



Chin State MCCT Programme
1st Post-Distribution Monitoring Report
April, 2018

PDM Data Analysis

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BACKGROUND

The PDM exercise was conducted over a month, from December 20, 2017 to January 20, 2018 during which time 756 respondents were selected for the interview. DSW fielded 65% of the surveys (using manual forms) while SCI fielded the remaining 35% (using electronic PDAs). A total of 188 wards and village tracts were sampled. Convenience sampling was used to reach the target population of 756.

Figure 1: Distribution of respondents by Township Figure 1 demonstrates the breakdown by Township and the sample is quite evenly distributed.

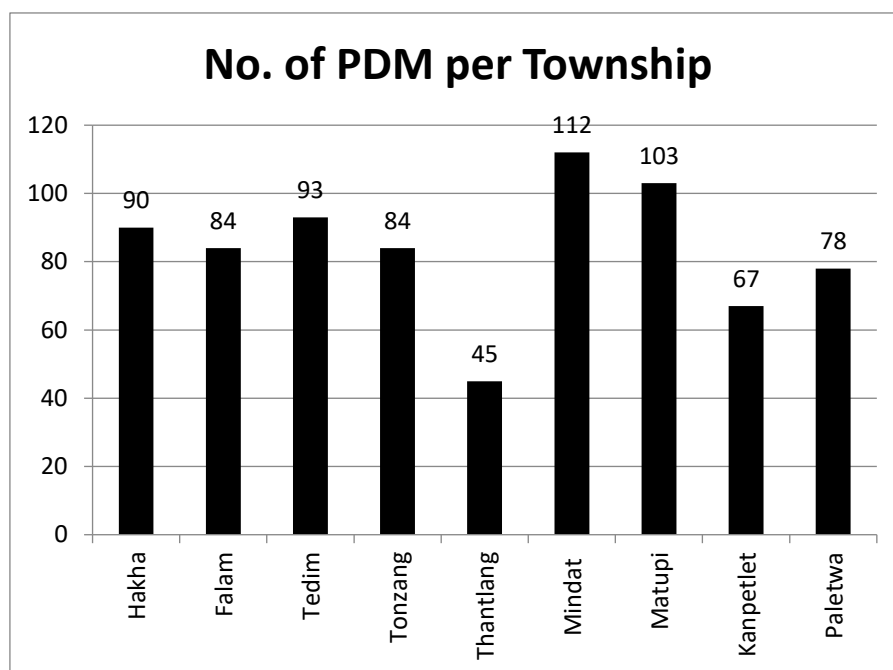


Figure 1: Distribution of respondents by Township

The qualitative methodology used for this PDM probed respondents on various aspects of the program including registration, payments and knowledge/awareness on various aspects of the program. It also probed respondents for changing cash spending patterns and changing awareness on health and nutrition. This report presents a summary of the results with the usual caveat that the quality of data need to checked – especially for the date fields.

Since respondents were purposively selected, this note does not attempt to predict percentages or make forecasts for the population of MCCT recipients. Rather, it uses the data to highlight the major findings and where necessary tries to point to township level differences.

BENEFICIARY PROFILE

Figure 2 depicts the **age distribution of respondents** selected for the PDM – both lactating and pregnant women. The bimodal age distribution has a mean of 28.7 years of age and the modal value was 30. There is some limited evidence of age heaping as can be seen in the spikes observed at certain ages. The age distribution of pregnant mothers is very similar to that of lactating mothers, although as expected, the frequencies are lower at all age groups. The PDM data shows some limited evidence of early pregnancies as well as late pregnancies and these cases could be considered for enhanced healthcare and psycho social counseling. As can be seen from Figure 3 most respondents were already mothers (65%) with children less than 12 months old. Nearly 85% of children born to respondents were under the age of 6 months. Among pregnant respondents, a majority were in their 3rd trimester (24% of all respondents).

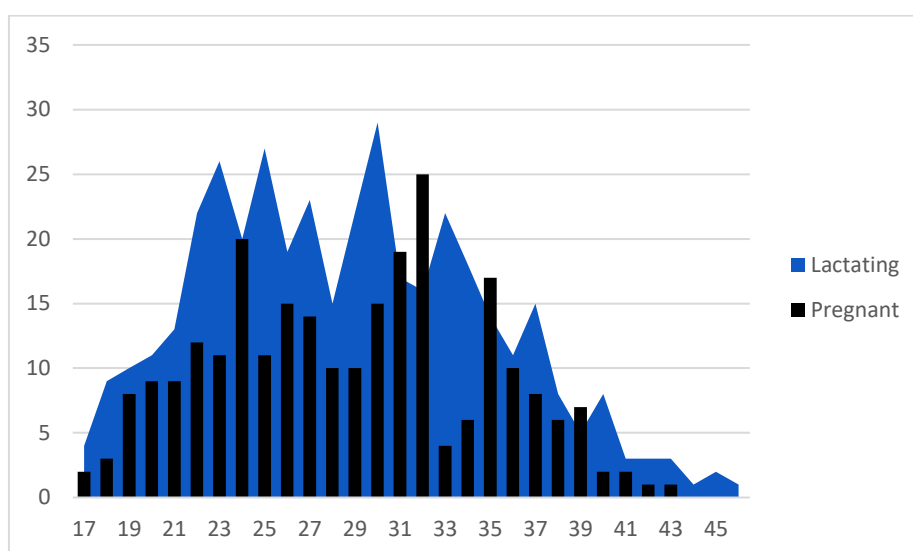


Figure 2: Age distribution of respondents

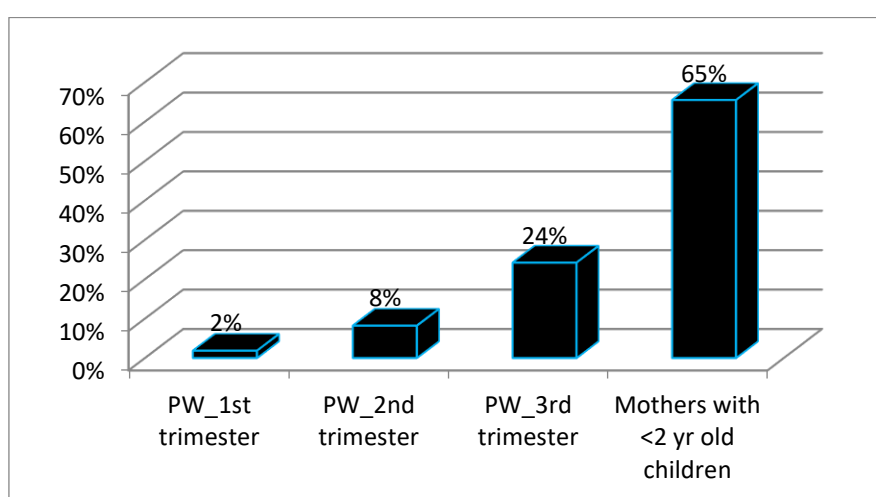


Figure 3: Status of respondents

The distribution of demographic characteristics follows interesting spatial variations. In nearly all townships there are some very young and some older beneficiaries (Figure 4). The median age of sampled respondents was the highest in Mindat (30+) and lowest in Hakha (25).

