specifically Target 16.1 to eliminate all forms of violence against women and girls) as well as SDG 5 on Gender Equality. Therefore, households that receive cash and care are expected to demonstrate enhanced positive results as compared to the cash-only intervention (further details on outcomes and pathways amongst intervention components are discussed in subsequent sections). Figure 1 depicts the key intervention components of the Child Grant 0-2 across lifecycle stages.[6]

Figure 1. Child Grant: Intervention Model



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

1.4 Literature Review of Evidence

15. Many studies of cash transfers demonstrate positive impacts that help governments and international donors understand the returns on their investment. First, cash transfers

6 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, which the evaluation sample may also be exposed to.

prioritize human rights, giving participants greater control over their spending choices by enabling them to access the goods and services that they value most. In contrast, in-kind approaches typically provide standard packages that may not meet the needs of participants optimally (Jaspars et al., 2007). Second, cash transfers enable recipients to make investments and address market failures that in-kind or service delivery programmes cannot, such as making down payments on land or repaying debts. Third, cash transfers can make limited funds go further, particularly in humanitarian and fragile settings, because it generally costs less to provide people with money than with in-kind or voucher assistance (Cabot Venton et al., 2015). For example, a study in multiple countries that compared cash transfers with food aid found that 18% more people could be assisted at no extra cost if programme beneficiaries received cash instead of food (Margolies & Hoddinott, 2014). Finally, cash transfers afford participants greater dignity, as they often do not have the same stigma attached as in-kind transfers.

16. Although there are ongoing debates around design features and targeting of national programmes in the African region and globally, recent research has shown that several popular critiques of cash transfers are not supported by the evidence. Through the Transfer Project, Handa and colleagues (2018) examine six common perceptions of national unconditional cash transfer programmes in Africa. For example, critics claim that cash will lead to higher spending on alcohol or tobacco, create dependency (inducing laziness and work disincentives), or increase fertility or inflation in prices of locally sold goods. Using eight rigorous evaluations, these authors show that these fears are not backed by evidence, and, in many cases, cash transfers actually work in the opposite direction (e.g., by delaying first births for female youth or through allowing households to build small businesses and productive activities). Although the authors are not able to determine explicitly the extent to which the unconditional nature of transfers contributes to these impacts, they note that at least in the case of human capital investments (in education), impacts observed across countries is of a similar or larger magnitude as compared to conditional programmes in Latin America. Supporters of unconditional programmes have long argued that conditional programmes in settings of low capacity and service provision penalise the most vulnerable segments of populations, who are unable to comply with conditions. It is because of these debates that scholars have emphasised the potential of soft conditions, including labelled transfers or behavioural nudges, rather than punitive conditions (Pellerano & Barca, 2017). We return to several of these debates and specific evidence underlying them in the subsequent review of literature.

1.4.1 Cash to Improve Child Wellbeing

17. In this study, child wellbeing, amongst the target age group under 24 months, encompasses nutrition, health (morbidity, access to vaccines, and postnatal services), stimulation and nurturing care (e.g., child activities/stimulation by male/female adults, play activities) and child protection (e.g., lack of unnecessary family separation; absence of violence, abuse, and neglect; birth registration) (UNICEF, 2007). Young child wellbeing is influenced by the wellbeing of the child's siblings, primary caregiver, household, and community. Therefore, the evaluation will also assess older children's schooling, material wellbeing and freedom from violence and child labour. In addition, determinants at the caregiver and household levels include female psychosocial wellbeing (i.e., life satisfaction and mental health), autonomy and freedom from violence and household economic standing, consumption, food security, investments, and resilience.

18. Unconditional cash transfers are multi-faceted, far-reaching tools for fostering child wellbeing because each household can determine how to use the cash to support their diverse needs. Nonetheless, there are limitations to the potential impacts of cash transfers. Cash transfers are demand-side interventions that are unable to address supply-side constraints

(UNICEF-East and Southern Africa Regional Office, 2015). Despite limitations, a wealth of research demonstrates the positive impacts of unconditional cash transfers on child wellbeing in sub-Saharan Africa (Garcia & Moore, 2012; UNICEF-East and Southern Africa Regional Office, 2015). The evidence summarised in this section supports the positive effects of cash transfers on the key factors for the current evaluation contributing to holistic child wellbeing and underscores the areas that need further research.

1.4.1.1 Child Nutrition

19. A child's nutritional status is conditioned by his or her dietary intake and health status, and these factors are predicated on household food security, care for mothers and children and access to healthy environments and services (de Groot et al., 2017). Evaluations of cash transfer programmes show that cash transfers are used primarily to improve food security and diet diversity to the benefit of all household members (Agüero, Carter, & Woolard, 2007; AIR, 2013; Asfaw, Pickmans, & Davis, 2016; Handa et al., 2013; Hidrobo et al., 2018; Pellerano et al., 2014; The Kenya Cash Transfer for Orphans and Vulnerable Children [CT-OVC] Evaluation Team, 2012; Vincent & Cull, 2009). A recent meta-analysis of 74 studies globally shows that, on average, cash transfers improve linear growth (height-for-age) and decrease stunting (by 2.1%), likely through increased dietary diversity, increase in consumption of animal-source foods and reduced incidence of diarrhoea (Manley et al., 2020). However, on average, impacts for measures of child weight-for-age and wasting were non-significant. Despite these promising averages, numerous individual impact evaluations of unconditional cash transfers in sub-Saharan Africa have failed to show impacts on children's nutrition—including in Ghana (Livelihood Empowerment Against Poverty [LEAP] 1000 Evaluation Team, 2018), Zambia (Handa et al., 2016), Kenya (Merttens, Hurrell, & Attach, 2013), Ethiopia (Berhane et al., 2015), Tanzania (Evans et al., 2014) and Uganda (Merttens et al., 2015). Several obstacles may prevent a child from receiving the benefits of increased household spending on food. For example, households may face supply-side constraints that can result in food scarcity; cultural feeding practices may introduce formula-based milk or limit additional food to male family members; and poor water, sanitation and disease environments may contribute to cycles of infectious disease and undernutrition (UNICEF Egypt, 2018). Furthermore, programme design or implementation characteristics may limit beneficial impacts, including insufficient transfer sizes, inconsistent transfer delivery, or short programme duration. Further research is necessary to determine how cash transfers paired with complementary interventions affect child nutrition, as well as determinants at the household, caregiver, and child levels (de Groot et al., 2017).

1.4.1.2 Child Health

20. Cash transfers can enable caregivers to afford healthcare and transportation costs, thereby removing barriers to accessing healthcare facilities. Systematic reviews of cash transfer programmes in sub-Saharan Africa have found that cash transfers tend to have a positive impact on maternal and child health (Bassani et al., 2013; Owusu-Addo, Renzaho, & Smith, 2018), including increased use of antenatal care and skilled birth attendance (Ekezia, Lamont, & Bhattacharya, 2017). However, there is insufficient evidence on the impact of cash transfers on healthcare use by children under age 5 (Bassani et al., 2013). For example, an evaluation of the Kenya CT-OVC did not identify substantial improvements in health-seeking behaviour among caregivers of children under age 5. However, 4 years after the programme was implemented, the study found that use of clinics increased by 15.8% for children under 30 months, health card ownership increased by 15.6% for children under 60 months and the percentage of children with full immunisation increased by 14.8% (Davis et al., 2016; Huan et al., 2017). Furthermore, cash transfer programmes in Lesotho, Ghana, and Zambia did not see

any increase in the use of child healthcare services because of lack of health resources accessible to target populations (AIR, 2013; Handa et al., 2013; Pellerano, 2014). The importance of addressing supply-side constraints is repeatedly emphasised in this literature.

1.4.1.3 Fertility and Early Pregnancy

21. Although there is often a fear, particularly in child grant models, that cash transfers will increase the fertility of women in an effort to gain (or extend) programme eligibility—rigorous evidence suggests this is not the case. A review of government-run unconditional cash transfers in Africa shows either no fertility impacts or increases in birth spacing and reductions in first pregnancy among young women (Handa et al., 2018). For example, an evaluation of the South African Child Support Grant found that time to second pregnancy was significantly longer for grant recipients when compared with a comparison group. The authors of the study argue that the economic independence facilitated by the grant creates a shift in power dynamics, increasing women's agency in determining their sexual and reproductive health and decreasing the necessity of transactional sex-based relationships. In addition, women benefit from access to health care and contraception and may choose to delay pregnancy because of improved education and job opportunities (Rosenberg et al., 2015). The same programme reduced rates of risky behaviour in girls, thereby reducing their risk of HIV/AIDS transmission (Crea et al., 2015). Furthermore, in Kenya, the government unconditional cash transfer targeted at households caring for orphans and vulnerable children reduced the likelihood of sexual debut by 23% amongst youth between 15 and 25 years old and delayed first pregnancy amongst women between 12 and 24 years old (Handa et al. 2014b; Handa et al., 2015). These dynamics are supported by broader literature from low- and middle-income countries (LMICs), indicating little evidence that cash transfers will induce women to become pregnant to maintain or gain eligibility for benefits.

1.4.1.4 Economic Migration and Related Family Separation

22. The current literature on the effects of cash transfers on domestic and international migration (and resulting family separation) is sparse and inconclusive. A recent review initially examining 269 papers found only 10 empirical studies which rigorously examined the link between social assistance and migration, generally finding that assistance reduces the likelihood of moving (Adhikari & Gentilini, 2018). However, this may not always be the case. For example, a study of cash transfers in Mexico (Stecklov et al., 2005) found that unconditional cash transfers ease access to credit and enable individuals to afford the costs of rural-to-urban migration or migration to the United States, particularly amongst comparatively better off samples. However, conditional cash transfers that incentivise education may reduce current rates of migration but could increase future rates of migration for education or job opportunities. Cash transfers have the potential to change the rate, timing and composition of economic migration, and more research is needed to determine their effects in Mozambique's context (Angelucci, 2011; Stecklov et al., 2005). More recently, several smaller cash transfer pilots have been implemented in Uganda with the explicit purpose of mitigating against family separation, with the general finding that cash transfers allowed households to invest in productive activities and generate income to keep children at home (Moret & Ferguson, 2018). There is also evidence of this link in larger government programs; for example, the South African Child Support Grant increased the probability that children lived with their biological parents (Mayrand, 2009). Despite the promising indication for economic strengthening of family units and implications for decreased family separation, these outcomes must be carefully considered alongside dynamics around the maternal double burden of care and productive work, with implications for child wellbeing.

1.4.1.5 Psychosocial Wellbeing

23. Poverty, economic insecurity and experiences of violence are correlated with higher rates of depression and poor mental health (Lund et al., 2011). Poverty and poor mental health produce a vicious cycle in which poor mental health decreases productivity and earnings and increases healthcare costs and social stigma. A recent meta-analysis including 38 studies from LMICs found a positive average effect of 0.10 standard deviations (SDs) across subjective wellbeing and mental health outcomes (McGuire et al., 2020). Furthermore, qualitative studies of cash transfer programmes in sub-Saharan Africa support increased psychosocial wellbeing, fostered by family wellbeing, strong community relationships and access to social services (Attah et al., 2016).[7] Attah and colleagues (2016) argue that cash transfers catalyse a 'virtuous cycle' whereby increased material wellbeing fosters higher self-esteem, which enables social integration and interactions, which then affect other outcomes, such as increased community support and improved school performance. Positive impacts on mental health have also been shown among adolescents and youth in households receiving unconditional cash transfers. For example, an evaluation of Malawi's Social Cash Transfer found that depressive symptoms of youth declined by 15 pps, with particularly strong impacts for females (Angeles et al., 2019). The authors identified pathways responsible for this impact, including key mechanisms of increases in education, caregiver wellbeing and social support. Furthermore, an evaluation of the Kenya CT-OVC found that youth in households that received unconditional cash transfers were 24% less likely to have depressive symptoms compared with the comparison group, with greater effects felt by male youth and orphans. Men expressed that they felt physically healthier and had a sense of hope and optimism (Kilburn et al., 2015).

1.4.1.6 Childhood Violence

24. Cash transfers have the potential to influence key risk factors for childhood violence, including through aforementioned caregiver poverty, social exclusion, and poor mental health. A recent review of social safety nets and experience of childhood emotional, physical, or sexual violence in LMICs found only 11 completed impact evaluations analysing 57 unique impacts on violence outcomes (Peterman et al., 2017). Amongst those, approximately one in five represented statistically significant, protective effects of programmes on childhood violence—with promising evidence related primarily to sexual violence amongst female adolescents in Africa. There are substantial gaps in terms of other measures (e.g., child discipline and young child measures), as well as regional gaps in understanding how cash and other social safety nets can affect childhood violence. Despite these gaps, cash transfers bundled with complementary programming aimed at violence-specific risk factors are seen as promising to affect multiple types of child protection outcomes, including abuse and neglect.

25. Cash transfers also may affect childhood violence through reductions in children's exposure to intimate partner violence (IPV) in the household. A growing evidence base demonstrates that cash transfers have the potential to reduce IPV. In a mixed-methods review of rigorous studies, 11 out of 14 quantitative studies (79%) and five out of eight qualitative studies (63%) demonstrated that cash transfers decreased IPV (Buller et al., 2018). Most quantitative studies examined more than one outcome—stronger impacts were seen for physical and sexual IPV, and weaker impacts were seen for emotional IPV and controlling behaviours. Since the review period, at least three additional evaluations of government-led cash transfer programmes, in Ghana, Mali and Togo, also showed reductions in IPV (Briaux et al., 2020; Heath et al., 2020; Peterman et al., 2021). Despite the promising conclusions of the review and evidence to date, more research is necessary to determine the intended and

7 Wellbeing is defined herein as self-acceptance, positive relations with others, autonomy, environmental mastery, purpose in life and personal growth (Attah et al., 2016).

unintended effects of diverse forms of cash transfers and cash programming on violence against women and children and their contributing factors in in LMICs broadly and Mozambique specifically.

1.4.1.7 Child Labour

26. Approximately 25% of children between 5 and 14 years old participate in child labour[8] in rural areas of Mozambique (UNICEF, 2014). Child labour is associated with weaker educational outcomes and risk of physical and mental harm. Cash transfer programmes can ameliorate the effects of economic shocks and prevent households from resorting to child labour as a source of income (Dammert et al., 2018; de Hoop & Rosati, 2014). However, there is also potential for unintended consequences. For example, a study of two unconditional cash transfers in Malawi and Zambia showed that as households increased their small businesses and productive work, children also increase participation in work, including potential exposure to hazards or long hours (de Hoop et al. 2019). However, in both cases, cash transfers also increased domains of children's wellbeing, including education and material wellbeing, suggesting a trade-off between household productive activities and child wellbeing. Conversely, a study in Liberia found that households that received unconditional cash transfers saw a decline in child labour of 18% (Miller & Themba, 2012). The relationship between cash transfers and child work/labour is complex, and further research is needed to understand how to militate against adverse effects for children, whilst still encouraging productive gains for households overall.

1.4.1.8 Early Marriage

27. Although there is potential for cash transfers to facilitate delayed transitions into marriage for adolescents and youth, evidence to date from Africa is mixed. Theoretically, impacts on early marriage are possible through several hypothesised mechanisms, including increases in children's education and reduced need for households to resort to harmful coping mechanisms (marrying off female youth) in the face of economic shocks. Despite promising evidence for female youth in a non-governmental organisation (NGO)-led programme in Malawi (Baird et al., 2011; Malhotra & Elnakib, 2021), evaluations conducted under the Transfer Project have shown no significant impacts on timing of marriage transitions for female and male youth in national cash transfer evaluations in Kenya, Malawi, Tanzania, and Zambia (Dake et al., 2018; Handa et al., 2015; PSSN Youth Evaluation Team, 2018). It is possible that part of this lack of impact is due to study design, whereby tracking protocol dictates that households, not individual members, are tracked over time. This means that if a youth leaves the household, only the main reason for leaving is recorded—and the study team does not necessarily observe if the youth is married or not (thus relying primarily on changes among youth who stay in study households for marriage outcomes). In addition, only a fraction of youth gets married every year, so it is possible that longer-term evaluations are needed above the 2- to 4-year timeframes in the Transfer Project studies. Finally, although cash transfers are seen as a promising to delay marriage transitions, it is also widely acknowledged that cash alone does not tackle numerous key divers of child marriage—including discriminatory gender and social norms—suggesting complementary services are needed to fully address this issue.

8 As per the Sustainable Development Goals, global stakeholders define child labour activities as (a) children between 5 and 11 years old doing at least 1 hour of economic activity or at least 28 hours of domestic work and (b) children between 12 and 14 years old doing at least 14 hours of economic activity or at least 42 hours of economic activity and domestic work combined (https://dashboards.sdgindex.org/map/indicators/children-involved-in-child-labor/values).

1.4.1.9 Education

28. A wealth of evidence demonstrates the positive impacts of cash transfers on education outcomes. Unconditional cash transfers boost enrolment and attendance rates in primary and secondary schools by removing direct and indirect financial barriers, such as costs of travel and books, as well as the opportunity cost of losing income from child labour (Baird et al., 2013). In a review of impacts on secondary school age enrolment under the Transfer Project, impacts are statistically significant in six out of eight evaluations included (government programmes in Ethiopia, Ghana, Kenya, Lesotho, Malawi, Zambia, and Zimbabwe) and range from 6.5 to 15.7 pps (Handa et al., 2018). However, removing obstacles to attending school does not necessarily translate into improved school outcomes, for a variety of reasons, including quality and supply-side constraints. For example, in Lesotho, cash transfers enabled a 6 pp increase in boys attending primary school, but there were no noticeable improvements in learning outcomes, such as test scores (Pellerano et al., 2014). Similarly, the Child Grant Programme in Zambia saw a 10 pp increase in school enrolment for children 4 to 7 years old, but the same benefits did not apply to older children who would attend primary and secondary school (Handa et al., 2016).

1.4.2 Cash Plus Care to Support Child Wellbeing

29. As detailed in earlier sections, it is widely acknowledged that social protection—and, specifically, cash transfers—have wide-ranging benefits for poor and vulnerable children and their families. However, their limitations are being increasingly recognised as well. These results have led to advocacy for 'cash plus' approaches that leverage synergies between cash and complementary services to address poverty alongside protection for vulnerable populations (Roelen et al., 2017). The scope of potential cash plus programme designs is highly diverse, and the optimal combination depends on the setting, the programme objectives, and the target population. In a framework proposed by Roelen and colleagues (2017), 'plus' components may be either integral (e.g., additional benefits or programming delivered to cash beneficiaries) or external (e.g., linkages or access to additional services for beneficiaries). These plus components can help address behavioural or supply-side limitations that cash alone may not be able to improve directly. Cash plus programming is designed with the underlying assumption that bundled programming can help reduce fragmentation and improve coordination because programmes often aim to target the same vulnerable populations.

30. Despite the increased interest in cash plus programming, there is relatively little rigorous evidence to show the relative contribution of plus components—or the synergistic effect of cash and plus components. For example, Little and colleagues (2021) conduct a systematic review to identify such studies that focus on early childhood outcomes in LMICs and identified 17 studies. Similar to the current investigation, a study in Bangladesh examining the impacts of a cash transfer alone, a food transfer alone or the same bundled with nutrition SBCC showed that although there were positive impacts on food security indicators in all study arms, however only those with bundled programming showed decreases in child malnutrition (Ahmed et al., 2016). Similarly, in a voucher programme with layered SBCC in Ethiopia, findings suggest that maternal nutrition knowledge and feeding behaviours are improved in the SBCC arm (while not in the voucher arm only); however, child nutrition improved among the group receiving both interventions (Park et al., 2018). In addition, a parenting programme integrated with a cash transfer in Niger appeared to have limited additional impacts beyond the positive impacts attributed to cash alone (which included exclusive breast-feeding, children's food security, and lower reliance on harsh discipline, amongst others) (Barry et al., 2017). Little and colleagues (2021) conclude that much more

research is needed on cash plus combination and impacts on children. At the project start, the current evaluation represented one of the first examples of a government social protection programme in which an attempt will be made to measure the impacts of cash alone and cash plus child protection components.

1.4.3 Social Protection for Child Wellbeing in Mozambique

31. Mozambique has taken important steps to develop a cash transfer programme to foster child wellbeing. As mentioned earlier, Mozambique adopted ENSSB I from 2010 to 2014 to implement a basic social protection programme, and the initiative directed greater funding towards MGCAS and INAS. ENSSB I successfully increased beneficiaries of social protection programmes from 160,000 beneficiary households in 2009 to 450,000 households in 2014. In addition, the value of cash transfers that beneficiaries received increased from 70 MZN in 2008 to 280 MZN for a single-person household and 580 MZN for a household with up to four dependents.[9] The majority of the work by INAS in ENSSB I was through PSSB, which provided cash transfers to households with permanent labour constraints due to old age, disabilities, or chronic disease.[10] These labour-constrained households had fewer children than the typical household. An evaluation of ENSSB I found that, because of PSSB's eligibility criteria, only 10% of households received programme benefits, and 40% of the elderly, 75% of people with disabilities and 95% of children were excluded from the programme countrywide (International Labour Organization, 2015). Other programmes within ENSSB I, such as PASD, also had limited coverage; they provided only short-term nutritional assistance but did not take measures to prevent chronic malnutrition.

32. ENSSB II (2016–24) attempts to improve targeting of the cash transfers by creating a grant specifically for children 0 to 2 years old, orphaned children in poor and vulnerable households and children-headed households. This child transfer and elderly transfer receive the largest budgets amongst ENSSB II programmes (Republic of Mozambique, 2016). This transfer aims to reduce child vulnerability and promote human development and is expected to be scaled nationwide to reach 1.4 million beneficiaries in 2024 (Republic of Mozambique, 2016). The Child Grant 0-2 is fully financed by donor funding via the United Nations Joint Programme on Social Protection, with substantial contributions by the UK Foreign, Commonwealth and Development Office (FCDO), the Government of the Netherlands, Irish Aid, and the Swedish International Development Cooperation Agency.

2 SCOPE OF EVALUATION

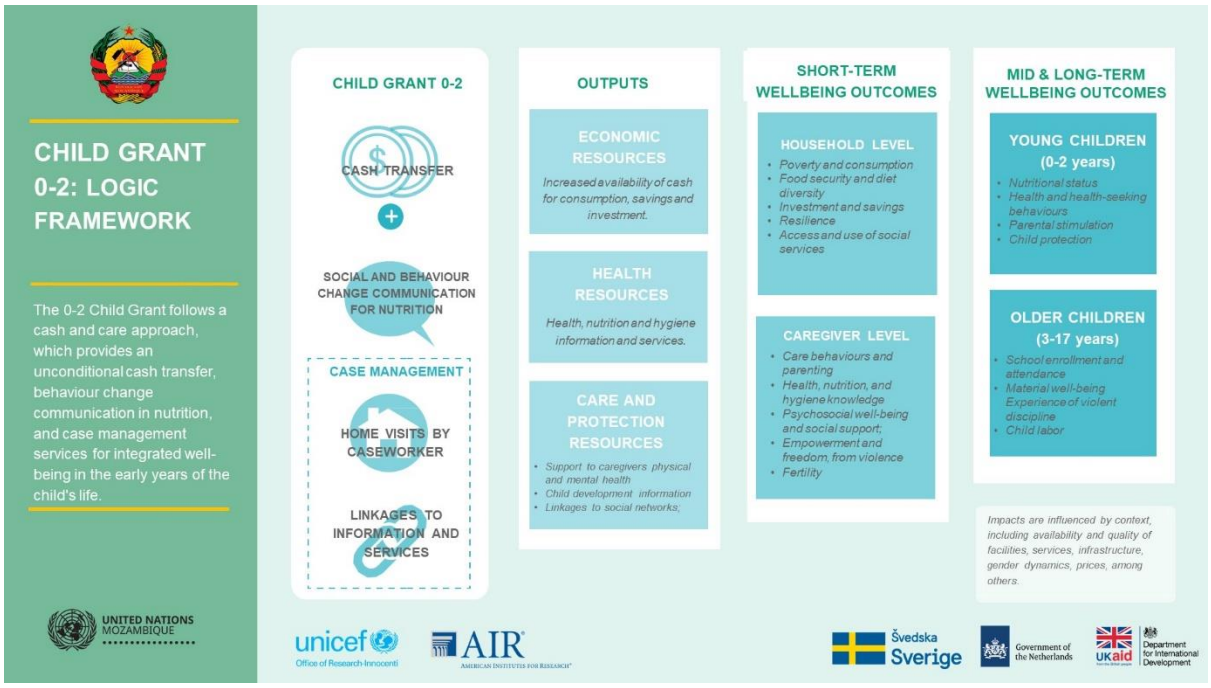
2.1 Logic Framework of the Intervention

Policy-relevant research and evaluation should be based on a logic framework that outlines the causal chain amongst activities, inputs, outputs, outcomes, and impacts, as well as the underlying assumptions (White, 2009). AIR, MGCAS and UNICEF confirmed the Child Grant 0-2 logic framework (

9 Note that values represent nominal values and do not account for inflation, which varied significantly on an annual basis over this period.
10 Most beneficiaries were single-person households that qualified due to old age.

33. Figure 2) during the inception meeting on 22 June 2018, and it reflects the evaluation's goals for improving child wellbeing.

Figure 2. Logic Framework



Fonte: UNICEF Moçambique. (2018). Materiais de Comunicação do Subsídio para Criança 0-2.

34. Households receive intervention components (left column), including a cash transfer paid to the primary caregiver of the child aged 0 to 2; community-level SBCC activities around positive nutrition and hygiene practices; and case management, consisting of periodic home visits by a community-level caseworker and referrals to information and services on the basis of need.

35. Building on Smith and Haddad's (2002) framework for child nutrition is the hypothesis that intervention components can result in meaningful resources for the households: (*a*) economic resources, (*b*) health resources and (*c*) care and protection resources. Households are hypothesised to use these resources for short-term benefits at the household level (increased food security, investment, and savings, amongst others) as well as at the caregiver level (improved care behaviours, improved psychosocial wellbeing, increased control over fertility decisions, amongst others). Once short-term outcomes are realised, 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 realised at the household level, young children (between 0 and 2 years old) may have improved nutritional status and dietary intake. 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), hypothesised outcomes include increased schooling and material wellbeing and reduced violent discipline and labour. For the intervention to turn outputs into short- and long-term outcomes, it is assumed: (1) There is institutional capacity to implement the cash transfer component as intended (e.g., cash payments are made regularly and in full; there is high uptake by eligible beneficiaries); (2) There is sufficient human and institutional capacity for the implementation of the case management component (e.g., households with need of case management activities are correctly identified and receive the supporting activities in a timely manner by well-trained operators); (3) The intervention targets efficiently and reaches households and caregivers of target children who are at need (e.g., there are limited household level exclusion errors and complementary activities reach the intended persons within the household) and (4) community-level markets and referral services

are functioning and available (e.g., a market for goods and services exists and is well functioning for participant households to buy consumption items, as well as sell products and services they produce, and quality referral health, social and protection services exist for participant households to access).

36. Although not explicitly indicated in the logic framework, for the majority of outcomes, it is hypothesised there may be direct effects from each intervention component (cash and care), as well as potential synergistic impacts across the two components. All outcomes depend both on implementation factors (size and regularity of the cash transfer, quality of case management services, exposure to SBCC, amongst others) and on contextual factors (distance and quality of facilities and services, food availability and prices, prevailing social norms, infrastructure—including water and sanitation—amongst others).

The logic framework (

Figure 2) is important in that it guides hypotheses for the evaluation. We will investigate many of the expected outcomes along the causal chain, focusing on *causal* analysis of impacts for those that are most likely to change during the 2-year study period. The intervention logic is explicitly rooted in a child-rights framework and takes a gender-sensitive approach, tackling the root causes of child multi-dimensional poverty and prioritizing female caregivers as the entry-point for economic and care services. Flowing from this framing, we take an explicit gender- and child-sensitive approach to choose of indicators and analysis throughout this report. For example, we explicitly include indicators of female caregiver empowerment, child protection and conduct disaggregated analysis for different gender- or age-related factors where possible (female vs male headed households, younger versus older caregivers, male versus female children). Unfortunately, because of the low proportions of children and caregivers with reported disabilities, we are unable to confidently conduct explicit disability-sensitive analysis. Contextual and operational components will be largely explored in the process evaluation; however, we will also present basic descriptive results of intervention participants' experience with the programme. In addition to components mentioned directly in

37. Figure 2, the evaluation seeks to measure some common, hypothesised, unintended consequences of cash transfers—for example, increases in fertility or consumption of temptation goods (alcohol). Although previous research has shown no such adverse effects, it is important to measure and demonstrate this in the context of the Child Grant 0-2 in Mozambique (Handa et al., 2018).

2.2 Evaluation Questions

38. The intervention logic framework motivates three evaluation questions for this study:

- Does cash alone have an impact on short-term wellbeing outcomes at the household, caregiver, and child levels?
- Is the impact of the cash-and-case management intervention larger than cash alone with respect to the same outcomes?
- 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?

39. These evaluation questions and overall evaluation objectives were jointly agreed during an inception phase and confirmed during the inception meeting on 22 June 2018 between AIR and evaluation partners, MGCAS and UNICEF. Because of the importance of gender for the intervention operations and impacts, there is an explicit focus on gender-equality indicators within the caregiver section and gender analysis across outcome indicators (by sub-group) where possible.

2.3 Domains of Interest

2.3.1 Primary Outcomes

40. The primary outcomes of interest are determined from the research questions and the intervention logic framework, informed by a child- and gender-sensitive approach. Outcome indicators that are standardised and easily collected within household surveys were prioritized. They also rely on certain assumptions regarding the hypothesised timeframe of impacts—focusing on outcomes that are feasible-to-measure changes within a 24-month period for the target group. The indicators and questionnaire modules used in the evaluation come from pre-validated and internationally/nationally tested survey modules. Where possible, modules and indicators follow those already used in Mozambique (e.g., DHS, Household Budget Surveys) or within other evaluations of cash transfers used in the Transfer Project in the East and Southern African regions.[11]

41. Child wellbeing for children under 24 months is one of the primary outcomes of the study. Improving target child's wellbeing, however, depends upon other household members also benefit from the intervention at different levels. Child wellbeing is assessed through a series of domains, specifically developmental, health, nutrition, and child protection. Child height and weight are measured using the internationally accepted standard for height boards

11 The Transfer Project (see https://transfer.cpc.unc.edu/) is a multi-country research initiative to provide rigorous evidence on the impact of large-scale national cash transfer programmes in sub-Saharan Africa. It is made up of a community of research, donor and implementing partners who focus on coordination of efforts and uptake of results, led by UNICEF, the Food and Agriculture Organization of the United Nations and the University of North Carolina. The project provides technical assistance in the design, implementation and analysis of government programmes in Ethiopia, Ghana, Kenya, Lesotho, Madagascar, Malawi, South Africa, Tanzania, Zambia and Zimbabwe, among others. Programmes are nationally owned and implemented by each government, and they focus on dissemination of results to national stakeholders, as well as regional workshops to enable cross-country learning and capacity building.

and scales. Table 2 provides examples of primary indicators used to measure each domain for children under 24 months. A full list of indicators was developed jointly with stakeholders during the inception period and presented across primary and secondary outcomes in the inception report (AIR, 2018). Further details for all indicators operationalized in this report are discussed in the corresponding results sections.

Table 2. Child Wellbeing Domains and Indicators (≤ 24 Months)

Domain	Indicator
Health and Health-Seeking Behaviours	Morbidity (e.g., diarrhoea, individual was sick during last two weeks, individual consulted health professional if sick) Feeding practices (e.g., exclusive breast-feeding, minimum acceptable diet) Completion of routine vaccination
Parental Stimulation	Number of activities with adults in the household Number of activities with caregiver
Nutritional Status	Stunting (height-for-age z-score) Wasting (weight-for-height z-score) Underweight (weight-for-age z-score) Mid-upper arm circumference (z score < -2)
Child Protection	Prevalence of birth registration Neglect (e.g., caregiver leaves child unsupervised)

2.3.2 Secondary Outcomes

42. Secondary outcomes relate to the household, caregiver, and older children. Household-level impacts are important because they create the preconditions for later impacts on children, including a higher level of consumption and overall financial standing. Table 3 provides examples of primary indicators used to measure each domain at the household level.

Table 3. Domínios e Indicadores a Nível do Agregado Familiar

Domínio	Indicador
Pobreza e Consumo	Pobreza (abaixo da linha nacional de pobreza) A pobreza extrema (abaixo da linha nacional de pobreza alimentar) Consumo mensal de alimentos per capita Consumo mensal não alimentar per capita Despesa total mensal de álcool e tabaco
Segurança Alimentar e Diversidade Alimentar	Número de refeições por dia Diversidade alimentar Estratégias de sobrevivência alimentar (escala acesso insegurança alimentar)
Investimento e Poupança	Valor poupado e emprestado (dívida) Activos produtivos e duradouros (incluindo gado) Despesas de insumos agrícolas e da colheita Gestão de pequenos negócios
Resiliência	Mecanismos para enfrentar choques
Acesso aos Serviços	Acesso a serviços sociais

43. Secondary outcomes additionally relate to the child's primary (female) caregiver. The primary caregiver receives the transfer directly and is thus expected to have some level of influence regarding how it is spent. Similarly, the caregiver is the entry point for the case management component, and our study assumes that the caregiver will leverage family

support and linkage to services to improve the wellbeing of all children in the household. Moreover, a significant body of literature suggests that cash transfer interventions that are designed as gender-sensitive have potential to affect women's empowerment and wellbeing directly, an important intrinsic goal for gender equality and human rights. Thus, this study investigates the impacts on caregiver knowledge and behaviours, psychosocial wellbeing, empowerment, freedom from violence, fertility, and family separation. Table 4 lists the domains for primary caregivers and examples of indicators to measure them.

Table 4. Primary Caregiver–Level Domains and Outcomes

Domain	Indicator
Knowledge	Health and nutrition knowledge
Psychosocial Wellbeing and Social Support	Subjective wellbeing (life satisfaction, happiness) Social support (e.g., quality and quantity of social support, group participation) Perceived stress scale Mental health (depressive symptoms)
Empowerment and Freedom from Violence	Autonomy, household decision-making (bargaining power) Financial standing, savings Intimate partner violence, attitudes supporting violence
Fertility	Total fertility, new pregnancies, contraceptive use
Family separation	Biological children living outside the household

44. Finally, secondary outcomes relate to other children between 3 and 17 years old in the household. The household may choose to spend some of the transfer on food for the household, reducing child labour and investing in their children's education. Furthermore, there may be additional beneficial effects for older children from the case management component because services are for all members in the household. Therefore, the study investigates effects on older children's education, material wellbeing, experiences of violent discipline, time use and experience of initiation rites (for adolescent girls only). Table 5 lists examples of the indicator to measure for each of these domains.

Table 5. Older Children's Domains and Indicators

Domain	Indicator
Schooling	School enrolment School attendance Expenditure on education
Material Wellbeing	Child has pair of shoes Child has blanket Child has two pairs of clothes
Violent Discipline	Violent discipline from caregiver (e.g., child is hit or slapped)
Time use	Hours spent last week on economic activities Hours spent last week on domestic activities (including hours spent on care and household chores)
Initiation (adolescent girls)	Underwent (or plans to undergo) initiation rights

45. In addition to the outcome indicators described in the preceding exhibits, the study collects a comprehensive set of demographic and household dwelling indicators to use as background characteristics in the analysis. Other indicators collected, but not listed earlier

include those to be used as mediators and moderators in explaining impacts and contextualise communities in which the beneficiaries live.

2.4 Additional Aspects

46. Geographic scope. The impact evaluation covers the following districts: Ilha de Moçambique, Nacala-a-Velha, Lalaua, Nacala Porto, and Mossuril. Ilha de Moçambique and Lalaua receive the cash-only intervention while Nacala-a-Velha receives the case management subcomponent. Nacala Porto and Mossuril serve as comparison districts for the evaluation.

47. Population. In the districts in which the impact evaluation is conducted, transfers were distributed nearly universally (exclusions could be made at the community level on the basis of wealth and social status) and unconditionally for households with children aged between 0 and 6 months old at enrolment in 2019.

48. Chronological scope. The impact evaluation is a 24-month evaluation. We collected baseline data the first trimester of 2019 and endline in the first trimester of 2021.

49. Relation to process evaluation. As discussed in Section 1, the impact evaluation is complemented with a process evaluation. The process evaluation focuses on questions regarding the intervention fidelity, including challenges and strengths of implementation. Both evaluations are intended to help the same group of policy makers and key stakeholders redesign the intervention to improve its operation. The two combined evaluations, which are jointly disseminated, comprise a full suite of information needed for policy makers to take decisions on the future of the intervention.

3 EVALUATION METHODOLOGY

3.1 Overview

50. The evaluation team designed a 24-month, longitudinal impact evaluation of the Child Grant 0-2 that compares two treatment arms ((*1*) cash only and (*2*) cash plus case management) to a comparison group (no treatment). By design, the evaluation takes and explicit gender-sensitive approach, focusing on both understanding the added value of the case management component (a gender-transformative plus component) as well as on understanding the overall impacts on gender equality and empowerment and disaggregated impacts by gender. We use a quasi-experimental geographic regression discontinuity design (RDD) for the impact evaluation (Gertler et al., 2010). RDDs can be used to identify intervention effects when intervention allocations are based on an assignment variable and provide stronger methodological designs than use of 'similar district' comparisons. For the purpose of the evaluation, key implementation districts in Nampula Province are Nacala-a-Velha and Ilha de Moçambique, which constitute the treatment group. All households in the treatment areas with a child under 11 months old (that is, born in August 2018 or after) were enrolled in the intervention, regardless of whether or not they are in the study sample. The intervention plan indicated enrolled children would benefit from intervention activities until they turn 2 years old (24 months), however at the time of writing, this 'graduation' was delayed because of initial delays in first payments.[12] The Child Grant 0-2 is nearly universally targeted such that any eligible household in a treatment district may enroll, with exceptions made at the community-level for households of high economic status.

12 Case management services were planned to be provided to beneficiary households for an average duration of 6 to 9 months, depending on the severity of the case and the needs of families. Therefore, it is possible these services stop before the target child turned 2 years old. It is equally likely they could last beyond this age threshold, depending on how long families required support and case closure rates.

51. The evaluation used households in the districts of Mossuril and Nacala Porto, which share borders with the treatment districts, to construct the comparison group. The logic behind the geographic RDD is that those who live in the treatment area right next to the border and receive the intervention 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. RDDs rely on relatively 'mild assumptions' to identify credible intervention impacts (Lee & Lemieux, 2010). In this setting, the distance to the border between districts can be interpreted as the assignment criterion.

52. The four districts for the impact evaluation border each other in a continuous geographic position. 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. Consultation with intervention stakeholders and from the endline data confirmed the following:

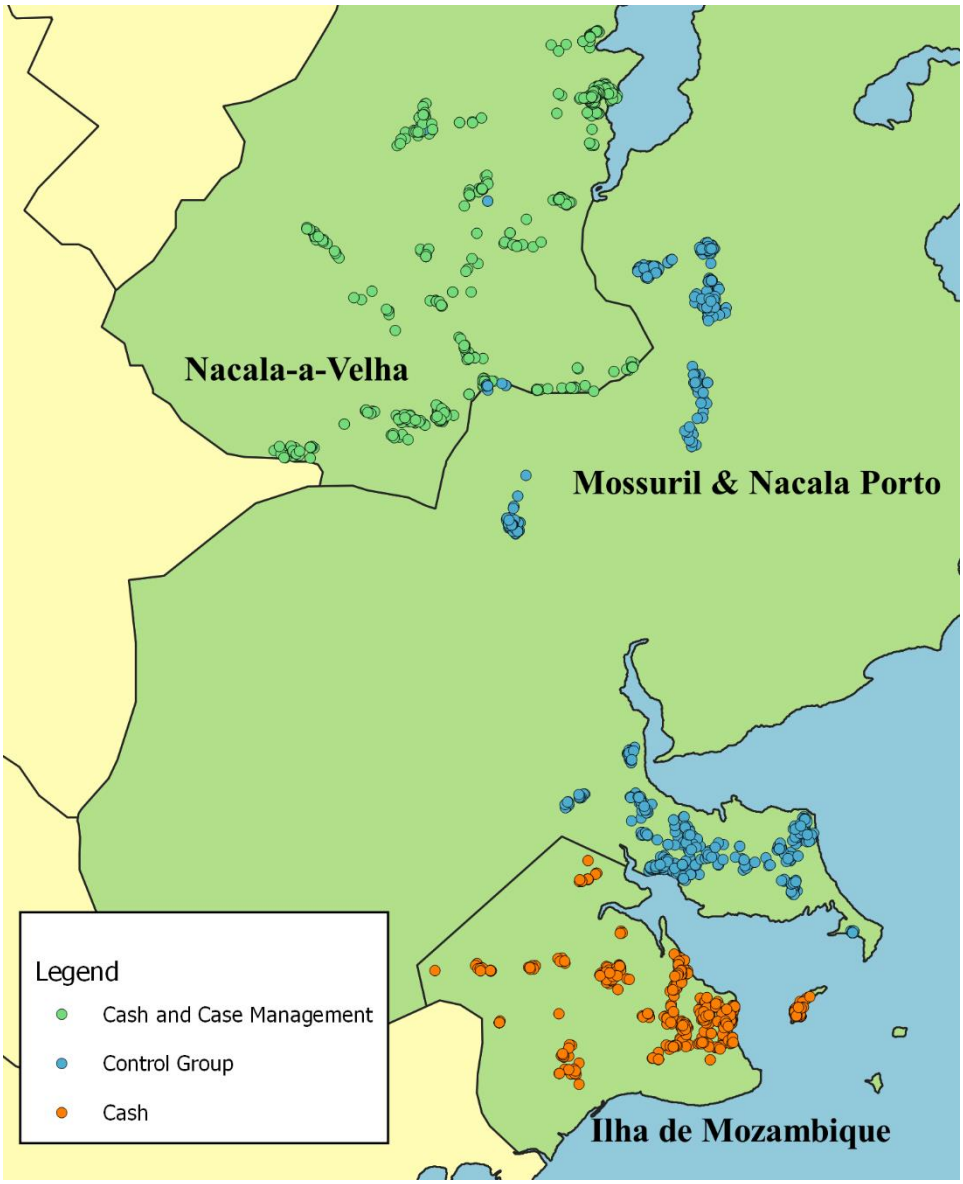
- Allocation was enforced at the border of the district through the intervention targeting and validation process. Our own data collected as part of the endline survey reinforce this point, as virtually no study participants in comparison districts report being enrolled in the intervention.
- There is no correlation anticipated between distance to the border and characteristics of households, especially related to outcomes of interest to the study, because poverty and malnutrition levels, culture, climate, agricultural practices, and policies are the same across the four districts. We verified this assumption for observable characteristics in the baseline report.
- Households are not very mobile, nor are they expected to move between districts to enrol in the intervention during the study timeframe. This could be a concern in the longer run of the intervention but not during the period of the study.
- We used GPS data points and accurately measured the distance to the border for each household.

53. In summary, the study comprised three arms:

- Households in Ilha de Moçambique that received cash (approximately 700 households at baseline).
- Households in Nacala-a-Velha that received cash plus care (approximately 700 households at baseline); and
- Households in Mossuril and Nacala Porto that received neither (approximately 700 households at baseline).

54. Figure 3 shows the study districts with GPS mapping of treatment households at baseline for the northern border in green, treatment households for the southern border in orange and comparison households in blue. For the purposes of analysis, we considered distance to the water-bound southern border, rather than the interior landlocked border. Approximately 95% of the sample is within 10 km of district borders, and the remaining 5% is within 15 km of district borders.

Figure 3. Visualisation of Study Sampling Across Study Districts



3.2 Identification Strategy

55. The evaluation team identified households with children under 6 months old to conduct the baseline study through a mini-listing exercise separate from the intervention enrolment exercise. The listing compiled information from health facility maternity books in key health facilities to develop a sample of eligible women (households) by community. For the purposes of the health facility listings, women were considered eligible if their entry into the maternity ward took place before 15 August 2019 (northern border) or before 1 September 2019 (southern border). Since the enumeration team moved from north to south conducting interviews, this ensured that the sampled children ranged from newborn to approximately 5.5 months for both borders.

56. Following the health facility listings, enumerators worked closely with local leaders, *Permanentes* (INAS technicians responsible for implementation activities) and health centres to identify and visit all households with a child under 6 months old at baseline living within selected communities (primarily living up to 10 km of the border between study districts). At baseline, enumerators then ordered communities (and households within communities) by

proximity to the border and completed interviews, moving away from the border to find new households until they reached the target number of households. At endline, we followed the same households that we interviewed at baseline. As we discuss in Section 5, we lost approximately 20% of the baseline households at endline. In the following sections, we describe in detail the attrition implications and the steps we took to ensure we estimated estimates appropriately.

3.3 Sampling

3.3.1 Locations

57. The aim of this evaluation was to estimate the average effect of the Child Grant 0-2 on a cohort of children under 6 months old at baseline. Thus, the evaluation sampled households at baseline with children under 6 months old who lived in the four study districts (primarily living up to 10 km of the border between study districts). We used a longitudinal approach wherein we followed over time the same households and children who were under 6 months old at baseline, who were between 24 and 30 months old at the 24-month follow-up, which took place in April 2021. In addition, 50 community-level surveys were conducted with local leaders, and 10 health facility surveys were collected by interviewing health staff at clinics serving the target population at baseline. At endline, we also collected information for the same communities and health facilities.

3.3.2 Power to Detect Effects

58. Power analysis is an important aspect of the impact evaluation. It enables us to determine the sample size required to detect an effect of a given size or larger—referred to as a *minimum detectable effect size* (MDES)—with a given degree of confidence. A properly designed evaluation should detect small but meaningful differences in effects for the outcomes of interest. In this section, we conduct a power analysis for the evaluation.

59. We determined our MDES on the basis of policy relevancy. Our review of the cash transfer literature in contexts similar to the context of the present study shows that a 0.25 SD improvement is a sensible effect size that would make the intervention relevant from a policy perspective. First, there is strong evidence that cash transfers have a positive effect on food security, in terms of both larger quantities and higher quality of food. For example, in evaluations of unconditional cash transfers that AIR conducted in Zambia and Zimbabwe, we found that programme beneficiaries increased food consumption between 0.25 to 0.34 SDs (AIR, 2016). More specifically, we found that beneficiaries increased consumption of animal products by more than 0.56 SDs. Second, in terms of productive outcomes, we found large increases in livestock ownership, with effect sizes between 0.37 to 0.58 SDs, as well as a 1.46 SD impact on ownership of non-farm productive assets. In our evaluation of the Child Grant Programme in Zambia, the overall asset index effects were 0.55 SD compared to 0.25 SD in the six-country graduation model study presented by Banerjee and colleagues (2015) and 0.40 SD in Uganda's programme evaluated by Blattman and colleagues (2016). Third, our estimates from the Zambia Child Grant show that the programme increased household participation in non-farm enterprises by 0.33 SD, an estimate that is lower than the impact reported by Blattman and colleagues (2016) of a programme that provided cash conditional on opening a business after receiving business skills training and ongoing supervision. Moreover, the revenue impacts in Zambia's Child Grant Programme are comparable to the 0.38 SD reported by Banerjee and colleagues (2015).

60. The evidence shows that powering the current study to detect effect sizes that are at least 0.25 SD will enable us to find impacts for most key outcomes at the household level.

Note, however, that the evidence on intervention impacts for outcomes related to the immediate determinants of child nutrition is more limited. Although there seems to be a relationship among nutritional outcomes, caregiver feeding behaviours and practices, and psychosocial care, there is very little evidence of the impact of cash transfers on these behaviours (de Groot et al., 2017). In particular, the literature shows that there are mixed results of the impact of social protection programmes on height-for-age outcomes of young children due in part to the difficulty of assessing this outcome over the short-term and the fact that the causes of stunting are complex and difficult to link to results. In addition, powering a study to detect effect sizes that are smaller than 0.25 SD not only may be irrelevant from a policy point of view but also will require a substantial increase in the sample size for the study, which in most cases will make the study financially prohibitive.

61. In order to attain the proposed MDES of 0.25 SD, we collected data from 700 households in each of the study arms for a total sample of 2,100 households at baseline. More specifically, for estimating the impacts of cash only, we collected data for 700 observations from Ilha de Mozambique and 350 observations in Mossuril close to the border between those two districts. In turn, for the comparison between cash plus case management and the comparison group, we collected data for 700 observations from Nacala-a-Velha and 350 observations in Mossuril and Nacala Porto close to the border between those districts. The proposed sample size assumed an 80% power and a 5% significance level. We also assumed that the baseline covariates could explain 30% of the variation in the outcomes of interest, as a result of being able to control by outcomes of interest at baseline. We estimated statistical power by first estimating the power needed for an individual-level randomised controlled trial (RCT) and then inflating the resulting sample size by the RDD design effect. The RDD is a less efficient estimator than simple random assignment by a factor of $D = \frac{1}{1-\rho^2}$, where ρ is the correlation between treatment status and distance to the border (Schochet, 2008) and D is the design effect. Assuming households are normally distributed around the border that determines eligibility for the child grant 0-2, we estimated that the correlation between the treatment indicator and distance to the border is 0.79. Thus, the design effect is 2.75. This means that the study's power is equivalent to that of an RCT with one-quarter of the observations used for the current study.

3.3.3 Sample Selection

62. The evaluation included 2,130 households at baseline, with approximately 700 in each of the study arms. We calculated the number of 2,100 households by conducting a power analysis, as described earlier, on the basis of data from other cash transfer evaluations in the region.

63. The inclusion criteria for the study were as follows:

- Household had at least one child under 6 months old at baseline (permanent resident).
- Households lived near the border in one of the four study districts at baseline—ideally, no more than 10 km from the district border; and
- Caregiver was available to be interviewed and agreed to participate in the study.

64. The exclusion criteria for the study were as follows:

- Household did not have any child under 6 months old at the time of the baseline survey;
- Household had a child under 6 months old at the time of survey; however, the child was visiting or temporarily staying with the household;

- Household lived outside the study districts; and
- Caregiver was not available to be interviewed or chose not to participate in the study.

65. An important aspect of the baseline sample is that instead of up to 20% of the most vulnerable households being targeted for case management in the cash and case management arm (Nacala-a-Velha), for the purpose of providing higher statistical power, we requested the implementation team to target approximately 50% of the households in Nacala-a-Velha. However, as discussed later, the proportion of households who actually received case management activities among those who were eligible was only 27% (according to self-reported data in the operational module of the endline survey). Thus, due to various reasons, the case management reached a lower proportion of household than anticipated by endline. In the following sections, we discuss the implications for the evaluation.

3.4 Impact Evaluation Analysis Plan

66. To implement the RDD for the evaluation of the Mozambique Child Grant 0-2, we compared the cash transfer recipient households from Ilha de Moçambique with eligible households in the neighbouring district of Mossuril and also compared the cash-and-case management eligible households from Nacala-a-Velha with a group of eligible households in Mossuril and Nacala Porto that did not receive the intervention. More specifically, in our setting, we used distance to each of the pilot district borders as the assignment variable for the RDD as discussed earlier. Households and children who lived just outside the start-up district border (e.g., Mossuril) were likely to be similar to those who lived just inside the start-up border (e.g., Ilha de Moçambique), and thus potentially could serve as a credible comparison group to estimate intervention impacts. We collected the GPS coordinates for each household in the study, which enabled us to calculate their distance from the border with its paired district.

67. The geographical RDD (Galiani, McEwan, & Quistorff, 2016; Keele et al., 2016) is valid when the following assumptions hold:

- The allocation of beneficiaries to the intervention is discontinuous at the border;
- The outcomes, covariates and unobserved characteristics are similar in value at the border prior to intervention implementation;
- The households and individuals do not adjust their location on the basis of the intervention; and
- The relationship between the assignment variable (i.e., distance to district border) and the outcome variables is accurately approximated.

68. Assumption 1 holds by design given that households from Mossuril and Nacala Porto did not benefit from the intervention at this stage regardless of how close they lived to the district border at baseline. We tested assumption 2 in the baseline report and in this report by determining the balance between treatment and comparison groups after baseline data collection and in the follow-up round when discussing how balance is maintained after attrition. We also tested assumption 3 at endline. Lastly, we used regression analysis to address assumption 4.

69. We collected data at two points in time: at baseline in February and March 2019 and one follow-up 25 months later in April 2021. We used the following difference-in-differences (DID) specification to estimate the intent-to-treat effect of the combined intervention activities (i.e.,

cash and case management) on the outcomes of interest after controlling for differences in outcomes for the treatment and comparison groups at baseline:

$$y_{ihdt} = \beta_0 + \beta_1 Post + \beta_2 T + \beta_3 \text{Post} * T + f(distance_{ihd0}) + \beta_4 X_{ihd0} + pair_d + \varepsilon_{ihdt} \quad (1)$$

70. Where y_{ihdt} is the outcome variable for child *i* in household *h* living in district *d* at time *t*. *Post* is an indicator equal to 1 for follow-up observations and 0 for baseline observations. T is an indicator for being eligible to receive the cash or the care activities. β_3 represents the impact estimate for the combined effect of the intervention. $Distance_{ihd0}$ is the assignment variable measuring the household's distance to the border, and X_{ihd0} contains baseline covariates to increase the efficiency of the estimates. For household-level outcomes, this set of variables includes household head demographics (gender, age, and education), a dummy for household religion and an index for COVID-19 disruption in community from follow-up.[13] In addition to the basic set of controls at the household level, for caregiver outcomes, we added caregiver age, level of educational attainment and marital status. Finally, in addition to the basic set of controls, for child-level outcomes, we included child age (in months, or years) and child sex (female). In addition, following literature suggesting the accuracy of sensitive questions can be improved by controlling for quality of enumerators, we included enumerator fixed effects for caregiver outcomes (including violence, mental health, stress, and empowerment) as well as violent discipline of children (Di Maio & Fiala, 2018). Following this intuition, we also included enumerator fixed effects to control for quality of child anthropometric measurement. We used robust (Huber-White) standard errors to obtain unbiased estimates in all analyses.

71. The term $pair_d$ merits additional explanation. The RDD in this context relies on households that are located along one of two borders: Ilha de Moçambique and Mossuril (south), and Nacala-a-Velha and Mossuril/Nacala Porto (north). The term $pair_d$ represents a fixed effect to account for differences between households located near the two borders (i.e., $pair_d$ takes the value 1 for the border between the districts of Ilha de Moçambique and Mossuril and 0 otherwise). By including a border fixed effect in all estimating equations, we essentially treated the sample as though all households are located near a single border.

72. We also used a second specification where we estimated intervention impacts for those eligible to receive the cash component, as well as the additional impact for those eligible for receiving the case management component. In particular, we estimate

$$y_{ihdt} = \delta_0 + \delta_1 Post + \delta_2 T + \delta_3 T_{cc} + \delta_4 \text{Post} * T + \delta_5 Post * T * T_{cc} + f(distance_{ihd0}) + \delta_6 X_{ihd0} + pair_d + \varepsilon_{ihdt} \quad (2)$$

73. Where all variables are defined as earlier and T_{cc} is an indicator for being eligible to receive the case management component. δ_4 represents the impact estimates for the cash transfer component, and δ_5 is the additional impact of being eligible for the case management

13 The index of COVID-19 disruption is a community-level measure of "high disruption," as measured by a binary variable of the top tercile on an index created through principal component analysis using the following 8 variables: (1) number of months (in the last 12 months) public primary schools in the community were disrupted due to COVID-19, (2) number of months (in the last 12 months) public secondary schools in the community were disrupted due to COVID-19, (3) number of months (in the last 12 months) health clinics in the community were disrupted due to COVID-19, (4) number of months (in the last 12 months) food markets in the community were disrupted due to COVID-19, (4) due to COVID-19, people in the community were affected by stores closing or operating on restricted hours, (5) due to COVID-19, people in the community were affected by social distancing and/or quarantines, (6) due to COVID-19, people in the community were affected by greater conflicts and arguments in the family, (7) since the beginning of COVID-19, the local administration has restricted travel inside this region to control the spread of COVID-19, and (8) since the beginning of COVID-19, the local administration has restricted travel to other regions to control the spread of COVID-19.

component. A statistically significant estimate for δ_5 means that there is an additional impact of the intervention for those eligible to receive the case management component on top of the cash impact. Note that, if households targeted to receive the case management component have for example a lower socio-economic status relative to those who are not targeted, the estimated impact of δ_5 could also be capturing some heterogenous effects of the intervention. Finally, to examine the impacts of both the pooled treatment (1) as well as treatment arms (equation 2) for different sub-groups, we run separate analyses by gender and age where possible. These include sub-groups at the household level (female versus male headed household), caregiver level (younger and older caregiver) and child level (boys versus girls, age groups).

4 DATA COLLECTION

74. Baseline and endline data collection were carried out with technical support from researchers at AIR, UNICEF Office of Research–Innocenti and UNICEF Mozambique approximately 24 months apart in 2019 and again in 2021. Baseline data collection was led by ELIM Serviços over a 6-week period from 11 February to 17 March 2019, and endline data collection was led by Dalberg Research in partnership with Arusha Ltd. over a 4-week period from 14 March to 16 April 2021. Due to the gender-sensitive nature of the study design, typical field teams consisted of five female enumerators, one female supervisor and a driver (although at endline several male supervisors were included in the team). Field teams were overseen by one or two field managers, in addition to researchers from AIR and UNICEF Innocenti, during the initial weeks of data collection. At endline, researchers from AIR and UNICEF Innocenti were unable to travel because of COVID-19 restrictions, so local consultants provided oversight with daily debriefs with the international team. To maintain comparability of treatment and comparison groups, teams first completed interviews at the northern border (Nacala-a-Velha and northern Mossuril/Nacala Porto), followed by the southern border (Ilha de Mozambique and southern Mossuril).[14] Interviews were conducted primarily in Makua on tablets by using SurveyCTO software. Data were uploaded on a regular basis to internet-based platforms where progress could be monitored, and data could be checked by researchers at AIR and UNICEF Innocenti to ensure quality and communicate any needed modifications to field teams. Additional details regarding training, piloting, quality control, ethical protocol and challenges encountered are detailed here.

