COUNTRY-LED FORMATIVE EVALUATION

The Maternal and Child Cash Transfer Programme in Chin and Rakhine States in Myanmar

Volume 1

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Department of Social Welfare (DSW)/Ministry of Social Welfare, Relief and Resettlement (MSWRR) and UNICEF Myanmar produces and publishes evaluation reports to fulfil a corporate commitment to transparency. The reports are designed to stimulate the free exchange of ideas among those interested in the study topic and to assure those supporting Department of Social Welfare (DSW)/Ministry of Social Welfare, Relief and Resettlement (MSWRR) and UNICEF work that it rigorously examines its strategies, results and overall effectiveness.

The evaluation report of the Maternal and Child Cash transfer programme in Chin and Rakhine States in Myanmar was prepared by Ashish Mukherjee, Kriti Gupta and Rai Sengupta on behalf of IPE Global Limited. The country-led evaluation was jointly commissioned by the Department of Social Welfare under the Ministry of Social Welfare, Relief and Resettlement, Myanmar and UNICEF Country Office, Myanmar and managed by the Evaluation Management Team comprising U Kyaw Lin Htin, Director, Social Protection Section, DSW/MSWRR, Erica Mattellone, Evaluation Specialist, UNICEF Cambodia; Samman Thapa, Chief, Social Policy and Child Rights Monitoring, UNICEF Myanmar; Nangar Soomro, Social Policy Specialist, UNICEF Myanmar and Phyu Phyu Win, Social Policy Officer, UNICEF Nay Pi Taw.

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Foreword

It gives us great pleasure to present the report of the Country-led Formative Evaluation of the Maternal and Child Cash Transfer Programme (MCCT) in Rakhine and Chin States in Myanmar. The evaluation was commissioned by the Department of Social Welfare and UNICEF in line with the Monitoring and Evaluation Framework of the MCCT Programme.

Myanmar articulated its commitment to social protection, and in particular to the protection of young children and their mothers in the National Social Protection Strategic Plan (NSPSP) and further endorsed this commitment in the Myanmar Sustainable Development Plan (MSDP). Additionally, the benefits of regular cash transfers and nutrition awareness on the lives of women and children have also been widely recognized. The MCCT has seen a successful implementation and a large reach that has gone well beyond 230,000 beneficiaries to date, and which expects to reach over half a million beneficiaries in the next two years.

This Formative Evaluation seeks to support the strengthening and scaling up of the MCCT interventions. Its formative nature and focus on the design and implementation allow for the lessons learned to be easily integrated into the programme. Thanks to the country-led nature of the evaluation, the report and its recommendations are fully built on government's structures and address government's needs for evidence. As such, the report is particularly well placed to inform both the programme's expansion and other national social protection initiatives.

Moreover, the findings and recommendations have been validated in various fora and key stakeholders were consulted along the way, making this final report a product of a consultative approach, that took into consideration the voices of the beneficiaries as well as the experiences and opinions of Government, UNICEF and Development Partners.

The findings of this Formative Agenda have already informed the development of a concrete action plan by the Department of Social Welfare, and some recommendations have already been set in motion – like the development of IT-based options to replace paper-based systems, to better facilitate management of larger beneficiary databases, process timely payments and support monitoring and evaluation. These actions will certainly help to improve and expand the MCCT, and more broadly to inform decision making in the sector.

This Formative Evaluation is not an isolated document. It is part of a larger learning agenda captured in the MCCT M&E Framework, which aims to support an evidence-based journey of the programme, and to enhance the effectiveness, efficiency, impact and sustainability of the programme not only in the evaluation regions, but in those areas that will see a programme expansion. The findings of this evaluation will not only inform this programme, but similar programmes of its kind in the region and globally.

We are delighted that many of the recommendations contained in this report have already seen progress. We hope that the operational guidance and system building outlined here will continue to support systematic strengthening of National Social Protection Strategy which supports women and children in the country, laying the foundation for national socioeconomic development that contributes to the peace and stability of the Nation.

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The *Country-led Formative Evaluation of the Maternal and Child Cash Transfer Programme in Chin and Rakhine States in Myanmar* was commissioned by UNICEF Myanmar, on behalf of the Department of Social Welfare (DSW), Ministry of Social Welfare Relief and Resettlement, Government of Myanmar. UNICEF Myanmar would like to thank officials from the Department of Social Welfare (DSW), Department of Public Health (DoPH) and General Administration Department (GAD) for their support, guidance and involvement in the evaluation process.

UNICEF Myanmar would also like to extend their gratitude to development partners – LIFT, World Bank, Save the Children, International Rescue Committee, and World Food Programme - for contributing their valuable insights to the evaluation.

Our heartfelt thanks go out to the members of the Evaluation Reference Group whose feedback helped strengthen the evaluation. Furthermore, we would also like to acknowledge the useful and timely inputs provided by the UNICEF East Asia and Pacific Regional Office (EAPRO) over this course of this endeavour.

Abbreviations and Acronyms

DAC	Development Assistance Committee
DoPH	Department of Public Health
DSW	Department of Social Welfare
EAPRO	East Asia and Pacific Regional Office
ECD	Early Childhood Development
EMT	Evaluation Management Team
FGD	Focus Group Discussion
GAD	General Administrative Department
IDP	Internally Displaced Person
IRC	International Rescue Committee
IVRS	Interactive Voice Response System
IYCF	Infant and Young Child Feeding
KAP	Knowledge, Attitudes and Practices
KII	Key Informant Interview
LIFT	Livelihoods and Food Security Fund
M&E	Monitoring and Evaluation
MCCT	Maternal and Child Cash Transfer Programme
MICS	Multiple Indicator Cluster Surveys
MNAPFNS	Myanmar National Action Plan for Food and Nutrition Security
MoALI	Ministry of Agriculture, Livestock, and Irrigation
MoE	Ministry of Education
MoHS	Ministry of Health and Sports
MoSWRR	Ministry of Social Welfare, Relief and Resettlement
MSG	Mother Support Group
MS-NPAN	Myanmar Multisectoral National Plan of Action on Nutrition
NRC	National Registration Card
NSPSP	National Social Protection Strategic Plan
OECD	Organisation for Economic Co-operation and Development
PDM	Post Distribution Monitoring
SBCC	Social Behaviour Change Communication
SC	Save the Children
SPS	Social Protection Section
TOC	Theory of Change
TOR	Terms of Reference
TRG	Technical Reference Group
UNEG	United Nations Evaluation Guidelines
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
WASH	Water Sanitation and Hygiene
WFP	World Food Programme

Executive Summary

Introduction

The Ministry of Social Welfare Relief and Resettlement (MSWRR), Government of Myanmar, through the Department of Social Welfare (DSW), is leading the social protection agenda outlined under the National Social Protection Strategic Plan. The DSW is in charge of the implementation of the key flagship programmes - one of which is the Maternal and Child Cash Transfer (MCCT) programme. The MCCT programme began in Chin State in June 2017, later expanded to Rakhine State and Naga land in January 2018 and further expanded to Kayah and Kayin States in October 2018. The ultimate objective of the MCCT programme is to improve nutritional outcomes for all mothers and children during *the first critical 1,000 days of life,* from conception to 24 months of age, that can perpetuate an intergenerational cycle of poor nutritional status.

In line with this, the MCCT programme aims to empower pregnant and lactating women with additional purchasing power (MMK 15,000 per month/10.5 USD) to meet their basic needs during the first 1,000 days, along with complementary awareness sessions on nutrition, health and hygiene. All pregnant women who enrol in the programme continue to receive programme benefits until their child reaches the age of 24 months. As of October 2019, the MCCT programme in Chin State had registered 33,723 women beneficiaries and made 13 bi-monthly payments. The Rakhine MCCT programme was rolled out in January 2018 and as of October 2019, the State had made 9 quarterly payments and covered 124,719 beneficiaries across the State.

Evaluation purpose, objectives and intended audience

The Country-led Formative Evaluation of the Maternal and Child Cash Transfer Programme in Chin and Rakhine States in Myanmar was commissioned by UNICEF Myanmar, in partnership with the Department of Social Welfare. The primary purpose of this formative evaluation was to foster learning and improvement within the MCCT programme by reviewing the design and implementation modalities of the program. It also sought to set out lessons learned (from the MCCT programme and other cash transfer interventions in the region) to strengthen the programme in Chin and Rakhine to set the ground for scaling-up.

Being *country-led*, this evaluation is integral for creating a culture of utilizing evidence and increasing accountability - which is a key factor in establishing capacities and systems so that the government can evaluate its development activities in the future. The primary user of the evaluation will be DSW, MSWRR - being the lead agency for the MCCT programme as well as implementing departments i.e. the Department of Public Health (DoPH) of the Ministry of Health and Sports (MoHS) and the General Administration Department (GAD). The findings of the evaluation can also be useful to relevant social protection development partners like UNICEF, LIFT, the World Bank, WFP, Save the Children and IRC, among others. Secondary users will include other government agencies and civil society organizations involved in cash transfer programming in Myanmar, UNICEF's Regional Office for East Asia and the Pacific (EAPRO) and others.

The key objective of this evaluation was to analyse the extent to which the MCCT programme has been appropriately designed and the efficiency and effectiveness of its implementation. The evaluation further sought to understand the usage of the cash transfer amount, the effectiveness of social and behaviour change interventions and whether the cash spending is translating into the intended objectives of the program. Other objectives of the evaluation include an assessment of the MCCT institutional capacity at various levels and an analysis of the effectiveness of support by the development partners.

The scope of this evaluation is *formative* (learning-oriented) in nature. The evaluation was not intended to be impactful or summative; it looked at evaluating the processes, procedures, implementation mechanisms and finding out whether beneficiaries in Chin and Rakhine States were satisfied with the services provided under the programme from 2017 till date.

Evaluation methodology

A non-experimental research design as well as theory-based *mixed methods* and utilization-focused *approach* were followed – combining quantitative and qualitative primary data collection while drawing upon inference from key programme documents including policy, design and implementation documents. Primary data collection tools included Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), Beneficiary Surveys and Case Studies. An important methodological aspect of this evaluation was its *participatory* and *learning-oriented* nature, involving stakeholders in the design and development of the evaluation process through interviews at both national and sub-national levels. Further, workshops were conducted, at both the inception stage and after the preliminary analysis of the findings, with the government, implementing bodies (at National and State level) and development partners, which helped validate and triangulate findings, obtain a wide range of perspectives and yield insights into the dynamics of the program. Another workshop to present the final evaluation report is planned.

Given the scope, a multi-stage systematic random sampling method was adopted. All 5 districts in Rakhine and 4 districts in Chin were covered as part of beneficiary survey. A sample of 409 beneficiaries in Chin and 463 beneficiaries (including beneficiaries in IDP camps) in Rakhine were reached. The evaluation team made serious efforts to make the sample as representative as possible and hard-to-reach areas (Paletwa township) and conflict prone zones (Maungdaw township) and 4 IDP camps - one each in Myaypon and Kyaukphyu and two in Sittwe were included to get an accurate picture of the beneficiary experience. Along with beneficiaries, the insights of spouses and community members were gleaned through FGDs. The evaluation team was able to complete data collection under challenging circumstances including heavy rains, landslides and security risks due to armed conflict in certain areas.

Analysis was conducted using the modified Organisation for Economic Co-operation and Development (OECD)/Development Assistance Committee (DAC) criteria of **relevance, efficiency, effectiveness** and **sustainability** as well as **equity, gender equality** and **human rights** considerations. The **United Nations Evaluation Group's (UNEG) ethical considerations and the evaluation guidelines** guided the evaluation team.

Key findings and conclusions

The evaluation findings and conclusions are organised around the OECD/DAC criteria of relevance, effectiveness, efficiency, sustainability and equity. A summary of the findings is presented below:

1. Relevance

The focus of the MCCT programme on children till age two was found to be relevant to the national agenda to address malnutrition and infant mortality. The programme was also seen to be aligned with the global focus on the first 1000 days of life and its potential in fuelling the cognitive development of a child. Moreover, the focus on nutrition and birth outcomes are evident from the introduction of birth spacing – wherein no mother can re-register for the programme with another pregnancy till two years after giving birth to the previous child. A key design feature of the MCCT programme is its universality - one that has ensured that no section of the society - including vulnerable members and minorities are left behind. In Rakhine, however, there were cases of beneficiaries not being able to register due to documents such as Antenatal Check-up (ANC) for women and immunization for children not being provided at the time of registration. It was confirmed by implementing bodies that certain conditions on registration and receipt of payment have now been imposed to discourage fake registrations and improve health outcomes - even though this is yet to be updated in the Operations Manual.

The Ministry of Health has been working on programmes aimed at improving the supply of health services (in particular, immunization and family planning). These supply side interventions are complemented by the demand focussed components of the MCCT, wherein the uptake of health services, birth spacing, and the consumption of nutritious food are promoted. Further, no other social

protection programmes in Myanmar presently target pregnant women/lactating mothers and their children. While some pilots targeting these sections are being run by development partners, there is no full-fledged parallel programme running, which the MCCT programme can complement at present.

The evaluation revealed that beneficiaries appreciated the cash transfer and used it primarily for food or spent it on health services. However, not all respondents, in both Chin and Rakhine, found the cash transfer amount to be adequate. Implementing staff also stated that the cash amount is not enough to warrant a significant shift in dietary patterns. At the same time, the preference for in-kind transfers over cash was limited, thus highlighting the appropriateness of cash as a direct benefit transfer in Myanmar's context. Key informant interviews with DSW (at Union and State level) and GAD (at township level) brought out that, within the given resources and using the paper-based systems currently in place, monthly payments are not viable. Therefore, the current frequency of cash payments emerges as the best solution. Content of Social and Behaviour Change (SBCC) sessions and use of eligibility conditions are design elements, which, if localized, can further improve programmatic relevance.

2. Effectiveness

In both Rakhine and Chin, it was observed that women are mostly using the money to buy more diverse food for themselves and the child. The use of the money to cover healthcare costs was stated by 36 percent and 56 percent of beneficiary respondents in Chin and Rakhine, respectively. The SBCC sessions have effectively guided beneficiary spending by improving knowledge and encouraging practices, such as, breastfeeding and dietary diversity.

The programme has done an effective job of communicating the program's tenets to beneficiaries in an informal manner. No significant issues in registration were observed even though a paper-based system is being used, which is prone to errors. The cash flow from the union level to beneficiaries is effective and there was no case mentioned where diversion of funds or financial leakage took place. The grievance redress and monitoring systems are however weak. Awareness of formal complaint mechanisms, such as having a focal person to deal with complaints and a complaint hotline, is still limited. Data validation and monitoring too have implementation weaknesses. Post Distribution Monitoring has been undertaken thrice in Chin State and once in Rakhine State – however, concerns have been raised that PDMs can be effective if frequency of visits is regularized and sample also covers the hard-to-reach areas to eliminate bias. The government, in tandem with the development partners (DPs) support, has developed the MCCT programme's design and implementation mechanisms. For effective learning and dissemination of lessons, coordination and cooperation become foremost – an aspect which needs to be strengthened in the programme.

3. Efficiency

The service delivery processes of the MCCT programme are taking place as per the Operations Manual and are efficient, given the current paper-based system of data entry and management. Both registration and cash disbursement points are conveniently located for the beneficiaries and a focus on operating efficiency (in terms of cost and time) to reach these points was seen. Further, maintenance of records of registration and payments is nearly universal. At the same time, efficiency gaps exist wherein certain processes are not implemented as frequently as mandated by the Operations Manual. Cash payments have not been regularized in Rakhine wherein the transfers are taking place at an interval of 6 months rather than the mandated 3 months. SBCC sessions are not conducted on a monthly basis in many townships and, when done, they often stretch to over an hour – making it unnecessarily prolonged and ineffective at the end. The average waiting time at registration and cash disbursement points is high, leading to over-crowding. Grievance redress and monitoring are two processes which need to follow the guidelines more strictly to improve efficiency.

Programme management remains stretched due to various demands, limited staffing and operational budget constraints. This affects the trainings and capacity building activities, which are currently inadequate and take place mainly at the union or state level. The cascading model of training where Case Managers train Ward/Village Administrators is not taking place in all townships. Refresher

trainings are also not being provided, which leads to implementing staff forgetting their learning from just a single session. While convergence mechanisms at higher levels establish clear demarcation of roles and responsibilities, convergence mechanisms at the field-level are largely informal and may be inefficient with programme expansion.

4. Sustainability

Given that the programme is using existing government staffing, the implementation costs can be assumed to be fiscally sustainable. While the existing implementation modalities of MCCT heavily relies on the HR capacities in its operations at all levels, there was no specific adaptation or arrangement to meet the programme's technical requirements; instead, it only assigns the already existing structure of State/Region office of DSW to take additional responsibilities of MCCT implementation. At the same time, the government's financial regulations are not adjusted to meet the programme implementation requirements (for example, there is no specific budget line to charge if additional trips are required for Case Manager or officials to perform their required duties of MCCT – PDM trips, M&E trips, SBCC coordination, etc.). The key gaps and bottlenecks that imperil the sustainability of the MCCT programme are human resource constraints and inadequate use of technology for payments and monitoring. In the long-run, as the programme grows, ensuring proper monitoring and restricting leakages will become even more crucial – this will require an increase in human resources and their capacities, and the introduction of technology for payments and monitoring – including an MIS system. Further, different states have slightly varied implementation models and it must be ensured that there is cross-learning among all relevant implementing bodies – DSW, DOPH, GAD, etc., and the programme as a whole (in each state) grows in a consolidated manner. It is important that state-specific models (with different components like inter-personal counselling, allowances, etc.) run by development partners are ultimately feasible after their handover to the DSW. To ensure sustained changes in behaviour and attitudes, the focus on SBCC should continue. However, the tools and the platforms for delivering SBCC should be revisited in order to widen the scope beyond the beneficiaries, and to include other influencers of change (spouses, other community members, etc.). Furthermore, the SBCC material should be calibrated to changing circumstances and practices in the future. It was positive to note that the programme did not have significant unintended negative consequences, except for the fact that beneficiaries felt anxious about their security while collecting the cash due to the prevailing conflict in some areas of Rakhine State.

5. Equity, gender equality and human rights

The MCCT programme focuses on women empowerment and gender equality by giving purchasing power to women to help them improve dietary diversity and intake and access to healthcare during pregnancy. Evidence of gender-neutral spending on the child was also found. It is however important to send the message to communities that it is the responsibility of both parents – and not mothers alone – to care for the child. In line with this, there is a need to include spouses and other community members in the SBCC sessions. Equity is a critical component of the program, particularly in Rakhine. To ensure equity, protection of human rights and coverage of vulnerable population, the programme includes IDP camps in its foray and also does not make the National Registration Card mandatory.

Lessons learnt

Analysis of the findings and review of similar programs gave way to certain learnings. These lessons will be key to the scale-up and replication of the programme to other areas. Further, these learnings will inform the blueprint of future cash transfer programming in other countries as well. Some of the key learnings are as follows:

- It is important to consider supply-side factors, such as, availability of basic health services, particularly presence of the midwives at each ward/village; availability of local foods; food prices; production pattern and market systems that allow access, to ensure that the cash is used as intended.

- Information gaps in cash transfer programmes can be avoided through the periodic reiteration of the eligibility, entitlements and ancillary services of the programme to beneficiaries.
- Behaviour change in a culturally and ethnically diverse context rests heavily on locally customised IEC material. Development programs that aim to transform knowledge systems of a community should ensure that the IEC material used is easily understood by various sub-groups and is customised to the vernacular of different regions.
- Lack of sufficient and well-trained staff creates efficiency gaps at various levels and can result in the negligence of certain responsibilities due to limited time and resources. Further, adequate funds should be earmarked for all programme activities prior to implementation and all levels of implementing staff should be provided with sufficient resources to undertake their responsibilities.
- In the long run, whether a cash transfer programme sustains or peters out depends on the level of integration and coordination among different ministries, especially for such a cross-sectoral development programme in the national policy agenda.

Other learnings include the fact that development programs in administrative contexts that are more paper based and less automated should avoid complicated documentation and record keeping. Further, as a programme matures, it is essential to make a shift towards automated functions and increased technological interventions to manage larger databases and for monitoring data. Moreover, awareness sessions on health and hygiene should not only be directed towards the primary beneficiaries (pregnant/lactating women) but should also involve husbands and community influencers – to adopt a shared approach towards child wellbeing.

Recommendations

i. Recruiting a cadre of Social Welfare Workers/Volunteers at the village and ward levels: To ensure effective implementation of the MCCT programme, it is important that the implementing agency has a direct contact with outreach to the community. This can be ensured through a well-trained and well-resourced cadre of social workers or volunteers, deployed by the DSW (in coordination with related implementing departments such as DoPH) for ensuring oversight and linking beneficiaries to services. This will require establishing a system of identification and selection of workers/volunteers from the local area (local health staffs may be involved in the process, since they are in a better position to suggest given the nature of their activities in the community); regular capacity building; provision of appropriate job-aid items, such as mobile phone/tablets, tools and materials etc.; budget provision for salaries/performance-based incentives; explore forms of non-financial incentives, such as recognition of good performance, reservation/ weightage in government jobs, etc.; mechanisms of managing attrition, refresher trainings, etc.

ii. Establishing a technology-based cash transfer management system and Management Information System (MIS): There is a need to establish an effective IT based system which will entail creation of an MIS team - defining structure, roles and responsibilities; deployment of staff; hardware and software procurement and maintenance plans; identifying and contracting service providers for MIS development and maintenance. Establishing business processes such as data, information, and records management; network management; information security and access control and data transfer within and across agencies.

iii. Gradual transition to electronic payment transfers: It is recommended to implement multiple e-payment systems, such as bank transfer and mobile wallet, on a pilot basis in specific geographies based on local feasibility and gradually expand the scope across more geographies. To improve delivery and transparency, payments can be contracted-out to private financial agencies. This will require mapping of payment service providers' mobile money, banks, agents etc.; contracting of financial service providers. Financial literacy trainings may also need to be implemented simultaneously given the limited education of beneficiaries to such systems.

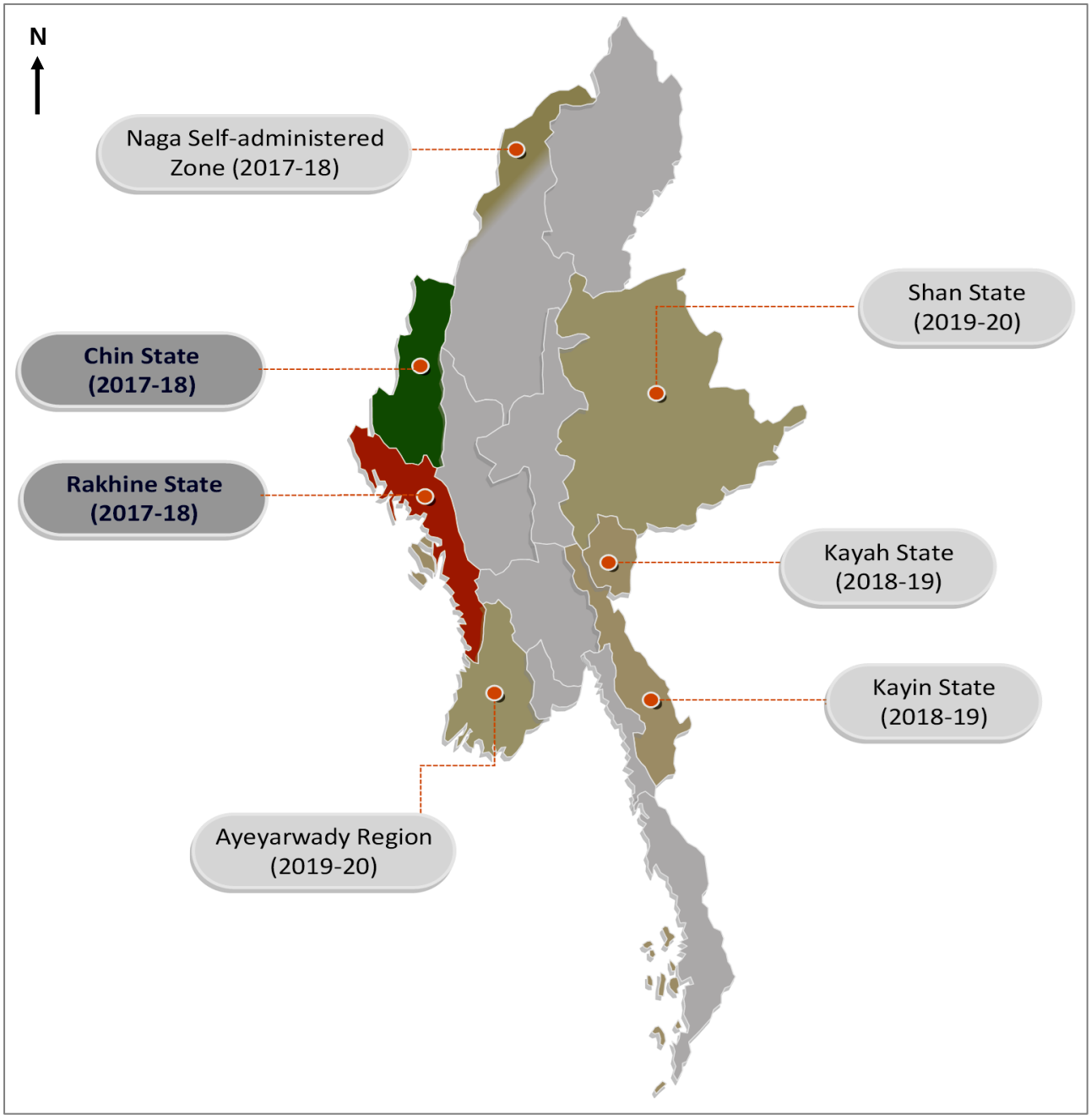
iv. Revisiting the operations manual: Review the layout of information – introduce flowcharts/diagrams, bulleted information that make processes/steps easier to understand. Given that a greater use of IT systems and relevant tools are proposed, the operations manual would need to incorporate step-by-step actions to be followed for identifying where electronic system (MIS) could be replaced or adapted. Based on feedback received from users, revisit the processes and forms to simplify them. Apart from clear definition of the roles and responsibilities of various stakeholders, suggestive steps for each of the activities to be conducted should be provided. However, certain degree of flexibility to States/Regions to modify the processes based on the local context is needed keeping in consideration that it is important to maintain technical fidelity, including the fidelity of implementing bodies in following the operations manual.

v. Strengthening institutional capacities at various levels: The existing Social Protection Section at the Union level in the Department of Social Welfare needs to be strengthened in terms of additional staffing, budgetary resources for programme management, capacity building and monitoring. Similarly, capacities of functionaries working at the sub-national level needs to be further strengthened.

