

# TRANSFER MODALITY RESEARCH INITIATIVE DESIGN AND EVALUATION RESULTS

Akhter Ahmed (IFPRI), John Hoddinott (Cornell University and IFPRI), and Shalini Roy (IFPRI)

*Presented by:* Akhter Ahmed, Country Representative, IFPRI Bangladesh

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# Motivation for TMRI design

- There is strong evidence that cash and food transfers improve household-level food security
- However, they show limited/mixed effects on children's nutrition in their “first 1,000 days”
- Are transfers alone insufficient to improve child nutrition? Is caregivers' lack of knowledge also a constraint that needs to be addressed with programming?
- TMRI was designed to answer this, through a pilot project providing cash/food transfers – either with or without programming that addressed caregivers' nutrition knowledge
- Designed as a randomized control trial (RCT) – comparing households receiving interventions (treatment arms) with similar households not receiving intervention (controls)
- Aimed to understand rigorously what type of intervention is most effective for improving household food security and child nutrition

## TMRI objective

Generate evidence to guide policy on the most appropriate safety net modalities for improving the **food security of the ultra-poor** and **nutrition of their children** in Bangladesh.

# TMRI DESIGN

# TMRI interventions

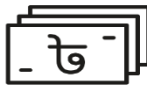
- Randomized controlled trial designed by IFPRI, implemented by WFP from 2012-2014
- Targeted mothers of children under-2 in very poor rural households
- Primary program interventions:



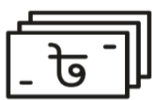
**Cash (Tk 1500 per month, via mobile banking)**



**Food (30 kg rice, 2 kg lentils, 2 liter of fortified oil worth Tk 1500)**



**$\frac{1}{2}$  Cash +  $\frac{1}{2}$  Food**

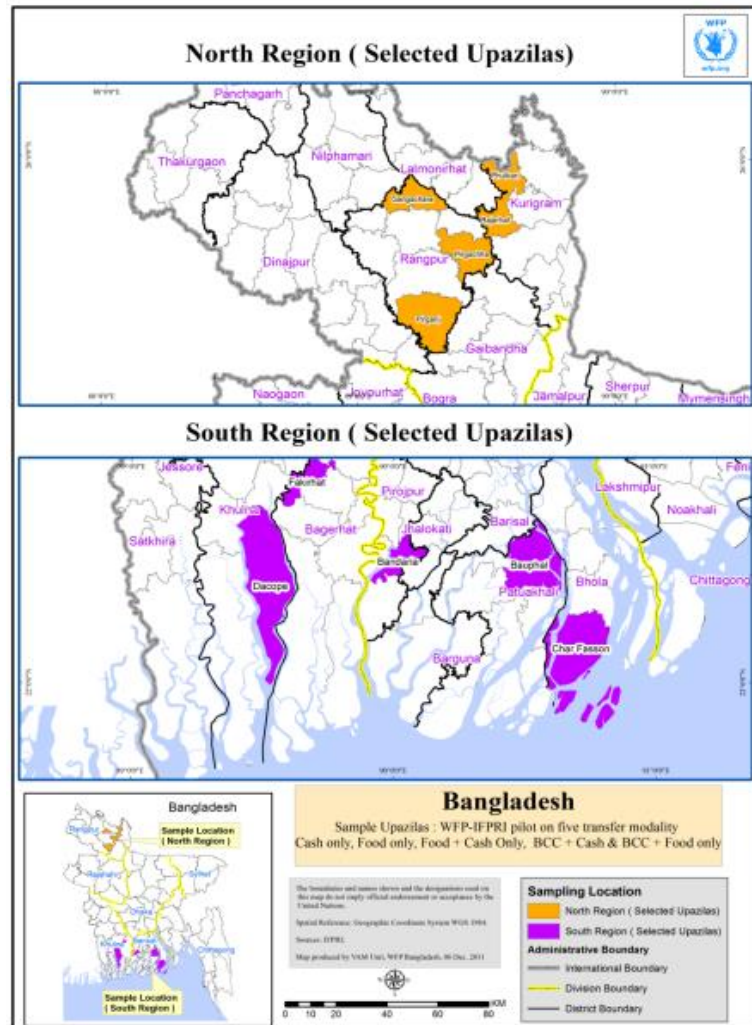


**Cash + Behavior Change Communication (*North*)**



**Food + Behavior Change Communication (*South*)**

# TMRI upazilas in the Northwest and the Southern regions



5 upazilas in 2 districts in the North:

- Rangpur
- Kurigram

5 upazilas in 5 districts in the South:

- Bagerhat
- Bhola
- Khulna
- Patuakhali
- Pirojpur

■ **Total sample size:** 5,000 households (split across North and South)

■ 4,000 program participants and 1,000 control households

# TMRI nutrition BCC

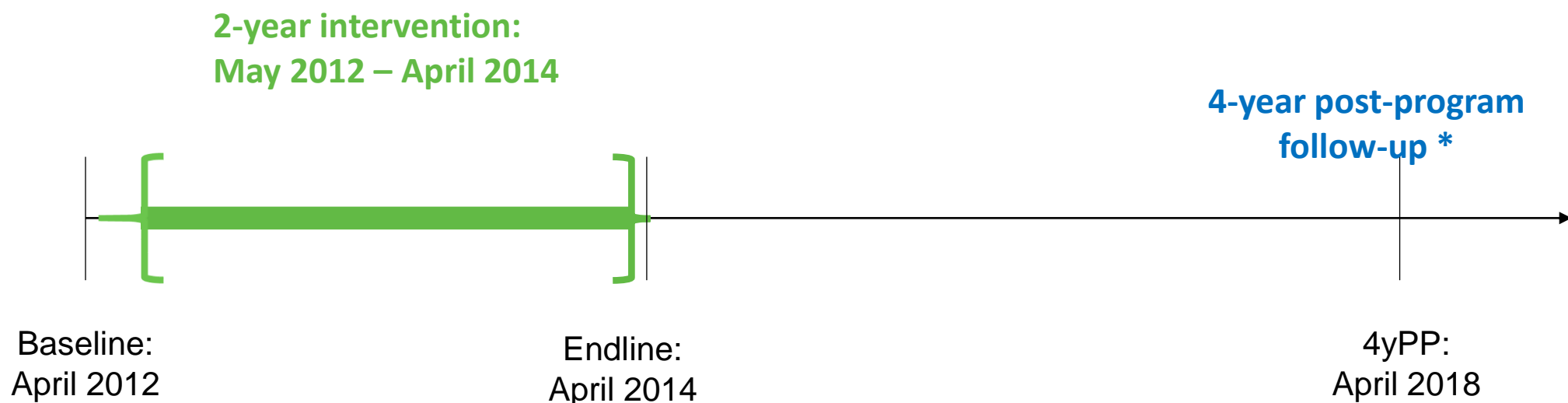
- **Weekly group meeting** of 9-15 mothers with a trained community nutrition worker, focusing on:
  - Overall importance of nutrition and diet diversity for health
  - Handwashing/hygiene for improving nutrition and health
  - Importance of micronutrients (vitamin A, iron, iodine, and zinc)
  - Feeding young children (breastfeeding, complementary feeding)
  - Maternal nutrition
  - Some combined sessions for other household members
- **Twice-a-month home visits** by community nutrition workers
- **Monthly meetings** with influential community leaders
- Transfers were conditional on attending BCC sessions for Cash+BCC and Food+BCC groups



BCC session

# TMRI data collection timeline

- IFPRI and DATA collected several rounds of data during and after the intervention on households, women, and children
- In this presentation, focus mainly on endline results – after 2 years of intervention