4.1 Training and Piloting

75. Training of the field team took place over a 2-week period prior to data collection in Nampula city. The training took place in Portuguese and Makua, led by AIR and ELIM Serviços and supported by UNICEF Innocenti (baseline) and by local consultants and Arusha Ltd. supported by AIR, UNICEF Innocenti and Dalberg Research (endline). Female applicants were recruited for the field team who had at least some university-level education, had experience in household surveys and were fluent in the local language (Makua). At endline, an attempt to employ the same enumerators was made, conditional on high performance, to increase familiarity and quality of the survey administration. Female enumerators were necessary, as the primary respondent was the target child's primary female caregiver, and numerous topics related to maternal health, gender and violence were seen as sensitive. Additional applicants were trained, and only those who were deemed the highest quality were selected. Applicants

14 At baseline, initially, the island portion of Ilha de Mozambique was not envisioned to be part of study sample, yet because of lack of qualifying mothers with children 6 months old at the range required on the survey within the designated catchment areas, it was added after consultation with stakeholders.

were judged on their comprehension of the survey instrument, fluency in the Makua language, participation in training exercises and tests, pilot performance and leadership skills.

76. Training consisted of in-class exercises to understand and master administration of the household survey instrument, practice with the computer-assisted personal interviewing (tablet) application, role-play and practice translating from Portuguese into Makua. The detailed review of the survey instrument also helped adapt questions and responses to the local context and improve the structure of the questions. In addition, special sessions were given on the role of the evaluation/ intervention, ethical protocol, fieldwork logistics and anthropometry training. The anthropometry theory and practicum were led by a nutrition specialist from UNICEF Mozambique, and all field team members who were expected to take anthropometrics were required to pass standardisation tests (measuring consistency and validity of a total of 10 mothers with children aged 0 to 2 years). At baseline, representatives from UNICEF Mozambique, MGCAS and INAS attended specific sessions to contribute to discussions about the ethical protocol and operational aspects of the intervention. At endline, training capacity was capped due to COVID-19, and additional stakeholders joined remotely when possible.

77. Two pilots were completed during both baseline and endline training. The first was completed at a health facility in Nampula city, where enumerators interviewed women visiting the clinic for growth monitoring visits (administration excluded anthropometric measurements). The second was completed at a rural community approximately 30 minutes outside of Nampula city, where enumerators completed full interviews and anthropometric measurements. Pilots were an opportunity for enumerators to practice administering the questionnaire, as well as an opportunity to check the SurveyCTO application and build data-checking programmes in advance of data collection. In addition to the main enumerator training, an additional day of training was conducted with the six selected supervisors (and one alternate) to cover the community and health facility questionnaires, as well as further discuss field logistics and referral protocols.

4.2 Ethical Protocol

78. AIR follows the United Nations Evaluation Group (UNEG) Code of Conduct, which requires both a conflict- and a gender-sensitive approach to research and adherence to the 'do no harm' principle, as well as transparency, confidentiality, accuracy, accountability, and reliability, amongst other key principles. With regard to the protection of vulnerable individuals and communities, AIR respects and adheres to the United Nations Declaration of Human Rights, the United Nations Refugee Convention, the Convention on the Rights of the Child and the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), as well as other human rights conventions and national legal codes that respect local customs and cultural traditions, religious beliefs and practices, personal interaction, gender roles, disability, age and ethnicity. Further, AIR ensured that the evaluation complied with UNICEF's Procedures for Ethical Research Involving Children and UNICEF's Procedures for Ethical Standards in Research, Evaluation, Data Collection and Analysis. And finally, the evaluation was guided by the ethical principles of openness, transparency, participation, independence, impartiality, credibility, responsibility, honesty, and integrity. The AIR evaluation team obtained approval letters from the AIR institutional review board (IRB) and from the National Committee of Bioethics for Health (Government of Mozambique) before data collection (see Annex D).

79. Evaluators have obligations to address ethical issues inherent in research, including ensuring the safeguarding of participants and no compromise regarding the independence, credibility, and impartiality of the study. Therefore, the study underwent ethical review and

received approval from the AIR IRB and the *Comité National de Bioética Para a Saúde* (Ref 704/CNBS/20). In addition, we consulted and adhered to the UNICEF standards and recommendations for ethical research involving children (Graham et al., 2013). Standard ethical procedures were part of the enumerator training, including aspects of informed consent, confidentiality, and protection of survey respondents. Enumerators were trained to show respect and dignity for participants, be impartial and make respondents feel their participation was voluntary. In addition, special attention was given to administering modules of child discipline and intra-household violence, as well as health- and protection-related referral protocols. Three levels of referrals were implemented in the survey (see the enumerator manual for more details regarding the specific protocol). First, anonymised district-specific referral cards, which contained contact information for female representatives of NGOs, social welfare, and legal (female police) services, were given to all women participating in the survey. Social welfare officers from each district joined the enumerator training at baseline so that enumerators made direct contact with each officer and so that officers fully understood the content and nature of the fieldwork. Second, direct referral forms were filed in the case of an acute protection concern. These forms were given to the field manager, who communicated the information to a child protection focal point at UNICEF based in Nampula for direct follow-up with provincial and district social welfare services. In addition, a closed WhatsApp group of supervisors, field managers, UNICEF Mozambique and UNICEF Innocenti communicated the occurrence of each direct referral for timely action—with no direct identifying information included.

80. The third level of referral related to the nutritional status of target children. All children who had oedema, or who were 3 SDs or less underweight (severe; as identified automatically by the SurveyCTO programme on entering anthropometric measurements), had health referral cards filed and were taken by the survey team to the nearest health facility (with caregiver permission). The same protocol was used for all children who were 2 SDs or less underweight (moderate), but no transportation was offered—instead enumerators recommended that caregivers take children to the nearest health facility at the earliest possible opportunity.

81. In addition to the typical ethical safeguards and protocols, at endline, COVID-19 posed an additional ethical challenge for the data collection. The team ensured all best practices were followed to reduce the risks to the survey team and participant population. From the outset, COVID-19 positivity rates were monitored to ensure levels implied a minimal risk at the population level. In addition, because of government mandates, extra permissions (and limitations on overall numbers) were required to conduct group-based trainings—which the team obtained. During training, all enumerators and trainers wore protective masks, and hand sanitising gel was provided. During training and fieldwork, all staff continued to wear protective equipment, and both temperatures and a COVID-19 symptom checklist were monitored to catch potential COVID-19 cases. In addition, all teams travelled and stayed (ate, slept) separately, instead of sharing accommodations (as is typical for field teams). For participants, a similar protocol was used. During the informed consent, enumerators alerted participants of possible COVID-19 dangers, offered information on COVID-19 infection modalities, and administered a COVID-19 symptom checklist. All participants who reported three or more symptoms in the previous 2 weeks were not interviewed and were referred to the nearest health facility. For those without COVID-19 symptoms, the enumerator offered protective masks and required the interviews be undertaken outside, with appropriate distance between the participant and enumerator. During fieldwork, no cases of COVID-19 were reported among the field team (however, several members sought care and received treatment for malaria).

4.3 Fieldwork and Challenges

82. Generally, the field teams were well received by district administrators and local communities. Visits were made to both district administrators and health centres to inform key stakeholders about the activities and receive permission to carry out surveys. In addition, at the local level, *Permanentes* and midwives were cooperative and willing to provide support to the field teams in locating women within their communities. Despite this, a major challenge for the field teams was locating the women on the health facility listing in each community (baseline) and re-locating women (endline). At baseline, typically, only up to one-half of the women on the listing were located, which could be due to mobility of women during childbirth periods. For example, it is common in Mozambique for a woman to travel from her residence to the residence of her mother or mother-in-law for childbirth and the postpartum period. Another explanation is that women are commonly known by nicknames and not their formal names, which were given on the health facility listing. Furthermore, it is possible that registration books used for pre-listing included women who were admitted for birth yet ultimately did not give birth in that particular health facility. For these reasons, field teams had to spend more time than expected looking for women who fit the criteria at baseline (with a child born before 15 August on the northern border or 1 September on the southern border). Perhaps for similar reasons, teams struggled to find the targeted 80% of the baseline sample at endline. After up to three call backs, and employing multiple strategies (e.g., using all available phone numbers, GPS coordinates, cross-checking with cash payment lists, attempting to contact women at pay points), a replacement sample was added of caregivers living in the same communities with a child of appropriate age range to achieve the target sample size. Further details regarding the baseline protocol for selecting the sample are available in the baseline report (AIR, 2020).

83. During data collection, enumerators were expected to complete two or three surveys per day, whilst supervisors managed logistics, took anthropometric measures with the assistance of the enumerators and completed community- and health facility–level surveys. Enumerators checked each interview, and supervisors compiled, checked, and uploaded surveys to the SurveyCTO platform via Wi-Fi hot spots in the evening of each day. Supervisors and field managers coordinated progress by using WhatsApp on a daily basis. Researchers at AIR and UNICEF Innocenti downloaded data every day to track progress and run data quality checks. AIR, UNICEF Innocenti and field managers debriefed at the end of each day with the field team during the first week and subsequently conducted routine calls to discuss any data issues as they were flagged. This system worked reasonably well, despite the lack of connectivity in some field locations, which led to challenges in communication.

84. Another challenge the AIR team faced during data collection is that around 21% of the baseline sample was lost at endline. We discuss this limitation in detail in Section 5.2. In that section, we provide evidence showing that there was no differential attrition between those that attrited at endline and those that remained. For the analysis, we used a large set of outcomes at the household, caregiver, and child level and found that attrition is not a source of concern for introducing selection bias. Nevertheless, we include controls in all our estimations to adjust for any slight imbalances.

5 SAMPLE DESCRIPTION AND ATTRITION ANALYSIS

5.1 Baseline Sample Description

85. The baseline report of the impact evaluation of this intervention presents a detailed description of this study's baseline sample (AIR, 2020). At baseline, the sample contained 2,130 households which ranged in size from two to 15 people, with the median household

containing five people. Due to the intervention's targeting, the sample is skewed toward children. The baseline sample contained very few people that were over the age of 50 and many children under the age of 6 months. The median age of the target child was 3 months, and 53% of them were girls. Men, most of whom were married, headed 87% of the households, and women headed the remaining 13% of households, most of which were also single-headed households. The vast majority of household heads were Muslim (90%), and nearly 45% had no formal education. Lastly, baseline housing and sanitary conditions were precarious. Less than one-half of the sample had access to safe drinking water and roughly two-thirds (66%) had access to a latrine.

5.2 Attrition Analysis

86. Attrition within a sample occurs when households interviewed at baseline are missing in the follow-up sample. In our context, mobility, the dissolution of households, and unavailability of households at the time of fieldwork, among other reasons, caused attrition and prevented us from interviewing some households during endline data collection. Attrition causes problems in conducting an evaluation by decreasing the sample size (leading to less precise estimates of intervention impacts) and introducing selection bias into the sample. This may lead to incorrect impact estimates if the treatment and comparison households lost to follow-up are significantly and meaningfully different from each (differential attrition).[15] We investigated differential attrition by testing whether treatment and comparison households that left the sample were statistically different across key background characteristics and outcome indicators. In addition, we tested for baseline balance between treatment and comparison households that were present both at baseline and endline (panel households). By doing this, we assessed whether comparing treatment and comparison units within the panel sample was methodologically valid and would provide us with causal estimates of the impact of the intervention.

87. The baseline sample consisted of 2,130 households, of which 445, or about 21%, were lost at endline (Table 6). Households in the treatment group were 0.15 SD or 6.3 pps more likely to attrit than comparison households; however, the evidence we present in this section suggests that there was no differential attrition. In general, we find differences between treatment and comparison among the 1,685 panel households were already present in the original baseline sample and are not a consequence of attrition. While some of these differences are statistically significant, the great majority are not meaningful; hence, they are not a concern for introducing selection bias. Nonetheless, we include controls in all our estimations to adjust for these slight imbalances.

Table 6. Household Attrition Rates by Study Arm

	All	Treatment	Comparison	SM Diff T-C
Households at Baseline	2,130	1,402	728	
Attritors	445	323	122	
Attrition Rate (%)	20.9%	23.0%	16.8%	0.15*** [0.017]

Notes: SM T-C Diff corresponds to the standardized mean difference in attrition rates between the treatment and comparison groups, adjusted by linear distance to district border (km) and an indicator for the northern border paired district comparison. Standard errors of difference are in square brackets. * p < .1. ** p < .05. *** p < .01.

15 Note that because this is not an RCT, attrition in our study may actually improve baseline balance under certain circumstances—namely, when those who attrit are the ones driving the statistical difference between the study groups for the entire sample at baseline.

88. In this section, we present baseline descriptive statistics for background characteristics for both the treatment and comparison households in the panel sample and check for equivalence between groups. In addition, we checked for equivalence between treatment and comparison households among the sample lost to follow-up. The indicator or variable being referenced is listed at the far left of the table, with all numbers in the same row relating to that variable. The first column of numbers titled 'All' represents the average value of the indicator for the panel sample. The second column of numbers titled 'Treatment' is the average value of the indicator for the treatment group panel sample, which is followed by the third column of numbers titled 'Comparison', representing the average of the comparison group panel sample in the study. The fourth column of numbers titled 'SM Diff T-C' is the standardised mean difference between the panel treatment and comparison group averages. We tested the standardised mean difference for statistical significance, indicated by an asterisk (*) or a group of them, depending on the significance level ($p < .1$, $p < .05$ and $p < .01$). We follow the guidelines of the What Works Clearinghouse regarding baseline equivalence: A standardised mean difference of 0.25 or less does not create concern for introducing selection bias, but statistical adjustments should be made at the analysis stage by introducing control variables when the standardised mean difference is between 0.05 and 0.25 (What Works Clearinghouse, n.d.). The attrition analysis will help us identify the set of control variables we will include in all estimations.

89. Columns five and six show the standardised mean difference between treatment and comparison households for the sample of attritors and for the entire baseline sample, respectively. In particular, the information provided in the last column is relevant because it tells whether treatment groups in the baseline sample (2,130 households) were statistically equivalent along a given outcome. This allows us to assess whether baseline imbalances in the panel sample (1,685 households) were already present in the original sample or are a result of attrition.

90. The panel sample corresponds to 1,685 households with an average of 5.2 household members. In total, 87% of the panel households were headed by men, most of whom were married, and women headed the remaining 13% of households, most of which were single headed. The vast majority of household heads were Muslim (90%), and nearly 35% had no formal education, with 48% having some or complete primary education and 16% having at least some secondary schooling. In terms of baseline balance, we found that although some of these baseline characteristics are statistically different between treatment and comparison panel households, none are meaningfully different (standardised mean difference < 0.25) and do not represent a concern in terms of selection bias (Column 4, Table 7).

91. Of note, in all variables for which we found a statistical imbalance between treatment groups in the panel sample, such statistical difference was already present in the baseline sample (Column 6, Table 7), indicating that these were inherited from the baseline sample and were not a consequence of attrition. Moreover, almost all characteristics that are statistically different between treatment and comparison attritors (Column 5, Table 7) are also statistically different *in the same direction* between treatment and comparison households in both the baseline sample and the panel sample. More precisely, the differences between treatment and comparison households in the sample of atrittors are statistically equal to the corresponding differences in the baseline sample and in the panel sample.[16] Overall, this combined evidence indicates that attritors are comparable to original baseline households and

16 Specifically, for all head characteristics, we cannot reject the hypothesis that the standardised mean differences between treatment and control households across the three samples (original, panel and attritors) are statistically equal. Null hypothesis (H0): Column 4 = Column 5 = Column 6. p-values of tests are not reported but are available on request.

panel households, further supporting the claim that attrition did not introduce selection bias into the panel sample.

Table 7. Characteristics of Household Head at Baseline

	Panel				Attritors	Baseline Sample
	Mean (SD)			SM Diff	SM Diff	SM Diff
	All (1)	Treatment (2)	Comparison (3)	T-C (4)	T-C (5)	T-C (6)
Household size	5.19	5.27	5.03	0.13***	0.23**	0.14***
	(1.83)	(1.91)	(1.68)	[0.05]	[0.09]	[0.04]
Household head is female	0.13	0.12	0.14	-0.03	0.10	-0.00
	(0.34)	(0.33)	(0.35)	[0.05]	[0.10]	[0.05]
Age of household head	35.01	34.51	35.89	-0.11**	-0.03	-0.10**
	(11.66)	(11.73)	(11.50)	[0.05]	[0.11]	[0.05]
Household head has no formal education	0.35	0.37	0.33	0.05	-0.03	0.03
	(0.48)	(0.48)	(0.47)	[0.05]	[0.11]	[0.05]
Household head has some or complete primary education	0.48	0.47	0.51	-0.09*	-0.13	-0.10**
	(0.50)	(0.50)	(0.50)	[0.05]	[0.11]	[0.05]
Household head has some secondary or more education	0.16	0.17	0.15	0.06	0.20*	0.09**
	(0.37)	(0.37)	(0.36)	[0.05]	[0.10]	[0.04]
Household head can read and write in at least one language	0.51	0.49	0.53	-0.05	0.06	-0.04
	(0.50)	(0.50)	(0.50)	[0.05]	[0.11]	[0.05]
Muslim	0.90	0.89	0.93	-0.12**	-0.28***	-0.15***
	(0.29)	(0.31)	(0.26)	[0.05]	[0.09]	[0.04]
Non-Muslim or non-religious	0.10	0.11	0.07	0.12**	0.28***	0.15***
	(0.29)	(0.31)	(0.26)	[0.05]	[0.09]	[0.04]
Observations	1,685	1,685	1,685	1,685	445	2,130

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding indicator or variable for panel households only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (5) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using all baseline observations. Robust standard errors are in square parentheses in columns (4) through (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

92. Turning to the characteristics of caregivers, we find that the average caregiver in the panel sample was 25 years old at baseline and had an education attainment quite similar to that of the household head, with most having no formal education (39%) or some or complete primary education (51%). Ten percent of caregivers had at least some secondary education. Approximately 85% of caregivers were married or cohabitating, and the remaining were either divorced, separated or widowed (9%) or never married (6%). Although some of the caregiver characteristics are statistically different between treatment and comparison panel households, none are meaningfully different, with standardised mean differences under our rule of thumb threshold (0.25) (Column 4, Table 8). For all variables where we find a statistical imbalance between treatment groups in the panel sample, such difference was already present in the original baseline sample, which indicates that these are not a consequence of attrition. Moreover, the differences between treatment and comparison households in the sample of atrittors are statistically equal to the corresponding differences in the baseline sample and in

the panel sample.[17] This combined evidence supports the claim that attrition did not introduce selection bias into the panel sample.

Table 8. Caregiver Characteristics at Baseline

	Panel				Attritors	Baseline Sample
	Mean (SD)			SM Diff	SM Diff	SM Diff
	All (1)	Treatment (2)	Comparison (3)	T-C (4)	T-C (5)	T-C (6)
Age (years)	25.74	25.40	26.35	-0.14***	-0.02	-0.13***
	(7.14)	(6.94)	(7.47)	[0.05]	[0.10]	[0.05]
No formal education	0.39	0.39	0.39	-0.02	-0.18	-0.05
	(0.49)	(0.49)	(0.49)	[0.05]	[0.11]	[0.05]
Some or complete primary education	0.51	0.49	0.54	-0.09*	0.04	-0.07
	(0.50)	(0.50)	(0.50)	[0.05]	[0.11]	[0.05]
Some secondary or more education	0.10	0.12	0.07	0.18***	0.20**	0.19***
	(0.31)	(0.33)	(0.26)	[0.05]	[0.10]	[0.04]
Can read and write in at least one language	0.22	0.25	0.17	0.22***	0.18*	0.21***
	(0.42)	(0.43)	(0.38)	[0.05]	[0.10]	[0.04]
Married/cohabitating	0.85	0.86	0.82	0.12**	-0.00	0.09*
	(0.36)	(0.34)	(0.39)	[0.05]	[0.11]	[0.05]
Divorced/separated/widowed	0.09	0.09	0.10	-0.05	0.02	-0.04
	(0.29)	(0.28)	(0.31)	[0.05]	[0.11]	[0.05]
Never married or cohabitating	0.06	0.05	0.08	-0.11**	-0.02	-0.09*
	(0.24)	(0.22)	(0.27)	[0.05]	[0.11]	[0.05]
Average age difference between caregiver and spouse (years)	6.25	5.93	6.83	-0.15***	0.04	-0.12**
	(5.59)	(5.58)	(5.55)	[0.06]	[0.12]	[0.05]
Observations	1,685	1,685	1,685	1,685	445	2,130

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding indicator or variable for panel households only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (5) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using all baseline observations. Robust standard errors are in square parentheses in columns (4) through (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

93. Baseline housing conditions of panel households were precarious. Less than one-half (just 38%) of the sample had access to safe drinking water, and only 20% treated their water to make it safe for drinking. Roughly two-thirds (66%) had access to a latrine. These statistics indicate that the baseline water, sanitation, and hygiene of the panel sample may limit the ability of the intervention to improve the nutrition of children. Poor sanitation and hygiene increase the likelihood of disease and diarrhoea, which in turn decrease child nutrition and can offset any benefits of increased food security. In addition, although several of the housing characteristics showed statistically significant standardized mean differences between treatment and comparison households in the panel sample, just one (i.e., primary wall material is purchasable) is over 0.25. However, an overall wealth index calculated via principal components analysis using housing characteristics and assets, although still significantly different, did not surpass the rule of thumb threshold (Table 9).

94. In line with what we observed for household head and caregiver characteristics, for all housing indicators where we found a statistical imbalance between treatment groups in the panel sample, such statistical difference was also present in the baseline sample (Column 6,

17 Specifically, for all caregiver characteristics, we cannot reject the hypothesis that the standardised mean differences between treatment and control households across the three samples (original, panel and attritors) are statistically equal. Null hypothesis (H0): Column 4 = Column 5 = Column 6. p-values of tests are not reported but are available on request.

Table 9). Furthermore, the differences between treatment and comparison households in the sample of atrittors are statistically equal to the corresponding differences in the baseline sample and in the panel sample.[18] This combined evidence supports the claim that attrition did not introduce selection bias into the panel sample with respect to housing conditions.

Table 9. Housing Characteristics at Baseline

	Panel				Attritors	Baseline Sample
		Mean (SD)		SM Diff	SM Diff	SM Diff
	All	Treatment	Comparison	T-C	T-C	T-C
	(1)	(2)	(3)	(4)	(5)	(6)
Household's main source of drinking water is safe	0.38	0.41	0.33	0.17***	0.29***	0.20***
	(0.49)	(0.49)	(0.47)	[0.05]	[0.11]	[0.05]
Distance (m) to water source	177.14	170.88	188.30	-0.05	-0.18	-0.07
	(282.16)	(284.76)	(277.36)	[0.05]	[0.11]	[0.05]
Household treats water to make it safe	0.20	0.20	0.19	0.06	0.10	0.06
	(0.40)	(0.40)	(0.39)	[0.05]	[0.11]	[0.05]
Household has fixed handwashing facility in home or yard	0.03	0.04	0.01	0.16***	0.16*	0.16***
	(0.17)	(0.20)	(0.11)	[0.04]	[0.09]	[0.04]
Household uses bucket/jug/kettle to wash hands	0.65	0.61	0.70	-0.18***	-0.21**	-0.19***
	(0.48)	(0.49)	(0.46)	[0.05]	[0.10]	[0.04]
Water available for handwashing	0.67	0.68	0.65	0.07	0.08	0.09
	(0.47)	(0.47)	(0.48)	[0.06]	[0.13]	[0.05]
Household members use latrine	0.66	0.63	0.72	-0.18***	-0.21**	-0.19***
	(0.47)	(0.48)	(0.45)	[0.05]	[0.10]	[0.04]
Household uses purchasable cooking fuel	0.35	0.38	0.31	0.19***	0.26**	0.20***
	(0.48)	(0.49)	(0.46)	[0.05]	[0.10]	[0.05]
Household uses firewood to cook	0.65	0.62	0.69	-0.18***	-0.26**	-0.20***
	(0.48)	(0.49)	(0.46)	[0.05]	[0.10]	[0.05]
Household owns house	0.83	0.80	0.87	-0.20***	-0.41***	-0.25***
	(0.38)	(0.40)	(0.34)	[0.05]	[0.09]	[0.04]
Number of rooms in household	3.91	3.89	3.95	-0.07	0.11	-0.04
	(0.96)	(0.97)	(0.93)	[0.05]	[0.10]	[0.05]
Primary roofing material is purchasable	0.35	0.32	0.41	-0.16***	-0.02	-0.13***
	(0.48)	(0.47)	(0.49)	[0.05]	[0.11]	[0.05]
Primary wall material is purchasable	0.77	0.82	0.68	0.37***	0.44***	0.38***
	(0.42)	(0.38)	(0.47)	[0.05]	[0.10]	[0.04]
Primary floor material is purchasable	0.52	0.55	0.46	0.20***	0.35***	0.23***
	(0.50)	(0.50)	(0.50)	[0.05]	[0.11]	[0.05]
At least one household member used a computer in past 12 months	0.02	0.02	0.00	0.15***	0.09	0.13***
	(0.13)	(0.15)	(0.07)	[0.04]	[0.10]	[0.04]
At least one household member used internet in past 12 months	0.03	0.03	0.02	0.07	0.07	0.08*
	(0.17)	(0.18)	(0.15)	[0.05]	[0.10]	[0.04]
At least one household member used mobile money in past 12 months	0.26	0.27	0.26	0.05	0.08	0.06
	(0.44)	(0.44)	(0.44)	[0.05]	[0.11]	[0.05]
Wealth index	-0.00	-0.07	0.13	-0.20***	-0.07	-0.17***
	(1.00)	(0.96)	(1.07)	[0.05]	[0.10]	[0.05]
Observations	1,685	1,685	1,685	1,685	445	2,130

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding indicator or variable for panel households only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (5) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using all baseline observations. Robust standard errors are in square parentheses in columns (4) through (6).

18 Specifically, for all housing characteristics, we cannot reject the hypothesis that the standardised mean differences between treatment and control households across the three samples (original, panel and attritors) are statistically equal. Null hypothesis (H0): Column 4 = Column 5 = Column 6. p-values of tests are not reported but are available on request.

Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

95. In general, this section shows that significant differences between treatment and comparison households in the panel sample are not a consequence of attrition and were already present in the baseline sample. Importantly, virtually none of these significant differences are meaningful (< 0.25 SM), and treatment and comparison panel households are well-balanced across key background indicators. Nonetheless, since some of these characteristics show standardised mean differences between 0.05 and 0.25, we followed the guidance of What Works Clearinghouse regarding baseline equivalence and include them as controls in all our impact estimations. Specifically, the analysis in this section suggests that we adjust for caregiver's age, education, and marital status; household head's gender, age, and education; and household size and use a dummy for household religion.

We complement the previous analysis by assessing the baseline balance of the panel sample and differential attrition between treatment and comparison groups for all variables and outcomes across all levels. In terms of baseline balance of the panel sample,

96. Table 10 shows that only 10 out of 284 (or approximately 4%) outcomes and characteristics analysed show statistical differences of magnitude higher or equal to 0.25 SD. Among the different levels, target child outcomes show the largest percentage of indicators with meaningful differences (7%), followed by background characteristics (3%), older child-level outcomes (3%), and household-level outcomes (2%). Importantly, where significant differences are observed, no discernible pattern is identified in terms of favouring treatment or comparison panel samples (in other words, there is no group which is clearly consistently better or worse off). Considering that there are only few baseline imbalances between treatment and comparison panel households, we conclude that the panel sample is balanced sufficiently for the analysis of intervention impacts. Additionally, adjusting all estimations with the set of background characteristics previously listed will further improve the causal identification of the impacts of the intervention.

With respect to differential attrition, we found evidence of meaningful statistical differences (>0.25 SD) between treatment and comparison attritor households in 23 out of the 251 (or approximately 8%) of the outcomes and background characteristics (

97. Table 10). In particular, there is evidence of differential attrition in 29% of the older child-level outcomes. However, this result does not pose a threat to the internal validity of the study. As noted above, only 3% of outcomes in the older child domain are meaningfully different between the treatment and comparison panel households. In other words, although the sample of attritors may be imbalanced along certain dimensions, the sample of analysis (i.e., the panel sample) remains sufficiently balanced across all levels. Hence, comparing treatment and comparison units within the panel sample is methodologically valid and will provide us with causal estimates of the impact of the intervention.

Table 10. Summary of Standardized Mean Differences above 0.25 SD in Background Characteristics and Outcomes Presented: Panel and Attritors

	Total number of outcomes/variables presented (A)	Number of outcomes/variables with SM differences > 0.25 SD in the panel sample (B)	Number of outcomes/variables with SM differences > 0.25 SD in the sample of attritors (C)	Percentage (Panel Sample) (A/B)	Percentage (Attritors) (A/C)
Background characteristics	36	1	2	3%	6%
Target child's outcomes	47	3	3	6%	6%
Household-level outcomes	108	2	7	2%	6%
Caregiver-level outcomes	26	0	1	0%	4%
Older children's outcomes	34	1	10	3%	29%
Total	251	7	23	3%	9%

Notes: SM = Standardized mean

5.3 Community- and Health Facility–Level Description

98. We re-visited the 11 health facilities (five in treatment areas and six in comparison areas) serving the study population at endline to investigate access to vaccines and services, as well as the cadre of medical staff. All units normally carry the Bacillus Calmette-Guérin (BCG) vaccine, as well as the vaccines for tetanus, measles, and polio; the only exceptions are with regard to the diphtheria and meningitis vaccines. One of the clinics in the comparison group (17%) does not generally carry the diphtheria vaccine, and two health facilities in the treatment group (40%) and one (17%) in the comparison group do not usually have the meningitis vaccine (Table 11).

Table 11. Services Available at Health Facilities

	Mean (SD)			
	All	Treatment	Comparison	N
Number of part-time medical professionals	13.27	3.40	21.50	11
	(31.14)	(5.08)	(41.71)	
Number of full-time medical professionals	19.27	11.40	25.83	11
	(29.37)	(7.80)	(39.53)	
Unit normally carries spermicides	0.45	0.40	0.50	11
	(0.52)	(0.55)	(0.55)	
Unit normally carries contraceptive implants	0.91	1.00	0.83	11
	(0.30)	(0.00)	(0.41)	
Unit normally carries aspirin	0.73	0.60	0.83	11
	(0.47)	(0.55)	(0.41)	
Unit normally carries oral rehydration salts	0.82	0.80	0.83	11
	(0.40)	(0.45)	(0.41)	
Unit normally carries antimalarial drugs	0.91	0.80	1.00	11
	(0.30)	(0.45)	(0.00)	
Unit normally carries penicillin injections or tablets	0.91	1.00	0.83	11
	(0.30)	(0.00)	(0.41)	
Unit normally carries diphtheria vaccines	0.91	1.00	0.83	11
	(0.30)	(0.00)	(0.41)	
Unit normally carries meningitis vaccines	0.73	0.60	0.83	11
	(0.47)	(0.55)	(0.41)	
Unit normally carries micronutrient powder	0.64	0.60	0.67	11
	(0.50)	(0.55)	(0.52)	
Unit normally carries ready-to-use therapeutic food	0.73	0.60	0.83	11
	(0.47)	(0.55)	(0.41)	
Unit normally offers vitamin A droplets	0.91	0.80	1.00	11
	(0.30)	(0.45)	(0.00)	

Note: Standard deviations in parentheses.

99. We also explored whether the COVID-19 pandemic and/or other factors affected the availability of health services in the study districts during the past year. Table 12 shows that although ambulatory health services were always available in more than 90% of the clinics (10 out of 11), mobile health services stopped operating at some point during the past 12 months in 50% of the facilities. It is not clear, however, what halted their operation, as the reported prevalence of COVID-19 in the catchment areas of the health clinics was relatively low. The average number of people who have tested positive for the virus per catchment area was less than four. Nonetheless, tests are also scarce such that, by the time of the endline data collection, none of the clinics had any in stock.

Table 12. COVID-19 and Other Factors: Cases and Unit Closures

	Mean (SD)			
	All	Treatment	Comparison	N
Closure of ambulatory services in past 12 months	0.09	0.00	0.17	11
	(0.30)	(0.00)	(0.41)	
Closure of mobile health services in past 12 months	0.50	0.40	0.60	11
	(0.53)	(0.55)	(0.55)	
Number of COVID-19 tests currently available	0	0	0	11
	(0)	(0)	(0)	
Number of people in unit's catchment area who have tested positive for COVID-19	3.73	2.80	4.50	11
	(6.45)	(5.22)	(7.74)	

Note: Standard deviations in parentheses.

6 IMPACTS ON CHILDREN UNDER 24 MONTHS (0 TO 6 MONTHS AT BASELINE)

100. Following the intervention logic framework, in this section we present impact estimates for a range of primary outcomes related to the wellbeing of the target child, across the following domains: (*a*) birth certification and child registration, (*b*) dietary diversity and infant and young child feeding (IYCF) practices, (*c*) immunisations, (*d*) parental stimulation and involvement, and (*e*) nutritional status. We followed up 1,685 target children from the panel households from baseline to endline.

101. In each subsection, we start by presenting baseline balance and attrition statistics for key indicators, and we then describe intervention impacts. Where applicable, we also describe differential impacts by the gender of the household head and the child. The gender of the head of the household is a key mediator given that households headed by women tend to face additional socioeconomic constraints and typically have fewer economically active adults.[19] It is also relevant to explore heterogeneous impacts between boys and girls given the gender differences on nutritional status – particularly on stunting – that have been documented for the country (UNICEF, 2020).

6.1 Birth Certificates and Child Registration

102. In line with the intervention logic framework, child registration and birth certification are expected to increase when families have additional resources to attend routine health visits, where documentation may be promoted, and pay associated administrative fees. In addition, information campaigns in treatment communities emphasising the importance of

19 One caveat to keep in mind when interpreting the analysis by gender of household head is that impacts for female-headed households will be a bit more imprecise (i.e., will have larger confidence intervals), given that the proportion of female-headed households in our sample was just 13%. Since there are fewer observations in this group, this affects the precision of our estimates

acquiring birth certificates and registering children could have further incentivised households to do so. Moreover, we may expect additional positive impacts for the case management group, as caseworkers encouraged households to obtain birth certificates as part of their care protocols (AIR, 2021). However, regarding registration, it is also possible that households in the cash and case management arm, who are more vulnerable, are less likely to pay for such service compared to those who receive cash and are not eligible for case management services.[20] We explore impacts on this domain by looking at two indicators: (*a*) whether the child has a birth certificate, which was collected both at baseline and endline, and (*b*) whether the child's birth has been registered at a Civil Registration Post (*Postos*), which was collected only at endline.

At baseline, about 26% of the panel children had a birth certificate. There were no meaningful baseline imbalances or differential attrition, as all standardised mean differences are below the 0.25 threshold (Table A.6.1). In terms of impacts, Table 13 shows that the intervention significantly increases the probability of having a birth certificate by 29 pps (pooled treatment), or about 60% with respect to the comparison endline mean. We estimate impacts on the probability of being registered via a single difference comparison between treatment arms at endline.

20 Birth registration is free only during the first 120 days after the child's birth.

103. Table 14 shows that the intervention significantly increased the probability of being registered by 30 pps (pooled impact), or about 150% with respect to the endline comparison mean. We documented an additional increase in this probability of 9 pps (or an additional 45%) among households eligible for the case management subcomponent, likely resulting from the linkages to information and services provided by caseworkers and counsellors.

104. We did not find any differential effects on these two outcomes by neither the gender of the child nor the gender of the household head—and thus do not present further heterogeneity results.

Table 13. Impacts on Target Child's Birth Certificate

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Child has a birth certificate	0.29***	0.29***	-0.01	0.48	3318
	(0.03)	(0.03)	(0.05)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors using the 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), 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 < .1. ** p < .05. *** p < .01.

Table 14. Impacts on Target Child's Birth Registration

Dependent Variable	Impact Estimates			Endline Mean	
	SD Pooled Treatments	SD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Child's birth was registered	0.30***	0.27***	0.09**	0.20	1637
	(0.02)	(0.03)	(0.04)		

Notes: CM = case management. Impacts are estimated using a single difference with robust standard errors among the 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, 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 < .1. ** p < .05. *** p < .01.

6.2 Dietary Diversity and IYCF Practices

105. On the basis of the Child Grant 0-2 theory of change, one of the primary direct impacts of the Child Grant 0-2 should be on food consumption. Thus, we expect to see an impact of the intervention on children's food intake and dietary diversity. We investigated child nutrition practices by looking at whether the target child consumed eight different types of foods the day before the survey—specifically breast milk, cereal, roots and tubers, legumes, dairy, meat/fish, vitamin A–rich foods and other fruits and vegetables.[21] We also considered two indicators developed by the World Health Organization (WHO)—the minimum dietary diversity (MDD) and the minimum meal frequency (WHO, 2018). These measures summarize different food intake indicators and provide simple and reliable metrics for assessing IYCF practices. The MDD gives us the proportion of children who consumed foods from five or more of the eight food categories, and the minimum meal frequency corresponds to the share of children who had at least four meals during the previous day.

106. Target children were between 0 and 6 months old at baseline. The average number of food groups they had consumed the day prior to the survey was 1.2, which is expected given their age group and consistent with most children consuming breast milk (85%) (Table A.6.2). Consumption of the other seven food types was significantly less frequent at baseline: 12% of the target children in the panel sample had consumed cereals; 6%, fruits and vegetables; 5%, meat or fish; 3%, vitamin A–rich foods; 3%, legumes; 1%, dairy; and 1%, eggs. When assessing the baseline balance between treatment and comparison children, we observed that those in the treatment group were more likely to consume breast milk and dairy and less likely to consume all the other six (solid) food groups. Although most of these standardised mean differences are significant, just a few are equal to or marginally greater than the 0.25 threshold. We conclude these do not represent a major concern for the validity of the impact estimates.

21 We recognize estimated impacts are affected by the date of the survey and the delivery of the cash payments. That is, the impacts of the transfer on food expenditures and overall expenditures most likely vary throughout the year because there is variation in the availability of other sources of income. Data at baseline and endline were collected in April 2021, which is the last part of the lean season in Nampula. On the other hand, program beneficiaries also received a lump sum cash payment (of 4-5 months) in March -April 2021. Impacts on expenditures may also vary if beneficiaries receive large lump sums relative to a scenario of receiving smaller but more frequent amounts. While we are unable to explore how impacts vary for different scenarios based on the data we have, both treatment and comparison households were interviewed at the same time, which allows us to estimate the true impacts of the intervention at a specific point in time. That said, the estimated impacts need to be interpreted for a specific time period and for a specific type of transfer delivery (larger and uncertain lump sums).

107. With respect to intervention impacts, we found that target children in the treatment group were not only consuming more meals but also having a more diversified diet (Table 15). Pooled impact estimates indicate that treatment children were having 0.41 more meals on average than were comparison children. We also found that the intervention increased the probability of consuming all different food groups in the previous day except for cereals, roots, and tubers, and breast milk. Cereals, roots, and tubers, the most consumed food group, were equally likely to be eaten by both treatment and comparison children (> 95%), while breast milk was significantly more likely to be consumed by comparison children. Given all target children are over 2 years old at endline, the latter could be because comparison mothers are breast-feeding their children longer to compensate for the lack of food.

108. Consistent with the above, we found positive pooled impacts on the total number of different food groups consumed yesterday and on the MDD indicator; pooled impacts corresponded to 14% and 100% increases over the endline comparison means for these two outcomes, respectively. Overall, these results are in line with the wealth of evidence on cash transfers documenting important improvements in food consumption and dietary diversity.

109. Impacts in this domain are generally driven by the cash component and we found few additional impacts for the case management-eligible target children on the probability of having consumed a certain type of food during the previous day. In particular, children in the case management subcomponent were significantly more likely to be fed cereals, roots and tubers, and fruits and vegetables than were those from households only receiving cash. In addition, the intervention has a positive effect on the probability of having consumed flesh food the day before only for children in cash-only households, not for those in households eligible to receive case management services.

110. Lastly, when investigating pooled impacts of the intervention by the gender of the household head, we found that the impact estimates (coefficients) on MDD and number of foods consumed yesterday were larger for male-headed households than for female-headed households; however, these figures are not statistically different between each other and thus are not reported here. Similarly, we do not find heterogenous impacts or present further impacts by the gender of the target child.

Table 15. Impacts on Dietary Diversity and Nutrition of Target Child

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Total number of food groups consumed yesterday	0.41***	0.38***	0.10	2.99	3338
	(0.08)	(0.09)	(0.11)		
Minimum dietary diversity	0.11***	0.11***	0.02	0.11	3338
	(0.02)	(0.02)	(0.03)		
Food groups consumed yesterday:					
Breast milk	-0.05**	-0.05**	-0.01	0.08	3338
	(0.02)	(0.02)	(0.03)		
Cereals, roots, and tubers	0.01	-0.00	0.05**	0.95	3322
	(0.02)	(0.02)	(0.03)		
Legumes	0.07***	0.06**	0.04	0.24	3311
	(0.02)	(0.03)	(0.03)		
Dairy	0.03***	0.04***	-0.02	0.02	3305
	(0.01)	(0.01)	(0.02)		
Flesh food (meat or fish)	0.06**	0.08***	-0.10***	0.69	3318
	(0.03)	(0.03)	(0.04)		

Eggs	0.08***	0.07***	0.03	0.14	3301
	(0.02)	(0.02)	(0.03)		
Vitamin A	0.11***	0.10***	0.01	0.14	3304
	(0.02)	(0.02)	(0.03)		
Other fruits and vegetables	0.09***	0.07**	0.08**	0.77	3319
	(0.02)	(0.03)	(0.03)		
Times child consumed solid/soft food yesterday	0.21***	0.21***	0.01	2.16	3336
	(0.06)	(0.07)	(0.09)		
Minimum meal frequency	0.07***	0.06***	0.02	0.04	3338
	(0.02)	(0.02)	(0.02)	2.99	3338

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors using the 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), 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 < .1. ** p < .05. *** p < .01.

6.3 Immunisations

111. Based on the intervention logic framework, there are reasons to expect positive impacts on health-seeking behaviours and immunisations, as cash transfers can enable caregivers to afford healthcare and transportation costs, thereby removing barriers to accessing healthcare facilities. Moreover, we may also expect additional positive impacts of the case management component if the family support services emphasize the importance of timely vaccinations and spark a positive behavioural change, but this will also depend on the quantity and quality of the family support sessions. However, if important supply-side constraints remain active (i.e., lack of accessible child healthcare services with sufficient inputs), neither the cash transfer nor the case management services will be enough to improve health and health-seeking behaviours amongst the target population. To assess the impact of the Child Grant 0-2 on inmunisations, we collected information on whether the child has a vaccination card and on several indicators for having received the number of age-appropriate doses of each specific vaccine (i.e., polio, pentavalente, pneumococcal, rotavirus, and measles) according to the country's vaccination calendar (Ministério de Saúde, 2018). In addition, we also looked at the probability of having received medication (deworming) and nutritional supplement (vitamin A), which are also part of the vaccination calendar. Lastly, given the precarious housing conditions of households in our sample, including poor access to drinkable water, we looked at whether the child has had diarrhoea in the past 2 weeks.

112. Table A.6.3 shows that 88% of the target children in the panel sample had a vaccination card at baseline. In terms of vaccinations, 90% had the BCG vaccine, providing protection against tuberculosis. For polio, 56% of the children had had the corresponding number of doses appropriate for their age at baseline. For the pentavalent vaccine, which protects against diphtheria, tetanus, whooping cough, hepatitis B, and *Haemophilus influenzae* type b, we observed that only 29% of the children at baseline had timely vaccinations. This trend continues for the pneumococcal and rotavirus vaccines, with only 27% and 36% of target children having had the recommended doses for their age at baseline. Almost no target children had received the measles vaccine at baseline (1%), which is expected, given that the immunisation schedule in Mozambique indicates that this vaccine should be received when a child is 9 months old. Also, very few children had received deworming medication (1%), which is also suggested when a child is 12 months old. Lastly, we observed that 8% of children in our sample had experienced at least one diarrhoea episode in the 2 weeks before the survey, a prevalence that is likely to increase at endline, since most

children will become exposed to contaminated water as they are weaned off breast-feeding. Overall, at baseline there are no meaningful statistical differences between the treatment and comparison group panel children. In addition, there is evidence of some differential attrition in just one indicator—having received deworming medications; however, the significant standardised mean difference of 0.27 is marginally over our rule of thumb threshold thus it is not a cause for concern.

113. Table 16 shows that the shares of children with vaccination cards, as well as the percentages of those who had been completely immunised against various diseases and viruses, have increased significantly from baseline. More than 97% of the sample has a vaccination card, a figure higher than the national average for children between 12 and 24 months of age (83%) (IMASIDA, 2015). Moreover, 99% of children were vaccinated against tuberculosis (BCG vaccine), and the shares of children who have had the complete series of the polio, pentavalent, pneumococcal, rotavirus and measles vaccines were all more than 74%—and usually between 80% and 90% - indicating that the proportion of fully-vaccinated children is well above the national average for children in their age group (64%) (IMASIDA, 2015).

114. In terms of impacts, we found that the intervention increased the propensity of having a vaccination card by 11 pps for children in the case-management subcomponent with respect to children in households receiving only cash, for whom we did not find an impact (Table 16). Given that almost all children in the study had a vaccination card at endline, this significant positive effect is due to (*a*) an imbalance at baseline between cash-only children and case management-eligible children, where the latter were significantly less likely to have a vaccination card, and (*b*) children in case management-eligible households catching up with those from cash-only households by endline.

115. The intervention did not have pooled impacts on the probabilities of having received the complete series of the polio, pentavalent, pneumococcal, rotavirus and measles vaccines, respectively. There is a positive pooled impact of 5 pps on the probability of having received the BCG vaccine, which is usually administer at birth. The pooled impact on the likelihood of having the BCG vaccine is not meaningful since almost all children (99%) are vaccinated against tuberculosis by endline. Specifically, the impact is arising mechanically from: a) a slight imbalance favouring comparison children at baseline, b) a ceiling effect for comparison children as 94% of them already had the BCG vaccine at baseline, and c) from treatment children catching up with comparison by endline.

116. We also see few minor pooled negative impacts of the intervention on the probability of having received deworming medication and vitamin A supplement in the past 6 months, although the latter is only significant at the 10% level. In addition, there is negative impact of 14 pps on the probability of being fully vaccinated against polio for the case management-eligible sample only. These results are puzzling as we do not expect the intervention to have an adverse impact on vaccinations and warrant further investigation. Table 11 suggest that vitamin A droplets were always available in over 90% of clinics serving both treatment and comparison communities, so this negative impact is likely not the result of lack of inputs. Relatedly, the adverse effect on the probability of being fully vaccinated against polio among case management-eligible children is likely not driven by differences in the availability of vaccines in health facilities across treatment groups. If it were so, we would most likely see effects for the pooled sample as well. Moreover, given that we do not find that the intervention affected the likelihood of having other types of vaccines, it is plausible that the impact on polio vaccination is spurious. Lastly, regarding deworming medication, it is unclear how to interpret this finding since the intervention did not ultimately change the incidence of diarrhoea.

117. Lastly, the prevalence of diarrhoea in the 2 weeks prior to the survey increased significantly from 8% at baseline to 40% by endline, though there is some evidence suggesting it increased 7pps or 18% *less* for care-eligible children. Nonetheless, the prevalence of diarrhoea in the sample is much worse than the national average for children 6 to 23 months old (11%) (IMASIDA, 2015), but it is expected due to the sanitary conditions in our sample. At baseline, just 38% of the panel households had access to safe drinking water, and only 20% treated their water to make it safe for drinking..

Table 16. Impacts on Target Child Immunizations, Vitamin A, Deworming and Diarrhoea

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Control	N
	(1)	(2)	(3)	(4)	(5)
Has vaccination card	0.02	-0.00	0.11***	0.97	3338
	(0.02)	(0.02)	(0.02)		
Has BCG vaccine	0.05***	0.05***	-0.03	0.99	3311
	(0.02)	(0.02)	(0.02)		
Polio vaccines	0.02	0.05	-0.14***	0.88	2787
	(0.03)	(0.03)	(0.05)		
PENTA vaccines	-0.05	-0.05	-0.02	0.84	2787
	(0.03)	(0.04)	(0.05)		
Pneumococcal vaccines	-0.03	-0.02	-0.02	0.84	2787
	(0.03)	(0.03)	(0.04)		
Rotavirus vaccines	0.03	0.03	0.01	0.92	2787
	(0.03)	(0.03)	(0.04)		
Measles vaccine	-0.02	-0.02	0.01	0.94	3273
	(0.01)	(0.02)	(0.02)		
Vitamin A dose	-0.04*	-0.04	-0.01	0.86	3258
	(0.03)	(0.03)	(0.03)		
Deworming medication	-0.07***	-0.06**	-0.03	0.81	3255
	(0.02)	(0.02)	(0.03)		
Had diarrhea in last 2 weeks	0.01	0.02	-0.07*	0.40	3299
	(0.03)	(0.03)	(0.04)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors using the 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), 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 < .1. ** p < .05. *** p < .01.

6.4 Parental Stimulation and Involvement

118. Following the intervention logic framework, we expected the cash component coupled with the care activities to increase the quality and quantity of parental stimulation. For example, the community-level SBCC intervention included messages of positive nutrition and hygiene practices to improve caregiving behaviours and case management home visits included counselling and awareness on positive parenting practices. Additional impacts of the case management component may be possible but depend on how successful the family support services are in promoting the physical and mental health of caregivers. We assessed the impact of the Child Grant 0-2 on parental stimulation and involvement by looking at

indicators adapted from UNICEF's Multiple Indicator Cluster Survey (MICS). We present indicators on whether someone in the households 15 years old or older (caregiver, parents, or others) had engaged in six different activities with the target child during the 3 days before the survey to understand whether children in our sample were exposed to different stimulating interactions. We then replicate these six activity indicators but look only at interactions between the primary caregiver and the target child. In addition, because adults are more likely to engage with children when they are more knowledgeable about child development, we asked caregivers about their perceptions of the age (in months) at which children can both see and hear. Finally, as a proxy for neglect, following the MICS, we asked how many days in the last week target children were left alone for at least 1 hour, or left under the supervision of another child for at least 1 hour (younger than 10 years old).

119. At baseline, we found that 3 days before the survey, household members in the panel sample had engaged, on average, in about two out of six different stimulation activities with the target child (Table A.6.4). Singing songs to the child, taking him or her outside for a walk and playing with the child were the most common ways of interaction, with 54%, 53% and 51% of any household member aged 15 or above engaging in each of them, respectively. The trends are very similar when we look at interactions between the main caregiver and the target child. In terms of acknowledging when children are receptive to external stimulus, caregivers stated that children can see and hear after they are about 3 months old, on average. The mean incidences of leaving the target child alone or in the care of another young child for more than 1 hour over the last week were 0.26 and 0.33 days, respectively. In terms of baseline balance, we document only one meaningful (≥0.25 SM difference) statistically significant difference between the treatment and comparison groups. The proportion of caregivers who had named, counted, or drew things with the target child 3 days prior to the baseline survey is 0.25 standard deviations higher in the comparison group. Nonetheless, since this difference is equal to our rule of thumb threshold and we do not observe any other indicators showing meaningful differences, we deem there are no concerns regarding baseline balance or differential attrition.

120. Table 17 shows the number of total activities done between any member of the household aged 15 or above and the target child in the past 3 days (row 1), which corresponds to the sum of the six subsequent individual indicators for each activity. The proportion of household members engaging in different activities with children increased over time as children grew older. Although we do not find an impact on the total number of activities, the intervention increased the individual probabilities of naming, counting, and drawing things with the child, and singing songs. In particular, this latter impact was driven by the case management-eligible sample. Overall, there is some evidence suggesting that the intervention changed the type of involvement of members of the household with children through increasing their propensity of engaging in certain types of activities. However, the total amount of activities in which children and adults engage has not been affected by the intervention.

121. Conversely, we do see a positive impact of the intervention on the number of activities done specifically between the target child and their main caregiver. The intervention increased the number of activities between children and caretakers by 0.23 activities (pooled impact, or 11% over the endline comparison mean), an effect primarily driven by the case management-eligible children, who have experienced a significant increment of 0.46 stimulating activities. While the impact on the probability of counting, and drawing things is driven by the cash component, the effect on the propensity to sing songs to child is coming from the case management sample. In addition, case management -eligible children also experienced significant increases in their probability of being told stories and read books by their caretakers, which do not apply to target children in cash-only households. Overall, this set of results suggest that family support services have been effective in promoting meaningful stimulation activities between main caregivers and children, a promising result indicating that the cash-case management arm of the intervention positively complements the cash-only component on child development.

122. In terms of child development knowledge, the average age at which caregivers reported that a child can see or hear increased from baseline to endline, though for treatment caregivers both perceived ages were significantly lower by 1.47 months (pooled impacts). This was a beneficial impact of the intervention, indicating caregivers may engage in stimulating behaviours with their children at an earlier age. The intervention also reduced the number of days from last week that the target child was left in the care of a young child (< 10 years old). Finally, we did not find any differential pooled intervention impacts by neither the gender of household head nor the gender of the target child—and thus do not present further heterogeneity results.

Table 17. Impacts on Target Child Development Indicators

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Number of activities any household member (≥15 years) did with target child	0.15	0.13	0.06	3.59	3338
	(0.12)	(0.13)	(0.17)		
Read books to child	0.01	-0.01	0.05	0.38	3338
	(0.03)	(0.03)	(0.04)		
Told stories to child	0.05	0.04	0.05	0.41	3338
	(0.03)	(0.03)	(0.04)		
Sang songs to child	0.06*	0.04	0.10**	0.72	3338
	(0.03)	(0.04)	(0.05)		
Took child for a walk outside the home	-0.00	0.00	-0.02	0.86	3338
	(0.03)	(0.03)	(0.04)		
Played with child	-0.06*	-0.04	-0.06	0.78	3338
	(0.03)	(0.03)	(0.05)		
Named, counted or drew things with child	0.09***	0.10***	-0.06	0.45	3338
	(0.03)	(0.03)	(0.04)		
Number of activities caregiver did with target child	0.23*	0.12	0.46***	2.18	3338
	(0.12)	(0.13)	(0.16)		
Read books to child	-0.02	-0.05*	0.09**	0.24	3338
	(0.03)	(0.03)	(0.04)		
Told stories to child	0.02	0.00	0.08*	0.25	3338
	(0.03)	(0.03)	(0.04)		
Sang songs to child	0.06*	0.02	0.15***	0.55	3338
	(0.04)	(0.04)	(0.05)		
Took child for a walk outside the home	0.07*	0.05	0.05	0.61	3338
	(0.04)	(0.04)	(0.05)		
Played with child	-0.02	-0.03	0.07	0.39	3338
	(0.04)	(0.04)	(0.05)		
Named, counted or drew things with child	0.12***	0.12***	0.03	0.14	3338
	(0.03)	(0.03)	(0.04)		
At what age can a child see?	-1.47***	-1.56***	0.39	5.00	3333
	(0.24)	(0.25)	(0.33)		
At what age can a child hear?	-1.47***	-1.57***	0.42	5.75	3333
	(0.22)	(0.23)	(0.30)		
Days last week child was left alone for more than 1 hour	0.14*	0.14*	-0.02	0.18	3338
	(0.07)	(0.07)	(0.10)		
Days last week child was left in the care of another child	-0.69***	-0.68***	-0.05	1.99	3338
	(0.10)	(0.11)	(0.14)		

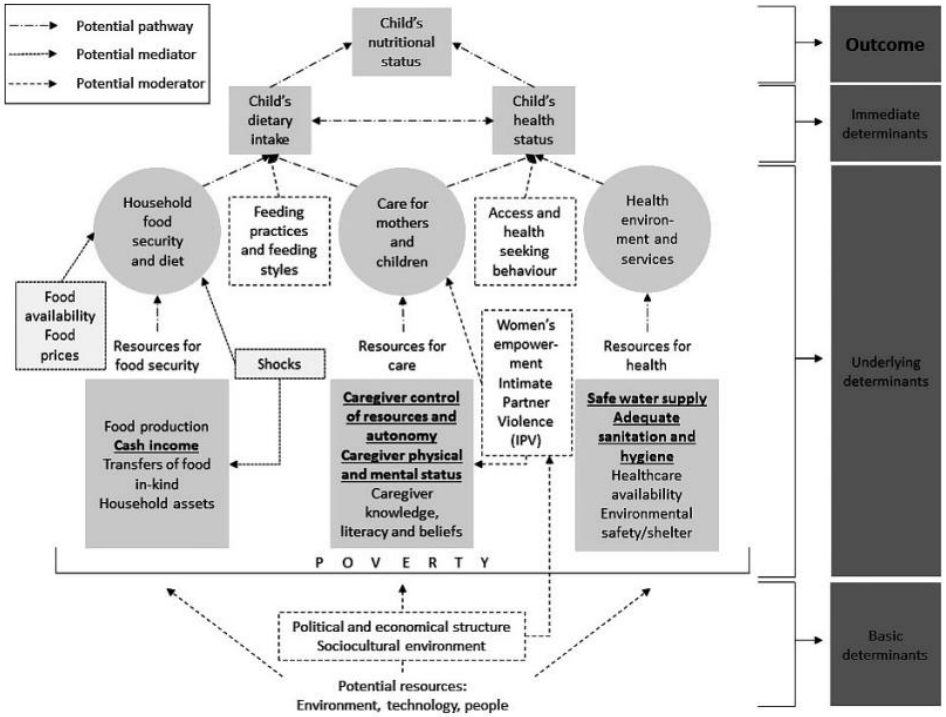
Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors using the panel sample. Column (1) presents impact estimates from a model with the treatment groups combined. Columns (2) and (3) present impact estimates from a model with an additional interaction 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 (gender, age), caregiver demographics (age, education, and marital status), 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. 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 < .1. ** p < .05. *** p < .01.

6.5 Nutritional Status

123. According to the intervention logic framework, increased food security and diet diversity that come from access to additional resources could result in improvement of the

nutritional status of children. However, several obstacles may prevent a child from receiving the benefits of increased household spending on food. For example, a comprehensive conceptual framework identifying underlying determinants of child nutrition can be used to explore the pathways through which additional resources from cash plus interventions like the Child Grant 0-2 can improve nutrition (Smith and Haddad (2002), de Groot et al. (2015)). According to the conceptual model, household food security, child and caregiver care, and a healthy environment are to the three main sets of underlying determinants influencing a child's nutritional intake and health status (see Figure 4). In turn, nutritional intake and health status act as the immediate determinants affecting the nutritional status of a child, our outcome of main interest, which is often operationalized through the standard indicators for underweight (weight-for-age z-score <-2), wasted (weight-for-length z-score <-2), and stunted (length-for-age z-score <-2). The framework also considers several moderators affecting the relationship between cash transfers and child nutrition, in particular: IYCF practices and styles, women's empowerment and IPV, and access and health-seeking behaviors of the caregiver.