Apart from the above, there is a need to strengthen the **grievance redress system**, **M&E system**, **inter-ministerial coordination arrangements and development partner coordination**. Further, there is scope for **strengthening the Social and Behaviour Change Communication** component, **outreach and awareness creation** to improve the effectiveness of the programme. **Improving transparency and accountability** will help build more trust of the community in the programme. Plans should include a mechanism to regularly adjust payment levels in response to rising prices. Flexibility to adjust the quantum of cash transfer to the inflation of prices of goods and commodities will bring in additional value to the project.

Country Map

Project Implementation Areas: Current and Future[1]



(**Source**: http://yourfreetemplates.com)

The year mentioned in the brackets in the map above denote the financial year in which the programme implementation began in the State/Region.

Areas covered under the Formative Evaluation – Chin and Rakhine States

MCCT implementation areas: Chin, Rakhine, Naga, Kayah, Kayin

Regions/States for MCCT's Expansion – Ayeyarwady Region, Shan

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[1] Social Protection Sub-Sector Coordination Group. (2018-22). MCCT Costed Sector Plan.

1. INTRODUCTION

The Ministry of Social Welfare Relief and Resettlement (MSWRR), Government of Myanmar, through the Department of Social Welfare (DSW), is leading the social protection agenda outlined under the National Social Protection Strategic Plan. DSW is in charge for implementation of key flagship programmes - one of which is the Maternal and Child Cash Transfer (MCCT) program. The ultimate objective of the MCCT programme is to improve nutritional outcomes for all mothers and children during *the first critical 1,000 days of life,* from conception to 24 months of age, that can perpetuate an intergenerational cycle of poor nutritional status. UNICEF Myanmar, in partnership with DSW, commissioned IPE Global Limited, to conduct a *Country-led Formative Evaluation of the Maternal and Child Cash Transfer Programme in Chin and Rakhine States in Myanmar*.

This evaluation was managed by an Evaluation Management Team comprising the Department of Social Welfare (DSW) and UNICEF with technical support provided by a Reference Group consisting of members of DSW; Ministry of Health and Sports (MoHS); General Administrative Department (GAD); Livelihoods and Food Security Fund (LIFT); World Bank; Save the Children: World Food Programme and International Rescue Committee, Myanmar.

This evaluation looked at the relevance, effectiveness, efficiency, sustainability of the MCCT and focused on key questions such as: What is working well? What can be improved? How will it support the expansion of the programme to other states and regions? The terms of reference for the evaluation is attached as **Annex 1**.

The results of the evaluation will provide major opportunities to DSW to further embed shock-responsive programme elements into design and implementation of the MCCT in Rakhine and Chin State, and the same can further feed into other states and regions.

This report presents the evaluation findings under seven sections. It is structured as follows: Section 1 is the introduction. Section 2 outlines the background and provides the context on the need for the cash transfer programme. It also includes the object of the evaluation detailing the fundamental information of the programme including its national, economic and social contexts. Section 3 provides the evaluation purpose, objectives and scope along with information on limitations of the evaluation. Section 4 presents the evaluation approach and methodology, as well as an overview of the quantitative and qualitative methods applied, techniques used during data collection and processing, and the analytical framework along with details of key stakeholders. Section 5 details the findings as per the key evaluation questions arranged under each of the OECD/DAC evaluation criteria, namely relevance, efficiency, effectiveness and sustainability, as well as an additional criteria of equity, gender and human rights. Section 6 reflects the conclusions and lessons learnt based on the findings. Section 7 provides the recommendations that are feasible, relevant to the objective of the evaluation and actionable by specific entities.

2. BACKGROUND AND OBJECT OF THE EVALUATION

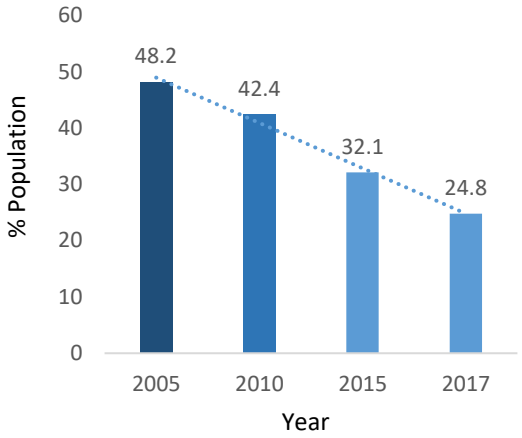
2.1. Country context

In 2018, Myanmar's per capita GDP growth rate was the second highest among countries in Southeast Asia, after Vietnam[1]. Economic prospects look promising with Myanmar's GDP expected to grow at 7 percent in 2019, an increase from the 6.6 percent GDP growth in 2018[1]. Myanmar has ample natural resources, a young, dynamic population and a large market of potential opportunities which can be tapped into. However, despite recent progress, Myanmar continues to struggle with several developmental challenges.

[1] Asian Development Outlook 2018 Update

While the share of population living in poverty[2] has halved from 48.1 percent in 2004/05 to 24.8 percent in 2017 (*see Figure 1*), vulnerability to poverty remains an issue. A third of the population is highly vulnerable to falling into poverty in the future, despite not being poor in 2017.[3] In rural areas, where 70 percent of the population resides, the poverty headcount is 2.7 times higher (30.2 percent) than in urban areas (11.3 percent)[3]. Further, since its independence in 1948, Myanmar has been afflicted by ethnic clashes – one of the longest running armed conflicts in the world and its impact may be witnessed in its development path. The remote border areas – including Rakhine, Chin (*see Box 1*) – and other areas emerging from conflict are mainly inhabited by Myanmar's minority ethnic groups who are particularly poor.

Figure 1. Poverty head count ratio at national poverty line



Box 1. A snapshot of the Chin and Rakhine States in Myanmar

Located in western Myanmar, ***Chin*** remains one of the least developed areas in Myanmar and is home to some of the most isolated communities in the country. Chin struggles with the highest poverty rate in Myanmar, where close to six out of 10 persons (58 percent) are poor.[3] In terms of social development indicators, Chin performs poorly and faces serious challenges like inadequate water and sanitation facilities, poor nutrition and health outcomes and insufficient child protection interventions.

Rakhine follows Chin as the second most under-developed state in the country with 41.6 percent of its population living below the poverty line.[3] Rakhine's developmental challenges are compounded by its susceptibility to natural disasters such as storms and floods. Healthcare facilities are also inadequate in this state, leading to low levels of institutional delivery and immunization. Moreover, the outbreak of communal violence in the state has severely affected its socio-economic landscape with consequences ranging from heightened food insecurity to imperilled livelihoods and education. Current armed conflict in Rakhine has also impacted the development potential of the state, having significant negative impact on the nutritional status of children and women.

2.2. Nutrition context

The poor nutrition indicators are closely linked to the high incidence of poverty in Myanmar. Despite recent progress, under-nutrition rates in Myanmar continue to be high. It is among the 24 high-burden countries in the world, with more than one-third of Myanmar's children suffering from chronic malnourishment[4]. According to the Myanmar Demographic and Health Survey 2015-2016[5], out of the children under 5 years of age, 19 percent of children were underweight, 29 percent of children below 5 years of age were stunted, and 7 percent were wasted. In line with the WHO thresholds, stunting prevalence in Myanmar is considered 'high' (20-<30%) and wasting is considered 'medium' (5-<10%).[6]

Stunting or low height for age in children is caused by poor nutrition during the first 1,000 days – from pregnancy to age two of the child. Furthermore, wasting or low weight for height is a severe process

[2] The poverty line in 2017 was 1,590 kyat per adult equivalent per day. Those with consumption levels at or below 1,590 kyat per day are considered poor. Beyond the 24.8 percent of the population that are classified as poor, a further 32.9 percent are non-poor insecure, or have per adult equivalent daily expenditures below 1.5 times the poverty line (i.e. between 1,590 and 2,385 kyat). Poverty remains high and is concentrated in rural areas. The share of the poor residing in rural areas stood at 87 percent in 2017.

[3] Myanmar Living Conditions Survey 2017, Poverty Report (Report 03, June 2019)

[4] https://myanmar.savethechildren.net/what-we-do/nutrition

[5] https://dhsprogram.com/pubs/pdf/FR324/FR324.pdf

[6] https://www.who.int/nutrition/team/prevalence-thresholds-wasting-overweight-stunting-children-paper.pdf

of weight loss that is often associated with acute starvation and confers doubling the risk of mortality following stunting[7]. Both stunting and wasting have long term harmful effects on children and adults including diminished development of mental and physical capacity. While poverty is the most significant reason, the causes of stunting and wasting are multifaceted and include inadequate dietary intake, high morbidity, household food insecurity, inadequate care and feeding practice[8]. Against this background, the need to fortify the nutrition of children in the first 1,000 days of life is reinforced, as it boosts immunity and makes them more likely to overcome diseases and complete more grades at school which eventually facilitates them to receive more wages and raise their standard of living.

Supply side challenges in the health and nutrition sector also prevail in the country. In 2016, only 35 percent of women in the age group of 15-49 years who gave birth in the previous 5 years, received vitamin A supplementation during the first 2 months after delivery[9]. Moreover, among children in the age group of 6-23 months, only 16 percent met the minimum standards with respect to all three Infant and Young Child Feeding practices (IYCF) (i.e. breastfeeding status, number of food groups consumed and number of times they were fed during the day or night). Further, Myanmar also exhibits poor dietary diversity in young children. In 2016, only 25 percent of children in the age group of 6-23 months had an adequately diverse diet — that is, they had been given foods from the appropriate number of food groups.[10]

MoHS has been working on five year strategic plan for nutrition known as “National Plan of Action for Food and Nutrition (NPAFN)” since 1996 in which nutrition-sensitive interventions have been considered despite coordination mechanism has not yet been much in place. Moreover, MoHS signed for Myanmar to be the member country of Global Scaling Up Nutrition (SUN) movement in 2013. The **Myanmar National Action Plan for Food and Nutrition Security (MNAPFNS)**[11] was conceptualized to tackle nutrition insecurity through a nation-wide strategy, and developed measures to tackle malnutrition with proven health-based interventions. The MNAPFNS laid the foundation for the development of the **Myanmar Multisectoral National Plan of Action on Nutrition (MS-NPAN)**, the first multi-stakeholder nationwide response of the Government of Myanmar. Spanning from 2018 to 2022, the MS-NPAN seeks to eradicate hunger and reduce all forms of malnutrition in mothers, children and adolescent girls; in particular, it seeks to reduce stunting in children under 5 years of age from the average of 29 percent at present to 19 percent by 2025[12]. To that end, the MS-NPAN focuses on the first 1,000 day period and targets pregnant and lactating women and children under five years with various nutrition-sensitive interventions.[13] MoHS led the process of MS-NPAN development in close collaboration with other ministries, UN agencies, NGOs and CSOs.

2.3. Social protection in Myanmar

There is mounting evidence that social protection through transfers in cash and food does not only alleviate poverty and reduce inequality, but also ensures improved result in health, nutrition and education outcomes as well[14]. Against the backdrop of poverty and nutritional deprivation in Myanmar, the role of social protection as a strategy to reduce inequality and promote people-centred development is paramount. To that end, the Government of Myanmar has instituted a broad set of policies and programmes to address the wide range of vulnerabilities in the country. The **Myanmar**

[7] https://thousanddays.org/the-issue/acute-malnutrition/

[8] https://reliefweb.int/sites/reliefweb.int/files/resources/WFPMYA_Nutrition_Apr16.pdf

[9] http://www.burmalibrary.org/docs22/LEARN-2016-UnderNutrition-in-Myanmar_Part_1-en.pdf

[10] https://www.unicef.org/eap/reports/asia-and-pacific-regional-overview-food-security-and-nutrition-0:

[11] http://ap.fftc.agnet.org/ap_db.php?id=870&print=1#_ftn1

[12] http://www.fao.org/3/CA0501EN/ca0501en.pdf

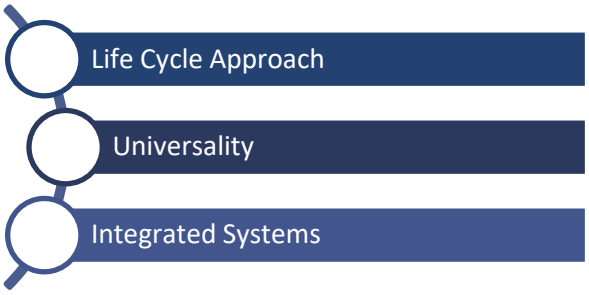
[13] The MS-NPAN is being implemented by various Ministries including Ministry of Health and Sports (MOHS), Ministry of Social Welfare, Relief and Resettlement (MoSWRR), Ministry of Education (MoE) and Ministry of Agriculture, Livestock, and Irrigation (MoALI)

[14] http://www.fao.org/3/a-i4819e.pdf

Framework for Economic and Social Reforms (FESR-2013) noted that "*social protection programmes can function as a 'circuit breaker' for inter-generational cycles of poverty and hunger*"[15].

Myanmar's **National Social Protection Strategic Plan (NSPSP)** is a significant step towards addressing economic and social vulnerabilities in a systematic and effective manner (*see Figure 2*). Endorsed at the end of 2014, the NSPSP envisions "*a universal social protection system based on the needs of all people that is supportive of the country's poverty alleviation and rural development programs*"[16]. The NSPSP seeks to create an inclusive, equitable system of social protection that contributes to human capital. This is done by facilitating access to essential social services such as education, health, housing and water; protects people from risks and shocks; addresses economic and social vulnerabilities and food insecurity over the life cycle and promotes economic opportunities and alleviates social exclusion.

Figure 2. Key principles of Myanmar's NSPSP



Of the 8 flagship programmes[17] of the NSPSP and the implementing Ministries/Government Departments, 4 of these interventions involve cash transfers. Key among these cash transfer programmes is the **Maternal and Child Cash Transfer (MCCT) Programme**. The importance attached to sequencing social protection interventions appropriately and early into the life cycle is reflected in the MCCT Programme, which seeks to improve nutrition status of the mother and child during the first critical 1,000 days of life.

2.4. The Maternal and Child Cash Transfer Programme (MCCT)

The MCCT programme began in Chin State in June 2017 and later expanded to Rakhine State and Naga land in January 2018 and further expanded to Kayah and Kayin States in Oct 2018. The ultimate objective of the MCCT Programme is to **improve nutritional outcomes for all mothers and children during the first critical 1,000 days of life** given that the time from conception to 24 months of age can perpetuate an intergenerational cycle of poor nutritional status.

The stunting and wasting levels of children under the age of five in Rakhine and Chin are very high when compared to Myanmar's average. Stunting in both states (37.5 percent and 41 percent, respectively) are above the WHO thresholds of stunting in emergency situations (>30 percent).[18] Moreover, wasting in Rakhine stands at 14 percent which is very close to WHO prevalence rates of wasting in emergency situations (> 15 percent)[19] (**Annex 2** provides facts on key nutrition and health indicators in Myanmar, Chin and Rakhine). Moreover, Rakhine and Chin's poor nutritional outcomes can be correlated with poor maternal health outcomes.

Table 1. Growth plan of MCCT programme

Period	Estimated Beneficiaries
2018/19	271,621
2019/20	626,260
2020/21	895,046
2021/22	1,228,060
2022/23	1,468,130

DSW has developed a costed sector plan which includes an expansion pathway of the MCCT for the next five years as given in Table 1. This will ensure that the programme has the largest coverage of the most vulnerable populations in the country. Moreover, approximately 48 percent of the total budget of the department is allocated to the MCCT covering the first 1,000 days of a child to build cognitive

[15] Myanmar National Social Protection Strategic Plan, December 2014
[16] Ibid.
[17] Ibid.
[18] https://data.unicef.org/topic/nutrition/malnutrition/
[19] Ibid.

capital – thus making Myanmar's social protection system strongly child-sensitive and ensuring that the investments result has maximum return provided other influencing factors permit.

The MCCT programme aims to empower pregnant and lactating women with additional purchasing power **(MMK 15,000 per month/10.5 USD)**[20] to meet their basic needs during the first 1,000 days along with complementary nutrition awareness sessions. This cash transfer is expected to improve their dietary intake and diversity, ensure better feeding practices for young children and improve affordability of basic health care during pregnancy and birth. The idea behind the cash transfer is not to cover the entire cost of health and nutrition needs but rather to provide supplementary income to be spent on nutrition and health. All pregnant women who enrol in the MCCT programme continue to receive programme benefits until her child reaches the age of 24 months. Invoking an open-door approach, new pregnant women/mothers are enrolled throughout the programme cycle.

MCCT programme beneficiaries (pregnant women and children under the age of two through their mothers) are entitled to:

- MMK 30,000 every two months in Chin and MMK 45,000 every 3 months in Rakhine until the child reaches the age of 24 months
- Membership in a local Mother Support Group (MSG) (Rakhine State MCCT yet to form MSGs)
- Monthly awareness sessions on nutrition, health & hygiene in their community through MSGs (through midwife's visits to beneficiary where MSGs have not been formed yet)

MCCT programme beneficiaries are responsible for:

- Attending the monthly/quarterly awareness sessions on nutrition, health and hygiene (only in Chin at this stage)
- Collection of cash from ward/village administrator's office (DSW officials in some areas of Rakhine State) every two/three months until the new child reaches the age of 24 months (they will be informed of the date by the W/VSPC or community in case of RSMCCT)
- Bringing the new child to ward/village administrator's office for beneficiary verification (as soon as possible, but no later than 45 days after the birth of the child)
- Participating in post-distribution monitoring surveys (as and when required)

As of October 2019, the MCCT programme in Chin State had registered 33,723 women beneficiaries and made 13 bi-monthly payments. The Rakhine MCCT programme was rolled out in January 2018 and as of October 2019, the State had made 9 quarterly payments and covered 124,719 beneficiaries across the State.

2.5. Implementation arrangements

The MCCT Programme is implemented across different levels of administration. At the **Union** level, the DSW's Social Protection section provides overall guidance and support to the implementation of the programme. At the **State**/Region-level, the State DSW plays key roles in approving beneficiary registrations, submitting budget requests to the Union level and financial management – flow of funds from State-level to ward/village-level with the support of General Administrative Department (GAD). The **District**-level stakeholders have limited responsibilities and, as per the operational guidelines, are responsible for financial management, addressing beneficiary complaints and reporting. The next level is the **Township**-level, where the DSW Case Managers support MCCT along with their statutory case management responsibilities. DSW township case managers are assisted by the Township GAD

[20] Around 24.5 percent of the population lives below poverty line, which means they have a per adult equivalent monthly expenditure of less than 47,700 kyat (approx. USD 33). A further 32.9 percent are non-poor insecure, with per adult equivalent monthly expenditure in the range of 47,700 to 71,550 kyat (approx. USD 33 to USD 50).

Officers for the transfer of funds, complaint resolution and programme monitoring. Lastly, at the **village/ward/IDP camp**-level, the relevant stakeholders are the Ward/Village Administrators, Mid-wife/Auxiliary mid-wife and Camp Leader, who play key roles in community sensitization, beneficiary registration, SBCC messaging, conducting awareness-raising sessions and redress of complaints. They are assisted in their operations by the Ward/Village Social Protection Committees. The **General Administrative Department (GAD)** and the **Department of Public Health (DoPH)** – the two implementing bodies of the MCCT programme – assist all levels of MCCT implementation. DoPH is also responsible for ensuring proper implementation of health services and provide support in delivery of community-based health and nutrition sessions. Additionally, Monitoring and Evaluation (M&E), Social and Behaviour Change Communication (SBCC) committees and Taskforces are also present for ensuring better service delivery. The roles and responsibilities for the implementing agents of the MCCT Programme are provided in **Annex 3** and the implementation process is detailed in **Annex 4**.

Key differences between the Chin and Rakhine MCCT programmes

Overall, MCCT's processes and systems are the same across the States. Aside from the difference in interval of receiving payments (bi-monthly for Chin and quarter-monthly for Rakhine), there are minor differences in the implementation process in the two States. The programme design of MCCT of Rakhine state has been kept "adaptive, flexible and basic" due to the prevailing conflict in the State. Post 2017 conflict, there is a significant number of camps for Internally Displaced Persons (IDP) in Northern and Central parts of the State. In central Rakhine, 129,000 IDPs, including over 120,000 people in camps, rely on humanitarian assistance for basic survival[21]. These IDP camps are marked by acute malnutrition, vulnerability to disaster and crisis and frequent clashes. Further, according to the Humanitarian Needs Overview (2019), 364,767 children in Rakhine (53 percent of all IDPs in the State) are displaced and need humanitarian assistance.

Given the significant number of IDPs and other prevailing socio-economic challenges, multiple modalities were developed and adopted for MCCT implementation in Rakhine State based on risk assessment and mitigation measures which takes into account elements of adaptation and shock responsiveness. Table 2 shows the different approaches to programme implementation, which were specifically designed for Rakhine State given its conflict-ridden context.

Table 2. The three approaches of the MCCT programme in Rakhine

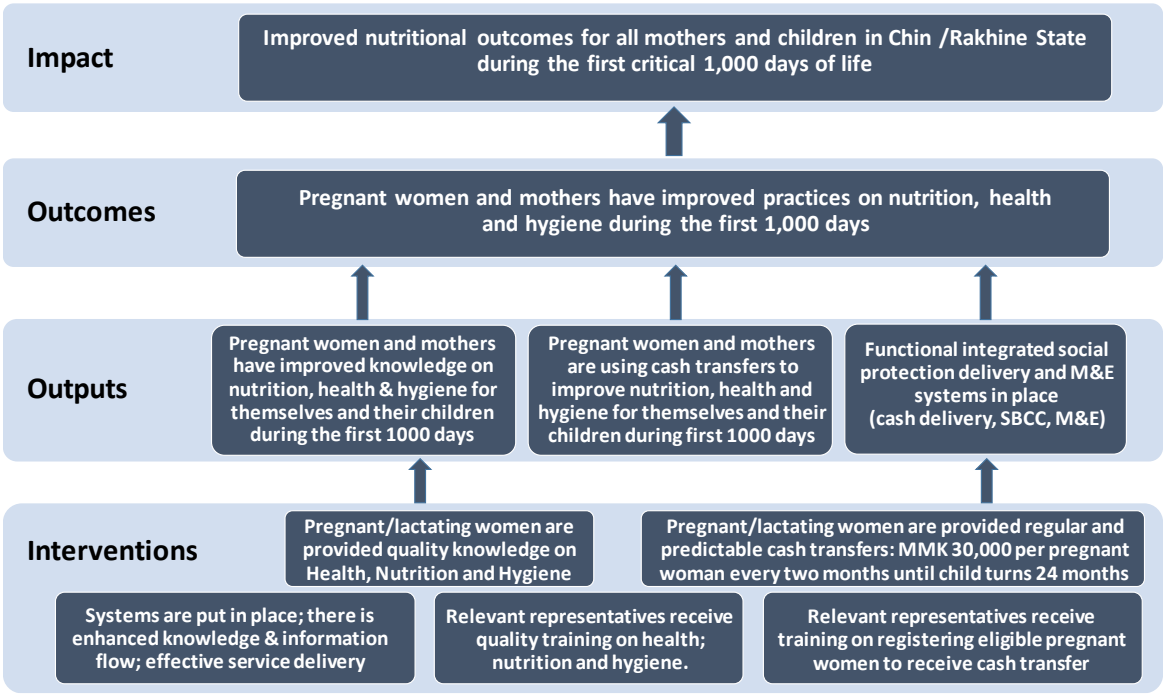
Characteristics	MCCT (Basic)	MCCT (Regular)	MCCT (Advanced)
Context	Protracted fragility and response in times of crisis	Regular/ typical context	Regular/ typical context
Basic conditions for achieving results	Availability of ANC services is limited and/or access is restricted; Markets for food and essential items are not functioning well and/or access is restricted; Cash delivery systems are very basic or do not exist; Trust in state system is low.	ANC services exist, can be accessed but are weak in quality; Markets for food and essential commodities are functioning well and are accessible to all; Cash delivery systems are evolving; Trust in state system is high.	ANC services exist, can be accessed and are of quality; Markets for food and essential commodities are functioning well and are accessible to all; Cash delivery systems are well established; Quality WASH services are available and accessible to all; Trust in state system is high.
Key Activities	Unconditional cash transfer; SBCC.	Unconditional cash transfer; SBCC. However, incentivize use of ANC, PNC and immunization support.	Unconditional cash transfer; SBCC. However, incentivize use of ANC, PNC, immunization, WASH

[21] Humanitarian Situation Report, No. 1, UNICEF Myanmar, March 2018

2.6. Theory of change

The original theory of change (ToC) of the programme was prepared during the design phase of the programme and is given below in Figure 3.

