Chin State MCCT Programme
2nd Post-Distribution Monitoring Report

October, 2018

Social Protection Section, Department of Social Welfare,

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1. Background

1.1 Overview of the MCCT Programme

The Maternal and Child Cash Transfer (MCCT) Programme is one of the eight flagship social protection programmes laid out by the Government of Myanmar in the National Social Protection Strategic Plan (NSPSP). The NSPSP was endorsed at the end of 2014, with an aim to promote human and socio-economic development, strengthen resilience to cope with disasters, enable productive investments and improve social cohesion. The MCCT Programme as a first of the flagship programmes, started in Chin State in June 2017 with technical support of UNICEF and financial support of LIFT. And then the programme rolled out to Rakhine, Naga land in January 2018. The MCCT programme has been recently scaled up to Kayah and Kayin State with effect from 1st October 2018.

1.2 Rationale, objectives and progress update of MCCT Programme in Chin

Nutrition indicators for mothers and children in Myanmar are worrisome. As per the preliminary results of the 2016 Demographic Health Survey, about 29% of children under 5 are stunted and 19% are underweight. Only 51% of children under 6 months are exclusively breastfed. Only 16% of children under 2 years receive the minimum acceptable diet. About 47% of women aged 15-49 year are anemic. The situation is worse in some states/regions. In Chin, for example, 41% of children are stunted.

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. This is because unmet needs during the first 1,000 days of life (from conception to 24 months of age) can perpetuate an intergenerational cycle of poor nutritional status. All pregnant women in Chin State are eligible for enrollment in the MCCT programme and they will continue to receive programme benefits until their new child reaches the age of 24 months. Once enrolled on the programme, the pregnant women and mothers receive:

- MMK 30,000 every two months
- Monthly awareness-raising on nutrition, health & hygiene

To date, MCCT programme in Chin State has registered approximately 25,000 women beneficiaries. The programme has made seven (07) bi-monthly payments to beneficiaries. The last payment was made to 23,153 beneficiaries. The details of the payments is given as under:

Table 1: Details of Payments

Payment Cycle	Number of Beneficiaries	Payment Month
1st	8515	October,2017

2nd	10678	November,2017
3rd	13383	December,2017
4th	16354	February,2018
5th	18310	April,2018
6th	20520	June,2018
7th	23153	August,2018

1.3 Post-Distribution Monitoring

The MCCT Post-Distribution Monitoring system will be an effective monitoring tool that will provide quantitative and qualitative information about the MCCT processes and outcomes. The PDM beneficiary survey will be the primary source of data for PDM, in conjunction with focus group discussions and market monitoring surveys. The PDM will generate robust information through both quantitative and qualitative monitoring to help DSW and key stakeholders in making informed decisions on the design and implementation of MCCT.

1.4 Objectives of the Post-Distribution Monitoring (PDM)

The objectives of the post-distribution monitoring are to provide regular/periodic data to Social Protection Section (SPS) to make informed decisions on the program design and implementation mechanism. The PDM also records beneficiaries' perceptions about the programme processes and how they are spending the money. PDM is also used to reinforce accountability, provide feedback for the programme improvement/immediate course correction and helps to identify the potential risks.

More specifically, PDM serves the following objectives for MCCT programme:

- To establish if beneficiary women have received the cash transfer and how the money is spent;
- To find out about beneficiary's coping mechanism;
- To identify types of challenges faced by beneficiary during the implementation of MCCT i.e registration, payment, awareness sessions and complaint management; and
- To gather perceptions and opinions from beneficiaries on various aspects (for example: empowerment/decision making on use of cash at home, increased financial control over resources, better nutrition).

