

TRANSFER MODALITY RESEARCH INITIATIVE DESIGN AND EVALUATION RESULTS

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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

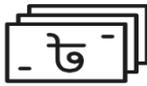
- Randomized controlled trial designed by IFPRI, implemented by WFP from 2012-2014
- Targeted mothers of children under-2 in very poor rural households
- Primary program interventions:



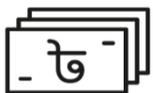
Cash (Tk 1500 per month, via mobile banking)



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



1/2 Cash + 1/2 Food

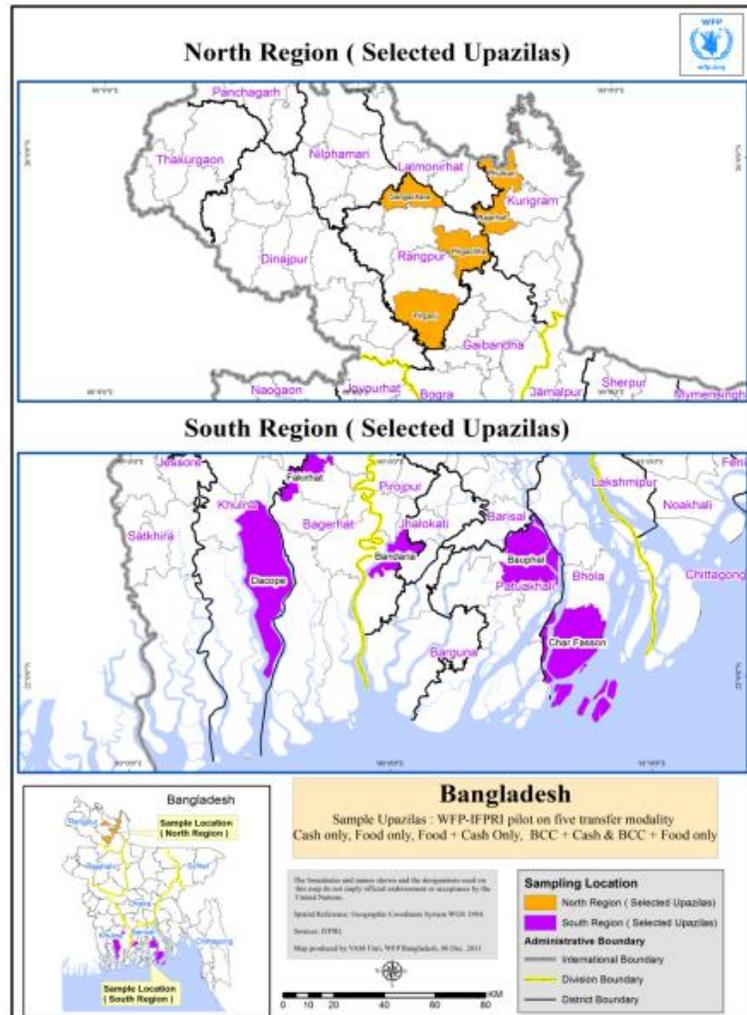


Cash + Behavior Change Communication (*North*)



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

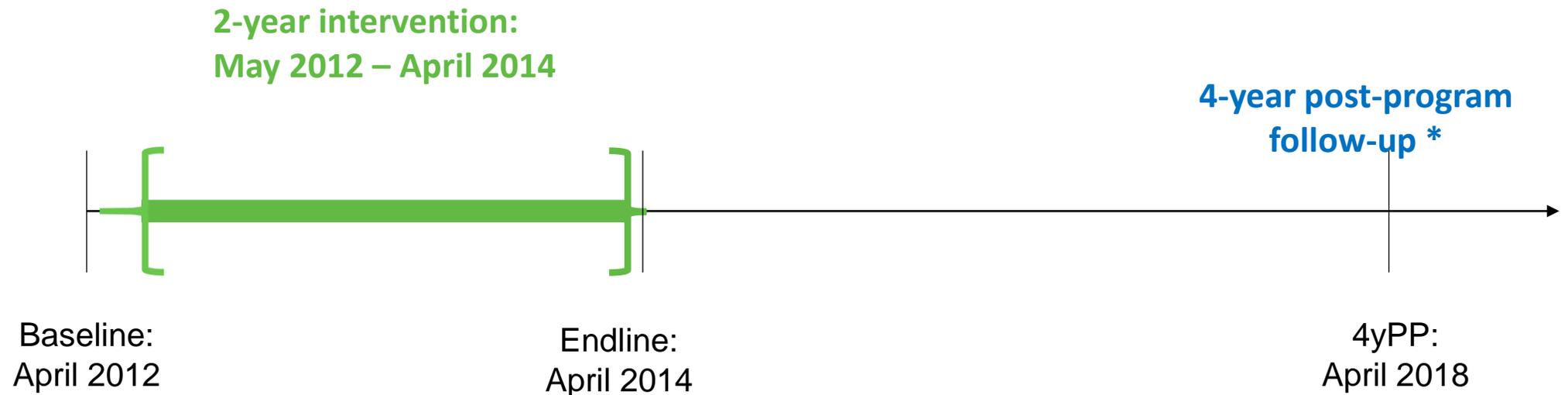
- **Weekly group meeting** of 9-15 mothers with a trained community nutrition worker, focusing on:
 - Overall importance of nutrition and diet diversity for health
 - Handwashing/hygiene for improving nutrition and health
 - Importance of micronutrients (vitamin A, iron, iodine, and zinc)
 - Feeding 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