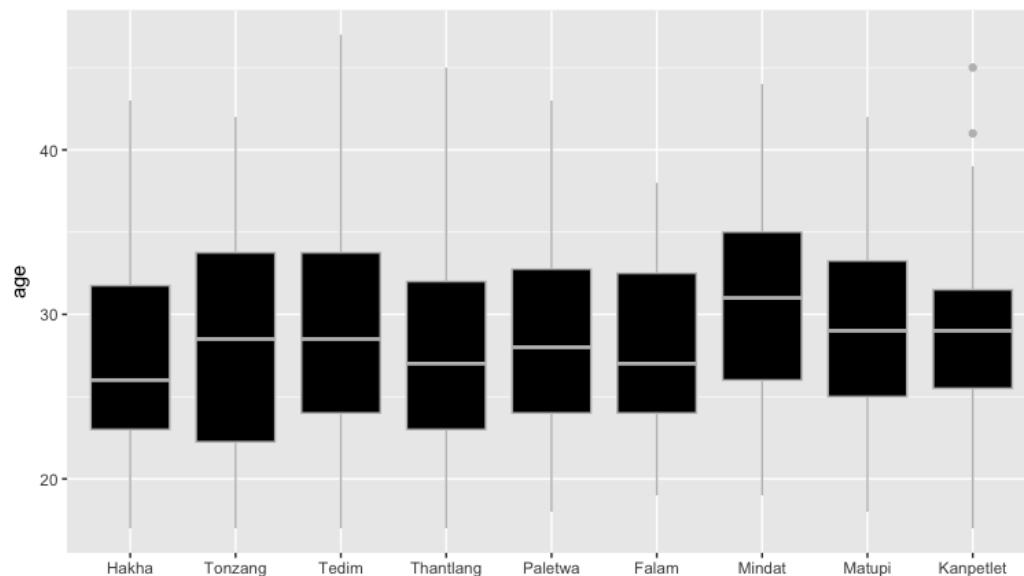


Figure 4: Median age distribution by township

Examining the **age distribution of children born** recently to respondents – the mean age in months was about 3.86 while half the children and most of the children (median and mode) were 4 months old. There is not much variation in the age distribution of new born babies across townships although in places like Thantlang, the distribution appears more compressed than other townships which could be due to the low sample size in Thantlang (Figure 5).

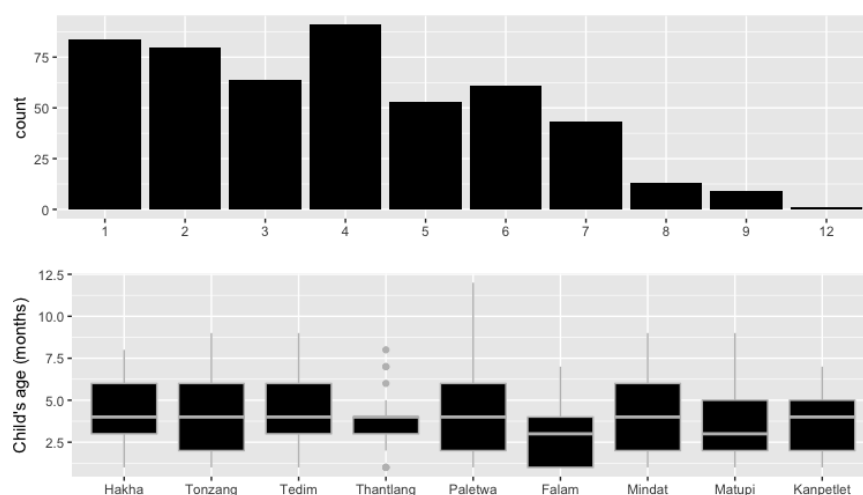


Figure 5: Child's age (mths)

Figure 6 shows the distribution of the **duration of pregnancy**, and displays a highly skewed distribution concentrated near 9 months. On average pregnant women in the sample were in the 7th month of pregnancy, half the women were in their 8th month of pregnancy (median), while most women were in their 9th month of pregnancy (mode) and about to deliver. These results owe to the fact that the program was initiated in June 2017 while the PDM interviews took place in early 2018. Most respondents enrolled earlier in the cycle and respondents who came enrolled just before the PDM have a lower duration of pregnancy. The PDM also picked up about 2 cases of women who had either miscarried or aborted their babies.

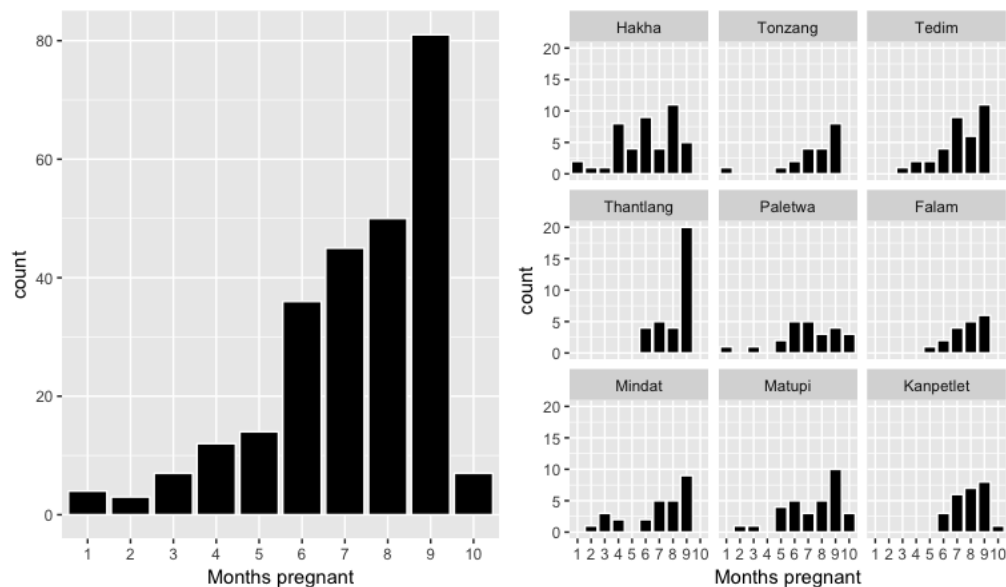


Figure 6: Pregnancy duration (mths)

Figure 7 plots the enrolment dates. Despite a few data errors, it can be seen that most respondents were from the first cohort of entrants to the Chin MCCT program.