1.5 PDM Beneficiary Survey Questionnaire:

The PDM beneficiary survey questionnaire has been developed keeping in view theory of change (TOC) of MCCT program and covers the following broad areas:

- Background and household characteristics of beneficiary household
- Information pertaining to beneficiary registration (how, time taken, when registered)

- Payment of MCCT cash transfer (process, how, when, frequency, how much & adequacy of the transfer)
- Usage of MCCT cash transfer
- Awareness Sessions (attendance, frequency and behavioural change)
- Complaints Mechanism (information about process, any complaints or suggestions)
- Beneficiary perceptions on empowerment & effectiveness of the transfer

1.6 Training of DSW Staff/Case Managers on PDM Beneficiary Survey

A one-day training of the MCCT Chin Staff (1 MCCT Coordinator, 1 District Coordinator and 22 Case Managers) was organized at SPS/DSW Office in NPT on 25th September 2017. The interactive training covered following sessions:

Session 1

- Introduction, Tools and Objectives of Post-Distribution Monitoring Process
- Process flow for the PDM process (sampling, logistics arrangement, preparation for the data collection, data collection, data analysis and reports generation)
- Interactive Quiz and Q&A

Session 2

- Guidelines for the data collection – conducting PDM beneficiary survey
- Route planning and Mapping exercise for PDM beneficiary survey
- Practice on Standard introduction statement & Q&A

Session 3

- PDM form – instruction to fill each question
- Role playing to practice the form
- Discussion on the tricky/difficult questions and how to approach them during the survey & Q&A
- Next Steps

1.7 Sampling and Data Collection for 2nd PDM beneficiary Survey:

The approved registered beneficiary list was used as the base to extract the sample for PDM beneficiary survey. Since the DSW Case Managers are required to visit 2-3 wards/4-6 villages in his/her township in line with follow-up on any statutory cases, provide overall oversight to MCCT programme activities in the township, the convenience sampling was used which covered around 4% of the beneficiaries after 4th payment cycle. The PDM survey was conducted during April and May 2018 and covered 596 beneficiary women. The interviews were held at the homestead of the beneficiary women.

Following is the township-wise breakdown of MCCT beneficiary respondents for the 2nd PDM.