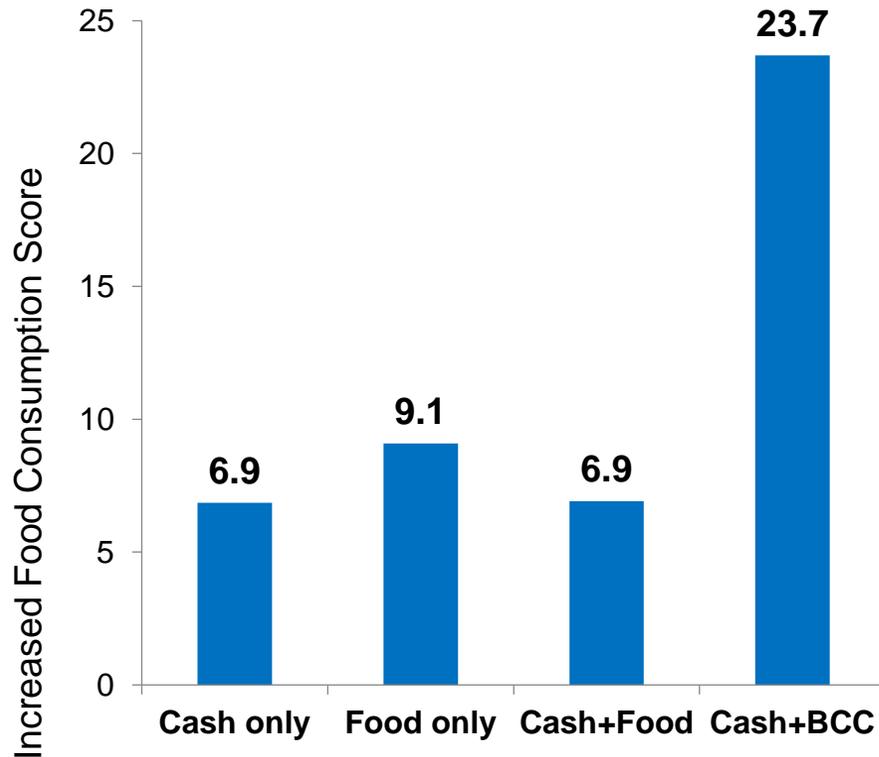
BCC was well-implemented

(based on endline survey data)