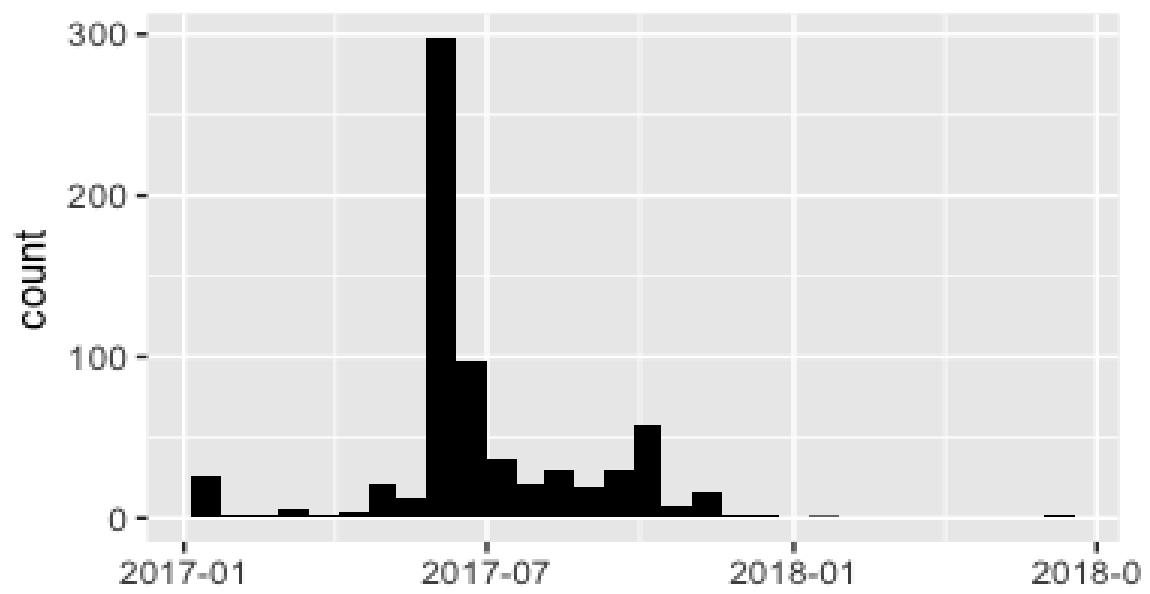


Figure 7: Enrolment date

PAYMENTS, WAITING TIME, USE OF CASH & ADEQUACY

93% of respondents reported **receiving their cash transfers regularly** every two months of 30,000 MMK. The remaining 7% (56 respondents) reported that they did not. The reasons were varied: 5 reported that the village head informed them that cash for distribution had not arrived to the village; 8 reported late registration; 15 reported extortion or being charged fees while another 11 respondents noted they did not know about the location and time of the payment. Except for Falam, these incidents were reported across all other townships, particularly in Thantlang and Hakha where more than 10-15% reported irregularities in their payments. This evidence suggests that although more than 9 in 10 respondents received their transfers on time and the appropriate amount, there remains an opportunity to further improve upon administrative controls to prevent extortion and ensure that all beneficiaries are paid on time and the appropriate amount. Pre-disbursement public announcements could also help to put some of these cases in public spotlight.

The **amounts received during the last payment** was also reported by respondents. Just over 90% of respondents who received their last payment reported receiving 30,000MMK, while another 8% reported receiving either 15,000MMK or 60,000 MMK. A small minority of respondents (less than 2% living in Hakha, Matupi and Paletwa) reported receiving amounts that are not in accordance with the cash transfer laws (not multiples of 15,000MMK). More than 85% of respondents said they were **informed about their last payment in advance**. However, the data suggest that many respondents in Thantlang (27%), Paletwa(21%), Matupi (21%) and Kanpetlet (18%) did not know about the payments in advance.

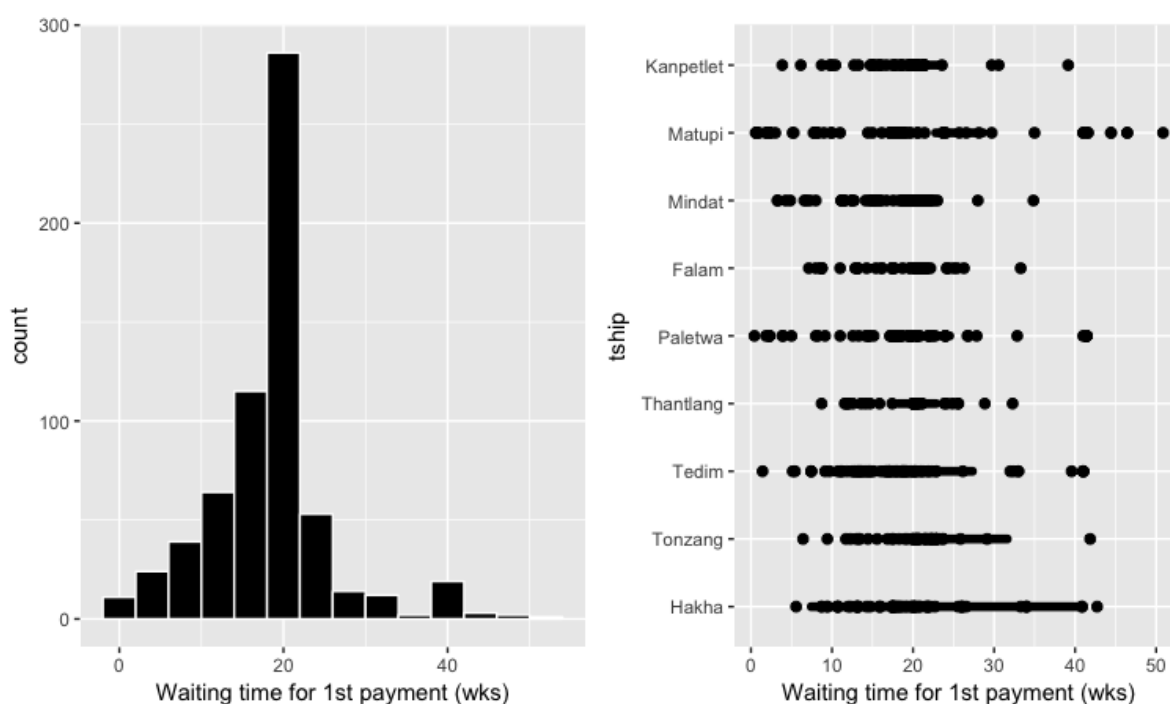


Figure 8: Weeks between enrolment and first payment

Using self-reported dates on which the respondent was registered in the MCCT program and the dates when they were first paid, it is possible to calculate the “**waiting time**” in terms of weeks. Waiting time is therefore a good measure of the time taken for the respondent to register, for the