Figure 4. Conceptual Framework of the Determinants that affect Child Nutritional Status



Source: de Groot et al. (2015)

124. Following the conceptual framework ,we collected anthropometric measurements of the target child, specifically weight and length both at baseline and endline, and mid-upper arm circumference (a measure of malnutrition) only at endline, by using high-quality length boards and scales endorsed by UNICEF.[22] At baseline, 10% of panel children were underweight, 7% were wasted, and 11% were stunted, with no meaningful differences (> 0.25 standardised mean difference) between treatment and comparison households (Table A.6.5). We present impacts on key anthropometrics and follow this with discussion of underlying determinants to help unpack our main findings.

125. The shares of underweight and stunted children increased to more than 32% and 51%, respectively, between baseline and endline (Table 18). These levels mean that children in our

22 We used electronic scales with a capacity of 150 kg × 100 g for mothers and children.

sample fared worse when compared to the national averages of these indicators for children of the same age range: 25% for underweight and 48% for stunting (DHS, 2011). In addition, the intervention did not affect any of the outcomes related to the child's nutritional status, with the probabilities of being underweight, wasted, and stunted being statistically equal across treatment and comparison children (Table 18). Even though the additional impact of the case management component seems to increase the likelihood of being underweight, this result is not a consequence of the intervention and stems from a large and significant baseline imbalance between household in the cash-only and case-management components. Case management-eligible children were almost 0.3 SD more likely of being underweight at baseline that children in cash-only households (Table A.6.6). In line with the previous results on nutritional status, there were no intervention effects when we looked at the mid-upper arm circumference indicator. Lastly, we investigated heterogenous impacts by both the gender of the household head and the gender of the child but did not find any differential effects.

Table 18. Target Child Nutrition Status

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Child has oedema	0.00	0.00	0.00	0.00	3370
	(0.00)	(0.00)	(0.00)		
Underweight (weight-for-age z-score < -2)	-0.01	-0.04	0.10**	0.32	3331
	(0.03)	(0.03)	(0.04)		
Wasted (weight-for-length z-score < -2)	-0.02	-0.02	-0.00	0.08	3311
	(0.02)	(0.02)	(0.03)		
Stunted (length-for-age z-score < -2)	0.03	0.02	0.04	0.51	3338
	(0.03)	(0.03)	(0.04)		
Mid-upper arm circumference z score < -2	0.03	0.02	0.02	0.12	1653
	(0.02)	(0.02)	(0.03)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors using the panel sample, except for the mid-upper arm circumference outcome, which uses a single difference. 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 (gender, age), 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 < .1. ** p < .05. *** p < .01.

126. Following the conceptual framework of underlying determinants of child nutrition, we map all available mechanisms and moderators collected in our study to help inform reasons for null impacts. Many of these indicators appear in more detail in later sections, however given the importance of child nutritional status, we summarize them here together (with determinants in non-italics, moderators in italics). Table 19 show main results for the pooled intervention, separated into three main groups: 1) household food security, 2) care for caregiver and child, and 3) healthy environment and services. Results of the first group shows that the intervention has an overall positive effect on household food security. Household monthly per-capita food expenditures raised by 10% while food insecurity decreased by 11%. Moreover, children seemed to have consumed part of the additional food resources as indicated by the meaningful increase in the MMF and MDD scores for the target child, presented earlier in this section. Furthermore, the increase in the MDD score also suggests an improvement in feeding practices as children enjoyed a greater diversity of essential micronutrients in their diets.

127. Results of the second group shows that the intervention led to improvements in caregiver behaviors as well as in their mental and physical health, which are ultimately essential for child development. Due to the Child Grant 0-2, stimulating interactions between caregivers and their children increased by 11%, and the physical and mental status of their caretakers also improved significantly: caregivers were less depressed, less stressed, reported higher levels of self-assessed decision-making power, and less emotional and physical IPV. These combined findings suggest that the Child Grant 0-2 had systematic beneficial impact across several relevant measures of the underlying determinants and moderators pertaining to the care pathway.

Table 19. Summary of complementary impacts on underlying determinants of child nutrition

	Immediate Determinants	Underlying Determinants and Moderators	Measures of Underlying Determinants and Moderators	Pooled Treatments (Coefficient)	% Change
Nutritional Status	Nutritional Intake	Household Food Security	HH: monthly per-capita food expenditures (MZN)	57.3**	10%
			HH: Food Insecurity Experience Scale	-0.79***	-11%
		Feeding practices and styles	TC: Minimum meal frequency (MMF)	0.07***	175%
			TC: Minimum dietary diversity (MDD)	0.11***	100%
		Care for Caregiver and Child	TC: Num. of activities caregiver-child (last 3 days)	0.23*	11%
			CG: Depressive symptoms (CES-D ≥ 10)	-0.07**	-11%
	Health Status	Women's Empowerment and IPV	CG: Stress (Cohen self-reported stress scale)	-0.84***	-5%
			CG: Self-assessed decision-making power (ladder)	0.43***	+8%
			CG: Emotional and/or physical IPV (12-month recall)	-0.13***	-38%
		Healthy Environment and Services	TC: Had diarrhea in the last 2 weeks	0.02	NA
			TC: Was sick during last 2 weeks	0.00	NA
		Access and Health Seeking Behaviors	HH: Main source of drinking water is safe	-0.02	NA
			HH: Treats water to make it safe	0.20***	105%
			HH: Has water available for handwashing	-0.04	NA
			HH: Has soap available for handwashing	0.24***	51%
			HH: Has latrine	0.07***	10%
			TC: Consulted health professional in the last 2 weeks (if sick)	0.02	NA
			TC: Has age-appropriate polio vaccines	0.02	NA
			TC: Has age-appropriate PENTA vaccines	-0.05	NA
			TC: Has age-appropriate pneumococcal vaccines	-0.03	NA
			TC: Has age-appropriate rotavirus vaccines	0.03	NA
			TC: Has age-appropriate measles vaccines	-0.02	NA

Notes: HH: Household, TC: Target Child, CG: Caregiver. Moderator variables are in *italics*. Impacts on household sanitary facilities and child morbidity are presented in Tables A.6.7 and A.6.8, respectively.

128. Conversely, we do not see systematic improvements across outcomes in group 3, linked to child health and a clean/safe environment. Even though the intervention significantly increased the probabilities of treating water to make it safe for drinking, having soap available for hand washing, and having a latrine, these improvements in the environment were not translated into better child health outcomes. The Child Grant 0-2 did not significantly decrease child morbidity, as shown by the null impacts on the incidences of diarrhoea and any kind of sickness in the past 2 weeks. As shown earlier, about 40% of panel children had an episode of diarrhoea in the past 2 weeks, potentially offsetting benefits of increased food security. In addition, the intervention did not prompt caregivers to seek the help of a health professional when their child is sick. We also fail to see systematic effects on immunisations. This joint evidence suggests that the lack of improvements in child nutrition is most plausibly due to binding constraints within the set of underlying determinants related to health and a clean/safe environment.

7 HOUSEHOLDS

129. In this section, we present and discuss the impacts of the intervention on household-level domains. On the basis of the intervention logic framework, we present results for (*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. Where applicable, we also describe impacts of the intervention by the gender of the household head, a key mediator, given that households headed by women tend to face additional socioeconomic constraints, as these are families with usually fewer adults who are economically active. One caveat to keep in mind for the analysis by gender of household head is that impacts for female-headed households will be a bit more imprecise (i.e., will have larger confidence intervals), given that the proportion of female-headed households in our sample is just 13%, which means that we do not have a large number of observations in this group, which ultimately affects precision.

7.1 Consumption

130. On the basis of the intervention theory of change, one of the primary direct impacts of the Child Grant 0-2 will be on the consumption and spending behaviour of recipient households. This occurs because the intervention provides cash coupled with low saving rates amongst the target population. Thus, we expect to see significant impacts of the intervention on levels of spending, with relatively higher impacts on items that are more sensitive to income. Expenditure, therefore, is a key mediating variable for subsequent child- and household-level impacts. We have thus included in our household survey a comparable version of the expenditure module of the Inquérito sobre Orçamento Familiar (IOF), which covers 145 separate expenditure groups across both food and non-food categories. The IOF is a national-level survey conducted by the Instituto Nacional de Estatística. The main objective of the IOF is to measure household income, expenditures, and other socioeconomic characteristics to obtain various indicators of household living conditions in Mozambique, including poverty rates. Using comparable IOF modules allows us to compare our evaluation sample to the national- and district-level characteristics in terms of consumption patterns and poverty rates.

131. Table A.7.1 shows baseline balance and attrition analysis for the average total per capita expenditures for households in our sample and disaggregates it by using the same groups used by the Instituto Nacional de Estatística for analysis. The results show that, on average, households in our evaluation sample spent 746 MZN per capita per month at baseline, which is equivalent to 4,035 MZN, given that at baseline the average number of

household members was 5.41 members (4,035 MZN = 746 MZN × 5.41). Given that the transfer was 540 MZN per eligible household, beneficiary households with one eligible child, on average, were expected to experience a 13.3% (540 MZN/4,035 MZN) increase in their household expenditures over current consumption levels because of the transfer. Evidence from evaluations of national cash transfer programmes in the sub-Saharan Africa region conducted by the Transfer Project suggest that, on average, to ensure widespread effects, transfer sizes should be equal to at least 20% of baseline household consumption (Davis & Handa, 2015). The real value of the transfer can be further affected by seasonal variations and eroded over time because of inflation. For example, according to analysis of consumption rates over time in rural Mozambique, there is considerable seasonal variation, as '*expenditures start to increase gradually around March/April, peak in July/August, drop sharply by nearly 25% around September and level off until February*' (The World Bank, 2018; p. 29). Thus, as the recall period for consumption in this survey refers to a period in which consumption rates are generally low (March/April), it is likely that the 14% simulated increase in household income over current consumption levels by using baseline data represents an upper bound. Note that the transfer size is a key parameter for programme effectiveness and that the value of the Child Grant 0-2 is lower than the preferred level (15% at best vs. 20%).

132. Of the total monthly expenditures per capita during the recall period at baseline, 443 MZN was devoted to food consumption and non-alcoholic beverages (49%), followed by 239 MZN to housing, water, electricity, gas, and other fuels (32%); 33 MZN to education expenditures (4.5%); and 23 MZN in clothing and footwear (3%). Note that very few resources were spent on health, transportation, communication, and alcoholic beverages (the latter likely because the sample is primarily Muslim). There is not a statistically significant difference in total expenditures between the treatment and comparison groups at baseline for the panel sample. We also did not find differences in expenditure levels between the two groups in any of the expenditure categories. Across the individual expenditure groups, three showed statistically significant differences across the panel sample (furniture/decoration, health, education), although none are meaningful in magnitude (> 0.25 SD). Two outcomes (furniture/decoration and education) exhibited signs of differential attrition. However, the attrited households may have marginally contributed to improving the balance at baseline of the panel observations, given that those who attrited had larger standardised mean differences relative to standardised mean differences in the panel sample.

133. In the baseline report (AIR, 2020), we compared the expenditure shares in our sample to the national expenditure shares reported in the IOF 2014–15 (Instituto Nacional de Estatística, 2015) and showed that households in our sample spent 49% of their budget on food relative to 36% in the IOF. Moreover, households in our sample and in the IOF spent a similar share on housing, water, electricity, gas, and other fuels, with households in our sample spending 32% relative to 25% nationally. The education expenditure share in our sample was 4.5% relative to only 1% in the IOF, and clothing expenditures represented 3% in our sample compared to 6% in the IOF. Most other expenditure categories did not represent more than 1% in our sample, whereas households in the IOF spend their budget on multiple expenditure categories, including transportation (9.7%), restaurants (8.4%), house maintenance (4.4%) and communication (4.1%). The fact that households in our sample spent most of their budget on few expenditure categories, with food and fuels representing 81% of total expenditures relative to only 61% for households in the IOF, indicates the very low socioeconomic conditions of households in our sample.

134. Table 20 shows the impact estimates for total per capita expenditure (Row 1) and then impacts on per capita spending on other consumption groups. The Child Grant 0-2 increased total per capita consumption spending by 118 MZN per month, which is very close to the average per capita value of the transfer (118 MZN × 5.41 members = 638 MZN). Thus, as

expected among very poor households, almost all the income from the intervention is consumed. The subsequent rows of Table 20 show the distribution of the increased spending by category. Most of the increased spending goes to food (57.3 MZN), which is 49% of additional spending (57.3/118), followed by the housing, water, electricity, gas, and other fuels category (28.3 MZN), or 24% of the additional spending, and clothing, or 22% of the additional spending. In contrast, the reported expenses on other categories were not only very small, but also the impacts were close to zero even if marginally significant. More specifically, the results also show a small negative impact of the intervention on furniture (-3.3 MZN), health (-0.25 MZN) and communication (-0.02 MZN) and a small positive impact on transportation (2.96 MZN). There were no intervention impacts on education, other items, or alcohol/tobacco consumption. Lastly, as expected, the results showed that there were no additional impacts on expenditure categories for those who, in addition to receiving the cash transfer, were also eligible to receive the case management component.

Table 20. Impacts on Monthly Per Capita Consumption Expenditures (MZN)

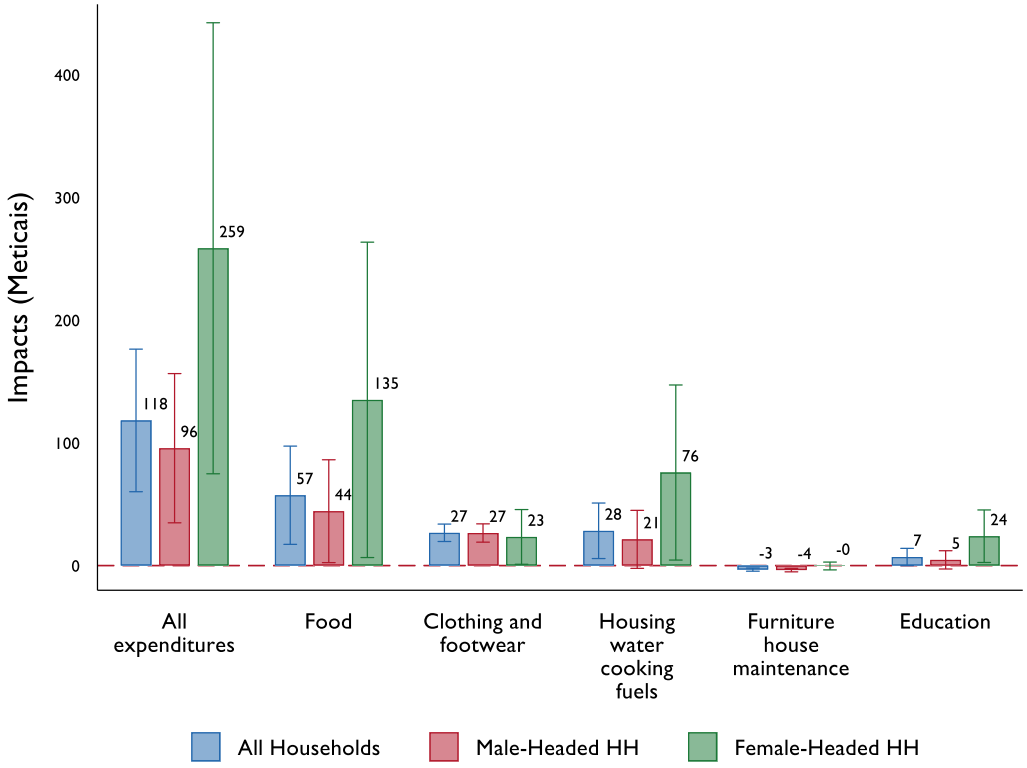
Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
All expenditures	118.2***	112.8***	24.0	878.8	3370
	(36.1)	(38.1)	(49.7)		
Food and non-alcoholic beverages	57.3**	54.2**	13.6	587.3	3370
	(25.3)	(26.8)	(34.9)		
Housing, water, electricity, gas and other fuels	28.3**	27.7*	3.23	236.5	3370
	(13.6)	(14.4)	(18.8)		
Education	6.95	6.94	-0.07	22.7	3370
	(4.49)	(4.76)	(6.20)		
Clothing and footwear	26.7***	25.7***	3.8	18.8	3370
	(4.6)	(4.91)	(6.4)		
Furniture, decorations and house maintenance	-3.3***	-4.07***	2.97***	11.3	3370
	(0.83)	(0.88)	(1.14)		
Transportation	2.96*	2.86	0.42	0.06	3370
	(1.78)	(1.88)	(2.45)		
Health	-0.25***	-0.25***	-0.01	0.51	3370
	(0.07)	(0.08)	(0.10)		
Communication	-0.02*	-0.02**	0.02	0.01	3370
	(0.01)	(0.01)	(0.01)		
Miscellaneous goods and services	-0.18	-0.16	-0.06	1.43	3370
	(0.28)	(0.29)	(0.38)		
Alcoholic beverages	-0.29	-0.33	0.13	0.02	3370
	(0.27)	(0.28)	(0.37)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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 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 < .1. ** p < .05. *** p < .01.

135. Figure 5 shows the impacts of the pooled treatment by gender of household head. The results showed that female-headed household seems to have experienced larger impacts on expenditures (259 MZN on total expenditures as a result of the intervention compared to an

impact of 96 MZN for male-headed households), and more specifically on the food category (135 MZN for female-headed households relative to 44 MZN for male-headed households) and on the housing, water, and cooking fuels category (76 MZN vs. 21 MZN for male-headed households). These results are not surprising because, as mentioned earlier, female-headed households tend to have a lower socioeconomic status and are usually households that spend a larger fraction of their income on food-related items and cooking fuels.

Figure 5. Pooled Impacts on Household Expenditures and Consumption 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), a dummy for household religion, and an index for COVID-19 disruption in community from follow-up.

136. It is also worth exploring impacts for the specific food groups, given the importance that food expenditures have for beneficiary households. Table A.7.2 breaks down the balance and attrition results by detailed food groups. The results show that, on average, most food expenditures were allocated to cereals and other bakery products (180 MZN), which represents 40% of all food expenditures (180/443), followed by fish and seafood (20%), vegetables and tubers (16%), oil and fats (6%), sugar and other confectionary products (4.5%), fruits (4.5%), meat (2.7%) and milk and dairy products (1.1%). In terms of balance within food groups, there were three statistically significant differences across the panel sample (oil and fats, fruits, and other), although none are meaningful in magnitude (> 0.25 SD). Two outcomes, sugars, and fruits, exhibited signs of differential attrition, but only one is larger than 0.25 SD. Nevertheless, the attrited households did not result in any imbalance at baseline for the panel observations, which are the ones used for estimating intervention impacts.

137. Table 21 reports impacts by detailed food groups. The overall increase in food spending is 57.3 MZN as reported in Table 20 (a 10% increase relative to the mean of the comparison group at endline). The results show that households eligible for receiving the cash transfer increased their consumption of vegetables (15.2 MZN), followed by dairy and eggs (10.5 MZN), oil and fats (9.1 MZN) and sugars (7.6 MZN). There is a clear shift away from cereals and toward vegetables and dairy, indicating an improvement in diet diversity among intervention recipients.

138. There were no differential impacts for households that, in addition to the cash transfer also received the case management component, except for a lower impact on the dairy and eggs category. That is, for these households, there was still a positive impact on the dairy and eggs food group of 6.7 MZN (=11.8 MZN – 5.1 MZN), which is statistically significant at the 1% level of confidence (results not shown), but the impact was lower than the one observed for those who received only the cash transfer (11.8 MZN). In terms of impact heterogeneity, we did not find any significant differences by household head gender.

Table 21. Impacts on Food Expenditure Categories (MZN)

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Food and non-alcoholic beverages	57.3**	54.2**	13.6	587.3	3370
	(25.3)	(26.8)	(34.9)		
Cereals and bakery products	-0.7	-5.6	20.3	280.7	3370
	(13.5)	(14.2)	(18.6)		
Fish and seafood	9.8	7.2	10.4	98.9	3370
	(6.9)	(7.3)	(9.5)		
Vegetables, potatoes and other tubers	15.2***	16.0***	-3.0	87.2	3370
	(5.1)	(5.4)	(7.0)		
Oil and fats	9.1***	9.6***	-1.8	30.0	3370
	(2.3)	(2.4)	(3.2)		
Sugar and confectionery products	7.6***	8.2***	-2.0	17.3	3370
	(1.9)	(2.0)	(2.6)		
Fruits	1.9	1.5	1.6	19.3	3370
	(1.9)	(2.0)	(2.6)		
Meat and meat derivatives	4.9	6.0*	-4.1	11.1	3370
	(3.2)	(3.4)	(4.4)		
Milk and dairy products, eggs	10.5***	11.8***	-5.1**	6.0	3370
	(1.7)	(1.8)	(2.4)		
Other	-1.1	-0.4	-2.9	36.9	3370
	(2.3)	(2.4)	(3.2)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), 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 < .1. ** p < .05. *** p < .01.

139. In the baseline report (AIR, 2020), we also compared the food consumption shares for households in our sample to households in the IOF 2014–15. The results showed that households in our sample had food consumption shares similar to those of IOF households. The most relevant differences were that households in our sample spent 7 pps less on cereals than did IOF households (47% for IOF and 40% in our sample), 8 pps less on meat and its derivatives (10.6% for IOF and 2.7% in our sample) and 8 pps more on fish and seafood (11% for IOF and 20% in our sample). The relatively large consumption of fish and seafood is due

to the close proximity of our sample to coastal areas, especially those households located in Ilha de Mocambique, the southern part of Mossuril, and some areas in Nacala-a-Velha and Nacala Porto.

7.2 Poverty

140. The expenditure data collected also allowed us to estimate the percentage of poor households in our sample. For the analysis, we used the total expenditures and food expenditures poverty lines from IOF 2014–15 for the province of Nampula and updated them to the 2021 values by using inflation rates for Nampula as reported by the Instituto Nacional de Estatística for the period 2015–21. In addition to estimating poverty rates, we also estimated poverty gaps for the two measures of poverty lines. For a given household, the poverty gap measures the distance from that household's expenditure level to the poverty line as a proportion of the poverty line. The linear and squared poverty gaps provide a clear way to characterize the distribution of the poverty rate and allowed us to account for intervention reductions in poverty for very poor households, even if those households were still below the poverty line.

141. In Table A.7.3, we present the balance and attrition results for the poverty indicators discussed earlier. The results showed that 86% of the households in our sample at baseline had total expenditures that were below the poverty line. The poverty rate compared to the food poverty line was lower, with 70.8% of households considered poor. In terms of poverty gaps, the linear poverty gaps were 46% and 32% with use of the total and food poverty lines, respectively, with no differences by treatment status. We did not observe statistically significant differences in poverty indicators between the treatment and comparison groups at baseline for the panel sample or any signs of differential attrition.

142. Although the last official estimation of poverty rates available in Mozambique is from 2015, it is still interesting to compare our sample with the 2015 poverty rates for Nampula and those for the whole country. On the basis of the IOF, the 2015 poverty rate based on total expenditures was 46.1% for the whole country and 57.1% for Nampula. In fact, Nampula was the province with the highest poverty rate in all of Mozambique, followed by Zambezia at 56.5%. As shown, households in our sample had a poverty rate that was 29 pps higher than the 2015 rate in Nampula and 40 pps higher than the national poverty rate. These percentages suggest that the districts selected for implementation in Nampula are some of the poorest districts in the province and in the country.

143. Table 22 provides more details on impacts on the three commonly used poverty indicators. Beginning with the poverty line based on all household expenditures, the intervention reduced the headcount rate by 8.8 pps (a 10% reduction in the number of households that are considered poor relative to the mean of the comparison group at endline), the poverty gap by 4.8 pps (a 13% decrease relative to the mean of the comparison group) and the squared poverty gap by 3 pps (approximately a 15% reduction relative to the mean of the comparison group at endline). For programmes that target people at the very bottom of the income distribution, these last two indicators are better measures of changes in welfare because it is highly unlikely for a programme to provide sufficient funds to lift people at the very bottom of the distribution above the poverty line. However, a significant positive movement below the poverty line will show up in the poverty gap and squared poverty gap indicators. Thus, this pattern of results is evidence of both the successful targeting approach of the intervention, as well as its impact on welfare. The results for the pooled treatments were similar with use of the food expenditures line. In terms of additional impacts for those households eligible for the case management component, the impacts were a bit larger, particularly for the poverty gap and squared poverty gaps. These results suggest that those

who were eligible for the case management component in Nacala-a-Velha had a lower socioeconomic status relative to those who were not prioritized for this component and received only the cash transfer.

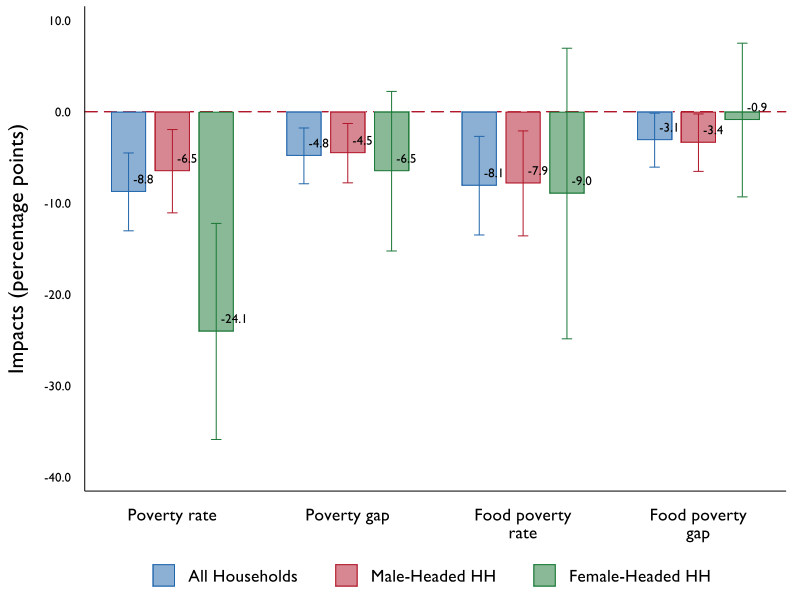
Table 22. Impacts on Poverty Indicators

Dependent Variable	Impact Estimates			Endline Mean	N
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	
All Expenditures Poverty Line	(1)	(2)	(3)	(4)	(5)
Headcount	-8.78***	-9.46***	2.53	83.99	3370
	(2.65)	(2.81)	(3.66)		
Poverty gap	-4.84**	-3.63*	-4.94*	37.11	3370
	(1.88)	(1.98)	(2.58)		
Squared poverty gap	-3.01*	-1.57	-5.81***	20.35	3370
	(1.55)	(1.63)	(2.12)		
Food Expenditures Poverty Line					
Headcount	-8.10**	-6.59*	-6.17	60.23	3370
	(3.30)	(3.49)	(4.54)		
Poverty gap	-3.12*	-1.57	-6.26**	21.59	3370
	(1.82)	(1.92)	(2.50)		
Squared poverty gap	-1.87	-0.45	-5.69***	10.32	3370
	(1.30)	(1.37)	(1.79)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), 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 < .1. ** p < .05. *** p < .01.

144. Figure 6 shows the impacts of the pooled treatment by gender of household head. The results showed that female-headed households experienced a larger reduction on the poverty rate on the basis of all expenditures. The reduction in the poverty rate for those households was 24 pps relative to a 6.5 pp reduction for male-headed households. This result confirms that female-headed households had lower incomes and benefited greatly from this type of social protection programme to lift them out of poverty.

Figure 6. Pooled Impacts on Poverty Rates 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), a dummy for household religion, and an index for COVID-19 disruption in community from follow-up.

7.3 Food Security

145. One of the goals of most cash transfer programmes is to improve the food security of beneficiary households. In this section, we assess the impacts on the number of meals per day and also use a battery of eight questions that allows us to construct the Food Insecurity Experience Scale (FIES) developed by the Food and Agriculture Organization of the United Nations, a metric to measure a household's severity of food insecurity by investigating access to adequate food (Ballard, Kepple, & Cafiero, 2013). The FIES index runs from 0 to 8, where 8 means a household is highly food insecure.

146. Table A.7.4 describes the food security balance and attrition for households in our sample at baseline. First, the descriptive statistics showed that households in our sample had, on average, 2.26 meals per day. Second, the average FIES score in our sample was 6.82 at baseline, which indicates that households in our sample had very high levels of food insecurity. Concerning the individual components of the index, more than 86% of households in our sample stated that, in the last 4 weeks before the survey, they were worried about not having enough food, were unable to eat healthy and nutritious food, ate fewer kinds of food, skipped a meal, ate less than needed, ran out of food, or were hungry but could not eat. In addition, 66% of households reported that at least one member did not eat for a whole day in the past 4 weeks because of lack of funds. We also used an indicator on access to preferred markets with high-quality foods (not in the standard FIES) to capture an additional dimension of food access with potential to be affected by cash transfers. At baseline, 75% of households could not access such preferred markets because of lack of money. In terms of attrition, none of the food security characteristics were statistically different between the treatment and comparison groups in a meaningful way in the panel sample. There was also no evidence of significant differential attrition at meaningful levels in the sample.

147. One of the goals of cash transfer programmes is to improve the food security of beneficiary households and specifically increase the number of meals eaten per day. As stated earlier, the intervention had large impacts on consumption, with more than 50% of the additional expenditures going toward food consumption. We found that these additional expenditures on food translated to greater food security, a finding consistent with our predictions conducted at baseline. Table 23 shows the impacts of the intervention on several food security indicators. The intervention increased the number of meals per day by 0.28 meals. This impact is equivalent to a 12% increase in the average number of meals relative to the average at baseline (0.28/2.26). In terms of the FIES, we observed a significant and meaningful reduction in food insecurity for households that received the cash transfer. The impact on the FIES reflects the large reductions on the individual food security indicators, with reductions ranging from 6 to 16 pps. Thus, the intervention improved household food security, with strong impacts on the reduction of food insecurity.

148. The results also indicated that for most outcomes there were no additional impacts for those eligible for the case management component, which is expected, given that most of the reduction in the food insecurity indicators should be driven mostly by the cash transfer. The only two outcomes for which there were additional reductions for the case management eligible outcomes were for being worried about not having enough food to eat and not eating for a whole day in the 4 weeks before the survey. These results provide additional evidence that households eligible for the case management component faced even larger economic constraints.

Table 23. Impacts on Food Security Indicators

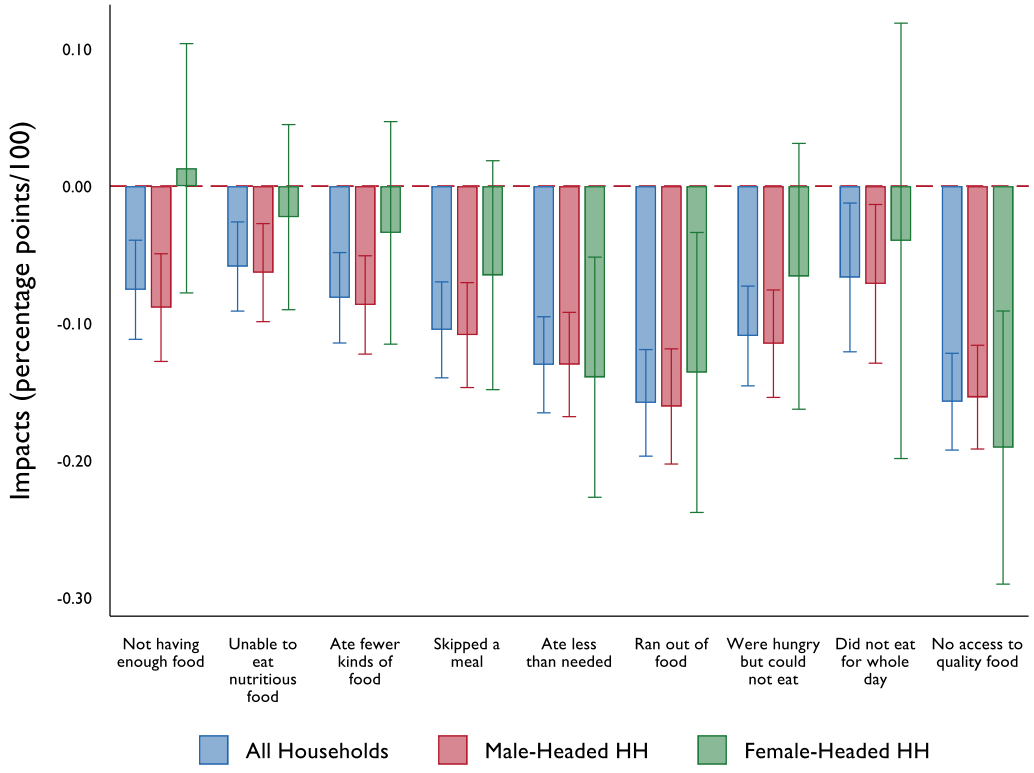
Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Average number of meals per day	0.28***	0.30***	-0.08	2.16	3370
	(0.04)	(0.04)	(0.06)		
In past 4 weeks, because of lack of money, household members…					
Worried about not having enough food to eat	-0.08***	-0.05**	-0.09**	0.95	3370
	(0.02)	(0.02)	(0.03)		
Unable to eat healthy and nutritious food	-0.06***	-0.05**	-0.02	0.96	3370
	(0.02)	(0.02)	(0.03)		
Ate fewer kinds of food	-0.08***	-0.07***	-0.04	0.96	3370
	(0.02)	(0.02)	(0.03)		
Skipped a meal	-0.11***	-0.10***	-0.02	0.95	3370
	(0.02)	(0.02)	(0.04)		
Ate less than needed	-0.13***	-0.13***	-0.00	0.96	3370
	(0.02)	(0.02)	(0.04)		
Ran out of food	-0.16***	-0.15***	-0.02	0.94	3370
	(0.03)	(0.03)	(0.04)		
Were hungry but could not eat	-0.11***	-0.10***	-0.04	0.95	3370
	(0.02)	(0.03)	(0.04)		
Did not eat for a whole day	-0.07**	-0.04	-0.10**	0.32	3370
	(0.03)	(0.04)	(0.05)		
Could not access preferred markets for high-quality foods	-0.13***	-0.13***	-0.01	0.81	3370
	(0.03)	(0.03)	(0.05)		
FIES index score (raw)	-0.79***	-0.70***	-0.34	6.99	3370
	(0.14)	(0.15)	(0.21)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), 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. 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 < .1. ** p < .05. *** p < .01.

149. We also assessed the heterogeneity of impacts on food security by the gender of the household head in Figure 7. For the discussed indicators, we did not observe statistically significant differences by gender largely because of the large confidence intervals that estimates for female-headed households had. That said, the results were mixed, given that, for some indicators, male-headed households seemed to have better impacts and for some others female-headed households were better off.

Figure 7. 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.

7.4 Asset Ownership

150. We also investigated the proportion of households owning agricultural tools and other types of durable assets. Assets not only serve as a source of productivity for rural households but also provide wealth stores important for protecting households against negative shocks. Some of the most widely available assets to households at baseline were agricultural assets such as hoes (86% of households) and machetes (59%). Other common household assets

included pestles (51%); non-gas, non-electric stoves (47%); televisions (21%); radios (13%); and motorcycles (11%). Note that just 41% of households reported having at least one sleeping bed. Overall, the proportion of asset ownership provided additional evidence of the low socioeconomic conditions of households in our sample. In Table A.7.5, we observed that hoes were the only asset for which there was a standardised mean difference greater than 0.25 in the panel sample at baseline in favour of the comparison group. There were no meaningful differences in the rates of asset ownership for any of the other assets at baseline in the panel sample, including an asset index constructed from the ownership indicator of the individual assets using principal components, which is a technique used to reduce a large set of variables to a small set that still contains most of the information

151. The intervention had a positive impact on the ownership of a wide variety of assets, particularly axes, machetes, hoes, pestles, stoves, bicycles, solar panels, chairs, tables, beds, and radios, ranging from 4 pp to 15 pp increases. These resulted in a significant impact on the overall asset index of 0.24 relative to the comparison group, with no additional impacts for the case management -eligible group (Table 24). In terms of treatment heterogeneity for the pooled treatments, we did not observe significant differences between male- and female-headed households in this regard (Figure 8).

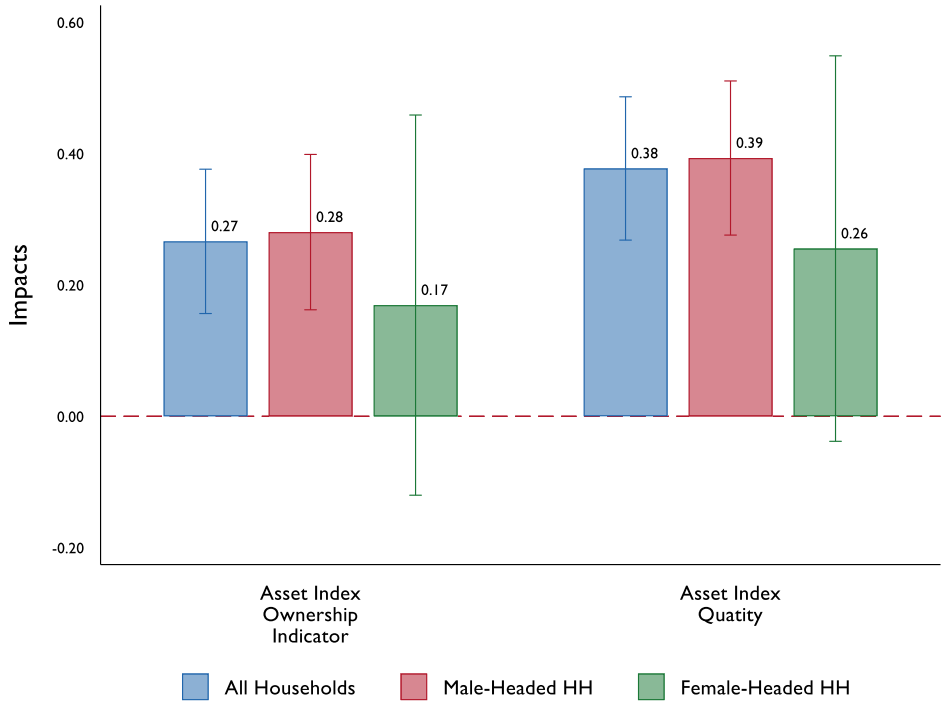
Table 24. Impacts on Household Ownership of Assets

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Asset Index	0.27***	0.24***	0.14	0.07	3370
	(0.07)	(0.07)	(0.10)		
Axe	0.15***	0.16***	-0.04	0.27	3370
	(0.03)	(0.04)	(0.05)		
Sickle	0.02	0.04	-0.06*	0.14	3370
	(0.02)	(0.02)	(0.04)		
Machete	0.15***	0.15***	0.01	0.55	3370
	(0.03)	(0.04)	(0.05)		
Hoe	0.07***	0.07***	0.00	0.95	3370
	(0.02)	(0.02)	(0.03)		
Pestle	0.08**	0.06	0.09	0.47	3370
	(0.03)	(0.04)	(0.05)		
Stove	0.10***	0.09**	0.06	0.41	3370
	(0.03)	(0.04)	(0.05)		
Fishing net	-0.01	-0.02	0.04	0.06	3370
	(0.02)	(0.02)	(0.03)		
Boat	0.01	0.01	0.01	0.04	3370
	(0.01)	(0.01)	(0.02)		
Motorcycle	0.03	0.02	0.04	0.11	3370
	(0.02)	(0.02)	(0.03)		
Bicycle	0.05***	0.05***	-0.01	0.07	3370
	(0.02)	(0.02)	(0.03)		
Solar panel	0.04**	0.03	0.05**	0.05	3370
	(0.02)	(0.02)	(0.03)		
Chairs	0.12***	0.12***	-0.00	0.58	3370
	(0.03)	(0.04)	(0.05)		
Tables	0.14***	0.15***	-0.03	0.33	3370
	(0.03)	(0.04)	(0.05)		
Beds	0.08**	0.04	0.15***	0.52	3370
	(0.03)	(0.04)	(0.05)		
Radio	0.04*	0.03	0.05	0.13	3370

	(0.02)	(0.03)	(0.04)		
Refrigerator	0.01	0.01	-0.01	0.06	3370
	(0.02)	(0.02)	(0.03)		
Television	0.04	0.02	0.05	0.23	3370
	(0.03)	(0.03)	(0.05)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), 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. 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 < .1. ** p < .05. *** p < .01.

Figure 8. Pooled Impacts on Household Asset Ownership Index by Gender of Household Head



Notes: Asset index (ownership) is constructed using principal components from the ownership of individual assets reported (1 if owned and 0 if not) to summarize the combined effects of the programme on all assets. Asset index (quantity) also uses principal components but takes into account the actual number of items the household owns. 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.

7.5 Credit and Transfers

152. Borrowing is a short-term way to alleviate financial shortfalls often associated with poverty. Borrowing helps households cope with emergencies, smooth out consumption or even seize small investment opportunities that could improve household welfare. However, poor households may not have access to credit if lenders do not think those households will be able to honor their debt. Thus, another potential positive impact that cash transfer beneficiaries can experience is that they have more, and more favorable, access to credit if

needed because the cash transfer can be used as collateral, increasing confidence from lenders.

153. In Table A.7.6, we show that 10% of households had an outstanding loan at baseline. Also, only 21% of households reported having access to credit if needed, which speaks once again about the low socioeconomic conditions of the households in our treatment and comparison areas. Lastly, 11% of households in the sample reported being able to give money or goods to other households. In terms of balance, none of the outcomes considered showed evidence of meaningful imbalances between treatment and comparison households at baseline or differential attrition for households that dropped from the endline.

154. In terms of impacts, in Table 25 we show that there is no effect on the probability of having an outstanding loan as a result of the intervention or on the value of the loan for those with a current loan. Although there was a 7-pp positive impact on the probability of having access to credit if needed for cash transfer households, there was a negative impact on this indicator for those who were eligible for the case management component. This result may be due to an imbalance at baseline for the case management eligible group. That is, at baseline, 29% of the households in the case management -eligible group reported access to credit relative to 19% reported by the remaining households. At endline, 37% of the case management -eligible households reported having access to credit relative to 36% for the households who are not eligible for the case management. Lastly, we observed an 11 pp increase in the probability that households in the pooled treatment group gave money or goods to other households. However, the impact for those in the case management -eligible group was lower, close to 4 pps (0.04=0.13-0.09) and not statistically significant.

Table 25. Impacts on Household Credit and Transfers

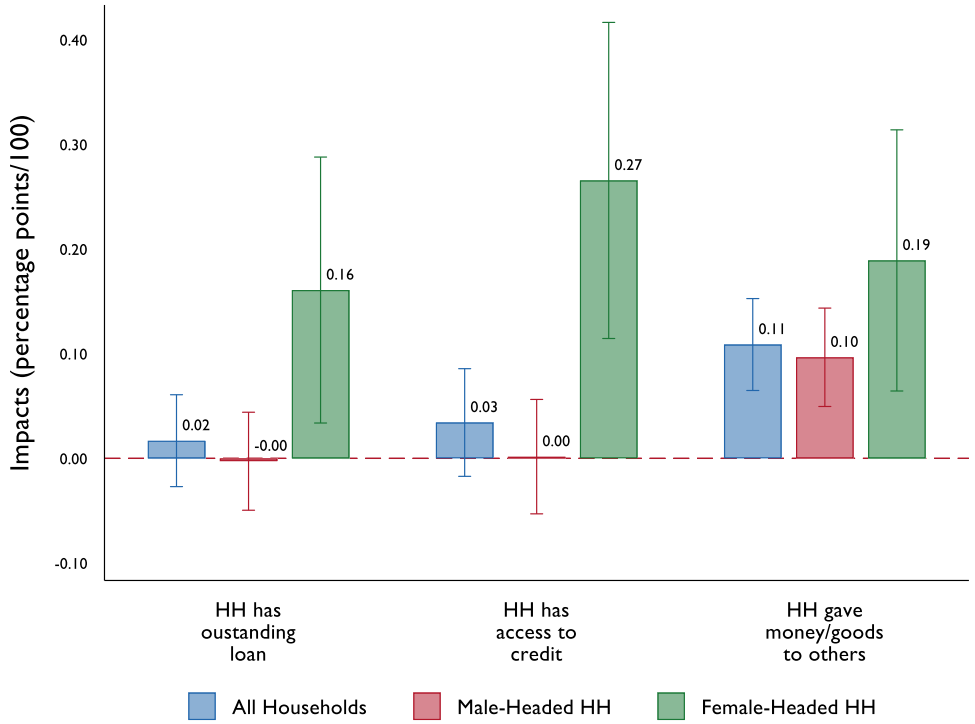
Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Has outstanding loan	0.02	0.03	-0.06	0.26	3370
	(0.03)	(0.03)	(0.04)		
Loan original value	-123.12	-125.59	9.60	994.03	649
	(192.13)	(217.69)	(285.06)		
Has access to credit if needed	0.03	0.07**	-0.14***	0.31	3370
	(0.03)	(0.03)	(0.05)		
Gave money/goods to another household in last 12 months	0.11***	0.13***	-0.09**	0.22	3370
	(0.03)	(0.03)	(0.04)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), 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. 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 < .1. ** p < .05. *** p < .01.

155. n terms of treatment heterogeneity, in Figure 9 we observe that although there was no impact on outstanding loans and access to credit for male-headed households, there were positive impacts on both outcomes for female-headed households. That is, relative to the comparison group, female-headed households who were part of the intervention were 16 pps more likely to have an outstanding loan and 27 pps more likely to report access to credit.

These results clearly indicate that the intervention was expanding credit opportunities for female-headed households, a group that can face large credit constraints. Lastly, there was no difference in the probability of giving money to other households between male- and female-headed households.

Figure 9. Pooled Impacts on Credit, Access to Credit and Transfers 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.

7.6 Livelihoods: Non-Farm Enterprise, Agricultural Production and Livestock Ownership

156. Given the theory of change, we expected the intervention to influence the livelihood activities of beneficiary households. On the basis of the demographic profile of the Child Grant 0-2 beneficiaries, we expected that the intervention would lead to an increase in productive activities, including the following sub-domains: (*a*) non-farm enterprises, (*b*) agricultural production, and (*c*) increase in ownership of livestock.

157. In terms of the first sub-domain, non-farm enterprises, in Table A.7.7, we show that 23% of households had a business at baseline, where the main activity was to have a trading business or offering services (18%), followed by processing or selling any agricultural by-products (6%) and fishing or having a fishing business (3%). The remaining economic activities were not reported, as they represent a smaller fraction of participating households. In terms of balance at baseline and differential attrition, none of the outcomes were statistically different from zero, meaning that the sample was balanced at baseline and those who dropped from the survey were not different in a meaningful way.

158. Regarding impacts, the results in Table 26 show that beneficiaries were 7 pps more likely to have a non-agricultural business (a 15.9% increase relative to the mean of the comparison group at endline), where the impacts were mostly driven by those devoted to offering services and trading (6 pp increase), followed by processing and selling agricultural by-products (4 pp increase). As expected, the impacts on these outcomes were entirely driven by the cash component of the intervention.

Table 26. Impacts on Household Non-Farm Enterprises

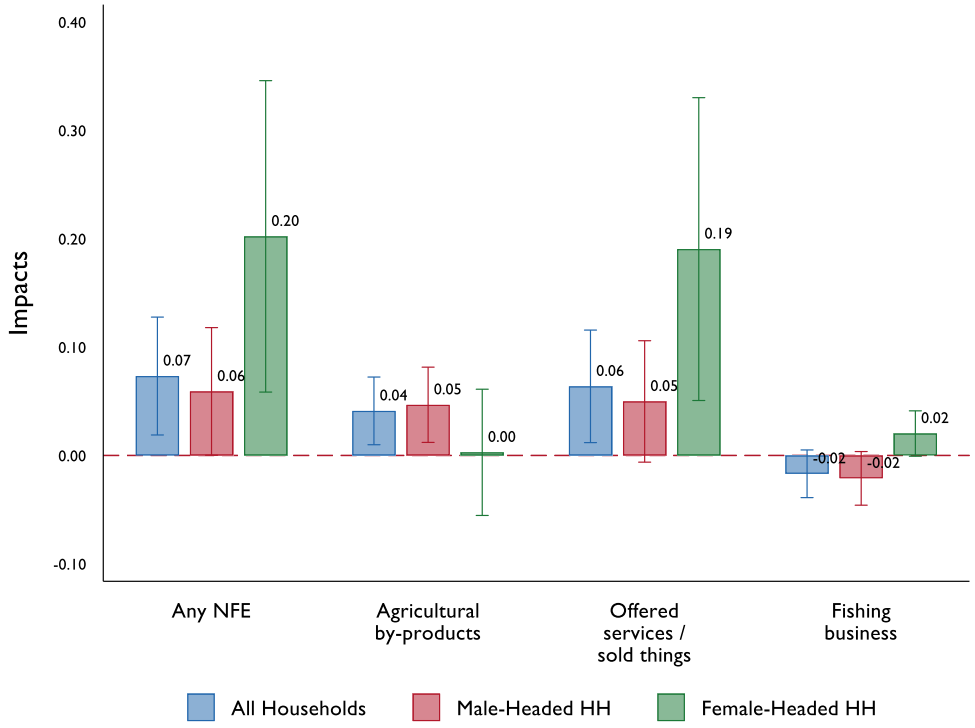
Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Any non-agricultural business	0.07**	0.07**	0.01	0.44	3370
	(0.03)	(0.04)	(0.05)		
Processed/sold any agricultural by-products	0.04**	0.05**	-0.04	0.09	3370
	(0.02)	(0.02)	(0.03)		
Offered services or sold anything	0.06**	0.06*	0.02	0.35	3370
	(0.03)	(0.03)	(0.04)		
Fishing or fish farming business	-0.02	-0.01	-0.01	0.05	3370
	(0.01)	(0.01)	(0.02)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), 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. 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 < .1. ** p < .05. *** p < .01.

In

159. Figure 10, we observed that female-headed households had much larger impacts than male-headed ones in terms of having a non-farm enterprise, which was mostly driven by the large impact on the probability of participating in commercial activities (i.e., offering services or selling things). Note, however, that the confidence intervals for the estimates of female household heads were relatively wide, which means that we cannot completely rule out that the impacts of male- and female-headed households were the same.

Figure 10. Pooled Impacts on Household Non-Farm Enterprises 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.

160. The second sub-domain analysed is agricultural production. As shown in Table A.7.8, we observed that the most common crops households in our sample produced at baseline were maize (14%), beans (11%), cassava (18%) and peanuts (13%). We also looked at the production in kilos for each one of those crops in the last 12 months before the survey to assess if cash transfer recipients changed their production as a result of the intervention. Although it is a common practice to assess production per unit of area, we found relatively large inconsistencies in the information reported from baseline and endline. Thus, we present the information of only quantity produced, which we believe to be more accurate. The results show that the average household produced 87 kilos of maize, 57 kilos of beans, 174 kilos of cassava and 88 kilos of peanuts. The relatively low involvement in the production of these crops resulted from households in our sample being located in coastal areas where trading is more prevalent.

161. In terms of balance and attrition, in Table A.7.8 we show that there are no major imbalances at baseline for the panel sample, except for the quantity of beans produced, which had a standardized mean difference on 0.26 SD. In terms of attritors, we also observed some signs of differential attrition for the probability of producing peanuts and for cassava production in kilos. Nevertheless, the attrited households did not create a meaningful imbalance in the panel sample at baseline.

162. We present the impact results on agricultural production in Table 27. The results did not provide a clear pattern of how the intervention affected agricultural decisions. On the one hand, the results showed that case management -eligible households were more likely to

produce any quantity of maize (13 pps higher than those who received cash) and peanuts (17 pps higher than those who received cash), but this did not necessarily translate into a higher quantity produced of those crops. On the other hand, we saw some negative impacts of the intervention on the probability of producing beans (10 pps lower than the comparison group) and cassava (12 pps lower than the comparison group). Again, the results did not indicate that for those who produced these two crops there was a statistically significant reduction in the quantity produced. A potential explanation for these negative impacts is that cash transfer recipients were able to increase their expenditures on legumes and tubers (Table 21), while some households may have decided to not produce them. Overall, the results suggest that the intervention did not affect the agricultural decisions of beneficiaries in an important way.

Table 27. Impacts on Household Agricultural Production

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
Household produced…	(1)	(2)	(3)	(4)	(5)
Maize	-0.01	-0.04	0.13***	0.36	3370
	(0.03)	(0.03)	(0.04)		
Beans	-0.09***	-0.10***	0.03	0.51	3370
	(0.03)	(0.03)	(0.04)		
Cassava	-0.12***	-0.12***	0.02	0.56	3370
	(0.03)	(0.03)	(0.04)		
Peanuts	0.01	-0.03	0.17***	0.25	3370
	(0.03)	(0.03)	(0.04)		
Quantity Produced (Kilos)					
Maize	-11.25	-11.26	0.43	72.51	887
	(9.48)	(10.02)	(11.13)		
Bean	-15.28	-11.99	-14.10	43.29	885
	(9.77)	(10.34)	(16.12)		
Cassava	-18.02	-5.29	-31.97	143.60	1061
	(13.32)	(14.35)	(19.12)		
Peanuts	5.83	7.61	-5.40	59.47	743
	(10.16)	(10.82)	(10.55)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), 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. 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 < .1. ** p < .05. *** p < .01.

163. The third domain assessed under the livelihoods category was livestock ownership rates. Owning livestock has two goals for households. First, some of the animals' by-products can be sold, which increases income sources for the household in addition to the cash transfer. Second, livestock, like any asset that retains value over time, can be used as a buffer stock that allows households to cope better with adverse episodes over time. In Table A.7.9, we show that households in the intervention area had very low levels of livestock ownership rates. The most common animals owned at baseline were guinea fowl (4%), chickens (3%), ducks (2%) and goats (1%). The low levels of livestock ownership reinforce the low wealth and asset stocks held by households in the sample. The results in the table also showed that there were no meaningful imbalances at baseline for the panel sample and none of the outcomes were affected by differential attrition.

164. In terms of impacts, the intervention slightly increased the ownership rates of goats, guinea fowl and ducks for households eligible for the case management component (Table 28). The relatively low impacts on these outcomes may be due to the low level of the transfer as discussed earlier, which may prevent beneficiaries from investing in costly assets and maintaining them as they wait for them to be productive. Moreover, there was no evidence of heterogeneous impacts by the gender of the household head (not shown).

Table 28. Impacts on Household Livestock Ownership (Share)

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Livestock index	0.01	0.00	0.04	0.06	3370
	(0.05)	(0.05)	(0.07)		
Goats	0.02**	0.01	0.03***	0.02	3370
	(0.01)	(0.01)	(0.01)		
Chicken	-0.00	-0.01	0.04**	0.05	3370
	(0.01)	(0.01)	(0.02)		
Guinea fowl	0.04*	0.03	0.02	0.10	3370
	(0.02)	(0.02)	(0.03)		
Duck	-0.00	-0.01	0.03*	0.07	3370
	(0.01)	(0.02)	(0.02)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), 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. 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 < .1. ** p < .05. *** p < .01.

7.7 Resilience: Shocks and Coping Strategies

165. A key issue in resilience is how households cope with shocks and, in particular, whether they must rely on 'negative' or irreversible coping mechanisms. We look at various shocks experienced by households the better to understand factors that affect their wellbeing and economic situation. Most of the shocks assessed include negative shocks, such as floods or droughts that destroy property or food sources.

166. The data show that 48% of households reported facing a negative shock in the last 12 months before the survey at baseline. The more frequently reported shocks were drought (14%), strong winds (11%), floods (10%) and crops and/or livestock being affected by a pest or a disease (9%). Overall, there was a large variety of shocks that affected the households in our sample. None of the shocks considered, however, affected the treatment and comparison groups differentially from the panel sample, and none of these outcomes exhibited meaningful levels of differential attrition (Table A.7.10).

167. We also reported the coping mechanisms that households that faced a negative shock used at baseline. In Table A.7.11, we show that the two most important coping mechanisms were using their own savings (48%) and receiving help from friends and relatives (36%). A large proportion of households did not have a strategy to cope with shocks (38%). The results show that there were no meaningful imbalances at baseline between the treatment and comparison groups for the panel sample. If anything, among those who attrited, there was a

0.28 standardised mean difference between treatment and comparison for those who received help from friends or relatives.

168. We also investigated if households in the treatment and comparison groups were affected differentially by COVID-19 in the household shock module, by including a self-reported question of if their household has been negatively affected by COVID-19 (Table 29).[23] Households in the panel treatment sample reported being 14 pps less likely to have any negative impacts from COVID-19 relative to the comparison group, where 26% of households reported being affected. It is possible that the transfer allowed beneficiary households to take additional care measures that households in the comparison group were not able to take.

Table 29. Impacts on Household Negative Effects of COVID-19

Dependent Variable	Impact Estimates			Endline Mean	
	SD Pooled Treatments	SD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Affected negatively by COVID-19	-0.14***	-0.17***	0.13***	0.26	1685
	(0.02)	(0.02)	(0.03)		

Notes: CM = case management. Impacts are estimated using a single difference with robust standard errors among the 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), 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. 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 < .1. ** p < .05. *** p < .01.

169. In terms of coping strategies, results in Table 30 show that households in the treatment group that experienced a negative shock were 3 pps less likely to obtain a credit to cope with the shock and 18 pps less likely to 'do nothing' relative to the comparison group. These two impacts were entirely driven by those households that received the cash transfer, indicating that transfers allowed households to cope better under exogenous negative circumstances. We did not find any differential impacts by the gender of the household head (not shown).