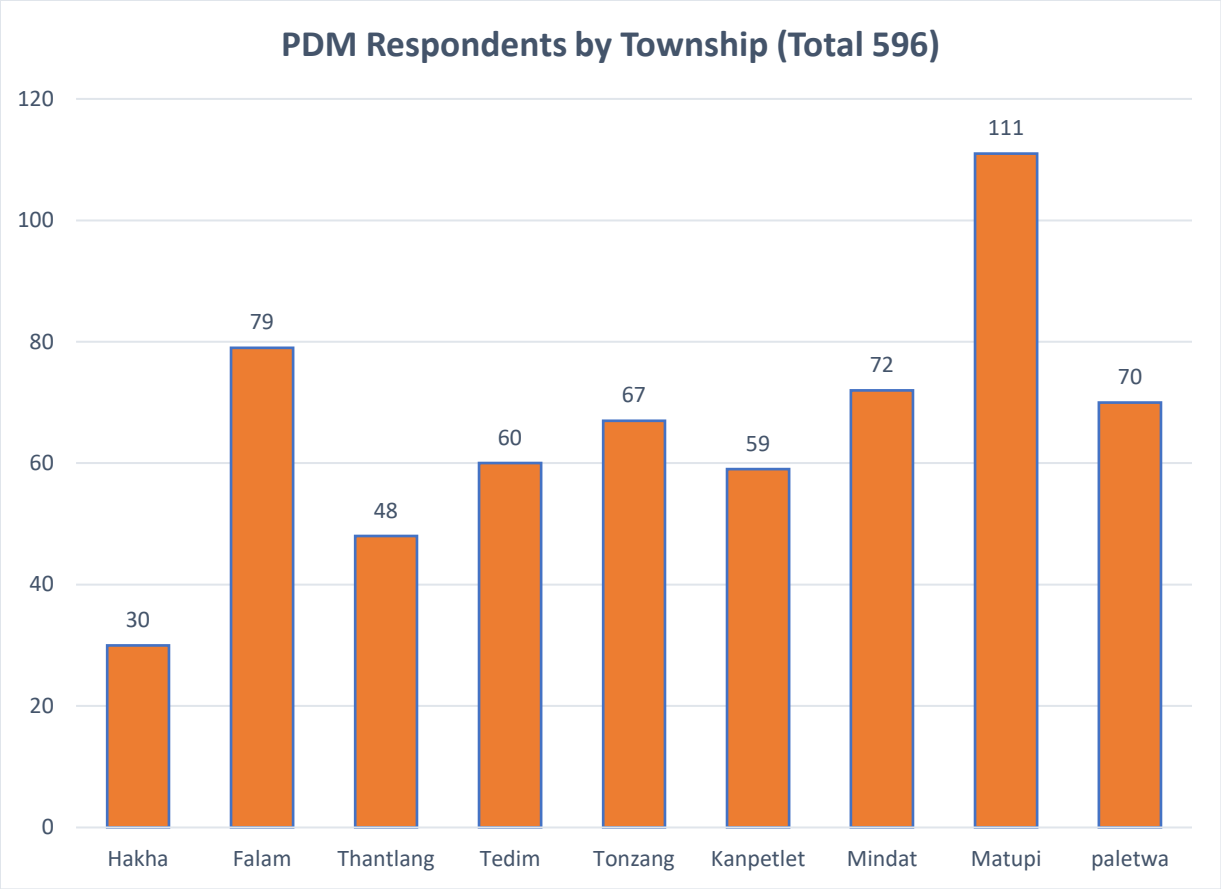

Figure 1: Township-wise PDM respondents

The PDM data was collected by using both paper based PDM forms and digital data collection supported by an android mobile application. The data entry of paper based forms was carried out in the month of June-July 2018.

2. Findings of the 2nd PDM

2.1 Profile of Beneficiaries (PDM Respondents)

All the surveyed respondents were pregnant women and mothers with children under two years. 75% of the respondents were mothers and 25% were pregnant women. Majority of respondent pregnant women (63%) were in their third trimester of the pregnancy, 27% in second trimester and 10% are in their first trimester of the pregnancy. 36% of the mothers have children of 3 or less than 3 months, 32% of children are between the age of 4-6 months and 32% of children falls between ages of 7-12 months. The average age of PDM respondent was 30 years, however minimum age was 17 years and maximum age of beneficiary was 43 years.