information to be captured and processed, verified and approved, financial arrangements completed and the cash finally delivered to the beneficiary. Respondents calculated waiting times ranged from less than 4 weeks to more than 50 weeks. The data shown in Figure 8 suggest that half the people have to wait around 19.4 weeks since registration to receive their benefit, most people had to wait 20 weeks, while on average, the waiting time was 18.6 weeks. It is worth noting that the distribution of waiting times is highly skewed and concentrated around the modal value. The skewness in the distribution can be explained by the fact that the program was started in May 2017 while the first payments took place in October 2017 and hence the long waiting time for most of the respondents. On the other hand, the waiting time for those who registered later (the flow) is considerably shorter as can be seen from Figure 9 where respondents who enrolled later (the flow) received their payments with a shorter waiting time.

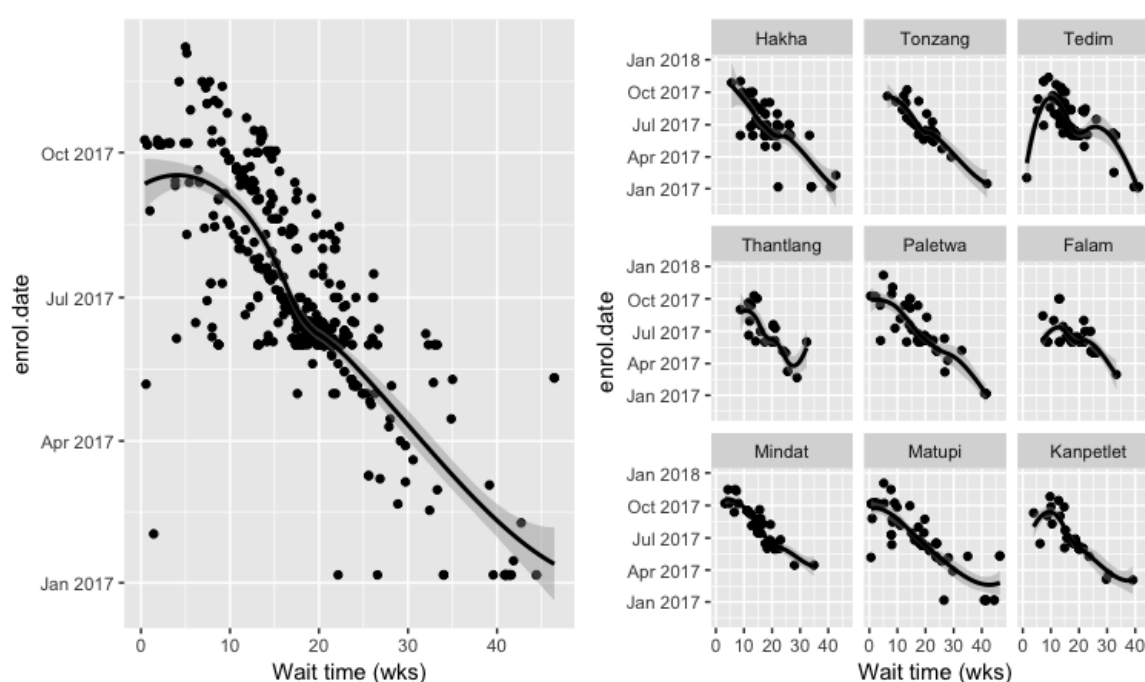


Figure 9: Enrolment date and waiting time in weeks

Respondents were also asked about **queueing times** or the time they had to wait at the payment point. The data are shown in Figure 10. Just under 50% of respondents were able to receive their payment in less than 15 mins while 30.2% had to wait for 15 to 30 minutes. More than 21% of the respondents reported queueing times of more than 30 minutes and 6% reported queueing times of more than 60 minutes. The results vary greatly by township. Paletwa, Tedim and Tonzang contained more respondents (30%-40%) with queueing times greater than 60 minutes.

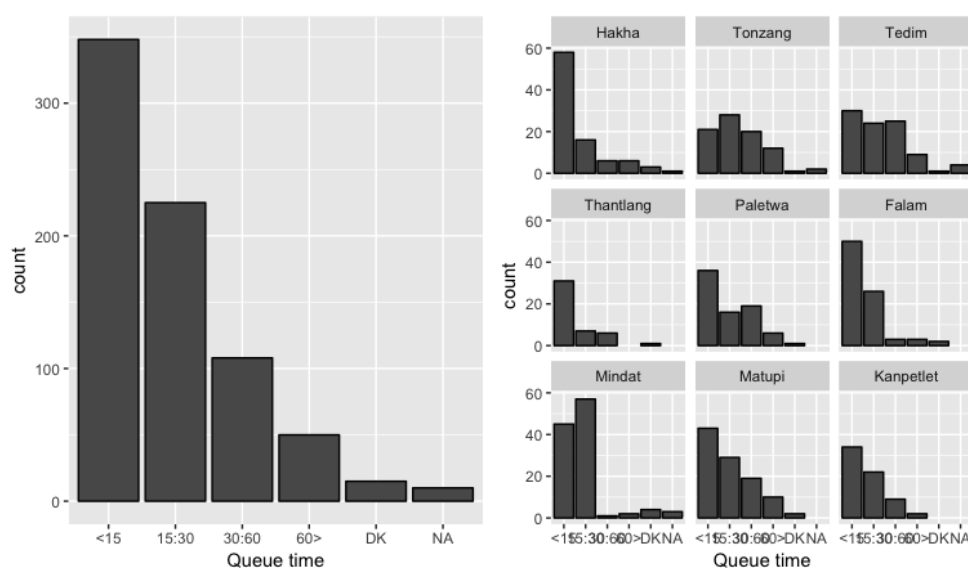


Figure 10: Queueing Times

Nearly all respondents indicated that they were **in charge of spending their cash transfers** (95%). Between 50%-75% of respondents reported on their **spending patterns**. The data are shown in Table 1 and suggest that cash transfers are primarily being used for *buying more food for respondents* (72%) and for *health care costs* (62%). 43% of the respondents reported spending more on food for their children while 32% bought more food for the family.