Table 30. Impacts on Household Coping Strategies for Negative Shocks

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Own savings	0.01	-0.00	0.05	0.62	2236
	(0.05)	(0.05)	(0.06)		
Received help from relatives/friends	0.03	0.05	-0.10*	0.43	2236
	(0.04)	(0.05)	(0.06)		
Changed eating patterns	0.00	0.01	-0.01	0.05	2236
	(0.02)	(0.02)	(0.02)		
Reduced adult consumption	0.00	0.01	-0.04	0.06	2236
	(0.02)	(0.02)	(0.02)		

23 The exact question was worded as follows: "During the last 12 months, was your household affected negatively by COVID-19 (due to social distancing or containment measures)"? This question was one of 19 different types of negative shocks in the last 12 months that households reported on experiencing and reported subsequent coping strategies to deal with these shocks.

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Obtained credit	-0.03**	-0.03***	0.02*	0.03	2236
	(0.01)	(0.01)	(0.01)		
Sold assets, land, livestock	0.01	0.01	-0.02*	0.01	2236
	(0.01)	(0.01)	(0.01)		
Intensified fishing/farming	-0.00	0.00	-0.02	0.05	2236
	(0.02)	(0.02)	(0.02)		
Other	-0.01	-0.00	-0.02	0.01	2236
	(0.01)	(0.01)	(0.02)		
None	-0.18***	-0.21***	0.08	0.27	2236
	(0.04)	(0.04)	(0.05)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), 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. 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 < .1. ** p < .05. *** p < .01.

7.8 Access to Other Programs

170. Lastly, we investigate the level of access to social programmes by households in our sample (Table A.7.12). This is important to assess to know if there was some sort of contamination or complementarities that may have affected estimated impacts. The most common programmes that households reported at baseline were education programmes (4% of households) and water and sanitation programmes (3%). There was no evidence of any imbalances at baseline between the treatment and comparison groups for any type of social programme in the panel sample. There was also no evidence of differential attrition. We also investigated the presence of social programmes at endline and did not find evidence of other programmes operating in the evaluation area at widespread levels (results not shown). The very low exposure that households in our sample had to other social programmes provides evidence that the estimated impacts reported in the evaluation occurred as a result of the Child Grant 0-2.

8 PRIMARY CAREGIVERS

171. Following the intervention logic framework, we next present evaluation sample descriptive statistics on the primary caregiver domains, including the following: (*a*) health and nutrition knowledge, (*b*) psychosocial wellbeing and social support, (*c*) empowerment and freedom from violence, (*d*) fertility and (*e*) family separation.[24] Where applicable, we also describe impacts of the intervention by caregiver age, stratifying the sample into two groups: (*a*) caregivers who were adolescents or youth at baseline (≤ 24 years) and (*b*) caregivers who were older (> 25 years). As child marriage and early pregnancy are significant issues of concern in Mozambique, with consequences for both women and their children, there is interest in understanding if the intervention was working equally well for young caregivers.

24 In this analysis, we drop 20 households for which the original female caregiver at baseline was replaced by a male caregiver. For the remaining households, the overwhelming majority (97.5%) interviewed the same female caregiver as at baseline—while a small percentage interviewed a different female caretaker, in the cases the original caregiver was temporarily absent (0.45%), had permanently left the household (0.45%), had died during the intervention period (0.33%) or was too sick to be interviewed (0.03%). Therefore, these results can essentially be interpreted as a panel of the same female caregivers.

172. The first domain includes information on five key IYCF and health areas, meant to complement information on household-level access to water and sanitation and young child behaviours, reported in other sections. It should be noted that because these questions were developed before the SBCC training materials were received, they cannot be interpreted as a holistic or complete representation of the SBCC messages as implemented. Table A.8.1 shows baseline balance and attrition analysis across five key knowledge indicators, operationalized as simple dichotomous indicators (i.e., whether the caregiver correctly identified knowledge regarding a topic), as well as a summary indicator (ranging from 0-5 correct answers). Overall, caregivers had high knowledge that babies should be breastfed immediately after birth (93%) and could name at least one reason for exclusively breastfeeding (78%). However, the duration of exclusive breastfeeding (6 months) was correctly identified by fewer caregivers (67%). Likewise, the percentage of caregivers who could identify at least one reason iron is important for children was slightly less than two-thirds (63%), and 57% could identify at least one source of iron. The average sum of knowledge questions was 3.58 (ranging from 0-5). Across the six indicators, two showed statistically significant differences across the panel sample, and two showed signs of differential attrition; however, none were meaningful in magnitude (> 0.25 SD).

173. Table 31 shows impacts of the intervention on caregiver health and nutrition knowledge outcomes. Overall, there were few pooled impacts of the intervention on any outcome, including the overall knowledge indicator, with the exception of a small and weakly significant increase (5 pp) on knowledge of iron sources (translating to a 6% increase over the endline comparison mean). Despite this, outcomes were increasing over time in both the treatment and comparison groups—potentially due to information and sensitisation received in growth monitoring visits among the entire study sample. In addition, there appeared to be a negative impact on some knowledge outcomes (exclusive breastfeeding, iron sources and the overall knowledge indicator) due to the case management component. It is not clear why there may be these differences, however there is suggestive evidence the negative impact on exclusive breastfeeding originates from baseline differences between the cash only and case management-eligible sample. We conclude these negative impacts in the case management eligible sample may be due to spurious associations and interpret evidence as overall null impacts (as indicated by the pooled treatment effect). Because there are virtually no pooled intervention impacts, we do not present additional analysis by caregiver age.

Table 31. Impacts on Caregiver Health and Nutrition Knowledge

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
Correctly identifies . . .	(1)	(2)	(3)	(4)	(5)
Sum of knowledge questions (0-5)	0.08	0.16**	-0.28***	4.29	3342
	(0.07)	(0.07)	(0.09)		
Baby should be breastfed immediately after birth	0.01	0.01	-0.03	0.83	3342
	(0.02)	(0.02)	(0.03)		
Baby should be exclusively breastfed for 6 months	-0.01	0.02	-0.12***	0.80	3342
	(0.03)	(0.03)	(0.04)		
At least one reason for exclusive breastfeeding	0.03	0.03	-0.02	0.89	3342
	(0.02)	(0.03)	(0.03)		
At least one reason iron is important for babies	0.01	0.03	-0.04	0.92	3342
	(0.02)	(0.03)	(0.03)		
At least one source of iron	0.05*	0.07***	-0.08**	0.85	3342
	(0.03)	(0.03)	(0.03)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors using the panel sample. Column (1) presents impact estimates from a model with 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), 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 < .1. ** p < .05. *** p < .01.

174. The second domain assessed for caregivers was psychosocial wellbeing and social support. To measure mental health, we used the Centre for Epidemiologic Studies Depression (CES-D) short form. The short form is based on 10 questions (reduced from a longer 20-question scale) and has been validated internationally and shown to have high internal consistency and reliability, including in studies from sub-Saharan Africa (Kilburn et al., 2018). The 10 questions refer to how the caregiver was feeling and behaving in the last week (7 days) prior to the survey and are answered on a 4-point Likert scale. Examples of these questions are as follows: '*Did you feel hopeful about the future*' or '*Did you feel depressed*'. To calculate the mental health scale, we summed the answers for the 10 questions to create a scale ranging from 0 to 30 in which higher scores reflected greater depressive symptoms. Following previous literature, we also constructed a binary indicator indicating whether the caregiver scored above a validated threshold for depressive symptoms (CES-D ≥ 10). Cronbach's alpha, a measure of internal consistency, for the CES-D in the sample was 0.75 at baseline and 0.81 at endline, indicating good internal consistency (where the rule of thumb was > 0.70).

175. In addition to mental health, we included measures of perceived stress and social support. Poverty-related stress can be a negative influence on individuals' lives, affecting their ability to cope with difficult situations, and is generally linked to negative outcomes for women and children, including risk of household conflict and violence. Inflammation, the biological reaction induced by chronic and acute stress, has been linked to numerous health outcomes, including morbidities and mortality (see Hjelm et al., 2017, for a review of relevant literature). Social support is a key determinant of mental and physical health, providing individuals with the emotional and instrumental resources to cope with stress and negative events in life. Stress was measured through the Cohen Perceived Stress Scale, which asks caregivers about difficulties, anxieties, and control issues within the last month (last 4 weeks) (Cohen et al., 1983). Examples of these questions are as follows: '*How often have you found that you cannot cope with what you had to do*' or '*How often have you felt that you were unable to control the important things in your life*'. Responses are given on a 5-point Likert scale and summed to create a stress scale ranging from 0 to 40, in which higher measures indicate more perceived stress. To measure social support, we used a shortened and adapted eight-question version of the Medical Outcomes Study Social Support Survey, originally developed to measure functional support among patients with chronic conditions (Sherbourne & Stewart, 1991). Examples of these questions are as follows: '*If you needed it, how often is someone available to turn to for suggestions about how to deal with a personal problem*' or '*to help with daily chores if you were sick*'. Responses were given on a 5-point Likert scale and aggregated into an index using principal component analysis. The social support measure has been validated and adapted in multiple settings and has shown good internal consistency. Cronbach's alpha for the perceived stress scale and the support scale were 0.76 and 0.89, respectively (at both baseline and endline), indicating good internal consistency in the caregiver sample.

176. In addition to the formal validated scales, we included two simple measures of self-assessed happiness and life satisfaction. The first measure asked caregivers to rate their level of 'happiness' (best vs. worst possible life) on a ladder ranging from 1 to 10. The second

measure asked how often in the last 12 months before the survey the caregiver had been satisfied with life and classified high satisfaction as answers including 'most' or 'all' of the time.

177. Table A.8.2 presents baseline balance and attrition statistics across the key outcomes in this domain, generally showing good balance with statistically significant differences in two outcomes (social support and self-assessed happiness). The magnitude of these differences was below the meaningful threshold; however, one outcome (life satisfaction) showed a significant difference (0.36 at the $p < .01$ level) indicating comparison attritors were worse off. Of note is the high baseline score on the CES-D of 12.42, which equates to 74% of caregivers showing depressive symptoms. This is extremely high compared with the prevalence of depressive symptoms recorded in other Transfer Project evaluations in countries including Kenya, Malawi, Tanzania, Zambia, and Zimbabwe (Kilburn et al., 2018).[25] The caregiver mean score on the Cohen Perceived Stress Scale at baseline was 18.85. Although there are no conventionally used cut-off points for the Cohen, rates were largely in line with those found in the Ghana LEAP 1000, which included a sample of pregnant or recently pregnant women, with levels of 21.8 in the baseline treatment sample (LEAP 1000 Evaluation Team, 2018).[26] The average ranking on self-assessed happiness was 4.91 (approximately the ladder mid-point), and approximately 29% of women reported they were satisfied with life most or all of the time.

178. Table 32 shows impacts on the six caregiver psychological wellbeing outcomes. The pooled treatment results in an improvement of one point on the CES-D scale and a 7 pp decrease in depressive symptoms (or an 11% decrease over the endline comparison mean). There were also significant decreases in perceived stress, although these were small in magnitude (-0.84 or a 5% decrease over the endline comparison mean), and a significant increase in self-assessed happiness (0.80 or a 16% increase over the endline comparison mean). Across all indicators, these pooled impacts appeared to be primarily driven by the cash component. The exception is for life satisfaction, where there was a statistically significant differential additional impact of 13 pp among the case management-eligible sample (or a 37% increase over endline comparison means).

Table 32. Impacts on Caregiver Psychological Wellbeing and Social Support

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
CES-D scale (0-30)	-1.05***	-0.98***	-0.25	11.25	3342
	(0.29)	(0.31)	(0.37)		
Depressive symptoms (CES-D ≥ 10)	-0.07**	-0.06**	-0.03	0.63	3342
	(0.03)	(0.03)	(0.03)		
Cohen stress scale (0-40)	-0.84***	-0.69**	-0.54	17.84	3342
	(0.30)	(0.32)	(0.39)		
Perceived social support scale	-0.10	-0.12	0.08	0.10	3342
	(0.12)	(0.13)	(0.16)		

25 For example, Kilburn and colleagues (2018) use data from baselines in Transfer Project evaluations in five countries and find average CES-D scores (prevalence of depressive symptoms) as follows from highest to lowest: (1) Tanzania 14-28 years: 11.76 (64%), (2) Malawi 13-19 years: 9.95 (48%), (3) Zimbabwe 13-19 years: 8.73 (38%), (4) Kenya 15-25 years (37%), and (5) Zambia 13-17 years (33%). Notably, the sample in Tanzania, which includes a comparatively older aged sample, is most similar to the rates in this sample. In addition, women appear to have worse scores in Tanzania, suggesting that the prevalence among women may align closer with the current sample.

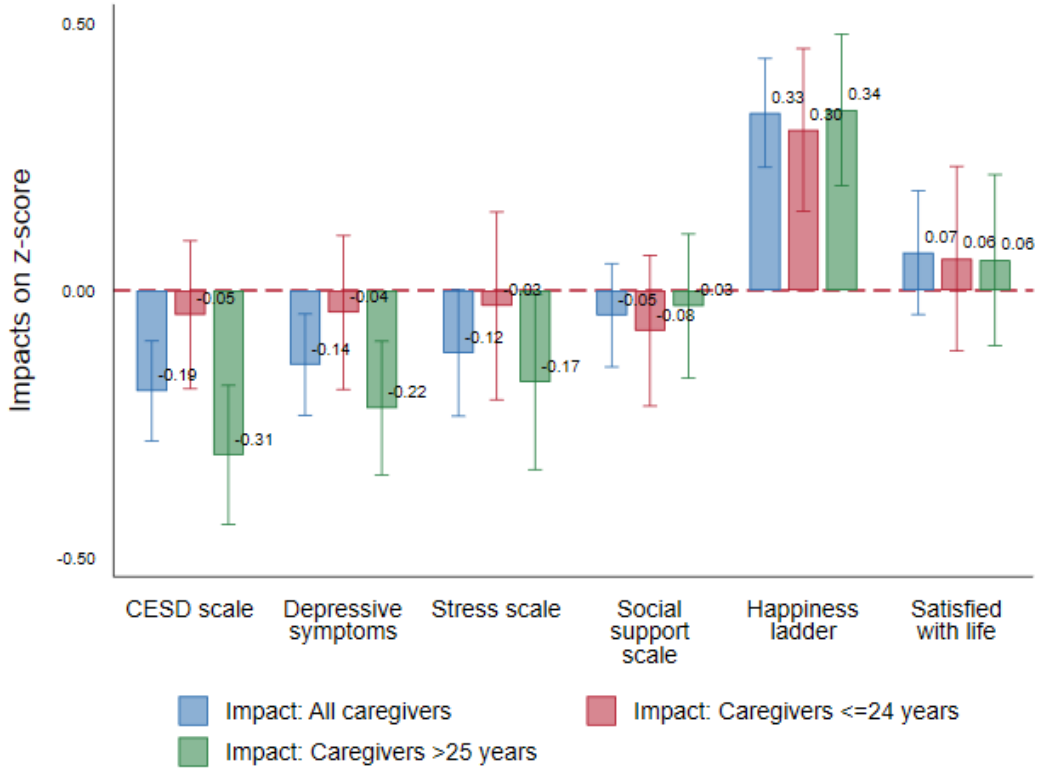
26 Note that the Ghana LEAP team did not normalize their indicators, so their mean was actually 31.8 and ranged from 10 to 50 (whereas we normalized ours to zero by subtracting 10). In addition, Hjelm and colleagues (2017) analysed the Cohen Perceived Stress Scale in two Transfer Project evaluations in Zambia; however, because they drop the four positively worded items, raw scores are not directly comparable to the 10-item version we analyse here.

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Self-assessed happiness (1-10, ladder)	0.80***	0.79***	0.04	4.89	3342
	(0.15)	(0.16)	(0.20)		
Satisfied with life (majority of time or always)	0.03	-0.00	0.13***	0.35	3342
	(0.03)	(0.04)	(0.04)		

Notes: CES-D = Centre for Epidemiologic Studies Depression scale; CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), 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 < .1. ** p < .05. *** p < .01.

179. Figure 11 shows the impacts of the pooled treatment by caregiver age. To facilitate comparison across outcomes in different units, outcomes are first converted into z-scores, standardizing each indicator in relation to the comparison group by wave. With one exception (impacts on happiness), where significant impacts were found in the pooled sample, they appear to be driven by the older sample. For the sample of caregivers who were youth, there were no significant impacts on the CES-D scale, depressive symptoms, or perceived stress.

Figure 11. Pooled Impacts on Caregiver Psychological Wellbeing and Social Support by Age of Caregiver



Notes: CES-D stands for Centre for Epidemiologic Studies Depression scale. 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=3,342), the sample of caregivers who are youth (N= 1,666) and older caregivers (N=1,676). 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.

180. The third domain is caregiver empowerment and freedom from violence. Table A.8.3 reports baseline balance and attrition for six caregiver status and empowerment outcomes, including financial standing (personal savings and household economic standing), self-assessed control over life, autonomy, decision-making power, and group participation. We first reported whether the woman herself currently was saving money.[27] We also included a self-assessed measure of household economic standing (subjective poverty) by asking the caregiver to rank her household on a 10-step ladder in comparison with other households in her community. We also presented a scale representing locus of control, which includes six questions regarding perceived choice and self-efficacy in everyday life. Examples of these questions are, in the last 12 months, how often did you feel that '*your life is determined by your own actions*' or '*you have the power to make important decisions that change the wellbeing of your children*'. Responses were given on a 5-point Likert scale and summed to create a locus-of-control scale ranging from 0 to 24. Internal consistency for the locus of control was high, with alpha values of 0.79 (baseline) and 0.82 (endline). Finally, we asked the caregiver to assess her overall decision-making power in her household and autonomy over choice and control in her life on a 10-step ladder, similar to that for subjective poverty. Finally, as a proxy for social capital, following the Women's Empowerment in Agriculture Index, we asked if the caregiver participated in nine different types of community groups (Alkire et al., 2013). These groups included productive groups (e.g., producer groups, credit, or savings groups) and other types of groups such as civic groups, religious groups, or local government. We constructed a binary indicator of whether the caregiver participated in at least one community group.

181. Baseline levels showed a very low percentage of women currently were saving money in cash (6%), and among those saving, the amount saved in the last 30 days was approximately 483 MZN (less than the monthly value of the transfer, not reported). Although rates of savings were low, they were comparable for women in Child Grant cash transfer evaluation baselines in Ghana (7%), but lower than found in Zambia (19%) (LEAP 1000 Evaluation Team, 2018; Natali et al., 2016). The average woman ranked herself on step 3.76 out of 10 in terms of subjective poverty, but the numbers were slightly higher for autonomy (5.00) and intra-household decision-making (4.79). Reported placement on autonomy and decision-making ladders were lower than in comparable samples of pregnant and recently pregnant women in the Ghana LEAP evaluation (endline comparison means of 5.6 on control over life and 5.5 on decision-making) (LEAP 1000 Evaluation Team, 2018). Finally, approximately one-quarter of caregivers participated in any community group. The most common groups were religious groups (15%); credit or micro-finance groups (10%); and agriculture, livestock, or fishery producer groups (3%) (not shown). Across the six indicators, four showed significant differences between the treatment and comparison groups, but none were of meaningful magnitude and none showed significant differences in the sample lost to follow-up.

182. Table 33 reports impacts for caregiver status and empowerment. There were pooled impacts on currently saving money (4 pp or 130% over the comparison endline mean), self-assessed autonomy (0.40 or 7% over the comparison endline mean), self-assessed decision-making (0.43 or 8% over the comparison endline mean) and self-assessed household economic standing (0.65 or 17% over the comparison endline mean). There were no impacts

27 At baseline, we also reported the amount in MZN she has saved in the 30 days before the survey; however, because of the low percentage saving any money, the sample was too small to analyse this indicator confidently (the number of total observations in this analysis would be only n=226). In the baseline report, we also presented the main reasons caregivers reported for saving money (for current savers, each woman was allowed to name up to three reasons). Overall, the main reasons were for medical or health expenses (34%), purchasing bulk food (26%) or other household consumables (22%), purchasing durable assets (18%) and emergency funds (16%). Relatively fewer caregivers reported saving for productive reasons, including starting a new business or purchasing agricultural inputs or tools.

on self-efficacy or on group participation from the pooled treatment. The majority of impacts appear to be driven by the cash arm of the intervention, with the exception of self-assessed household economic standing and group participation, where there was an additional impact among the case management-eligible sample (of 0.41 or 12% over the endline comparison mean for economic standing and of 8 pp or 20% over the endline comparison mean for group participation).

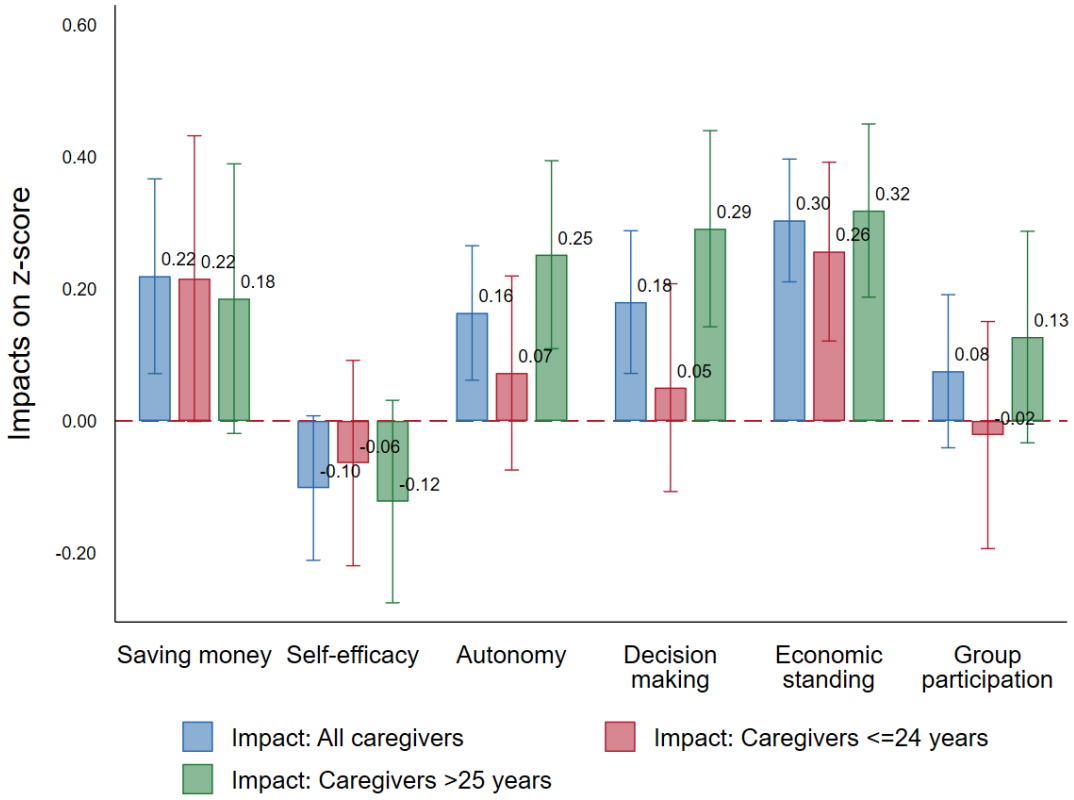
Table 33. Impacts on Caregiver Status and Empowerment

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Currently saving money	0.04**	0.04*	0.01	0.03	3342
	(0.02)	(0.02)	(0.02)		
Control over life and self-efficacy (0-24)	-0.41	-0.34	-0.24	13.28	3342
	(0.27)	(0.29)	(0.35)		
Self-assessed autonomy (1-10, ladder)	0.40***	0.48***	-0.27	5.95	3342
	(0.15)	(0.16)	(0.20)		
Self-assessed decision-making power (1-10, ladder)	0.43***	0.45***	-0.04	5.72	3342
	(0.15)	(0.16)	(0.20)		
Self-assessed household economic standing (1-10, ladder)	0.65***	0.53***	0.41**	3.49	3342
	(0.12)	(0.13)	(0.16)		
Participates in at least one community group	0.03	0.01	0.08**	0.41	3342
	(0.03)	(0.03)	(0.04)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), caregiver demographics (age, education, and marital status), 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. 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 < .1. ** p < .05. *** p < .01.

183. Figure 12 shows the impacts of the pooled treatment by caregiver age. Similar to the psychological wellbeing domain, to facilitate comparison across outcomes in different units, we first converted outcomes into z-scores, standardising each indicator in relation to the comparison group by wave. Similar to the previous domain, where significant impacts were found in the pooled sample, they appear to be driven by the older sample. The only exception was economic standing, where impacts accrued to both groups.

Figure 12. Pooled Impacts on Caregiver Status and Empowerment by Age of Caregiver



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=3,342), the sample of caregiver who are youth (N= 1,666) and older caregivers (N=1,676). 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.

184. A module on intra-household conflict and violence was administered to caregivers who had ever been partnered or lived with a man. Of the full sample of 3,342 caregiver observations, 82% were currently partnered or living with a man, and 13% had been partnered or living with a man in the past, resulting in a functional sample for the module of 3,058 observations. In addition, because of ethical considerations, the module was administered only when privacy could be obtained through the entire interview time (e.g., no interruptions). Privacy was obtained in 97% of the cases, resulting in a total possible sample size of 3,065.[28] Finally, because of ethical concerns, only caregivers 18 years old and older were asked direct questions about emotional and physical IPV. Therefore, the total possible sample size for the IPV indicators ranged up to 2,868, depending on if particular questions/indicators were answered or skipped by a particular woman. As detailed in earlier sections, as well as the inception report, numerous safeguards were put in place to mitigate against potential risk or harm experienced by women as a result of participating in the survey. These included

28 In addition, women were allowed to 'refuse' to answer any question in this module and skip to the next. The number of missing responses because of refusals was low; however, to maximize potential for disclosure, missing responses were handled as follows: When one question was skipped, but another question within a violence type was answered affirmatively, the type was coded as '1' and treated as non-missing. However, when one question was skipped and all other questions within a type were answered non-affirmatively, the type was treated as missing, as it is unclear whether the type should be coded as '1' or '0'. Because of this coding rule, the sample sizes for the IPV indicators across types vary slightly.

anonymised referral information given to every woman regardless of IPV disclosure, as well as options for direct referrals to social welfare services.

185. We first present indicators for IPV risk, in particular whether the partner had been drunk at least once in the last month. Partner alcohol use, particularly heavy episodic (binge) drinking, is consistently associated with IPV in cross-country studies (Heise & Fulu, 2014). Alcohol not only lowers inhibitions and impairs decision-making but also increases willingness to take risks, and conflict over drinking itself may be a trigger for arguments or violence. We also presented proxy measures for IPV by asking women if in the last 12 months they had been afraid of their partner (and, if so, how much of the time). Because IPV is known to be under-reported, and because proxies are more easily asked in short surveys (including triage for services), these questions can be informative if they are highly correlated with actual experiences of IPV.

186. In addition, we collected information on attitudes condoning IPV to understand the context and potential personal norms among women in the sample. We followed the items used in the *Inquérito de Indicadores de Imunização, Malária e HIV/SIDA* (IMASIDA) (2015), which ask women to reflect on whether a husband is 'justified' to beat his wife under five different scenarios. As summarized in the baseline report, approval of wife beating ranged from 15.7% (if she burns the food) to 28.1% (if she refuses to have sex with him) among women in the sample (AIR, 2020). Approximately 39% of women reported justifying IPV in at least one scenario. These attitudes are more accepting of IPV compared with findings in the national sample from the IMASIDA (2015), which show that women rarely justify individual IPV scenarios (ranging from 2% to 8% of the time) and overall justify IPV in at least one scenario 14% of the time.

187. For measures of IPV, we followed conventions and implemented a modified version of the Conflict Tactics Scale, recommended by the WHO and widely used by the DHS (Hindin et al., 2008). We aligned individual questions with those implemented in IMASIDA (2015), which were tested and validated nationwide in Mozambique. These questions ask about behaviourally specific instances in the last 12 months and include six questions representing controlling behaviours, three questions representing emotional IPV and seven questions representing physical IPV (with increased severity). Because of the sensitive nature of the measures, we did not collect information on sexual violence. This ultimately results in the inability to distinguish potential impacts on an important (and severe) type of IPV experienced by women—particularly as previous research has found impacts on combined measures including sexual IPV (Buller et al., 2018). Examples of indicators of controlling behaviours are whether the partner '*insisted on knowing where you were at all times*' or '*got angry if you spoke with another man*'. Examples of indicators of emotional IPV are whether the partner '*belittled or humiliated you in front of other people*' or '*insulted you or made you feel bad about yourself*'. Finally, examples of indicators of physical IPV are whether the partner '*punched you with his fist or an object that could hurt you*' or '*threatened or attacked you with a knife, gun or any other weapon*'. For lead indicators, we computed measures of past year (12 months) prevalence for each type of IPV, including an aggregated measure of emotional and/or physical IPV.

188. We first describe dynamics around women's partnerships from the baseline report. Using the full sample of women in partnerships, we showed women reported first marrying or cohabiting with partners on average at age 17.6 years and reported first becoming pregnant on average at age 18.1 years. This means approximately 50% of women can be classified as having been child brides (married before age 18 years). Baseline balance and attrition analysis (Table A.8.4) shows that alcohol use among partners was low (only 4% of all partners), likely because of the primarily Muslim study population. The percentage of women who were afraid

of their partners 'most of the time' was high at 28%. In total, 61% of women at baseline reported controlling behaviours, 15% reported emotional IPV, 14% reported physical IPV and 22% reported emotional and/or physical IPV. These percentages are approximately in line with the national statistics, which report an overall prevalence of 12% for emotional and 14% for physical IPV (controlling behaviours were not collected on a 12-month recall for the national survey) (Ministério da Saúde et al., 2015). Across the eight indicators, two showed significant differences between the treatment and comparison groups, and one showed evidence of differential attrition, but none were meaningfully different in magnitude.

189. Table 34 shows impacts on intra-household conflict and violence measures, indicating reductions in attitudes accepting IPV driven by the cash component (pooled impacts of a 0.26 decrease or 20% decrease over the endline comparison means in the number of instances supporting IPV, pooled impacts of an 8 pp decrease in at least one reason supporting IPV, or a 16% decrease over endline comparison mean). Although there were no impacts on partner heavy drinking episodes, reports of being fearful of the partner or controlling behaviours, there were strong reductions on core IPV outcomes ranging from 9 to 13 pp. There impacts indicated reductions of 38% (emotional IPV and any IPV) and 45% (physical IPV) over a 12-month period. Furthermore, there was an additional impact of the case management subcomponent on emotional IPV (11 pps), any IPV (10 pps) and fear of partner (10 pps). These impacts are in line with those reported by Buller and colleagues (2018), which shows that where reductions in IPV are found from cash transfers, they range from 11% to 66%, typically measured over 6- to 12-month recall periods.

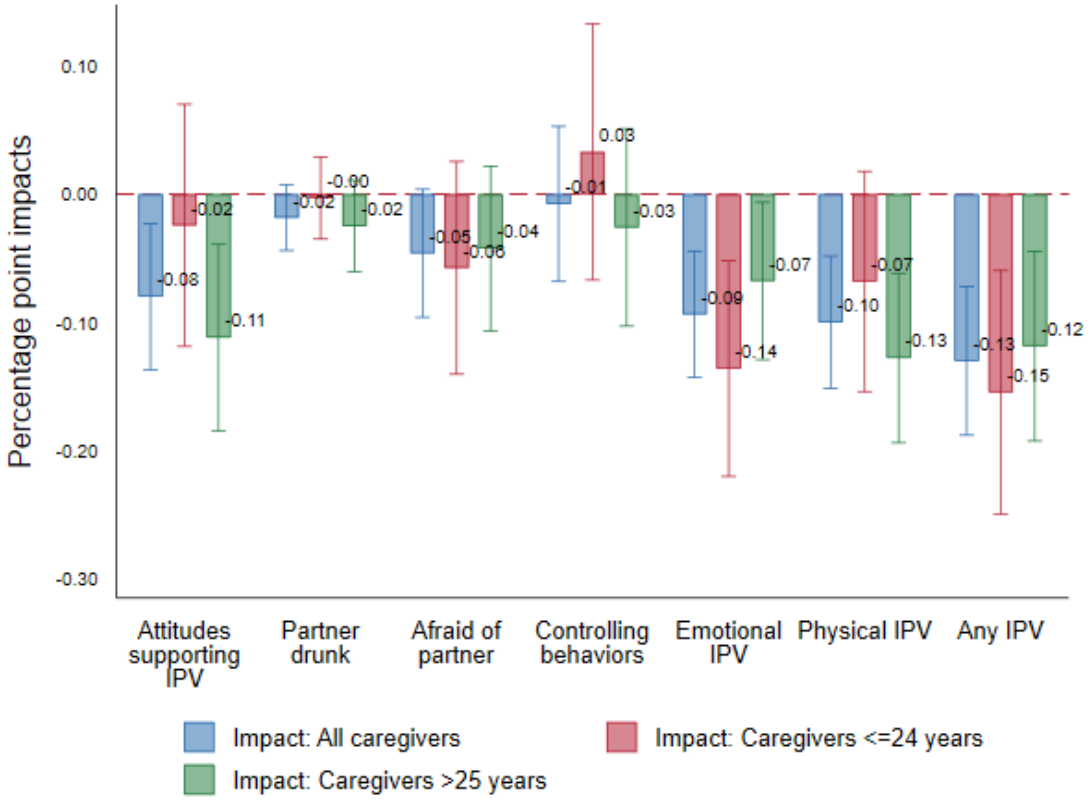
Table 34. Impacts on Caregiver Intra-Household Conflict and Intimate Partner Violence

Dependent Variable	Impact Estimates			Endline Mean	N
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	
	(1)	(2)	(3)	(4)	(5)
Attitudes accepting IPV (scale, 0-5)	-0.26**	-0.31**	0.20	1.29	2794
	(0.11)	(0.12)	(0.15)		
Attitudes accepting IPV: at least one reason	-0.08**	-0.09**	0.04	0.49	2794
	(0.03)	(0.04)	(0.05)		
Partner drunk at least once a month	-0.02	-0.01	-0.03	0.03	2856
	(0.01)	(0.02)	(0.02)		
Afraid of partner most of the time	-0.04	-0.01	-0.10***	0.23	2868
	(0.03)	(0.03)	(0.04)		
Controlling behaviours (12-month recall)	-0.01	0.02	-0.07	0.53	2818
	(0.04)	(0.04)	(0.05)		
Emotional IPV (12-month recall)	-0.09***	-0.06*	-0.11***	0.24	2851
	(0.03)	(0.03)	(0.04)		
Physical IPV (12-month recall)	-0.10***	-0.08**	-0.05	0.22	2817
	(0.03)	(0.03)	(0.04)		
Emotional and/or physical IPV (12-month recall)	-0.13***	-0.10***	-0.10**	0.34	2814
	(0.03)	(0.04)	(0.05)		

Notes: CM = case management. Sample includes only caregivers aged 18 and older who were ever partnered and able to be interviewed in private. Impacts are estimated using difference-in-differences with robust standard errors among the 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), caregiver demographics (age, education, and marital status), 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. 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 < .1. ** p < .05. *** p < .01.

190. Figure 13 shows the impacts of the pooled treatment by caregiver age, showing impacts across sub-groups were mixed. For outcomes of attitudes supporting IPV and physical IPV, impacts were driven by older women; however, for other outcomes, impacts appear to be driven by younger caregivers (including emotional and any IPV).

Figure 13. Pooled Impacts on Caregiver Intra-Household Conflict and Intimate Partner Violence by Age of Caregiver



Notes: Indicator of attitudes supporting IPV is defined as reporting at least one supporting reason. 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=2,868), the sample of caregivers who are youth (N= 1,150) and female-headed households (N=1,718). 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.

191. The last domains within the caregiver section are fertility and family separation. These domains are particularly of interest to policy makers who may fear that child grants may inadvertently increase pregnancies and overall fertility if women try to qualify or remain eligible for benefits. Past research in sub-Saharan Africa has demonstrated that there is little evidence supporting this dynamic, and in some cases cash transfers have actually reduced the likelihood of early pregnancy for female youth (Handa et al., 2018). However, it is important to show these analyses for Mozambique specifically. In addition, there is interest in understanding if the care component increases family reunification by reducing the number of biological children of caregivers who are living outside the home (due to, among others, economic concerns, and the inability to support children).

192. To examine these concerns, we present six outcomes. First, we examine an indicator of if the caregiver is currently pregnant or has been pregnant in the past 24 months (since baseline). Second, we examine the caregiver's total completed fertility, or the number of

children ever born. Next, we report on fertility intentions of the target woman through a question which asks her ideally how many *additional* children she would like to have. Lastly, we report on proxy measures for child separation: (*a*) the number of biological children under 18 years living outside the household, and (*b*) an indicator for any children under 18 living outside the household. Because of the unique sample of women who had just given birth at baseline, we analysed these outcomes with cross-sectional analysis at endline.[29] Thus, we do not present baseline balance or attrition tables for these outcomes.

193. Table 35 shows impacts indicating a reduction of 9 pp (22% reduction over endline comparison mean of 41%) in current or recent pregnancies. These impacts accrue primarily due to the cash component. There are no other overall or additional effects of the intervention on total fertility rates, contraceptive use, or fertility ideals, with total completed fertility of 4.03 in the endline comparison group, 31% of the endline comparison group currently using a long-term contraceptive and women in the comparison group desiring an additional 1.86 children on average. Although there is no overall impact on family separation, there is an additional reduction in the number of children living outside the home because of the case management subcomponent of 0.27 (or a 34% reduction over an average endline comparison mean of 0.82 children). This translates into a reduction of any child living outside the household of 8 pp (or a 29% reduction over the endline comparison mean of 31%). The favourable impacts on child separation are not entirely unexpected, as at baseline the majority (63%) of caregivers with any children living outside the home (n=363) reported that the primary reason was economic (AIR, 2020).[30] Pooled impacts are very similar by caregiver age, and thus are not reported.

Table 35. Impacts on Caregiver Fertility and Family Separation

Dependent Variable	Impact Estimates			Endline Mean	
	SD Pooled Treatments	SD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Currently pregnant or pregnant in the last 24 months	-0.09***	-0.09***	-0.02	0.41	1624
	(0.03)	(0.03)	(0.04)		
Total fertility rate (children ever born)	-0.13	-0.12	-0.08	4.03	1627
	(0.09)	(0.10)	(0.14)		
Currently using long-term contraception	0.04	0.03	0.05	0.34	1627
	(0.03)	(0.03)	(0.04)		
Ideal number of additional children	-0.02	0.02	-0.07	1.86	1627
	(0.10)	(0.11)	(0.15)		
Any biological child < 18 years lives outside the home	0.01	0.03	-0.08**	0.31	1627
	(0.03)	(0.03)	(0.04)		
Number of biological children < 18 years living outside the home	0.00	0.09	-0.28**	0.82	1627
	(0.07)	(0.08)	(0.11)		

Notes: CM = case management. Impacts are estimated using single differences with robust standard errors among the 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), 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 < .1. ** p < .05. *** p < .01.

29 This is because there is virtually no variation in pregnancies and births at baseline, and outcomes like contraceptive use may be skewed because of postpartum infertility (due to lactational amenorrhea when women are breast-feeding and not menstruating).

30 Additional reasons given were for education (33%), because the child was already married or had a family of their own (10%) and other reasons (10%). Note that in the case a caregiver had more than one child living outside the home, they could give one primary reason per child.

194. Although these results are encouraging, indicating that the intervention was helping families reunite and reduce pregnancies and fertility of the primary caregiver in the short term, it is also useful to understand behaviours and outcomes more broadly among women of reproductive ages. We replicate findings among all women 10 to 49 years old living in sample households, increasing the sample size by approximately 1,000 women (not shown). For this broader sample, we did not collect data on contraceptive use or ideal fertility. Results were consistent with those for the primary caregiver, whereby the intervention reduced current or recent pregnancies by 6 pp (21% over the endline comparison mean of 29%), driven by the cash component. In addition, the case management component reduced the number of children and the occurrence of any children outside the home. The primary difference was the lack of impact on total fertility rates, which may in part be due to the overall lower age of this sample.

9 OLDER CHILDREN

195. In this section we present evidence on the impact of the intervention on older children (primarily those aged 3 to 17 years) along four main domains: (*a*) material well-being, (*b*) schooling, (*c*) time allocation, including on school and work (both productive and care work) and (*d*) violence against children, including assessment of initiation rites among female children.

196. Although the intervention targets young children (aged 0-6 months), the unconditional nature of the grant and the logic framework suggests a range of potential effects on all children living in the recipient household. These effects are largely expected to be positive (beneficial), however there is also some potential for adverse effects, specifically around time use (i.e., if households engage in additional productive work relying on contributions by children) or if there are tradeoffs made between investments in younger versus older children. There were total of 3,164 children aged 3 to 17 years in the sample at baseline, and 4,264 children aged 3 to 17 at endline for a combined possible total sample size of 7,428. Generally, the largest group is made of children of primary school ages, or 6 to 11 years (comprising nearly half the sample in across survey waves). All estimates in this section are disaggregated by child's age and gender. We highlight the most relevant results as part of the main narrative, however full sub-sample results for each group can be found in Annex B.

9.1 Material Well-being

197. In addition to measures of deprivation presented at the household-level, we examine the impact on child's material well-being, including the ownership of a pair of shoes or sandals, a change of clothes, a blanket and reported use of a mosquito net for sleeping. These are the most commonly used indicators of child's material needs in low-income settings, recommended by the United National General Assembly Special Session (UNGASS) on monitoring and evaluation of orphans and other vulnerable children (UNICEF, 2005). Following the UNGASS guidance, we also create an indicator of combined material needs, as an indicator of owning all three items: shoes or sandals, a change of clothes and a blanket.

198. At baseline, children's clothing is the most 'met need'. Approximately 85% of children in both treatment and comparison groups had a change of clothes (Table A.9.1.1). Meanwhile owning a pair of shoes or sandals is the least met need (45%), followed by owning a blanket (49%). Table A9.1.1 shows the baseline balance and attrition analysis across these four indicators as well as the combined indicator, owning all three items. The sample was well-balanced at the baseline, with only one outcome (shoes) showing significant differences (but smaller than the SM difference rule of thumb magnitude of 0.25). In addition, the two indicators show evidence of differential attrition at high levels. For shoe ownership, this

magnitude is 0.35, and for the combined indicator, the magnitude is 0.28, thus impacts should be interpreted with caution.

199. Table 36 shows the intervention impacts on the aggregate indicator of material well-being for the full sample of children, and for the constituent items. For the full sample, the intervention increases the coverage of material well-being by 21 pp, or a 58% increase over the endline comparison mean. The magnitude of these average impacts for all three needs are twice as large compared to those observed in Ghana for ownership of shoes and an extra pair of clothing (LEAP 1000 Impact Evaluation Team, 2018), but somewhat smaller to those that were observed in Zambia (AIR, 2016) and Malawi, both for a combined indicator of having all three items (CPC 2016). Impacts also show strong and statistically significant effects of the intervention on the proportion of children in possession of a pair of shoes or sandals (17 pps) as well as for having a blanket (17 pps). The impact of sleeping under a mosquito net is positive but smaller at about 13 pps. Lack of impact on clothing could be due to the high levels across both groups (at the endline 96% of the treatment and 94% in the comparison group report owning a change of clothing). Across all samples, these impacts appear to accrue based on the cash transfer component, rather than the case management component, which is consistent with the strong hypothesized link to economic security. For only one item (slept under a mosquito net), there is an additional beneficial impact of the case management component (7 pp) over the cash alone).

Table 36. Impacts on Material Well-Being Among Children aged 3 to 17

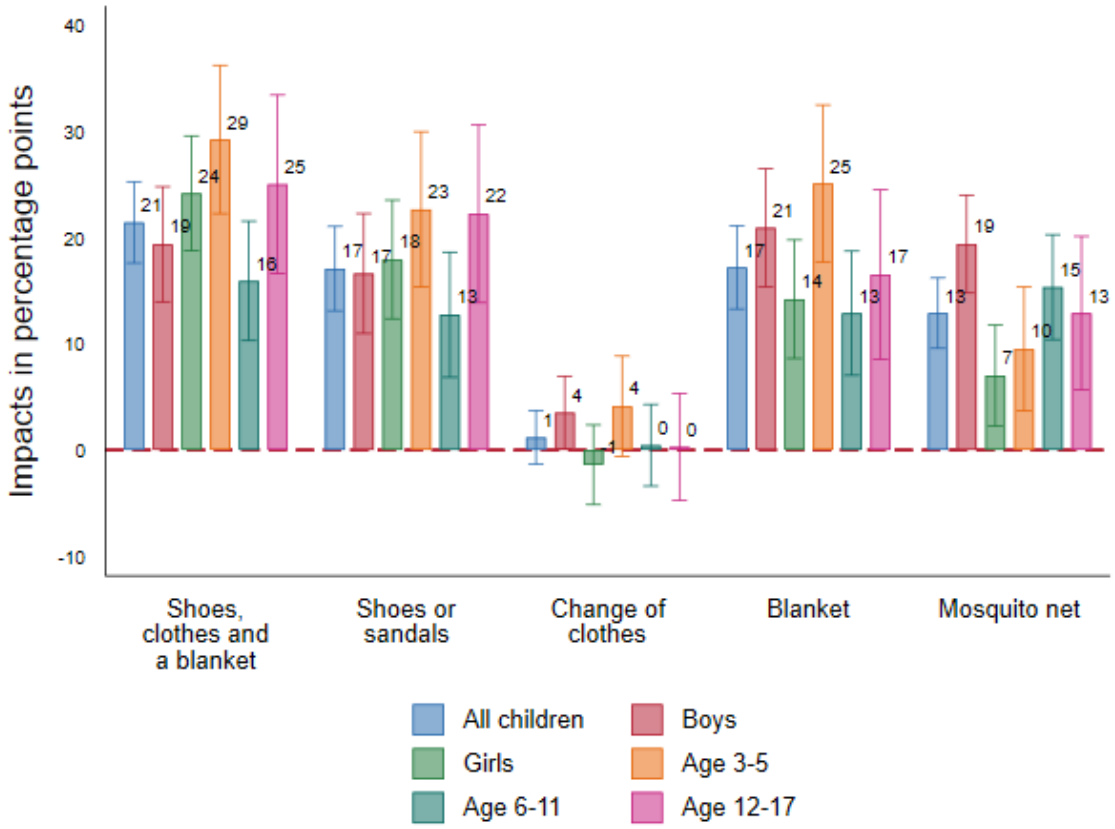
Dependent Variable	Impact Estimates			Endline Mean	N
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	
	(1)	(2)	(3)	(4)	(5)
Has shoes, clothes and a blanket	0.21***	0.22***	-0.01	0.36	6822
	(0.02)	(0.03)	(0.03)		
Has a pair of shoes or sandals	0.17***	0.17***	-0.01	0.45	6826
	(0.02)	(0.03)	(0.03)		
Has a change of clothes	0.01	0.01	0.00	0.94	6830
	(0.01)	(0.02)	(0.02)		
Has a blanket	0.17***	0.19***	-0.05*	0.65	6828
	(0.02)	(0.02)	(0.03)		
Slept under a mosquito net last night	0.13***	0.11***	0.07***	0.80	6821
	(0.02)	(0.02)	(0.03)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among children in the household panel sample. Column (1) presents impact estimates from a model with the treatment groups combined. Columns (2) and (3) presents impact estimates from a model with an additional interaction term for households who were 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 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), 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, 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. * $p < .1$. ** $p < .05$. *** $p < .01$.

200. Figure 14 illustrates the pooled intervention impacts on the material possessions indicator and separate items across sub-groups. The disaggregated analysis on the combined index by gender and age group shows that the effects are the highest for young children (aged 3 to 5), as well as those aged 12 to 17 (about 29 pps and 25 pps, respectively). These age groups also show the largest impacts on the individual indicators of having shoes and a blanket. Notably, impacts for sleeping under mosquito nets and access to the blanket appear to be larger in magnitude among boys as compared to girls. No major gender differences are

observed in other indicators. For more details on these estimations by gender and age group, see Table B9.1.1.

Figure 14. Pooled Impacts on Child Material Well-Being by Gender and Age



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 estimating the impact of the pooled treatment—using the full sample (N=6,822), girls only (N=3,495), boys only (N=3,327) and age groups (ages 3-5, N=1,923, 6-11, N=3,253; ages 12-17, N=1,646). 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, and an index for COVID-19 disruption in community from follow-up.

9.2 Schooling

201. The year proceeding the endline data collection was unprecedented for school-aged children across Mozambique. Following a trend in many African countries, the government closed all primary and secondary schools on March 23rd, 2020 due to the COVID-19 pandemic. The endline data collection took place only weeks after schools official reopening on the 22nd of March 2021 after a year-long school closure. According to UNESCO assessment, Mozambique children missed 471 days of schooling. This is similar to other countries in the region. The severe disruption of learning was hardly compensated by the distance learning organized by district educational authorities under the guidance of the MINEDH. According to a telephone-based national survey taken in September 2020, only one in five primary school students had communicated with the teacher during the week prior to interview (UNICEF Mozambique 2021c). Many caregivers named the lack of support from teachers and the school as a major factor preventing child's distant learning. The northern provinces, including Nampula, generally did worse than those in the Center and South.

202. Driven by the evidence from many African countries on the positive effects of unconditional child grant transfers on schooling decisions (Davis, et al 2016), we examine

impacts on education outcomes operationalized through six indicators at the child-level: (*a*) ever attended school; (*b*) currently attending school; (*c*) current grade (*d*) school participation (or number of days attended in the last week) and (*e*) educational expenditure in the last 12-months (including those on enrollment fees, books and other school supplies, uniforms and sports clothing, transport to school). For the latter three indicators, the sample is restricted to the sample of children who report currently attending.

203. Three quarters of the total sample of children aged 6 to 17 (75%) ever attended school at the baseline – a proxi of school enrollment. A similar proportion (70%) reported ever attending school at the time of the endline survey with no difference between comparison and treatment groups (Table A9.2.1). Across the five indicators, three showed statistically significant differential attrition, with all but only two (current grade and expenditures) exceed the accepted threshold of SM 0.25. Although we account for the differences by controlling for a range of individual child, caregiver, and household characteristics in the model, impacts on these outcomes should be interpreted with caution.

204. Table 37 shows impact on main education outcomes for all school-aged children (aged 6 to 17). Despite COVID-19 challenging the educational context, we do not see any dramatic withdrawal of children from schooling in either group. Results show a 5 pps increase in the probability of ever attending school (or 8% over the endline comparison group mean) due to the intervention, which are primarily attributable to cash component of the intervention. In addition, children in the treatment group are also 5 pps more likely to currently attend school (or 8% over the endline comparison mean), but the effect is marginally significant. The magnitude of the impact is in line with findings for the same indicator in Tanzania for children aged 4 to 16 years old (PSSN Youth Evaluation Team, 2018).

205. In contrast to these findings, we observe a decline of 0.32 days in the probability of school attendance in the last full week of school. The observed effect is primarily driven by the additional impact of case management component of the intervention and significant only among girls. Comparison of the baseline and endline data suggests a major overall shift from full time to part time attendance pattern due to the supply side constraint (limited students' numbers through introduced safety measures in schools. At the baseline, on average 82% of children aged 6-11 and 86% of children aged 12-17 attended the school 5 days a week (out of those who currently attended) compared to roughly 10% at the endline (in both groups). Since reopening in March 2021, most schools followed the guidance of district educational authorities admitting students on a rotational basis (two-three times per week) to keep class numbers low and prevent the spread of COVID-19. Each school established their own routine based on the school size and specific community conditions. At endeline, the largest proportion of children in the pooled sample attended the school two or three days per week (17% of 6–11-year-olds and 29% of 12–17-year-olds).

206. Change between the treatment and comparison groups are relatively small and more nuanced in comparison to the overall scale of changes in both groups due to COVID-19 school conditions.[31] The observed differences are likely to be related to school-based factors in specific communities. For example, a higher proportion of children in Nacala-a-Velha report not going to school at all (0 days)—this effect may be driven by school closures in certain care communities. Additional tests with controls for enumerators effects seem to confirm this explanation given each enumerator was covering a designated community/settlement area. Moreover, this sample pattern is observed for school expenditures, whereby the case management component is linked to lower spending. Further investigation by expenditure

31 Robustness check considering bias introduced by the enumerators has been investigated. As the enumerators are aligned with communities, including enumerator fixed effects at endline removes any significance in the pooled treatment group statistics on this indicator. The lack of school-based data limits further investigation.

components shows that this effect is driven by school fees, suggesting perhaps children in the same communities where attendance is zero, may not have initiated payments for school fees.

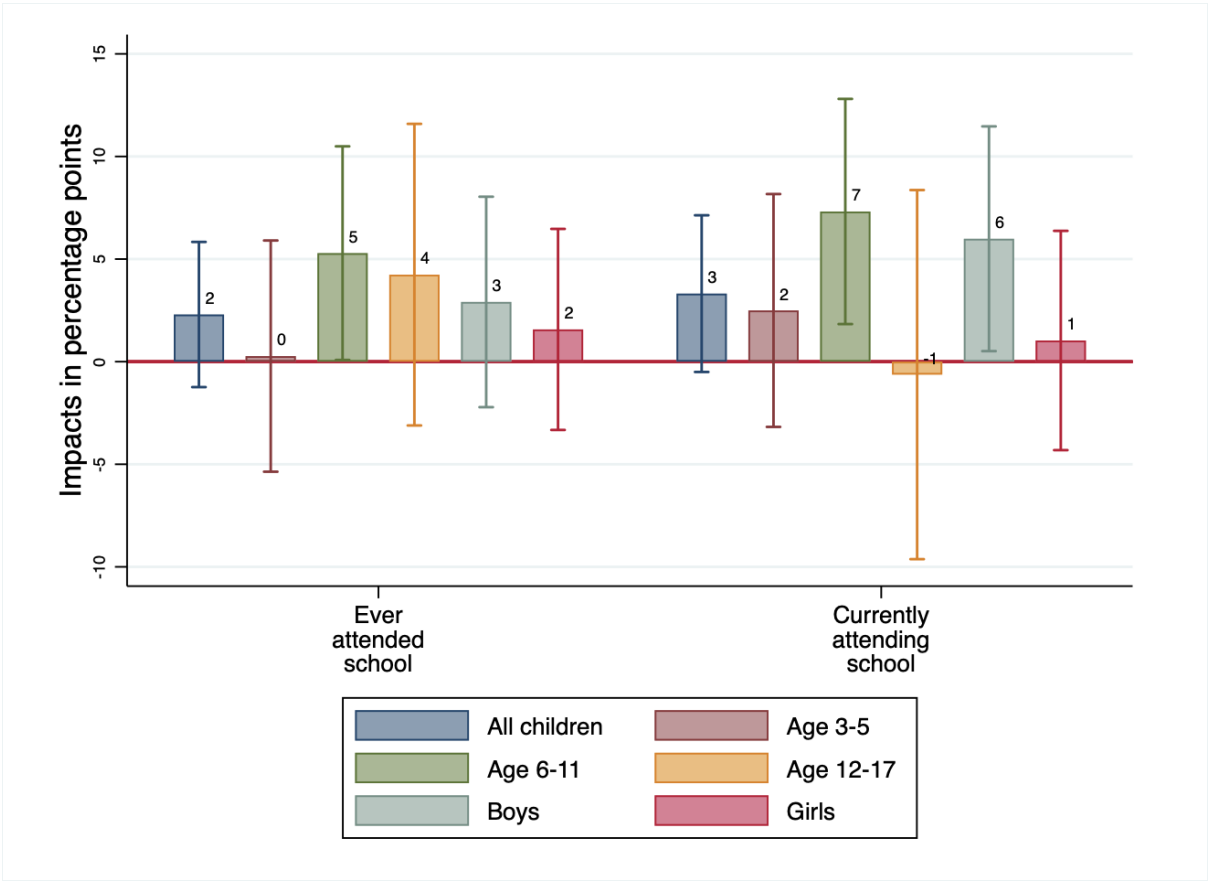
Table 37. Impacts on Educational Outcomes for Children Aged 6 to 17

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Has ever attended school	0.05**	0.07**	-0.05	0.62	4872
	(0.03)	(0.03)	(0.04)		
Currently attending school	0.05*	0.07**	-0.05	0.64	4466
	(0.03)	(0.03)	(0.04)		
Current grade	0.04	0.08	-0.16	4.24	3079
	(0.11)	(0.12)	(0.14)		
Number of days in school (last full week of school)	-0.32***	-0.04	-0.96***	2.00	3082
	(0.11)	(0.11)	(0.14)		
Spending on schooling (12-months)	-5.41	11.12	-59.25**	153.86	3082
	(21.17)	(22.53)	(27.38)		
School enrollment fees (12 months)	-11.00*	-5.68	-18.77**	8.80	3082
	(5.70)	(6.06)	(7.37)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among children in the household panel sample. Column (1) presents impact estimates from a model with the treatment groups combined. Columns (2) and (3) presents impact estimates from a model with an additional interaction term for households who were 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 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), 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, 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. * $p < .1$. ** $p < .05$. *** $p < .01$.

207. Figure 15 shows impacts by gender and age for ever attending and currently attending school. Results show impacts are driven by boys and the 6-to-11-year age group (the age groups more sensitive to new school entry). Although we do see an additional 10 pp impact of the case management component among girls (not presented here), it does not translate into pooled effects.

Figure 15. Pooled Impacts on Ever Attended School and Currently Attending by Gender and Age



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 estimating the impact of the pooled treatment. 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, and an index for COVID-19 disruption in community from follow-up.

9.3 Time Use

208. Evidence shows that the effects of cash grants on child labour and schooling decisions are complex and interlinked with family investments in productive assets and microenterprise resulting from cash grants support (de Hoop et al, 2020). Understanding effects in children's time use complements the evidence presented in the previous section on educational outcomes and provides a more comprehensive picture of child schooling versus work. In this section we present results on child's time allocation related to *(a)* schooling, *(b)* productive activities, *(c)* paid and unpaid work and *(d)* household chores. We measure these domains through a set of 13 standard time use indicators capturing specific activities with the reference period of the last 24 hours (collecting water, collecting firewood, taking care of family members and domestic tasks), and the last week (farm activities, helping in non-agricultural business, caring for livestock or poultry, fishing activities). The latter captures activities that might not happen every day. In addition, the endline survey collected data on three indicators capturing the frequency of child's engagement in productive activities outside household during the past rainy season. All results are based on data from the household questionnaire, in which the main caregiver is asked to provide education and labour information about all household members.