Figure 3. Theory of change for MCCT programme



The theory of change of the MCCT programme looks to impact the nutritional outcomes for all mothers and children during the first 1,000 days of a child's life through provision of income support, facilitating behaviour change and building national capacity for social protection. This cash transfer is supposed to provide supplemental income to beneficiaries to ensure spending on essential health and nutrition requirements to improve nutrition, health and hygiene for themselves and their children during first 1,000 days. In addition to the cash transfer, pregnant women and mothers are also provided appropriate knowledge on health, nutrition and hygiene to help them understand the best use of the cash transfer and increase their knowledge on critical issues such as dietary diversity, vaccination and health services, sanitation, etc. On the supply side, systems are put in place to ensure effective service delivery and information flow. Training is also provided to relevant representatives on registering eligible beneficiaries and on health, nutrition and hygiene. These demand and supply side activities are together expected to lead to improved practices on nutrition, health and hygiene, leading to improved nutritional outcomes for all mothers and children during the first critical 1,000 days of life.

Given that the MCCT programme is evolving with some modifications in the implementation processes being done and proposed further in the near future, it is an opportunity to re-visit the existing theory of change. Based on the conceptual framework for child nutrition, review of secondary literature and the understanding gained during the formative evaluation, an attempt has been made by the evaluation team to provide recommendations for reconstructing the theory of change, along with the underlying set of assumptions to be kept in consideration, which is provided in **Annex 5**.

2.7. Monitoring and evaluation framework

The MCCT programme has a well-designed monitoring and evaluation (M&E) framework which outlines the plan to understand whether the intended results are being achieved as planned and what corrective action may be needed to ensure delivery of the intended results. The monitoring framework

comprises the plan for implementation monitoring (through work schedules; financial flows, registration data, complaints, etc.); results monitoring (through done through administrative data, survey data, post distribution monitoring, qualitative interviews and case managers reports) and situation monitoring (markets and environment through CSOs). The evaluation framework includes a formative evaluation and an impact evaluation.

This report presents the findings, conclusions and recommendations of the formative evaluation. With respect to evaluation activities, baseline data was collected for Chin but not for Rakhine, owing to the conflict situation in the State and the underway formative evaluation. LIFT and DSW have planned for an outcome evaluation for Chin MCCT in 2020-2021. As per the evaluation framework for the programme, DSW, with support from UNICEF, has commissioned an independent formative, learning-oriented evaluation of the MCCT programme. This is in line with the international best practices on M&E and the evaluation is guided by the Organisation for Economic Co-operation and Development's (OECD) Development Assistance Committee (DAC) criteria of relevance, effectiveness, efficiency and sustainability, as well as equity, gender equality and human rights considerations. The feedback received from the beneficiaries, communities and other stakeholders that will be useful in understanding the key issues and improving the delivery and design of the cash transfer programme. Examples of such evaluations include the formative evaluation of World Food Programme's Livelihoods Programme, Karamoja, Uganda; Evaluation of the CARD and UNICEF Cash Transfer Pilot Project for Pregnant Women and Children, Cambodia; etc.

3. EVALUATION PURPOSE, OBJECTIVES AND SCOPE

3.1. Purpose and use of the evaluation findings

The *purpose* of this formative evaluation, in line with the Terms of Reference, is to:

- **Foster learning and improvement** in the provision of regular and predictable cash transfer to pregnant women and mothers with children under 2 years of age in Chin and Rakhine;
- **Review the efficiency and effectiveness** of the programmes design, operations, implementation and delivery, and the extent to which outputs and outcomes have been achieved;
- **Set out lessons learned** to strengthen the MCCT programme in Chin and Rakhine which will also inform the replication and scale-up of the programme;
- **Compare the programme** with other cash transfer interventions in the region in order to derive lessons and best practices wherever applicable.

To ensure credibility, the evaluation process was independent in defining the scope and methodology, considering and presenting achievements and challenges. The views and experiences of DSW, implementing partners, UNICEF and other development partners were however considered to produce actionable recommendations on defined indicators.

The primary user of the evaluation is the Department of Social Welfare (DSW) of the Ministry of Social Welfare, Relief and Resettlement (MSWRR), being the lead agency for the MCCT programme and implementing partners i.e. the Department of Public Health (DoPH) of the Ministry of Health and Sports (MoHS) and the General Administration Department (GAD). The evaluation findings can also be useful to relevant social protection development partners: UNICEF, LIFT, the World Bank, WFP, Save the Children and IRC, among others. Secondary users include other government agencies and civil society organizations involved in cash transfer programming in Myanmar who work directly or indirectly with beneficiaries – particularly women, children and their family members. It is expected that the evaluation will be used to strengthen the design/ implementation of the MCCT Programme in Chin and Rakhine and inform about the replication and scale-up of the same to other areas.

3.2. Objectives

The *objectives* of this formative evaluation, in line with the Terms of Reference, include the following:

1. Analyse the extent to which the MCCT programme has been appropriately designed (reconstructing the theory of change), efficiently and effectively implemented (including registration and coverage, inclusion and exclusion errors, the cash distribution mechanism, financial management, data management, etc.), and its cost-effectiveness in comparison to other comparable cash transfer interventions (e.g., regarding administrative costs, etc.);
2. Understand how MCCT beneficiaries (and families) have used the money provided, their level of satisfaction, adequacy of the transfer level and the extent to which the spending of the money translated (or did not) into benefits for children while achieving overall objectives set for the MCCT programme;
3. Understand the use and effectiveness of Mother Support Groups and Social and Behavioural Change Communication awareness sessions to achieve MCCT's objectives;
4. Assess the institutional capacity at Union and State levels, township and wards or village level for management and implementation of the MCCT programme while identifying key gaps and bottlenecks in relation to the MCCT programme life cycle; and
5. Assess the effectiveness of the support provided by development partners (including technical and financial side) in the design, implementation and monitoring phases of the programme.

The analysis of appropriateness of the MCCT programme design, efficiency and effectiveness and its implementation requires a deep understanding of the use of cash transfer money by beneficiaries, as well as an assessment of the institutional capacity at the national and sub-national levels. In addition, identifying key gaps and bottlenecks and assessing the effectiveness of development partners' support will help achieve the purpose of the evaluation, being to foster learning and improvement, and setting out lessons learnt. The findings will also help UNICEF strengthen its advocacy around the efficacy of cash transfer for health and nutrition outcomes. Further, the Government, NGOs and other stakeholders will also benefit from the evaluation and use the findings for designing any other future cash transfer interventions.

3.3. Scope of the evaluation

The scope of this evaluation is formative (learning-oriented) in nature. As per the TOR, the evaluation is not intended to be an impact evaluation, but one that looks at the evaluating processes, procedures, implementation mechanisms and whether beneficiaries are satisfied with the services provided under the MCCT programme in **Chin** and **Rakhine** States from 2017 till date.

Box 2. Formative vs summative evaluations

Summative evaluations focus on the effects of the intervention on the target groups and on what the intervention has achieved. Conversely, formative evaluations are typically conducted either during programme development or at early stages of implementation and aim at improving the design of the intervention and focus the attention on understanding what works, what does not work and the factors behind performance.

Formative evaluations also have an important organizational learning component, which makes them highly participative. Formative exercises require a high degree of engagement, intense consultation and direct interaction with internal stakeholders during the inception phase. This explains the intense consultative approach adopted during the design of the present evaluation.

This formative evaluation will provide learnings and recommendations for delivery of the programme, which should be verified and assessed during the summative evaluation of the programme.

4. EVALUATION APPROACH AND METHODOLOGY

4.1. Approach

Keeping in mind the purpose of the evaluation, a non-experimental research design and a *theory-based mixed methods* and *utilization-focused* approach were followed – combining quantitative and qualitative primary data collection while drawing upon inference from key programme documents including policy, design and implementation documents. By theory based we mean that the team used the theory of change to draw conclusions about whether and how an intervention contributed to observed results. Moreover, the evaluation being formative was not experimental or quasi experimental in nature and therefore, using the theory of change to assess the appropriateness of the design of the programme was more appropriate. Utilization focused means that the evaluation can be judged on its usefulness to its intended users. Therefore, the approach was participatory and planned in a way to enhance the likely utilization of both the findings and of the process itself to inform decisions and improve performance. In the beginning of the evaluation itself, the team sought key evaluation questions from all stakeholders to be included in the framework to ensure that all stakeholders have particular sections of interest in the report and that the report is utilized. Further, workshops were conducted at both the inception stage and after the preliminary analysis of the findings, with the government, implementing bodies (at National and State level) and development partners, which helped validate and triangulate findings, obtain a wide range of perspectives and yield insights into the dynamics of the program. Another workshop to present the final evaluation report is planned.

4.2. Methodology

The evaluation was conducted using an evaluation framework (presented in **Annex 6**) that conforms to the modified Organisation for Economic Co-operation and Development (OECD)/Development Assistance Committee (DAC) criteria of **relevance, efficiency, effectiveness** and **sustainability**, as well as, **equity, gender equality** and **human rights** considerations.[22] Impact as a criterion has been excluded in line with the Terms of Reference, with this being a formative evaluation and not an end line or impact evaluation. The key evaluation aspects were triangulated in the evaluation matrix presented in **Annex 7**, which presents the OECD-DAC criteria, the evaluation questions and the data and information sources.

Further, key stakeholders of the MCCT programme including the Rights Holders (rights-holders are individuals or social groups that have particular entitlements in relation to specific duty-bearers) and Duty Bearers (duty bearers are those actors who have a particular obligation or responsibility to respect, promote and realize human rights and to abstain from human rights violations[23]) were identified, and a detailed stakeholder analysis carried out (presented in **Annex 8**). The list of key stakeholders along with the objective of data collection, the tools which were used, and the broad category of questions is provided in **Annex 9**.

The evaluation was divided into three phases: inception, data collection and report writing. The key evaluation aspects, the data collection methods and the analytical methods to be applied, informed activities in each phase. The activities and deliverables in each phase of the evaluation are presented ahead (*see Figure 4*).

[22] The OECD-DAC criteria reflect the core principles for evaluating development assistance and have been adopted by most development agencies as standards of good practice in evaluation. The DAC evaluation quality standards provide guidance on the conduct of evaluations and for reports with the aim to improve the quality of development intervention evaluations. The DAC criteria are important because they inform how international development is undertaken within commitments on Aid Effectiveness.

[23] Glossary, Gender Equality: UN Coherence and You

Figure 4. Evaluation phases

Phases	Phase I: Inception	Phase II: Data Collection	Phase III: Report Writing
Activities	▪ Literature review[24] ▪ Secondary data analysis ▪ Drafting of data collection tools ▪ Drafting of Inception Report ▪ Inception mission (incl. stakeholder meetings and field mission to Chin) ▪ Inception workshop	▪ Training of enumerators ▪ Field testing and finalization of data collection tools[25] ▪ Data collection ▪ Data processing ▪ Development of output tables ▪ Development of preliminary findings ▪ Country mission to conduct KIIs with Union level stakeholders[26] ▪ Validation workshop to present preliminary findings	▪ Data analysis and secondary literature review ▪ Developing final recommendations based on Knowledge, Attitude and Practice study, cost effectiveness analysis & reconstructed Theory of Change ▪ Drafting of evaluation report ▪ Drafting of final presentation ▪ Drafting of executive summary
Deliverables	▪ **Inception Report** ▪ **Inception workshop**	▪ **Validation workshop** ▪ **Data sets/output tables**	▪ **Final Evaluation Report** ▪ **Executive Summary** ▪ **Final Presentation**

Secondary information review was done to build an understanding of the cash transfer programme. This was followed by primary information collection from implementing agents, beneficiaries, government counterparts, donors and other stakeholders. The primary information was collected through quantitative and qualitative data collection methods, such as survey, key informant interview (KIIs) and focus group discussions (FGDs).

Sampling for quantitative data collection: The sampling for the household survey was done taking into consideration the available beneficiary estimates, as of April 2019, for both Rakhine and Chin. Using the formula below, the representative sample size for Rakhine and Chin were estimated separately:

$$n = \frac{c^2 Np\,(1-p)}{(A^2N) + (C^2p\,[1-p])}$$

Where:

- n is the sample size required
- N is the whole target population in question (91,800 in Rakhine State and 30,500 in Chin State)
- p is the average proportion of records expected to meet the various criteria, (1-p) is the average proportion of records not expected to meet the criteria. We have taken this value to be 0.5 in our case to get the maximum sample size.
- A is the margin of error deemed to be acceptable (calculated as a proportion) e.g. for 5% error either way A = 0.05
- c is a mathematical constant defined by the Confidence Interval chosen i.e. how sure we need to be of the result). *For 95% confidence level, the value of constant c = 1.96*

Considering a 5 percent non-response rate, a sample size 417 in Chin State and 424 in Rakhine State was estimated. Further, a total of 40 beneficiary respondents across 4 IDP camps were proposed to

[24] List of documents reviewed is provided in **Annex 10**

[25] Data collection tools attached as **Annex 11**

[26] The list of people interviewed is attached as **Annex 12**

be surveyed in Rakhine State, to understand the situation in the IDP camps. The actual coverage is presented in Table 3 ahead.

Sampling methodology: Given the scope, a multi-stage systematic random sampling method was adopted. All 5 districts in Rakhine and 4 districts in Chin were covered as part of beneficiary survey.

At the **first stage**, all selected townships within the districts were listed based on the following indicators - Total Population Size and Total Female Population Size (2014 Myanmar Population and Housing Census); No. of Internally displaced people from UNOCHA Camp Coordination Camp Management data; and Antenatal care coverage for at least one visit (%), Proportion of infants with low birth weight (%) and Malnutrition under three years (%) from MMR_MOH/DHP, Township Health Profile. A combination of using data on these indicators, inputs from stakeholders during the inception workshop (workshop proceedings report given in **Annex 13**) and purposive sampling given the challenging context in some areas of Rakhine and Chin was done to select the townships. The selected list of townships and sample size covered is presented in the table below:

Table 3. Sample size

State	District	Township	No. of beneficiary surveys conducted	No. of IDIs conducted	No. of FGDs conducted
Chin	Falam	Tedim	136	7	1
	Haka	Thantlang	84	8	1
	Matupi	Paletwa	114	7	1
	Mindat	Kanpetlet	75	7	1
		Total	**409**	**29**	**4**
Rakhine	Sittwe	Sittwe*	151	11	1
	Kyaykphyu	Kyaykphyu*	69	7	1
	Maungdaw	Maungdaw	56	8	1
	Mrauk-U	Myaypon*	134	7	1
	Thandwe	Thandwe	53	7	1
		Total	**463**	**40**	**5**

* includes coverage of 10 beneficiaries each in 4 IDP camps – one camp each in Myaypon and Kyaukphyu and two camps in Sittwe.

In the **second stage**, within the identified township, the number of beneficiaries for each village/ ward were listed and arranged in descending order and classified into 3 strata, – High number of beneficiaries, Medium number of beneficiaries and Low number of beneficiaries. From each stratum, using a computer-generated random number 1 village was selected. **Therefore, a total of 3 villages were selected**.

Based on the required sample size for the township (as estimated above), the total number of households were equally selected across the 3 villages. Disaggregation of Urban and Rural population (wards and villages) was done using Probability Proportional to Size (PPS) sampling. IDP camps in Rakhine State were also sampled in addition to wards and villages.

Note: In some cases, there has been a deviation between the ward/village sampled and the actual ward/village that was visited for data collection. This was on account of heavy rains, poor road connectivity and landslides on the route to these wards/villages – which could potentially compromise the safety of the survey team. Consequently, these wards/villages were replaced by safer and geographically close alternatives. Due to this, it is possible that the collected data is not fully representative of all geographies in Chin and Rakhine – particularly the conflict affected and monsoon-affected regions. We however ensured that the closest alternate is selected to the ward/village being replaced so that homogeneity in majority of the findings can be ensured. Further, the sampling

assumptions held, and non-response rate was lower than 5 percent. Data errors were also very few and Computer-Assisted Personal Interviewing was used for data collection with in-built logic.

- For Chin replacements, the geographically closest village, which is safely accessible, was chosen.
- For Rakhine replacements, we have either: (a) taken the replacement recommendation of an accompanying UNICEF officer; (b) taken the recommendation of a DSW officer, after permission has been given by UNICEF; (c) chosen the geographically closest village which is safely accessible after permission has been given by UNICEF.

The details of changes have been provided in **Annex 14**.

In the **third stage**, the beneficiaries were selected using random sampling method. In the sampled villages and wards, the beneficiary list available and maintained by the frontline health worker was obtained. The total number of beneficiaries available was divided by the sample (number) required to provide the sampling interval. The third beneficiary was selected and thereafter using the interval the other beneficiaries were selected. The selected beneficiaries were then contacted, and their consent taken for the survey. In case of refusal, replacement was done using the same method.

All quantitative surveys were administered via **Computer-Assisted Personal Interviewing (CAPI),** whereby our surveys were administered face to face with interviewers carrying tablets with pre-scripted questionnaires.

Qualitative data collection: Qualitative data was also collected to provide contextual information and triangulation of the quantitative data, as well as, to identify and capture factors that are not easily quantifiable. The sample selection for the key-informant interviews (KIIs) and in-depth interviews (IDIs) was purposive. The key stakeholders at the national, provincial and district level were listed. Each identified stakeholder was thereafter contacted for scheduling of interviews and discussions.

The sample for the focus group discussions (FGDs) with beneficiaries and community members, was selected based on availability and willingness to participate in the interactions at the village level. The village with the highest beneficiary population among the already selected ones, for the quantitative survey were the location for conducting the FGDs. For beneficiary groups, preference was given to those who had not been covered as part of the quantitative survey. The quantitative and qualitative data collection exercise took place in parallel and while developing the data collection tools, it was ensured that triangulation of data through the quantitative and qualitative tool takes place.

4.3. Data analysis

As we used a mixed method approach, both quantitative and qualitative data was collected for triangulation. Quantitative data was analysed using descriptive statistics. Qualitative data was evaluated using an iterative analytical process for thematic identification and triangulation based on the feedback from multiple stakeholders.

Data on the same topic was collected from multiple sources and by different methods to cross-validate data and capture different dimensions of the same process to reduce respondent bias. Moreover, having a participatory approach ensured that several stakeholders were contacted multiple times to ensure that data is triangulated throughout the course of the evaluation. The workshops (inception and validation) were also key in fostering discussion between different stakeholders and ensure data triangulation.

Comparisons to and lessons from similar cash transfer interventions in other countries in the region were also included as part of the analysis – particularly from IPE Global's recent work in cash transfer programmes and maternal health. The initial findings report provided an assessment of the acceptability of specific intervention strategies.

4.4. Increasing reliability and validity of data collection and analysis

In order to increase the reliability and validity of our evaluation methods, the following methods were used during preparation of data collection tools, field work and data analysis:

- Having a variety of item types (multiple-choice, open-ended, quantitative and qualitative) in questionnaires, presenting and accounting for multiple response types and ensuring objective answers;
- Triangulation of data by cross verification of main findings from two or more sources and through interaction with beneficiaries in two format types, survey interviews and FGDs;
- Validating findings from multiple stakeholders;
- Well-documented audit trail of materials and processes; and
- Making references to quantitative aspects wherever possible.

4.5. Risks, limitations and mitigation measures

During the inception phase, certain risks and challenges in conducting this evaluation were identified. These have been given in the table 4 below along with mitigation measures undertaken.

Table 4. Risks, challenges and mitigation measures

Risk/Challenge	Mitigation Measure
Due to cancellation of the inception workshop and other delays in the inception phase, data collection had to be done right in the middle of the monsoon season, thereby affecting mobility and access.	Two additional weeks were added for data collection. Some villages that became inaccessible were replaced in due consultation with the DSW.
Situation in some townships of Rakhine is currently in a critical state due to which data collection in northern Rakhine and also in some central areas may not be possible.	Data collection was undertaken only in areas where there is no eminent risk to the team. If some specific areas are not covered, the reasons for the same are clearly given in the evaluation report and best alternative sample was taken.
In some cases, quality of data may have been compromised due to linguistic and cultural barriers and context specific information shared by the respondents.	The majority of enumerators were selected either from Chin or from Rakhine states and had at least 2 years' experience working across different regions of Myanmar.
Respondents may have been reluctant or unwilling to share sensitive and personal information, as well as, information related to usage of cash.	To mitigate the reporting bias, surveyors carefully explained to all the respondents that the evaluation was a learning-based exercise and also emphasised that their anonymity and confidentiality would be protected. Further, the questions were asked in a sensitive manner to allow for genuine and spontaneous responses.

Apart from the risks that were identified, the evaluation also faced some limitations. Firstly, while all precaution was taken to ensure true and unbiased responses by the beneficiaries, there may still be instances of the respondents being resistant to critically engage on aspects of their experiences, which they may fear will reflect badly on themselves, government agencies or other stakeholders. Secondly, there was risk that the accuracy of data would be compromised by linguistic and cultural barriers. Even with the use of highly skilled interviewers and translators, it is likely that some information was lost in the translation process particularly with regard to complex, detailed and highly context-specific information. Thirdly, given the nascent stage of public financial management in Myanmar, administrative costs regarding MCCT are not captured as separate budget items and cannot be isolated from the overall department budget, therefore calculating cost effectiveness and cost efficiency is not possible. Also, due to lack of information on costs of similar programmes, it is not possible to make cost comparisons. Lastly, given some areas which posed a risk either because of conflict and climatic conditions could not be covered in the evaluation, it is possible that the findings

are not one hundred percent representative of all geographies in Chin and Rakhine – particularly border areas and difficult to reach areas (where landslides and road closure is common in monsoons).

4.6. Equity, gender and human rights

In line with the UNEG Handbook on Integrating Human Rights and Gender Equality in Evaluation, as well as the UNICEF Handbook on How to Design and Conduct Equity-Focused Evaluations, the evaluation integrated equity, gender equality and human rights considerations in the conduct of the evaluation. In particular:

- The evaluation criteria and questions sought information on whether equity, gender equality and human rights issues were integrated into the design, planning and implementation of the project;
- The evaluation followed a participatory and consultative approach throughout the engagement lifecycle. During consultations with the key stakeholders of the project, efforts were made to ensure that the evaluation is able to capture important insights;
- During the process of data collection, a gender balanced team was maintained;
- Other than beneficiaries and implementing agents, focus groups discussions which included husbands, non-beneficiaries and heads of household were also conducted to ensure equity and get an insight on the opinion of the community regarding gender equality;
- Post purposively selecting villages, random sampling of beneficiaries was undertaken to ensure equity;
- The evaluation ensured that a diverse set of stakeholders involved in the project are met during the data collection so as to ascertain that the perspective of all the stakeholders is triangulated, analysed and reflected in the evaluation, thereby ensuring equity.

4.7. Ethics and United Nations evaluation guidelines

The evaluation was driven by several ethics and guidance documents. An integral component of the literature review during the inception phase was to review these so as to embed the UNEG evaluation ethics and principles in the thought process of the evaluation team.[27] The design of the evaluation incorporated a clear human rights, equity and gender perspective. The team paid close attention to ensuring that the aforementioned dimensions have been integrated into the interventions, such as inclusion of women and excluded communities, and the effects of the cash transfer programme on such groups. This is also explicitly reflected in the evaluation tools and the methodology proposed.

To ensure impartiality, the evaluation team considered the views of all stakeholders. The UNEG norms and standards were carefully observed. Furthermore, UNEG's ethical considerations have been respected, particularly in relation to including the view of community members. Prior to the start of the data collection phase, all enumerators were trained on the UNEG's ethical considerations and guidelines, so as to ensure that data collection took place according to high standards of ethics and sensitivity. The team ensured that sensitive information derived from the FGDs, KIIs and Surveys was secured with utmost confidentiality. Any interactions with stakeholders was done with prior consent. Informed consent statement was prepared and attached to the household questionnaire, semi-structured questionnaire for KII and FGD guides. All participants were informed of their rights to anonymity and confidentiality throughout the data collection process. The researchers informed the

[27] The documents reviewed include the UNEG Norms and Standards for Evaluation (2016), the revised evaluation policy of UNICEF (2018), UNEG Ethical Guideline for Evaluation (2008), UNICEF Procedure for Ethical Standards and Research, Evaluation and Data Collection and Analysis (2015). UNICEF-adapted UNEG Evaluation Reports Standards (2017) and Global Evaluation Reports Oversight System (GEROS) Handbook (2017), UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation, and UN-SWAP Evaluation Performance Indicator.

participants that they are not required to answer any question that they felt uncomfortable during the discussion and would be given the opportunity to ask questions or to clarify and make comments, if they have any, at the end of the discussion. Children were not interviewed as a part of the evaluation as the focus is on improving the health and nutrition status of children through health-seeking and improved dietary practices of mothers.