Table 1: Changes in the use of cash

Use of cash	Number saying “Yes”	Total valid responses	% Yes
Buying more food	70	524	13%
More variety for self	418	579	72%
More variety for child	224	523	43%
More variety for family	152	480	32%
More baby formula	174	473	37%
More baby milk	109	449	24%
Health care costs	340	552	62%
More snacks	118	436	27%
Shoes/Clothes	89	451	20%
Blankets	99	465	21%
Created from Chin PDM Data (Excel file translated into English)			

A few respondents also bought clothes/shoes (20%) and blankets/warm items (21%). *Of concern is the fact that 37% of respondents reported buying more snacks while 20% bought more baby formula and 14% bought baby milk.* The latter two categories of expenditures are especially worrisome as most children are about 4 months old and should be exclusively breast fed and at the same time could be symptomatic of mothers nutritional and health risks.¹

¹ In addition to these changes in the pattern of spending, about 8% of the respondents with valid answers (37) were also using the cash transfers to augment their savings

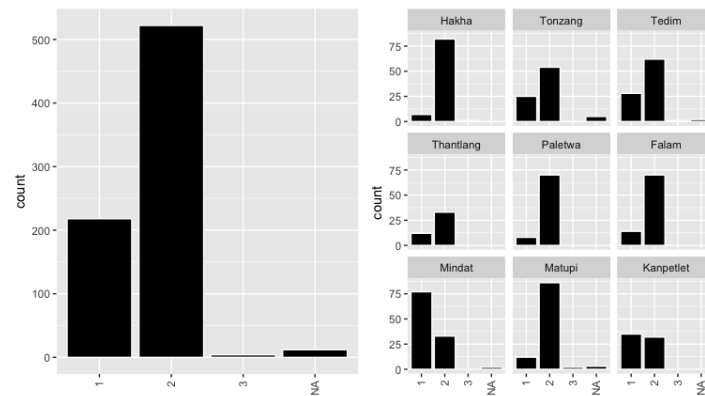


Figure 11: Sharing of cash transfers

Nearly 7 out of 10 respondents reported that they did not **share their cash transfer** with anyone else (Figure 11, 1 = Yes, 2 = No, 3 = DK). Among the 30% who did report sharing their benefit (218 cases), the data suggest that respondents were more likely to share their cash transfer with another family member (90%) compared to their husbands (8%). These patterns are observed in nearly all the townships except for Mindat, and to some extent Kanpetlet, where an overwhelming majority of respondents were more likely to share their cash (Figure 11).

As regards perceptions about the **adequacy of the cash transfer** (15000 MMK per month),² respondents presented a mixed picture of their perceptions. The data, shown in Figure 12 indicate that an overwhelming majority (42.2%) felt that the cash could cover only some (partial) of the full cost of purchasing adequate nutrition for mother and child. Another 28% felt that the cash transfer could cover most costs. Almost an equal number of respondents felt that the cash was not enough (15%) as well as enough to fully cover the costs (14%). There are interesting regional variations though. In Hakha and Kanpetlet, most respondents felt that the cash was enough to cover costs. In Thantlang fewer respondents felt that the cash was not enough compared to those who felt it covered costs fully or mostly. In Matupi, almost the same number of respondents felt that the transfer was enough, or partially enough. These regional differences reflect a variety of factors including local prices, availability of food, cultural attitudes and practices, as well as socioeconomic circumstances.

² In the future, in addition to the adequacy, PDMs could ask about the desired frequency of payments.

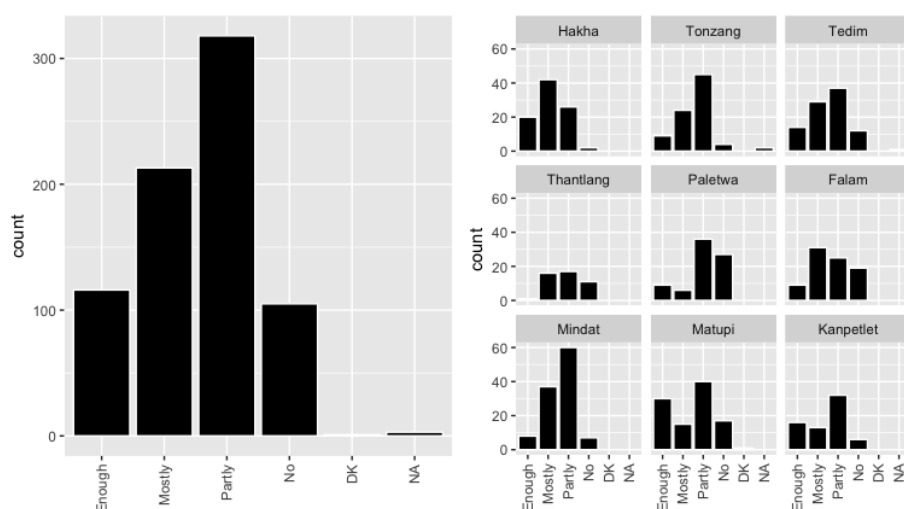


Figure 12: Perceptions about the adequacy of the current cash transfer

Respondents were also given the opportunity to state their **desired amount of cash transfer** (Figure 13). The data suggest that just under half of all respondents (48%) felt that the monthly cash transfer should be double the current amount (30,000 MMK/month). Another 20% felt that it should be about 20,000 MMK per month. Finally, nearly 15% felt that the monthly cash transfer should be about 50,00 MMK per month. Only 4.6% felt that the desired amount was correct at 15,000 MMK per month. Township level data also reveal similar trends.