209. Table A.9.3 shows baseline balance and attrition analysis. Children aged 5 to 17 in the pooled sample spent, on average, 2.7 hours daily on household chores and activities such as

collecting water, firewood, taking care of family members and other domestic tasks. This is substantially more than 1.7 hours spent for the formal education. In addition, the pooled sample shows a total of 1.5 hours spent in the last week on productive activities for pay or as a part of the family business (farm activities, non-agricultural business, caring for livestock or poultry, and fishing activities). Across the 16 indicators of this domain, 11 show baseline differences across the panel sample, which are well below the recommended minimum threshold of SM 0.25. We also observe the differential attrition on eight indicators including six exceeding the minimum threshold levels (taking care of family members: 0.26, schooling: 0.49, studying at home: 0.27, days in land preparation: 0.37 and non-harvest work: 0.40 and days in harvesting: 0.27). While we control for differences with a set of household, community and individual level indicators, results on these indicators should be taken with caution.

210. Table 38 presents impacts on a set of time use indicators for a pooled sample of children aged 5 to 17. Given the COVID-19 context it is not surprising to see a reduction in time allocated to school related activities across comparison and treatment groups. We find that children in treatment households spent on average 0.31 fewer hours in formal education and 0.48 fewer hours in all activities related to schooling (including commute to school and homework). Although the comparison and treatment groups spend almost equal time on schooling at the endline (0.59 and 0.64 respectively), the treatment group had higher mean allocation at the baseline implying a disproportionately large reduction (70 minutes compared to 52 minutes in the comparison group). The results support the findings discussed earlier, regarding the negative impact on the number of days in school but should be taken with great caution given the differential attrition mentioned earlier. It is possible that more school motivated children left the sample, affecting the estimate.

211. Cash transfers were found to increase children's time allocation on household chores in Malawi and Zambia (de Hoop et al. 2020). In Mozambique the intervention demonstrates small but statistically significant reductions in the average time spent by children on household chores - 0.27 fewer hours (-12%) across difference activities including collecting firewood, taking care of family members, and other domestic tasks. The differences are driven primarily by the cash component. On aggregate, children are reported to spend about one hour and a half per day on those activities. There is also little change between baseline and endline means on domestic tasks and time spent collecting firewood, suggesting that these are household tasks that are relatively stable or less sensitive to changes in time availability (e.g., more time due to reduced school hours during COVID-19).

212. The largest impact observed across the pooled sample of children relates to children's time allocation on productive activities. On aggregate, children in treatment households spent on average 0.96 fewer hours (-40%) on all such activities with biggest reductions observed in farm activities (0.58 fewer hours) and fishing (0.28 fewer hours) Hours on farming activities increased substantially for both groups between the baseline and endline, likely to absorb some time freed from formal schooling. However, the increase for children in treatment households was much smaller (38 minutes) compared to the comparison group (70 minutes). This impact on productive activity primarily accrues through the cash component of the intervention. Observed reductions in days children spend in harvesting and land preparation in the past rainy season seem to support this finding. However, only in harvesting, which demonstrates 0.81 fewer allocated days, the effect is significant for pooled effects driven by the cash arm. In land preparation and non-harvest work, an additional impact of case management is observed (a reduction of 1.2 days and 1.5 days respectively) but not in the pooled sample.

Table 38. Impacts on Time Use of Children Aged 5 to 17

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
Hours (last 24 hours)	(1)	(2)	(3)	(4)	(5)
All domestic work and care (the last 24h)	-0.27**	-0.22*	-0.10	2.30	5773
	(0.12)	(0.13)	(0.16)		
All productive activities (the last week)	-0.96***	-0.89***	-0.35	2.37	5773
	(0.25)	(0.25)	(0.33)		
All school related activities (the last 24 h)	-0.48***	-0.37**	-0.37	1.35	5773
	(0.17)	(0.18)	(0.23)		
Schooling	-0.31***	-0.25**	-0.20*	0.59	5773
	(0.10)	(0.10)	(0.13)		
Commuting to school	-0.08	-0.03	-0.18	0.59	5773
	(0.10)	(0.10)	(0.13)		
Studying at home	-0.09**	-0.08*	-0.00	0.18	5773
	(0.04)	(0.04)	(0.05)		
Collecting water	0.03	0.05	-0.04	0.67	5773
	(0.05)	(0.05)	(0.06)		
Collecting firewood	-0.11***	-0.08	-0.08	0.42	5773
	(0.04)	(0.05)	(0.06)		
Other domestic tasks	-0.10**	-0.09	-0.06	0.92	5773
	(0.06)	(0.06)	(0.08)		
Taking care of family members	-0.09*	-0.09*	-0.04	0.33	5773
	(0.05)	(0.06)	(0.07)		
Sleeping	-1.46***	-1.75***	1.10***	9.15	5773
	(0.15)	(0.16)	(0.20)		
Hours (last week)					
Farm activities	-0.58***	-0.52**	-0.26	1.89	5773
	(0.19)	(0.21)	(0.26)		
Helping in non-agricultural business	-0.11***	-0.09**	-0.08	0.08	5773
	(0.04)	(0.05)	(0.06)		
Caring for livestock or poultry	0.01	0.02	-0.03	0.03	5773
	(0.02)	(0.03)	(0.03)		
Paid work	0.01	0.03	-0.09	0.07	5773
	(0.06)	(0.06)	(0.09)		
Fishing activities	-0.29***	-0.29***	0.01	0.30	5773
	(0.07)	(0.08)	(0.10)		
Days (last rainy season)					
Land preparation	-0.46	0.14	-1.15**	3.66	5773
	(0.37)	(0.40)	(0.49)		
Non-harvest work	0.09	0.33	-1.50***	2.47	5773
	(0.32)	(0.34)	(0.43)		
Harvesting	-0.81***	-0.67**	-0.58	3.05	5773
	(0.27)	(0.29)	(0.36)		

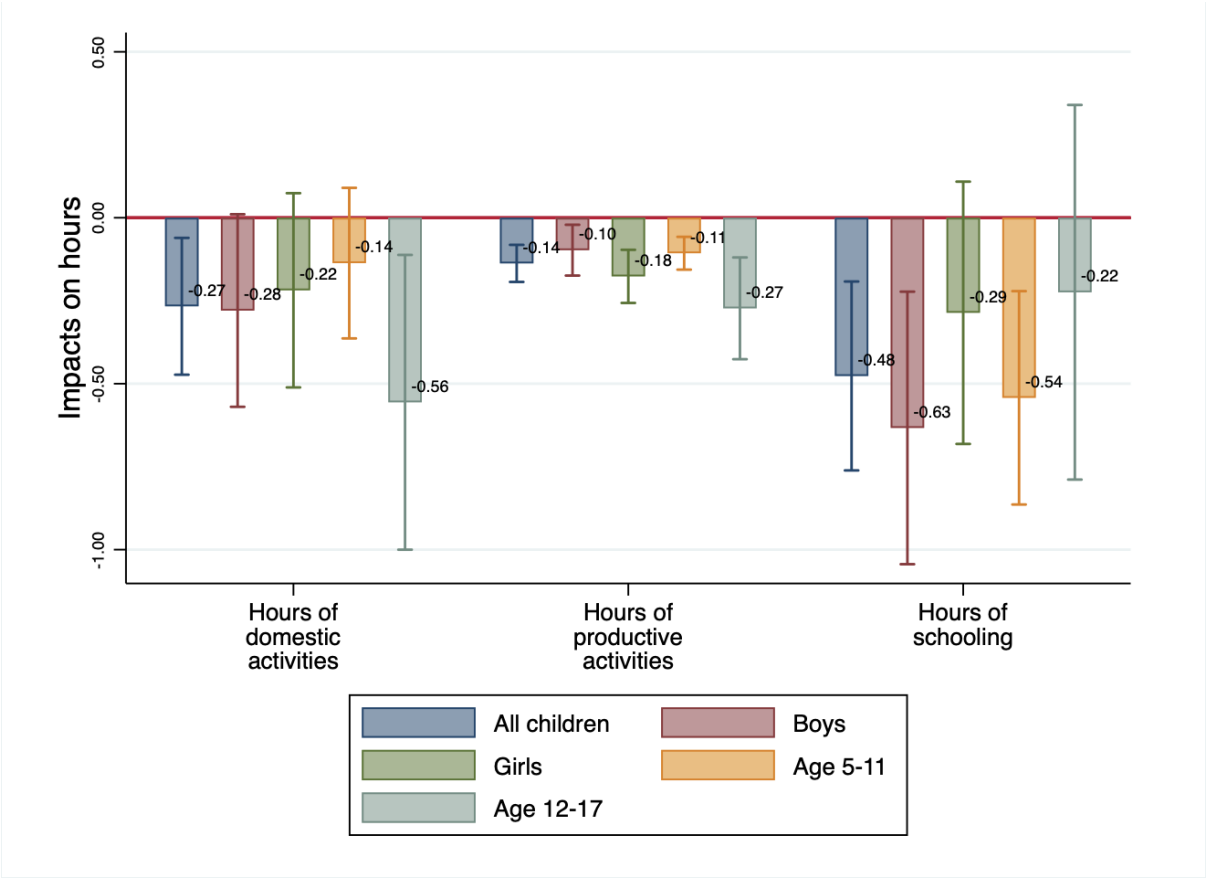
Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among children living in the household panel sample. Column (1) presents impact estimates from a model with the treatment groups combined. Columns (2) and (3) present impact estimates from a 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, 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 < .1. ** p < .05. *** p < .01.

213. Overall, the results do not demonstrate significant reallocation of time between different types of economic activities (paid or unpaid) due to the intervention, as it was observed in other countries. For example, in Tanzania (PSSN Youth Evaluation Team, 2018, impact assessment found a shift from paid labour to family-based economic activities. In Malawi, children shifted away from work for pay to non-livestock agricultural activity (CPC,

2016) and in Zambia children worked more for the household enterprise (AIR, 2016). Although, there are major changes in children's time use patterns between baseline and endline surveys in both groups, these are likely to result from contextual factors such greater time availability of children after school closure. If anything, the intervention seems to serve as a buffer, protecting children in the treatment group to some extent from the increased demand for agricultural and other work.

214. Figure 16 shows that the impacts on children's time use by gender and age, focusing on aggregated indicators. The figure shows that impacts on school related activities are primarily driven by reductions among 5- to 11-year-olds (0.56 fewer hours). The decline in child's contribution to taking care of family members and other domestic chores is driven by impacts among 12- to 17-year-olds, likely because they spent about twice as much time in those activities as 5- to 11-year-olds. Boys are more likely to reduce the time spent on domestic activities (0.28 hours) and productive activities (0.10 hours). In contrast to girls, we also see a reduction in their time allocated to schooling (0.63 fewer hours) There is no significant change in girls' time allocations to domestic tasks but a notable reduction on time spent on productive activities (-0.18). Girl's time on domestic chores is driven by household demands as well as social norms and likely to be highly inelastic to change. A small reduction in time spent on more laborious tasks of collecting firewood (0.16, not shown here) is equal in magnitude between cash and case management component but marginally significant for the latter. Full results of impacts by treatment arm, age group and gender are included in Tables B.9.3.1 – B.9.3.3).

Figure 16. Pooled Impacts on Children's Time Use by Gender and Age



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 estimating the impact of the pooled treatment—using the full sample (N=7,038), girls only (N=3,492), boys only (N=3,331) and age groups (ages 5-11, N=4,985; ages 12-17, N=2,053). 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, and an index for COVID-19 disruption in community from follow-up.

9.4 Violence Against Children

215. Following the MICS, we collected measures of violent discipline of all children aged 1 to 14 years residing in households (UNICEF, 2010). We use the MICS-6 questionnaire, adapted from the Parent-Child Conflict Tactics Scale, which asks about 10 specific behaviours in the last month (30 days). Three items ask about positive disciplinary behaviours, and seven ask about violent disciplinary behaviours. The seven questions measure violent discipline and can be categorised into psychological aggression (two questions) and physical punishment (five questions). Examples of psychological aggression include the following: '*Shouted, yelled at or screamed at him/her*' or '*Called him/her dumb, lazy or another name like that*'. Examples of physical punishment include the following: '*Spanked, hit or slapped him/her on the bottom with bare hand*' or '*Hit or slapped him/her on the face, head or ears*'. We omitted one of the MICS questions on physical punishment because of its severity and related ethical implications (i.e., the measure of beating him/her up, hitting him/her over and over as hard as possible). The three questions which measure non-violent discipline include, for example, '*explaining why a behaviour is wrong*' or '*giving him/her something else to do*'. Finally, we asked a question related to norms around the use of violent discipline—namely, whether the caregiver believes '*that in order to bring up, raise and educate a child properly, the child needs to be physically punished*'. For this analysis, we used multiple cross-sections of any child living in the study sample, regardless of if they appeared in both waves, resulting in a sample size of 8,062 child observations.

216. Table A.9.4.1 shows baseline balance and attrition for the lead indicators, showing that 47% of children were reported to have experienced any non-violent discipline in the month preceding the survey, 41% of children were reported to have experienced psychological aggression, and 32% were reported to have experienced physical punishment, for a combined total violent discipline prevalence of 48%. Furthermore, in 13% of cases, the caregiver believed violent discipline to be necessary to raise children. All indicators showed good balance at baseline, and only one indicator (belief in violent discipline) showed any differential attrition (however, not over the 0.25 threshold). Although levels of violent discipline appeared to be widespread, these were lower than numbers presented in a cross-country analysis of more than 30 countries, showing almost three out of four children experienced psychological aggression in the last 30 days, and nearly one-half experienced physical punishment (UNICEF, 2010).

217. Table 39 reports impacts on violent discipline. Results showed that overall, the intervention reduced the occurrence of psychological aggression (7 pp or 14% over the endline comparison mean), any violent discipline (9 pp or 16% over the endline comparison mean) and caregiver belief that violent discipline is necessary to raise children (4 pp or 67% over the endline control mean). There was no overall impact on physical punishment. In addition, the overall intervention appears to have reduced caregiver report of non-violent discipline (10 pp or 13% over endline comparison means)—which ideally would be maintained or increased due to positive parenting practices.[32] There was a strong additional impact of the case management component across outcomes, ranging from 6 to 17 pps, indicating this component had a strong independent effect on reducing violent discipline. This was particularly notable for physical punishment, where the case management component

32 Further investigation is needed to understand this result. One possible explanation is that caregivers are spending more time working in the treatment groups—thus spending less time with children (and less need to use non-violent discipline).

resulted in an additional decrease of 17 pp (or a 63% decrease over the endline comparison mean.

Table 39. Impacts on Violent Discipline of Children Aged 1 to 14 Years

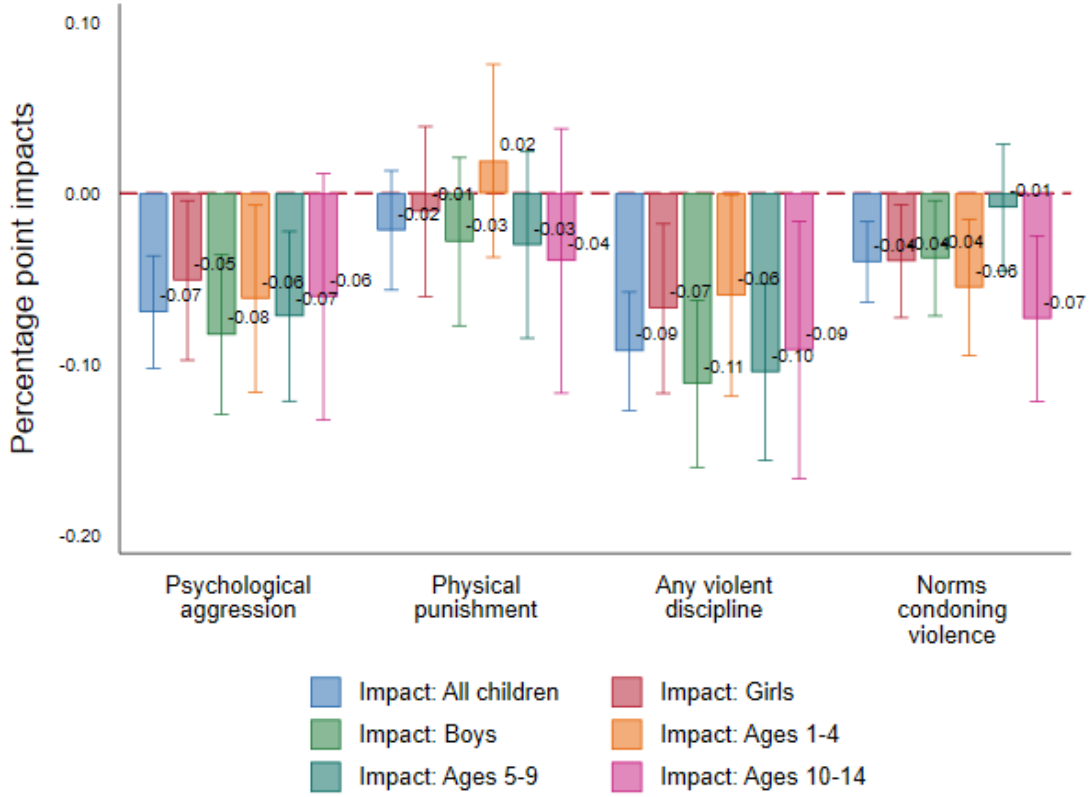
Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
Last 30 days . . .	(1)	(2)	(3)	(4)	(5)
Any non-violent discipline	-0.10***	-0.07***	-0.10***	0.77	8062
	(0.02)	(0.02)	(0.03)		
Any psychological aggression	-0.07***	-0.05**	-0.06**	0.51	8062
	(0.02)	(0.02)	(0.03)		
Any physical punishment	-0.02	0.03	-0.17***	0.27	8062
	(0.02)	(0.02)	(0.03)		
Any violent discipline	-0.09***	-0.07***	-0.07**	0.58	8062
	(0.02)	(0.02)	(0.03)		
Caregiver believes violent discipline necessary to raise children	-0.04***	-0.01	-0.10***	0.06	8062
	(0.01)	(0.01)	(0.02)		

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. * $p < .1$. ** $p < .05$. *** $p < .01$.

We examined overall impacts by using cross-sections of children living in study households by sex (boys and girls) and by age group (ages 1-4, 5-9 and 10-14 years) (

218. Figure 17). Overall, there were few obvious differences between impacts on boys and girls. However, impacts for boys were slightly larger in magnitude (overall reductions in any violent discipline were 11 pp for boys and 7 pp for girls). Baseline levels of violent discipline were also very similar between boys and girls. When we examined impacts by age group, impacts on any violent discipline appeared to accrue primarily to the older age groups and were smaller and not significant for the youngest group (ages 1-4). In addition, reduction in norms condoning violence appeared to be strongest in the oldest age group (ages 10-14), where the reductions were the largest and significant (7 pp). Impacts of the pooled model on physical punishment were null across all sub-samples for the pooled treatment; however, similar to the full sample analysis, there were large and significant additional impacts of the case management component (ranging from 13 to 20 pp reductions). This sub-sample analysis shows that the beneficial impacts of the entire intervention, and the additional benefit of the case management component, appeared to be universal among all children, regardless of sex or age. This evidence adds to a handful of recent evidence showing that cash and cash plus have the ability to reduce violent discipline of young children in beneficiary households in Mali (Heath et al., 2018), Bangladesh (Roy et al., 2019) and the Philippines (Lachman et al., 2021).

Figure 17. 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 estimating the impact of the pooled treatment—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.

219. Finally, to anticipate a household's likelihood of marrying off adolescent girls, we asked for all girls aged 10 to 18 years if they had undergone initiation rites and, if so, at what age.[33] For those who had not yet undergone initiation rites, we asked when this is planned and constructed indicators of planned initiation in the current year or next year. Although these are only proxy measures, it is possible that they could signal intention of a household to delay marriage of a female child. In total, 1,457 girls aged 10 to 18 reside in study sample households across baseline and endline. Table A.9.4.2 reports baseline balance and attrition, showing approximately 39% of the sample had undergone initiation rites (at an average age of 14.3 years). Among those who had not yet undergone rites, 13% reported planning to undergo initiation in the year of the survey or the following year. The latter indicator showed statistical differences between treatment and comparison groups in the panel sample (at 0.27 SD), which may be in part due to the small sample size for this outcome (N=494). Although there is no evidence of differential attrition, this indicates cautious interpretation of this outcome.

220. Table 40 reports impacts on initiation rites of female children. There were no measurable impacts of the intervention on any of the indicators. For the latter two indicators

33 In Mozambique, initiation rites are part of a "coming of age" ceremony, where girls are perceived to be entering womanhood or ready to start a family thereafter. While the format varies, traditionally, these rites take place once or twice a year during which girls who have reached puberty go to stay with older women who teach them about domestic duties, sexual relations and married life. In addition, girls may be 'initiated' into sexual activity by a man hired by the community.

(age underwent initiation and plans to undergo initiation), the sample sizes were small; therefore, no additional analysis was undertaken by age of the child. This relatively low sample size is likely in part due to the demographics of households with young children that are unlikely to have large numbers of adolescents.

Table 40. Impacts on Initiation Rites of Female Children Aged 10 to 18 years

Dependent Variable	Impact Estimates			Endline Mean Comparison	N
	DD Pooled Treatments (1)	DD Cash (2)	Additional Impact CM (3)	(4)	(5)
Undergone initiation rites	0.01	0.01	-0.01	0.23	1457
	(0.04)	(0.05)	(0.05)		
Age underwent initiation rites (years)	0.22	0.33	-0.41	13.59	473
	(0.39)	(0.42)	(0.44)		
Plans to undergo initiation rites this or next year	-0.05	-0.02	-0.07	0.06	984
	(0.04)	(0.05)	(0.05)		

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), 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 < .1. ** p < .05. *** p < .01.

10 OPERATIONS AND IMPLEMENTATION FIDELITY

221. Operations and implementation fidelity are important in explaining ultimate impacts for beneficiaries. Transfer Project evidence from across the region has shown that in some cases, challenges in implementation (e.g., lumpy and inconsistent payments) can explain why impacts are observed or not (Davis et al. 2016). Questions around program operations and implementation are the focus of a dedicated process evaluation report, informed by qualitative methods (AIR, 2021). However, at endline, we collect some complementary information on beneficiary perspectives in a module on implementation and operations. We present key descriptive information in this chapter to help triangulate and explain some of the impacts observed from both the cash and case management components. Similar to other descriptive tables, we present sample averages by study arm and test for SM differences across arms (as appropriate).

222. We first examine knowledge and take-up of the intervention across the full panel sample. Universally, the Child Grant 0-2 is known in treatment districts, where 97% of the sample has heard of the it. In the comparison sample, just over half (56%) of caregivers had heard of the Child Grant 0-2 (a statistically meaningful difference). Among the treatment sample, approximately 89% of caregivers report receiving at least one benefit (either cash or case management)—and this percentage is slightly higher in the cash group (90%) versus the case management-eligible sample (85%), although not statistically different. These levels are not unusual as compared to similar evaluations—for example, in Ghana's LEAP 1000, at endline 97.5% of treatment households had heard of the programme, and 88.3% had ever received a payment from LEAP (LEAP 1000 Impact Evaluation Team, 2018). Of note is the low self-report of the case management component. Of the case management-eligible group, just under one-third (27%) report receiving at least one home visit or consultation with a SDSMAS technician or *Permanente* as part of the intervention, and 6% of the cash only group report the same. This percentage is lower than anticipated based on the plans for case

management roll-out and may have implications for estimating the ITT effect. In other words, if a lower percentage of the case management-eligible sample is actually receiving services, the impacts of this component may be underpowered. This indicates a more complex analysis attempting to estimate impacts of the case management on the treated (treatment-on-the-treated, or TOT analysis) may be useful to explore in the future. On the other hand, it is also possible that caregivers did not fully report receipt of services or confused the case management with another intervention. The fact that some of the cash-only group reported some receipt of case management as well, indicates this may be a possible explanation. Alternatively, it is possible that some of the Nacala-a-Velha sample that was not intended to receive case management were enrolled based on perceived vulnerability. Virtually none of the comparison group report receiving cash or case management services, indicating the district borders served as suitable divisions for identifying intervention and non-intervention households.

Table 41. Intervention Knowledge and Take-Up

	Mean (SD)				Diff	Diff	
	Pooled Treatment	Cash Only	CM Eligible	Comparison	Pooled vs Control	Cash Only vs CM Eligible	N
Knows about cash transfer in community	0.97	0.97	0.97	0.56	0.41***	-0.00	1,685
	(0.17)	(0.17)	(0.18)	(0.50)	[0.02]	[0.01]	
Received payments or other services	0.89	0.90	0.85	0.00	-	-0.04	1,685
	(0.32)	(0.30)	(0.36)	(0.00)		[0.02]	
Received CM component	0.11	0.06	0.27	0.00	0.11	0.22	956
	(0.31)	(0.23)	(0.45)		[0.01]	[0.03]	

Notes: CM = case management. Models use a single difference specification to compare the variable means between the pooled versus comparison group and between the cash only versus those who were eligible for case management. Only panel observations are used. Robust standard errors in square brackets. No controls used in regressions. * p < .1. ** p < .05. *** p < .01.

223. We next asked caregivers in treatment areas who knew about the intervention what the perceived eligibility criteria was for the cash component (N=1,047). Table 42 shows that caregivers overwhelmingly identified women with young children as the eligibility criteria (93%), with other common responses being individuals caring for many orphans/children (12%), very poor individuals (12%), or individuals who have a disability or are elderly (10% each) (caregivers could mention multiple reasons). While there are some differences in opinion among the cash only and case management-eligible groups, these are typically small and in line with expectations (e.g., the case management eligible sample gives a broader range of answers, including disability and poverty.

Table 42: Cash Eligibility Criteria According to Beneficiaries

	Mean (SD)			Diff	
	Pooled Treatment	Cash Only	CM Eligible	Cash Only vs CM Eligible	N
Pregnant women	0.04	0.03	0.06	0.03**	1,047
	(0.19)	(0.17)	(0.25)	[0.02]	
Women with young children	0.93	0.94	0.87	-0.07***	1,047
	(0.26)	(0.23)	(0.34)	[0.02]	
Individuals caring for many orphans or children	0.12	0.10	0.18	0.09***	1,047
	(0.32)	(0.30)	(0.39)	[0.03]	
Sick individuals	0.02	0.01	0.05	0.03**	1,047
	(0.14)	(0.11)	(0.21)	[0.01]	
Widowed individuals	0.04	0.03	0.05	0.01	1,047
	(0.18)	(0.18)	(0.21)	[0.01]	
Individuals who are not able to work	0.06	0.05	0.07	0.02	1,047

	(0.23)	(0.22)	(0.26)	[0.02]	
Individuals with a disability	0.10	0.09	0.14	0.06**	1,047
	(0.30)	(0.28)	(0.35)	[0.02]	
Old individuals	0.10	0.09	0.12	0.03	1,047
	(0.30)	(0.28)	(0.33)	[0.02]	
Very poor individuals	0.12	0.09	0.21	0.12***	1,047
	(0.32)	(0.29)	(0.41)	[0.03]	
Other	0.01	0.01	0.00	-0.01	1,047
	(0.09)	(0.09)	(0.06)	[0.01]	
Don't know	0.01	0.01	0.02	0.01	1,047
	(0.11)	(0.09)	(0.14)	[0.01]	

Notes: CM = case management. Table presents information for beneficiary households in the panel sample. Comparison between the cash only and cash plus case management-eligible means is estimated in a regression with no controls and robust standard errors. * p < .1. ** p < .05. *** p < .01.

224. We also solicit information on caregiver's experience with receiving cash, among those in treatment areas who report ever receiving at least one transfer (N=956). Table 43 shows that among those ever receiving a transfer, virtually all (99%) are still participating in the intervention—and that on average households have 1.1 caregivers participating (or 10% of households have two caregivers participating). In total, caregivers report receiving 4.6 payments, for a total of 10,509 MZN. This total amount is roughly equivalent to 20 months of payments (540 MZN each), thus is approximately in line with expectations, however, is much lumpier than expected. Evidence of payment delays are also discussed in the process evaluation and may have led to the inability of caregivers to plan out and efficiently use the funds for investment or large purchases. This irregularity in payment cycles is reflected in caregiver expectations about future payments—55% of caregivers do not know when their next payment will be, and those who do indicate payments may not be given for another 4 months. In addition, 59% of caregivers say they do not know if they will keep receiving the transfer in the future. In terms of actually receiving the transfer, 90% indicate they feel safe when collecting the transfer. However, 16% (N=153) indicate they were asked to or gave money in order to receive the transfer.[34] This dynamic was also observed in the process evaluation and could in part be related to the lack of change at pay points, requiring women to give up a small amount of the transfer (AIR, 2021).

225. In terms of other characteristics of the cash distribution, 83% of caregivers reported they identified someone who can pick up the transfer when they are not able to do so (primarily spouses, followed by other family members). In addition, caregivers spend 72 minutes and 3 MZN on average when picking up the transfer. Finally, 42% of caregivers state that they alone decide how to use the transfer, while 50% indicate they consult their spouse about how to use the transfer.

Table 43. Implementation of Cash Component

	Mean (SD)				
	Pooled Treatment	Cash Only	CM Eligible	Diff Cash Only vs CM Eligible	N
Still participating in the intervention	0.99	0.99	0.99	-0.01	956
	(0.09)	(0.07)	(0.11)	[0.01]	
Number of beneficiaries in household	1.10	1.09	1.12	0.03	956
	(0.34)	(0.31)	(0.40)	[0.03]	
Number of payments received	4.56	4.49	4.80	0.32**	956
	(1.69)	(1.61)	(1.89)	[0.14]	
Total amount received (MZN)	10,509.29	10,986.97	9,010.11	-1,976.86*	956

34 Of those 153 caregivers, 116 (76%) reported that they were asked to give the money and they did so, 27 (17%) offered to give some money and it was accepted, 9 (6%) were asked to give money but the caregiver refused, and 2 (1%) offered money voluntarily and the other person did not accept it.

	(17,458.36)	(18,452.74)	(13,810.77)	[1,137.47]	
Don't know when the next payment is	0.55	0.45	0.86	0.41***	956
	(0.50)	(0.50)	(0.35)	[0.03]	
Months until next payment	3.99	3.87	5.45	1.58	421
	(11.16)	(10.75)	(15.56)	[2.81]	
Don't for how long will receive payments	0.59	0.50	0.88	0.38***	956
	(0.49)	(0.50)	(0.33)	[0.03]	
Feels safe when collecting the transfer	0.90	0.90	0.90	-0.00	956
	(0.30)	(0.30)	(0.31)	[0.02]	
Asked or gave money to receive transfer	0.16	0.18	0.10	-0.08***	956
	(0.37)	(0.39)	(0.31)	[0.02]	
Identified someone to pick up payment when beneficiary not able to	0.83	0.82	0.85	0.03	956
	(0.38)	(0.39)	(0.36)	[0.03]	
Time required to pick up payment (minutes)	74.04	73.34	76.27	2.93	956
	(84.43)	(85.52)	(81.05)	[6.20]	
Transportation costs to pick up payment (MZN)	3.63	3.84	2.94	-0.90	952
	(10.63)	(10.74)	(10.26)	[0.78]	
Consults no one about transfer use	0.42	0.44	0.37	-0.07*	956
	(0.49)	(0.50)	(0.48)	[0.04]	
Consults spouse about transfer use	0.50	0.49	0.54	0.05	956
	(0.50)	(0.50)	(0.50)	[0.04]	

Notes: CM = case management. Table presents information for beneficiary households in the panel sample. Comparison between the cash only and cash plus case management eligible means is estimated in a regression with no controls and robust standard errors. * p < .1. ** p < .05. *** p < .01.

226. Table 44 shows the range of self-reported ways the transfer was spent (multiple responses allowed). Similar to the impact evaluation results, caregivers overwhelmingly report these spend the cash on food and nutrition (98%), followed by shoes and clothing (93%) and health care (46%). Very few caregivers report using the transfer for productive activities, including investment or business (3%) or savings (3%), indicating households are using the cash to meet urgent basic needs, and are unable to leverage transfers for larger purchases.

Table 44. Use of Cash by Beneficiaries

	Pooled Treatment	Mean (SD) Cash Only	CM Eligible	Diff Cash Only vs CM Eligible	N
Food and nutrition	0.98	0.99	0.97	-0.01	956
	(0.12)	(0.11)	(0.16)	[0.01]	
Formal education	0.03	0.02	0.05	0.03*	956
	(0.17)	(0.15)	(0.21)	[0.02]	
Other education	0.00	0.00	0.00	0.00	956
	(0.06)	(0.06)	(0.07)	[0.00]	
Health care	0.46	0.46	0.46	0.00	956
	(0.50)	(0.50)	(0.50)	[0.04]	
Shelter	0.03	0.03	0.01	-0.02*	956
	(0.16)	(0.17)	(0.11)	[0.01]	
Clothing and Shoes	0.93	0.93	0.90	-0.03	956
	(0.26)	(0.25)	(0.29)	[0.02]	
Investment or business	0.03	0.03	0.03	0.00	956
	(0.16)	(0.16)	(0.17)	[0.01]	
Social occasions	0.00	0.00	0.00	-0.00*	956
	(0.06)	(0.06)	(0.00)	[0.00]	
Savings	0.03	0.02	0.03	0.01	956
	(0.16)	(0.15)	(0.18)	[0.01]	
Other	0.08	0.08	0.06	-0.02	956
	(0.27)	(0.28)	(0.25)	[0.02]	

Notes: CM = case management. Table presents information for beneficiary households in the panel sample. Comparison between the cash only and cash plus case management-eligible means is estimated in a regression with no controls and robust standard errors. * p < .1. ** p < .05. *** p < .01.

227. Finally, we examine some aspects of the case management component, starting with perceptions of eligibility—shown in Table 45 among the group reporting receiving any case management visits (N=104). Overall, the caregivers believed child protection concerns were the main reason (68%) for case management eligibility, with mention of being a young mother or having an early pregnancy (6%) and poverty (6%) as other reasons. IPV concerns were rarely mention, as were substance abuse, mental health, and disabilities. Approximately 19% of the sample receiving case management reported not knowing the reason why they were selected for the case management component. These reasons are in line with the qualitative self-reported responses presented in the process evaluation (AIR, 2021).

Table 45. Case Management Eligibility Criteria According to Participants

	Mean	N
Young mother	0.06	104
	(0.25)	
Concerns about child protection	0.68	104
	(0.47)	
Concerns about domestic violence	0.05	104
	(0.21)	
Household is poor	0.06	104
	(0.25)	
Don't know	0.19	104
	(0.40)	

Notes: Table presents means and standard deviations for households in the case management eligible group who reported receiving any case management component activities and are also in the panel sample.

228. Table 46 gives details on the case management component among those reporting receiving services. In total, caregivers reported an average of 2.3 visits, with the last visit occurring 4.6 months ago. Approximately 87% of caregivers report that they are still expecting to receive additional visits. Lastly, the 99% of caregivers say that the person in charge of their case treats them well (43% reporting that case workers were respectful and 56% reporting they were very respectful). These figures reinforce the possibility that case management was under-reported or faced implementation constraints in the study sample. Further investigation is needed to understand the levels of case management services received in triangulation with the process evaluation and monitoring data.

Table 46. Implementation of Case Management Component Among Case Management Participants

	Mean	N
Visits or calls received	2.29	104
	(1.37)	
Months since last visit/call	4.56	103
	(3.54)	
Households is expecting additional visits	0.87	104
	(0.34)	
Case person was respectful	0.43	104
	(0.50)	
Case person was very respectful	0.56	104
	(0.50)	

Notes: Table presents means and standard deviations for households in the case management eligible group who reported receiving any case management activities and are also in the panel sample.

11 RECOMMENDATIONS AND LESSONS LEARNED

229. These evaluation results lead to recommendations and lessons learned, which can inform future cash transfer and social protection programming in Mozambique and beyond. In this section we discuss the most relevant lessons learned, followed by some specific recommendations.

230. The evaluation team developed recommendations for the Child Grant 0–2 based on the research findings from the impact evaluation and with inputs from the process evaluation findings. These recommendations were informed by discussion and presentations UNICEF Mozambique and to the broader technical advisory group led by MGCAS throughout the evaluation timeline. At the time of writing, these lessons and recommendations had been presented and/or revised over half a dozen times in coordination with UNICEF and the technical advisory group. The impact evaluation team coordinated with the process evaluation team via communication throughout the evaluation process, sharing draft versions of the reports, discussing results, as well as attending the joint presentations with stakeholders to gain joint feedback on the findings. As a result, there is important overlap in terms of key recommendations in both reports and the two reports provide reinforcing (rather than contradicting) recommendations. Note that some lessons learned and recommendations that are exclusively based on qualitative data are not discussed in this report.

231. We organize the lessons learned and recommendations in terms of overall intervention design, the transfer value and duration, the payment regularity, the operational performance, as well as how to bolster child nutrition in the intervention areas and support adolescent caregivers—taking into account both gender- and child-sensitive findings—and how the intervention can advance the responsivity towards both gender equality and child rights).

232. **Overall intervention design.** The first lesson learned from the results of this evaluation is 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, and caregiver and child health, well-being, and freedom from violence. Most impacts at the household level are attributable to the cash component, while some specific impacts for the caregivers and the children derive both from the cash and case management components. Due to the untargeted nature of the SBCC, 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 benefited from the additional impacts from the SBCC specifically. Despite being nearly universal (among caregivers of children 0 to 2), the intervention 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 partnerships before the age of 18, alongside poor mental health and inability to save money for emergencies or investments. With ongoing experience of shocks (including COVID-19) locally and nationally, safety nets such as the Child Grant 0-2 provide an essential safeguard to ensure health and well-being of young children and families.

233. **Recommendation 1 – to MGCAS: to maintain the current unconditional design, while planning for scale-up of the intervention to other districts in Nampula and beyond.** In the immediate future, the intervention should be offered to the comparison group districts, and neighbouring areas in the Nampula province.

234. Despite the wide-ranging beneficial effects of the intervention, when assessing the impacts on the different levels and domains, some are small (or modest) in comparison to similar programmes in the region—while for others, there are null effects. Therefore, we conclude there are several factors related to intervention design and implementation that may have prevented it from realizing its full potential. Therefore, we recommend the following actions:

235. 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 transfers in the sub-Saharan Africa region conducted by the Transfer Project suggest that, on average, to ensure widespread effects, transfer sizes should be equal to at least 20% of baseline household consumption (Davis & Handa, 2015). Our 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 lead to longer-run sustainable impacts when households no longer receive the transfer. Thus, as the transfer size is a key parameter for intervention effectiveness, our findings raise an opportunity to revisit benefit levels, or at a minimum suggest close monitoring over time is needed to ensure the real value does not decrease further.

236. Recommendation 2 – to MGCAS: revisit benefit levels, or at a minimum suggest close monitoring over time is needed to ensure the real value does not decrease further.

237. 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. In addition, most beneficiaries reported not knowing how long they would continue to receive the transfers. This short duration, which can be complicated by enrolment lags and payment delays, further limits the potential for sustainability of impacts. A longer duration of eligibility would allow increased investment in productive activities and human capital of children. In many other Child Grant models, women become eligible during pregnancies, thus extending the period for critical investments (e.g., covering the first 1,000 days)—or children remain eligible up to age 5 years old.

238. Recommendation 3 – to MGCAS: In addition to revisiting benefit levels, we recommend assessing if participation can be extended to include the pregnancy period or additional years for children.

239. While the relative trade-offs between transfers during the pregnancy period versus post-1000 day (over the age of two years) in any given location are not fully clear, the literature emphasizes the critical period of pregnancy in determining later child wellbeing outcomes. Therefore, one strategy would be to first shift enrolment to the pregnancy period (e.g., triggered by prenatal care visit during the second trimester) in order to facilitate first transfers before childbirth. This shift would also build in a buffer period if transfers continue to be lumpy, such that first transfers remain at a minimum close to the time of birth. It may also encourage women to seek prenatal care early (if it was widely known that visits triggered enrolment). Thereafter, efforts could shift to expanding the overall age range of eligibility to include under 5 children, or older as funding allows.

240. Payment regularity. Beneficiaries reported both irregularity in payment intervals (lumpy payments) and uncertainty about payment dates (as well as their participation in the intervention). Households are more likely to invest in productive activities using the cash transfer when they have a clear understanding of timing of future payments. However, as discussed in the operational section, if beneficiaries cannot plan and anticipate payments, they may not be willing to make investments or miss critical timing of seasonal-based opportunities. We recognize that some of these implementation challenges may have been resulted from COVID-19 constraints.

241. Recommendation 4 – to MGCAS: attention so that current and future participants can follow a specific payment plan to minimise uncertainty and maximise their financial planning capacity.

242. **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 component generated positive impacts for some key outcomes, in particular those around violence, child protection, and child separation. This suggests that a 'cash and care' approach may be an effective way to address some of the key complex vulnerabilities that households with young children face.

243. **Recommendation 5 – to MGCAS: continuing the joint implementation of the cash and case management components and ensure that the care activities are further supported to ensure maximum synergistic benefits for participants.** We recognize the complexity and challenges inherent in delivering the case management services and underscore the wide-ranging implementation-specific recommendations made in the process evaluation report.

244. **Bolstering programming on child nutrition.** The intervention did not have a measurable impact on child nutrition, a key intervention target and important child health and development metric. At endline, over half of children were stunted, and 40% of children had diarrhoea in the previous 2 weeks preceding the survey. The lack of impacts on child nutritional status is in spite of a large increase in dietary diversity and food security among children and households—indicating other factors—for example environmental and hygiene may be constraints to improving child nutrition. While the SBCC component of the intervention may have contributed to some positive behaviors and nutrition knowledge, these were not captured through knowledge questions implemented in this study. In addition, it is possible that a delay in the full initiation of SBCC activities may have contributed to a reduced probability of favorable synergistic impacts on child nutrition and related outcomes

245. **Recommendation 6 – to MGCAS: that entry points for convergence between district-level nutrition intervention and the Child Grant 0-2 be explored and leveraged,** beyond the light-touch 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.

246. Supporting adolescent caregivers. While our results suggest the intervention had a range of beneficial impacts for caregivers, across several categories, these benefits appeared to be driven by older caregivers. Younger caregivers, namely adolescent mothers, and those under age 24 may need additional support to ensure the same range of beneficial impacts. The case management component of the 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**.**

247. **Recommendation 7 – to MGCAS: emphasis be continued in serving adolescent and young mothers, and linkages be made wherever possible as part of the case management component with adolescent-specific or friendly services**. In addition, attention to the specific barriers adolescent girls might experience across different intervention components (e.g., travel to pay points, control, and decision-making over transfers) should be given across all aspects of implementation.

248. **Recommendation 8 – to MGCAS: These considerations should be complimented 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.

249. Additional research needed. As discussed above, there are some aspects that the impact evaluation was not able to assess fully. First, some components of the intervention, namely the SBCC component, was implemented in a way that did not allow the evaluation design to assess its impacts. This component be an important complement of cash transfers and case management activities and future research is needed to assess its potential. Second, as discussed above, the nutritional status of the target children was unaffected by the intervention. While there is mixed evidence in the literature in terms of the ability that cash transfers have to improve long-term nutritional status of children, more research is needed to understand how cash plus approached are able to produce positive results for this type of nutritional outcomes. Lastly, additional research is also needed to assess the full impact of the case management activities. As discussed, there were many implementation aspects that may have limited the full potential of this component, partly due to the restrictions that the COVID-19 pandemic imposed on those implementing face-to-face activities.

12 CONCLUSIONS

250. In this report, we investigate the impacts of the Child Grant 0-2 on child well-being and the intermediate impacts on poverty and vulnerability at the household- and caregiver-levels over a 24-month period. This evaluation is the first rigorous evaluation of a national child-focused social protection intervention in Mozambique and adds to scarce regional evidence on cash plus models. These results complement process evaluation findings, which assessed intervention fidelity, identified the challenges to and facilitators of implementation, examined barriers accessing cash and case management services, and investigated beneficiary experiences with the intervention (AIR, 2021).

251. We investigated impacts on four main levels: (*a*) target child level (0 – 6 months at baseline), (*b*) household level, (*c*) caregiver level, and (*d*) older children (aged 3 to 17 years). Some key results of the evaluation, organized by these main levels, are as follows:

252. Target child: We examine outcomes related to the wellbeing of the target child, across the following domains: *(a)* birth certification and child registration, *(b)* dietary diversity and IYCF practices, *(c)* immunisations, *(d)* parental stimulation and involvement, and *(e)* nutritional status. We found strong and sizable impacts on children's birth certification and registration, with impacts originating from both the cash and case management components. In addition, there are beneficial (and sizable) impacts on nearly all dietary diversity and IYCF—including number of meals, minimum dietary diversity, minimum meal frequency and consumption of legumes, dairy, meat and fish, eggs, vitamin A foods and other fruits and vegetables. In terms of immunisations, the results are mixed, with positive impacts only on having a vaccination card (from the case management component) and having been vaccinated for BCG (from the cash component), but negative impacts on deworming or vitamin A doses. Regarding parental stimulation, caregivers report an increase of 11% in activities with the target child (partially driven by the case management component), although no impacts were found for other household members (aged 15 and above). Lastly, we did not find any impacts of the intervention on underweight, wasting and stunting. Levels of stunting are high at endline (ranging from 51% to 54%), which indicates that additional interventions are needed to address malnutrition for this population. In general, the results for the target child were similar regardless of the gender of the child, which suggests that the intervention benefitted boys and girls similarly.

253. Household level: In terms of household-level domains, we look at (*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 (translating to a 13% increase over endline comparison means), driven primarily by food expenditures, as well as expenditures on housing and utilities, clothing and footwear and transportation. In line with the existing evidence on impacts of cash transfers, we note that we did not find an increase in alcohol or tobacco consumption as a result of the intervention. The overall increase in expenditures translates in reductions in poverty rates of similar magnitude (8 pp or 10% decrease in poverty headcounts, 5 pp or 13% decrease in the poverty gap). Food insecurity also decreases, both in terms of the FIES as well as the number of meals eaten per day. Households invest in non-farm activities, increasing operation of any enterprise by 7 pp (or 16% over endline comparison means). While there are increases in household asset ownership, there is no change in livestock ownership or agricultural activity. Finally, households in the treatment group are less likely to report they were affected negatively by COVID-19 (14 pp or 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 component. In addition, across several domains, impacts appear to be driven by female headed households—indicating the intervention has been particularly beneficial for this more vulnerable demographic.

254. Caregiver level: At the caregiver level, we examine the following domains: (*a*) health and nutrition knowledge, (*b*) psychosocial wellbeing and social support, (*c*) empowerment and freedom from violence, (*d*) fertility and (*e*) family separation. Across several key health and nutrition knowledge domains, including knowledge of exclusive breastfeeding, there are no consistent or strong impacts—demonstrating the intervention components related to knowledge uptake have not been successful in changing these outcomes. However, there were strong impacts across nearly every other domain: Caregivers have fewer depressive symptoms (-7 pp or 11% decrease), less stress (0.84 or 5% decrease), report higher levels of happiness and are more satisfied with life (case management component only). Caregivers are saving more money (4 pp or 130% increase), and report higher levels of autonomy, decision-making power, and self-assessed financial standing. There are also notable reductions in attitudes accepting intimate partner violence (IPV), and lower emotional, physical, and combined experience of IPV in the last 12 months (the latter decreasing by 13 pp or 38% over endline comparison means). Lastly, there are no adverse impacts on pregnancy or fertility found, with the intervention decreasing current or recent pregnancies and the case management component reducing child separation. 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 in several domains appear to be driven by older caregivers (those >25 years at baseline), as compared to adolescents or caregivers who are youth.

255. Older children: We examine a range of outcomes for older children (primarily those aged 3 to 17 years) along four main domains: (*a*) material well-being, (*b*) education outcomes, (*c*) time allocation, including on school and work (both productive and care work) and (*d*) violence against children, including assessment of initiation rites among female children. We find strong impacts on maternal well-being of children, with increases of 21 pp (58% over endline comparison means) of having shoes, a change of clothes and a blanket. We find weaker impacts on education outcomes, with a 5 pp (8%, weakly significant) impact on current school enrolment and no positive impacts on either school attendance (number of days per week attended) or expenditures. These may have to do with differences in return to schooling or procedures implemented due to COVID-19. We find reductions in child time

spent in both in domestic activities, as well as productive activities, across a range of outcomes. Finally, we find strong decreases in violent discipline of children (9 pp decrease or 16% over endline comparison means), as well as caregiver beliefs violence is necessary to raise children (4 pp decrease or 67% over endline comparison means). The latter two outcomes show strong additional impacts attributable to the case management component. While there are some differences originating from age groups in these impacts, there are fewer differences by gender of the child—suggesting beneficial intervention impacts are accruing to both boys and girls.

256. **Operational performance:** Results show that the Child Grant 0-2 is well-known and approximately 91% of the sample (entirely in treatment areas) report ever receiving cash transfers or services. Participants overwhelmingly identify caregivers with young children as the main eligibility criteria (93%), with other perceived factors being caring for orphans and vulnerable children, disability, and poverty. Despite reporting receiving the equivalent of 20 months of transfers on average (10,509 MZN) over the intervention period, the transfers were lumpy (on average over 4.6 payments) and unpredictable—with caregivers largely unable to identify when they would receive their next transfer. At pay points, caregivers report feeling safe (90%), spending on average 74 minutes picking up money, and 83% had designated someone to pick up the funds when they were not able to. Caregivers primarily report spending the transfer on food and nutrition for the family (98%), clothing and shoes (93%) and health care (46%), with few mentioning productive investments or being able to save the money. Finally, a lower-than-expected proportion of the eligible sample reported receiving the 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).

Table 47. Summary of key impact evaluation findings across domains

Target child (aged 0-6 at baseline)	Pooled treatments (coefficients) (1)	Percentage change (2)	Additional beneficial impact of case management (3)
Child has birth registration	0.30***	+150%	X
Minimum dietary diversity (MDD)	0.11***	+100	-
Has a vaccination card	0.02	NA	X
Number of activities caregiver did with child (last 3 days)	0.23*	+11	X
Wasted (weight-for-length z-score <-2)	-0.02	NA	-
Stunted (length-for-age z-score <-2)	0.03	NA	-
Household-level			
Monthly per-capita expenditures (MZN)	118.2***	+13%	-
Monthly per-capita food expenditures (MZN)	57.3**	+10%	-
Poverty headcount (all expenditure line)	-8.78***	-10%	-
Poverty gap (all expenditure line)	-4.84**	-13%	X
Food insecurity experience index (FIES)	-0.79***	-11%	-
Operates any non-farm enterprise	0.07**	+16%	-
Livestock ownership	0.01	NA	-
Affected negatively by COVID-19 shock	-0.14***	-54%	-
Caregiver-level			
Summary score of nutrition and health knowledge (0-5)	0.08	NA	-
Depressive symptoms (CES-D ≥ 10)	-0.07**	-11%	-
Stress (Cohen self-reported stress scale)	-0.84***	-5%	-
Currently saving money	0.04**	+130%	-
Self-assessed decision-making power (ladder)	0.43***	+8%	-
Emotional and/or physical IPV (12-month recall)	-0.13***	-38%	X
Currently pregnant or pregnant in the last 24 months	-0.09***	-22%	-

Any biological child <18 years lives outside the home	0.01	NA	X
Older children (primarily ages 3-17)			
Material well-being (shoes, cloths and blanket) (ages 3 to 17)	0.21***	58%	-
Currently attending school (ages 6 to 17)	0.05*	8%	-
Child time use (domestic chores, hours last 24 hours)	-0.27**	-12%	-
Child time use (productive activities, hours last week)	-0.96***	-40%	X
Any violent discipline (ages 1-14)	-0.09***	-16%	X
Caregiver believes violent discipline necessary to raise children	-0.04***	-67%	X

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 < .1. ** p < .05. *** p < .01.

257. This impact evaluation, alongside the process evaluation, provides concrete evidence of the beneficial impacts of cash plus interventions for children, caregivers, and families. The research shows a clear rationale for scale-up, however points to several ways the intervention 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, we are limited in our ability to test and attribute 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 quality of case management. These results also do not address the cost-effectiveness of different intervention 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 have provided an essential safety net in the face of ongoing shocks in Mozambique.

13 REFERENCES

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ANNEX A. ADDITIONAL BASELINE BALANCE AND ATTRITION TABLES

Table A.6.1. Baseline Balance and Attrition on Health and Nutrition of Target Child

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Child has a birth certificate	0.26	0.23	0.30	-0.16***	1,681	-0.20*	443
	(0.44)	(0.42)	(0.46)	[0.05]		[0.11]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.6.2. Baseline Balance and Attrition on Nutrition Practices of Target Child

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Total number of food groups consumed yesterday	1.16	1.11	1.26	-0.15**	1,685	-0.21*	445
	(0.97)	(0.77)	(1.25)	[0.06]		[0.11]	
Minimum dietary diversity	0.02	0.01	0.05	-0.27***	1,685	-0.14	445
	(0.15)	(0.09)	(0.21)	[0.06]		[0.13]	
Food groups consumed yesterday:							
Breast milk	0.85	0.87	0.82	0.16***	1,685	-0.15	445
	(0.35)	(0.34)	(0.39)	[0.05]		[0.09]	
Cereals, roots, and tubers	0.12	0.12	0.11	0.02	1,685	0.12	445
	(0.32)	(0.33)	(0.32)	[0.05]		[0.10]	
Legumes	0.03	0.01	0.06	-0.27***	1,678	-0.41***	442
	(0.17)	(0.12)	(0.23)	[0.06]		[0.15]	
Dairy	0.01	0.01	0.00	0.11***	1,678	0.11*	443
	(0.07)	(0.09)	(0.00)	[0.04]		[0.06]	
Flesh food (meat or fish)	0.05	0.03	0.09	-0.25***	1,683	-0.23*	445
	(0.23)	(0.18)	(0.29)	[0.06]		[0.12]	
Eggs	0.01	0.00	0.01	-0.05	1,668	0.07	439
	(0.07)	(0.06)	(0.09)	[0.05]		[0.13]	
Vitamin A	0.03	0.02	0.06	-0.25***	1,681	-0.15	442
	(0.18)	(0.13)	(0.24)	[0.06]		[0.11]	
Other fruits and vegetables	0.06	0.04	0.11	-0.28***	1,685	-0.24**	445
	(0.24)	(0.19)	(0.31)	[0.06]		[0.12]	
Times child consumed solid/soft food yesterday	0.21	0.24	0.15	0.12**	1,683	0.12	445
	(0.75)	(0.80)	(0.65)	[0.05]		[0.10]	
Minimum meal frequency	0.01	0.01	0.01	0.06	1,685	-0.08	445
	(0.10)	(0.11)	(0.08)	[0.05]		[0.11]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.6.3. Baseline Balance and Attrition on Target Child Immunizations, Vitamin A, Deworming, and Diarrhoea

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Has vaccination card	0.88	0.88	0.89	-0.04	1,685	-0.03	445
	(0.32)	(0.33)	(0.31)	[0.05]		[0.11]	
Has BCG vaccine	0.90	0.88	0.94	-0.16***	1,668	-0.14	436
	(0.30)	(0.32)	(0.25)	[0.05]		[0.11]	
Polio vaccines	0.56	0.55	0.59	-0.08	1,134	0.20	303
	(0.50)	(0.50)	(0.49)	[0.06]		[0.13]	
PENTA vaccines	0.29	0.27	0.32	-0.10	1,134	0.00	303
	(0.45)	(0.44)	(0.47)	[0.06]		[0.13]	
Pneumococcal vaccines	0.27	0.26	0.28	-0.06	1,134	0.04	303
	(0.44)	(0.44)	(0.45)	[0.06]		[0.13]	
Rotavirus vaccines	0.36	0.34	0.40	-0.12*	1,134	0.01	303
	(0.48)	(0.47)	(0.49)	[0.06]		[0.13]	
Measles vaccine	0.01	0.01	0.02	-0.06	1,639	-0.00	422
	(0.12)	(0.11)	(0.14)	[0.06]		[0.10]	
Vitamin A dose	0.11	0.10	0.11	-0.02	1,624	0.27***	421
	(0.31)	(0.30)	(0.31)	[0.05]		[0.09]	
Deworming medication	0.02	0.03	0.01	0.14***	1,625	0.12**	422
	(0.15)	(0.16)	(0.10)	[0.05]		[0.06]	
Had diarrhea in last 2 weeks	0.08	0.08	0.08	0.01	1,654	0.03	440
	(0.27)	(0.27)	(0.26)	[0.05]		[0.10]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.6.4. Baseline Balance and Attrition on Child Development Target Child

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Number of activities any household member (≥15 years) did with target child	2.08	2.00	2.23	-0.13**	1,685	-0.14	445
	(1.80)	(1.76)	(1.85)	[0.05]		[0.10]	
Read books to child	0.14	0.13	0.16	-0.06	1,685	-0.09	445
	(0.35)	(0.34)	(0.36)	[0.05]		[0.10]	
Told stories to child	0.18	0.17	0.20	-0.07	1,685	-0.07	445
	(0.39)	(0.38)	(0.40)	[0.05]		[0.10]	
Sang songs to child	0.54	0.51	0.59	-0.16***	1,685	-0.09	445
	(0.50)	(0.50)	(0.49)	[0.05]		[0.11]	
Took child for a walk outside the home	0.53	0.51	0.55	-0.08	1,685	-0.09	445
	(0.50)	(0.50)	(0.50)	[0.05]		[0.10]	
Played with child	0.51	0.52	0.50	0.05	1,685	-0.04	445
	(0.50)	(0.50)	(0.50)	[0.05]		[0.11]	
Named, counted or drew things with child	0.18	0.15	0.24	-0.22***	1,685	-0.23**	445
	(0.39)	(0.36)	(0.42)	[0.05]		[0.11]	
Number of activities caregiver did with target child	1.92	1.83	2.07	-0.14***	1,685	-0.20*	445
	(1.73)	(1.68)	(1.82)	[0.05]		[0.11]	
Read books to child	0.11	0.11	0.13	-0.06	1,685	-0.06	445
	(0.32)	(0.31)	(0.33)	[0.05]		[0.10]	
Told stories to child	0.15	0.14	0.17	-0.07	1,685	-0.06	445

	(0.36)	(0.35)	(0.37)	[0.05]		[0.10]	
Sang songs to child	0.51	0.48	0.56	-0.16***	1,685	-0.13	445
	(0.50)	(0.50)	(0.50)	[0.05]		[0.11]	
Took child for a walk outside the home	0.51	0.49	0.54	-0.10**	1,685	-0.16	445
	(0.50)	(0.50)	(0.50)	[0.05]		[0.10]	
Played with child	0.48	0.49	0.46	0.05	1,685	-0.08	445
	(0.50)	(0.50)	(0.50)	[0.05]		[0.11]	
Named, counted or drew things with child	0.16	0.13	0.22	-0.25***	1,685	-0.32***	445
	(0.37)	(0.33)	(0.41)	[0.05]		[0.11]	
At what age can a child see?	3.00	2.97	3.05	-0.06	1,680	-0.03	445
	(1.25)	(1.14)	(1.42)	[0.06]		[0.09]	
At what age can a child hear?	3.38	3.37	3.41	-0.03	1,681	-0.01	445
	(1.35)	(1.40)	(1.26)	[0.05]		[0.10]	
Days last week child was left alone for more than 1 hour	0.26	0.26	0.25	0.03	1,685	-0.06	445
	(0.86)	(0.87)	(0.83)	[0.05]		[0.10]	
Days last week child was left in the care of another child	0.33	0.29	0.41	-0.11**	1,685	-0.15	445
	(1.02)	(0.90)	(1.19)	[0.06]		[0.13]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.6.5. Baseline Balance and Attrition on Target Child Nutrition Status

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Child has oedema	0.00	0.00	0.00	0.05	1,685	0.00	445
	(0.02)	(0.03)	(0.00)	[0.05]			
Underweight (weight-for-age z-score < -2)	0.11	0.12	0.09	0.10**	1,684	-0.15	445
	(0.31)	(0.32)	(0.28)	[0.05]		[0.11]	
Wasted (weight-for-length z-score < -2)	0.07	0.07	0.06	0.05	1,668	-0.18	438
	(0.26)	(0.26)	(0.24)	[0.05]		[0.12]	
Stunted (length-for-age z-score < -2)	0.12	0.11	0.13	-0.04	1,685	-0.22*	445
	(0.32)	(0.32)	(0.33)	[0.05]		[0.12]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.6.6: Baseline Balance on Target Child Nutrition Status - Cash-Only and Case-Management Components

	Panel				
		Mean (SD)		CM-Cash	
	All	CM	Cash (3)	SM Diff	N
	(1)	(2)		(4)	(5)
Child has oedema	0.00	0.00	0.00	0.09	1,079
	(0.03)	(0.04)	(0.00)	[0.09]	
Underweight (weight-for-age z-score <-2)	0.12	0.16	0.07	0.26***	1,078
	(0.32)	(0.37)	(0.26)	[0.07]	
Wasted (weight-for-length z-score <-2)	0.07	0.09	0.06	0.14**	1,068
	(0.26)	(0.29)	(0.23)	[0.07]	
Stunted (length-for-age z-score <-2)	0.11	0.16	0.07	0.24***	1,079
	(0.32)	(0.36)	(0.26)	[0.07]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. Robust standard errors are in parentheses. Regressions control for linear distance to district border (km) and an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.6.7: Impacts on Sanitary Condition

	Impact Estimates			Endline Mean	
Dependent Variable	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Main source of drinking water is safe	-0.02	-0.03	0.07	0.29	3370
	(0.03)	(0.04)	(0.05)		
HH treats water to make it safe	0.20***	0.22***	-0.06	0.19	3361
	(0.03)	(0.03)	(0.04)		
Water available for handwashing	-0.04	-0.05	0.03	0.72	2197
	(0.04)	(0.04)	(0.06)		
Soap/detergent	0.24***	0.24***	0.00	0.32	3370
	(0.03)	(0.04)	(0.05)		
Latrine	0.07**	0.07**	0.00	0.69	3370
	(0.03)	(0.03)	(0.04)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), 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. 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 < .1. ** p < .05. *** p < .01.

