Baseline Study on Graduation Component of the NOBO JATRA Development Food Security Activity in Khulna and Satkhira District: Cohort 2

Prepared for

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HDRC Human Development Research Centre

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Dhaka: June 2018

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Executive summary

Bangladesh has made impressive achievement in poverty reduction. Head count poverty ratio has declined from 56.6% in 1991-92 to 24.3% in 2016 (using upper poverty line). Over the decades, the evolution of development practices in this country has unfolded the obvious fact that poor are heterogeneous and "poverty never results from the lack of one thing, but from many interlocking factors" (Sen 2005). In this context, Murdoch (1999**)** strongly argues that poorer households should be served by other interventions than [alone] credit".

NOBO JATRA[1] is one such integrated approach that targets 14,000 poorest households to achieve *"Improved gender equitable food security, nutrition and resilience of vulnerable people within Khulna & Satkhira districts in Bangladesh;* it uses a set of sequential interventions to achieve this goal. The overall objective of this assignment was to prepare a baseline benchmark for the selected potential outputs and indicators of the NOBO JATRA Graduation Program.

The baseline survey was conducted in Khulna and Satkhira district. It covered extreme poor households as sample in treatment area of Cohort 2 before inception of the Nobo Jatra graduation program intervention as well as similar (the counterfactuals) households in control within identical geographical location. Shymnagar, Kaliganj, Koyra and Dacope Upazilas were considered as treatment areas. On the other hand, Assasuni Upazila of Satkhira district was selected as control area. The survey used structured questionnaire to collect data.

Sample drawn in this survey was stratified and selected in two stages. The survey included 816 households equally distributed between treatment and control area. Literacy centers formed by the program were contemplated as primary sampling unit (PSU) for treatment area while villages within selected control area were considered as PSU. PSUs were selected through Probability Proportional to Size (PPS) method.

The average household size in treatment and control area were 4.0 and 3.7 respectively. The economic condition of households differed in case where the household head is a female and/or a person in the household have some form of disability. The summary of the major findings of baseline study on NOBO JATRA cohort 1 is presented below.

Food consumption

The food expenditure, irrespective of treatment and control area, was the highest in amount. Still, none of the households in intervention or control area was food secured. The study explored that 75.0 percent and 72.7 percent of the total expenditure was made for food consumption in treatment and control households respectively. There had lack of protein and fruit consumption which proves that their dietary diversity was not satisfactory and requires improvement. 17.2 percent treatment households were severely food insecure. The corresponding percentage was even higher among control (28.7%) households.

Livelihood

A 36.8 percent household in treatment area and 48.0 percent households in control area were living below USD 1.25 line. Moreover, 69.1 percent households in treatment area and 85.8 in control area were living below US$ 1.90 threshold.

[1]NoboJatra Program, Graduation Program Operational Manual, World Vision Bangladesh, June, 2017

Around 80 percent households both in the treatment and control area reported that at least one member of their households was involved in day laboring activities. Surprisingly, more than 50 percent household members were agricultural day laborer in both areas. Survey results indicate that only 9.1 percent household in treatment area were involved in kitchen gardening while they were about 2 percent in control. This difference is found statistically significant (P= 0.000). Moreover, only 24.8 percent household in treatment and 16.7 percent in control owned livestock.

Access to financial services/ savings and lending practices

A 37.7 percent of the households in treatment and 22.1 percent in control group had cash savings in formal financial institutions (Private Commercial Bank/ Government Commercial Bank/ Post Office/NGO). Most of the households (treatment: 92.9% and control: 96.2%) saved less than BDT 5,000. About three-fourths of the households' saving incidence (treatment: 71.4% and control: 83.7%) occurred in 'NGOs', remotely followed by 'Local Samiti/Cooperative' (treatment: 19.5% and control: 13.5%).

Data amply corroborates that 60.5 percent households in treatment and 50.9 percent in control group received credit in last one year. A large portion of the households (treatment: 46.9% and control: 65.3%) received credit less than 10,000 BDT. For households in treatment area 45.3 percent credit incidence was sourced from 'NGOs', 5.8 percent from local money lenders and rest were from relatives/friends and local cooperatives/samitis *Credit was found to be primarily used for purchasing food; the next important use of the major portion of credit was for payment of loan/credit.*

Education

The literacy rate in treatment area is 35.2 percent and 36.6 percent in control area. Nearly one-fourth of the population is at school going age (5-16 years) but a significant percentage of such population is not continuing school (treatment: 17.9% and control: 24.7%). This study assessed education component of human capital where average years of schooling, adult literacy rate, children's school enrollment status and skills development training received are the proxy indicators for assessment in the baseline situation. *The estimated mean years of schooling for the population of 5 years and above in the treatment area is 2.90 while the same is 2.80 in the control area* and this difference is not statistically significant (p=0.313).

Landholding

Homestead landlessness among the households was very high. They usually constructed houses on *Khas* land or lived on other people's lands. Findings confirm that 41.2 percent treatment households had no homestead of their own whereas it was 42.6 percent among control households. Agriculture landlessness was much more prevalent among the rural ultra poor households compared to homestead landlessness.

Social Safety Net

More than three-fourths of the surveyed households (treatment: 81.6% and control: 75.5%) received support from the Social Safety Net Programs (SSNPs). However, this apparently high rate of inclusion in the SSNPs was attributed to mainly two programs: i) Vulnerable Group Feeding - an irregular program with very limited food support, ii) Stipend for Students

- a universal program. However, *if the irregular SSNPs (Vulnerable Group Feeding, Gratuitous Relief, and Test Relief) and universal education Stipend Program are excluded from the analysis, then it is found that only 26.7 percent of the treatment households received benefits from other SSNPs.* It is worth mentioning that a large portion of the old age population did not receive 'Old Age Allowance'. In treatment group, only 18.8 percent of the older age females received it.

Health

In the study areas, irrespective of treatment and control, the status of health indicators except the use of family planning methods was found low. The contraceptive prevalence rate was 79.0 percent in treatment and 88.3 percent in control areas. Most of the current users depend on public health sources. A 70.2 percent household in treatment and 96.0 percent in control area collect drinking water from safe sources. Data confirms that 53.0 percent households in treatment and 84.1 percent in control area used hygienic latrine.

Women

Around half of women (55.6% in treatment and 45.5% in control) who got married in last two years preceding the survey were below 18 years of age. Women's involvement in decision making regarding marriage of their son/daughter (treatment: 63.8% and control: 39.8%) and selling of land (treatment: 13.5% and control: 11.7%) was much lower. However, savings (treatment: 56.9% and control: 53.5%) and lending practice (treatment: 57.7% and control: 54.1%) among women was high.

A large percentage of women in treatment and control households enjoyed mobility in terms of going to local shops/hat/bazar, visiting parents/relatives/friends, and workplaces alone.