Impact evaluation of the DFID Programme to accelerate improved nutrition for the extreme poor in Bangladesh
Programme context in Bangladesh

- History of poor government nutrition programming

- Recent history of innovative community programmes in health and nutrition

- Rationale for testing combination of livelihoods (L) and nutrition (N) interventions:
  - Address immediate and underlying causes of child malnutrition
  - Accelerate improved nutrition in extreme poor households
  - Contribute to evidence base
Evaluation objectives

1. To assess the impact of the combination of direct (nutrition-specific) and indirect (nutrition-sensitive) interventions in three different DFID programmes on nutritional status of children under two years.

2. To explain this impact, drawing on wider qualitative and quantitative evidence describing programme-specific and wider societal/contextual processes with the potential to impact on programme outcomes; and

3. To assess the cost effectiveness of integrating direct and indirect interventions in the three livelihood programmes and to specify the best delivery model for doing so.
<table>
<thead>
<tr>
<th>Programme</th>
<th>Coverage</th>
<th>Types of intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chars Livelihood Programme (CLP)</strong> (phase II: 2010-2016)</td>
<td>78,026 extreme poor households (312,000 individuals) in vulnerable NW charms</td>
<td>Provision of assets (e.g. cows), cash stipends/village savings and credit groups, infrastructure support (e.g. plinth construction), WASH, homestead gardening, social development support (e.g. women’s empowerment).</td>
</tr>
<tr>
<td><strong>Economic Empowerment of the Poorest Programme</strong> (‘Shiree’ or EEP) (2008-2015)</td>
<td>Evaluation selected ESEP Concern project which targeted 22,500 extreme poor households in Haor region</td>
<td>Provision of productive assets (e.g. ducks, hens), savings and credit groups, access to productive land, homestead gardening</td>
</tr>
<tr>
<td><strong>Urban Partnership for Poverty Reduction (UPPR) Programme</strong> (2008-2015)</td>
<td>3 million poor and extreme poor in urban areas</td>
<td>Savings and credit groups, trainings, apprenticeship and education grant support, settlement and WASH support.</td>
</tr>
</tbody>
</table>
DFID Programme design – nutrition component (2 years delivery)

• Community Nutrition Workers (CNWs) as main delivery mechanism

• Target groups: pregnant and breastfeeding women, adolescent girls, children <5

• Combination of ‘hard’ and ‘soft’ inputs:
  • Delivery of **micronutrients** (IFA, MNP) and **deworming treatment**
  • **Household-level counselling** on Infant and Young Child Feeding (IYCF) practices
Evaluation design & methods

• Mixed methods theory-based design

• Three interwoven components to address three objectives:

  1. **Quantitative impact evaluation** (baseline & endline survey of 11,000 HHs*) – quant estimates of outcomes and impacts of direct nutrition and livelihoods interventions

  2. **Exploratory/explanatory** (process evaluation and qualitative sub-components) – explored causal processes and contextual analysis to explain *how* and *why* interventions had impact

  3. **Cost effectiveness** - assessment of programme performance in relation to VfM (economy, efficiency, effectiveness, equity), cost modelling to assess cost-driven variables
Design of quantitative component

- Can be conceptualized by imagining three possible ‘paths’ for a particular household, depending on which (if any) interventions it receives

![Graph showing three paths: Livelihoods only (L), Combination of Livelihoods + Direct Nutrition (L+N), and No intervention (C)].
Inputs
- Programme assumptions

Outputs
- Programme assumptions

Programme evaluations
- Quantitative impact evaluation
- Cost-effectiveness evaluation
- Exploratory/explanatory evaluation of community and programme processes

Monitoring information
- Independent multi-method evaluation (IDS, IFFRI, ITAD)

Programme monitoring and evaluation frameworks
- Existing programme monitoring and evaluation frameworks

Outputs
- Behavioural change approach is robust enough to overcome habits, traditional practices, social norms and other influences external to the programme. Beneficiaries continue to follow new practices between programme input points, and continue to receive timely supplements and de-worming.
- Number of HHs benefiting from
  - Improved infant and child feeding practices
  - Improved micronutrient intake
  - Improved hygiene behaviour
  - Improved worm control

Outcomes
- Improved dietary and micronutrient intake
- Improved health status in beneficiary population

Impacts
- Reduced child undernutrition in beneficiary population attributable to programme, in a cost-effective way.
  (Impact, but not evaluated: reduced maternal and adolescent girl undernutrition)
- Evaluation outcome: better global knowledge on effective package of direct and indirect nutrition interventions at greatest cost-effectiveness.
Evaluation design and methods - primary impact pathway for nutrition impacts

CNWs convey regular accurate nutrition messages on relevant topics to mothers; exposure/trust is sufficient → Mothers retain this info; their nutrition knowledge/attitudes improve → Mothers act on changed knowledge/attitudes; their IYCF practices improve → Changed IYCF practices are large and meaningful; child anthropometry improves

Contextual factors such as households’ economic well-being, food security, women’s decision making, time-use, health and WASH improved sufficiently to enable/at least not hinder uptake/impacts
Findings – Delivery of Nutrition Component

• Delays to ‘N’ delivery (procurement of micronutrients)
• Early recruitment problems (↓ likelihood of CNWs same village as beneficiaries)

• Separate structures for L and N delivery & reporting
• Evidence of unresponsive supervision/monitoring