Table A.6.8: Impacts on Morbidity of Target Child

Dependent Variable	Impact Estimates			Endline Mean	
	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
Sick during last 2 week	0.00	0.04	-0.14***	0.49	3322
	(0.03)	(0.04)	(0.05)		
Consulted Heath Professional or Doctor	0.02	0.01	0.04	0.82	1228
	(0.04)	(0.05)	(0.06)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among the 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), 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. 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 < .1. ** p < .05. *** p < .01.

Table A.7.1. Baseline Balance and Attrition on Monthly PC Consumption Expenditures

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
All expenditures	746.03	744.63	748.50	0.01	1,685	0.01	445
	(509.23)	(507.05)	(513.50)	[0.05]		[0.11]	
Food and non-alcoholic beverages	443.63	448.12	435.64	0.04	1,685	-0.05	445
	(336.73)	(342.15)	(327.00)	[0.05]		[0.11]	
Housing, water, electricity, gas and other fuels	239.30	232.10	252.12	-0.08	1,685	-0.05	445
	(207.96)	(195.31)	(228.37)	[0.05]		[0.11]	
Education	33.17	34.89	30.09	0.09*	1,685	0.33***	445
	(66.39)	(69.20)	(61.01)	[0.05]		[0.09]	
Clothing and footwear	23.50	23.01	24.37	-0.01	1,685	0.09	445
	(60.39)	(61.74)	(57.95)	[0.05]		[0.12]	
Furniture, decorations and house maintenance	4.34	5.11	2.97	0.19***	1,685	0.26***	445
	(11.04)	(11.96)	(9.04)	[0.05]		[0.10]	
Transportation	0.82	0.00	2.29	-0.07	1,685	0.01	445
	(33.76)	(0.00)	(56.30)	[0.07]		[0.05]	
Health	0.21	0.27	0.12	0.17***	1,685	0.12	445
	(0.81)	(0.90)	(0.61)	[0.04]		[0.11]	
Communication	0.00	0.01	0.00	0.06	1,685	0.00	445
	(0.11)	(0.14)	(0.00)	[0.04]			
Miscellaneous goods and services	0.82	0.83	0.80	-0.01	1,685	0.05	445
	(3.62)	(3.56)	(3.72)	[0.05]		[0.11]	
Alcoholic beverages	0.18	0.29	0.00	0.03	1,685	0.12	445
	(5.19)	(6.49)	(0.00)	[0.02]		[0.12]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.7.2. Baseline Balance and Attrition on Food Expenditure Categories

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Food and non-alcoholic beverages	443.6	448.1	435.6	0.04	1,685	-0.05	445
	(336.7)	(342.1)	(327.0)	[0.05]		[0.11]	
Cereals and bakery products	180.0	185.1	170.9	0.08	1,685	-0.02	445
	(185.1)	(189.5)	(176.7)	[0.05]		[0.11]	
Fish and seafood	86.9	85.5	89.3	-0.04	1,685	-0.18	445
	(95.4)	(95.8)	(94.8)	[0.05]		[0.12]	
Vegetables, potatoes and other tubers	72.0	72.6	71.0	0.03	1,685	0.10	445
	(68.8)	(67.4)	(71.3)	[0.05]		[0.12]	
Oil and fats	26.5	25.3	28.7	-0.1**	1,685	-0.12	445
	(30.6)	(30.4)	(30.7)	[0.05]		[0.1]	
Sugar and confectionery products	19.9	19.4	20.8	-0.04	1,685	-0.31**	445
	(28.9)	(28.1)	(30.2)	[0.05]		[0.13]	
Fruits	19.7	20.4	18.4	0.08*	1,685	0.20*	445
	(27.6)	(28.5)	(25.9)	[0.05]		[0.11]	
Meat and meat derivatives	11.8	12.2	11.0	0.03	1,685	-0.02	445
	(44.7)	(45.9)	(42.4)	[0.05]		[0.12]	
Milk and dairy products, eggs	4.9	4.2	6.1	-0.09	1,685	-0.01	445
	(19.9)	(16.4)	(24.9)	[0.06]		[0.12]	
Other	21.9	23.4	19.3	0.14***	1,685	0.18	445
	(27.7)	(29.7)	(23.4)	[0.04]		[0.12]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using

only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.7.3. Baseline Balance and Attrition on Poverty Rates

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
All Expenditures Poverty Line	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Headcount	85.99	86.01	85.97	-0.01	1,685	-0.05	445
	(34.72)	(34.71)	(34.75)	[0.05]		[0.11]	
Poverty gap	46.47	46.36	46.67	-0.03	1,685	0.00	445
	(28.21)	(28.58)	(27.56)	[0.05]		[0.11]	
Squared poverty gap	29.55	29.65	29.36	-0.00	1,685	0.02	445
	(24.32)	(24.91)	(23.27)	[0.05]		[0.10]	
Food Expenditures Poverty Line							
Headcount (Food)	70.86	70.16	72.11	-0.06	1,685	-0.00	445
	(45.45)	(45.78)	(44.88)	[0.05]		[0.11]	
Poverty gap (Food)	32.38	32.37	32.40	-0.02	1,685	0.01	445
	(28.21)	(28.77)	(27.22)	[0.05]		[0.10]	
Squared poverty gap (Food)	18.44	18.75	17.89	0.03	1,685	0.04	445
	(21.31)	(22.02)	(19.98)	[0.05]		[0.10]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.7.4. Baseline Balance and Attrition on Food Security Indicators

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Average number of meals per day	2.26	2.23	2.33	-0.17***	1,685	-0.24**	445
	(0.57)	(0.56)	(0.59)	[0.05]		[0.10]	
In past 4 weeks, because of lack of money, household members…							
Worried about not having enough food to eat	0.87	0.88	0.85	0.07	1,685	-0.12	445
	(0.34)	(0.33)	(0.36)	[0.05]		[0.11]	
Unable to eat healthy and nutritious food	0.89	0.90	0.89	0.02	1,685	-0.16	445
	(0.31)	(0.30)	(0.31)	[0.05]		[0.10]	
Ate fewer kinds of food	0.90	0.90	0.88	0.05	1,685	-0.18*	445
	(0.31)	(0.30)	(0.32)	[0.05]		[0.11]	
Skipped a meal	0.89	0.89	0.89	0.00	1,685	-0.12	445
	(0.32)	(0.32)	(0.32)	[0.05]		[0.11]	
Ate less than needed	0.88	0.89	0.87	0.03	1,685	-0.12	445
	(0.32)	(0.32)	(0.33)	[0.05]		[0.11]	
Ran out of food	0.86	0.87	0.86	-0.00	1,685	0.06	445
	(0.34)	(0.34)	(0.34)	[0.05]		[0.11]	
Were hungry but could not eat	0.87	0.87	0.88	-0.05	1,685	-0.08	445
	(0.33)	(0.34)	(0.33)	[0.05]		[0.11]	
Did not eat for a whole day	0.66	0.65	0.66	-0.03	1,685	0.03	445
	(0.48)	(0.48)	(0.47)	[0.05]		[0.11]	
Could not access preferred markets for high quality foods	0.76	0.75	0.77	-0.06	1,685	-0.15	445
	(0.43)	(0.43)	(0.42)	[0.05]		[0.11]	
FIES index score (raw)	6.82	6.84	6.79	0.01	1,685	-0.10	445
	(2.08)	(2.07)	(2.08)	[0.05]		[0.10]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using

only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.7.5. Baseline Balance and Attrition on Household Ownership of Assets

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Asset Index	0.01	-0.00	0.02	0.00	1,685	0.01	445
	(1.00)	(1.01)	(0.99)	[0.05]		[0.10]	
Axe	0.34	0.33	0.36	-0.07	1,685	-0.16	445
	(0.47)	(0.47)	(0.48)	[0.05]		[0.11]	
Sickle	0.08	0.08	0.06	0.09*	1,685	-0.09	445
	(0.26)	(0.28)	(0.24)	[0.05]		[0.10]	
Machete	0.59	0.59	0.60	-0.02	1,685	-0.16	445
	(0.49)	(0.49)	(0.49)	[0.05]		[0.11]	
Hoe	0.86	0.81	0.94	-0.36***	1,685	-0.52***	445
	(0.35)	(0.39)	(0.24)	[0.04]		[0.09]	
Pestle	0.51	0.52	0.48	0.08	1,685	0.01	445
	(0.50)	(0.50)	(0.50)	[0.05]		[0.11]	
Stove	0.47	0.46	0.47	0.02	1,685	0.07	445
	(0.50)	(0.50)	(0.50)	[0.05]		[0.11]	
Fishing net	0.05	0.06	0.03	0.10**	1,685	0.13	445
	(0.21)	(0.23)	(0.18)	[0.05]		[0.12]	
Boat	0.03	0.02	0.03	-0.08	1,685	-0.16	445
	(0.16)	(0.14)	(0.18)	[0.05]		[0.13]	
Motorcycle	0.11	0.10	0.14	-0.12**	1,685	-0.08	445
	(0.32)	(0.30)	(0.34)	[0.05]		[0.11]	
Bicycle	0.07	0.06	0.10	-0.15***	1,685	-0.06	445
	(0.26)	(0.23)	(0.30)	[0.05]		[0.11]	
Solar panel	0.05	0.05	0.05	-0.00	1,685	0.14*	445
	(0.22)	(0.22)	(0.21)	[0.05]		[0.08]	
Chairs	0.47	0.46	0.49	-0.05	1,685	-0.14	445
	(0.50)	(0.50)	(0.50)	[0.05]		[0.11]	
Tables	0.35	0.35	0.35	0.01	1,685	-0.06	445
	(0.48)	(0.48)	(0.48)	[0.05]		[0.11]	
Beds	0.41	0.40	0.44	-0.06	1,685	-0.12	445
	(0.49)	(0.49)	(0.50)	[0.05]		[0.11]	
Radio	0.13	0.13	0.14	-0.02	1,685	0.07	445
	(0.34)	(0.33)	(0.34)	[0.05]		[0.11]	
Refrigerator	0.05	0.06	0.05	0.06	1,685	0.13	445
	(0.23)	(0.23)	(0.21)	[0.05]		[0.10]	
Television	0.21	0.22	0.20	0.07	1,685	0.16	445
	(0.41)	(0.41)	(0.40)	[0.05]		[0.10]	

Notes: Asset index is constructed using principal components from the ownership of individual assets reported to summarize the combined effects of the programme on all assets. The index provides a way to interpret the overall Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.7.6. Baseline Balance and Attrition on Household Credit and Transfers

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Has outstanding loan	0.10	0.11	0.07	0.15***	1,685	-0.02	445
	(0.30)	(0.32)	(0.26)	[0.05]		[0.11]	
Loan original value	1,024.47	991.60	1,118.29	-0.01	158	0.03	43

	(976.60)	(938.73)	(1,084.32)	[0.03]		[0.06]	
Has access to credit if needed	0.21	0.23	0.18	0.12**	1,685	-0.00	445
	(0.41)	(0.42)	(0.38)	[0.05]		[0.11]	
Gave money/goods to another household in last 12 months	0.11	0.11	0.11	0.00	1,685	-0.03	445
	(0.31)	(0.31)	(0.31)	[0.05]		[0.11]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.7.7. Baseline Balance and Attrition on Household Non-Farm Enterprises

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Any non-agricultural business	0.23	0.22	0.25	-0.06	1,685	0.13	445
	(0.42)	(0.41)	(0.43)	[0.05]		[0.10]	
Processed/sold any agricultural by-products	0.06	0.05	0.06	-0.04	1,685	0.09	445
	(0.23)	(0.22)	(0.24)	[0.05]		[0.11]	
Offered services or sold anything	0.18	0.18	0.20	-0.07	1,685	0.15	445
	(0.39)	(0.38)	(0.40)	[0.05]		[0.10]	
Fishing or fish farming business	0.03	0.03	0.03	-0.02	1,685	0.02	445
	(0.16)	(0.16)	(0.16)	[0.05]		[0.11]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.7.8. Baseline Balance and Attrition on Household Agricultural Production

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
Household produced…	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Maize	0.14	0.16	0.10	0.16***	1,685	0.14	445
	(0.35)	(0.37)	(0.31)	[0.05]		[0.10]	
Beans	0.11	0.09	0.14	-0.15***	1,685	-0.10	445
	(0.31)	(0.29)	(0.34)	[0.05]		[0.11]	
Cassava	0.18	0.16	0.21	-0.14***	1,685	-0.04	445
	(0.38)	(0.36)	(0.41)	[0.05]		[0.11]	
Peanuts	0.13	0.16	0.08	0.22***	1,685	0.30***	445
	(0.34)	(0.37)	(0.28)	[0.04]		[0.09]	
Quantity Produced (Kilos)							
Maize	87.64	89.62	82.22	0.11	235	-0.37	65
	(71.53)	(72.51)	(69.06)	[0.14]		[0.37]	
Bean	57.47	61.17	53.01	0.26*	183	0.17	42
	(37.97)	(36.56)	(39.37)	[0.15]		[0.30]	
Cassava	174.25	182.86	162.62	0.17	296	0.55**	72
	(134.79)	(143.27)	(122.02)	[0.12]		[0.25]	
Peanuts	88.43	89.71	84.06	0.11	221	-0.47	70
	(68.18)	(65.55)	(77.08)	[0.18]		[0.48]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control

for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.7.9. Baseline Balance and Attrition on Household Livestock Ownership (Share)

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Livestock index	-0.14	-0.13	-0.16	0.05	1,685	-0.07	445
	(0.47)	(0.49)	(0.42)	[0.05]		[0.12]	
Goats	0.01	0.00	0.02	-0.19***	1,685	0.08	445
	(0.08)	(0.04)	(0.13)	[0.07]		[0.06]	
Chicken	0.03	0.03	0.03	-0.00	1,685	0.01	445
	(0.16)	(0.16)	(0.16)	[0.05]		[0.12]	
Guinea fowl	0.04	0.04	0.04	0.01	1,685	0.05	445
	(0.20)	(0.20)	(0.19)	[0.05]		[0.09]	
Duck	0.02	0.03	0.02	0.00	1,685	0.04	445
	(0.16)	(0.16)	(0.16)	[0.05]		[0.09]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.7.10. Baseline Balance and Attrition on Negative Household Shocks

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Experienced at least one shock in last 12 months	0.48	0.50	0.45	0.10**	1,685	0.22**	445
	(0.50)	(0.50)	(0.50)	[0.05]		[0.11]	
Drought	0.14	0.13	0.16	-0.09*	1,685	-0.05	445
	(0.35)	(0.34)	(0.37)	[0.05]		[0.11]	
Floods	0.10	0.12	0.06	0.18***	1,685	0.20**	445
	(0.29)	(0.32)	(0.24)	[0.05]		[0.09]	
Winds	0.11	0.11	0.10	0.05	1,685	-0.14	445
	(0.31)	(0.32)	(0.30)	[0.05]		[0.10]	
Crop/livestock pests/disease	0.09	0.08	0.11	-0.08	1,685	0.11	445
	(0.29)	(0.28)	(0.31)	[0.05]		[0.11]	
Crop/harvest destroyed	0.06	0.04	0.08	-0.19***	1,685	-0.00	445
	(0.23)	(0.20)	(0.28)	[0.06]		[0.09]	
Illness/accident household member(s)	0.06	0.05	0.06	-0.01	1,685	0.10	445
	(0.23)	(0.22)	(0.24)	[0.05]		[0.11]	
Death of household income earner	0.05	0.05	0.03	0.09**	1,685	0.02	445
	(0.21)	(0.23)	(0.18)	[0.05]		[0.11]	
Divorce/separation/death/migration	0.05	0.05	0.04	0.06	1,685	0.13	445
	(0.22)	(0.23)	(0.21)	[0.05]		[0.09]	
House destroyed	0.07	0.06	0.08	-0.11**	1,685	-0.12	445
	(0.25)	(0.23)	(0.28)	[0.06]		[0.11]	
Conflict in the community	0.01	0.01	0.01	0.04	1,685	0.00	445
	(0.11)	(0.11)	(0.10)	[0.05]		[0.10]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.7.11. Baseline Balance and Attrition on Coping Strategies

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Own savings	0.48	0.47	0.50	-0.07	806	-0.12	205
	(0.50)	(0.50)	(0.50)	[0.07]		[0.17]	
Received help from relatives/friends	0.36	0.35	0.37	-0.03	806	0.28*	205
	(0.48)	(0.48)	(0.48)	[0.07]		[0.16]	
Changed eating patterns	0.01	0.01	0.01	-0.02	806	0.00	205
	(0.10)	(0.10)	(0.10)	[0.09]			
Reduced adult consumption	0.01	0.01	0.01	-0.07	806	0.00	205
	(0.09)	(0.07)	(0.10)	[0.09]			
Obtained credit	0.00	0.00	0.00	0.00	806	0.18	205
	(0.00)	(0.00)	(0.00)			[0.18]	
Sold agricultural /assets/land/livestock	0.01	0.01	0.01	-0.04	806	-0.00	205
	(0.11)	(0.10)	(0.12)	[0.08]		[0.22]	
Intensified fishing/farming	0.01	0.01	0.02	-0.13	806	-0.41	205
	(0.10)	(0.07)	(0.13)	[0.09]		[0.28]	
Other	0.02	0.03	0.02	0.06	806	-0.04	205
	(0.16)	(0.17)	(0.13)	[0.07]		[0.20]	
None	0.38	0.42	0.31	0.24***	806	0.06	205
	(0.49)	(0.49)	(0.46)	[0.07]		[0.16]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.7.12. Baseline Balance and Attrition on Household Access to Other Programs

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
In the last 12 months, household received money or goods from…	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Cash transfer program	0.00	0.01	0.00	0.04	1,685	0.00	445
	(0.07)	(0.07)	(0.06)	[0.05]			
In-kind food assistance program	0.01	0.01	0.01	0.00	1,685	0.00	445
	(0.11)	(0.10)	(0.11)	[0.06]			
Public works program	0.01	0.01	0.02	-0.06	1,685	-0.08	445
	(0.12)	(0.11)	(0.13)	[0.06]		[0.08]	
Farmer or agricultural program	0.00	0.00	0.00	0.03	1,685	0.00	445
	(0.05)	(0.05)	(0.04)	[0.05]			
Other income generation programs	0.00	0.00	0.00	0.05	1,685	-0.08	445
	(0.03)	(0.04)	(0.00)	[0.04]		[0.23]	
Community health campaigns or health programs	0.02	0.02	0.03	-0.06	1,685	-0.10	445
	(0.14)	(0.13)	(0.16)	[0.06]		[0.11]	
Water or sanitation programs	0.03	0.03	0.05	-0.16***	1,685	-0.10	445
	(0.18)	(0.16)	(0.22)	[0.06]		[0.12]	
Social welfare or psychosocial support program	0.00	0.00	0.00	0.00	1,685	-0.56	445
	(0.00)	(0.00)	(0.00)			[0.39]	
Education or school program	0.04	0.03	0.04	-0.01	1,685	-0.03	445
	(0.18)	(0.18)	(0.19)	[0.05]		[0.09]	
Youth services or activities	0.00	0.00	0.00	-0.10*	1,685	-0.11	445
	(0.04)	(0.00)	(0.07)	[0.06]		[0.18]	
Other programme	0.02	0.01	0.02	-0.05	1,685	0.05	445
	(0.13)	(0.12)	(0.14)	[0.06]		[0.03]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control

for linear distance to district border (km) and are an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.8.1. Baseline Balance and Attrition on Caregiver Health and Nutrition Knowledge

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
Correctly identifies. . .	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Sum of knowledge questions (0-5)	3.58	3.50	3.70	0.05	1,671	0.11	445
	(1.29)	(1.32)	(1.20)	[0.04]		[0.09]	
Baby should be breastfed immediately after birth	0.93	0.93	0.94	-0.06	1,671	0.20*	445
	(0.26)	(0.26)	(0.24)	[0.05]		[0.11]	
Baby should be exclusively breastfed for 6 months	0.67	0.69	0.63	0.00	1,671	-0.03	445
	(0.47)	(0.46)	(0.48)	[0.04]		[0.08]	
At least one reason for exclusive breastfeeding	0.78	0.75	0.84	-0.02	1,671	0.02	445
	(0.41)	(0.43)	(0.37)	[0.04]		[0.09]	
At least one reason iron is important for babies	0.63	0.60	0.68	0.08**	1,671	0.17*	445
	(0.48)	(0.49)	(0.47)	[0.04]		[0.09]	
At least one source of iron	0.57	0.55	0.62	0.10***	1,671	0.03	445
	(0.49)	(0.50)	(0.49)	[0.04]		[0.08]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison and enumerator fixed effects. * p < .1. ** p < .05. *** p < .01.

Table A.8.2. Baseline Balance and Attrition on Caregiver Psychological Wellbeing and Social Support

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
CES-D scale (0-30)	12.42	12.16	12.89	0.00	1,671	0.09	445
	(4.72)	(4.92)	(4.29)	[0.04]		[0.09]	
Depressive symptoms (CES-D ≥ 10)	0.74	0.71	0.79	0.03	1,671	0.07	445
	(0.44)	(0.45)	(0.41)	[0.04]		[0.08]	
Cohen stress scale (0-40)	18.85	18.75	19.03	-0.01	1,671	-0.10	445
	(3.52)	(3.89)	(2.74)	[0.04]		[0.10]	
Perceived social support scale	-0.02	0.15	-0.31	0.08**	1,671	0.11	445
	(2.16)	(2.16)	(2.13)	[0.04]		[0.07]	
Self-assessed happiness (1-10, ladder)	4.91	4.81	5.07	-0.11**	1,671	0.02	445
	(2.46)	(2.48)	(2.40)	[0.04]		[0.09]	
Satisfied with life (majority of time or always)	0.29	0.30	0.29	0.04	1,671	-0.36***	445
	(0.46)	(0.46)	(0.45)	[0.05]		[0.12]	

Notes: CES-D stands for Center for Epidemiologic Studies Depression scale. Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison and enumerator fixed effects. * p < .1. ** p < .05. *** p < .01.

Table A.8.3. Baseline Balance and Attrition on Caregiver Status and Empowerment

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Currently saving money	0.06	0.07	0.04	0.17***	1,671	0.05	445
	(0.24)	(0.26)	(0.19)	[0.05]		[0.15]	
Control over life and self-efficacy (0-24)	10.92	11.16	10.48	0.08*	1,671	0.09	445
	(4.05)	(4.15)	(3.82)	[0.05]		[0.09]	
Self-assessed autonomy (1-10,	5.00	4.87	5.24	-0.09**	1,671	-0.11	445

ladder)	(2.59)	(2.65)	(2.47)	[0.04]		[0.08]	
Self-assessed decision-making power (1-10, ladder)	4.79	4.66	5.01	-0.10**	1,671	-0.14	445
	(2.43)	(2.44)	(2.41)	[0.04]		[0.09]	
Self-assessed household economic standing (1-10, ladder)	3.76	3.63	4.00	-0.06	1,671	-0.09	445
	(2.23)	(2.22)	(2.23)	[0.04]		[0.09]	
Participates in at least one community group	0.24	0.25	0.22	0.04	1,671	0.13	445
	(0.43)	(0.44)	(0.42)	[0.05]		[0.10]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison and enumerator fixed effects. * p < .1. ** p < .05. *** p < .01.

Table A.8.4. Baseline Balance and Attrition on Caregiver Intra-Household Conflict and Violence

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Attitudes accepting IPV (0-5)	1.16	1.15	1.16	-0.04	1,284	0.02	319
	(1.73)	(1.78)	(1.66)	[0.05]		[0.11]	
At least one reason supporting IPV	0.41	0.39	0.44	-0.06	1,284	0.07	319
	(0.49)	(0.49)	(0.50)	[0.05]		[0.12]	
Partner drunk at least once a month	0.04	0.04	0.04	-0.02	1,321	-0.02	324
	(0.20)	(0.20)	(0.20)	[0.06]		[0.14]	
Afraid of partner most of the time	0.28	0.28	0.28	0.05	1,325	0.23**	329
	(0.45)	(0.45)	(0.45)	[0.05]		[0.11]	
Controlling behaviours (12-month recall)	0.61	0.60	0.64	0.03	1,300	0.15	319
	(0.49)	(0.49)	(0.48)	[0.05]		[0.12]	
Emotional IPV (12-month recall)	0.15	0.18	0.11	0.15**	1,315	0.12	327
	(0.36)	(0.38)	(0.31)	[0.06]		[0.14]	
Physical IPV (12-month recall)	0.14	0.14	0.13	0.00	1,291	-0.19	314
	(0.35)	(0.35)	(0.34)	[0.07]		[0.15]	
Emotional and/or physical IPV (12-month recall)	0.22	0.25	0.18	0.12*	1,290	-0.09	316
	(0.42)	(0.43)	(0.39)	[0.06]		[0.14]	

Notes: Sample includes only caregivers aged 18 and older who were ever partnered and able to be interviewed in private. Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison and enumerator fixed effects. * p < .1. ** p < .05. *** p < .01.

Table A9.1.1: Baseline Balance and Attrition of Child Material Possessions Aged 3 to 17

Dependent Variable	Mean (SD)			Panel		Attiritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
Has shoes, clothes and a blanket	0.31	0.32	0.30	0.06	3,157	0.28***	702
	(0.46)	(0.47)	(0.46)	[0.04]		[0.08]	
Has a pair of shoes or sandals	0.45	0.47	0.40	0.15***	3,161	0.35***	705
	(0.50)	(0.50)	(0.49)	[0.04]		[0.08]	
Has a change of clothes	0.85	0.86	0.84	0.05	3,163	-0.00	703
	(0.36)	(0.35)	(0.37)	[0.04]		[0.09]	
Has a blanket	0.49	0.48	0.50	-0.02	3,161	0.11	704
	(0.50)	(0.50)	(0.50)	[0.04]		[0.09]	
Slept under a mosquito net last night	0.75	0.75	0.75	-0.01	3,157	-0.03	702
	(0.43)	(0.43)	(0.43)	[0.04]		[0.09]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using children in the panel household observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6).

Regressions control for linear distance to district border (km) and an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A9.2.1 Baseline Balance and Attrition for School Outcomes for Children Aged 6 to 17

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treat	Comparison	SM Diff	N	SM Diff	N
Has ever attended school	0.75	0.75	0.75	0.02	1,889	0.14	405
	(0.43)	(0.43)	(0.43)	[0.04]		[0.10]	
Currently attending school	0.70	0.70	0.70	0.02	1,889	0.19*	405
	(0.46)	(0.46)	(0.46)	[0.05]		[0.11]	
Current grade	4.16	4.22	4.04	0.09	1,321	0.37***	276
	(2.03)	(2.04)	(2.01)	[0.06]		[0.13]	
Number of days in school (last full week of school)	4.58	4.59	4.57	0.03	1,321	0.03	277
	(1.14)	(1.10)	(1.22)	[0.06]		[0.13]	
Spending on schooling (12 months)	267.75	276.79	249.21	0.09*	1,321	0.60***	277
	(342.56)	(357.98)	(308.09)	[0.05]		[0.14]	

Notes: 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 care treatment groups combined. Column (2) and (3) presents programme estimates from a model with an additional interaction term for households who were eligible for the care component. The coefficient in Column (2) represents the impact of the cash transfer relative to the control group and Column (3) represents the additional programme impact for households who were eligible for the care 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, 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 care component. * p < .1. ** p < .05. *** p < .01.

Table A9.3.1: Baseline Balance and Attrition on Time Use for Children Aged 5 to 17

Dependent	Mean (SD)			Panel		Attritors	
Variable	All	Treatment	Comparison	SM Diff	N	SM Diff	N
Hours (last 24 hours)	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Schooling	1.69	1.81	1.45	0.18***	2,407	0.49***	524
	(2.10)	(2.13)	(2.02)	[0.04]		[0.09]	
Commuting to school	1.58	1.59	1.56	0.02	2,407	0.16	524
	(2.09)	(2.09)	(2.10)	[0.04]		[0.11]	
Studying at home	0.26	0.29	0.21	0.14***	2,407	0.27***	524
	(0.70)	(0.71)	(0.69)	[0.05]		[0.06]	
Collecting water	0.83	0.81	0.87	-0.07	2,407	0.13	524
	(0.94)	(0.91)	(1.00)	[0.05]		[0.11]	
Collecting firewood	0.47	0.46	0.49	-0.03	2,407	0.16	524
	(0.92)	(0.87)	(1.03)	[0.05]		[0.11]	
Other domestic tasks	1.01	1.00	1.01	-0.00	2,407	0.29***	524
	(1.14)	(1.12)	(1.17)	[0.04]		[0.10]	
Taking care of family members	0.52	0.56	0.44	0.13***	2,407	0.31***	524
	(1.02)	(1.03)	(0.99)	[0.04]		[0.11]	
Sleeping	7.23	7.32	7.06	0.09**	2,407	-0.06	524
	(2.46)	(2.44)	(2.48)	[0.04]		[0.11]	
Hours (last week)							
Farm activities	0.94	0.99	0.84	0.04	2,407	0.04	524
	(3.33)	(3.66)	(2.56)	[0.04]		[0.09]	
Helping in non-agricultural business	0.25	0.29	0.17	0.10**	2,407	-0.02	524
	(1.21)	(1.29)	(1.03)	[0.04]		[0.15]	
Caring for livestock or poultry	0.22	0.23	0.19	0.04	2,407	0.11***	524
	(1.10)	(1.03)	(1.22)	[0.05]		[0.02]	
Paid work	0.19	0.19	0.18	0.01	2,407	0.11***	524
	(1.09)	(0.51)	(1.75)	[0.07]		[0.03]	
Fishing activities	0.26	0.29	0.18	0.09*	2,407	0.15*	524
	(1.26)	(1.11)	(1.52)	[0.05]		[0.08]	
Days (last rainy season)							
Land preparation	2.01	1.65	2.72	-0.13**	2,407	-0.41**	524
	(7.81)	(6.38)	(10.07)	[0.05]		[0.17]	

Non-harvest work	1.76	1.41	2.47	-0.14***	2,407	-0.44**	524
	(7.24)	(5.53)	(9.77)	[0.05]		[0.18]	
Harvesting	1.26	1.16	1.46	-0.04	2,407	-0.17	524
	(4.88)	(4.70)	(5.23)	[0.04]		[0.12]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using panel observations only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and an indicator for the northern border paired district comparison. * p < .1. ** p < .05. *** p < .01.

Table A.9.4.1. Baseline Balance and Attrition on Violent Discipline of Children Aged 1 to 14 Years

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Any non-violent discipline	0.47	0.49	0.43	0.04	3,055	0.07	668
	(0.50)	(0.50)	(0.50)	[0.03]		[0.08]	
Any psychological aggression	0.41	0.42	0.41	-0.01	3,055	0.12	668
	(0.49)	(0.49)	(0.49)	[0.03]		[0.08]	
Any physical punishment	0.32	0.32	0.31	0.00	3,055	0.11	668
	(0.46)	(0.47)	(0.46)	[0.04]		[0.09]	
Any violent discipline	0.48	0.50	0.46	0.04	3,055	0.12	668
	(0.50)	(0.50)	(0.50)	[0.03]		[0.08]	
Caregiver believes violent discipline necessary to raise children	0.13	0.14	0.12	0.03	3,055	0.19***	668
	(0.34)	(0.35)	(0.32)	[0.04]		[0.07]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using children in panel households only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison and enumerator fixed effects. * p < .1. ** p < .05. *** p < .01.

Table A.9.4.2. Baseline Balance and Attrition on Initiation Rites of Female Children Aged 10 to 18 Years

Dependent Variable	Mean (SD)			Panel		Attritors	
	All	Treatment	Comparison	SM Diff	N	SM Diff	N
	(1)	(2)	(3)	(4)	(5)	(6)	(7)
Undergone initiation rites	0.39	0.40	0.38	0.08	684	0.19	189
	(0.49)	(0.49)	(0.49)	[0.09]		[0.19]	
Age underwent initiation rites (years)	14.03	14.04	14.03	-0.04	270	-0.44	95
	(2.09)	(2.04)	(2.23)	[0.13]		[0.27]	
Plans to undergo initiation rites this or next year	0.13	0.15	0.09	0.27**	414	0.38	94
	(0.34)	(0.36)	(0.28)	[0.12]		[0.23]	

Notes: Columns (1) to (3) report baseline means and standard deviations for the corresponding outcome using children in panel households only. SM Diff in Column (4) reports the standardized mean difference between treatment and comparison groups at baseline using only panel observations. SM Diff in Column (6) reports the standardized mean difference between treatment and comparison groups at baseline using only observations that left the endline sample. Robust standard errors are in squared parentheses in Columns (4) and (6). Regressions control for linear distance to district border (km) and are an indicator for the northern border paired district comparison and enumerator fixed effects. * p < .1. ** p < .05. *** p < .01.

ANNEX B. ADDITION IMPACT ANALYSIS TABLES

Table B9.1.1: Impacts on Material Well-Being (Combined Indicator) Among Children Aged 3 to 17 by Gender and Age

	Impact Estimates			Endline Mean	
Sample	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
All	0.21***	0.22***	-0.01	0.36	6822
	(0.02)	(0.03)	(0.03)		
Boys	0.19***	0.19***	0.02	0.35	3327
	(0.03)	(0.04)	(0.05)		
Girls	0.24***	0.25***	-0.05	0.37	3495
	(0.03)	(0.04)	(0.05)		
Ages 3-5	0.29***	0.29***	0.01	0.31	1923
	(0.04)	(0.04)	(0.06)		
Ages 6-11	0.16***	0.17***	-0.02	0.34	3253
	(0.04)	(0.04)	(0.05)		
Ages 12-17	0.25***	0.25***	-0.02	0.45	1646
	(0.05)	(0.05)	(0.06)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among children in the household panel sample. Column (1) presents impact estimates from a model with the treatment groups combined. Columns (2) and (3) presents impact estimates from a model with an additional interaction term for households who were 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 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), 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, 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 < .1. ** p < .05. *** p < .01.

Table B.9.3.1: Impacts on Hours Spent on Schooling for Children Aged 5 to 17 by Gender and Age

	Impact Estimates			Endline Mean	
Sample	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
All	-0.48***	-0.37**	-0.37*	1.35	5773
	(0.17)	(0.18)	(0.23)		
Boys	-0.63**	-0.46*	-0.57*	1.44	2821
	(0.24)	(0.26)	(0.33)		
Girls	-0.29	-0.25	-0.18	1.27	2952
	(0.24)	(0.25)	(0.18)		
Age 5-11	-0.54***	-0.45**	-0.32	1.25	4125
	(0.19)	(0.20)	(0.26)		
Age 12-17	-0.22	-0.01	-0.69	1.65	1648
	(0.35)	(0.37)	(0.44)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among children in the household panel sample. Column (1) presents impact estimates from a model with the treatment groups combined. Column (2) and (3) presents impact estimates from a model with an additional interaction term for households who were 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 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), 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, 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 < .1. ** p < .05. *** p < .01.

Table B.9.3.2: Impacts on Hours Spent on Domestic Work and Taking Care of Family Members for Children Aged 5 to 17 by Gender and Age (aggregate indicator)

	Impact Estimates			Endline Mean	
Sample	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
All	-0.27**	-0.22*	-0.10	2.30	5773
	(0.12)	(0.13)	(0.16)		
Boys	-0.28*	-0.22	-0.25	2.31	2821
	(0.17)	(0.18)	(0.23)		
Girls	-0.22	-0.17	0.03	2.29	2952
	(0.17)	(0.18)	(0.22)		
Age 5-11	-0.14	-0.11	0.05	1.79	4125
	(0.13)	(0.14)	(0.17)		
Age 12-17	-0.56**	-0.48*	-0.17	3.77	1648
	(0.27)	(0.28)	(0.34)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among children in the household panel sample. Column (1) presents impact estimates from a model with the treatment groups combined. Column (2) and (3) presents impact estimates from a model with an additional interaction term for households who were 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 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), 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, 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 < .1. ** p < .05. *** p < .01.

Table B.9.3.3: Impacts on Hours Spent on Farm Activities (last week) for Children Aged 5 to 17 by Gender and Age

	Impact Estimates			Endline Mean	
Sample	DD Pooled Treatments	DD Cash	Additional Impact CM	Comparison	N
	(1)	(2)	(3)	(4)	(5)
All	-0.96***	-0.89***	-0.36***	2.07	5773
	(0.12)	(0.13)	(0.33)		
Boys	-0.68**	-0.58	-0.41	2.19	2821
	(0.35)	(0.37)	(0.46)		
Girls	-1.24***	-1.14***	-0.33	2.54	2952
	(0.37)	(0.39)	(0.48)		
Age 5-11	-0.75**	-0.82**	-0.19	1.20	4125
	(0.21)	(0.22)	(0.28)		
Age 12-17	-1.91***	-1.38*	-1.78**	5.68	1648
	(0.71)	(0.76)	(0.91)		

Notes: CM = case management. Impacts are estimated using difference-in-differences with robust standard errors among children in the household panel sample. Column (1) presents impact estimates from a model with the treatment groups combined. Column (2) and (3) presents impact estimates from a model with an additional interaction term for households who were 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 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), 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, 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 < .1. ** p < .05. *** p < .01.

ANNEX C. 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.

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 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.

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.[35]

35 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 Lalua 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

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).

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.

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 C1. 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%

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.

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 < .1. ** p < .05. *** p < .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%).

ANNEX D. EVALUATION DOCUMENTATION

D.1. TERMS OF REFERENCE

unite for children

unicef

UNICEF Mozambique

TERMS OF REFERENCE

Purpose of the assignment:

To design the overall impact evaluation of the UNICEF Child Grant pilot program and carry out the evaluation of its year-one pilot phase, to be implemented in 2 districts in Mozambique

1. Background and Context

Cash transfer programs are an increasingly popular social protection tool among governments to reduce poverty and social vulnerability, recognizing the two are mutually reinforcing. It is important to recognize that cash transfers alone are rarely, if ever, sufficient to overcome the broad-based and interrelated social, economic and health risks children face. Thus linkages between social protection programs and existing government and other services should be strengthened to best support beneficiaries. This recognition has led advocates to highlight "cash plus", or cash transfer programs bundled with light-touch or more intensive complementary interventions as important investment areas. The rationale behind this is that government cash transfers identify the poorest and most vulnerable members of society with the aim of smoothing consumption and improving food security, and linking vulnerable populations to other services may have synergistic impacts on their wellbeing. In this way, beneficiaries may be reached with health or social services, or may be able to leverage the cash to achieve greater impacts on their productive activities and future wellbeing

Mozambique has had a social protection system in place since 2007 and social protection has become an important element in the political debate in the push for a more inclusive poverty alleviation approach.

The Government of Mozambique explicitly recognizes in various strategic documents, such as Five-Year Government Plan (PQG) 2015-2019 and National Development Strategy (ENDE) 2015-2035 the importance of social protection systems in securing the well-being of the population and in fostering economic and social development. Over the past decade, the social protection system in Mozambique has been consolidated, with the establishment of a legal and regulatory framework for basic social protection, and the elaboration and enactment of a National Strategy for Basic Social Security, now in its second phase of development

The new National Basic Social Security Strategy, or ENSSB II, covering the period 2016-2024, endorsed by the Council of Ministers in February 2016, provides a unique opportunity to address this fragmentation and better align those involved to deliver an ambitious set of targets

One of the critical characteristics of the new ENSSB is that it is child-sensitive and seeks, among others, to reduce childhood malnutrition in Mozambique. The evidence is clear that cash transfer programs targeting children have the potential to effectively promote both economic growth and aspects of social equity in a meaningful and sustainable manner. Furthermore, early interventions during crucial developmental stages generate the highest returns on this investment. The ENSSB II expands the PSSB to include a Child grant, targeting a) children aged 0-2 years, known as the '*Subsídio de Primeira Infância*' or early childhood allowance, b) child-headed households and c) orphaned children in poor households. The expansion of the PSSB to children 0-2 years old aims to reach 12,000 children in 2018 and 50,000 by 2022

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UNICEF will support the design, testing, implementation and scale-up of the new child grant. One of the key objective of the Child grant is to address the persistent level of stunting and malnutrition in the country and it is aimed to promote positive behavior-change related to adoption of positive nutrition practices, to ensure the allowance is complemented by nutrition counselling as well as the protective and preventive services to address risks related to child protection. The ENSSB II, including the child grant programme, are based on the principle of 'Cash & Care' recognizing that cash is not enough to generate accelerated positive results for children and overcome the complex social and economic risks and vulnerabilities the targeted households and their children face. 'Cash & Care', (also known as "Cash Plus") encompasses a wide range of "plus" activities and linkages, with the ultimate aim to integrate programmes across sectors and address different dimensions of poverty to more effectively support the poorest groups with the hope of inducing synergistic impacts.

Given that the grant is time-bound (two years) and focuses on nutritional outcomes, the design will need to incorporate a rapid registration of beneficiaries, a system of engaging with pregnant women (e.g. enrolment during prenatal care), will be developed a real time monitoring system, and timely payment modalities, building on or linked to already existing registration systems. In terms of implementation, the Child Grant will be designed and tested starting in late 2017/early 2018, and be implemented on a graduation basis (up till enrolled children reach the age of two), according to government targets. Using existing government systems, the Child Grant will be piloted in 2 districts with high levels of malnutrition.

Justification: Prior to the start of full scaling up of the Child Grant, the conceptualization of a rigorous impact evaluation with respective calculation of the sample size, composition and selection of the treatment and control groups is needed.

In 2017, the design of the Child Grant will be finalized and will identify targeted communities. To guide the qualitative and quantitative impact evaluation of implementing the Child Grant it will include identification of beneficiary (treatment) groups and control groups. The results of the impact evaluation, together with other relevant data, will be used to inform and guide MGCAS in the scale-up of the Child Grant. The Child Grant will also be used to promote access and uptake for critical basic services (birth registration, health services, etc).

The evaluation aims to examine how economic support and linkages to existing services can improve child well-being, including early child development and nutrition-related outcomes, in the first 2 years of life of children.

As a pilot intervention in Mozambique, this evaluation will provide critical information on the impact of the Child Grant in addition to its feasibility on a larger scale. Evaluation results and recommendations will inform key decision makers such as government representatives and donors. It will also allow UNICEF and program partners to learn from the evaluation results and adjust the program's approach for the following years, and will add to global learning on "cash plus" and the possible synergistic impacts of cash and care.

2. Objectives, Purpose and Expected Results

In collaboration with UNICEF Social Policy, Research and Evaluation section, the selected institution is expected to design the impact evaluation of the Child Grant Pilot (evaluation design and tools for the 2-year pilot programme) and carry out the evaluation and data collection for year-one pilot phase.

Key objectives are:

1.1. To develop the overall impact evaluation design (study design/identification strategy), including development of power calculations, study protocol, baseline and end-line instruments and data collection procedures that should be cost-effective and allow for monitoring results and performing an impact assessment in the medium and long term, over the course of 2 years of the pilot program;

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1.2. Conduct data collection and evaluation of the year-one pilot phase;
1.3. Identify all eligible households in study districts and study sample through an enumeration/sampling listing exercise (data to be subsequently used by UNICEF/government for programme enrolment);
1.4. Estimate the impact of the Child Grant, and to inform whether there are significant differences between children who benefited from "cash and care" intervention, the ones who received only cash, and a control group with children who did not received cash or care[1]. The assessment will look at results in terms of: nutrition (consumption, diversity etc.), growth/anthropometrics, early childhood development indicators, caregiver behaviours, household consumption, and other key outcomes, such as adolescent pregnancies (additional to be defined once the care package is developed)
1.5. At the end of year-one assess whether all new eligible cases have become beneficiaries given the universal nature of the grant;
1.6. Communicate impacts to UNICEF Mozambique, government and stakeholders via reports, briefs and dissemination (validation) workshops (one after baseline, one after year one evaluation).

The overarching research questions to be answered by the impact evaluation are:

1. How and to what extent can a cash transfer programme and/or cash plus care improve nutrition-related outcomes and improve the well-being of children during their first 2 years of life?
2. How and to what extent does the "care" component provide a substantial difference in child well-being indicators compared with cash only?

Specific and more detailed research questions will be identified during the inception phase of the program, and may necessitate interviews and workshops with key stakeholders

The evaluation team is also expected to work together with UNICEF colleagues in identifying the primary program beneficiaries through a listing exercise, identify the evaluation sample, and perform randomization of communities into study arms. The inception report should also include: 1) estimation of the number of eligible children and caregivers per community since there is no official data available regarding the number of children 0-2 and pregnant women residing in each community and power calculations of minimum clusters per study arm and households per cluster to estimate impacts of the programme on key child nutrition and well-being outcomes.

Intervention to be evaluated: The Child Grant will use geographical targeting (universal approach in selected communities. It means that in the selected communities all children 0-2 will be included in the program, with age as the only eligibility criteria. As previously mentioned, the programme will initially be piloted in 2 districts in Zambezia province, targeting in total 12000 children 0-2 (6000 children per district x 2 districts = total 12000 children) in the first year of intervention. Furthermore, out of the 6000 children in selected districts, 3000 will receive cash only and other 3000 will receive cash and care (graph below)[2].

Graph 1: Planned distribution of children beneficiaries of the Child Grant Pilot

[1] A four arm, "care only", with children receiving only the care component may not be feasible due to operational reasons. However companies may provide, information and estimates of the 3 arms option (cash, cash+care, control), or 4 arms. (cash only, cash + care, care only, control).

[2] A four arm, "care only", with children receiving only the care component may not be feasible due to operational reasons. However companies may provide, information and estimates of the 3 arms option (cash, cash+care, control), or 4 arms.(cash only, cash + care, care only, control)

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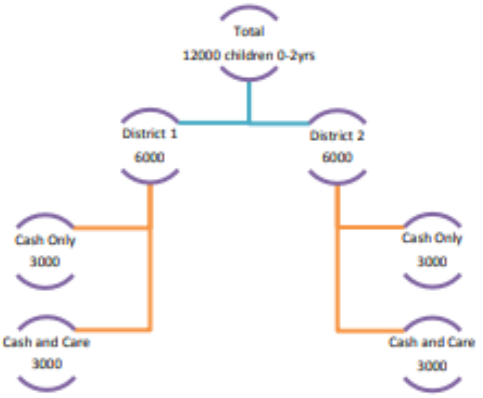

Information collected during the evaluation will guide the remodelling of the national PSSB, and the final impact assessment will guide the redesign of the grant and its scale up at national level.

3. Methodology and Technical Approach

A rigorous approach with a cluster randomized control trial is preferred to investigate the causal linkage that relates inputs, activities and outputs to impacts. In order to conduct a rigorous quantitative impact assessment, it should include determining the sufficient sample size through power calculations, identification of eligible beneficiaries and study sample, and randomization of communities to study arm. To estimate midterm impacts, both baseline and 12-month follow-up data will be collected. Additionally, embedded qualitative interviews will be collected with a sub-sample of the study population to inform both the design and interpretation of quantitative data, providing vital context. Mixed methods may include surveys, key informant interviews, and focus groups.

The preferred design is experimental, with a randomized cluster sampling at community level, for the implementation of a universal geographical targeting approach will be used. In each district a number of community will receive cash only (3000 children); in other cash and care (3000 children, and in other nothing, as control group (the size of the control group to be determined by the sampling design)[3]. As **the child grant has a universal approach** within the target area, all children 0-2 in selected communities will be included in the program. The number of communities to be included in each of the 3 groups will be chosen based on estimate number of children 0-2 calculated from existing data (census estimate, ANC data, birth registration data etc.). A list of communities per each group will be defined and included until the planned number of children is reached. In the *cash and care* communities the *care* component will be rolled out at the same time of the cash according to the planned design.

After the identification of selected communities, a listing/registration exercise will identify all eligible children as well as pregnant women (6 or more months pregnant), to be included in the program.

Based on past experience, it will be important to have particular attention to support the acceptance at central and local level of a randomized approach. At central level it will be important to have a specific event to present the importance of a RCT approach to policy makers. At local level it will be important to engage district authorities and village leaders in the final selection of communities to be included in the baseline and in the different modalities of intervention. The induction phase should assess the level of acceptance of a randomized approach and finalize the design accordingly.

[3] A four arm, "care only", with children receiving only care component may not be feasible due to operational reasons. However companies may provide, information and estimates of the 3 arms option (cash, cash+care, , control) , or 4 arms.(cash only, cash + care, care only, control)

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This evaluation will not involve children as direct respondents, with the exception of collection of anthropometric measures (height, weight, length; information on children will be provided by head of household/caregivers, and however particular attention should be paid to any potential ethical issues[4]. Moreover, the design of the evaluation and the evaluation process should explicitly address the *Ethical Guidelines for Evaluation* set out by the United Nations Evaluation Group (UNEG)[5], *Strategic Guidance Note on Institutionalizing Ethical Practice for UNICEF Research* and *UNICEF Procedure for Ethical Standards in Research, Evaluation, Data Collection and Analysis*.

4. Specific tasks and activities

The main activities and tasks under this consultancy can be grouped as follows:

1. Literature/data review - published and unpublished documents and relevant statistical data shall be provided by the UNICEF SPEAR section. Other data may need to be gathered in the field or through key informant interviews. Background material will provided in terms of Grant design, situation of children in Mozambique, estimated population of the district, etc.;
2. Participation in research workshop with government (objective is to make the case for randomization)
3. Inception report, including evaluation design for a 2-year pilot, the study protocol and list of instruments/questionnaire to be developed (questionnaires should not be required to be finalized at this stage). This report will detail study design, sampling procedures for enumeration, study sample selection and then baseline data collection;
4. Finalization of instruments, approval of ethical clearance;
5. Sub-contract data collection firm;
6. Training and completion of enumeration (LTA holder to co-facilitate with data collection firm);
7. Listing (census) of all target population of children 0-2 and pregnant women in selected locations (this will also serve as a pre-registration of beneficiaries);
8. Identification of control group
9. Baseline training, data collection;
10. Baseline analysis and report
11. Participation in baseline workshop to present the results and validate the data
12. Finalization of follow-up (year-one data collection) questionnaires, annual re-submission for ethical clearance
13. Listing and data collection for year-one follow-up
14. Follow up analysis and report
15. Participation in follow-up workshop

The **final evaluation report of year one** should integrate all evaluation findings after year one of implementation It will support the internal program's review for the second year. The report should be developed in accordance with the UNICEF-developed GEROS (Global Evaluation Reports Oversight System)[6] and template to facilitate the production of a compliant document. It should also address the UNICEF-Adapted UNEG Evaluation Reports Standards[7]. The report should include i) an executive summary, ii) an explanation of the evaluation's purpose, objectives and scope, iii) the description of the methodology applied to the evaluation, iv) the evaluation findings

4 The UNICEF Office of Research - Innocenti released in October 2013 Ethical Research Involving Children, an online resource that brings together expert thinking about key ethical issues involving children and how these might be addressed in different evaluation contexts. See http://www.unicef-irc.org/publications/706.

5 United Nations Evaluation Group, Ethical Guidelines for Evaluation, UNEG, New York, 2007. See https://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/about_iom/eva_techref/ UNEG_ethical_guidelines.pdf.

6 For further information about reporting requirements, see: United Nations Children's Fund, Global Evaluation Reports Oversight System (GEROS), UNICEF, 2013. See http://www.unicef.org/evaluation/files/GEROS_Methodology_v7.pdf.

7 UNICEF Evaluation Office, UNICEF-Adapted UNEG Evaluation Reports Standards, UNICEF, 2010. See http://www.unicef.org/evaldatabase/files/UNEG_UNICEF_Eval_Report_Standards.pdf.

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not only responding to the criteria and questions but also based on evidence derived from data collection and analysis methods, v) conclusions presenting reasonable judgements based on the findings, substantiated by evidence and providing pertinent insights into the program, vi) recommendations relevant to the object and purpose of the evaluation and developed with the involvement of key stakeholders.

A first version of the report will be presented in a validation workshop with partners, community members and key stakeholders. In addition to the final report, the evaluation team should develop evaluation briefs, such as summaries and PowerPoint presentation, which will contain a summary of the evaluation and key messages.

5. Deliverables

Deliverable	Timeframe
1. Research workshop with government (national and local level) on the importance of randomization for policy design;	By mid-September 2017
2. **Inception report**, including evaluation design for a 2-year pilot, study protocol for year-one evaluation and a list of instruments/questionnaire to be developed (questionnaires should not be required to be finalized at this stage). This report will detail study design, sampling procedures for enumeration, study sample selection and then baseline data collection; the inception report may be in English or Portuguese.	
3. Finalization of instruments, approval of ethical clearance;	
4. Sub-contract data collection firm;	Mid-December 2017
5. Training and completion of enumeration (LTA holder to manage with data collection firm)	
6. Baseline training and data collection; Provide weekly summaries of data collection progress, contact and interview completion rates;	
7. Provide raw data files for individual, community quantitative data and qualitative transcripts in Portuguese and English) to UNICEF Office as fieldwork is progressing (this includes data files and qualitative transcripts – English and Portuguese). Promptly respond to queries on potential data collection errors	
8. Provide cleaned, document data from quantitative surveys (household, youth and community) in Stata format	
9. **Baseline analysis and report**. The report is to be submitted in word digital format, in English and Portuguese.	
10. Baseline report validation workshop in Maputo with key stakeholders	November 2018
11. Ethics approval renewal submission (12-months) and updated year-one end-line questionnaires	
12. Co-facilitate data collection training and oversee implementation of data collection for 12-month follow-up	
13. Electronic copies of **raw and clean baseline and year-one data sets**. Datasets should be submitted to UNICEF in Stata Format.	
14. Organize a validation workshop of the initial results of the year-one follow-up	
15. **First draft of the evaluation report** including all the evaluation findings of the year-one pilot phase of the program. The report may be delivered in English or Portuguese	End-December 2018
16. Validated **end of year-one report** with all evaluation findings. The report should be delivered using the UNICEF-developed GEROS format, in paper and word digital forms, in English and Portuguese.	

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Deliverable	Timeframe
17. Updated and finalized user-friendly **evaluation data collection tools and guidelines** to be applied over the two-year program implementation, to be submitted in English and Portuguese	
18. **Evaluation brief and PowerPoint presentation** containing a summary of the evaluation and key messages, in English and Portuguese	

A detailed workplan, additional/revised tasks should be included in the technical proposal

7. Management and Time Period for the Consultancy

The selected consultancy firm will report directly to the **Social Policy, Research and Evaluation Section**. Meetings with program partners and the Government will be arranged with the support of the UNICEF Child Protection, Health and provincial coordinator. Meetings with program beneficiaries and key stakeholders in targeted districts will be arranged with the support of provincial coordinators and UNICEF partners.