The researchers ensured that the methods applied in the evaluation of the cash transfer programme causes no physical or psychological harm to the participants. The team strictly followed the obligation of evaluations: ***independence, impartiality, credibility, no conflict of interest, honesty and integrity,*** and ***accountability***. The evaluators also observed the obligations towards the participants including ***respect for Dignity and Diversity, Rights, Confidentiality,*** and ***Avoidance of Harm***.

Once the data had been collected and analysed, the evaluation team ensured that there is ***accuracy, completeness*** and ***reliability*** reflected in the presentations and reports, as per the UNEG guidelines on the Evaluation Process and Product. Furthermore, ***transparency*** in accessibility of the data collected, presentations and reports were taken into sincere consideration. The evaluation methodology was presented to the government, UNICEF and other stakeholders during the inception report presentation workshop and confirmation was sought. Similarly, the preliminary findings were also presented and discussed in a validation workshop.

4.8. Quality assurance

IPE Global ensures adherence to an ethical code of conduct and employee behaviour by staff members and consultants working full time or part time. **Annex 15** details the Quality Policy Statement, Policies, Procedures and Practices for Quality Outputs, Quality Management System, Staff for Quality Assurance, Value for Money and Internal Controls at IPE Global. In line with this, the current assignment was subject to rigorous quality assurance and control. For this evaluation, a pool of experts was deployed, out of which 2 experts, having expertise in nutrition and experience in conducting evaluations, who reviewed and quality assured all deliverables. At the inception stage, the experts examined and assessed the appropriateness of the evaluation design and methodology; and that the same conforms to the terms of reference (ToR) for the assignment. The data collection tools were also reviewed by experts. Careful development of the questionnaire with emphasis on correct wording of the questions, followed by pilot testing the questionnaire with subjects not included in the sample helped ensure that the data collected is reliable. Overall, quality assurance was undertaken at all four steps of data collection – material development, recruitment, field data collection and data validation, as detailed in Table 5 below.

Table 5. Quality assurance methods

Material Development	Recruitment	Field Data Collection	Data Validation
▪ **Verification of the translated data collection tools in the local context** ▪ **Pre-testing of tools – observations documented and incorporated in the final tools**	▪ Existing pool of field personnel with verified credibility ▪ Strict adherence to qualifications and experience ▪ Contingency for dropouts and rejections ▪ Retention initiatives	▪ In-built logical checks in CAPI ▪ Field level checks ▪ Time stamp: start and end time of interview ▪ GPS monitoring ▪ Daily progress reports	▪ Data consistency / quality checks ▪ Validation – range, outliers ▪ 100% data validation using a checklist ▪ Back checks for 25% households, at least telephonically

Experienced data collection staff were deployed after proper training. The data collection process was supervised by trained staff. Field-level errors were eliminated through stringent supervision of field work and review of the filled questionnaires. Supervisors oversaw interviewers during field work, including overseeing their survey implementation through live spot-checks, as well.

Quantitative data was collected via **Computer-Assisted Personal Interviewing (CAPI)** whereby the surveys were administered face to face with interviewers carrying tablets with pre-scripted questionnaires. A series of logic checks are built into every questionnaire and controlled via the NField software logic so that interviewers cannot proceed to the next question if contradictory or nonsensical answers were given. Further, customized error-checking programs were run on the entered data to detect missing values and to filter out any inconsistencies and logical errors. The errors reported were corrected by physical reference to original schedules.

5. EVALUATION FINDINGS AND ANALYSIS

The findings presented ahead for both, Chin and Rakhine States, have been organised against the Organization for Economic Co-operation and Development's Development Assistance Committee (OECD/DAC) criteria of relevance, effectiveness, efficiency and sustainability. In addition to these, equity, gender and human rights considerations were a key part of the evaluation. However, the key findings for Chin and Rakhine have also been separately provided in **Annexes 16** and **17** respectively.

5.1. Relevance

The section looks at the design of the programme to understand the contextual appropriateness, the adequacy of cash transfer, complementarities with other programmes and usage of cash.

Programme Design: Is the Programme design and logic (incl. the theory of change) relevant and appropriate to the situation of women and children in Chin and Rakhine States?
Undernutrition in Myanmar continues to be a challenge. In 2016, 29 percent of under-five children were stunted and 7 percent were wasted[28]. The MCCT programme aims to improve nutrition of mothers and children during the first critical 1,000 days of life to address the intergenerational cycle of poor nutritional status. The Director General of DSW, Dr. San San Aye has emphasized on the need of this programme for the future of the country, stating that *"this is not expenditure but investment in children."* Given that Chin and Rakhine State had some of the poorest indicators in terms of health and nutrition, it was appropriate to start with these. However, Chin and Rakhine present unique challenges in terms of the treacherous terrain of the former and conflict in the latter. This meant that systems and infrastructure in these areas are weak and feasibility of introducing technology-based solutions is limited. Globally, there is a focus on the power of the first 1,000 days for the cognitive development of a child – "The right nutrition in the first 1,000 days between a women's pregnancy and her child's second birthday builds the foundation for a child's ability to grow, learn and thrive"[29] The MCCT programme is a right step in this direction, focusing on improving women's Health and Nutrition; increasing awareness around breastfeeding and dietary diversity; and providing access to better diets for babies and toddlers in the form of cash. Further, studies have shown that frontline health workers have a vital role to play in promoting good nutrition in the first 1,000 days, especially in areas where doctors and hospitals are often unavailable, too far away, or too expensive[30] as is the case in Rakhine and Chin. The MCCT programme, in relying on the Midwives and Auxiliary Midwives to impart health and nutrition education is in line with global recommendations.
Targeting and coverage: Is the Programme targeting the right group of stakeholders to achieve the Programme's objectives (incl. the most vulnerable ones)?
The MCCT programme follows the principle of 'universality' – wherein all pregnant women and mothers of children under the age of 2 are eligible to receive the cash transfer. The programme does not mandate the use of any unique identity document, such as, the National Registration Card (NRC) for registration in the

[28] Myanmar Demographic and Health Survey 2015-16
[29] www.thousanddays.org
[30] Nutrition in the first 1000 days, State of the World's Mothers 2012, Save the Children

program. Given the context of Myanmar, this is a positive step to ensure that minorities and vulnerable populations, who do not possess an NRC are not excluded. In the sample areas, the programme was seen to have reached all sections of the society- including vulnerable groups. During focus group discussions with beneficiaries and community members and key informant interviews with midwives and ward/village administrators, everyone confirmed that no one was being excluded due to economic, social or any other condition in either Chin or Rakhine.

In Rakhine, however, there were cases of people not getting registered due to lack of documents, such as, proof of antenatal check-up for women and immunization for children. The Union and State DSW teams confirmed the observation that certain conditions have now been imposed to register and receive payment in order to reduce fake registrations and improve health outcomes even though this is not reflected in the Operations Manual. No documentation of these conditions being enforced and shared with all townships in Rakhine was found and as a result the understanding of the documents needed for registration is unclear with the field level staff.

While the sampling covered all districts of Chin and Rakhine, it was not possible to visit very remote locations in Chin due to poor weather conditions and border areas in Rakhine due to on-going conflict. It is therefore possible that cases of exclusion exist in these hard-to-reach and conflict areas.

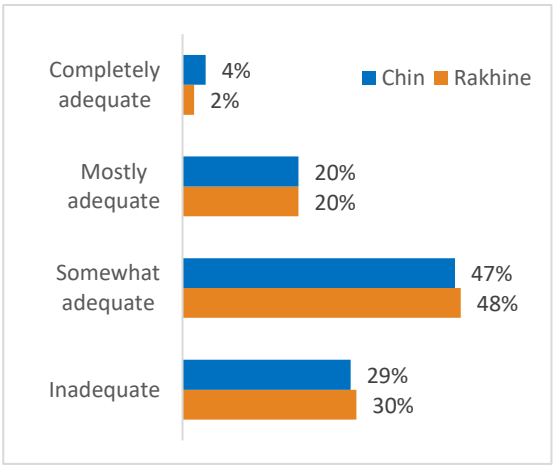
Adequacy of cash transfer amount and regularity of payment:

To what extent is the size and regularity of the cash transfer adequate to the needs of women and children? Have the different needs of pregnant women, mothers and their children been met within the objectives of the Programme?

The MCCT programme is empowering pregnant and lactating women with additional purchasing power of MMK 15,000 per month. For administrative ease, in Chin this amount is distributed every two months while in Rakhine, ward administrators who are functionaries of the General Administrative Department distribute it every three months. Key informant interviews with DSW (at Union and State level) and GAD (at township level) brought out that within the given resources and using the paper-based systems currently in place, it is not possible to bring about monthly payments. Given this, the current frequency is the best solution.

Regarding the size of the cash transfer, the Union office of DSW clearly stated that the cash transfer amount is not intended to cover the entire cost of nutrition and health services for the beneficiary but rather provide a supplemental amount to support access to these services. Based on the discussions with relevant stakeholders, it is understood that the size of the cash transfer, of MMK 15,000 per month for the MCCT, was determined not just by considerations of budget availability but was also estimated on the basis of food poverty gaps and using the cost of diet method. The cost of accessing health healthcare and medicines, was also factored-in to arrive at the cash transfer value. The cash transfer amount is aimed at providing additional resources to meet the nutritional needs of the mother/child pair and not designed to address a household consumption gap. Due to data limitations we are unable to make precise and detailed calculations. As per estimates, the size of cash transfers works out to over 13 percent of the food expenditure of the poor (based on the 2015 household survey). The amount is adequate to contribute to greater consumption of more diverse and nutritious foods and/or to covering transportation costs to access health and nutrition services.

Figure 5. Beneficiary opinion on adequacy of cash transfer amount



In Chin, 29 percent of beneficiaries found the cash transfer amount to be inadequate, 47 percent found it somewhat adequate while 20 percent found it mostly adequate. The remaining 4 percent were completely satisfied with the cash transfer amount. Similar results were found in Rakhine (*see Figure 5*). The midwives also stated that the cash amount is not enough to warrant a significant shift in dietary patterns, however some difference is present.

Although the amount provided is not sufficient for a child, we tell them that they can at least buy more nutritious foods than before - Midwife, Sittwe, Rakhine State

On an average, beneficiaries and implementing staff, such as, the DSW State Director of Chin, Village Administrators and Midwives recommended doubling the amount.

> ***From the PDM a report, it is seen that the money is enough but personally, I think the money is less; providing 1000 MMK per day will be much better - DSW Director, Chin State***

Evidence from Sub-Saharan Africa suggests that transfer amounts that comprise around 20 percent of pre-program household consumption resulted in larger program impacts across households.[31] Also, a review of five CCTs in Latin America concluded that, in countries where the size of the transfer is larger (15 percent to 25 percent of total monthly household expenditures), the effect of transfer size on children's nutritional status is greater.[32] Further, small and regular cash transfer payments increase the probability of the cash being used for health and nutrition rather than other expenses such as paying off debt.

The operational evaluation for LEAP (Ghanaian Livelihood Empowerment Against Poverty Program) revealed that payment irregularity prevented families from smoothing consumption and that its impact on the lives of the poorest communities in Ghana was limited by a number of functional factors – broadly related to size and regularity of payment.[33] The MCCT programme in learning with this, needs to ensure that payments are not delayed and are delivered on time especially in far-off and conflict affected areas such as Paletwa in Chin State and Maungdaw and Buthidaung in Rakhine State.

The MCCT Programme has fulfilled the nutritional and health requirements of mothers and their children. (more details on the usage of cash transfer is in the section under *'Effectiveness'*)

How well is this Programme complementing other Government and development partners' interventions in Chin and Rakhine States to address the needs of women and their children? Was the choice to use cash rather than in-kind assistance justified in terms of needs (among different social/gender groups), availability of markets and beneficiary & government preferences?

The Ministry of Health has been working on programmes aimed at improving the supply of health services with a particular focus on immunization and family planning. These supply side interventions are complemented by the demand focussed components of the MCCT, wherein the uptake of health services, birth spacing (wherein no mother can re-register for the programme with another pregnancy till two years after giving birth to the previous child), and the consumption of nutritious food is promoted through awareness sessions and cash transfers.

The MCCT programme complements these efforts by increasing demand for these services through improved knowledge and also access through provision of cash. Cash rather an in-kind assistance was preferred by beneficiaries as its usage could be divided on a need-basis between nutrition and health services by the mothers.

Was the usage of the cash by beneficiaries in line with the programme objectives?

The cash transfer is expected to enable pregnant/ lactating women to improve their dietary intake and diversity, ensure better feeding practices for young children and improve affordability of basic health care during pregnancy and birth.

In line with this, primary evidence from this evaluation shows consumption of better quality of food and increased expenditure on household health. Implementing agents who regularly interact with the beneficiaries (such as midwives and ward administrators) confirmed that the cash is being used to access health services and diverse nutrition, which earlier would not have been affordable.

> ***We teach the beneficiaries to use the money on nutritious foods when they come and collect the money. The money usually ends up being used for the child, not for their husbands – Camp Leader, Sittwe, Rakhine State***

[31] Innocenti Research Brief, How much do programmes pay? Transfer size in selected cash transfer programmes in Sub-Saharan Africa, Asian Development Bank, 2009

[32] Ruel, Marie & Leroy, Jef & Verhofstadt, Ellen. (2009). The impact of conditional cash transfer programmes on child nutrition: A review of evidence using a programme theory framework. The Journal of Development Effectiveness. 1. 103-129. 10.1080/19439340902924043.

[33] The stories of cash transfers and impact evaluations in Sub-Saharan Africa, FAO, UNICEF, Oxford University Press, 2016

Is the programme congruent to other social protection programmes related to nutrition of pregnant women and children under the age of 2?
At present, no other social protection programs in Myanmar target pregnant women/lactating mothers and their children. While some pilots targeting these sections are being run by development partners, there is no full-fledged parallel programme running, which the MCCT programme can complement at present.

5.2. Effectiveness

The effectiveness evaluation criteria measured the extent to which the MCCT programme attained its objectives including, how effective is its programme design in improving consumption patterns, improving knowledge and practices and inclusion, and how effective were the field operations and programme delivery mechanisms.

Is the Programme targeting the right group of stakeholders to achieve the Programme's objectives (incl. the most vulnerable ones)?
The MCCT programme is a universal program. It does not mandate the use of any unique identity document, such as, the National Registration Card (NRC) for registration in the program, which is a step towards the inclusion of vulnerable communities and minority populations who may not possess this document. In the areas sampled by us, the programme has ensured that no sections of society- including vulnerable members -are left behind. Interactions with beneficiaries and implementing agents confirmed that no one was being excluded due to economic, social or any other condition in the sampled areas in either Chin or Rakhine. However, in Rakhine- there were cases of people not getting registered due to lack of documents, such as, proof of antenatal check-up for women and immunization for children. ***"There are no cases of exclusion. Even if there is no book, the mid-wife and township officer work together to take them into record."- Auxiliary Midwife, Tedim, Chin State***
To what extent has the selection of eligible pregnant women, mothers and their children under two years complemented the coverage of other social programmes to reach to the worst-off and most vulnerable women? Are there any gaps in relation to coverage of the MCCT Programme (incl. any systematic inclusion and exclusion errors) or any hindering factors for women to enrol the Programme?
At present, no other social protection programs in Myanmar target pregnant women/lactating mothers and their children. While some pilots targeting these sections are being run by development partners, there is no full-fledged parallel programme running, which the MCCT programme can complement at present. No systematic inclusion and exclusion errors were observed with respect the coverage of the program. The programme has reached out to vulnerable sections and minority populations, and no exclusion was reported on account of economic, social or any other condition in the areas sampled.
Community sensitization: How effective was the process of information dissemination in terms of awareness regarding the programme?
The programme has effectively informed the beneficiaries and community members about the program, its entitlements and the process of registration. In Chin, all beneficiaries were aware of the correct criteria of inclusion into the programme while in Rakhine 99 percent of beneficiaries had correct knowledge. Community members such as teachers, elders and husbands of beneficiaries also stated during FGDs that the ward/village administrators and midwives had raised awareness of the programme – both formally (in community meetings) and informally (during inter-personal communication). The dependence on informal methods was observed to be higher in the sampled areas. 40 percent of beneficiaries sampled said that they had been informed of the programme during visits by midwives, whereas 11 percent mentioned that they had been informed by their friends and relatives. The ward/village administrator is to introduce the MCCT programme to the community and engage them in formation of the ward/village social protection committee within a week of the administrator receiving his training. In Chin, 78 percent beneficiaries stated that community meetings are being held, however, only 22 percent stated that they received information about the programme from these sessions. All ward

administrators in Chin stated that they had undertaken this community meeting to discuss the MCCT program. It is likely that while these meetings are held, attendance is low and information regarding MCCT is flowing through other channels, such as, informally by administrators or the midwife or by community members. In Rakhine, 63 percent of beneficiaries stated that they received information of the programme at the community sensitization meeting, while 27 percent of them were informed by midwives during health check-ups.

It stands to reason that gathering of potential beneficiaries on a single day on short notice will lead to low attendance rates and low information levels among beneficiaries, especially in Chin where transportation is expensive and difficult. While the beneficiary survey and FGDs with beneficiaries and community members showed that beneficiaries had correct information on the program's eligibility and benefits (both in Chin and Rakhine) – they are receiving this using informal methods and not through the community meetings. Currently, the Operations Manual does not state any requirement for the implementing staff to re-iterate the main objectives, eligibility criteria and guidelines periodically to beneficiaries.

Posters had been provided to the implementing staff once during the beginning of the programme, however their use was not widespread. It is likely that posters get damaged in a short period of time and need to be replaced. The mechanism of this replacement is not yet in place. The use of technology such as mobile phones for information dissemination is currently not in use.

Operational Processes:

How adequate have the field operational processes been, including training, state and ward and village level community sensitization, beneficiary outreach, enrolment, payments, and the complaints and feedback mechanism? How well are the monitoring and other reporting mechanisms functioning (incl. the process of data entry and data management - MIS)?

How effective have the Programme delivery mechanisms been, with recommendations for any necessary amendments?

Certain field operational processes such as community sensitisation have performed well. The programme has done a good job of communicating the program's tenets to beneficiaries in an informal manner. No significant issues in registration and cash transfers were observed even though a paper-based system is being used, which is prone to errors.

The grievance redress and monitoring systems are however weak with a large section of the beneficiary population being unaware of the formal complaints redress mechanism. Data validation and monitoring too has implementation weaknesses. While some aspects are clearly defined in the operations manual (such as validation of proxies) these are yet to be implemented on the field.

Implementing agents at the State and township levels confirmed receiving training and stated that the quality of training material was good, but very general and insufficient to handle programme specificities. However, the trainings did not reach the ward and village administrators in all townships, particularly Thantlang and Paletwa in Chin and Myaypon, Thandwe and Kyaukphyu in Rakhine.

Registration

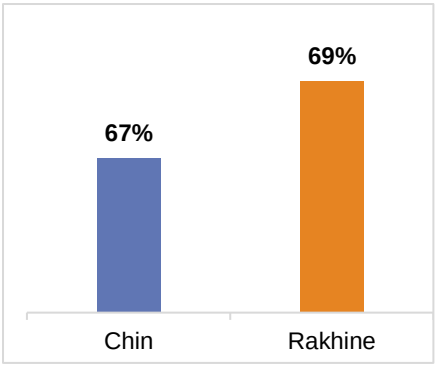
The Ward/Village Administrators and Camp Leader were clear on the process of registration and the overall process was effectively undertaken with the same process being used in all townships in Chin and Rakhine. However, some confusion with respect to document requirement for registration is present. Beneficiaries reported that documents such as MCH booklet, child's birth registration etc. are commonly asked documents even though there is no specific mention of any document requirement for registration in the operations manual. One key point raised by beneficiaries reducing programme effectiveness is the delay in confirmation of pregnancy and registration, leading to them missing out on at-least a couple of months of payment since no retroactive payment process in present.

Cash transfer

The cash flow from the union level to beneficiaries is effective and no leakage of funds at any level was reported. While no cases of beneficiaries not receiving their entitlement was found, the absence of mandated two witnesses during cash disbursal may reduce programme effectiveness and lead to leakages.

In Chin, 33 percent of beneficiary respondents stated that no witnesses were present when cash was disbursed. 31 percent of beneficiaries in Rakhine stated this.

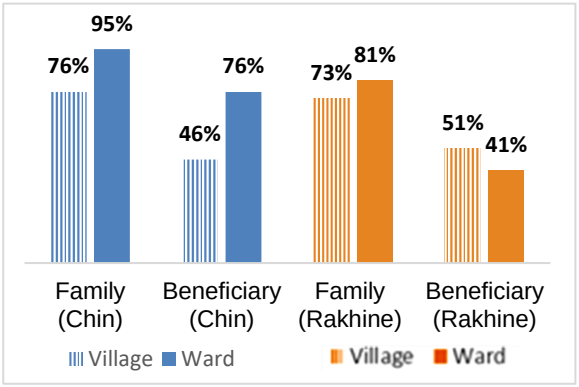
Figure 6. Presence of witnesses during cash disbursement



There is a clear understanding and distribution of the roles and responsibilities of the cash transfer between DSW and GAD at each level. However, for GAD, the cash distribution adds a lot of work pressure, as well as, responsibility to the ward/village administrators who are already busy. GAD officials were of the opinion that using banking system, ATM cards and mobile payments need to be explored in the near future as cash payments are not sustainable in the long run.

In Chin, while 95 percent of families in wards and 76 percent of families in villages owned a mobile phone, ownership of mobile phones by beneficiaries was 76 percent in wards and 46 percent in villages. However, in Rakhine, 81 percent of families in wards and 73 percent in villages had at least one mobile phone in their household, while 51 percent beneficiaries in wards, 41 percent in villages owned a mobile phone themselves. In the IDP camps in Rakhine, the mobile phone ownership stood at 65 percent.

Figure 7. Ownership of mobile phones



World Bank is looking to use multiple payment models in Shan and Ayeyarwady region including mobile payments and the banking system. Save the Children is undertaking a small-scale pilot of the MCCT programme in urban areas for migrant workers. Mobile money will be used to make the cash transfer and tracking of cash withdrawal patterns will be undertaken to develop an understanding of the cash usage. This study will also help in understanding how migration can be incorporated into MCCT's design. Some benefits and challenges of e-payment systems are given below.

Table 6. Benefits and challenges of e-payment systems[34]

Benefits	Challenges
Accountability: Reduced opportunity for diversion of funds	**Illiteracy:** Illiteracy coupled with lack of previous exposure to technology or banking. Some recipients give the PINs away and require help from others to access cash, potentially exposing them to coercion and deception.
Security: Increased personal security of staff and recipients	**Eligibility:** Registering for branchless banking account can require formal documentation/ identification, which many of the poorest do not have and which people affected by a disaster may have lost.
Private Sector Partnerships: Government/ Agencies transfer the risk of storing and moving cash to the service provider and help service providers reach an untapped market	**Glitches of Emergent Systems:** Demand created by cash transfers can cause problems for small-scale agents with limited cash flow. E-payment systems (except smart cards) require reliable network connectivity.
Speed: Recipients access cash transferred via mobile payments more quickly	
Cost Effectiveness: While initial set-up costs are higher, e-payments realise cost efficiencies over time	

Ambiguity in the Operations Manual was found in two cases – (i) when beneficiaries miss payment and (ii) in cases of miscarriage and abortion. Regarding missed payment – while the Chin MCCT manual does not mention any process to be followed, the Rakhine MCCT manual states *"that in case of uncollected payments, the remaining funds should be kept in a secure and dry place until the next visit of the ward/village*

[34] New technologies in cash transfer programming and humanitarian assistance, Overseas Development Institute Humanitarian Practice Network, 2012

administrator/programme officer to the Village Tract or Township GAD Office. For the first time uncollected payment, the funds will be added in the next payment and in case the payment remain uncollected for the 2 consecutive payments, the payment to that beneficiary will be frozen till verification." However, it does not mention how the beneficiary can collect the money in the presence of witnesses at a later date or whether she or her proxy will get money for two instalments (missed and current) together in the next cycle. Regarding miscarriage, during KIIs with midwives, it was found that they are the ones responsible for reporting miscarriage and abortion. After a miscarriage, beneficiaries are paid for two additional months before their exit from the program. This was confirmed by multiple sources, however, the same is not mentioned in the Operations Manual.