However, by endline (late 2015):

• Most CNWs met recruitment criteria and displayed appropriate knowledge when tested (even low educated)......................
• Most mothers reported receiving MNPs, HH visits and +ve experience with CNWs (though 21% EEP Concern; 33 % UPPR = no visit in last 12 months)

............BUT.....
Table 3.17: Summary of percentage of mothers reporting topics covered during last household visit, by programme

<table>
<thead>
<tr>
<th>Topic</th>
<th>CLP</th>
<th>EEP Concern</th>
<th>UPPR programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any aspect of breastfeeding</td>
<td>81.4</td>
<td>81.4</td>
<td>78.6</td>
</tr>
<tr>
<td>Any aspect of complementary feeding</td>
<td>62.0</td>
<td>49.4</td>
<td>57.5</td>
</tr>
<tr>
<td>Breastfeeding topics discussed</td>
<td>2.4</td>
<td>2.0</td>
<td>2.2</td>
</tr>
<tr>
<td>Complementary feeding topics discussed</td>
<td>1.0</td>
<td>0.6</td>
<td>0.9</td>
</tr>
</tbody>
</table>

Source: Quantitative endline household survey, cross-section sample.
### Table 3.28: CNW time allocation, by programme

<table>
<thead>
<tr>
<th>Mean hours per day</th>
<th>CLP</th>
<th>EEP Concern</th>
<th>UPPR programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Doing household visits</td>
<td>3.3</td>
<td>2.8</td>
<td>2.5</td>
</tr>
<tr>
<td>Conducting group sessions with pregnant women or women with children under two</td>
<td>0.4</td>
<td>0.8</td>
<td>0.5</td>
</tr>
<tr>
<td>Total contact time with clients</td>
<td>3.7</td>
<td>3.6</td>
<td>3.0</td>
</tr>
<tr>
<td>Travel time to meet clients</td>
<td>2.0</td>
<td>2.6</td>
<td>2.4</td>
</tr>
<tr>
<td>Total time spent travelling and meeting clients</td>
<td>5.7</td>
<td>6.3</td>
<td>5.4</td>
</tr>
</tbody>
</table>

Source: CNW survey.

**Mean travel time**

Typical Haor settlement – rainy season
Findings – knowledge & IYCF practices

- **No impact on most IYCF practices** (including e.g. EBF, early Bfing & colostrum, MDD, MAD, fruits/veg, animal-source foods)

- **But a small number of positive improvements in both knowledge and practice around iron rich foods/supplementation**...
  - Improved knowledge of benefits of iron and IFA consumption
  - Increased consumption of iron-rich/fortified foods and iron supplementation (12-13% improvement in iron rich foods; 15-21% supplements)

And one other area to do with exclusive breastfeeding
- Improvements in not giving water/other liquids before 6 months (largest changes in EEP Concern – 11/12% reduction)
Findings – barriers to behaviour change?

- Lack of financial resources
- Shortage of time
- Fear of food wastage
- Taste preference
- Perceived social value of food
- Lack of motivation to change
- Limited decision-making power on childcare and food purchases
- Strongly held family/community beliefs on appropriate childcare/IYCF behaviour
Findings – delivery of wider programme

• Livelihood programmes implemented effectively (presence of assets and community groups, infrastructure etc.)

• although... some beneficiary targeting + asset selection issues

• Beneficiaries reported substantial overall benefits in qualitative focus communities (with some caveats)

• +ve improvements for nutrition beneficiaries in CLP and EEP for ANC (incl. ANC visits; maternal diets; vaccinations (CLP only))
Overall – impacts

Small impacts on small # of IYCF and other outcomes

- CNWs generally trusted and had appropriate knowledge
- Changes in small areas of IYCF knowledge (e.g. iron)
- Limited improvements in IYCF practices – iron rich foods / supplements; not giving water <6m
- Already good knowledge/practice on BFing
- Iron supplements / MNPs largely distributed as expected (eventually)

Behaviours only improving where no additional time/resource inputs required of families?

No change in most IYCF outcomes. No anthropometric impacts

- Lower than expected intensity/frequency, lack of tailored conversations (poor CNW competencies)
- No changes in most IYCF knowledge and attitudes
- No change in most IYCF practices

Broader reported barriers to behavioural change (time / resources / family practices)
Wider evidence on BCC in nutrition

• Most effective when
  • includes analysis of IYCF problems at household level
  • assesses practicability with care-giver
  • provides individualised support and motivation
  • delivered via multiple channels

• ‘Alive & Thrive’ programme: targeted IYCF via intensive one-to-one counselling plus mass media, community mobilisation and policy advocacy

• ‘TMRI’ programme: targeted child stunting via intensive group and one-to-one IYCF wider community mobilisation plus combination of food or cash transfers. CNW: beneficiary ratio was 1:15
Recommendations

- **Adaptation to design of BCC delivered by CNWs**
  - Greater frequency and duration of counselling sessions
  - Greater focus on IYCF areas considered weak (e.g. complementary feeding)
  - Adapt messaging to context and ensure it is practicable

- **Target wider range of BCC approaches/channels**

- **Target other community and household members**

- **Address wider economic, social and gender barriers**

- **Improve monitoring systems**
Impact evaluation of the DFID Programme to accelerate improved nutrition for the extreme poor in Bangladesh: Final Report

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