The evaluation work will be home-based with frequent travels to Maputo and Zambézia province for field work and meetings. The contract will start **22 June 2016** and end on **31 December 2018**. The assignment may be extended to cover data analysis and impact assessment in the following years of the program.

8. Technical Proposal and Detailed Estimated Budget

Applicants are requested to prepare and submit in separate e-mails:

1) a **technical proposal** that highlights the capacity of the applicant consultancy firm to organize and implement large scale data collection and analysis. It should include i) a detailed proposed methodology and design structure of the impact assessment for the 2-year duration of the program (including composition and selection criteria for control group), detailed work plan and quality assurance mechanisms. The proposal will assess if information will be collected on all the beneficiaries or only on a sample of them, justifying sample design, size and characteristics ii) assessment of ethical concerns and risks and appropriate mitigation measures; iii) team members, their roles in the team and whether they are available to travel to Maputo and Zambézia for field work and meetings, iv) CVs of all the team members, including the team leader, v) a sample of their writing, for example, a report or written product from a previous study or evaluation.

2) a **proposed budget** that must be all inclusive of professional fees, travel expenses and a clear breakdown of operational. Professional fees are to be detailed by professional level. The proposed budget must also be linked to the key deliverables outlined in Point 6 above.

The payment will be performed in 4 instalments, as follows:

35% upon satisfactory completion of deliverable 1-3, by mid-September 2017
25% upon satisfactory completion of deliverables 4 – 9, by mid-December 2017
20% upon satisfactory completion of deliverables 10 – 14, by November 2018
20% upon satisfactory completion of deliverables 15 – 18, by end-December 2018

9. Qualification Requirements
Consultancy firms may apply.

Requirements for the consultancy firms:

- legal standing (i.e., registration or founding statute),

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- minimum of two (2) positive references from previous clients in relation to studies or evaluations for development programmes that highlight both quantitative and qualitative research, and

Required qualifications of the primary consultant / research team leader

- Ph.D. in economics, public policy, or related social science.
- Minimum of 7-10 years of relevant work experience in developing and carrying out longitudinal, quantitative impact evaluations and randomized control trials for a development programme, preferably on topics related to early childhood development, nutrition or social protection in Africa.
- Strong methodological knowledge and skills in impact evaluation design, longitudinal data collection, quantitative data analysis and reporting for development programmes.
-
- Excellent communication skills, writing and oral presentations to effectively discuss the design and to report findings, focusing on producing useful and accessible findings.
- Fluency (verbal and written) in English.
- Fluency (verbal and written) in Portuguese would be an asset.

Additional required qualifications of at least one person in the team

- Previous experience working in Mozambique.
- Good understanding of Mozambican socio-cultural, economic and political environment and local networks.
- Verbal fluency communicating in Portuguese.

Additional required qualifications of at least one person in the team

- Previous experience and knowledge designing and applying adequate assessment tools

Previous experience evaluating social protection programs

8. Evaluation Process

The relative weight between the technical criteria and budget will be 80-20 respectively.

Technical Criteria	Technical Sub-criteria	Maximum Points
Overall Response	Overall completeness of response as per the ToR	5
Maximum Points		**5**
Consultancy Firm and Key Personnel	Range and depth of experience with similar projects in social protection and in region Client references Key personnel: relevant experience and qualifications, roles distributions and availability to work in the field	10 5 20
Maximum Points		**35**
Strength of the technical proposal	Quality of the proposed evaluation design and data collection methods Quality of the proposed work-plan, management structure and monitoring and quality assurance processes Sustainability of the overall evaluation design and data collection procedure Assessment of ethical concerns and risks and appropriateness of mitigation measures	20 10 5 5
Maximum Points		**40**
Total Maximum		**80**

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D.2. ETHICAL CLEARANCE

REPÚBLICA DE MOÇAMBIQUE
MINISTÉRIO DA SAÚDE
COMITÉ NACIONAL DE BIOÉTICA PARA A SAÚDE
IRB00002657

Exmo. Senhor
Dr. Juan Bonilla
AIR

Ref:704/CNBS/20 **Data 03 de Dezembro de 2020**

Assunto: Renovação da aprovação do protocolo de estudo intitulado: "***Avaliação do programa Subsídio para a criança 0-2 anos***"

O Comité Nacional de Bioética para a Saúde (CNBS) analisou o pedido de renovação anual da aprovação do protocolo de estudo intitulado: " ***Avaliação do programa Subsídio para a criança 0-2 anos",*** *e sobre* o mesmo o CNBS chegou a seguinte conclusão:

Não havendo nenhum inconveniente de ordem ética que impeça a continuação do estudo, o CNBS dá a autorização.

Todavia, recomenda aos investigadores que mantenham o CNBS informado do decurso do estudo.

A aprovação da renovação tem a validade de um ano, terminando esta a 03 de Dezembro de 2021. Os investigadores deverão submeter o pedido de renovação da aprovação um mês antes de terminar o prazo.

Sem mais de momento, queiram aceitar as nossas cordiais saudações.

O Presidente

Dr. João Fernando Lima Schwalbach

Endereço:
Ministério da Saúde - 2º andar dto
Av. Eduardo Mondlane / Salvador Allende
Maputo - Moçambique

C.Postal: 264
Telefone: +258 82 406 6350
E-mail: cnbsmocambique@gmail.com

IRB Determination

Institutional Review Board

American Institutes for Research

1000 Thomas Jefferson Street, NW

Washington, DC 20007

IRB00000436 FWA00003952

B&P Number: 87274

Project number:

Project/Proposal title: UNICEF MOZ CHILD GRANT IE

Programme: Practice Area w/ Strategy

Project Director: Victoria K. Rothbard

IRB Reviewer: Elizabeth T. Spier

Project Activity: Revised instruments for 2021 renewal

Determination:

On the basis of the review this amendment, the IRB has determined that the updates, as described in the materials submitted, continue to be research and involve human research participants. The research is approved because the selection of participants is equitable and the risks to the participants are minimised and are reasonable in relation to the knowledge that may reasonably be expected to result. There are no risks greater than those ordinarily encountered in daily life or during routine test or activities. The procedures for obtaining informed consent are appropriate and the procedures for protecting the confidentiality of the collected data are adequate. Data collection may proceed.

IRB Signature(s):

Elizabeth T. Spier, IRB Representative

02/16/2021

Please keep in mind that any material changes made to the study or the study procedures require the submission of an updated IRB package.

D3. SURVEY INSTRUMENT

ESTUDO DO BEM-ESTAR DA CRIANÇA DE MOÇAMBIQUE

INSTRUMENTO DE AGREGADO FAMILIAR

2021

Esboço final para o trabalho de campo

- A ordem dos módulos é ilustrativa e pode ser programada no CAPI, em diferentes sequências

SECÇÃO 1A: CONFIRMAÇÃO DOS MEMBROS DA LINHA DE BASE

Instruções: *Primeiro, gostaria de confirmar os membros do agregado familiar (AF) da última vez que conversamos em fevereiro/março de 2019, para ver se eles ainda fazem parte do AF. Isso é, vou te perguntar se as seguintes pessoas, que faziam parte do AF há dois anos, ainda vivem aqui, comem da mesma panela ou compartilham recursos econômicos. Pessoas que geralmente estão aqui, mas que estão temporariamente ausentes, em um hospital ou em um internato, ainda contam como membros da família se planejarem retornar.*

1	2	3	3	4	5	6	7
ID	Nome do membro [preenchido no CAPI]	[NOME] é atualmente membro deste agregado familiar? 1 = Sim 2 = Não >> Q5	Confirmar sexo 1 = Masculino 2 = Feminino [pré-preenchido, com opção de editar]	Confirme a idade que membro tinha na linha de base [em anos completos] [pré-preenchido, com opção de edição] >> Próximo membro	Por que [NOME] não é mais um membro do agregado? 1 = Mudou por motivos de trabalho/econômicos 2 = Mudou para ir a escola 3 = Se casou e saiu do AF 4 = Nunca foi membro do AF (ficou apenas temporariamente) 5 = Falecido 6 = Mudou por motivos de doença/saúde 7 = Não conhece a pessoa / não existe >> próximo membro 8 = Cuidadora e/ou a criança-alvo não faz mais parte do AF (então o membro anterior não é mais relevante) 9 = Não sei / razão desconhecida 10 = Mudou por outro motivo, especifique	Quando [NOME] saiu do AF? [Verifique a data: não deve ser antes de 2/2019] [MM/AAAA]	Para onde [NOME] se mudou? 1 = Mesma communidade 2 = Comunidade diferente no mesmo distrito 3 = Distrito diferente na mesma província 4 = Fora da província (para a área rural) 5 = Maputo 6 = Fora da província (para área urbana) 7 = Fora de Moçambique 8 = Não sei >> Próximo membro
01							
02							
03							
04							
05							
06							
07							
08							

8. Existem outros membros do agregado familiar que residem aqui atualmente que se aderiram nos últimos dois anos, incluindo nascimentos [isso é, que se aderiram depois da pesquisa da linha de base em fevereiro-março de 2019]? **[SE NÃO, CONFIRME QUE TODOS OS MEMBROS ATUAIS ESTÃO LISTADOS NO ROSTER]**	1 = Sim 2 = Não >> Seção 1C

SEÇÃO 1b: MEMBROS QUE ADERIRAM AO AGREGADO FAMILIAR DESDE FEVEREIRO-MARÇO 2019

Instrução: Por favor, me dê os nomes de todos os membros que agora vivem neste agregado familiar (AF), mas que não faziam parte da família em fevereiro-março de 2019, e agora comem da mesma panela ou compartilham recursos econômicos. Para se qualificarem como membros novos do AF, eles devem ter vivido com a família por seis meses ou mais. Inclua membros que normalmente vivem aqui, mesmo que não estejam agora porque estão viajando, visitando outros membros da família, estão em um hospital ou em um internato ou faculdade, etc.

1	2	3	4	5		6	7	8	9	10
								APENAS PARA MEMBROS COM 10 OU MAIS ANOS		
IDENTIFICAÇÃO	Nome do membro	Sexo 1 = Masculino 2 = Feminino	Qual é a relação de [NOME] com o chefe da família? 1 = Chefe da família 2 = Cônjuge 3 = Filho(a) 4 = Neto(a) 5 = Sogro(a) 6 = Genro/Nora 7 = Outro familiar 8 =Adoptado/ Acolhido/Enteado 9 = Empregada doméstica 10 = Não-familiar	Qual é a idade de [NOME] agora? Registre a idade exacta, em anos completos, de todos os membros. Para menores de 36 meses, registre também o número de meses desde o último aniversário (use o livro de saúde infantil ou certidão de nascimento, se disponível).		De onde [NOME] se mudou? 1 = Mesma comunidade 2 = Comunidade diferente no mesmo distrito 3 = Distrito diferente na mesma província 4 = Fora da província (para a área rural) 5 = Maputo 6 = Fora da província (para área urbana) 7 = Fora de Moçambique 8 = Novo bebê / recém-nascido 9 = Não sei	Qual é a religião de [NOME]? 1 = Católico 2 = Moçulmano 3 = Cristão 4 = Protestante 5 = Sem religião 6 = Outra, especifique	Qual é o estado civil atual de [NOME]? 1 = Casado ou a morar junto, monogâmico 2 = Casado ou a morar junto, polígamo 3 = Divorciado ou separado 4 = Viúvo(a) 5 = Nunca casado ou viveu maritalmente Se 3 - 5 >> próximo membro	O cônjuge ou parceiro de (NOME) mora nesta casa? 1 = Sim 2 = Não (>>Próximo membro)	COPIE O CÓDIGO DE IDENTIFICAÇÃO DO CÔNJUGE (SE HOUVER MAIS DO QUE UM CÔNJUGE, O DO PRIMEIRO)
				IDADE EM ANOS	**SE <36 MESES: MESES DESDE O ÚLTIMO ANIVERSÁRIO**					
51										
52										
53										
54										
55										
56										
57										
58										
59										
60										

SECÇÃO 1c: LISTA DO AGREGADO FAMILIAR (TODOS OS MEMBROS ATUAIS - ANTIGOS + NOVOS)

	1	2	3	4	5	6	7	8	9	10	11
	MEMBROS <u>NOVOS</u> COM IDADES ENTRE OS 0 E OS 19 ANOS				**MEMBROS ENTRE OS 0 E OS 19 ANOS**			**APENAS PARA MEMBROS COM IDADES ENTRE OS 0 E OS 5 ANOS**			
IDENTIFICAÇÃO	A mãe biológica de [NOME] está viva? ESCREVER IDENTIFICAÇÃO =SIM, MÃE ESTÁ VIVA E NO AGREGADO FAMILIAR 88=SIM, MAS NÃO FAZ PARTE DO AGREGADO FAMILIAR 99=NÃO, MÃE MORREU 77=NÃO SABE	[NOME] tem irmãos biológicos da mesma mãe (morando dentro ou fora da casa)? 1=SIM 2=NÃO (>>Q4) 9=NÃO SABE (>> Q4)	Quantos irmãos biológicos são mais jovens que [NOME]? [Digite o número, se nenhum = 0]	O pai biológico de [NOME] está vivo? ESCREVER IDENTIFICAÇÃO =SIM, PAI ESTÁ VIVO E NO AGREGADO FAMILIAR 88=SIM, MAS NÃO FAZ PARTE DO AGREGADO FAMILIAR 99=NÃO, PAI MORREU 77=NÃO SABE	O [NOME] tem um par de sapatos ou sandálias? 1=SIM 2=NÃO 9=NÃO SABE	O [NOME] tem pelo menos 2 conjuntos de roupas? 1=SIM 2=NÃO 9=NÃO SABE	O [NOME] tem um cobertor? 1=SIM 2=NÃO 9=NÃO SABE	O [NOME] tem uma certidão de nascimento? Se sim, posso ver? 1=Sim, vista 2=Sim, não vista 3=Não	O nascimento de (NOME) foi registrado? [Conservatória de Registro Civil] 1=SIM 2=NÃO (>>Q11) 9=NÃO SABE	Quando é que o nascimento de (NOME) foi registrado? 1=Dentro de 90 dias do nascimento 2=Entre 3 meses e 1 ano desde o nascimento 3=Após 1 ano desde o nascimento **(>>PRÓXIMA SECÇÃO)**	Qual é a principal razão pela qual o nascimento de (NOME) não foi registrado? 1=É muito caro 2=Tenho que viajar para longe 3=Não sabia que deveria ser registrado 4=Não achei importante 5=Não sabia onde registrar 6=Outra (especifique) 9= Não sabe
01											
02											
03											
04											
05											
06											
07											
08											
09											
10											

SECÇÃO 2: EDUCAÇÃO DE TODOS OS MEMBROS DO AGREGADO FAMILIAR COM 3 OU MAIS ANOS DE IDADE

	1	2	3	4	5	6	7	8	9a	9b	9c	9d
	MEMBROS NOVOS COM 3 ANOS OU MAIS				**MEMBROS COM 3 ANOS OU MAIS**							
IDENTIFICAÇÃO	O [NOME] pode ler e escrever em alguma língua? 1=Portugues 2= Makhuwa 3=Outra 4=Nenhuma	[NOME] já frequentou a escola? 1=Sim **>>Q4** 2=Não	Qual foi a principal razão pela qual [NOME] nunca frequentou a escola? **[VER CÓDIGOS ABAIXO]** **>> Próxima pessoa**	Qual é o grau mais alto que [NOME] terminou? **[VER CÓDIGOS ABAIXO]**	Atualmente, [NOME] está a frequentar a escola? 1=Sim **>> Q7** 2=Não	Por que é que [NOME] não está atualmente na escola? **[VER CÓDIGOS ABAIXO]** >> **Q9a**	Em que ano é que [NOME] está? **[VER CÓDIGOS ABAIXO]**	Na última semana completa de escola, quantos dias [NOME] compareceu o dia todo? [0-5 dias excluindo semanas sem escola]	Nos últimos 12 meses, quanto gastou para [NOME] nos seguintes itens:			
									Matricula/ Propinas e Mensalidades (Em MT)	Livros escolares e outros materiais escolares (Em MT)	Uniforme escolar ou roupa desportiva (Em MT)	Transporte escolar (Em MT)

Códigos para P4 e P7:
Creche 01
Primario EP1 (G1) 02
Primario EP1 (G2) 03
Primario EP1 (G3) 04
Primario EP1 (G4) 05
Primario EP1 (G5) 06
Primario EP2 (G6) 07
Primario EP2 (G7) 08
Secundario ESG1 (G8) 09
Secundario ESG1 (G9) 10
Secundario ESG1 (G10) 11
Secundario ESG2 (G11) 12
Secundario ESG2 (G12) 13
Tecnico Elementar 14
Tecnico Basico 15
Tecnico Medio 16
For. De Professores 17
Superior 18
Nao Sabe 98

Códigos para P3 e P6:
Demasiado novo 1
Já atingiu o nível que eles queriam 2
Precisou desempenhar atividades de trabalho ou cuidados, incluindo na quinta ou em casa 3
Não está interessado na escola 4
Muito caro para ir à escola 5
Escola muito distante 6
Não é apropriado crianças do sexo feminino irem à escola (cultura) 7
Não acredita que escolaridade aumenta o salário 8
Poderia aprender tudo de útil em casa 9
Muito doente para participar 10
Não há lugares disponíveis na escola local 11
Nenhuma escola de religião apropriada disponível 12
Inseguro 13
Engravidou ou casou 14
Devido a COVID-19 15
A criança tem deficiência / limitação de aprendizagem ... 16
Outro motivo (especificar) 17

SECÇÃO 3A: SAÚDE DE TODOS OS MEMBROS DO AGREGADO FAMILIAR

	1	2	3	4	5	6	7	8	9	10	11			12
IDENTIFICAÇÃO	[NOME] esteve doente ou ferido durante as **últimas 2 semanas**? 1=Sim, doente/ ferido 2 = Não**>>Q8** 8=Não sabe**>>Q8**	Durante as últimas 2 semanas, [NOME] teve que interrompe r as actividades habituais por causa desta condição? 0=Não SE SIM: INDIQUE O NÚMERO DE DIAS (1 – 14)	Durante as últimas 2 semanas, [NOME] consultou um profissional de saúde, visitou um centro de saúde ou consultou um curandeiro tradicional por causa esta ferida/doença? 1=SIM (**>>Q5**) 2=NÃO	Se não, qual foi o principal motivo? 1=Falta de dinheiro/muito caro 2=Muito longe 3=Não acredita na medicina 4=Falta de profissionais de saúde 5=Baixa qualidade/serviços 6=Não requer assistência médica/não é grave o suficiente 7=Devido ao COVID-19 8=Outra, especifique **>>Q8**	Na visita mais recente, quem [NOME] consultou? 01=Doutor 02=Dentista 03=Enfermeira 04=Assistente médico 05=Parteira 06=Farmacêutico 07=Vendedor de medicamentos/químicos 08=Agente Comunitário de Saúde (APE) 09=Curandeiro tradicional 10=Parteira Formada 11=Parteira Não Formada 12=Espiritualista 13=Outra (especifique) 98=NS [Marque todos que se aplicam]	Onde foi a consulta? 1=Instalação pública 2=Instalação privada 3=Farmácia 4=Casa do APE 5=Curandeiro tradicional 6=Loja de Medicamentos 7=Vendedor de medicamentos 8=Outra (especifique) 9=NS [Marque todos que se aplicam]	No total, quanto foi gasto com a medicação e consulta de [NOME] **nas últimas 2 semanas?** **[TANTO EM DINHEIRO COMO EM ESPECIE]** **[VALOR EM MT]** **[INSIRA '00' SE NENHUM]**	Durante as últimas 2 semanas, [NOME] adquiriu algum medicamento ou material médico? **[OUTRO QUE NÃO INCLUÍDO NA P7!]** 1=SIM 2=NÃO **(>>Q10)**	No total, quanto foi gasto em remédios ou materiais médicos de [NOME] **nas últimas 2 semanas?** **[VALOR EM MT]**	O [NOME] tem alguma deficiência que limite a sua participação total nas actividades do dia-a-dia: como ver, ouvir, caminhar, memória, cuidar de si ou comunicar? 1=SIM 2=NÃO **(>>Q12)**	Que tipo de deficiência [NOME] tem? 1=Cego 2=Surdo/Mudo 3= Deficiência mental 4=Paralítico 5=Braço amputado/ atrofiado 6=Perna amputada/ atrofiada 7=Outra, especifique **[Registre até 3 deficiências]**			[NOME] dormiu debaixo de uma rede mosquiteira na noite passada? 1= Sim, sem tratamento 2= Sim, tratado 3= Não 9= NS
											1º	2º	3º	

SECÇÃO 3B: SAÚDE REPRODUCTIVA E FERTILIDADE DE MULHERES COM IDADES ENTRE 10 E 49 ANOS

	1	2	3	4	5	6	7	8	9	10	11a	11b	12a	12b	13	14
	PERGUNTAR APENAS ENTRE OS 10 E OS 18 ANOS [Membros antigos do AF: aqueles Q1 = 2 or Q1 =9 @ BL]			**PREGUNTAR APENAS ENTRE OS 10 E OS 49 ANOS**												
IDENTIFICAÇÃO	[NOME] passou por ritos de iniciação? 1=SIM 2=NÃO (>>Q3) 9=NS (>>Q3)	Se sim, com que idade? [Idade em anos]	Se não, para quando isso é planeado? 0=Não vai acontecer 1=Este ano (2021); 2=Próximo ano (2022); 3=Ano seguinte (2023) 9=NS	[NOME] está grávida agora ou [NOME] esteve grávida nos últimos 24 meses? 1=SIM 2=NÃO (>>Q10) 9=NS (>>Q10)	[NOME] consultou alguém para atendimento pré-natal durante esta ou na última gravidez? 1=SIM (>>Q7) 2=NÃO	Qual é o principal motivo de (NOME) não ter cuidados pré-natais? (>>Q9) **[VER CÓDIGOS ABAIXO]**	Quem (NOME) consultou? [**VER CÓDIGOS ABAIXO]**: **MARQUE TODOS QUE SE APLICAM]**	Quantas vezes [NOME] recebeu cuidados pré-natais durante esta / última gravidez? [número] 98 = NS	Quem assistiu o nascimento desta / última gravidez? [VER CÓDIGOS ABAIXO, MARQUE TODOS OS QUE APLICAM] 8 = Ainda não deu à luz 9 = Bebê perdido / nasceu morto	[NOME] já deu à luz alguma vez? 1=SIM 2=NÃO >> **Proxima mulher**	No total, quantas crianças [NOME] deu à luz que nasceram vivas?	Quantas crianças [NOME] deu à luz que nasceram vivas, mas não moram nesta casa? [número] If 0 >> **Q14**	Quantos desses filhos são crianças (menores de 18 anos)? Se 0 >>Q**14**	Onde estão esses filhos agora (uma marca para cada um)? [**VER CÓDIGOS ABAIXO]**	Qual é a principal razão pela qual o filho não está a morar consigo (uma marca para cada um)? [**VER CÓDIGOS ABAIXO]**	[NOME] já deu à luz uma criança que nasceu viva mas morreu mais tarde? **[SE NÃO, INVESTIGAR:** Quero dizer, para uma criança que já respirou ou chorou ou mostrou outros sinais de vida - mesmo se ele ou ela tenha vivido apenas alguns minutos ou horas? **]** [Insira o número total, 0 se nenhum]

Códigos para Q6	**Códigos para Q7/Q9**	**Códigos para Q12b**	**Códigos para Q13**
Motivos económicos..... 01 Não há assistência médica disponível 02 Cuidados de saúde muito longe. 03 Não necessário ..... 04 Pessoal de saúde não é amigável05 Longas esperas nas instalações . 06 Prefere parteiras comunitárias.. 07 Devido ao COVID-19…….08 Outro, especifique 09	Doutor..... 01 Enfermeira ..... 02 Parteira auxiliar..... 03 Parteira tradicional ..... 04 Agente de saúde da comunidade05 Madrinhas ou matriarcas..... 06 Outro, especifique 07	Família alargada..... 01 Centro de acolhimento ..... 02 Família de acolhimento..... 03 Guardião ..... 04 Vive de forma independente sozinho ou com a sua própria família.....05 Vive de forma independente, na rua ou fora ..... 06 Outro, especifique ..... 07 NS……09	Motivos económicos..... 01 Motivos de educação..... 02 Motivos de saúde ..... 03 Conflito/violência ..... 04 Eles têm família própria ..... 05 Outro, especifique 06

SECÇÃO 4: CONDIÇÕES DE HABITAÇÃO

Esta secção foi tirada directamente do IOF 2015 com acréscimos do MICS 6.

	Pergunta	Respostas	Saltar
1	Qual é a principal fonte de abastecimento de água para beber usada pelos membros deste agregado familiar?	Água canalizada dentro da casa ..... 1 Água canalizada no quintal ..... 2 Água canalizada na casa do viziho..... 3 Água do fontinária..... 4 Água do furo..... 5 Água do poço com bomba manual..... 6 Água do poço protegido sem bomba ..... 7 Água de nascentes protegidas ..... 8 Água de nascentes não protegidas ..... 9 Água da cisterna (ou tanque movel ou camião)..... 10 Água do poço não protegido..... 11 Água do rio, lago, lagoa..... 12 Água de chuva..... 13 Água em garrafa..... 14 Outra (especifique) 15	Se 14 **>>Q4**
3	Trata a água de alguma maneira para ficar segura para beber?	1=SIM 2= NÃO 9= NÃO SABE	Se 2 ou 9 **>> Q5**
4	O que costuma fazer para tomar a água segura para beber? [Marque todos que se aplicam]	Ferver ..... 1 Adicionar Lizivia/Cloro ..... 2 Adicionar "certeza" ..... 3 Filtrar com um pano..... 4 Usar filtro de água (cerâmica, areia, composto)..... 5 Desinfecção solar ..... 6 Deixar repousar e assentar ..... 7 Outra (especifique) 8	
5	Gostaríamos de saber onde os membros desta casa lavam as mãos. Você pode por favor me mostrar onde os membros da sua casa costumam lavar as mãos? [Registre resultado e observação]	**OBSERVADO** 1=Instalação fixa observada (pia/torneira) no domicilio 2=Instalação fixa observada (pia/torneira) no quintal /parcela 3= Objeto móvel observado (balde/jarro/chaleira) **NÃO OBSERVADO** 4= Não há lugar para lavar as mãos no domicilio /quintal/lote 5=Sem permissão para ver 6=Outro, especifique	Se 4-6 **>>Q7**
6	[Enumerador: Observe a presença de água no local para lavar as mãos, verifique a torneira / bomba ou bacia, recipiente de água do tanque ou objetos semelhantes para a presença de água]	A água está disponível..... 1 A água não está disponível..... 2	
7	Há sabão ou detergente, ou cinza / lama / areia presente no local para lavar as mãos ou na casa? [Marque todos que se aplicam]	Barra de sabão ou sabonete líquido..... 1 Detergente (pó / líquido / pasta) ..... 2 Cinza / Lama / Areia ..... 3 Nenhum.....4	
9	Qual é o tipo de latrina na casa principal? INQ. CASO A RESPOSTA SEJA "LATRINA", PEÇA PARA VER.	Retrete ligada a fossa septica..... 1 Latrina melhorada..... 2 Latrina tradicional melhorada..... 3 Latrina nao melhorada..... 4 Nao tem latrina ..... 5 Latrina partilhada / latrina da casa do vizinho.....6	
10	Qual é a principal fonte de energía ou combustível que o agregado familiar usa para cozinhar?	Electricidade..... 1 Gas ..... 2 Petroleo/Parafina/Querosene..... 3 Carvao vegetal..... 4 Carvao mineral ..... 5 Lenha..... 6 Fezes de animais ..... 7 Outra (especifique) 8	
11	Qual é a principal fonte de energía ou combustível que o agregado familiar usa para iluminação?	Electricidade..... 1 Gerador 2	

		Panel Solar ..... 3 Gas ..... 4 Petroleo/Parafina ..... 5 Querosene ..... 6 Vela ..... 7 Bateria ..... 8 Pilha ..... 9 Lanterna ..... 10 Outra (especifique) 11	
12	A quem pertence a habitação onde vive o agregado familiar?	Propria ..... 1 Arrendada ..... 2 Cedida 3	>>Q14 >>Q15
13	Se é arrendada, qual é o valor mensal da renda?	Valor MT	>>Q16
14	Se é própria, qual é o valor mensal que cobraria de renda ?	Valor MT	
15	Se é cedida, qual é o valor mensal que pagaria de renda ?	Valor MT	>>Q16
16	Quantas divisões tem esta casa? (incluindo a sala)		
17	Destas divisões quantas usam para dormir?		
18	Qual é o material principal usado na cobertura/telhado da casa?	Laje de betao ..... 1 Telha ..... 2 Chapas de lusalite ..... 3 Chapas de zinco ..... 4 Capim/estacas/palmeira ..... 5 Outra (especifique) 6	
19	Qual é o material principal usado nas paredes?	Adobe/bloco de adobe ..... 1 Bloco de cimento ..... 2 Bloco de tijolo ..... 3 Paus maticados ..... 4 Madeira/zinco ..... 5 Bambu/canico/palmeiras ..... 6 Outra (especifique) 7	
20	Qual é o material principal usado na construção do piso?	Terra batida ..... 1 Madeira rudimentar ..... 2 Adobe ..... 3 Parquet ..... 4 Madeira/serrada ..... 5 Mosaico/marmore/tijoleira ..... 6 Cimento ..... 7 Outra (especifique) 8	
21	Nos últimos 12 meses, membros deste agregado familiar usaram computador ou internet (independentetemente do local do uso) or mobile money (Mpesa o outros)? [Insira Identificação dos membros que usam cada serviço]	A. Computador B. Internet C. Mobile money	

SECÇÃO 5: SEGURANÇA ALIMENTAR (FAO Escala de Experiência Global de Insegurança Alimentar, FIES)

	Pergunta	Respostas	Saltar
1	Quantas refeições, excepto lanches, normalmente tem num dia?	Um.....1 Dois.....2 Três.....3 Mais de três.....4	
2	Nas **últimas quatro semanas**, você ou outras pessoas em sua casa se preocuparam por não terem comida suficiente por falta de dinheiro ou de outros recursos?	Sim.....1 Não.....2	
3	Nas últimas **quatro** semanas, você ou algum membro do agregado familiar não conseguiu comer alimentos saudáveis e nutritivos devido à falta de dinheiro ou de outros recursos?	Sim.....1 Não.....2	
4	Nas últimas **quatro** semanas, você ou algum membro do agregado familiar tiveram apenas alguns tipos de alimentos devido à falta de dinheiro ou de outros recursos?	Sim.....1 Não.....2	
5	Nas últimas **quatro** semanas, houve alguma ocasião em que você ou outras pessoas do seu agregado familiar tiveram que saltar uma refeição porque não havia dinheiro suficiente ou outros recursos para conseguir comida?	Sim.....1 Não.....2	
6	Nas últimas **quatro** semanas, houve algum momento em que você ou outras pessoas do seu agregado familiar comeram menos do que achava que deveriam devido à falta de dinheiro ou de outros recursos?	Sim.....1 Não.....2	
7	Nas últimas **quatro** semanas, houve algum momento em que o seu agregado familiar ficou sem comida por falta de dinheiro ou de outros recursos?	Sim.....1 Não.....2	
8	Nas últimas **quatro** semanas, houve algum momento em que você ou outras pessoas do seu agregado familiar que estavam com fome, mas não comeram porque não havia dinheiro suficiente ou outros recursos para a alimentação?	Sim.....1 Não.....2	
9	Nas últimas **quatro** semanas, houve algum momento em que você ou outras pessoas do seu agregado familiar ficaram sem comer durante um dia inteiro por falta de dinheiro ou de outros recursos?	Sim.....1 Não.....2	
10	Nas últimas **quatro** semanas, houve um momento em que sua família não conseguiu acessar os mercados preferidos (aqueles com alimentos de maior qualidade ou onde você pode fazer compras em grandes quantidades) devido à distância ou por não ter fundos de transporte para ir lá?	Sim.....1 Não.....2	

SECÇÃO 6: ACTIVIDADES ECONÓMICAS E UTILIZAÇÃO DO TEMPO (5 OU MAIS ANOS DE IDADE)

Enumerador: Observe que as horas semanais não podem exceder 168 horas.

IDENTIFICAÇÃO	ÚLTIMAS 24 HORAS							
	ACTIVIDADES DE TAREFAS DOMÉSTICAS E DE CUIDADOS				EDUCAÇÃO			DORMIR
	1	2	3	4	5	6	7	8
	Quantas horas [NOME] passou ontem a buscar água? [SE MAIS DO QUE 0 MAS <1 HORA, INSIRA "1"]	Quantas horas [NOME] passou ontem a buscar e cortar lenha (ou outros materiais combustíveis)? [SE MAIS DO QUE 0 MAS <1 HORA, INSIRA "1"]	Quantas horas [NOME] passou ontem em tarefas domésticas (limpar, lavar, cozinhar, compras)? [SE MAIS DO QUE 0 MAS <1 HORA, INSIRA "1"]	Quantas horas [NOME] passou ontem cuidando de crianças, idosos ou membros do agregado familiar doentes? [SE MAIS DO QUE 0 MAS <1 HORA, INSIRA "1"]	Quantas horas [NOME] passou ontem na escola/universidade outra instituição de educação formal? [SE MAIS DO QUE 0 MAS <1 HORA, INSIRA "1"]	Quantas horas [NOME] passou ontem a deslocar-se para a escola/centro educativo (ida e volta)? [SE MAIS DO QUE 0 MAS <1 HORA, INSIRA "1"]	Quantas horas [NOME] passou ontem a estudar em casa/explicação escolar? [SE MAIS DO QUE 0 MAS <1 HORA, INSIRA "1"]	Quantas horas [NOME] passou ontem dormindo? [SE MAIS DO QUE 0 MAS <1 HORA, INSIRA "1"]
	HORAS	HORAS	HORAS	HORAS	HORAS	HORAS	HORAS	HORAS

SECÇÃO 6: ACTIVIDADES ECONÓMICAS E UTILIZAÇÃO DO TEMPO (5 OU MAIS ANOS DE IDADE, continuação)

IDENTIFICAÇÃO	ÚLTIMOS SETE DIAS					ÚLTIMA ÉPOCA DAS CHUVAS		
	9	10	11	12	13	14	15	16
	Durante os últimos sete dias, quantas horas [NOME] gastou em trabalho agrícola, excluindo atividades pecuárias, para o agregado familiar (seja no cultivo de culturas ou noutras tarefas agrícolas) numa propriedade pertencente, alugada ou partilhada pela família? [ARREDONDAR ATÉ A PRÓXIMA HORA INTEIRA; Se gasto mais de 0 mas <1 hora, digite "1"]	"Durante os últimos sete dias, quantas horas [NOME] passou ajudando em qualquer empresa doméstica não agrícola ou não pesqueira do agregado familiar (por exemplo, como comerciante, vendedor de mercado, barbeiro, costureira, carpinteiro, ou taxista)?" [ARREDONDAR ATÉ A PRÓXIMA HORA INTEIRA; Se gasto mais de 0 mas <1 hora, digite "1"]	Durante os últimos sete dias, quantas horas [NOME] passou cuidando de gado ou aves pertencentes à família? [ARREDONDAR ATÉ A PRÓXIMA HORA INTEIRA; Se gasto mais de 0 mas <1 hora, digite "1"]	Durante os últimos sete dias, quantas horas [NOME] teve un trabalho remunerado com alguém que não é membro da família, por exemplo, uma empresa, governo, trabalho Ganho-Ganho ou Biscato? [ARREDONDAR ATÉ A PRÓXIMA HORA INTEIRA; Se gasto mais de 0 mas <1 hora, digite "1"]	Durante os últimos sete dias, quantas horas [NOME] gastou em atividades de pesca? [ARREDONDAR ATÉ A PRÓXIMA HORA INTEIRA; Se gasto mais de 0 mas <1 hora, digite "1"]	Quantos dias da passada época das chuvas [NOME] passou a preparar a terra, a plantar (por exemplo, a arar)? [SE SEM DIAS, DIGITE "0"]	Quantos dias na última estação das chuvas [NOME] passou na sacha, fertilização, outros trabalhos não relacionados à colheita? [SE SEM DIAS, DIGITE "0"]	Quantos dias na última estação das chuvas [NOME] passou na colheita? [SE SEM DIAS, DIGITE "0"]
	HORAS	HORAS	HORAS	HORAS	HORAS	DIAS	DIAS	DIAS

SECÇÃO 7A: ACTIVOS DOMICILIARES, PRODUCTIVOS E DURÁVEIS

Código de item	**Item** *Perguntar por cada bem*	1. O seu agregado familiar tem [ITEM]? 1= SIM 2= NÃO >> próximo item	2. Quantidade?	3. Nos últimos 12 meses o AF comprou um bem? 1= SIM 2= NÃO >> próximo item	4. Quanto gastou nessas compras? [MT]
01	Machado				
02	Foice				
03	Catana				
04	Enxada				
05	Pilão				
06	Fogão				
07	Grade para lavoura				
08	Carroça				
09	Carro				
10	Charrua				
11	Máquina de costura				
12	Moagem				
13	Rede de pesca, Arma de pesca				
14	Barco, Canoa				
15	Trator				
16	Motorizada				
17	Bicicleta				
18	Arma de caça				
19	Painel Solar				
20	Cadeiras				
21	Mesas				
22	Camas				
23	Rádio				
24	Geleira				
25	Televisores				
26	Fogões a gás				
27	Fogões eléctricos				

SECÇÃO 7B: PROPRIEDADE DE GADO

1	Este agregado familiar possuía gado, animais de criação ou aves de capoeira nos **últimos 12 meses**?	1=SIM 2=NÃO **>> Próxima secção**				
		2	3a	3b	4a	4b
Código do gado	**Nome**	Quantos/Quantas [NOME] tem agora?	Comprou algum ..[..].. nos últimos 12 meses?		Vendeu algum ..[..].. nos últimos 12 meses?	
			# comprados (se nenhum, escreva 0 >> 4a)	Valor total de compra de todos os comprados **[MT]**	# vendidos (se nenhum, escreva 0 >> próximo animal)	Valor total de vendas de todos os vendidos **[MT]**
01	Animais de tracção, como burros, cavalos, bois					
02	Bovinos, incluindo bezerros					
03	Ovelhas					
04	Cabras					
05	Porcos					
06	Coelhos					
07	Galinhas					
08	Galinha cafriar					
09	Patos					
10	Outras aves de capoeira (galinha do mato)					
11	Peixes					
12	Outros animais					

SECÇÃO 7C: DÉBITOS, CRÉDITOS E TRANSFERÊNCIAS

	Pergunta				Respostas		Saltar
1	O seu agregado familiar tem dívidas pendentes com outras famílias ou instituições, contraídas nos últimos 12 meses (incluindo compras a crédito)?				Sim .....1 Não 2		→ Q7
		2	**3**	**4**	**5**	**6**	
	Identificação do Empréstimo	Quanto tempo tem o empréstimo (em meses)?	Qual é (ou foi) a principal fonte do empréstimo? **VER CÓDIGOS ABAIXO**	Qual é (ou foi) o objectivo principal do empréstimo? **VER CÓDIGOS ABAIXO**	Qual é (ou foi) o valor total emprestado? **Em MT**	Qual é o valor actual pendente? **Em MT**	
	01						
	02						
	03						

CÓDIGOS PARA Q3

Familiar.....1
Amigo/Vizinho.....2
Mercearia/comerciante local 3
Agiota 4
Empregador.....5
Instituição religiosa 6
Instituições de Micro-financiamento 7
Banco (comercial)..... 8
ONG..... 9
Outro (especifique.....10

CÓDIGOS PARA Q4

a) **Família**
- Para atender às despesas do dia-a-dia 01
- Para uma emergência (funeral, médica, etc) 02
- Para pagar dívidas 03
- Para pagar as dívidas de outra pessoa..... 04
- Por razões sociais, como casamento, viagem ou dote de noiva 05
- Para educação de si mesmo, filhos, irmãos ou outros..... 06
- Para alugar o apartamento da sua família 07

b) **Activos**
- Para comprar ou construir uma casa 08
- Melhorar a casa 09
- Para adquirir bens ou propriedades familiares que não sejam carros ou motociclos..... 10
- Para comprar um carro, motociclo/bicicleta 11
- Para comprar um terreno 12

c) **Agricultura e pesca**
- Para compra de gado, peixe, etc..... 13
- Para melhoramentos agrícolas, como irrigação, uma barragem, cercas, preparar a terra 14
- Para implementos agrícolas, como o arado, a enxada, etc..... 15
- Para insumos agrícolas, como sementes, fertilizantes 16
- Para equipamento de pesca, como redes, motobomba, etc. 17

d) **Negócio**
- Para expandir o seu negócio/comprar acções de negócios..... 18
- Para começar um negócio 19
- Para investir no negócio de outra pessoa..... 20

e) **Outro (especificar)**..... 21

7	O seu agregado familiar poderia obter um empréstimo ou uma compra a crédito se pedisse?	Sim .....1 Não 2	
8	O agregado familiar **enviou**/deu algum dinheiro, bens ou presentes (incluindo alimentos) a alguém que não faz parte do agregado familiar nos últimos 12 meses?	Sim .....1 Não 2	**→Q10**
9	Qual é o valor global de todo o dinheiro, bens ou presentes enviados pelo agregado familiar a indivíduos não membros do agregado familiar nos últimos 12 meses? **Em MT**	VALOR: _____	
10	O agregado familiar **recebeu** algum dinheiro, bens ou presentes (incluindo alimentos) de alguém que não faz parte do agregado familiar nos últimos 12 meses?	Sim .....1 Não 2	→ **PRÓXIMA SECÇÃO**
11	Qual é o valor global de todo o dinheiro, bens ou presentes recebidos pelo agregado familiar de indivíduos não do agregado familiar nos últimos 12 meses? **Em MT**	VALOR: _____	

SECÇÃO 7D: PRODUTOS E INSUMOS AGRÍCOLAS

1. Algum membro deste agregado familiar **ou alguém em seu nome cultivou alguma cultura** ou tentou cultivar na última época agrícola já finalizada, isto é, **entre Outubro de 2019 e Junho de 2020**?						1=SIM 2=NÃO **>> PRÓXIMA SECÇÃO**
2		3	4	5	6	7
Que culturas plantou? • **[REGISTRE UMA RESPOSTA PARA CADA TIPO DE CULTURA - COMEÇANDO COM ÁREA TOTAL DA TERRA DEVIDA A CADA CULTURA. REGISTRE AS MAIORES TRÊS CULTURAS PRIMEIRO - ANTES DE RECOLHER DADOS SOBRE CADA UMA.]**		• Qual foi a área plantada nesta cultura? • [Metros quadrados] •	• Quantos quilos de [CULTURA] colheu durante esta temporada? • • **[PARA TODAS AS CULTURAS APLICÁVEIS, RELATE O PESO DE NÃO PROCESSADO, CRU OU SEM CASCA CONFORME APROPRIADO]** •	Quantos quilos da colheita de [CULTURA] foram vendidos no total? • **[PARA TODAS AS CULTURAS APLICÁVEIS, CERTIFIQUE-SE QUE O VALOR VENDIDO É NÃO-PROCESSADO, CRU OU SEM CASCA CONFORME APROPRIADO]** • • **Se 0 >>Q7**	Qual foi o valor total das vendas de [CULTURA]? • **[ESTIMAR O VALOR DOS PAGAMENTOS EM ESPÉCIE]** • • • • •	Quanto da [CULTURA] colhida durante a época agrícola foi para consumo do seu agregado familiar **consumir**? • **[PARA TODAS AS CULTURAS APLICÁVEIS, CERTIFIQUE-SE QUE O VALOR VENDIDO É NÃO- PROCESSADO CRU OU SEM CASCA, CONFORME APROPRIADO]**
Nome	**Código da Cultura**	• **Área**	• **KGS**	• **KGS**	• **MT**	• **KGS**
		•	•	•	•	•
		•	•	•	•	•
		•	•	•	•	•

	Pergunta	**Respostas**			
	ENTREVISTADOR: Gostaríamos de lhe fazer algumas perguntas sobre as despesas relacionadas com insumos para a actividades agrícola durante a última época agrícola concluída (2019-2020 no último Outubro até Junho). Para culturas permanentes, se houver apenas uma colheita, forneça o gasto total de cada item para a última colheita.				
8	Durante a ÚLTIMA ÉPOCA AGRÍCOLA (concluída), o agregado familiar teve despesas relacionadas com insumos para a produção de culturas, incluindo a contratação de mão-de-obra?	A. 1=SIM 2=NÃO >> Próximo item	B. Que quantidade comprou?		C. Quanto gastou em [CUSTO] durante a **ÚLTIMA ÉPOCA AGRÍCOLA (concluída)?** **[SOMA DE DINHEIRO E VALOR ESTIMADO DE PAGAMENTOS EM ESPÉCIE]** **[MT]**
			QTD	Unidade	
	A. Fertilizante			KG	
	B. Pesticidas (incluindo fungicidas e herbicidas)			LITRO	
	C. Sementes e plantas jovens			KG	
	D. Mão-de-obra para produção agrícola			DIAS	
	E. Transporte relacionado à produção agrícola e venda de cultura				
	F. Aluguer de bois			HECTARES	
	G. Trator ou colheitadeira			DIAS	
	H. Outro, (especifique)				

Código da culturas		
01=Milho 02= Feijões 03=Batatas doces 04=Feijão oloko 05=Arroz 06=Amendoim 07= Feijão nhemba 08= Mapira 09=Mandioca	10=Batata reno 11=Feijao boer 12=Bananas 13=Coco 14= Algodão 15=Gergelim 16=Manga 17= Cajú 18=Cana de açúcar 19=Tabaco 20= Chá	21=Abacate 22=Cacau 23=Sisal (fio) 24=Cloves 25= Café 26=Girassol 27=Tomates 28=Cebola 29=Mexoeira 30=Outros, especifique

SECÇÃO 7E: EMPRESAS NÃO AGRÍCOLAS

	Pergunta	Respostas	Saltar
	Nos últimos 12 meses, alguém deste agregado familiar ...	*NOTA: Inclua empreendimentos comerciais domésticos que tenham sido encerrados permanentemente ou temporariamente durante os últimos 12 meses.*	
1a	… possuía um negócio não agrícola ou prestava serviços não-agrícolas a partir de casa ou de uma loja familiar, como dono de lavagem de carros, serralheiro, mecânico, carpinteiro, alfaiate, barbeiro, etc.?	Sim .....1 Não 2	
1b	… processou e vendeu quaisquer sub-produtos agrícolas, incluindo farinha, cerveja local, sementes, etc., mas excluindo os sub-produtos animais, peixe fresco/processado?	Sim .....1 Não 2	
1c	… possuía uma empresa comercial numa rua ou num mercado?	Sim .....1 Não 2	
1d	... ofereceu algum serviço ou vendeu qualquer coisa na rua ou num mercado, incluindo lenha, carvão caseiro, madeira para construção, medicina tradicional, esteiras, tijolos, móveis, cestos, palha, etc.?	Sim .....1 Não 2	
1e	… conduziu um táxi ou carrinha de caixa aberta de propriedade da família para fornecer serviços de transporte ou de mudanças?	Sim .....1 Não 2	
1f	… possuía um bar ou restaurante?	Sim .....1 Não 2	
1g	… possuía qualquer outro negócio não agrícola, mesmo que fosse uma pequena empresa a partir de casa ou na rua?	Sim .....1 Não 2	
1h	… Possuía uma empresa de pesca ou piscicultura?	Sim .....1 Não 2	
	ENUMERADOR: EXISTE UM "1" PARA QUALQUER DAS QUESTÕES 1a ATÉ 1h?	1=Sim → CONTINUE ABAIXO 2=Não → PRÓXIMA SECÇÃO	

	2			3	4
IDENTIFICAÇÃO DO NEGÓCIO	Que empresas não agrícolas o agregado familiar operou **nos últimos 12 meses**? **[REGISTRE ATÉ TRÊS, EM ORDEM DE IMPORTÂNCIA]**			No seu agregado familiar, quem é que tem a responsabilidade principal por esta empresa? **[INSIRA O PID DO MEMBRO DO AGREGADO FAMILIAR]**	Desde esta época no ano passado, quantos meses durou a operação do negócio? **[ESCREVA O NÚMERO DE MESES]** **[ESCREVA 01 SE MENOS DE UM MÊS]**
	Descrição das actividades	Código principal	Código secundário		
01					
02					
03					

P2: Código para actividades de negócios

Pequeno comércio, pequena loja de venda de retalho, roupas, etc.....01	Peixeira.....12
Mini-mercado, loja de bebidas, take-away, restaurante, matadouro 02	Insumos agrícolas, alugueres.....13
Venda de tempo de transmissão, dinheiro móvel 03	Costureira.....14
Moagem ou processamento de alimentos.....04	Outro, especifique.....15
Venda de carvão ou lenha.....05	
Mecânico, reparações electrónicas, reparação de bicicletas.....06	
Curandeiro tradicional ou relacionado à saúde 07	
Táxi, transportes 08	
Cabeleireira, barbeiro 09	
Carpinteiro, fabrico de tijolos 10	
Artesanato, cesta, tecelão de esteira 11	

SECÇÃO 8A: CONSUMO E COMPRA FREQUENTE DE ITENS (SEMANAL)

Ordem	O agregado familiar consumiu [produto] na ultima semana?	Sim…..1 Nao…2 >> próximo produto	Quantidade [Utilizar a unidade de medida em (P2b)]	Unidade Medida padrão a utilizar	Valor do [produto] que comprou (MT)	Valor do [produto] que produzido por si mesmo (MT)	Valor do [produto] que recebeu de graca (como presentes) (MT)
		1	2a	2b	3	4	5
A	PRODUTOS DE PADARIA, DE PASTELARIA, CEREAIS E OUTROS PRODUTOS À BASE DE CEREAIS						
101	Arroz sem casca			kg			
102	Arroz com casca			kg			
103	Milho (Grão)			kg			
104	Mapira em grão			kg			
105	Mexoeira em grão			kg			
106	Farinha de milho			kg			
107	Farinha de trigo			kg			
108	Farinha de mapira			kg			
109	Farinha de mexoeira			kg			
110	Farinha de mandioca			kg			
111	Cerelac			kg			
112	Nestum			kg			
113	Flocos			kg			
114	Pão			unidade			
115	Bolachas			Kg			
116	Bolos			unidade			
117	Massa cotovelo (MACARRÃO)			kg			
118	Massa Esparguete			kg			
B	CARNE E DERIVADOS DE CARNE (FRESCO, REFRIGERADO OU CONGELADO) E ANIMAIS COMPRADOS VIVOS PARA O CONSUMO						
201	Carne de vaca			kg			
202	Miudezas de bovino (mão de vaca, fígado, coração, rim, dobrada, língua, tripa)			kg			
203	Carne de porco			kg			
204	Carne de cabrito			kg			
205	Carne de ovelha			kg			
206	Frango (galinha) morto			kg			
207	Pato morto			kg			
208	Peru morto			kg			
209	Miudezas de aves (patas, moelas, figado, cabeca, etc)			kg			
210	Carne de caça			kg			
211	Frango (galinha) vivo			unidade			
C	PEIXES, MOLUSCOS, CRUSTÁCEOS E ALIMENTOS DERIVADOS						
301	Peixe fresco, refrigerado ou congelado			kg			
302	Carapau fresco, refrigerados ou congelados			kg			
303	Camarão fresco, refrigerado ou congelado			kg			
304	Peixe seco			kg			
305	Camarão seco			kg			
306	Conservas de peixe enlatado (atum, sardinha, etc)			kg			
D	LEITE E SEUS DERIVADOS E OVOS						
401	Leite fresco			l			
402	Leite condensado			kg			
403	Leite em pó			kg			
404	Leite em pó para bebés			kg			
405	Iogurte			l			

406	Queijo			kg			
407	Ovos frescos de galinha			unidade			

E	**ÓLEOS E GORDURAS**						
501	Manteiga e Margarinas			kg			
502	Óleo alimentar			l			
F	**FRUTOS**						
601	Laranja			kg			
602	Limão			kg			
603	Tangerina			kg			
604	Bananas			kg			
605	Manga			kg			
606	Papaia			kg			
607	Ananás			kg			
608	Maçãs			kg			
609	Amendoim (casca e miolo)			kg			
610	Coco (inteiro e ralado)			unidade/kg			
G	**PRODUTOS HORTÍCOLAS, INCLUI BATATA E OUTROS TUBÉRCULOS**						
701	Alface			unidade			
702	Folhas de aboboreira			kg			
703	Folhas de mandioqueira			kg			
704	Folhas de batata doce			kg			
705	Folha de feijão nhemba			kg			
706	Cacana			kg			
707	Couve			kg			
708	Repolho			kg			
709	Tomate			kg			
710	Pimento			kg			
711	Quiabo			kg			
712	Abóbora e abobrinha			kg			
713	Alho			kg			
714	Cebola			kg			
715	Cenoura			kg			
716	Feijão Manteiga			kg			
717	Feijão Nhemba			kg			
718	Feijão Jugo			kg			
719	Feijão Boer			kg			
720	Ervilha			kg			
721	Batata reno fresca			kg			
722	Batata doce			kg			
723	Mandioca fresca			kg			
724	Mandioca seca			kg			
725	Tapioca			kg			
H	**AÇÚCAR, DOCES DE FRUTA, PRODUTOS DE CONFEITARIA, MEL, CHOCOLATE E OUTROS PRODUTOS À BASE DE AÇÚCAR (ND)**						
801	Açúcar branco			kg			
802	Açúcar castanho			kg			
I	**PRODUTOS ALIMENTARES, N.E. (ND)**						
901	Sal grosso ou fino			kg			
902	Caldos			grama			
J	**REFRIGERANTES E BEBIDAS**						
1001	Chá (Folhas de chá)			kg			
1101	Água Mineral			l			
1102	Refrescos (Refrigerentes)			l			
1103	Sumos de fruta			l			
1201	Tontonto (Nipa, Cachasso, etc)			l			
1202	Tentação, Boss, Knock Out, etc			l			
1301	Vinho			l			
1302	Mal coado (cabanga, Chilalassana, etc)			l			

1401	Cerveja com álcool			l			
1501	Consumo de água			l			
P	**ELECTRICIDADE (ND)**						
1601	Consumo de electricidade			kwh			
Q	**COMBUSTÍVEIS LÍQUIDOS (ND)**						
1701	Petróleo			l			
R	**COMBUSTÍVEIS SÓLIDOS (ND)**						
1801	Lenha			saco			
1802	Carvão vegetal			saco			
Y	**APARELHOS NÃO ELÉCTRICOS E OUTROS PRODUTOS, PARA CUIDADOS PESSOAIS (ND)**						
1901	Fraldas descartáveis			unidade			

SECÇÃO 8B: CONSUMO E COMPRA FREQUENTE DE ITENS (MENSAL)

IDENTIFI-CAÇÃO	**O agregado familiar comprou [produto] nos últimos 30 dias?**	**Sim…1 Nao…2 >> Próximo produto**	**Valor do [produto] que comprou (MT)**
	VESTUÁRIO E CALÇADO		
301	Tecidos para vestuario		
302	ARTIGOS DE VESTUÁRIO PARA HOMENS: Calças, calções, camisas, t-shirts ou camisetes, casacos, fatos completos, e cuecas para homem (novas e usadas)		
303	ARTIGOS DE VESTUÁRIO PARA SENHORA: Calças, calções, camisas, casacos, fatos completos, saias, vestidos, capulanas, cuecas e cintas, e soutiens para senhora (novas e usadas)		
304	ARTIGOS DE VESTUÁRIO PARA CRIANÇAS (3 A 13 ANOS): Calças, calções e bermudas, camisas e blusas, saias, vestidos, camisolas, cuecas e (bikini) e Boxers, fatos de banho, e t-shirts ou camisetas para crianças (novas e usadas)		
305	ARTIGOS DE VESTUÁRIO PARA BEBÉS (0 A 2 ANOS): Calças, calções, camisas, t-shirts ou camisetes, vestidos, babygrow (tipo macacão), botas de tecido ou malha, camisolas ou casacos de malha, cuecas (calcinhas) plásticas, e fraldas de tecido para bébés (novas e usadas)		
306	Uniforme de trabalho		
307	ACESSÓRIOS DE VESTUÁRIO PARA HOMENS: Chapéus, bonés, bóinas, gorros, cintos, suspensórios, gravatas e lenços de assoar (inclui vacilap) para homens (novos e usados)		
308	ACESSÓRIOS DE VESTUÁRIO PARA SENHORAS: Lenços de cabeça, de pescoço, chale, chapéus e bóinas, cintos, lenços de assoar (inclui vacilap), xailes e similares para senhoras (novos e usados)		
309	CALÇADO PARA HOMENS: Sapatos, chinelos, pantufas de quarto, sandálias, sapatilhas (tenis), e botas para homens (novos e usados)		
310	CALÇADO PARA SENHORAS: Sapatos, chinelos, pantufas de quarto, sandálias, sapatilhas (tenis), e botas para senhoras (novos e usados)		
311	CALÇADO PARA CRIANÇAS (3 A 13 ANOS): Sapatos, chinelos, pantufas de quarto, sandálias, e sapatilhas (tenis) para crianças (novos e usados)		
312	CALÇADOS PARA BEBÉS (0 A 2 ANOS): Sapatos, chinelos, sapatos de pantufas, sandálias, e sapatilhas (tenis) para bébés (novos e usados)		
313	REPARAÇÃO, LIMPEZA E ALUGUER DE CALÇADO: Reparação de calcado e vestuario		
	HABITAÇÃO, ÁGUA, ELECTRICIDADE, GAS E OUTROS COMBUSTIVEIS		
401	Tintas, cimento, tornieras, tubos, válvulas, juntas, curvas, tacos, ladrihlos, azulejos, mosaicos e outros materiais para revestimento, vidros para janelas, madeira, artigos de madeira, metal e artigos de metal		
402	Serviços de canalizador, electricista, pintor, carpinteiros, vidraceiros serralheiros, pedreiros, ladrilhadores e similares		
403	Consumo de gás canalizado o em garrafas		
	MOBILIÁRIO, ARTIGOS DECORAÇÃO, EQUIPAMENTO DOMÉSTICO E MANUNTENÇÃO CORRENTE DE HABITAÇÃO		
501	MOBILIÁRIO, ARTIGOS DE ILUMINAÇÃO E DECORAÇÃO: Armários móveis, guarda-fatos, cómodas, estantes, sofás, berços, espelhos, castiçais e velas		
502	ROUPAS E ARTIGOS DE CAMA: Lençóis, fronhas, cobertores, djuvets, colchas, edredons, mantas, almofadas, travesseiros, redes mosquiteiras, e colchões (excepto pneumáticos)		