Training

Ensuring proper and adequate capacity building and training of implementing agents in a benefit transfer programme is essential. This becomes even more crucial in the absence of MIS systems and technological checks. The MCCT programme follows a cascading model of trainings wherein State Coordinators and Case Managers receive trainings from the national level staff, and they gave trainings to the Ward Administrators. All State Coordinators and township Case Managers confirmed that they had received the training and stated that the quality of training material was good. However, the trainings did not reach the ward and village administrators in all townships, particularly Thantlang and Paletwa in Chin and Myaypon, Thandwe and Kyaukphyu in Rakhine. Midwives stated receiving training from the health department however no specific trainings from DSW regarding the MCCT programme were reported.

> ***I received a training for conducting SBCC sessions and I do not think it is sufficient. Since we are generalized in our role, every aspect needs to improve - Midwife, Sittwe, Rakhine State***

As per the state DSW staff, trainings do happen periodically, however all the trainings were at the state capitals – Hakha and Sittwe. In Chin, the periodicity of these trainings was once a quarter while this is unknown for Rakhine. Trainings centred on the operations guidelines, data entry, report writing, basic book-keeping and case management.

The State Coordinators and Case Managers felt that the trainings were largely general and were insufficient. Further, they felt that there are many forms to be filled by ward/village administrators who may be unable to fill them properly and correctly without adequate and high-quality training. This was echoed by ward/village administrators themselves. Further, the use of technology, such as, video conferencing or using pre-recorded videos was not found.

As part of the training, the operations manual was supposed to be disseminated to all implementing staff. In Chin, from state to the ward/village level, these operations manual were largely found, however in Rakhine, very few functionaries had the manual. The operations manual and all other training material was reported to be in Burmese rather than local languages and dialects, which was found to be a challenge. However, development partners also cautioned that the resource need for translation, quality of translation and consistency of wording should be ensured for translation in local dialects.

Data validation and monitoring

For the MCCT programme data validation and verification process, six steps (apart from Post Distribution Monitoring) have been outlined in the operations guideline. The processes are verification of proxies, verification of geographic coverage, verification of categorical data, verification of incomplete records, verification through ANC information and verification of date ranges. While these processes are mandated in the guideline, actual implementation of these is yet to begin. In the absence of the MIS, undertaking these verifications can improve data quality and dissuade fraudsters.

Monitoring and evaluation frameworks have been developed for both the States, Chin and Rakhine. The frameworks provide information on the activities needed to be monitored and evaluated; responsible agents for monitoring and evaluation activities, timing of monitoring and evaluation activities methods for monitoring and evaluation are carried out (methods); and resource requirement. The monitoring framework focuses on 2 activities – monitoring implementation and monitoring results while the results framework focusses on formative and impact evaluations to guide the programme's decision-making process. An M&E Committee comprising members from the government and DPs, is tasked with the responsibilities to guide the overall monitoring and evaluation of the MMCT Programme.

Monitoring activities are partially being undertaken with 3 PDMs having been completed in Chin and 2 in Rakhine even though the framework mandates this to be undertaken every two months. Case Managers

reports are prepared sporadically and their usage and feeding into the operational guidelines/implementation plan is unclear. Qualitative interviews with pregnant women/mothers, market/price situation monitoring at baseline and secondary review of administrative data are three activities which have not yet been implemented.

PDM is conducted on a selection of 5 percent beneficiaries with a stratified sample taken from all areas of the state and then randomly selecting beneficiaries. This activity provided the implementing staff with crucial and regular information on payment amount and regularity; conduct of SBCC sessions and usage of cash. The findings from the beneficiary survey of this evaluation are in line with the findings of the PDM in both Chin and Rakhine thereby re-enforcing its validity. DSW officials including the Director of SPS appreciated the conduct of the PDMs and its usefulness for regular monitoring of the programme. LIFT, the agency funding the Chin MCCT programme, was also appreciative of the PDM. Development partners too found the PDMs to be useful and some were involved in its sampling and data collection. Some concerns were however raised that the PDMs do not cover the hard to reach and conflict areas and may be presenting rather biased findings.

Field visits by functionaries including the township Case Manager and DSW state officials were reported by officials themselves and the DSW State Office confirmed monitoring reports being received. The format of the two-weekly report (the audience for which includes Government departments at the union level as well as development partners) includes completed tasks, work-in-progress, activities to be undertaken, complaints and findings from the field visit. However, during KIIs with the Case Managers and State Coordinators, they shared that due to high work-load, they are unable to undertake field visits regularly and are not able to visit every village per quarter as per the mandate. Moreover, monitoring does not entail taking any photographs or recordings.

Currently all systems (registration, attendance, complaints, etc.) are paper based with data entry being undertaken at the township level. No MIS systems are currently in place; however, a social protection MIS is currently being developed by DSW in consultation with UNICEF and other development partners. In the absence of the MIS, there are operational limitations to validate the data and build self-check mechanisms to ensure correct and complete data entry.

Usage of cash:

To what extent and how has the cash transfer been used for better consumption of the mother (considering food quality, quantity and diversity)? How has the cash transfer supported mothers and new-born children nutrition and healthcare? Are there any unintended results?

Provision of cash to food insecure households can lead to reduced malnutrition in multiple ways – through increased expenditure on food; increased quality and quantity of diet, frequency of meals, protein and micronutrient intake; improved treatment of disease; and increased expenditure on household health and sanitation[35]. However, provision of cash to households does not ensure its correct usage. Cash transfers while allowing beneficiaries to spend more on better quality or more quantity of food and accessing health services does not necessary mean they will indeed do so. Health visits are also influenced by individual beliefs, attitudes and relationships to other household members.

In Chin and Rakhine, cash has improved access to health services and better nutrition in cases where inadequate dietary intake and food insecurity is due to access issues, i.e. where the goods and services people need and prioritize are available, but they cannot purchase them. Primary evidence shows consumption of better quality of food and increased expenditure on household health. 99 percent of beneficiaries in Chin and 98 percent in Rakhine stated that the MCCT programme had allowed them improved access to food and health services. The midwives and administrators who regularly interact with beneficiaries were of the opinion that while most women are spending the cash on the baby and themselves, there are instances when the family is using the money to cover debt or use it for household expenses especially in cases of extreme poverty – however no such instances were reported in the beneficiary survey. Further, cash is supporting the basic needs and livelihoods of households with malnourished children and compensate caregivers for the time required to participate in knowledge and education awareness sessions.

It was observed, in both Rakhine and Chin, that women are mostly using the money to buy more diverse food for themselves and the child rather than buy more quantity of food. The use of the money to cover healthcare costs, such as medicines, transportation for hospital visit and consultation fees was stated by 36 percent

[35] The impact of cash transfers on nutrition in emergency and transitional contexts: A review of evidence, ODI, 2012

beneficiaries in Chin and 56 percent of beneficiaries in Rakhine. Significant variations was found across townships (*see Figures 8 and 9*).

Figure 8. Use of cash to access healthcare services in Chin

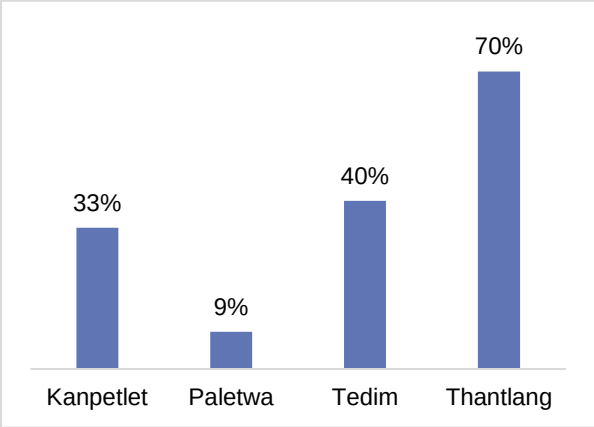
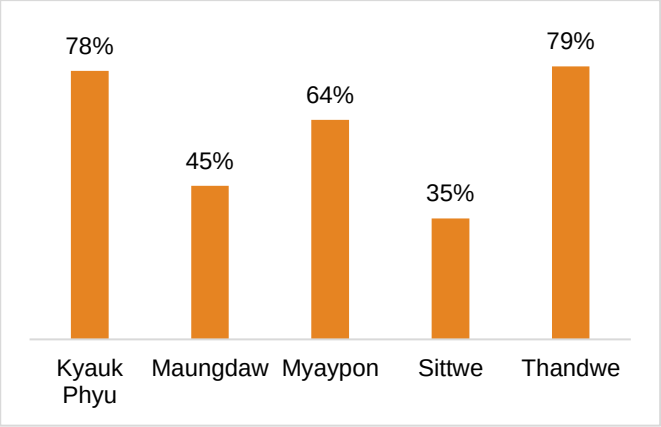


Figure 9. Use of cash to access healthcare services in Rakhine



In Rakhine, high expenditure of the cash transfer money on baby formula was found. This was surprising since breastfeeding percentages are also very high. Officials from DoPH were of the opinion that use of baby formula is because of a lack of knowledge on its use and need. In addition, there is a lack of enforcement of proper inspection and health code for baby formula and normal milk powder is sold in the name of baby formula. UNICEF's health and nutrition experts stated that it is likely that women do not understand the benefits of breastfeeding and moreover do not have the time and therefore resort to using baby formula. It was also shared that there is a lot of advertisement and promotion for using baby formula by the industry, which may be causing this high use.

This analysis is based on beneficiary response and perception of field level beneficiaries and will need to be analysed further during the impact evaluation of the program.

The programme did not have any unintended negative consequences with respect to cash usage, but some women expressed concerns over their security during cash disbursement (More details in the section under '*Equity, and gender equality and human rights'*)

How effective have the awareness-raising SBCC sessions been delivered by the local auxiliary midwife to mother support groups from both the implementers and women's perspective?

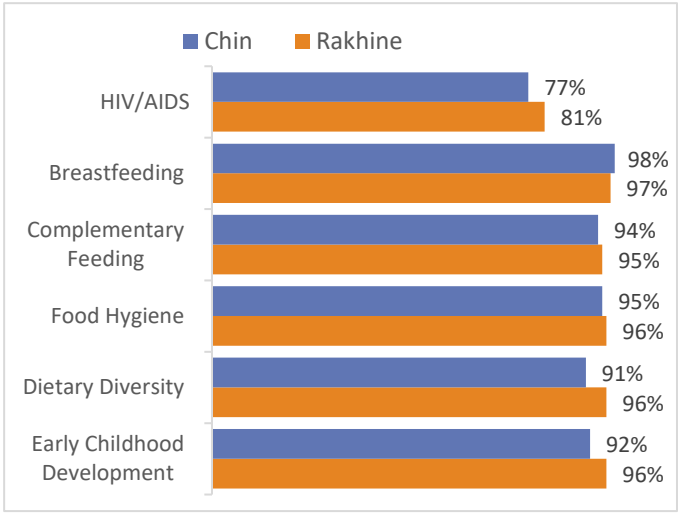
A key component of the MCCT programme are the monthly nutrition and SBCC awareness sessions for beneficiaries organized by the midwife and/or auxiliary midwife. The midwife is responsible for organising the pregnant and lactating mothers into a "Mothers Support Group". The mothers themselves at the first meeting, ideally a woman who has had a child before, elect a leader among the mothers. Seven topics have been identified for these sessions and include birth spacing, dietary diversity and nutrition, breastfeeding, hygiene practices such as hand washing, growth monitoring, etc. The state health departments from Chin and Rakhine State noted that while the SBCC sessions complement the cash transfers, they are already a mandate of the health department and are not specific to the MCCT program. The Communication for Development team at UNICEF felt that while these sessions are useful and a good way to increase knowledge, however, women are reluctant to come to these sessions due to other priorities and thereby their attendance is often low.

Attendance data from Chin revealed that between December 2017 and September 2019, the average number of women attending each SBCC session was 11. Further analysis of township wise data showed that the highest and lowest average numbers of women per session were in Tedim (18 women) and Falam (9 women) while the remaining townships had an attendance between 10 and 13.

During the SBCC sessions, 70 percent of respondents in Chin stated that they were told about the vaccination campaigns; 55 percent were told about the local sanitation and hygiene programs and 44 percent were informed of the WASH programs. Information on early childhood and day-care programs was imparted to 26 percent and 25 percent of respondents respectively.

With regard to the topics covered during the SBCC sessions, most beneficiaries reported that breastfeeding as a topic was covered during the SBCC sessions (*see Figure 10*). All topics were well-covered in Kanpetlet and Paletwa. SBCC on HIV/AIDS was lower in all townships, however it was quite significant in Kanpetlet and Paletwa. Tedim's coverage on dietary diversity and food hygiene was much lower than the other townships. Almost all beneficiaries stated that the SBCC sessions were useful in gaining knowledge about health and nutrition. It must be noted that LIFT is providing financial incentive to midwives for conducting the SBCC sessions in Chin.

Figure 8. Topics covered during SBCC sessions as reported by beneficiaries'



Rakhine saw surprisingly positive results even though regular MCCT is yet to start in most areas and cash was being distributed through mobile teams till recently. Over 95 percent of beneficiaries said that breastfeeding, complementary feeding, dietary diversity, food hygiene and early childhood development were topics covered in the SBCC sessions. This knowledge sharing may be a part of efforts made by NGOs or information disseminated by the mobile teams rather than as a result of the mother's support group sessions as these sessions have only recently started and are not taking place in the whole of Rakhine.

The targeting of the SBCC sessions only towards beneficiaries and not towards husbands and family members was a point raised by both beneficiaries and community members during FGDs. The beneficiaries in both Chin and Rakhine stated that their family members too played an important role in raising a child and changing perceptions needed their active participation in SBCC activities as well. Midwives too corroborated this.

> ***In our community, in a family where the woman lives with her mother-in-law and husband, the beneficiary does not have decisional power and she cannot spend money for either herself or the child. I think that the effectiveness is around 50 percent. Father Support Groups for sharing fund support activities and including family members, who have decisional power at household-level, in the SBCC sessions will be better for the effectiveness of the programme - Midwife in Tedim, Chin***

Apart from this inter-personal communication, there are posters, flip-charts and pamphlets, which have been developed by the Ministry of Health and Sport (MOHS). Midwives are given annual plans for covering each topic during these awareness sessions and are also provided tools such as guidebooks. Ministry of Health shared that these materials were developed by the Health Literacy Promotion Unit and were rebranded for MCCT. 96 percent of respondents in Chin stated that practical demonstrations and tools were used during the sessions to help them remember and apply the concepts in their daily routine and 95 percent said that they did apply the concepts.

> ***Practical actions (for example: to get to know more about 3 categories of nutrition, we held a cooking competition) - Midwife, Thantlang, Chin State***

There was a divergence in the responses of the midwives when asked if they used any practical tools for demonstrating the concepts taught during the SBCC sessions. While some stated that they use pictures and other tools to illustrate concepts of health and hygiene, others mentioned that no such methods were used. Development partners were of the view that the current IEC material is very comprehensive, however also complicated – providing too many messages. Further, it was noted that while a lot of material has been produced, its distribution is not a streamlined process.

The Health Literacy Promotion Unit, with National Nutrition Centre providing support, is currently developing a national level SBCC strategy. A technical working group has been formed for this and DSW is also a part of it along with donors and INGOs. The strategy will include the messages to be disseminated, ways of communication these messages along with the tools and training material.

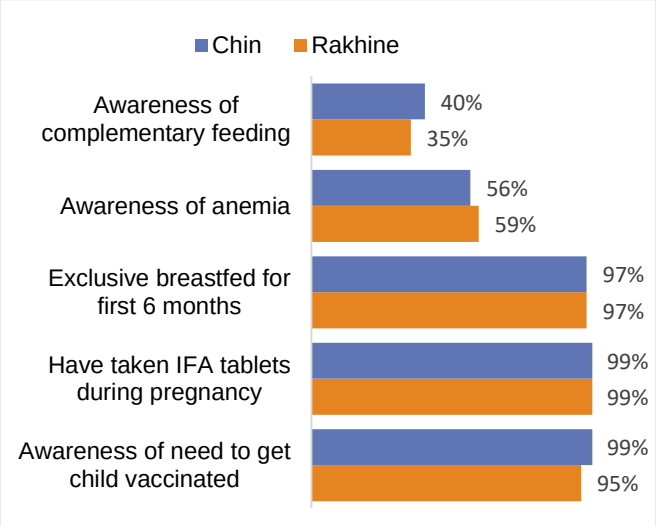
Knowledge, Attitudes and Practices

The UNICEF's Extended Model of Care identifies certain 'care giving behaviours'- care for pregnant/lactating women, feeding/breastfeeding, health and hygiene seeking practices – as crucial for the growth, development and survival of children. Globally, there is growing concurrence on how strengthened knowledge systems of caregivers (mothers in particular) play a crucial role in ensuring improved nutrition and ECD outcomes for children. A study in the Ghanaian context revealed that an increase in maternal childcare knowledge may contribute significantly to child's nutritional status in Ghana if there is concurrent improvement in socioeconomic circumstances of women living in deprived rural communities.[36] In line with this, the SBCC sessions of the MCCT Programme are intended to augment the existing knowledge and practices of the pregnant women and mothers, in the areas of health, nutrition and hygiene.

Overall, there have been noteworthy enhancements in the knowledge, attitudes and practices of beneficiaries- around breastfeeding, vaccination and consumption of Iron and Folic Acid (IFA) tablets. Implementing agents too reported improvements in the knowledge of the beneficiaries, highlighting the effectiveness of the awareness sessions.

In both, Chin and Rakhine, 99 percent of the beneficiaries surveyed claimed to have taken IFA tablets during their pregnancy. However, only 17 percent in Chin and 20 percent in Rakhine could correctly state that correctly that IFA tablets need to be consumed for 180 days during pregnancy. On being asked whether they knew about anaemia, only 56 percent in Chin and 59 percent in Rakhine answered in the affirmative. There were also significant knowledge gaps regarding preventive measures for anaemia, and the number of days for which IFA tablets should be consumed. Greater emphasis is required on explaining the condition, its symptoms and the ways to prevent it, in addition to IFA supplementation.

Figure 9. Knowledge and practice levels on some key indicators in Chin and Rakhine



There was near-universal concurrence among the beneficiaries surveyed that breast milk is the first food a baby should receive. However, the practice of exclusive breastfeeding for the first six months seems limited given the fact that only 31 percent in Chin and 33 percent in Rakhine could correctly state that complementary feeding needs to be initiated at 6 months. Almost all beneficiaries in Chin (99 percent) and Rakhine (98 percent) were aware of the need to get their child vaccinated.

The transition from exclusive breastfeeding to family foods, referred to as complementary feeding, typically covers the period from 6 to 24 months of age. The period of introducing foods in addition to breastfeeding is a very vulnerable transition period. It is the time when malnutrition starts in many infants, contributing significantly to the high prevalence of malnutrition in children under five years of age world-wide.[37] In this context, it is crucial that the topic of complementary foods be reiterated during SBCC sessions.

Development Partner support:

How effective is the support (technical and financial) provided by development partners in the design, implementation and monitoring of the MCCT Programme?

The MCCT programme is currently on-going in four states (Chin, Rakhine, Kayin and Kayah) and one region (Naga region) with two more to begin the programme in 2020 (Shan State and Ayeyarwady Region). Each state and region has slightly different implementing mechanisms and different kinds of support being provided by the development partners (DPs). In Chin State, LIFT is providing financial support for a period of 2 years, which is ending in December 2019. This support includes providing allowances to midwives for conducting SBCC sessions, unlike in Rakhine where there are no such allowances. It is also providing financial support

[36] Saaka M., Relationship between Mothers' Nutritional Knowledge in Childcare Practices and the Growth of Children Living in Impoverished Rural Communities, NCBI, 2014

[37] https://www.who.int/nutrition/topics/complementary_feeding/en/

for Kayin and Kayah while World Bank is providing a loan for Shan and Ayeyarwady. UNICEF provided technical assistance during programme design and is now developing the programme MIS. Save the Children has been undertaking small pilot cash transfer programs to inform DSW on the learnings and best practices from these and undertakes the Post Distribution Monitoring (PDM). World Food Programme and International Rescue Committee are providing technical assistance on registration mechanism, monitoring, grievance redress and designing the PDM.

For coordination between the development partners at the national level, a Sub-Sector Coordination Group having development partners and the government is in place. This group is mandated to meet quarterly, however, it currently meets twice a year. DSW is the chair of this committee and UNICEF facilitates meetings. For Rakhine, there is a Technical Reference Group of development partners comprising World Bank, Save the Children, IRC, WFP and UNICEF. No such group is present for Chin.

As a part of this evaluation, multiple consultations were held with all development partners. They were present in all information dissemination workshops and each brought unique insights for the program. All development partners have played a key role in design and implementation of the MCCT program. However, DSW must be vary that having different development partners in different states with different implementation modality (such as mode of payment and conditionality) may prove to be challenging to consolidate in the future given limited decentralization in Myanmar.

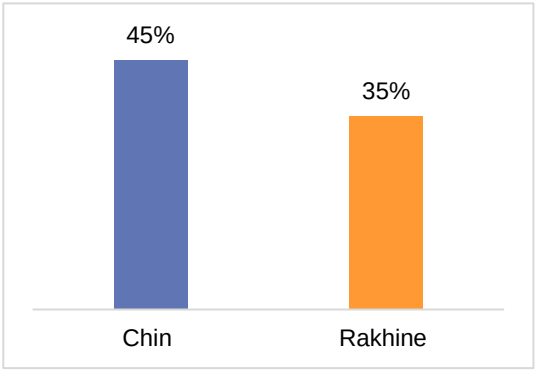
Development partners have made a significant contribution in the design, implementation and monitoring of the MCCT programme. Moreover, the DPs have ensured that the capacities of the government are also built for sustained programme effectiveness. One aspect, which needs careful consideration, is that different partners have different approaches to the MCCT programme, which may lead to complexities in managing the National MCCT programme. This does not mean that contextualization should not be present, however, uniformity in basic programme design such as conditions, enrolment requirements, frequency of SBCC sessions, etc. needs to be ensured.

Grievance redress:

Are there any grievance redressal mechanisms available and if so, are they effective?

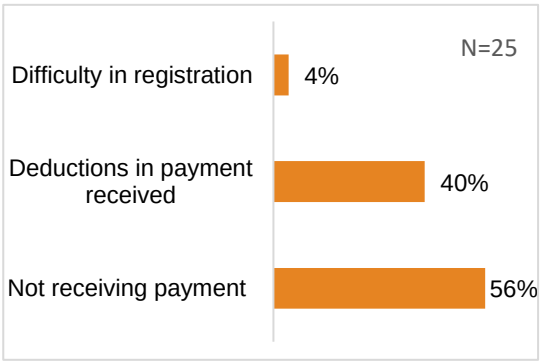
A grievance redress mechanism for the MCCT programme is provided as a part of the operations manual. A focal person to redress complaints is elected in each ward, village and camp who is supposed to receive in-person complaints duly filled in the complaint/feedback management form. However, awareness of formal complaint mechanisms such as the complaint focal person and hotline was observed to be limited. Only 45 percent beneficiaries in Chin and 35 percent in Rakhine were aware of the Complaints Focal Person. This reduces the effectiveness of the grievance redress system as beneficiaries are mostly presenting their complaints to the ward/village administrator, who is the implementing agent himself and is not a neutral party. Further, these complaints are not officially written in a form but rather are orally and informally resolved. No documentation on complaints from Chin was found.

Figure 10. Beneficiary awareness of Complaints Focal Person in Chin and Rakhine



A DSW hotline number is also available for beneficiaries to make complaints in Rakhine. Information regarding this helpline was not found in many prominent places nor did beneficiaries have significant knowledge on its use. Beneficiaries can also send written complaints using a self-reporting form or feedback to DSW.

Figure 11. Nature of complaints in Rakhine



As per the data received from DSW, since 2018, only 25 complaints were received from Rakhine. These complaints came via the helpline (56 percent), by letters (20 percent), remaining were lodged by phone directly to union level staff. 56 percent (14 complaints) were regarding not receiving payment and 40 percent (10 complaints) were regarding deductions being made in payment received and 1 complaint

was regarding not being able to register (*see Figure 13*). No documentation on the resolution of the complaints were available, however, DSW officials did say that they were resolved in a timely manner. In the cases related to deduction of payment, it was learnt that the village tract administrator had ostensibly deducted payments to cover their transportation costs.

As per the operations guideline, state DSW is supposed to constitute a complaints management committee to review and respond to complaints. However, no clear hierarchy is available stating which type of complaints are to be resolved by which level nor have escalation mechanisms with timelines been given. There is also no mechanism available by which anonymous complaints can be made by beneficiaries.

5.3. Efficiency

The section on efficiency will help in understanding the MCCT program's service delivery achievements and gaps, financial management systems and implementation efficiency in terms of monitoring, reporting, timeliness, opportunity costs, dissemination of lessons, convergence and cost efficiency.

How well has the delivery process been managed, considering the time and resources at each stage of implementation and coordination among DSW at the union, state, district, township and village levels, in partnership with GAD and DoPH?

Certain processes such as community sensitisation and registration are taking place fairly smoothly given the current paper-based system and resources available. Cash disbursement and SBCC sessions have been largely streamlined over time in Chin (except Paletwa) but need to be regularized in Rakhine where both cash payment and SBCC are sporadic. Grievance redress and monitoring are two processes, which need to follow the guidelines more strictly and improve efficiency.