\* Selected arms only



# TMRI EVALUATION RESULTS

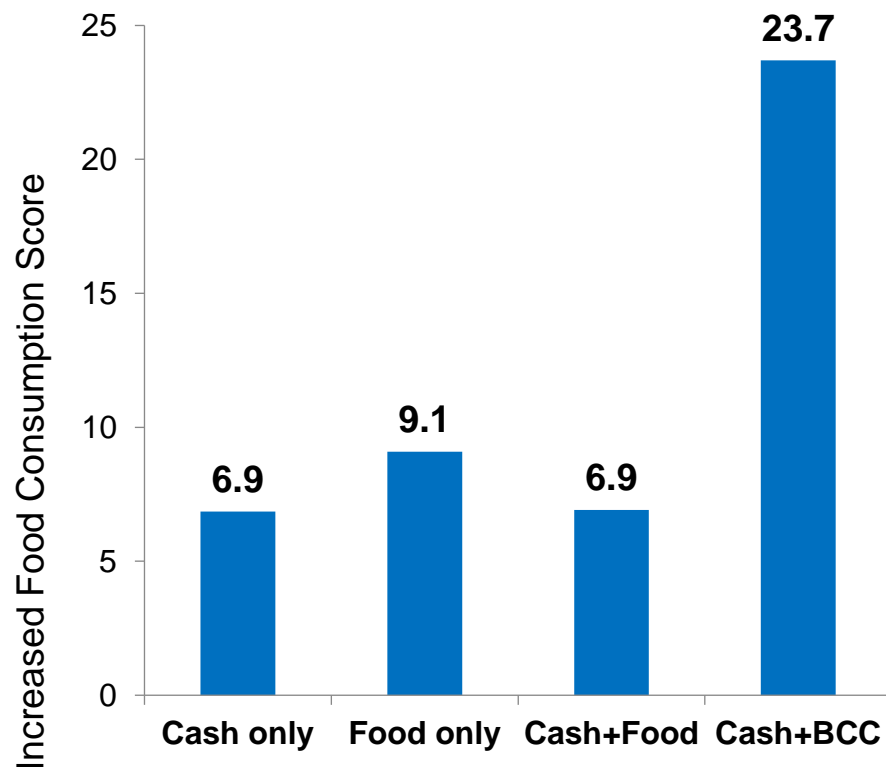
# BCC was well-implemented

(based on endline survey data)

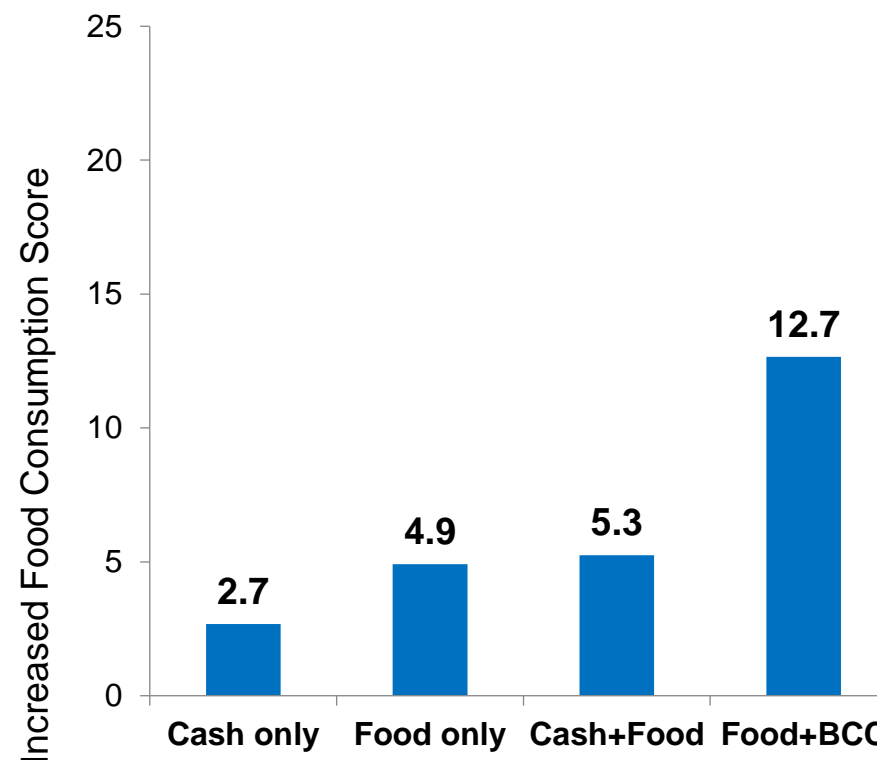
- **Community nutrition workers providing BCC were well-trained**
  - On a test of nutrition knowledge, average scores were very high
- **BCC was intensive**
  - Households in +BCC arms attended ~48 sessions per year (out of 52)
  - ~83% respondents reported that if they missed a session, the nutrition worker followed up with a home visit
- **BCC increased participant mothers' knowledge**
  - Cash+BCC and Food+BCC increased nutrition knowledge scores by 40% (no significant effect of transfers without BCC)

**At endline, all modalities significantly improved household diets in both regions – but adding BCC had a greater impact (using WFP's Food Consumption Score: 0-112)**