503	ROUPAS: Toalhas de mesa, guardanapos, naperões, panos de limpar a loiça, tarpetes para casa de banho, toalhas de banho, roupões de banho, e cortinas		
504	FOGÕES, FORNOS, MICROONDAS, PLACAS E SIMILARRES: Fogões a petróleo, outros fogões ou outro combustível, fornos eléctricos, ou fogão ndzilo		
505	PEQUENOS UTENSILÍOS DOMÉSTICOS ELÉCTRICOS (SD): Batedeiras eléctricas, cafeteiras e chaleiras eléctricas, esprermedores de frutas e triturador de sementes comestíveis eléctrico, grelhadores eléctricos, torradeiras eléctricas, ou moinhos de café eléctricos		
506	ARTIGOS METÁLICOS DE USO DOMÉSTICO E DE DECORAÇÃO: Colheres, facas e garfos, avulso, em metal, faqueiros em metal		
507	OUTROS ARTIGOS DE USO DOMÉSTICO E DE DECORAÇÃO, NÃO ELÉCTRICOS: Louça e outros artigos de mesa e de cozinha, de matérias plásticas ou de outros materiais (panelas, tachos, frigideiras e similares)		
508	PRODUTOS DE LIMPEZA E MANUTENÇAO CORRENTE DE HABITAÇÃO: Ceras, detergentes líquidos (sabão líquido, limpa vidros etc), detergentes em pó, sabão, desinfectantes, insecticidas e desodorizantes de ambiente, ou lixívia		
509	OUTROS BENS DOMÉSTICOS NÃO DURADOUROS: Guardanapos, rolos, louça de papel, papel de alumínio e película aderente, escovas e vassouras para uso doméstico, panos de limpar o chão e pó, esfregões e palha-de-aço, fósforos, molas para roupa, pregos, parafusos e similares, e velas para iluminação excepto decorativas		
510	Serviços de empregados domésticos		
	SAUDE		
601	Medicamentos, antibioticos (cotrimoxazol, cloraquina, outros comprimidos, aspirina, paracetamol, etc)		
602	Analisis em clinica, e outros servicos medicos nao mencionados na seccao da salud (radiografia, cirurgia, etc)		
	TRANSPORTES		
701	Baterias, peças, pneus, lubrificantes, aluguer de veículos, óleo, etc		
	COMUNICAÇÃO		
801	Telefone fixo (pre-pago, pos-pago) (Blá blá), e serviços de ligação à Internet ou de transmissão de dados		
802	Comunicações da rede movel (pos-pago=por contrato)		
	LAZER, RECREAÇÃO E CULTURA		
901	Jogos, bicicletas e brinquedos		
902	Serviços de desportivos, recreativos, músicos, cinemas, concertos, e outros serviços		
903	Aluguer de equipamentos e acessórios para actividades desportivas, recreativas		
904	Entrada em piscinas, estádios de futebol, pavilhões , pistas, feiras e parques de diversão		
905	Lotaria, totoloto , totobola, etc. (compra de bilhete, matriz, etc)		
10	**RESTAURANTES, HOTÉIS, CAFÉS E SIMILARES**		
1001	Dormidas em hoteis, residenciais, pensões e similares		
11	**BENS E SERVIÇOS DIVERSOS**		
1101	SALÕES DE CABELEIREIROS E OUTROS ESTABELECIMENTOS DE CUIDADOS: Corte de cabelo, produtocs para cabelo, pintura, disfrizagem, lavagem, enrolamento, tranças e outros serviços de cabeleireiro para senhora, ou tratamentos de pele, maquilhagem, manicure, pedicure, depilação e serviços similares		
1102	PERFUMES, COSMÉTICOS E PRODUTOS DE HIGIENE E BEZEZA : Aftershave e bálsamos para a barba, perfumes, águas de colónia e desodorizantes (Rolon, Sprays, …), batons e vernizes, champôs, cremes, óleos, gel para cabelo e corpo e espumas para barbear, lacas, protectores e bronzeadores solares ou pastas dentífricas		
1103	OUTROS PRODUTOS PARA CUIDADOS PESSOAIS: Sabonetes, guardanapos, toalhetes de papel, lenço de papel, esponjas de banho, papel higiénico ou pensos e tampões, higiénicos		
1104	ARTIGOS DE JOALHARIA, BIJUTARIA E RELOJOARIA E SUA REPARAÇÃO (D): Jóias e pedras preciosas, artigos de bijuteria, cronómetros, ou reparação de artigos de joalharia, de bijutaria e relojoaria		
1105	MALAS, CARTEIRAS E ARTIGOS SIMILARES DE USO PESSOAL E SUA REPARAÇÃO: Carteiras, porta moedas, bolsas e sua reparaçã, malas, sacolas, pastas, sacos de viagem e sua reparação		
1106	ARTIGOS DE USO PESSOAL PARA FUMADORES E SUA REPARAÇÃO: Boquilhas, cachimbos, cigarreiras e bolsas para tabaco, isqueiros, ou cinzeiros		
1107	CRECHES, INFANTÁRIOS E AMAS: Creches e infantários privados e públicos (inclui Pré-escolar)		
1108	OUTROS SERVIÇOS, N.E:.Emissão de documentos (bilhete de identidade, certidões, passaportes e similares), anúncios na imprensa (jornais e rádio)		
1109	OUTROS SERVIÇOS, N.E:.Serviços funerários, caixões, de justiça (registros prediais, notariado, honorários a advogados e similares), ou fotocópias		
1110	OUTROS SERVIÇOS, N.E.:Serviços de justiça (registros prediais, notariado, honorários a advogados e similares) ou fotocópias		

SECÇÃO 9A: MECANISMOS DE CHOQUE E DE SUBSISTÊNCIA

		1	2A	2B
ID DO CHOQUE		Durante os últimos 12 meses, o seu agregado familiar foi afectado negativamente por qualquer um dos seguintes [CHOQUE]? Sim=1 Não=2 (**>>PRÓXIMO CHOQUE**)	O que é que o seu agregado familiar fez em resposta a [CHOQUE] para tentar recuperar o seu antigo nível de bem-estar? ANOTE AS DUAS ESTRATÉGIAS DE SUBSISTÊNCIA MAIS IMPORTANTES PARA O CHOQUE. SE O CHOQUE ACONTECEU MAIS DE UMA VEZ DURANTE OS ÚLTIMOS 12 MESES, PERGUNTE SOBRE O INCIDENTE MAIS RECENTE. SE APENAS UMA ESTRATÉGIA, MARQUE "00" NA SEGUNDA. **Utilize os códigos de estratégias de subsistência**	
			Estratégia de subsistência mais importante	**Segunda estratégia de subsistência mais importante**
101	Seca/chuvas irregulares			
102	Inundações/Deslizamentos			
103	Ventos/Ciclones			
104	Nível excepcionalmente alto de pragas ou doenças de culturas/animais			
105	Colheita/safra destruída (ex. Fogo)			
106	Morte de gado			
107	Preços excepcionalmente baixos para a produção agrícola			
108	Custos excepcionalmente altos de alimentos ou insumos agrícolas			
109	Fim da assistência regular/remessas de ajuda do agregado familiar externo			
110	Doença grave ou acidente de membro(s) do agregado familiar			
111	Nascimento no agregado familiar			
112	Morte do membro do agregado familiar que providencia os rendimentos			
113	Separação do agregado familiar (divórcio/separação/morte/migração)			
114	Pagamento de lobolo (dote da noiva)			
115	Roubo de dinheiro/valores/activos/produção agrícola			
116	Altos custos de educação			
117	Casa destruída (como incêndio, inundação, ventos)			
118	Conflito na comunidade			
119	CORONA VIRUS (incluindo distanciamento social / medidas sanitárias)			

IDENTIFICAÇÃO DA ESTRATÉGIA DE SUBSISTÊNCIA:

Contou com as próprias poupanças 1
Recebeu ajuda incondicional de família/amigos 2
Recebeu ajuda incondicional do governo 3
Recebeu ajuda incondicional de uma ONG/instituição religiosa 4
Mudanças nos padrões de alimentação (dependeram de opções alimentares menos caras ou menos preferidas, reduziram a proporção ou o número de refeições por dia, ou os membros do agregado familiar saltaram a alimentação de um dia, aumentaram o consumo de alimentos silvestres, membros comeram fora de casa etc.) 5
Consumo de adultos reduzido para as crianças comerem 6
Os membros do agregado familiar assumiram mais um emprego 7
Membros adultos do agregado familiar que não estavam a trabalhar tiveram que arranjar trabalho 8
Membros do agregado familiar migraram 9
Despesas reduzidas em saúde e/ou educação 10
Obteve crédito/pediu empréstimo 11
Vendeu ativos agrícolas ou duráveis, terrenos/edifícios, plantações, gado ou outros 12
Intensificou (mais dias, mais horas) a pesca/agricultura 13
Enviou as crianças para morarem noutro lugar 14
Envolveu-se em esforços espirituais - oração, sacrifícios, consulta com adivinhos 15
Pagamento PSSB ou outro benefício de outro programa de proteção social 16
Plantou árvores ou construiu estruturas de conservação 17
Crianças enviadas para trabalho remunerado 18
As crianças trabalharam mais em casa ou na agricultura/empresa familiar (não remunerada) 19
A criança menina casou-se (recebeu a labolo) 20
Outro (especifique) 21
Nenhum 99

SECÇÃO 9B: EXPERIÊNCIA COM OUTROS PROGRAMAS

		1	2	3
	Nome do Programa ou Serviço	**Nos últimos 12 meses**, algum membro do seu agregado familiar recebeu dinheiro ou bens, incluindo alimentos, vestuário, gado ou medicamentos, ou beneficiou-se de algum dos seguintes tipos de programas? 1 = SIM 2 = NÃO >> **PRÓXIMO PROGRAMA / P4**	Quem estava fornecendo esse suporte ou oferecendo este serviço? 1 = programa do governo 2 = ONG 3 = Programa religioso 9 = NÃO SABE	Qual o valor total da assistência recebida deste programa nos últimos 12 meses? **[CONVERTA ASSISTÊNCIA EM ESPÉCIE PARA MT]** >> **PRÓXIMO PROGRAMA**
01	Programa de transferência de dinheiro			
02	Programa de assistência alimentar (em espécie)			
03	Programas de obras públicas			
04	Programa de apoio agrícola (incluindo pecuária ou subsídio de insumos)			
05	Outros programas / serviços para geração de renda, incluindo empreendedorismo ou microcrédito, treinamento para pequenas empresas			

06	Campanha de saúde comunitária ou programa de saúde (incluindo campanha de informação sobre nutrição infantil / alimentação infantil)			
07	Programa de água ou saneamento			
08	Bem-estar social ou programa de apoio psicossocial			
09	Programa de educação ou apoio escolar, incluindo programas de alfabetização			
10	Serviços ou atividades para jovens			
11	Outro programa, especifique			

4	**Nos últimos 12 meses,** algum membro do seu agregado familiar recebeu dinheiro ou bens, incluindo alimentos, vestuário, gado ou medicamentos de pessoas individuais (amigos, familiares, outros) que não façam parte do seu agregado familiar?	1 = SIM 2-NÃO >> **PRÓXIMA SEÇÃO**	
5	Qual é o valor total da assistência recebida de todos esses membros não-domiciliares **nos últimos 12 meses**?	**[CONVERTA ASSISTÊNCIA EM ESPÉCIE PARA MT]**	

SECÇÃO 10A: SAÚDE MATERNA E DO RECÉM-NASCIDO

Estas perguntas devem ser feitas à mãe ou a cuidadora principal da criança alvo (2 a 2.5 anos) ou qualquer outra nova cuidadora principal [CAPI: Se respondente é do sexo masculino, Seção 0, Q11 = 1 >> Seção 10B].

	1	**2**	**3**	**4**	**5**	**6**	**7**
ID of the child	Qual é o estado civil atual de [NOME]? 1 = Casado ou a morar junto, monogâmico 2 = Casado ou a morar junto, polígamo 3 = Divorciado ou separado (>> Q4) 4 = Viúvo(a) (>> Q4) 5 = Nunca casou-se ou viveu maritalmente (>> Q4)	Seu cônjuge ou parceiro mora neste agregado? 1 = Sim 2 = Não (>> Q4)	COPIE O ID DO CÔNJUGE (SE MAIS DE UM CÔNJUGE, INCLUA O PRIMEIRO)	Casais usam vários métodos para atrasar ou evitar a gravidez. Está a usar neste momento algum método para atrasar ou evitar engravidar? 1=Esterilização feminina ou masculina 2=DIU 3=Injectável/implantes 4=Pílula 5=Preservativos 6=Diafragma/espuma/geleia 7=Método de dias padrão/método de ritmo 8=Método de amenorreia lactacional 9=Coito interrompido 10=Não está a usar nenhum método 11=Outra, especifique	Idealmente, quantas mais crianças gostaria de ter? [Número] [CAPI: Se a criança estiver morta, Secção 0, Q12 == 3 >> Secção 10A, Q29]	Agora eu gostaria de falar sobre [NAME], a criança alvo. Desde que [NAME] nasceu, quantas vezes você levou [NAME] para sessões de controle de peso?	Você ainda está a amamentar [NAME]? 1 = SIM (>> Q9) 2 = NÃO

	8	**9**	**10**					
ID of the child	Com que idade parou de amamentar [NOME]? **[Registrar a idade em meses completos]**	Com que idade (em meses) deu pela primeira vez a [NOME] água ou outros líquidos além do leite materno? [00=MENOS DE UM MÊS] [98=AINDA NÃO]	Com que idade (em meses) deu pela primeira vez a [NOME] alimentos sólidos ou semi-sólidos? [00=MENOS DE UM MÊS] [98=AINDA NÃO]					

SECÇÃO 10A: SAÚDE MATERNA E DO RECÉM-NASCIDO (CONTINUAÇÃO)

25	**26**			
Teria [NOME] sido amamentada ontem durante o dia ou a noite? *[Indicar como "Sim" mesmo se a criança foi amamentada por uma outra mulher que não é a mãe (incluindo leite dado com colher, copo, biberão…]*	Quantas vezes durante o dia ou noite [NOME] consumiu… [Vezes]			
1=SIM 2= NÃO 9= NÃO SABE	a.	b.	c.	d.
	…Leite artificial infantil?	…leite enlatado em pó, ou leite fresco	…iogurte?	…papinhas?

27	**28**
Por favor, pode dizer tudo o que [NOME] comeu ontem, durante o dia ou à noite, seja em casa ou fora de casa? [*Cada vez que o respondente se lembrar e dizer os alimentos consumidos pela criança escreva o número correspondente no grupo de alimentos correspondentes (linhas a-q abaixo)]* 1=SIM 2= NÃO 9= NÃO SABE	Quantas vezes o [NOME] foi alimentad

a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.	n.	o.	o ontem comida sólida, semi-líquida ou mole?
Papas, chima, pão, arroz, esparguet, bolachas, ou outra comida feita de cereais?	Abóbora, cenoura, ou batata-doce de polpa amarela ou alaranjada?	Batata de polpa branca, inhame branca, mandioca ou qualquer outro tubérculo, batata-reno?	Qualquer verdura de folhas verde-escura (feijão, folhas de mandioca, couve, folhas de batata doce, Tseke (Nhewe)?	Manga madura, papaia madura, goiaba de polpa vermelha ou outro alimento rico em vitamina A?	Qualquer outra fruta ou vegetal (banana, maça, tomate, limão, laranja, tangerin, uvas, couve)?	Fígado, rim, coração ou outros órgãos?	Qualquer carne, tal como carne de vaca, de porco, de ovelha, de cabrito ou pato, rato ou outra carne de caça?	Ovos?	Peixe fresco ou seco ou mariscos ?	Alguma comida feita com feijão, ervilha, lentilha, amêndoas ou sementes?	Queijo, iogurte ou outros produtos feitos de leite?	Alimentos feitos com óleo, amendoim, gergelim ou manteiga/ margarina?	Alimento Terapeutico Pronto para Uso (ATPU) ou, super cereais (CSB)?	Micro-nutrientes em pó?	[Vezes]

29																		
Agora vamos ver se não esquecemos de nenhum alimento. Você comeu durante o dia de ontem algum desses alimentos como: 1= SIM; 2= NÃO																		
a.	b.	c.	d.	e.	f.	g.	h.	i.	j.	k.	l.	m.	n.	o.	p.	q.	r.	s.
Arroz, milho, mapira, mexoeira, pão, massas, papas, inhame / madumbe, banana verde?	Batata Reno, batata-doce, mandioca?	Feijão, ervilhas, lentilhas, soja?	Amendoim, amendoeira, sementes de gergelim, abóbora, castanhas de caju?	Leite, queijo, iogurte ou outros produtos lácteos, creme de leite, nata ?	Fígado, rins, moelas, coração, dobrada?	Carne bovina, porco, cabrito, coelho, frango, pato, pássaro, rato, ratazana, carne de caça selvagem?	Peixes, mariscos ou frutos do mar frescos ou secos (lagosta, lula, polvo, ostras, carangue jo?	Ovos de aves de capoeira ou qualquer outra ave como pato, codorniz?	Tsec (amaranthus), agrião, folhas de batata doce, folha de abóbora, folha de mandicoca ou de feijão, quiabo, moringa, espinafre?	Abóbora, cenoura, pimentão vermelho, batata-doce de polpa alaranjada?	Manga, papaia, maracujá, pêssego?	Couve, tomate, alface, beringela, pepino, pimentão verde, beterraba?	Laranja, maçã, pêra, uva, ananás, frutos silvestres, tangerina, melância?	Você utilizou Óleo, gordura ou manteiga para cozinhar ?	Alimentos açucarados, como chocolates, doces, e biscoitos, bolos, doces ou sorvetes?	Tomou folha de chá (preto) ou café sem açucar imediatamente antes ou depois da comida ?	Utilizou ingredientes, mesmo que em pequenas quantidades para dar sabor, tais como pimentões, especiarias, ervas, peixe em pó, massa de tomate, caldos de sabor ou sementes ?	bebeu sumos açucarados, sumos de frutas, refrigerantes, bebidas de chocolate, iogurte ou chá com açúcar ou café com açúcar?

SECÇÃO 10B: IMUNIZAÇÕES E MEDICAÇÃO

Estas perguntas devem ser feitas à mãe ou ao cuidador principal da criança alvo (2 a 2.5 anos). [CAPI: Se a criança estiver morta, Seção 0, Q12 == 3 >> Seção 11 Disciplina Infantil]

	1	2													3	4	5
Identificação da criança	Tem um cartão onde as vacinas de [NOME] estão registradas? (SE SIM), posso ver? 1=Sim, vista 2=Sim, não vista 3=Não	Verificar o cartão de saúde para ver o histórico de vacinação. Se o cartão de saúde não estiver disponível, pergunte ao entrevistado. Para as vacinas ENP, VOP e Pneumocócica e Rotavírus, registrar o número de vezes que a vacina foi recebida. 1=SIM; 2=NÃO; 9=NS													[NOME] recebeu uma dose de vitamina A nos últimos 6 meses? 1=SIM 2=NÃO 9=NS	[NOME] recebeu medicação de desparasitação nos últimos 6 meses? 1=SIM 2=NÃO 9=NS	[NOME] teve diarreia nas últimas duas semanas? 1=SIM 2=NÃO 9=NS
		BCG Vacinação contra a tuberculose - isto é, uma injecção no braço ou no ombro que geralmente causa uma cicatriz	**POLIOMIELITE** Gotas de vacina na boca para protegê-lo da poliomielite				**PENTA** Uma injecção na coxa ou nas nádegas para impedir que tenha tétano, tosse convulsa ou difteria			**PNEUMOCÓCICA** Uma injecção geralmente aplicada na parte superior da coxa direita para prevenir a pneumonia?			**ROTAVÍRUS** Líquido na boca para prevenir a diarreia?		**SARAMPO** Uma vacina no braço aos 9 meses ou mais tarde para evitar que tenha sarampo			
			0	1	2	3	1	2	3	1	2	3	1	2				

SECÇÃO 10C: DESENVOLVIMENTO DA CRIANÇA

Estas perguntas devem ser feitas à mãe ou ao cuidador principal da criança alvo (2 a 2.5 anos); Extraído da ferramenta PATH (componentes da escala MICS)

	1						2	3	4	5	
Identificação da criança	Nos **últimos 3 dias**, você ou qualquer membro do agregado familiar com mais de 15 anos de idade fez alguma das seguintes actividades com [NOME]? **[REGISTRE TUDO O QUE FOR MENCIONADO]** A=MÃE (prestadora de cuidados feminina principal) B=PAI (prestador de cuidados masculino principal) X=OUTRO Y=NINGUÉM Z=NAO SABE						Durante o dia, quando é que costuma jogar com [NOME]? [ENTREVISTADOR, leia um de cada vez e peça uma resposta]: Brinca com [NOME]. . .? A = Ao dar banho à criança? B = Ao dar comida à criança? C = Ao vestir a criança? D = Quando faz tarefas domésticas? E = Durante o trabalho no campo? F = No tempo livre? [Marque todos que se aplicam]	Normalmente, com que idade uma criança consegue ver? [Meses]	Normalmente, com que idade uma criança consegue ouvir? [Meses]	Quantos dias na semana passada [NOME] foi:	
	a. Ler livros ou vê imagens com [NOME]?	b. Contar histórias para [NOME]?	c. Cantar músicas para [NOME] ou com NOME, incluindo canções para durmir?	d. Levar [NOME] para um passeio fora de casa, complexo, quintal ou recinto?	e. Brincar com [NOME]? (ex. cu-cu, palmas, escondidas?)	f. Dizer o nome, contar ou desenhar coisas com [NOME]? (ex. "É um cão")				A. Deixou sozinho por mais de uma hora?	B. Deixou aos cuidados de outra criança, isto é, alguém com menos de 10 anos, por mais de uma hora?
	A B X Y Z	A B X Y Z	A B X Y Z	A B X YZ	A B X YZ	A B X YZ	A B C D E F				

	6	7	8
Identificação da criança	Com que frequência você tem problemas para acalmar [NOME] quando está chorando ou chateado? 1 = quase nunca 2 = Menos da metadedo do tempo 3 = A metade do tempo 4 = Mais da memetade do tempo 5 = quase sempre	Durante o dia normal, com que freqüência o seu bebê [NAME] fica agitado e irritado? 1 = quase nunca 2 = uma ou duas vezes por dia 3 = par de manhã e tarde / noite 4 = Várias vezes por dia 5 = Quase toda hora	Em geral, em comparação com a maioria das crianças, com que freqüência a sua criança chora e reclama? 1 = quase nunca 2 = menos que a média 3 = sobre média 4 = Mais que a média 5 = quase sempre

SECÇÃO 11: DISCIPLINA DA CRIANÇA

O entrevistado para esta secção deve ser o prestador de cuidados principal (mulher) da criança alvo seleccionada com idade entre 2-2.5 anos; Pergunte para cada criança de 1 aos 14 anos (inclusive) [módulo MICS]

	2									
Identificação da criança	Os adultos usam certas maneiras de ensinar às crianças o comportamento correto ou de resolver um problema de comportamento. Vou ler vários métodos que são usados. Diga-me se <u>você ou qualquer outro adulto do seu agregado familiar</u> usou este método com [NOME] <u>nas últimas quatro semanas</u>. 1=SIM 2=NÃO									
	A. Tirou privilégios, proibiu algo de que [NOME] gosta ou não o/a deixou sair de casa	B. Explicou porque é que o comportamento de [NOME] estava errado	C. Abanou-o(a) violentamente a [NOME]	D. Gritou com ele/ela	E. Deu-lhe algo diferente para fazer	F. Espancou, bateu ou deu-lhe uma bofetada nas nádegas com a mão	G. Bateu-lhe nas nádegas ou noutro lugar do corpo com algo como um cinto, pente, pau ou outro objecto duro	H. Chamou-o/a de deficiente, preguiçoso(a) ou outro nome assim	I. Bateu-lhe ou deu-lhe uma bofetada no rosto, cabeça ou orelhas	J. Bateu-lhe ou deu-lhe uma bofetada na mão, braço ou perna

Depois de completar as perguntas para cada criança separadamente, faça a pergunta abaixo (apenas***uma vez*** por agregado familiar!):

3	Acredita que, para criar ou educar adequadamente uma criança, ela precisa ser castigada fisicamente?	Sim ..... 1 Não ..... 2 Não sabe / Sem opinião 8

SECÇÃO 12: EMPODERAMENTO DAS MULHERES, BEM-ESTAR EMOCIONAL, PREFERÊNCIAS E CAPITAL SOCIAL

O entrevistado para esta secção deve ser o prestador de cuidados principal (mulher) da criança alvo com idade entre 2 e 2.5 anos do agregado familiar [CAPI: Se respondente é do sexo masculino, Seção 0, Q11 == 1 >> Seção 13].

	Pergunta	Respostas	Saltar
1	Algumas pessoas tentam poupar dinheiro para comprar algo especial no futuro, ou para segurança em caso de emergência. Está actualmente a poupar (em dinheiro)?	Sim ..... 1 Não..... 2	→ **Q4**
2a	Quanto popouem dinheiro nos últimos 30 dias?	MT: _____	
2b	Quanto você popou totalmente em dinheiro?	MT: _____	
3	Quais são as três coisas mais importantes para as quais está a poupar dinheiro? **[LISTE ATÉ 3 RESPOSTAS** **NÃO LER, PERMITIR RESPOSTA DO ENTREVISTADO]**	Para comprar itens a grosso ou outros alimentos ..... A Para comprar consumíveis domésticos (iluminação, combustível, sabão em pó) ..... B Taxas escolares/despesas escolares ..... C Para comprar roupa nova/sapatos ..... D Despesas médicas/cuidados de saúde ..... E Para pagar dívidas ..... F Para comprar bens duráveis domésticos (móveis, panelas/frigideiras, rádio, etc.) ..... G Para comprar gado ..... H Comprar insumos ou ferramentas agrícolas ..... I Para adquirir activos para iniciar uma nova actividade de pequena empresa/geração de renda ..... J Para fazer melhorias em casa (novo telhado, latrina)..... K Para comprar um novo terreno ou casa ..... L Para gastar em serviços (cabelo, beleza, desporto, compras em associações, funções religiosas, etc.) ..... M Cerimónias ..... N Fundos de emergência ..... O Outro, especifique X	
4	Agora, eu gostaria de perguntar sobre uma situação hipotética. Por favor, pense sobre o que faria se esta situação acontecesse. Suponha que alguém da sua confiança lhe dá algum dinheiro. Você pode optar por receber MT 1000 agora ou outro valor numa data posterior. O que escolheria? Esta não é uma situação real e não há dinheiro real. **CIRCULE '1' (PRIMEIRA OPÇÃO) OU '2' (SEGUNDA OPÇÃO)**	A. MT 1000 agora ou MT 1000 daqui a um mês..... 1 2 B. MT 1000 agora ou MT 3000 daqui a um mês .....1 2 C. MT 1000 agora ou MT 750 daqui a um mês ... .1 2 D. MT 1000 agora ou MT 2000 daqui a um mês... ... 1 2 E. MT 1000 agora ou MT 1500 daqui a um mês.....1 2 F. MT 1000 agora ou MT 2500 daqui a um mês.....1 2	
5	[modificado **Pesquisa de Suporte Social do Estudo de Resultados Médicos**] As pessoas às vezes procuram companheirismo, assistência ou outros tipos de apoio. Se precisasse, com que frequência alguém está disponível...	**Categorias de resposta:** Nenhuma das vezes ..... 1 Poucas vezes ..... 2 Algumas das vezes ..... 3 A maioria das vezes..... 4 Sempre..... 5	
a	para ajudá-lo se estivesse demasiado doente para sair da cama?	1 2 3 4 5	
b	para levá-lo ao médico se precisar?	1 2 3 4 5	
c	para preparar as suas refeições, se fosse incapaz de fazê-lo sozinho?	1 2 3 4 5	
d	ajudar nas tarefas diárias se estivesse doente?	1 2 3 4 5	
e	passar um bom tempo?	1 2 3 4 5	
f	recorrer a sugestões sobre como lidar com um problema pessoal?	1 2 3 4 5	
g	para entender os seus problemas?	1 2 3 4 5	
h	amar e fazê-lo sentir-se querido?	1 2 3 4 5	

	Pergunta	Respostas	Saltar
6	[Escala de stress Cohen] **[O período de referência é das últimas 4 semanas]**	**Categorias de resposta:** Nunca.....1 1 dia por semana (Quase nunca).....2 2-3 dias por semana (Às vezes).....3	

	As perguntas a seguir questionam sobre os seus pensamentos e sentimentos durante o último 4 semanas. Por favor, indique quantas vezes se sentiu ou pensou de uma determinada maneira.	4-5 dias por semana (Frequentemente)……4 6-7 dias por semana (Muito frequentemente/sempre) …..5	
a	Nas últimas 4 semanas, quantos dias ficou chateada por causa de algo que aconteceu inesperadamente?	1 2 3 4 5	
b	Nas últimas 4 semanas, quantos dias se sentiu incapaz de controlar as coisas importantes da sua vida?	1 2 3 4 5	
c	Nas últimas 4 semanas, quantos dias se sentiu preocupada, nervosa e/ou stressada?	1 2 3 4 5	
d	Nas últimas 4 semanas, quantos dias se sentiu confiante sobre a sua capacidade de lidar com os seus problemas pessoais?	1 2 3 4 5	
e	Nas últimas 4 semanas, quantos dias se sentiu que as coisas estavam a indo como queria?	1 2 3 4 5	
f	Nas últimas 4 semanas, quantos dias descobriu que não conseguia lidar com todas as coisas que precisava fazer?	1 2 3 4 5	
g	Nas últimas 4 semanas, quantos dias conseguiu controlar as irritações na sua vida?	1 2 3 4 5	
h	Nas últimas 4 semanas, quantos dias se sentiu que tinha as coisas sob controlo?	1 2 3 4 5	
i	Nas últimas 4 semanas, quantos dias ficou chateada por causa de coisas que estavam fora do seu controlo?	1 2 3 4 5	
j	Nas últimas 4 semanas, quantos dias se sentiu as dificuldades a acumularem-se ao ponto de não conseguir superá-las?	1 2 3 4 5	
7	**[Local de controlo]** Nos últimos 12 meses, com que frequência sentiu que…	**Categorias de resposta:** Nenhuma das vezes ..... 1 Poucas vezes ..... 2 Algumas das vezes ..... 3 A maioria das vezes..... 4 Sempre..... 5	
a	A sua vida é determinada pelas suas próprias acções	1 2 3 4 5	
b	Tem o poder de tomar decisões importantes que mudam o curso da sua vida	1 2 3 4 5	
c	Tem o poder de tomar decisões importantes que mudam o bem-estar dos seus filhos	1 2 3 4 5	
d	Tem o poder de tomar decisões importantes que mudam o bem-estar do seu agregado familiar	1 2 3 4 5	
e	É capaz de proteger os seus próprios interesses (questões que são importantes para você) no seu agregado familiar	1 2 3 4 5	
f	É capaz de proteger os seus próprios interesses (questões que são importantes para você) fora do seu agregado familiar (por exemplo, na comunidade, em grupos nos quais participa)	1 2 3 4 5	
g	Está satisfeito com a sua vida	1 2 3 4 5	
8	**EMPODERAMENTO DAS MULHERES (vinhetas)**		
a	Algumas pessoas sentem que têm liberdade de escolha e controlo completamente sobre as suas vidas, enquanto outras pessoas acham que o que fazem não tem nenhum efeito real sobre o que lhes acontece. Imagine uma escada onde, no degrau mais baixo, o primeiro degrau, estão pessoas que sentem que não têm liberdade de escolha nem controlo sobre as suas vidas, e no degrau mais alto, o décimo degrau, estão pessoas que sentem que têm total liberdade de escolha e total controlo sobre as suas vidas. Em que degrau da escada sente que está hoje? [*Mostrar a escada*]	1 2 3 4 5 6 7 8 9 10	
b	Até que ponto se sente capaz de tomar decisões no seu agregado familiar, por exemplo, decisões sobre onde gastar o dinheiro, decisões sobre a educação ou saúde do seu filho ou decisões sobre se deve ou não trabalhar? Imagine uma escada onde, no degrau mais baixo, no primeiro degrau, estão pessoas que sentem que não têm poder de decisão, e no degrau mais alto, o décimo degrau, estão pessoas que sentem que são capazes de tomar todas as decisões que desejam. Em que degrau da escada sente que está hoje? [*Mostrar a escada*]	1 2 3 4 5 6 7 8 9 10	
c	Agora quero que pense em felicidade. Imagine uma escada com degraus numerados de um na parte inferior a dez na parte superior.		

	Suponha que dizemos que o topo da escada representa a melhor vida possível para si e a parte inferior da escada representa a pior vida possível para si. Em que degrau da escada sente que está hoje? [*Mostrar a escada]*	1 2 3 4 5 6 7 8 9 10	
d	Agora quero que pense sobre a situação económica do seu agregado familiar. Imagine uma escada com degraus numerados de um na parte inferior a dez na parte superior. Suponha que dizemos que o topo da escada representa aqueles que são os melhores (mais ricos) na sua comunidade e a parte inferior da escada representa aqueles que são os piores (mais pobres) na sua comunidade. Em que degrau da escada sente que o seu agregado familiar está hoje? [*Mostrar a escada]*	1 2 3 4 5 6 7 8 9 10	
9	**Saúde Mental (formulário abreviado CES-D 10)** **Em seguida, gostaria de lhe perguntar com que frequência tem certos sentimentos. Diga-me quantos dos últimos 7 dias […]:**		
A	Dormiu bem?	1 = Raramente (<1 dia) 2 = Algumas ou poucas vezes (1-2 dias) 3 = Ocasionalmente ou moderadamente (3-4 dias) 4 = Na maioria das vezes ou sempre (5-7 dias)	
B	Estava feliz?		
C	Teve problemas para se concentrar?		
D	Sentiu-se esperançosa (otimista) em relação ao futuro?		
E	Sentiu que tudo o que fez foi um esforço?		
F	Sentiu-se sozinha?		
G	Sentiu-se deprimida?		
H	Sentiu que não conseguia "seguir em frente"?		
I	Ficou incomodada com coisas que geralmente não a incomodam?		
J	Sentiu-se com medo?		

	ASSOCIAÇÃO DE GRUPO [do módulo de capital social da WEAI]								
	Agora, gostaria de perguntar sobre grupos na comunidade. Estes podem ser grupos formais ou informais e habituais .								
		a	b	c	d	e	F	g	h
		Grupo de produtores agrícolas/pecuários/pesqueiros (incluindo marketing)	Grupo de crédito ou microfinanciamento (incluindo poupança, Xitique)	Grupo de ajuda mútua ou segurador (incluindo sociedades funerárias)	Grupos comerciais ou empresariais	Grupos cívicos (melhoria da comunidade) ou grupo de caridade (ajuda aos outros)	Grupo religioso	Outro grupo de mulheres ou homens (rapazes/raparigas) (apenas não contado)	Grupo do governo local
10	Existe um [GRUPO] na sua comunidade (onde mora)?								
11	Você/algum membro do agregado familiar é um membro activo deste grupo? 1 = Sim, respondente 2 = Sim, outro membro do agregado familiar 3= Sim, respondente e outro membro do								

	agregado familiar 4=Não								

SECÇÃO 13: NUTRIÇÃO E CONHECIMENTO DA ALIMENTAÇÃO

O entrevistado para esta secção deve ser o prestador de cuidados principal da criança alvo (2 - 2.5 anos).

NÃO SOLICITE NEM FORNEÇA CÓDIGOS, PERMITA QUE O ENTREVISTADO RESPONDA E MARQUE TUDO O QUE SE APLICAR

	Pergunta	Respostas	Saltar
1	Quanto tempo depois do parto deve um bebé ser amamentado pela primeira vez?	Imediatamente/dentro de uma hora .....1 Dentro de um dia .....2 Após um dia.....3 Após mais de um dia .....4 O bebé não deve ser amamentado .....5 Não sabe.....9	
2	Até que idade deve um bebé ser amamentado exclusivamente (apenas leite materno, nem mesmo água?)	Idade em meses: .....|___|___| Não sabe.....99	
3	Porque um bebé com menos de 6 meses deve ser amamentado exclusivamente? **[NÃO LEIA AS RESPOSTAS; REGISTRE TUDO O QUE FOR MENCIONADO]**	Protege o bebé contra doenças .....A O leite materno contém tudo o que o bebé precisa nos primeiros 6 meses .....B Ajuda o bebé a crescer melhor.....C Mãe menos propensa a engravidar..... D Atrasa o regresso da menstruação da mãe .....E O leite materno é limpo, seguro e conveniente.....F O leite materno é grátis/acessível..... G Reduz o custo dos cuidados de saúde ..... H Outro .....X Não sabe.....Z	
4	Com que idade deve o bebé começar a receber líquidos (incluindo água) além do leite materno?	Idade em meses: .....|___|___| Não sabe.....99	
5	Com que idade o bebé deve começar a receber alimentos (como papa) além do leite materno?	Idade em meses: .....|___|___| Não sabe.....99	
6	O que pode acontecer às crianças se não receberem ferro suficiente (seja na sua dieta ou através de suplementos de ferro)? **[NÃO LEIA AS RESPOSTAS; REGISTRE TUDO O QUE FOR MENCIONADO]**	Aprendizagem comprometida.....A Desenvolvimento comprometido.....B Crescimento lento/altura menor.....C Baixa imunidade ..... D Sentir-se cansado .....E Tornar-se anémico .....F Outro .....X Não sabe.....Z	
7	Pode me dizer alguns alimentos que são uma boa fonte de ferro? **[NÃO LEIA AS RESPOSTAS; REGISTRE TUDO O QUE FOR MENCIONADO]**	Carne (carne de vaca, cabra, etc.), frango, peixe .....A Vegetais de folhas verdes.....B Ovos.....C Leite materno ..... D Feijão/ervilha .....E Alimentos comercialmente fortificados .....F Outro .....X Não sabe.....Z	
8	Que tempero é muitas vezes fortificado com iodo (um nutriente importante para o desenvolvimento do cérebro)?	Sal.....1 Outra .....2 Não sabe.....9	
9	Quantas vezes por dia um bebé de 12 a 24 meses de idade que ainda está a amamentar deve comer? (refeições e lanches)	Número .....|___|___| Não sabe.....99	

10	O que deve fazer quando o seu filho com mais de 6 meses de idade tiver diarreia? **[NÃO LEIA AS RESPOSTAS; REGISTRE TUDO O QUE FOR MENCIONADO]**	Dar Soluções orais para re-hidratação .....A Dar menos comida que o habitual .....B Dar a mesma quantidade de comida que o habitual.....C Dar mais comida que o habitual..... D Dar menos líquidos do que o habitual.....E Dar a mesma quantidade de líquido, como de costume....F Dar mais líquido do que o habitual ..... G Manter a amamentação..... H Aumentar a amamentação.....I Dar xarope .....J Dar a medicação tradicional .....K Dar água tratada ..... L Outra .....X Não sabe.....Z	

SECÇÃO 14: IMPLEMENTAÇÃO DO PROGRAMA

No.	Pergunta	Respostas	Saltar
1	Você conhece o programa de subsídio para criança [nome local] que está operando nesta comunidade? **[ENUMERADOR: Se a resposta é "NÃO", explique o que o programa de Subsídio de Criança é para verificar novamente]**	Sim .....1 Não 2	**Se 2 → Próxima secção**
2	Quem você acha que está qualificado para receber a transferência monetária para crianças? [Marque todas as que aplicam]	Mulheres grávidas .....A Mulheres com filhos pequenos..... .B Mulheres com filhos menores de 6 meses..... C Indivíduos cuidando de muitos órfãos/crianças..... D Pessoas doentes..... E Pessoas viúvas..... F Indivíduos que não são capazes de trabalhar.....G Pessoas com deficiência.....H Idosos.....I Indivíduos muito pobres.....J Outro (especifique)..... K Não sei..... L	
3	Você acha que o processo de seleção para o programa é **claro**?	Sim, muito claro..... 1 Sim, algo claro.....2 Neutro.....3 Não, não tão claro.....4 Não, nada claro.....5	
5	Você ou qualquer outro membro da família já recebeu pagamentos ou outros serviços do programa?	Sim .....1 Não 2	**Se 2 → Próxima secção**
6	Posso ver seu cartão de identificação do programa? Enumerador: Cópia o ID do indivíduo	XXXXXXXXXXXX [12 dígitos] 999999999999 = ID não disponível ou ilegível	
7	Você ou qualquer outro membro de seu agregado familiar **ainda** participa do programa e espera receber pagamentos ou outros serviços do programa?	Sim .....1 Não 2	**Se 1→ Q9**
8	Se não, porque não?	Não é mais elegível..... 1 Beneficiário mudou-se fora do agregado .....2 Perdeu a coleta de pagamentos consecutivos .....3 Abandonou o programa voluntariamente: não precisava..... 4 Abandonou o programa voluntariamente: o programa não funcionou corretamente..... 5 Abandonou o programa voluntariamente: muitas Condições..... 6 Inscrito em outro programa de transferência de dinheiro..... 7 Não seguiu regras (condições).....8 Outro, especifique .....9 Não sei / 10	

9	Quantas pessoas elegíveis existem neste agregado familiar?	Um…… 1 Dois……..2 Tres…… 3 Quatro ou mais…….. 4	
10	Quando foi a última vez que você recebeu um pagamento? **Liste o mês e o ano.**	Mês: ..... |___|___| Ano:..... |___|___|___|___|	
11	Quanto você recebeu?	Valor recebido em MT Não sei / Não lembro 99999	
12	No total, quantos pagamentos você recebeu?	Número	
13	No total, quanto dinheiro você recebeu?	Valor recebido em MT Não sei / Não lembro 99999	
14	Quando você espera o próximo pagamento?	Número de meses Não sei ……..98 Nunca ……99	
15	Por quanto tempo no futuro você espera continuar recebendo esse dinheiro?	Número de meses Não sei ……..98 Mais / resto da minha vida.....99	
16	Para o último pagamento, quanto tempo você precisou viajar até o ponto de pagamento para receber o pagamento e voltar? [Só tempo de viagem] **[Sempre registre horas e minutos. Por exemplo. 1.5 horas equivalem a 1 hora e 30 minutos. 40 minutos são 0 horas e 40 minutos. 2 horas são 2 horas e 0 minutos]**	Horas:..... |___|___| Minutos:..... |___|___| Não sei / Não lembro 99	
17	Para o último pagamento, quanto você gastou com transporte para ir de sua casa até o ponto de pagamento e voltar?	Valor gasto com transporte em MT Não sei / Não lembro 9998	
18	Você identificou alguém que pode representá-lo no ponto de pagamento para cobrar seu pagamento se você estiver doente, ferido ou não puder receber o pagamento sozinho?	Sim, esposo ……..1 Sim, outro membro do agregado (não cônjuge)…... 2 Sim, outro familiar que moura fora do agregado ….3 Sim, amigo……4 Sim, líder da comunidade……5 Não……..6	
19	Em algum momento antes ou depois do pagamento, você **foi solicitado** a dar dinheiro/presentes OU **voluntariamente deu** dinheiro/presentes a alguém para receber o pagamento?	Você foi solicitado a dar e você deu…….. 1 Você foi solicitado a dar e você recusou…….. 2 Você voluntariamente ofereceu e a pessoa aceitou.. 3 Você ofereceu voluntariamente, mas a pessoa recusou ……..4 Não dei dinheiro ou presentes a ninguém do programa……..5 Não sei / recusou responder…….. 6	
20	Em geral, você se sente seguro para retirar o dinheiro do ponto de pagamento e levá-lo de volta para casa?	Sim, sinto-me seguro…… 1 Não, me sinto inseguro ao voltar para casa…… 2 Não, me sinto inseguro no ponto de pagamento….. 3 Não, me sinto inseguro no ponto de pagamento E ao voltar para casa…….. 4	
21	Neste agregado, quem geralmente decide como o pagamento do programa é usado?	ID Membro:..... |___|___|___|	
22	Em geral, quem [NOME] consulta ao decidir como usar o pagamento do programa?	Ninguém……1 Esposo…… ..2 Outros membros adultos do agregado…….. 3 Crianças…… 4 TODOS os membros do agregado…… 5 Outra pessoa na comunidade ……6	
23	Você deu algum dinheiro a familiares, amigos ou outras pessoas que moram fora do agregado como presentes ou contribuições para causas sociais?	Sim ……1 Não ……..2	
24	Em geral, quais são as três coisas principais para as quais o pagamento do programa é usado.	Alimentação e nutrição…… A Educação formal (taxas, livros, uniformes, etc.)….. B Outra educação (creche, outra escola religiosa)…... C Saúde…… D Abrigo / Alojamento / Aluguel…… E Roupas/sapatos (não inclui uniformes escolares)… F Investimentos/empresa pequena …….. G Ocasiões sociais formais, como casamentos ou funerais…… H	

		Poupança / VSLA…… I Outros gastos, especifique ……J	
	ACOMPANHAMENTO FAMILIAR		
25	Você ou qualquer outro membro do agregado familiar alguma vez recebeu uma visita ao domicílio ou consulta por telefone de um Permanente ou de um Técnico de SDSMAS como parte do programa?	Sim ……1 Não ……..2	**Se 2 → Próxima secção**
26	Por que você acha que foi selecionado para receber essas visitas para serviços adicionais? [Marque todas as que se aplicam]	Mãe Jovem/ Mulher jovem gravida…… A Preocupações sobre proteção infantil…….. B Preocupações sobre violência doméstica……..C Saúde mental/necessidade de apoio psicossocial…. D Abuso de substâncias (álcool ou drogas)……..E Família / pessoa é muito pobre…… F Nascimento de gêmeos precisam de suporte extra ..G Parto difícil, complicações…….. H Criança ou cuidador incapacitado…… I Outro (especifique)…….. J Não sei……..K	
27	Quantas vezes algum permanente ou técnico o visitou ou fez uma consulta por telefone (no total, mesmo que sejam pessoas diferentes)?	Número de vezes	
28	Quando foi a última vez que você foi visitado / contatado por um permanente ou técnico? **[Listar mês e ano]**	Mês: …… |___|___| Ano:…… |___|___|___|___|	
29	Você acha que o responsável pelo caso a tratou com respeito e teve seus melhores interesses em mente?	Foi muito respeitoso……. 1 Foi respeitoso…… 2 Foi desrespeitoso…….. 3 Foi muito desrespeitoso……..4	
30	Você ainda está recebendo / planeja receber mais serviços e visitas no futuro?	Sim ……1 Não ……..2	

	For each support / service type	
31	**32**	**33**
Pensando em toda a ajuda recebida desde o início do programa, que tipo de suporte / serviços eles forneceram ou indicaram? [Marque todas as que se aplicam]	Foi fornecido o acompanhamento e você conseguiu acessar o suporte / serviço? 1 = Sim 2 = Não	Você acha que o apoio dado ajudou você e sua família a superar obstáculos e alcançar melhores resultados de bem-estar? 1 = Discordo totalmente 2 = Discordo 3 = Concordo 4 = Concordo totalmente

Types of support / services
1 = Serviços de saúde (Hospital, centro de saúde, atendimento medico)
2 = INAS (serviço de atenção para recebimento de apoios)
3 = PGR / Polícia (denuncia ou informação)
4 = Escola (encaminhamento para inscrição na escola)
5 = SDMAS para apoio psicossocial
6 = Apoio da comunidade (grupo de machamba, liderança comunitária)
7 = Notariado para registo de nascimento ou obtenção de cartão de identidade
8 = Outro (especifique)
9 = Não sabe

SECÇÃO 15: MÓDULO DE CONFLITO INTRA-FAMILIAR

O entrevistado para esta secção deve ser o cuidador principal (mulher) da criança elegida com idade entre 2 e 2.5 anos do agregado familiar.

	Pergunta	Respostas	Saltar
1	**VERIFIQUE O LISTA DO AGREGADO FAMILIAR:** ☐ ACTUALMENTE FORMALMENTE CASADA OU A VIVER COM UM HOMEM → CONTINUAR ☐ FOI FORMALMENTE CASADA OU A VIVER COM UM HOMEM (nos últimos 12 meses) → CONTINUAR (leia as perguntas no pretérito perfeito) ☐ FOI FORMALMENTE CASADA OU A VIVER COM UM HOMEM (mas não nos últimos 12 meses) → CONTINUAR (leia as perguntas no pretérito perfeito) ☐ NUNCA SE CASOU OU VIVEU COM UM HOMEM → PRÓXIMA SECÇÃO		
2	**VERIFIQUE A PRESENÇA DE OUTROS:** **NÃO CONTINUE ATÉ QUE A PRIVACIDADE EFICAZ SEJA GARANTIDA - Se a privacidade for interrompida durante a entrevista, salte → P14** ☐ Privacidade obtida → Continuar ☐ Privacidade não é possível → P14		
3a	Com que idade você se casou ou começou a viver com seu parceiro / cônjuge?	[Idade em anos]	
3b	Com qual idade você engravidou pela primeira vez (mesmo que não tenha resultado em um nascimento)?	[Idade em anos]	
4a	Nos últimos 12 meses, você teve medo de seu marido/parceiro?	Muitas vezes …… 1 Às vezes …… 2 Nunca …… 3	
4b	Nos últimos 12 meses, com que freqüência seu (ex) marido/parceiro bebe (bebeu) álcool?	Todos os dias ou quase todos os dias....1 Uma vez ou duas vezes por semana.....2 1 a 3 vezes em um mês..... 3 Menos de uma vez por mês..... 4 Nunca..... 5 Não sabe / Não lembra..... 8 Recusa / Nunhuma resposta..... 9	Se 5 →P5
4c	Nos últimos 12 meses, quantas vezes você viu seu marido parceiro bêbado? Você diria que a maioria dos dias, semanalmente, uma vez por mês, menos de uma vez por mês, ou nunca?	Todos os dias ..... 1 Uma vez por semana..... 2 Uma vez por mês.....3 Menos de uma vez por mês..... 4 Nunca.....5 Não sabe / Não lembra..... 8 Recusa / Nunhuma resposta..... 9	
5	Algumas vezes o marido se chateia das coisas que a sua esposa faz. Na sua opiniao, se justifica que o marido bata na esposa nas seguintes situações?	a. Se ela sai sem lhe despedir? b. Se ela cuida mal os fihos? c. Se ela discute com ele? d. Se ela nega fazer sexo com ele? e. Se ela queima comida? Sim ..... 1 Não ..... 2 Não sabe/recusa responder …… 8	
6	**VERIFIQUE A IDADE** ☐ <18 ANOS → P14 ☐ ≥18 ANOS → Continuar		

LEIA AO ENTREVISTADO [DHS IMASIDA 2015 (Moçambique)]: Agora gostaria de lhe fazer perguntas sobre alguns outros aspectos importantes da vida duma mulher. Sei que algumas destas perguntas são muito pessoais. No entanto, as suas respostas são cruciais para ajudar a compreender a condição das mulheres em Moçambique. Deixe-me assegurar-lhe que as suas respostas são completamente confidenciais e não serão partilhadas com ninguém, ninguém mais saberá que lhe perguntaram sobre estas questões, e estas perguntas não serão feitas a mais ninguém neste agregado familiar.

			B. Com que frequência isto aconteceu durante os últimos 12 meses:?			
7	As próximas perguntas são sobre coisas que acontecem a muitas mulheres e que o seu (último) marido/parceiro pode ter feito consigo. O seu (último) marido/parceiro alguma vez…	A. Alguma vez?	Frequente-mente	As vezes	Rara-mente	Nunca
	a. Ficou irritado por você falar (ter falado) com outro homem?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	b. Suspeitou que você é (era) infiel?	Sim ..... 1 → Não 2	1	2	3	4

		Não sabe/recusa responder 8				
	c. Tentou impedi-la de ver os seus amigos?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	d. Tentou restringir o contacto com a sua família de nascimento?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	e. Insistiu em saber onde está (estava) a toda a hora?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	f. Não confiou em si para gastar dinheiro?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	g. Rebaixou-a ou humilhou-a na frente de outras pessoas?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	h. Ameaçou magoá-la ou a alguém de quem gosta?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	i. Insultou-a ou fê-la sentir-se mal consigo mesmo?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4

8	Alguma vez o seu (último) marido/parceiro lhe fez alguma uma das seguintes coisas:	A. Alguma vez?	B. Com que frequência isto aconteceu durante os últimos 12 meses:?			
			Frequente-mente	As vezes	Algumas vezes	Nunca
	a. empurrá-la, sacudi-la ou atirar-lhe algo?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	b. dar-lhe uma chapada?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	c. torcer-lhe o braço ou puxar-lhe o cabelo?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	d. socar-lhe com o punho ou com um objeto que pode te magoar?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	e. dar-lhe um pontapé, arrastá-la ou baté-la?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	f. tentar sufocá-la ou queimá-la de propósito?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4
	g. ameaçar ou atacá-la com uma faca, arma de fogo ou qualquer outra arma?	Sim ..... 1 → Não ..... 2 Não sabe/recusa responder 8	1	2	3	4

9	Nos últimos 12 meses, mais alguém no seu agregado familiar lhe bateu, esbofeteou, pontapeou ou fez mais alguma coisa para magoá-la fisicamente? REGISTRE TUDO O QUE FOR MENCIONADO	Mãe/madrasta ..... A Pai/padrasto ..... B Irmã/irmão ..... C Filha/filho ..... D Outro familiar ..... E Outros não-familiares ..... F Ninguém/não magoou ..... G	
	VERIFICAR: P8a-g ou P9: pelo menos um 'SIM' → P10 P8a-g e P9: todos "NÃO" → P14		

10	Pensando sobre o que você experimentou entre as diferentes coisas de que temos falado, nos últimos 12 meses, seus filhos ou crianças que moram na casa assistiram durante qualquer uma das vezes que você estava sendo fisicamente ferida?	Sim ..... 1 Não 2	
11	Pensando sobre o que vivenciou entre as diferentes coisas sobre as quais estivemos a falar, nos últimos 12 meses, já contou isto a alguém, ou procurou ajuda de algum serviço para impedir que isto acontecesse?	Sim ..... 1 Não 2	→P13
12a	A quem contou? REGISTRE TUDO O QUE FOR MENCIONADO SONDAGEM: Mais alguém?	Amigos ..... A Pais ..... B Irmão ou irmã ..... C Tio ou tia ..... D Família do marido/parceiro ..... E Filhos ..... F Vizinhos ..... G Polícia ..... H Médico/profissional de saúde ..... I Sacerdote/líder religioso ..... J Conselheiro ..... K ONG/organização de mulheres ..... L Líder local ..... M Outro (especifique) X	
12b	De quem procurou ajuda? REGISTRE TUDO O QUE FOR MENCIONADO SONDAGEM: Mais alguém?		
14	Agradeça à entrevistada pela sua cooperação e assegure-a sobre a confidencialidade das suas respostas. Ofereça-lhe um cartão de referência anónimo, independentemente da divulgação de violência. Se as perguntas foram interrompidas, vá para o próximo módulo e entregue o cartão de referência depois de todas as actividades serem concluídas.		

Teve que interromper o módulo de entrevista sobre conflito porque algum adulto estava a tentar escutar ou entrar na sala ou interferir de alguma outra forma?	Uma vez	Mais de uma vez	Não
Marido/parceiro	1	2	3
Outro adulto masculino	1	2	3
Adulto feminino	1	2	3

15	Comentários/explicação do entrevistador por não concluir o módulo de violência doméstica: _____	

SECÇÃO 16: ANTROPOMETRIA

MEÇA O CRIANÇA ALVO DE 2-2.5 ANOS (EQUIVALENTE A 24-30 MESES).

Registre o peso e o comprimento com a criança deitada, com o mínimo de roupa, tomando o cuidado de registrar as medidas na linha correta para cada criança. Verifique o nome do indivíduo e o número da linha na listagem de agregados familiares antes de registrar as medições. Observe também e registre se a criança tem edema ou não. CAPI: Se a criança está morta, Seção 0, Q12 == 3 >> Seção 00]

[INSTRUÇÕES: Serão feitas duas medições de altura e peso para cada indivíduo e, se a diferença for > 0,5 cm ou 0,5 kg, uma terceira medição deverá ser feita para verificar as duas primeiras medições.]

	0	1	2	3	4	5	6	7	8	9	10
ID DO MEMBRO	[NOME] está disponível para ser medido? 1 = Sim 2 = Não >> Próxima seção (Seção 00)	Qual é o dia, mês e ano de nascimento de [NOME]? (DD/MM/AA)	Qual é a fonte de informações sobre a data de nascimento do indivíduo? 1 = Certidão de nascimento 2 = Registro batismal 3 = Cartão clínico 4 = Registro doméstico 5 = Determinado usando calendário local de eventos 6 = Recordação da mãe/prestador de cuidados 7 = Recordação por outras pessoas 8 = Outro (especifique)	Foi [NOME] medido? 1 = SIM, Deitado (>> P5) 2 = SIM, de Pé (>> P5) 3 = NÃO	Porque não? 1 = Não estava em casa durante o período do inquérito, 2 = Muito doente, 3 = Deficiente ou deformado, 4 = Não quer 5 = Outro (especifique) (>>Próxima seção (Seção 00)	Peso em quilogramas [USE DUAS CASAS DECIMAIS]	Estava [NOME] despido ao minimo? 1 = Sim 2 = Não, a criança não pode ser completamente despida	Comprimento em centímetros [USE UMA CASA DECIMAL]	Perimetro Braquial Use sempre o braço esquerdo e escreva os valores em centímetros. [USE UMA CASA DECIMAL] NÃO ARREDONDE os valores obtidos	Verifique se há edema (apenas crianças) 1 = Edema presente 2 = Edema não presente 3 = Não tem a certeza 9 = Não verificado (especificar razão)	Voce referiu a crianças alvo ao unidade sanitariá? 1=Sim 2 = Não
		|__|__|/|__|__|/|__|__|__|__|				|___|___.|___||__ _|		|___|___|___|.|___|	|___|___.|___|		