Programme management at the Union level remains stretched due to various demands and limitation of staffing and budget. Similarly, at the State/Region and Township levels managerial, financial and technical capacity to manage service delivery are also limited.

Convergence between DSW, DoPH and GAD has been observed at the higher levels in the form of committees and clear demarcation of roles and responsibilities. However, the field level convergence mechanisms are largely informal and may be inefficient with programme expansion.

Service provision and infrastructure

The MCCT programme aims to address health, nutrition and hygiene practices of pregnant women and mothers to ensure improved nutritional outcomes. Demand side programmes, such as, MCCT however need to be cognizant of supply side considerations to ensure efficient programme design and implementation. According to the Chin Health Report, 2018 published by MoHS, the ratio of health workers (doctor, nurse, midwife) is 0.99 per 1,000 people in Chin. Further, out of the existing rural health centers and sub-rural health centers in the State, only 67 out of 412 meet the MoHS standard design. In Rakhine, there are many challenges to the provision of health care services including geographical difficulties and also different perception of diverse communities.

As of September 2017, MoHS in cooperation with WHO and other local NGO/ INGO was providing primary health care services in 208 sites in 12 Townships through 40 mobile health teams.[38] For over 3.3 million population of Rakhine State, MOHS is providing health care services by (1) 500-bedded hospital, (5) 100-bedded hospitals, (52) 50-bedded hospitals, (6) 25-bedded hospitals, (46) 16-bedded hospitals, (121) Rural Health Centres and (558) sub-centres.[39] Given these supply side challenges, it was the view of DSW at the union level, as well as, development partners that unconditional cash transfer is currently the appropriate design in Chin and Rakhine to ensure efficient implementation.

The other aspect of service delivery crucial to a cash transfer programme is the country's mobile and banking infrastructure. In Myanmar, till a decade ago, the country had virtually no formal banking sector. However, there is a rapid expansion of private banking, as well as, mobile money providers. In Myanmar around 2013,

[38] Report on Public Health Emergency Service in Rakhine State, September 2017

[39] *Ibid.*

mobile penetration rate was 12 percent, but the sector went through exponential growth and in 2018 reached 105 percent mobile phone penetration[40] according to Realizing Digital Myanmar Report (Telenor). Mobile devices are becoming integral parts of the communication methods for most of the rural and urban population[41]. This provides an opportunity for the evolution of cash transfer programs in Myanmar, which DSW is looking to explore.

Human resource

Limited human resource is a key challenge for DSW cited by all implementing agents and development partners. Currently DSW does not have any ward/village level functionaries and only have case managers at the township level. Frontline workers of the health department – midwives are imparting the SBCC sessions while GAD's frontline workers – ward/village administrators registering beneficiaries and distributing cash. For other functions, community members are mobilized in the form of a complaint focal person and mother's support group leader. The Director General of Director of Social Welfare, Dr. San San Aye emphasized on the need for cooperation with GAD and MoPH as they have ground level functionaries who are close to the public.

Township case managers expressed the need for more staff due to very heavy workloads and stated that they are often unable to focus on cases of child protection due to constant MCCT work. This was corroborated by child protection experts of development agencies who said that in 2014, DSW started a programme on child protection and township case managers have a mandate to investigate and resolve cases on child abuse, trafficking etc. However, as a result of the MCCT, there are now some case managers who focus only on case management and others who only focus on MCCT.

As a part of the expansion of the MCCT program, volunteers are being recruited and trained as frontline DSW representatives in Shan and Ayeyarwady. The union level of DSW also shared that recruiting volunteers is not a new idea and has been done before and it has been found that the training cost for volunteers is very high. Moreover, as no incentives will be provided, ways to incentivize volunteerism has to be explored such as an easier path to becoming a paid worker after serving as a volunteer. The health department has been using volunteers in several schemes such as malaria control and can share lessons learnt and best practices on the subject. Another point raised was regarding the quality of staff hired and it was shared that specific guidelines with minimum educational requirement and experience should be developed for hiring of DSW staff.

How well has the financial management system been established, including reporting reconciliation?

Financial management in Myanmar is in its nascent stage and currently only transfer costs are calculated program-wise while implementation costs are mostly not channelled through budget lines that are dedicated to the MCCT program.

It was positive to note that record keeping of cash payments in beneficiary cards is almost universal.

How well are the monitoring and other reporting mechanisms functioning (incl. the process of data entry and data management - MIS)?

Monitoring activities are partially being undertaken with 3 PDMs having been completed in Chin and 2 in Rakhine even though the MCCT M&E framework mandates this to be undertaken every two months.

Most implementing agents interviewed were aware of their responsibilities with regard to programme monitoring, but few confirmed actually performing them at the required frequencies. Further, lack of staff is a common complaint attached to programme monitoring.

Currently all systems (registration, attendance, complaints, etc.) are paper based with data entry being undertaken at the township level. No MIS systems are currently in place- but is in the process of being developed in consultation with UNICEF and other DPs.

[40] Mobile Phone Penetration refers to the number of SIM cards or mobile phone number in a certain country, it does not refer to the number of mobile phone devices. This information is represented by the mobile phone penetration rate which shows the number of SIM cards used in a given country.

[41] Rajan Acharya for Myanmar Business Today, 23 April 2019

How cost-efficient is the MCCT Programme implementation compared to other modalities and mechanisms? What potential is there for efficiency savings at all stages?

Since measurement of outcomes and impacts is beyond the scope of this evaluation, a cost effectiveness analysis is not possible. Further, given the limitations of availability of data on costs, including a lack of information on government staff costs, overhead costs and contribution by development partners, a cost efficiency analysis is also not possible.

Cost effectiveness

Cost-effectiveness analysis measures the cost of achieving intended programme outcomes and impacts, such as improved food consumption or dietary diversity, etc., and can compare the costs of alternative ways of producing the same or similar benefits. Since measurement of outcomes and impacts is beyond the scope of this evaluation, a cost effectiveness analysis is not possible. Further, given the limitations of availability of data on costs, including a lack of information on government staff costs, overhead costs and contribution by development partners, a cost efficiency analysis is also not possible.

Global evidence however shows that cost-efficiency improves as cash transfer programmes evolve from small pilots to expand programme coverage. The total cost-transfer ratio for Mexico's PROGRESA fell sharply from 2.34 in year 1 to 1.05 in year 4, mainly due to the rapid increase in transfer volumes. The ex-ante TCTR for the Nigeria Child Development Grant declined from 2.04 in year 2 (the first year of transfers) to 1.49 in year 5. Kenya's Hunger Safety Net Programme followed a similar pattern. Likewise, administrative costs during the start-up of *Progresa/Oportunidades* in Mexico in 1997-2000 showed a similar evolution, set-up and roll-out costs gradually gave way to operational costs as the programme grew, falling from 71 percent to 15 percent of administrative costs between year 1 and 4.

Low cost-efficiency does not necessarily mean low cost-effectiveness, and vice versa.[42] A higher administrative cost may be necessary to improve social outcomes. It is also important to note that in order to effectively ascertain value for money for cash transfer programmes, comparing cost-efficiency against international benchmarks is critical, however, great care must be exercised to interpret these benchmarks in the light of problems of comparability between different methods of measuring cost; contexts; programme objectives and designs; size of the programmes; programme cycle; etc.

Whether cash transfers represent value for money (VFM) depends not only on the programme's effectiveness but also on how the costs compare with alternative uses of public funds, including donor contributions. While evidence may be available on potential benefits, data insufficiencies and conceptual challenges make comparisons difficult.

DFID's guidance on measuring and maximising value for money in social transfers provides the 3e's conceptual framework to capture VFM using a balanced approach. (*see Box 3*).

[42] The administrative costs may be high (low cost efficiency) but impacts may be much higher leading to high cost effectiveness. Similarly, there may be high cost efficiency but impacts may be low (low cost effectiveness)

Box 3. The 3e's framework[43]

The value for money can best be understood in terms of the results chain, which shows how money is converted into inputs, which in turn generate activities (or 'processes'), produce outputs (the specific, direct deliverables of a programme) and finally result in outcomes (changes in social or economic well-being) and impacts (related to the longer-term, higher level goals of programmes). VfM therefore depends critically on the validity of the causality embedded in the 'logic' of the results chain (or theory of change), which in turns depends on the strength of the evidence and the reasonableness of the assumptions upon which it is built, along with the degree to which the results chain is subject to exogenous risks.

VfM is thus ultimately about the relationship between the money that enters the chain (the costs) and the resulting outcomes and impact. However, VfM can be assessed at different points in the chain. There are basically three levels of VfM analysis, corresponding to the '3Es' of economy, efficiency and effectiveness:

- **Economy** relates to the price at which inputs are purchased (consultants in design phase, targeting costs, management information systems, payment mechanisms, independent evaluations). Economy in procurement is important for in-kind transfer programmes such as food distribution and school feeding, and for public works programmes, but is still significant in 'pure' cash transfer programmes, for example in purchasing a management information system (MIS), a delivery service or an impact evaluation.
- **Efficiency** relates to how well inputs are converted to the output of interest, which is transfers delivered to beneficiaries. Cost-efficiency analysis spans both economy and efficiency, focusing on the relationship between the costs of a social transfer programme and the value of the transfers delivered to beneficiaries.
- **Effectiveness** relates to how well outputs are converted to outcomes and impacts (e.g. reduction in poverty gap and inequality, improved nutrition, reduction in school drop-out, increased use of health services, asset accumulation by the poor, increased smallholder productivity, social cohesion). Cost-effectiveness analysis measures the cost of achieving intended programme outcomes and impacts and can compare the costs of alternative ways of producing the same or similar benefits.

How timely was the programme in relation to needs of different social groups, and comparatively with other cash transfer programmes? How could timeliness have been improved?

The programme was observed to be timely in informing beneficiaries of the cash disbursement date a week in advance. However, a major gap in timely programme delivery emerges in the frequency of cash disbursement across many townships in Rakhine, wherein the cash transfers are taking place at an interval of 6 months, rather than 3 months. Evidence shows that irregular and infrequent payments can inhibit the ability of households to be able to smooth their consumption (e.g. covering health care costs or being consistent in their ability to consume a varied diet), with associated detrimental effects on child health indicators[44],

Other gaps in timeliness have been observed in the delivery of beneficiary registration cards, disbursement of cash at the pay points and grievance redress in areas of poor internet and phone connectivity. Timeliness can be improved by streamlining and regularising payments in Rakhine. Ensuring more human resources to disburse funds swiftly and manage the delivery of key programme documents is also important.

How efficient was access to the programme in terms of potential private / opportunity costs from the beneficiary perspective, and considering different social groups?

Efficiency in access to the programme – in terms of time and cost – has been observed. Table 7 ahead provides a process-wise summary of efficiency gains and gaps in the implementation process.

[43] DFID Guidance on measuring and maximising value for money in social transfer programmes, 2nd edition, April 2013

[44] Bastagli, F.; Hagen-Zanker, J.; Harman, L.; Sturge, G.; Barca, V.;Schmidt, T.; Pellerano, L. Cash transfers: what does the evidence say? a rigorous review of the impacts of cash transfers and the role of design and implementation features. Overseas Development Institute, London (2016), 40p

Table 7. Achievements and gaps in the implementation process

Process	Achievements	Gaps
Registration	▪ **The registration process is fair, smooth and efficient.** ▪ The registration points are **conveniently located for beneficiaries**. ▪ 79 percent of beneficiaries surveyed in Chin and 88 percent in Rakhine stated that they had to spend less than half an hour to reach the registration point. It stands to reason therefore that the beneficiaries do not have to spend much time or cost to enrol in the programme. ▪ **Beneficiaries are able to register in one attempt.** ▪ 92 percent of beneficiaries surveyed in Chin and 91 percent in Rakhine confirmed that only one attempt was needed for registration. ▪ **Maintaining records of registration in the registration form book is near universal.**	▪ **Beneficiary cards are not received by beneficiaries in a timely manner.** On average it takes between 2-3 months to receive this document. In Rakhine, 40 percent of the beneficiaries surveyed stated that it took more than 3 months to receive this card. ▪ **The physical space at the registration points is often inadequate** for the number of mothers and children waiting, leading to over-crowding and longer waiting time. ▪ **Many implementing staff wanted that forms required for registration be streamlined/combined.** ▪ **At present, there are no retroactive payments in the MCCT programme.** If there is a delay in mothers in getting to know about their pregnancy and registering, they miss out on some month(s) of payment.
Cash Disbursement	▪ **Generally, the implementing agents inform the beneficiaries of the cash disbursement date a week in advance** (as confirmed by 61 percent of beneficiaries surveyed in Chin and 74 percent in Rakhine). ▪ Guidelines for cash transfer programming mandate **locating the pay point at a reasonable distance from the beneficiaries' community**.[45] In line with this, there is **high level of operating efficiency in terms of time and cost taken to reach pay point** under the MCCT programme. In Chin, only 4 percent of the beneficiaries surveyed stated that they had to spend money to reach the disbursement point. (In the range of 500-1000 MMK). The proportion of such beneficiaries is higher in Rakhine (42 percent). These beneficiaries stated that they spent money in the range of 1000-2000 MMK to reach the pay point. ▪ **Record keeping in beneficiary cards is almost universal.**	▪ Across many townships in Rakhine, **the cash transfers are taking place at an interval of 6 months, rather than 3 months.** ▪ **The average waiting time at the payment point is not fixed.** Close to half of the beneficiaries in both States (49 percent of beneficiaries in Chin and 46 percent in Rakhine) stated that the waiting time at the pay point often stretches to over an hour. ▪ Difficult travelling conditions and inclement weather conditions **lead to late distribution of cash.**

[45] Guidelines for Cash Transfer Programming, International Red Cross and Red Crescent Movement, 2007

Process	Achievements	Gaps
SBCC Sessions	▪ Implementing staff at the Ward/Village sensitize the beneficiaries about the SBCC sessions and invite them to these sessions in a **timely, open and efficient manner.**	▪ Many townships reported that the SBCC sessions **are not conducted by Midwives on a monthly basis** (as mandated in the Operations Manual). ▪ 43 percent of beneficiaries surveyed in Rakhine and 39 percent in Chin stated **that the sessions are more than 1.5 hours long.** This may be a hindrance to the women attending these sessions due to the duration of the sessions. ▪ Many beneficiaries are unable to hear/comprehend the concepts **due to the sessions getting very crowded in some townships.** Having smaller groups for these sessions, and using a microphone was suggested.
Grievance Redress	▪ It is **more efficient to resolve complaints at the point of service delivery**, where information and transaction costs are lowest.[46] Under the MCCT Program, **grievances are mostly resolved at the ward/village level** and are seldom sent for resolution to the township or state levels. ▪ **Of the grievances that are resolved formally, the majority of them were solved within 2 weeks.** In Chin, 80 percent of the complaints resolved were done so in less than 2 weeks. In Rakhine, this figure is 42 percent.	▪ Certain areas with poor internet and phone connectivity face delays in complaint resolution. A case manager in Chin stated that *"Delays take place because the phone signal is bad. In some villages phone signal is so bad that they cannot report complaints to us quickly."* ▪ In Rakhine, out of the 7 complaints registered most of the complaints (4) registered formally have not been resolved as yet. ▪ The uptake of the formal grievance resolution system is very low.
Programme Monitoring	▪ A cash programme should be monitored **to ensure that it remains relevant** and **to check whether it is being implemented as planned.** It is particularly important where there are repeated cash transfers over a period of months (or years).[47] ▪ Most implementing staff in the MCCT programme are **aware of their responsibilities with regard to programme monitoring.**	▪ **Many implementing staff have to use their own funds for various activities of programme monitoring**- including transportation and maintaining photocopies of health records. ▪ **Lack of staff is a common complaint attached to programme monitoring.**
Training	▪ **Recurrent trainings** are important components of successful programme implementation. Programme implementers should understand the program's overall aim, the criteria and rationale for selection (if appropriate), and the process for receiving the transfer. [48]	▪ Of the implementing staff who received training, many of them mentioned that they had been **trained only at the beginning of the programme- and had not received trainings ever since.** ▪ In line with this, many implementing staff requested for **more frequent 'refresher trainings.**

[46] Grievance mechanisms for social protection programmes: stumbling blocks and best practice, International Policy Centre for Economic Growth, April 2016
[47] Guidelines for Cash Transfer Programming, International Red Cross and Red Crescent Movement, 2007
[48] The Cash Transfer Implementation Guide, Mercy Corps, 2017

Is there an efficient mechanism for dissemination of lessons-learnt and best practices?
At present, the PDM findings are disseminated to a large number of stakeholders and this is useful in programme monitoring and understanding, on an on-going basis, what is working and what is not. However, best practices and lessons learnt are not yet being prepared and disseminated from those PDM findings. Given that different states have varying design features, implementing models and support from different implementing partners, a platform which brings together the best practices and lessons learnt is required. **Convergence** As discussed above, convergence plays a central role in this programme – between DSW, DoPH and GAD at all levels (union, state and ward/village). At higher levels convergence was stated by all three departments such as SBCC material developed by DoPH being used for the MCCT and each department having clearly demarcated roles and responsibilities. At the ward/village level too, especially in Chin, administrators and midwives stated being in close contact to ensure proper implementation of programme activities including registrations, payments and beneficiary exit. There is however a scope for improvement convergence as well. For example, currently the payment day (conducted by the health department) do not take place on the same day thereby reducing programme efficiency as beneficiaries have to spend time, effort and money twice to complete MCCT activities and also its effectiveness through reduced attendance at SBCC sessions. Another aspect of convergence which monitoring and evaluation experts spoke about was convergence between the programme implementation teams in different states. Given the fact that different states have different design features, implementing models along with support from different implementing partners, a platform, which brings together the best practices and lessons learnt will be required. Also, as this is a government program, it will be important to have an integrated programme for ease of implementation and monitoring.
Is the programme congruent to other social protection programmes related to nutrition of pregnant women and children under the age of 2?
At present, no other social protection programs in Myanmar target pregnant women/lactating mothers and their children. While some pilots targeting these sections are being run by development partners, there is no full-fledged parallel programme running, which the MCCT programme can complement at present.
How does this programme compare in terms of cost to similar programmes being run in the region?
Given the limitation of availability of data cost for the MCCT, as well as, costs of other programmes, this has not been possible.

5.4. Sustainability

The sustainability section assess whether the benefits of the MCCT programme are likely to continue after completing the transfer value, how the program's existence can be continued in the long run, how the programme can be scaled up and what are the lessons for future.

Capacity gaps and bottlenecks: What aspects can be further strengthened to inform future replication of the MCCT Programme at the national level given the current capacities at the national and sub-national levels?
Limited human resource is a challenge within the MCCT program, with many implementing agents not being able to discharge their duties efficiently and effectively due to heavy workloads. Adequacy in human resources is an aspect that requires strengthening. Additionally, trainings for elected functionaries such as complaint focal person and mothers support group leader is an area that also needs to be strengthened. At present, there is no trainings available for them. These are key gaps that can limit programme sustainability. Another aspect that needs to be strengthened is the current system of paper-based system of monitoring data and recording payments. As the programme grows, the data to be managed will inevitably grow as well. Consequently, transition to technology driven platforms is imperative. Further, as the project grows and ages, considerations such as linking the cash transfer amount to inflation and having a process of updating SBCC sessions with changing contexts and practices will need to be included to ensure sustainability and impact.

To what extent can the major capacity gaps and bottlenecks at national and sub-national levels be overcome during the life-cycle of this project?
The key gaps and bottlenecks for the sustainability of the MCCT Programme are human resource constraints and lack of use of technology for payments and monitoring. In the absence of technological solutions, human resource numbers and capacities need to be enhanced. Currently, DSW does not have ward/village level functionaries and has to rely on DoPH and GAD for last-mile delivery, which may not be sustainable in the long-run. Further, capacities of elected functionaries such as complaint focal person and mothers support group leader are not being honed. There are no trainings or documents available for them to use for carrying out their duties. These are key gaps that can limit programme sustainability To mitigate human resource constraints, volunteers are being recruited and trained as frontline DSW representatives in Shan and Ayeyarwady. Greater community involvement in programme delivery at the field level is being called upon by DSW which should help address inadequacies in ward/village staff. Currently registrations and cash payments are being done using paper-based forms. Data entry is manually undertaken at the township levels and this is prone to errors and also has limited functionality for detecting discrepancies. Further, as per the current design, there is no necessity to submit a unique id for registration. As the programme grows, methods need to be in place to ensure that fake registrations, duplicate registrations and payments and erroneous payments are not commonly happening – without a unique code to identify beneficiaries and a MIS system, this is challenging. Further, an MIS is currently being developed by DSW in consultation with UNICEF and other development partners, which should largely help overcome the challenges in tracking payments and maintaining large data bases. In addition, with the rapid expansion of private banking and mobile money providers, the prospects of integrating technology in cash disbursement become more promising. Further, mobile based cash transfers are being undertaken by World Bank and Save the Children which can provide a useful blueprint to transition to technology based cash payments.
To what extent are the benefits of the Programme likely to continue should development partners (DPs) funding and support be ceased? How development partners can support future replication of the Programme to ensure its long-term sustainability?
The MCCT programme has a major focus on SBCC sessions alongside the cash transfers. Given that these sessions are already a mandate of the health department and are not specific to the MCCT program, the benefits from these sessions- enhanced knowledge and changed behaviours among the beneficiaries regarding health and nutrition- are likely to continue even when DP support stops. Further, birth spacing is a key design feature of the MCCT programme whose benefits are likely to perpetuate even when DP funding ceases. A key manner in which DPs are helping in making the programme sustainable is by focusing on enhancing systems such as MIS creation and also through building government capacity. For replication to the national level, similar levels of support can be envisioned for the DPs to ensure long term sustainability.
What are the lessons that can be learned to inform future sustainability and replication of the MCCT Programme?
A key lesson learnt is that the scale-up of development projects from a pilot stage to a more broad-based form must seriously consider incorporating technology to automate processes, maintain larger data bases and monitor funds. Further, the element of adaptability should be embedded in all development programs. Programs should be able to adapt to the changing/emerging needs of the societies that they serve. Another key lesson learnt from the MCCT programme is that in the long run, whether a cash transfer programme sustains or peters out depends on the policy environment and the level of support tendered by existing governance structures.
Is the programme sustainable without creating any external funded institutions?
Currently, several development partners (e.g. Save the Children) are also undertaking pilot cash transfers and SBCC programs. While there is plenty of coordination between DSW and the DPs, it needs to be ensured that the pilot areas continue having access to MCCT benefits even after withdrawal of DP support.

In Chin, midwives are receiving incentives from LIFT to carry out the SBCC sessions. This will not continue once DSW takes over financing the Chin MCCT programme. It is to be observed whether discontinuing the incentives affects the conduct of SBCC sessions and if so an incentive structure (financial or non-financial) may be needed to sustain these sessions. Such design considerations should be taken into account from the beginning and only those elements which can be sustained post withdrawal of donor funding should be included.

Further, as the project grows and ages, considerations such as linking the cash transfer amount to inflation and having a process of updating SBCC sessions with changing contexts and practices will need to be included to ensure sustainability. As per the cost of sector plan, the DSW is rapidly expanding its budget and envisions extending the programme to 11 states and regions by 2022/23. The expansion in DSW budget is a key step towards programme sustainability and reduced dependence on external funding.

What are some best practices, which were witnessed in this programme that are replicable at the national level?

One of the best practices in this programme is the introduction of **birth spacing** (women registration in the programme after 2 years of last pregnancy) which helps reduce the risk of poor birth and child nutrition outcomes. Replication of the programme at the national level can consider similar in-built mechanisms to monitor birth spacing – such as no beneficiary receiving payment for multiple children unless there is a case of multiple births in one delivery.

Another best practice emerges in the program's **focus on inclusion**. The MCCT programme is universal and does not mandate the possession of any unique identity document for enrolment, ensuring greater coverage. The focus on reducing exclusion errors is also evident from the concerted efforts made to regularly sensitise the community on the program- so that no one (including vulnerable sections) is left behind.

Ensuring the sustainability of nutrition and health gains through SBCC sessions is also a good practice. The expansion of the MCCT programme should go beyond enabling immediate consumption, and also target long-term behaviour change and a transition towards good nutrition and health practices through similar knowledge sessions.

The MCCT programme has a **well-developed M&E framework**, and a clearly defined data validation and verification process. Further, rounds of PDM have been conducted in both Chin and Rakhine to provide crucial and regular information on the programme performance. The MCCT program's system of data validation and monitoring is a best practice which should inform the scale up of the programme as well.

The MCCT Programme is **DSW-led** with technical and financial support being tendered by DPs. This model of DP engagement also comes up as a best practice since it ensures the continuity of programme by the government, even after DP support ceases.

5.5. Equity, gender equality and human rights

The section on equity and gender looks to understand how equitable the MCCT programme was to different social groups, whether the programme achieved similar success in different locations, whether human rights were strengthened and whether there were any unintended consequences.

Equity and gender equality:

Was the programme design and delivery equitable to different social groups and gender?

The MCCT programme has made concentrated effort to ensure universal inclusion. To ensure equity and protection of human rights, the programme has not mandated the requirement of the National Registration Card (NRC) – a unique identity card given to each Myanmar national. While this has challenges in beneficiary registration and monitoring, it does go a long way in ensuring equity and inclusion. Further, with the inclusion of IDPs in the programme foray – it is serving the most vulnerable sections of society.