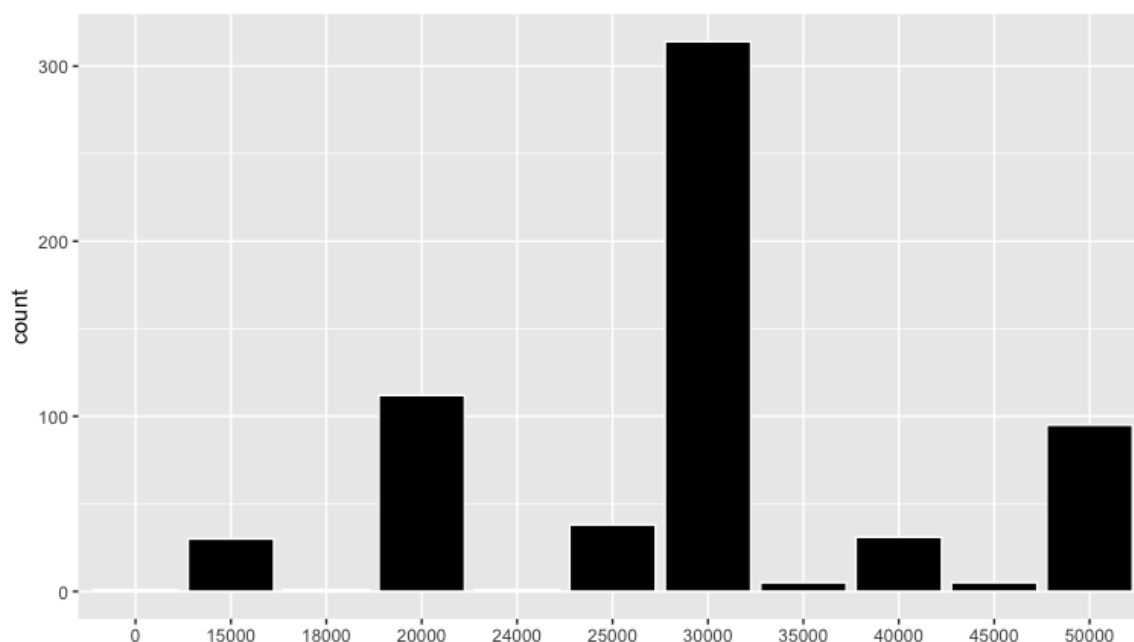


Figure 13: Desired amount of cash transfer (MMK per month)

Correlating the respondent's answers between the perception of adequacy and the desired benefit amount provides a consistency check of the responses. Figure 14 plots the reported results and it can be seen that those perceiving the benefits to be inadequate, in general preferred higher benefit amounts. Nearly all the respondents who felt that the benefit amount was not sufficient to meet

their full costs of nutrition revealed a preference for benefit amounts ranging between 30,000 MMK – 50,000+ MMK per month. Those who felt that the benefits were meeting their full costs or most of the costs, desired lower benefit amounts between 15,000 MMK and 30,000 MMK per month.

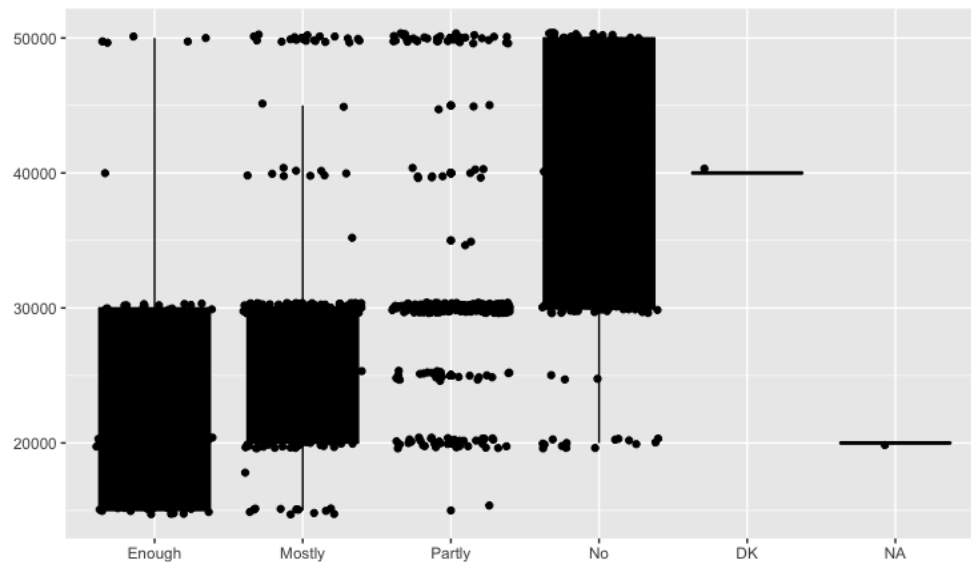


Figure 14: Adequacy versus desired amount

ATTENDANCE AT MONTHLY MOTHER GROUP SESSIONS AND GENERAL AWARENESS ABOUT COMPLAINTS AND WITNESSES

Nearly 265 respondents provided accurate information on the **dates they received awareness sessions**. The dates of the first mother group sessions were concentrated around the end of 2017 – about 7 months after the program had been announced and the first cycle of payments were being made (Figure 15).

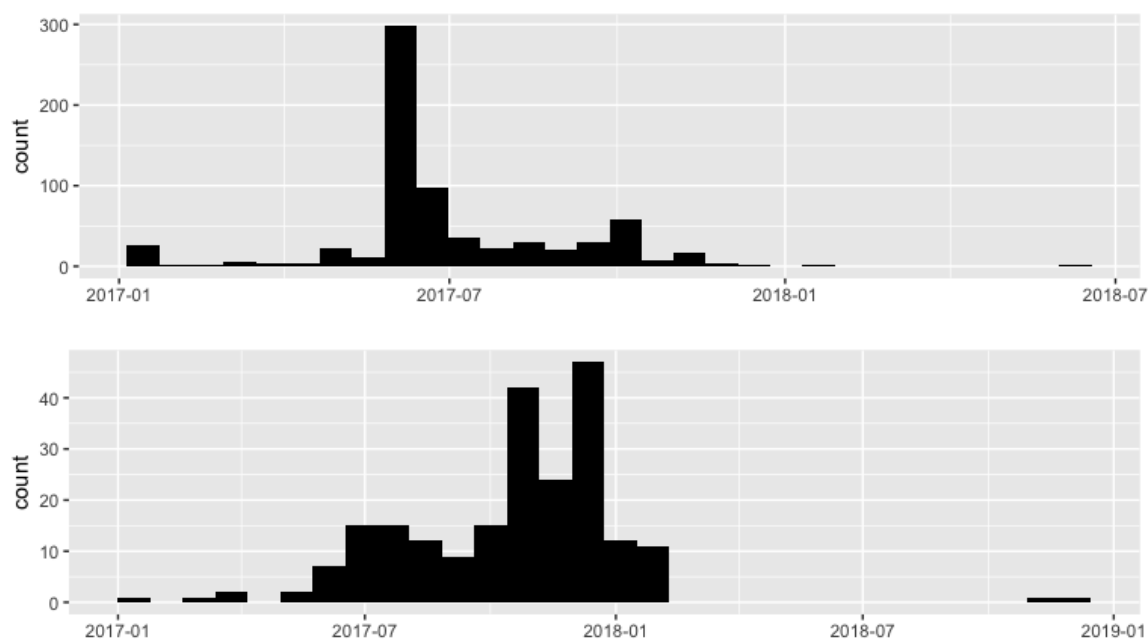


Figure 15: Enrolment dates (top) and 1st mother group session dates (below)

Attendance at regular mother group sessions, as per the valid responses from respondents – came to about 43% (230 respondents) while 52% (278 respondents) said they had not attended regular sessions (Figure 16). Another 5% (31 respondents) did not know/refused to answer. The number of sessions missed were more or less evenly distributed from 1 month to 5 months (Figure 17). The spike seen in the category of others reflect the fact that many respondents reported that mother support group sessions were not yet available in their village (60% of those in this category). Other reasons for not attending regular mother group sessions are shown in Table 2. Many respondents were unaware of either the time or the place at which these sessions took place. For some respondents the date/time/location was inconvenient or too far.