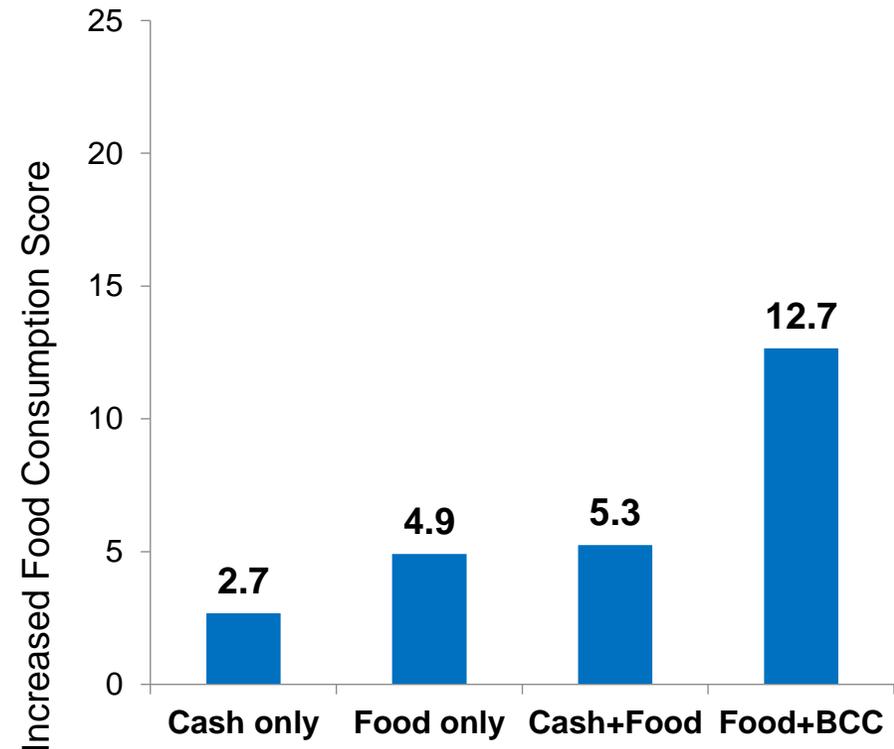
- **Community nutrition workers providing BCC were well-trained**
 - On a test of nutrition knowledge, average scores were very high
- **BCC was intensive**
 - Households in +BCC arms attended ~48 sessions per year (out of 52)
 - ~83% respondents reported that if they missed a session, the nutrition 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)

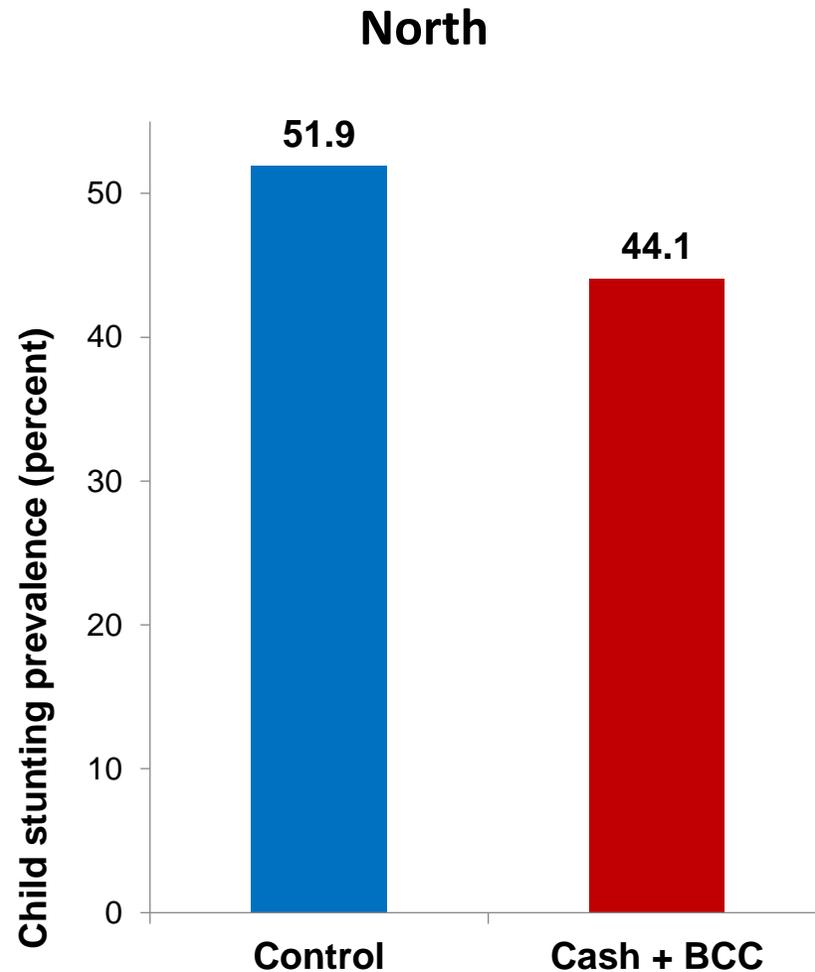


At endline, most interventions increased food groups consumed by children – but adding BCC increased these most, particularly when combined with Cash in the North

On which food groups did treatment arms cause significant increases in child food frequency?

| | NORTH | | SOUTH |
|-----------------------|--|-----------------------|--|
| Cash | Fruit | Cash | Eggs |
| Food | Legumes | Food | Legumes |
| ½ Cash, ½ Food | Legumes | ½ Cash, ½ Food | No significant impacts |
| Cash+BCC | Legumes Leafy green vegetables Fruit Meat Fish Eggs Milk/dairy | Food+BCC | 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