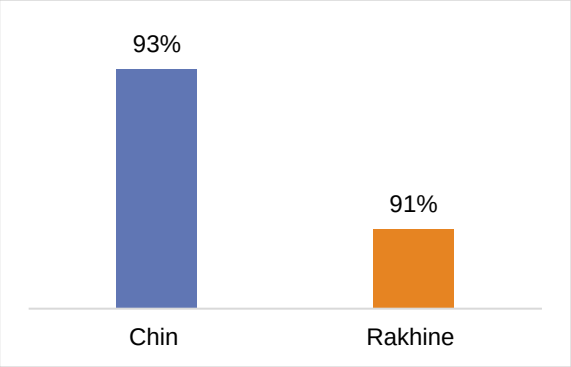
The programme was reported to be equitable with no instances of discrimination, with respect to access to cash transfers and opportunity of participation in health and education sessions amongst beneficiaries. Implementing agents (village administrators and midwives) too confirmed that cash transfers and SBCC

sessions are given to all eligible beneficiaries without bias. This was echoed by government officials at the National and State level.

Also, the MCCT programme has empowered the beneficiary women to participate in household decision making and positively influence the family's health and nutrition status. Further, the programme also provides evidence of gender-neutral spending for the child. However, fulfilling the soft conditions of the programme was perceived to be the exclusive responsibility of the pregnant woman/mother.

Globally, there is a growing body of evidence on how cash transfers can empower women to participate in household decision making and positively influence the family's health and nutrition status.[49] This linkage between cash transfers and gender empowerment is reinforced by the beneficiary experience in both Chin and Rakhine. 93 percent of beneficiary respondents in Chin and 91 percent in Rakhine stated that they themselves are the primary decision makers on how the cash amount is to be used. Furthermore, the MCCT programme also provides evidence of gender-neutral spending. 87 percent of respondents in both the States confirmed that they would spend the money in the same manner no matter what the gender of the baby.

Figure 14. Beneficiaries stating themselves being the primary decision maker for cash transfer usage



At the same time, when cash transfer programmes specifically target female-headed households or women within households, they require women to take full responsibility for programme participation requirements (such as attending parenting workshops, ensuring that children attend school or taking them to compulsory medical check-ups). By imposing these tasks on women alone, programmes may perpetuate gender stereotypes (such as child rearing being a woman's task only) and undermine women's human rights.[50] In the MCCT programme too, fulfilling the soft conditions of the programme (such as attending the SBCC sessions and child registration) is perceived to be the exclusive responsibility of the pregnant woman/mother. There were very few instances of men accompanying their wives to the SBCC sessions and considered these lessons only for the women to help them take care of the house and children. Most men did not consider this to be their responsibility.

> ***Men do not come at all. They say it is your thing and it is the baby thing so they do not come - Beneficiary FGD, Sittwe, Rakhine State***

Did the programme achieve the same level of success in different places and with different social groups?

Similar levels of programmatic success were observed in both Chin and Rakhine. Beneficiary experience of the various processes – registration, disbursement, grievance redress – did not have much divergence in the two areas.

In Rakhine however, the SBCC Sessions are still in their nascent stage and consequently their effects on the beneficiaries' knowledge and practices is not as pronounced as in Chin.

Our analysis of the IDP camps in Rakhine did not reveal any major differences in programmatic success-reinforcing that the programme had similar benefits across different social groups including vulnerable sections.

Human rights:

How have human rights been strengthened through this programme?

The MCCT Programme does not mandate the collection of NRC– a unique identity card given to each Myanmar national- for beneficiary registration. While this has challenges in registration and monitoring, it goes a long way in ensuring inclusion and in strengthening human rights, particularly in the IDP camps.

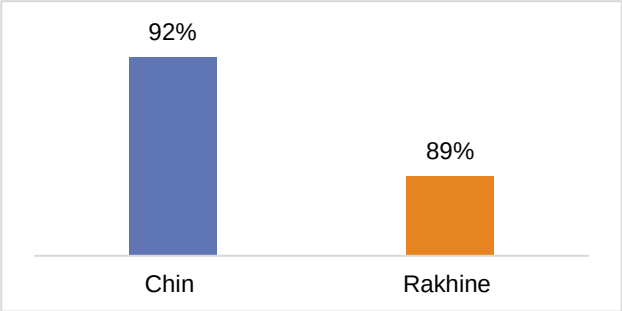
[49] Molyneux M. and Thomson M., Cash transfers, gender equity and women's empowerment in Peru, Ecuador and Bolivia, 2011

[50] Gender and Cash Transfers: A Human Rights Based Approach, Issue Brief 3, UNRISD, December 2016

Unintended Consequences:
Were there any negative effects felt by any social groups?

In the MCCT programme, no unintended negative consequences were observed with regard to cash usage. Nearly all beneficiaries surveyed (99 percent in Chin and 100 percent in Rakhine) stated that there have been no conflicts within the household over the utilization of the cash transfer received. However, accessing the cash amount and attending SBCC sessions posed some level of security risk to many of the beneficiaries across both States. 92 percent of beneficiary respondents in Chin and 89 percent in Rakhine expressed concerns of their safety when going to collect the cash.

Figure 12. Beneficiaries stating security concerns while going to collect cash



6. EVALUATION CONCLUSIONS AND LESSONS LEARNT

Relevance

The MCCT programme is part of a life-cycle approach to social protection, covering birth to age two and transitioning to cash allowance and school feeding programs as the child grows older. The design of the MCCT programme and its focus on children till age two is appropriate, in line with the needs of the country and in keeping with global best practices to address malnutrition and infant mortality. Further, efforts are underway to address the supply side challenges that Myanmar faces pertaining to health provision (as per the National Health Plan) and MCCT is appropriately complimenting this as a demand side intervention. The programme's universal approach is ensuring that no sections of society including vulnerable members are left behind. While the MCCT programme in Rakhine has three different approaches for implementation, given the conflict situation in the State, it does not have provision for the states to customize the activities of the programme to local needs and contexts and no decentralization to the States is present. Content of the SBCC sessions and use of conditions are design elements, which, if localized, can improve programmatic relevance.

Given entrenched patriarchal structures, improvement in women's empowerment is a slow process. The qualitative findings for the MCCT programme indicate that a majority of women felt that the cash transfer had positively impacted their life and increased their self-esteem and self-confidence. The cash transfer also appears to have improved their knowledge of childcare and nutrition practices. The cash transfer amount and frequency are constrained by budget and logistical considerations. As the programme expands and better systems are in place, it would be prudent to review the feasibility of increasing cash transfer frequency – particularly as mobile payments become more common.

The evaluation revealed that the cash transfers beneficiaries appreciate the cash transfers and they used the cash primarily for food or spent it on health services. The preference of in-kind transfers over cash was limited. However, the programme faces several implementation challenges that are influenced by geographic inaccessibility, long distances to reach health centres, and poor road conditions which worsen during the rainy season. These constraints affected both the ability of implementers to deliver the cash and conduct SBCC sessions as per the mandated guidelines, as well as, the participation of beneficiaries in the programme and their likelihood of attending the SBCC sessions or receiving the cash.

KEY LESSONS LEARNT

- Universal transfer programs are crucial for ensuring that the programme covers all sections of the population – including vulnerable populations and minorities. However, even within universal programs, it is essential to clearly specify the documents needed for enrolment – to ensure clarity among all levels of implementers and the beneficiaries, and no one is left behind.
- Birth spacing can be introduced as a soft or nudge condition for similar cash transfer programs to reduce the risk of poor birth and child nutrition outcomes if there is adequate availability of family planning methods and knowledge among beneficiaries.
- It is important to ensure that the intended uses of cash transfers are easily available in the local environment of the beneficiaries. Supply side factors such as local markets, production patterns, ease of access to commercial products, access to institutional services need to be taken into consideration – particularly while designing nutrition-focused cash transfer programs. This will help ensure fruitful utilization of cash, and achievement of the overarching objectives of the programme.
- Programme design as it expands should allow for some degree of flexibility to calibrate implementation in terms of cash distribution mechanisms, methods to conduct SBCC etc. to the differing needs/contexts of various regions within a country given the vastly different contexts including prevalence of health care facilities and infrastructure. Some level of devolution of decision making powers to the states may also be needed as the programme expands. It should however be ensured that there is harmony in the different implementation modalities in each state so that programme management at the union level is not difficult.

Effectiveness

The government, in conjunction with development partner inputs and support, developed the MCCT program's design and implementation mechanisms. DPs have provided both technical and financial support in the program, which has helped address early teething problems. With MCCT being a DSW led programme, to achieve programme effectiveness, the government should ensure that the programme design and implementation does not undergo change when transitioning from donor to government funding such as providing allowances to midwives in Chin. With multiple DPs being a part of the social protection landscape, coordination and cooperation is foremost to ensure learning and most importantly dissemination of learnings, an aspect which needs to be strengthened in the programme.

The programme has done a good job of communicating the programme's tenets to beneficiaries in an informal manner. More emphasis on formal channels of disseminating programme information such as during existing community meetings, through radio, television and through IEC material would further ensure spread of correct and unbiased information. Correct information of the programme eligibility and entitlements has ensured that beneficiaries are not cheated, and leakages are minimized. With the improvement in internet and mobile banking services, a shift to the use of these methods is preferable to ensure timely payments, better monitoring and reduce the dependence on the frontline workers. This will however reduce the touch-points implementing staff have with beneficiaries, which will need to be compensated with the use of technology and IEC material. It will be essential to learn from the use of mobile payments in Shan and Ayeyarwady and customize the payment modalities and spread of SBCC messages to the specific contexts on urban and rural areas.

Difficult terrain in Chin and years of conflict in Rakhine has impoverished the people of these States and the MCCT programme has helped supplement their income to access nutrition and health services. The beneficiaries are taking lessons from the SBCC sessions and are using the cash to buy more diverse food for themselves and their baby. They are also using the money to cover healthcare costs. The SBCC sessions seem to have played an important role in guiding beneficiary spending by improving knowledge and guiding practices such as breastfeeding and dietary diversity. This is more pronounced in Chin since SBCC sessions are now slowly starting in Rakhine. The focus of women on the MCCT programme has positives in terms of empowering women, however it is also perpetuating the thought that it is the woman's responsibility alone to take care of a child.

Beneficiaries who have received cash transfers are able to exercise control in expenditure-related decision-making. However, the cash transfer had little impact in changing decision-making power within the household, with husbands and in-laws exercising primary control over money expenditure and nutrition intake for pregnant women.

No significant issues in registration and cash transfers were observed even though a paper-based system is being used, which is prone to errors. The grievance redress and monitoring systems are however weak. Awareness of formal complaint mechanisms such as complaint focal person and complaint hotline was limited. Further, there is no end-to-end mechanism to monitor complaints resolution such as turnover time, type of resolution and resolution authority. There is a need to identify the level at which specific complaints will be resolved (for example – corruption charges need to straight away reach union level while delay in payment may be sent to the township level). An escalation mechanism from ward/village to township to union level with clear timelines too needs to be in place. Data validation and monitoring too has implementation weaknesses. While some aspects are clearly defined in the operations manual (such as validation of proxies) these are yet to be implemented on the field. With the development of the social protection MIS, the grievance and monitoring mechanisms are expected to be streamlined, however in the meantime, proper implementation of the guidelines needs to be ensured.

It was positive to note that the programme did not have significant unintended consequences except for the fact that beneficiaries felt some-what afraid for their security while collecting the cash.

KEY LESSONS LEARNT

- Behaviour change in a culturally and ethnically diverse context rests heavily on locally customised IEC material. Development programs that aim to transform knowledge of a community should ensure that the IEC material used is easily understood by various sub-groups and is customized to the vernacular of different regions.
- Information gaps in cash transfer programs can be avoided through the periodic reiteration of the tenets and entitlements of the programme to beneficiaries. Guidelines reinforcing main objectives, eligibility criteria and intended uses of cash can help keep the community and beneficiaries updated. In addition, ways in which beneficiaries can access and avail of ancillary services- such as grievance redress- should be reinforced from time to time.
- Operational guidelines should have clear instructions, without ambiguities, to ensure effectiveness - the guidelines do not list all possible scenarios which can possibly occur and ways to handle these. Absence of clarity of actions to be taken can lead to confusion among implementers and lead to ineffective service delivery, such as, in cases when beneficiary or the proxy is unable to come to collect the cash.
- While cash transfers can enhance access health and nutrition, transfers alone may not be sufficient to ensure health and nutrition outcomes. Supplementary interventions to increase awareness on health, hygiene, nutrition and child rearing go a long way in ensuring effective use of the cash transfer. Given that households are dynamic and may involve many influencers, supplementary awareness interventions are key to creating an enabling eco-system – so that the cash is used for the right purposes.

Efficiency

The delivery of MCCT programme starts with community sensitization and registration of beneficiaries. These processes are taking place as per the operations manual and are fairly smooth given the current paper-based system and available resources. Improvements in terms of holding more community meetings to disseminate programme objects, timely issuing of beneficiary cards and having a comfortable and larger space for meetings and registrations were some key findings. In order to ensure correct filling of forms and avoid delays in registration due to incorrect data entry, more training and instructions on form filling is needed. The cash disbursement process and SBCC sessions are the implementing activities, which are being conducted by GAD and DoPH respectively. These have largely streamlined over time in Chin (except Paletwa) but need to be regularized in

Rakhine where both cash payment and SBCC are sporadic. In times of rain or conflict, systems get affected and delays are seen. Location of sessions and reaching the cash disbursement/SBCC sessions is not difficult, however, waiting time in both is quite high. Grievance redress and monitoring are two processes which need to follow the guidelines more strictly to improve efficiency.

Programme management at the Union level remains stretched due to various demands and limitation of staffing and budget. Similarly, at the State/Region and Township levels managerial, financial and technical capacity to manage service delivery are also limited. This is affecting the trainings and capacity building activities, which are currently inadequate and take place mainly only at the union or state level. The cascading model of training where case managers train ward/village administrators is not taking place in all townships. Further, lack of refresher trainings, learning videos and video conferences on a regular basis is proving to be inefficient as agents often forget their learnings from just a single session. Training of midwives is the mandate of the health department and while it is taking place, it does not specifically focus on MCCT.

Financial management in Myanmar is in its nascent stage and currently only transfer costs are calculated program-wise while implementation costs are for the most part not channelled through budget lines that are dedicated to the MCCT programme. In the first two years, the aim is to calculate and isolate delivery costs to make programmes efficient and easy to track. By year three, the costs including opportunity costs should be analysed by external experts and by year four, a distinct operational budget for cash delivery should be allocated to both DSW and GAD, according to the costed sector plan.

Cost-effectiveness analysis measures the cost of achieving intended programme outcomes and impacts and can compare the costs of alternative ways of producing the same or similar benefits. However, given the limitations of availability of hard data on costs, as well as, on values of direct and indirect benefits, it is difficult to conclude whether the MCCT programme is more or less cost-effective than other types of interventions.

Given the stretched and limited resources of DSW and lack of field presence, convergence with other departments – especially GAD and DoPH is of critical importance. While convergence mechanisms at higher levels including committees and clear demarcation of roles and responsibilities is present, at the field level convergence mechanisms are largely informal and may be inefficient with programme expansion. Convergence between different state departments to ensure seamless transfer of best practices and lessons also needs to be improved as the programme grows and different implementation modalities are tested.

The findings from both Chin and Rakhine raised some important points, which need to be reviewed at the impact evaluation stage. These included not having retroactive payments, timeliness of cash transfer (particularly in Rakhine where conflict continues) and registering, as well as, resolving grievances through formal mechanisms. The impact of using paper-based systems and more concrete data on usage of cash should also be explored during the end-line impact evaluation.

KEY LESSONS LEARNT

- Lack of staff creates efficiency gaps at various levels and can result in the negligence of certain responsibilities due to limited time and resources. Ensuring adequate human resources is essential for timely delivery of development programs on a large scale.
- Cash transfer programs, in administrative contexts, that are more paper based and less automated should avoid complicated documentation and record keeping. This will help reducing the workload on implementing staff so that they can focus better on timely service delivery.
- Adequate funds should be earmarked for all programme activities prior to implementation and implementing staff should be provided with sufficient resources to undertake their responsibilities. Alternatively, provisions for reimbursement should be instituted. Implementing bodies should not have to expend their own resources to undertake programme related activities – as they may disincentivise them from carrying them out at all.

Sustainability

Given that the programme is using existing government staffing the implementation costs can be assumed to be fiscally sustainable. While the existing implementation modalities of MCCT is heavily rely on the HR capacities in its operations at all levels, there was no specific adaptation or arrangement to meet the programme's technical requirements rather just assigning the already existing structure of State/Region office of DSW to take additional responsibilities of MCCT implementation. At the same time, the government's financial regulations are not adjusted to meet the programme implementation requirements (for example, there is no specific budget line to charge if additional trips are required for Case Manager or officials to perform their required duties of MCCT (PDM trips, M&E trips, SBCC coordination, etc.). There are however certain elements that are being supported by DPs, such as, incentives to midwives in Chin for conducting SBCC sessions and PDMs. In the long run the sustainability will also depend on ensuring proper monitoring and ensuring that there are no leakages. This requires an increase in human resources and their capacities and the introduction of technology for payments and monitoring including a MIS system. It must also be ensured that development partners do not start any state specific design or implementation models, which cannot be taken-up by DSW (such as allowances, IPC sessions etc.).

Different states have slightly varied implementation models and it must be ensured that there are cross-learnings and the programme as a whole (in each state) grows in a consolidated manner. DSW has prepared the budget expansion to ensure that external funding needs reduce over time and the government takes over the programme funding over a five to six year period. To ensure continuing of gains of the program, the focus on SBCC should continue, however, it should be expanded to cover not just beneficiaries but also husbands and families.

KEY LESSONS LEARNT

- In the long run, whether a cash transfer programme sustains or peters out depends on the policy environment and the level of support tendered by existing governance structures. The level of integration of such an initiative in the national policy agenda is crucial to determine its sustainability and long-term impact.
- Scale-up of development projects from a pilot stage to a more broad-based form must seriously consider incorporating technology to automate processes, maintain larger data bases and monitor funds.
- The element of adaptability should be embedded in all development programs. Programs should be able to adapt to the changing/emerging needs of the societies that they serve. In particular, programs that seek to change sustain changes in behaviours and attitudes should be able to calibrate BCC components to changing contexts.

Equity and gender equality

The MCCT programme focuses on women empowerment and gender equality by giving purchasing power to women to help in improving dietary diversity and intake, and access to healthcare during pregnancy. It is however important to send the message to communities that it is the responsibility of both parents – and not mothers alone to care for the child and include fathers and family members in the SBCC sessions. Equity is a critical component of the program, particularly in Rakhine. By not mandating NRC and including IDP camps, inclusion of vulnerable populations is seen to be a key programme principle in its design. Further, no cases of exclusion were reported by either beneficiaries or field level implementing staff showcasing that largely the principle of inclusion is being followed. *(Instances of exclusion in far-off areas, which were not a part of the sample may still be possible.)*

KEY LESSONS LEARNT

- When women are the designated recipients of a cash transfer programme, they are empowered to take key decisions in cash usage and are more able to contribute to the health and nutrition outcomes in the household. Their receipt of the cash transfers meant that they were less dependent on husbands for money to meet some of the basic needs.[51]
- Cash transfer programmes that specifically target women beneficiaries often make the fulfilment of the conditions of the programme incumbent on women alone. This may perpetuate unequal gender roles and stereotypes, such as, child rearing being the duty of the mother only. In view of this, even when child-nutrition focused cash transfer programs target women beneficiaries primarily, certain programme components should also involve male members of the community – to adopt a unified approach towards child wellbeing.

7. RECOMMENDATIONS

The recommendations have been developed based on the analysis of the findings and conclusions of the formative evaluation, lessons learned from other cash transfer programmes and discussions with various stakeholders. The broad recommendations were presented to key stakeholders during the validation workshop and inputs received have been taken into consideration. The following recommendations are presented in order of priority based on evaluator's assessment and stakeholders' opinions of the importance and timelines of actions considering the conclusions presented in the previous section:

i. Recruiting a cadre of Social Welfare Workers/Volunteers at the village and ward level

(**Responsibility**: Dept. of Social Welfare (DSW) **Priority**: High **Timeline**: Immediate)

The current implementation model requires collaboration and involvement of staff from different sectors. To ensure effective implementation of the MCCT programme, it is important that the implementing agency (DSW) has a direct connect with the community. This can be ensured through a well-trained and well-resourced cadre of social workers or volunteers. Dedicated workers/volunteers deployed by the DSW can ensure oversight and linking beneficiaries to services. The workers/ volunteers will form the frontline representative of the DSW at the village/ward level who can provide support in areas of implementation and monitoring of not only MCCT activities, but also for some of the other social assistance functions, e.g., child protection, etc.

The key responsibilities of these functionaries should include - awareness creation of MCCT/ key social protection programmes; digital registration; mobilization of beneficiaries for pay-out and SBCC sessions; limited messaging on ANC, nutrition and immunization; grievance redress for MCCT, as well as, other social protection schemes

Actions required: Establishing a system of identification & selection of workers/volunteers from the local area (local health staffs may be involved in the identification process, since they are in a better position to suggest given the nature of their activities in the community, such as, IYCF counselling, etc.); regular capacity building; provision of appropriate job-aid items, such as, mobile phone/tablets, tools and materials, etc.; budget provision for salaries/performance-based incentives; explore forms of non-financial incentives, such as, recognition of good performance, reservation/ weightage in government jobs, etc.; mechanisms of managing attrition, refresher trainings, etc.

[51] Women in Myanmar typically decide on and are responsible for small daily expenditures, but men may control large expenditures and spend more on personal consumption, while women tend to spend more on family needs first. Myanmar housewives traditionally keep hold of and save the money that men earn, but this does not mean that they are able to control spending. Decisions related to large family expenditures are made either jointly or mainly by men. (*Gender Equality and Women's Rights in Myanmar: A Situation Analysis. © Asian Development Bank, United Nations Development Programme, United Nations Population Fund, and the United Nations Entity for Gender Equality and the Empowerment of Women. https://openaccess.adb.org*)

While expenditure will have to be made towards regular training of volunteers and managing attrition, the costs incurred should be looked at as an investment towards building human capital, which has intrinsic advantages. Getting local married women to act as volunteers can possibly result in low attrition thereby reducing costs on multiple trainings. Convergence or using volunteers functioning under other programmes, such as, health, etc. may also be explored. Combining training areas into a multi-facetted training curriculum can also help the volunteer to provide better integrated services to the communities.

To begin with the use of volunteers can be piloted in specific geographic areas which are hard to reach, under-served and have high levels of under nutrition. Based on the experience the model can be expanded to cover other areas in a phased manner.

It may be noted that that MoHS has already deployed volunteers in certain areas. Care needs to be exercised to ensure that there is no overlap of functions and there is convergence in utilization of such volunteers. Setting up harmonization mechanisms in deployment and capacity building of volunteers by entities such as, government departments, NGOs, DPs will also be useful.

ii. Establishing a technology-based cash transfer management system and Management Information System (MIS)

(**Responsibility**: DSW supported by UNICEF **Priority**: High **Timeline**: Immediate)

Currently the programme lacks a technology-based system to manage cash transfers and an information system to ensure effective implementation and decision making. An effective IT based system will lead to increased efficiency in managing cash transfers; reduces chances of fraud and leakages; improved oversight and coordination with other schemes; potential for establishment of a common payment system across schemes; more effective emergency response, and improved ability to transition beneficiaries across schemes as their circumstances change.

Actions required: The following will be required:

a) *Technical and management processes*: Creation of an MIS team - defining structure, roles and responsibilities; deployment of staff; hardware and software procurement and maintenance plans; identifying and contracting service providers for MIS development and maintenance.

b) Business processes: Data, information, and records management; network management (service standards and disruption tolerance); information security and access control; and data transfer within & across agencies.

It should also be ensured that indicators for the MIS are discussed with all relevant stakeholders for completeness. Capturing data on variables such as *attendance rate per beneficiary, beneficiaries missing payments, etc.* should also be explored.

Note: A crucial aspect of any MIS is to assign a unique identification number to the individual or households included in the program. For example, using a national identification number, it is much easier to configure the beneficiary database to eliminate duplication and can also be useful if it is required to cross-check information with other relevant programs. In case such a unique identification number does not exist or is limited in coverage, the MIS design must resolve this problem through the generation of numbers unique to the program. Sophisticated data-matching algorithms (first and last names, etc.) will also need to be developed if de-duplication exercises are to be carried out. In the long term, beneficiary databases across programs and payment systems can be integrated, which can lead to costs reduction and greater efficiency.

It was indicated during the validation workshop, that some actions have been initiated by DSW in this regard and an IT system that integrates registration, case management system and cash transfer systems in a digital platform if being explored. However, a key challenge to effectively design, develop

and deploy the system, is the limited in-house capacity of the Department. Therefore, support from Development Partners in this regard is crucial.