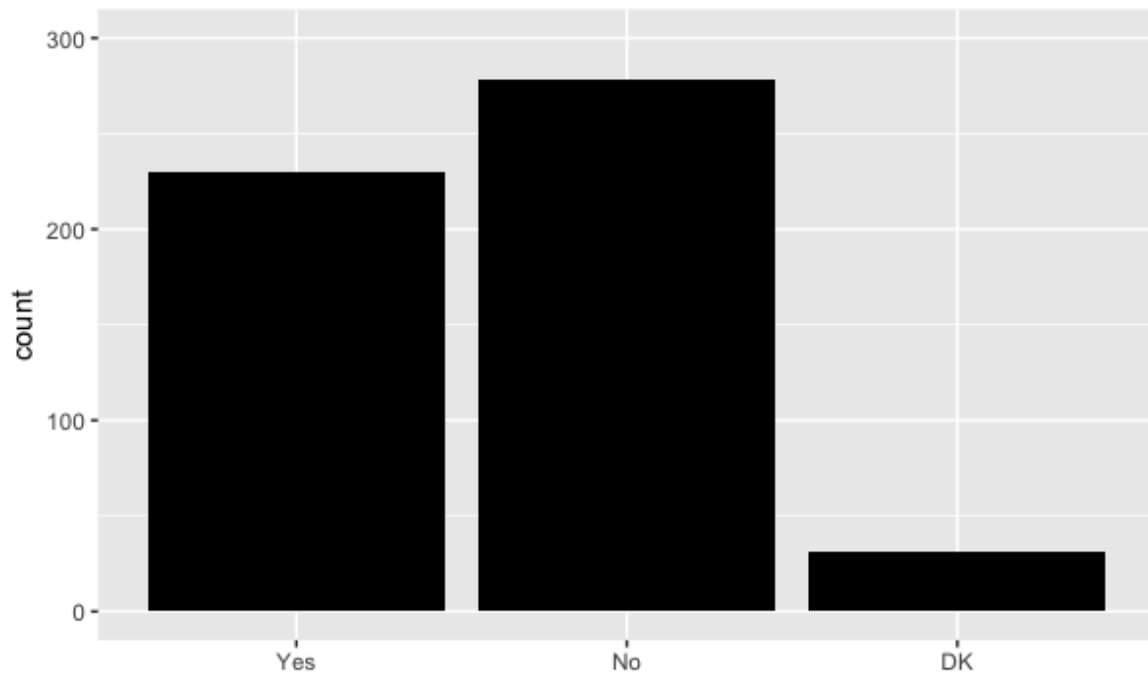


Figure 16: Regular attendance at mother group sessions

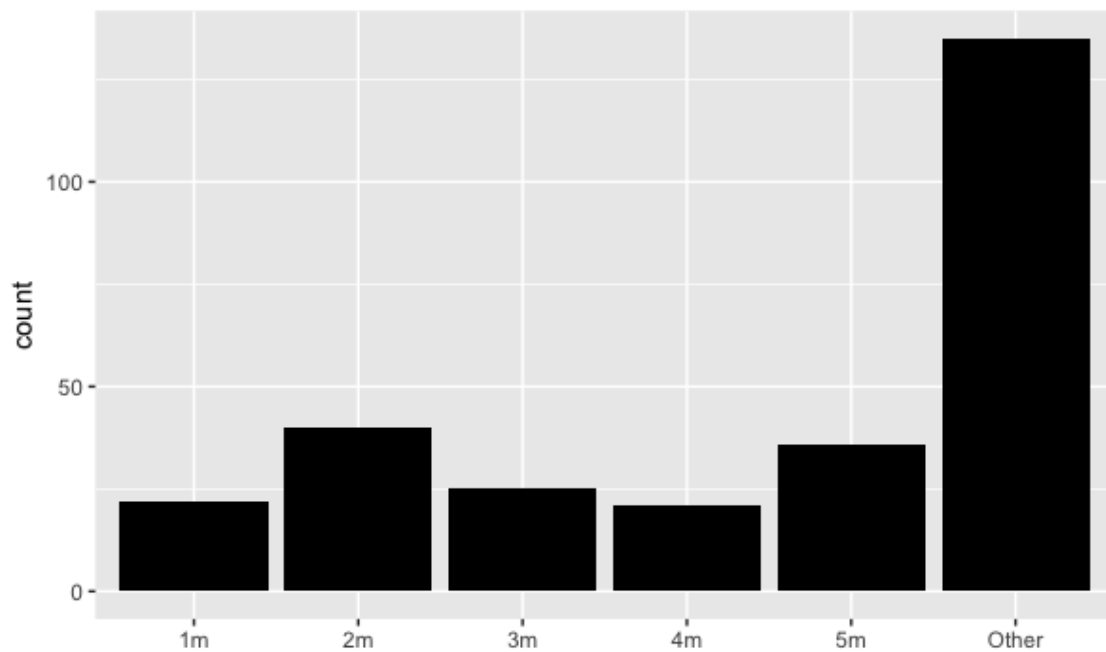


Figure 17: No. of months absent from mother group sessions

Table 2: Reasons for not attending monthly mother group sessions regularly

Reason	Yes	N Valid	%
Did not know where	144	205	70.2

Did not know when	104	200	52.0
Too far	7	144	4.9
Inconvenient date/time	14	144	9.7
Do not understand	1	141	0.7
Don't find it useful	1	141	0.7
No such facility	54	144	37.5
Source: From Chin PDM Data files			

The benefits of attending mother group sessions can be seen in the form of **changes reported in various kinds of behavioral patterns** (Table 3: Changes from mother group sessions). Of those attending regularly (278 cases), many respondents reported increased knowledge about the importance of dietary diversity (69%), exclusive breastfeeding (54%), improved knowledge on child/infant feeding (40%), importance of seeking ANC (37%), Immunization schedules (37%) and importance of health care (38%). In addition, many respondents reported increased awareness on household hygiene (34%) and 20% felt that mother group sessions also allowed them to access knowledge and expertise through other pregnant women. Other areas such as improved knowledge on birth spacing, personal hygiene and general knowledge on health and nutrition appear not to have improved in comparison.