**North (baseline: 43.7)**



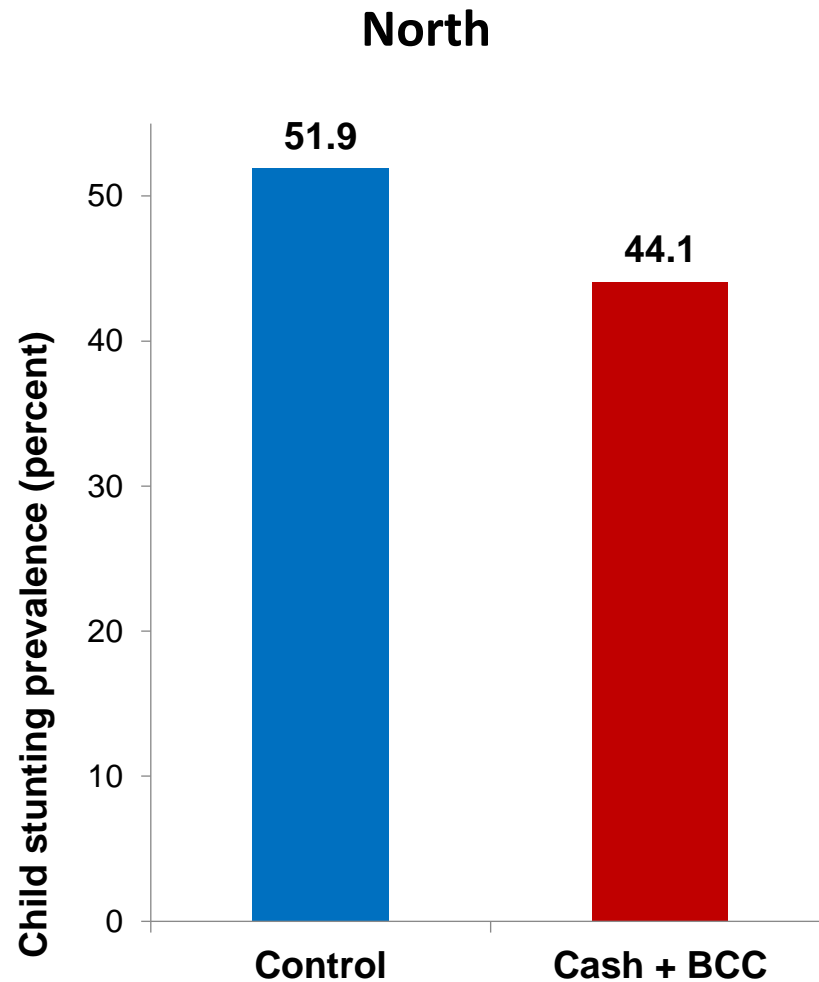
**South (baseline: 50.9)**



# At endline, most interventions increased food groups consumed by children – but adding BCC increased these most, particularly when combined with Cash in the North

On which food groups did treatment arms cause significant increases in child food frequency?			
NORTH		SOUTH	
<b>Cash</b>	Fruit	<b>Cash</b>	Eggs
<b>Food</b>	Legumes	<b>Food</b>	Legumes
<b>½ Cash, ½ Food</b>	Legumes	<b>½ Cash, ½ Food</b>	No significant impacts
<b>Cash+BCC</b>	Legumes Leafy green vegetables Fruit Meat Fish Eggs Milk/dairy	<b>Food+BCC</b>	Legumes Leafy green vegetables Fruit Fish Eggs

## At endline, only Cash+BCC in the *North* reduced child stunting



- In the *North*, Cash+BCC significantly reduced the prevalence of child stunting by **7.8 percentage points**, which is three-times the national average trend decline.
- Other modalities in the *North* had no impact on child nutritional status.
- No impact on nutritional status of children in the *South*.

## 4-year post-program data supports sustainability of findings

- Evidence suggests BCC (particularly weekly group trainings) empowered women and led to a range of sustained impacts beyond child nutrition.
- At 4-year postprogram, in households that had received BCC:
  - Lower maternal depression
  - Lower maternal experience of intimate partner violence
  - Lower household poverty
  - More time spent stimulating the child

## Policy implications (1 of 2)

- If policy objective is to improve the diets of poor households, both cash and food transfers are effective.
- If policy objective is to **improve the nutritional status of children** from the poorest households, **transfers alone are inadequate.**



## Policy implications (2 of 2)

- High quality **BCC together with transfers** – especially cash transfers – can significantly improve **child nutrition** and anthropometric outcomes.
- Adding BCC to transfers also led to a range of **sustained benefits for households, women, and children** four years post-program