Box 4. Tracking of funds under India's nutrition cash transfer programme

Context: The *Pradhan Mantri Matru Vandana Yojana* (PMMVY) is a maternity benefit programme launched by the Government of India. It provides cash transfers to pregnant women so that their wage loss during the months before and after childbirth can be partially compensated to enable them to take adequate rest before and after delivery of the first living child. The cash incentive is contingent upon the fulfilment of conditions relating to maternal and child health. This pan-country scheme reaches out to 6.5 million beneficiaries and as of 2018, funds amounting to INR 18.47 billion have been disbursed.[52]

The intervention:

a. PMMVY relies on two software applications. Beneficiary data and eligibility fulfilment is entered on **PMMVY-Common Application Software (CAS)** and payments are delivered using **Public Fund Management System (PFMS)** application. Maker-checker balances have been built in the system wherein data entry and approval are separated functions to ensure cross checking.

b. Beneficiary's authenticity is gauged using their **State issued unique identification numbers**. Reliance on unique identification number helps in thwarting instances of an errant data entry operator falsifying an actual beneficiary's bank account details.

Rationale: These interventions effectively integrate technology in implementing and monitoring scheme on a pan-India basis. Reliance on the PMMVY CAS automates the coverage of the scheme and reduces exclusion errors. State level dashboards check the disbursement of funds and help prevent leakages. Fraud is prevented through checks on beneficiary authenticity.

iii. Gradual transition to electronic payment transfers

(**Responsibility**: Dept. of Social Welfare **Priority**: High **Timeline**: Over 2 years)

A growing body of evidence shows that linking the delivery of cash transfers with increased access to financial services can increase the social protection impact of social transfer schemes.[53] When cash is transferred to beneficiaries through e-payment modes, such as, mobile phone accounts or smartcards, there is potential to cut costs and reduce leakages compared to physical payment methods. E-payment systems can also improve accessibility and security for programme recipients, which is important for reaching vulnerable groups. However, e-payment in Myanmar will have its challenges. While smartphone penetration is high across the country, a large number of beneficiaries do not have access to a data-enabled smartphone. Another challenge is the low digital and financial literacy, especially of rural women. Nevertheless, the widespread growth of mobile phone coverage and m-transfer services in developing countries suggests that these constraints can be overcome.

Experience has also shown that approaches initiated by aid agencies to e-payment service providers in emerging markets have the potential to influence the scale up of the branchless banking agent network to where it is needed for humanitarian purposes, especially if agencies work together to pool their requirements.

In a randomized experiment of a mobile money cash transfer programme in Niger, a country with one of the highest adult illiteracy rates and lowest phone penetration in the world, we find evidence of benefits of mobile cash transfer. Household diet diversity was 9% – 16% higher among households who received mobile transfers, and children ate an additional one-third of a meal per day. These results can be partially attributed to time savings associated with mobile transfers, as programme recipients spent less time traveling to and waiting for their transfer.[54]

It is expected that electronic payment will improve the efficiency and regularity of payments and reduce the burden on GAD staff. Therefore, it is recommended to implement multiple e-payment

[52] Year End Review- 2018, Ministry of Women & Child Development, Government of India
[53] Designing and Implementing Financially Inclusive Payment Arrangements for Social Transfer Programmes (DFID)
[54] Jenny C. Aker, Rachid Boumnijel, Amanda McClelland, and Niall Tierney, "Payment Mechanisms and Antipoverty Programs: Evidence from a Mobile Money Cash Transfer Experiment in Niger," Economic Development and Cultural Change 65, no. 1 (October 2016): 1-37.

systems, such as bank transfer and mobile wallet, on a pilot basis in specific geographies based on local feasibility and gradually expand the scope across more geographies.

Actions required: To improve delivery and transparency, payments can be contracted-out to private financial agencies. This will require mapping of payment service providers' mobile money, banks, agents etc.; contracting of financial service providers.

It may be noted that limited education of beneficiaries to such systems can impede their trust in the payment mechanisms in the beginning. Financial literacy trainings may therefore also need to be implemented simultaneously. Further, supervision is critical to ensure accountability because third parties may not have the same accountability channels as public institutions. Supervision may be in the form of spot checks and regular monitoring of payment process indicators through Case managers/ volunteers/ partner agencies.

Box 5. Lessons learnt from Ethiopia[55]

Despite the very different political and security context, experiences from Ethiopia highlight how implementing digital cash transfer in safety net programs has its own initial challenges but can pave the way for a well-integrated mobile money ecosystem, if a stable environment and Government commitment are present.

In the context of the World Bank's Ethiopia Rural Productive Safety Net (ERPSNP) program, one of the largest safety net programs in Sub-Saharan Africa, digital payments to beneficiaries were piloted in 2013/2014 and key challenges emerged. First, low phone penetration among beneficiaries and low capacity in taking up a new technology increased setup costs for providing handsets and building awareness. In addition, despite the benefits in terms of cost-efficiency in receiving payments, beneficiaries showed resistance to the new delivery method. Similarly, when UNICEF initiated electronic payment through the M-BIRR mobile money platform for the Tigray Social Cash Transfer Programme (TSCTP), one of the main challenges was beneficiaries forgetting the Personal Identification Number to access their account. In the past five years, there has been some progress on this front, with lack of capacity and cultural sensitivity challenges being addressed. The Government of Ethiopia is now planning an important scale-up of digital payments for safety nets programs in the country, with increasing number of beneficiary households receiving cash assistance through mobile money.

This illustrates how digital payments to channel humanitarian assistance can contribute to the development of a mobile money ecosystem, by improving Government-donor coordination, implementing communication and awareness campaigns, and stimulating network effects to create a critical mass of users.

iv. Revisiting the operations manual

(**Responsibility**: DSW supported by DPs **Priority**: High **Timeline**: Immediate)

While operations manual specific to the State have been provided and are exhaustive, there are some gaps/ ambiguities in certain areas. There is a need to revisit the same and provide clear instructions for actions to be taken. Examples of common scenarios, complicated issues may be added to enable the user to get a better understanding. Further, as the programme evolves over time amendments are required in the manual. The manual should provide a brief and concise description of cash transfer modalities and other programme components; roles and responsibilities of each functionary using an easy to understand visual presentation. Moreover, it must be ensured that any changes being undertaken in terms of programme design such as expanding documentation requirement is documented and reflected in new versions of the operations manual.

Actions required: Review the layout of information – introduce flowcharts/diagrams, bulleted information that make processes/ steps easier to understand. Given that a greater use of IT systems and relevant tools are proposed, the operations manual would need to incorporate step-by-step actions to be followed for identifying where electronic system (MIS) could be replaced or adapted. Based on feedback received from users, revisit the processes and forms to make them simpler. Apart from clear definition of the roles and responsibilities of various stakeholders, suggestive steps for each of the activities to be conducted should be provided. Provide certain degree of flexibility to

[55] Mobile Money Ecosystem in South Sudan, Altai Consulting, June 2019

States/Regions to modify the processes based on the local context, however, keeping in consideration that technical fidelity is maintained and implementing bodies follow the operations manual with fidelity.

Consultative workshops with stakeholders from region/state governments can be conducted to review and improve the operations manual with a view to strengthen the delivery of the cash transfer to local context. Further, the Department should aim to review the same once every six months as the programme is rapidly evolving and is planned to be expanded across geographies. All changes in design and implementation mechanisms should be documented and shared with respective implementing agents regularly and in a timely manner.

v. Strengthening institutional capacities at various levels

(**Responsibility**: Dept. of Social Welfare **Priority**: High **Timeline**: Over 1 – 2 years)

Given the fact the Department of Social Welfare implements social welfare services across eight different areas, the overall organizational structure of the Department will need to be reviewed in light of its overall mandate. However, as the MCCT programme is being expanded and will eventually have a national scope, it is important to establish the programme around a standard operational cycle implemented through robust MIS supported systems. This will require strengthening the capacities as various levels and having a dedicated team working exclusively on the MCCT. Further, there is a need to introduce training components to strengthen institutional capacity as a whole on the various aspects of programme implementation, including M&E and financial management practices.

Actions required: The existing Social Protection Section at the Union level in the Department of Social Welfare needs to be strengthened, in terms of additional staffing, budgetary resources for programme management, capacity building and monitoring. Similarly, capacities of functionaries working at the sub-national level also needs to be strengthened. Further, keeping in mind the proposal for deployment of volunteers, responsibilities of implementing personnel can be outlined and a training needs assessment carried out to inform development of specific training programmes for each category of functionaries. For the implementation of training, technology-based tools may be explored, such as, use of videos for trainings will help reduce time and cost of training sessions and allow implementers to revise learnings as needed.

vi. Strengthening grievance redress systems

(**Responsibility**: Dept. of Social Welfare **Priority**: High **Timeline**: Over 1 year)

Guidelines for grievance redress mechanisms have been provided in the operations manual for both States, however, their implementation appears to be relatively weak, exhibiting potential for further improvements.

Actions required: Establish appropriate mechanisms for grievance redress that can easily be accessed by beneficiaries and also provides for anonymity for reporting cases of irregularities – publicity of the Helpline/Hotline number; provision of suggestion/complaints cards at village GAD offices along with a complaint box; SMS based complaint reporting; escalation mechanisms, can consider MSG leader to also act as complaints focal person.

Proper maintenance of record of complaints must be ensured along with clear mechanisms of feedback on action taken/resolution to Ward/Village Social Protection Committees. Guidelines to this effect may be developed. This can be an effective mechanism to get feedback from community and beneficiaries to review and improve the programme on-going basis for health and nutrition services.

The following should be kept in consideration while finalizing the grievance redress system:

- There is an assigned focal person who manages the system. There may be different focal points for different levels to whom people can appeal if they are dissatisfied with the decision made at their level;
- The provision and process of the grievance redress mechanism is well publicized;

- The complaints form is available and on submission of the form, a receipt is provided to the complainant;
- Information about the complaint and its resolution is captured in the management information system (MIS). The information should be accessible by relevant stakeholders with appropriate data privacy being maintained;
- There is a committee-based hearing process, which is open to the public, for certain categories of complaints, such as registration issues at community level, etc.; and
- Complaints are addressed within a specific timeline, generally around two weeks.

Given that there are low levels of literacy in various pockets, volunteers should be trained to provide support in the grievance redress process.

In the long run, an IVRS based single window grievance redressal system can be set up, integrated with the existing Helpline, that will generate backend workflows directed towards responsible officers on grievance disposal chain. The resolution should be time bound and each workflow will have to be closed within stipulated number of days.

vii. Strengthening M&E system

(**Responsibility**: DSW supported by DPs **Priority**: High **Timeline**: Over 1 year)

While PDMs are providing monitoring data, external monitoring supported by DPs/ NGOs needs to be explored so as to receive feedback on the implementation activities and take corrective actions wherever required. At a later stage, once implementation mechanisms have been set-up and service delivery is smoothened, third party monitoring, programme evaluations, particularly impact evaluations, should be undertaken. Use of community structures to monitor the programme activities on ground should also be explored.

Actions required: Review the M&E framework in light of the various programme changes proposed and develop a monitoring plan for the States/Regions to follow. This should include reporting templates/ tools, frequency, and tools for aggregation (web-enabled MIS); training and supporting the States/Regions to collect information/ data on a regular basis; collecting and aggregating results data from the States/Regions and reporting programme performance to relevant stakeholders, including putting up programme data in the public domain, on a regular basis.

viii. Stronger inter-ministerial coordination arrangements and development partner coordination required

(**Responsibility**: DSW, DoPH and GAD **Priority**: High **Timeline**: Over 1 year)

Collaboration amongst the principal Ministries and Departments is critical to achieve the nutrition goals. Improved coordination is required between the Departments of Social Welfare, Health and General Administration at the Union, State and field levels.

Strong political commitment, efficient cooperation, sufficient administrative and institutional capacities, as well as, adequate financial resources are required to ensure coordination mechanisms work well. While some of these are in place, there is a need to reinforce cooperation and develop joint action plans.

Further, coordination between UN organizations and other development organizations working towards improving nutrition outcomes, is very much important to maximize efficiencies.

Actions required: Prioritize strengthening local and sub-national coordination alongside the establishment of national coordination mechanisms. Key stakeholders such as, MoPHS/DoPH, especially nutrition team should be involved in planning and agreeing on implementation strategies in a way that MCCT cash transfer programme complements the work of MoPHS and vice versa with regard to SBCC on improving nutrition outcomes.

Setting up joint working committees at the State/Region and township levels that not only include the various stakeholder departments, but also development partner agencies working in the area, will be helpful in improving implementation of the MCCT programme. The committees at the State/Region level can meet every quarter and the township level committee can meet more frequently, may be every two months, to review and address implementation issues timely.

Developing guidelines on coordination mechanisms and creating platforms to discuss gaps/issues on a regular basis; sharing of programme data and establishing feedback mechanisms will contribute to the strengthening implementation of the programme.

ix. Strengthening the Social and Behaviour Change Communication component

(**Responsibility**: DSW and MoHS **Priority**: High **Timeline**: Over 1 year)

Payment events are key opportunities to convey messages on nutrition and health-seeking behaviour, as well as, providing programme information. However, as the programme moves towards electronic payments systems this touch point will no longer be available. Therefore, there is a need to strengthen the BCC component by introducing various channels of communication. Further, the findings indicate the need to reach out to husbands and male members of the family to break the psychological barrier about pregnancy and childcare being only women's activity and create awareness in the community for support and facilitation to ensure behaviour change. Further, given the diversity of communities and therefore practices pertaining to nutrition and health, it is likely that specialized sections addressing myths, taboos and good practices for each state and perhaps community may be needed.

Actions required: Develop a comprehensive communication strategy including a component to reach out to husbands and male members of the family. Given that that there is high use of smartphones among men and mobile games, as well as, use of social media (Facebook) are quite popular, diffusion of key messages through social media can help nudge behaviours.

Since husbands are often head of the household and/or primary decision makers on seeking health care for the family, engagement with husbands for improving maternal and child nutrition can lead to significant improvements in husbands' behavioural determinants and the nutrition support they provide to their wives during pregnancy. Targeting husbands and young adults (they will be the husbands tomorrow and hence necessary to engage them early on) through mobile games may be explored. Gamification has become an increasingly popular approach to disease prevention and health promotion. Android based gaming application for husbands and young men that can operate offline can be designed and developed. An interactive and engaging nutrition-based gaming app can trigger and drive positive behaviour change regarding nutrition practices.

The communication strategy should explore various communication channels, including traditional communication methods, as well as, technology-based channels that can reduce costs and complement physical interactions, for reaching out to pregnant and lactating women and their families.

Build capacities of volunteers, midwives, nurse midwives, for interpersonal counselling of pregnant women and lactating mothers and improving maternal nutrition by busting their fears, inhibitions and nudge them into improved pregnancy behaviour, such as, positive outlook to weight gain, include habits of diet diversity, help them identify frequent occasions of small meals, promote timely ANCs, opting for institutional delivery, etc. It will open discussion on good and effective feeding practices for children, such as, colostrum feeding, exclusive breast feeding, timely initiation of complimentary feeding and well advised IYCF habits.

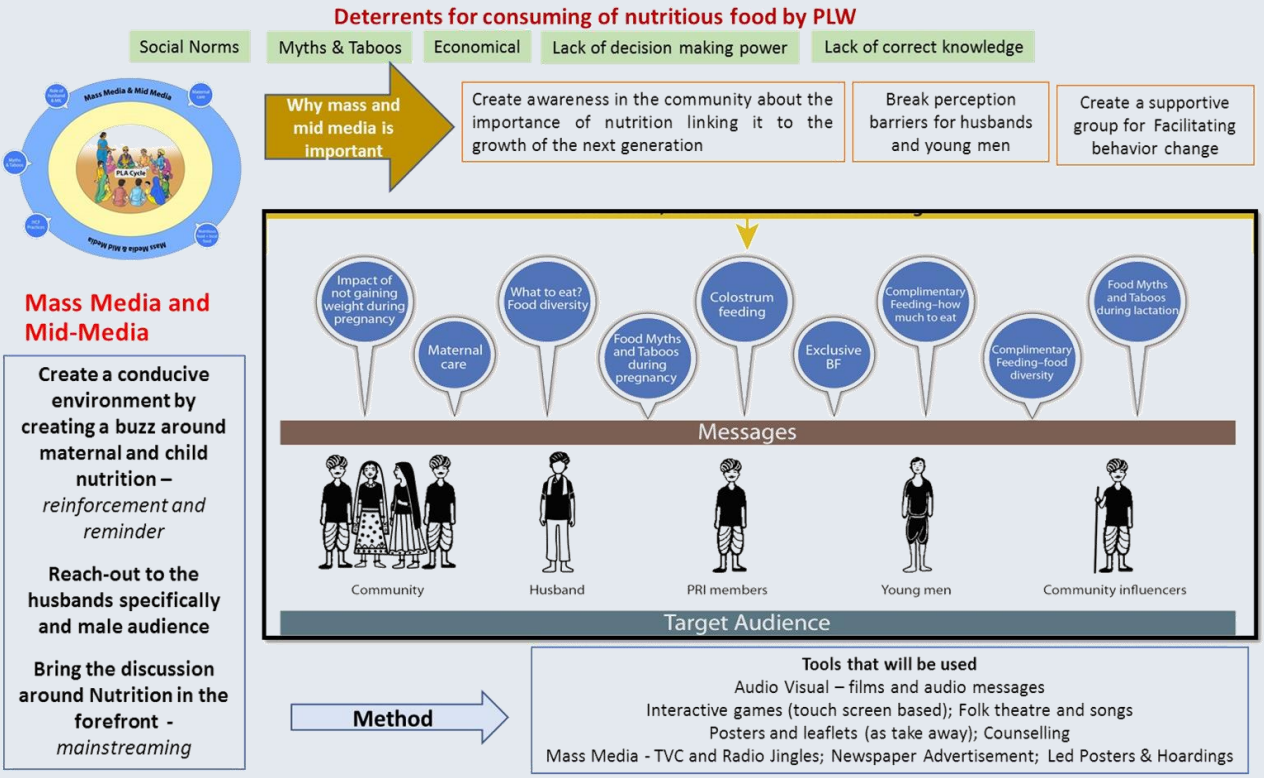
It must also be ensured that the sessions continue to take place on a regular basis. Providing a monthly allowance to midwives in Chin State was one of the factors, which ensured timeliness of sessions. This can also be considered with a view to harmonize incentives across states and regions, after assessing the cost implication.

Repeated and reinforced communication of messages in local dialects and via mediums that are understood by the beneficiaries will be helpful in promoting appropriate dietary practices. These messages such be contextualized based on the prevalent practices in those areas and communities.

Box 6. Involving community and families in maternal and child nutrition

Context: Under a programme in Rajasthan (India), RajPusht, the community is being involved to break food-based myths and challenge social norms, as well as, individual beliefs to promote appropriate Infant and Young Child Feeding (IYCF) practices.

Innovation: Use of technology, such as, games as well as interactive activities such as songs and plays to increase the community's knowledge on the importance of nutrition for the woman and child to break the cycle of inter-generational cycle of poverty.



Rationale: Mothers alone can rarely bring about changes in nutrition and health-seeking behaviour. It is important to include family members (especially husbands) and the community in the dialogue and use a variety of tools to reach out to community members to ensure reinforcement of messages and constant reminders.

x. Strengthen outreach and awareness-raising

(**Responsibility**: Dept. of Social Welfare **Priority**: Medium **Timeline**: Over 1 year)

Several local stakeholders, particularly implementers, carry out communication, outreach, and awareness-raising functions. This can be further strengthened through use of social welfare volunteers/NGOs to create awareness about the various elements of the MCCT program, improve overall perceptions concerning the MCCT programme, raise awareness, increase knowledge, and mobilize communities and families to support women in adopting health and nutrition seeking behaviours among pregnant and lactating women and women with children under two.

Actions required: Develop communication material on programme eligibility, entitlements and processes, as well as, on appropriate health and nutrition behaviours in local dialects to cater to the local contexts. Thereafter, the functionaries should be trained on use of such material.

Box 7. Examples of outreach and awareness raising

The egg initiative in Odisha (India)

Context: Odisha is one of the few states in India to provide eggs to combat under-nutrition in India. The government provides 5 eggs a week for children aged 3-6 years and 3 eggs a week each to pregnant mothers, lactating mothers and children aged 6 months – 3 years as Take-home Ration under Supplementary Nutrition programme of the government's Integrated Child Development Services (ICDS).

The intervention: Beneficiaries (children and their mothers) of the SNP took part in an egg relay competition in six villages of Odisha, India. There were 10 teams in each village with one child and one mother as team members. The village head and frontline health workers also participated to stress the relevance of eggs in combating child under nutrition. There was a community member who dressed as an egg at the event to leave a visual impact and to generate conversation around eggs being

Rationale: The initiative led to increased awareness on the importance of egg as a super food to fight malnutrition in the local community.

Targeting Anaemia through innovative testing

Context: The Reduction in Anaemia through Normative Innovations (RANI) is a Bill and Melinda Gates Foundation funded research project currently under implementation in Angul district of Odisha, India. RANI aims to reduce anaemia among women of reproductive age (WRA).

The intervention: RANI adopts a Participatory Learning and Action (PLA) approach in increasing awareness about anaemia. One of its interventions is testing the haemoglobin levels of WRA within women's Self Help Groups and the community.

Innovative blood shaped cards of different colours indicating severity of anaemia (green, yellow, orange, red) are used to convey the results with the low-literate population along with relevant to dos. Individual tracking cards are used to monitor haemoglobin progress.

Rationale: The testing results are shared at the individual, group and inter-village level to trigger demand for anaemia redressal solutions like uptake of IFA and iron rich food.

xi. Improving transparency and accountability

(**Responsibility**: Dept. of Social Welfare **Priority**: Medium **Timeline**: Over 2 years)

Transparency is generally defined as the open flow of information amongst stakeholders.[56] Therefore, making official programme data publicly available improves transparency and builds in public accountability. It is good practice to post programme information on processes and indicators on the internet and public platforms.

[56] Holzner B, Holzner L (2006) Transparency in global change: the vanguard of the open society. University of Pittsburgh Press, Pittsburgh

Actions required: Develop a Facebook page or a website for the MCCT programme to put up all related information on MCCT, guidelines, etc. for benefit of implementers and also display relevant programme data, for public access, including information on payment contracts with third party providers. The FB page/website would need to be updated regularly and therefore internal responsibilities should be assigned for updating the different pages in terms of data and other content. Automated internal routines should be put in place to alert the relevant persons on the need to update their pages. Given that an IT based MIS is proposed, linking the same with the website to provide relevant data will be very useful. The Helpline/Hotline or a Viber number can be publicized through the above to obtain feedback on the programme.

Set up a system of putting list of registered beneficiaries and list of rejected applicants (with reasons of rejection) at village GAD office; introducing social audit mechanism in areas where community-based organizations exist.

Box 8. Pantawid Pamilyang Pilipino Program

The **Pantawid Pamilyang Pilipino Program** is a human development program of the government of Philippines that invests in the health and education of poor households, particularly of children aged 0-18 years old. Implemented by the Department of Social Welfare and Development (DSWD), it is one of the key poverty alleviation programs of the national government that seeks to contribute in breaking the intergenerational transmission of poverty in the country. Patterned after the conditional cash transfer scheme implemented in other developing countries, the Pantawid Pamilya provides cash grants to beneficiaries provided that they comply with the set of conditions required by the program. The program has one of the most comprehensive poverty targeting databases in the world today, covering 75 percent of the country's population. It has been used extensively to identify poor and near-poor beneficiaries for national and local government programs.

The program website (https://pantawid.dswd.gov.ph/) makes available to the public, data related to the program and monitoring including, quarterly progress updates, evaluation reports, assessment studies, etc. are publicly available on the website (https://pantawid.dswd.gov.ph/data-updates/). This is a good way to ensure transparency and reduce data discrepancies.

xii. Adjusting size of cash transfer in relation to inflation

(**Responsibility**: Dept. of Social Welfare **Priority**: Low **Timeline**: Over 2 years)

Presently the cash transfer amount is not adjusted to account for inflation. This implies that over time the purchasing power of the transfers might decline. Plans should include a mechanism to regularly adjust payment levels in response to rising prices.

Actions required: Develop a mechanism to adjust the value of cash transfer as per the food price inflation. The implementation of such a mechanism will require proper inflation forecasting, assessment of local markets and building a contingency fund into the programme budget.

In Kenya, the Hunger Safety Net Programme (HSNP) cash transfer could buy only one-third of the food basket against which it was calibrated within just 18 months of the programme's inception in 2007 (Devereux, 2012). In Malawi, transfers via the Food and Cash Transfers (FACT) project in 2005/06 and Dowa Emergency Cash Transfers (DECT) project in 2006/07 were index linked to a basket of basic food and non-food items, and were adjusted before each monthly disbursement (Wheeler and Devereux, 2010). In other countries, adjustments are made in an ad hoc fashion, as is the case for Brazil's *Bolsa Família*. In the aftermath of the recent food, fuel and financial crisis, Bolsa Família benefits were raised by 10%. In Mexico, *Oportunidades* monthly payments to the poorest families increased by 24% in 2008 (Grosh et al., 2013)[57]

[57] Bastagli, Francesca. (2014). Responding to a crisis: The design and delivery of social protection. 10.13140/2.1.1234.7208.