Table 3: Changes from mother group sessions

Increased knowledge area	Yes	Total attended	%
Importance of diet diversity	193	278	69%
Importance of exclusive breast feeding	149	278	54%
How to feed infant/child	112	278	40%
Seeking ANC	103	278	37%
Immunizations	102	278	37%
Health care for child	107	278	38%
Maintaining good hygiene	95	278	34%
Network access through other pregnant women	56	278	20%
Personal hygiene	6	278	2%
Birth spacing	2	278	1%
General knowledge on health and nutrition	8	278	3%
No changes reported	1	278	0%
Others	4	278	1%

Respondent's knowledge about the complaint focal persons in their village is limited to less than 20% of the respondents with valid answers. As can be seen from Figure 18 most respondent's (80%) did not know about the complaints focal person. This lack of knowledge is similar across most townships except Tonzang and Tedim where comparatively larger share of respondents had heard of the complaints person (40% and 42% respectively). The data shows very little variation with respect to date of enrolment which is rather concerning as the enrolment cycle has been ongoing for little under a year. Increased communication on this matter to beneficiaries is a prudent solution.

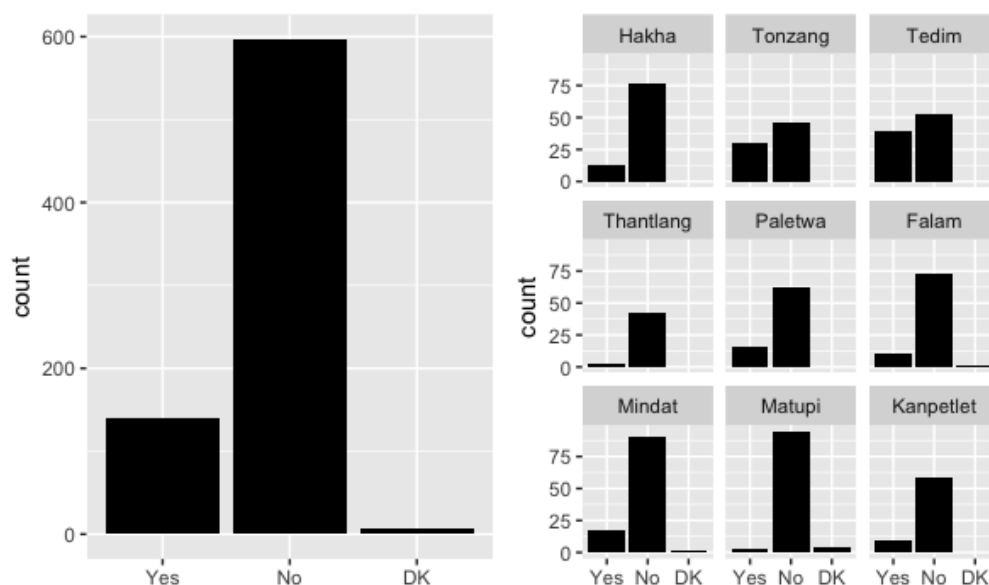


Figure 18: Knowledge about complaint focal person

In contrast, nearly 62% of respondents knew **who the responsible witnesses were** during payments while 37% were unaware (Figure 19). This pattern is more or less the same across townships except in Mindat where significantly more respondents reported not knowing the witnesses.

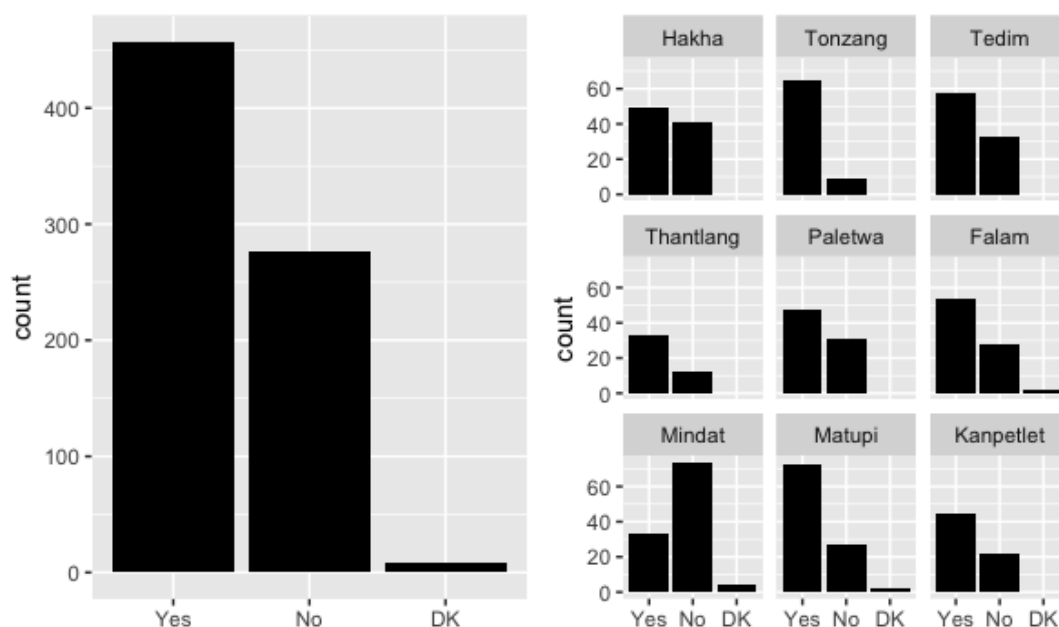


Figure 19: Knowledge about witness during payment

Combining data on knowledge about complaints and knowledge about witnesses, it can be seen (Table 4) that nearly 32% of all respondents did not know about both the focal person for complaints as well as the witnesses during payments. Another 48% knew about the witnesses but

not about the complaints focal person. Only 13% knew of both the complaints focal person and the witnesses.

Table 4: Knowledge about complaints and witnesses (%)

Knowledge about complaints	Knowledge about witnesses during payment		
	Yes	No	DK
Yes	12.5	6.1	0
No	48.1	31.5	1
DK	0.7	0.0	0.14

Source: Created from Chin PDM data

RECOMMENDATIONS

Respondents provided **recommendations about the program**. An overwhelming majority of respondents who had recommendations supported the program. Most of the recommendations suggested an increase in the benefit amount, increase in the frequency of payments and continuation of the program in the longer term. Some recommendations had to do with improving the clarity of communications, both before and after payments among stakeholders.

In conclusion, this note reported on a wide set of variables collected in the first PDM for the Chin MCCT. The results are clearly encouraging for a first generation MCCT program in a low income low infrastructure setting. At the same time, the data point to areas where further attention could be warranted (such as in communication/awareness).

For the next PDM – the lessons learnt in fielding this tool as well as refresher trainings and further improvements in the data entry protocols are areas that need some attention. In particular, it may be fruitful to ensure uniformity in survey tools to avoid heterogeneity in data entry quality.