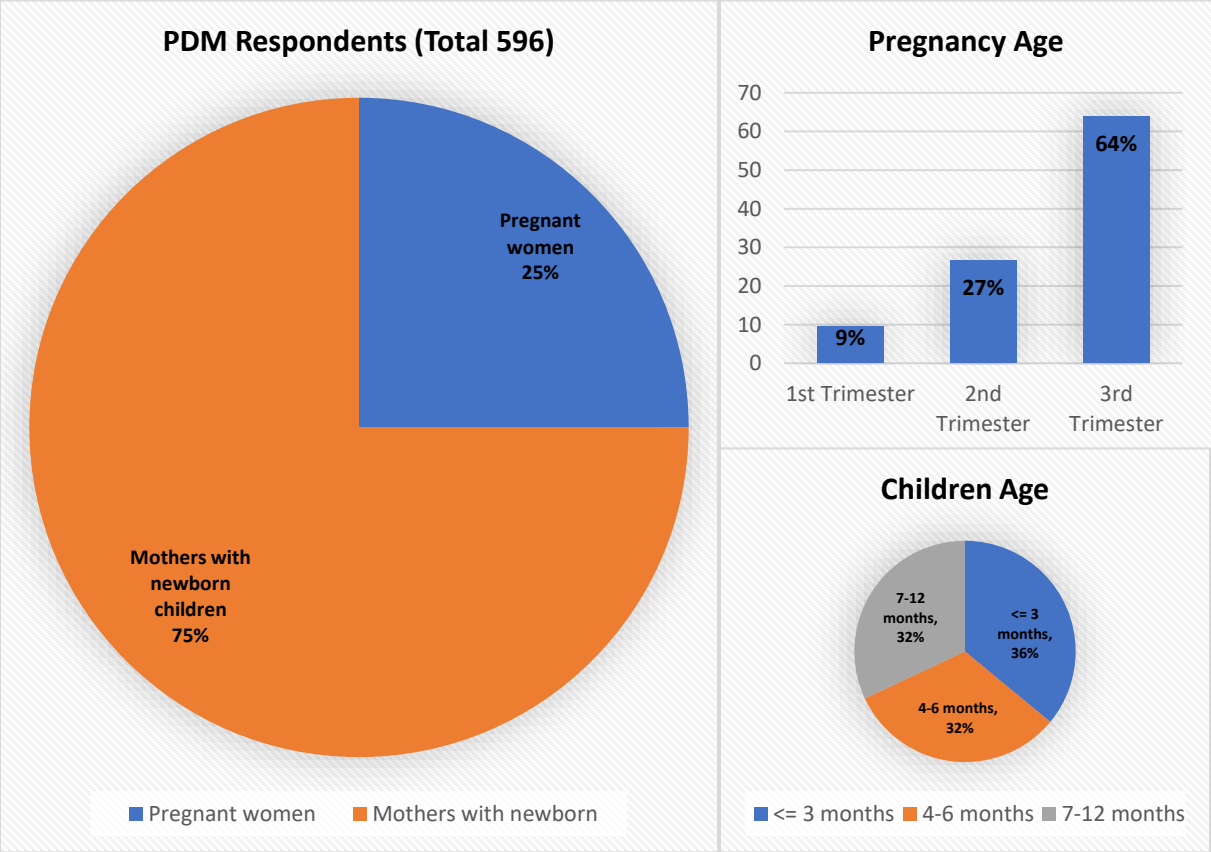

Figure 2: Demographic Status of PDM Respondents

2.2 Collection of Cash Transfer (Payment)

2.2.1 The status of receiving regular payment

Out of the total respondents, 91% of respondents collected regular bi-monthly payments of MMK 30,000 after they registered into the programme. However, 9% respondents reported that they missed at least one payment. Majority of the respondents have registered into the programme in the last two quarters of 2017.

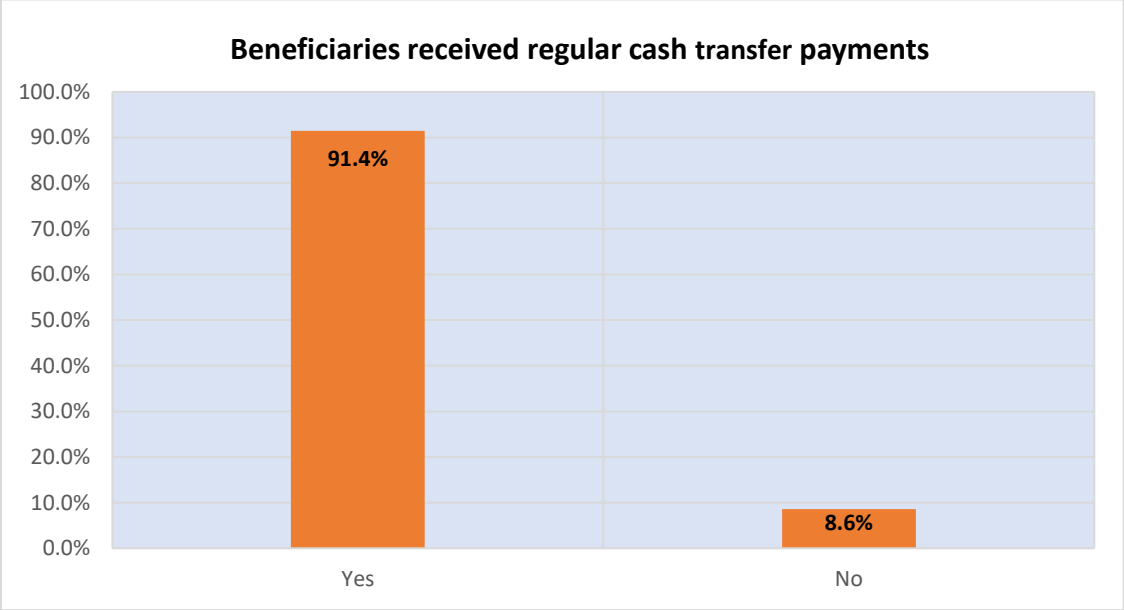

Figure 3: Receipt of Regular MCCT payments

2.2.2 Details of missing payment

Beneficiaries who did not collect regular payments were asked about the details of missed payments. 47% stated that they did not collect 1st bi-monthly payment. 26% reported that they did not collect their 2nd bi-monthly payment, rest of the respondents (26.6%) shared that either they missed 3rd bi-monthly payment or any other payment.

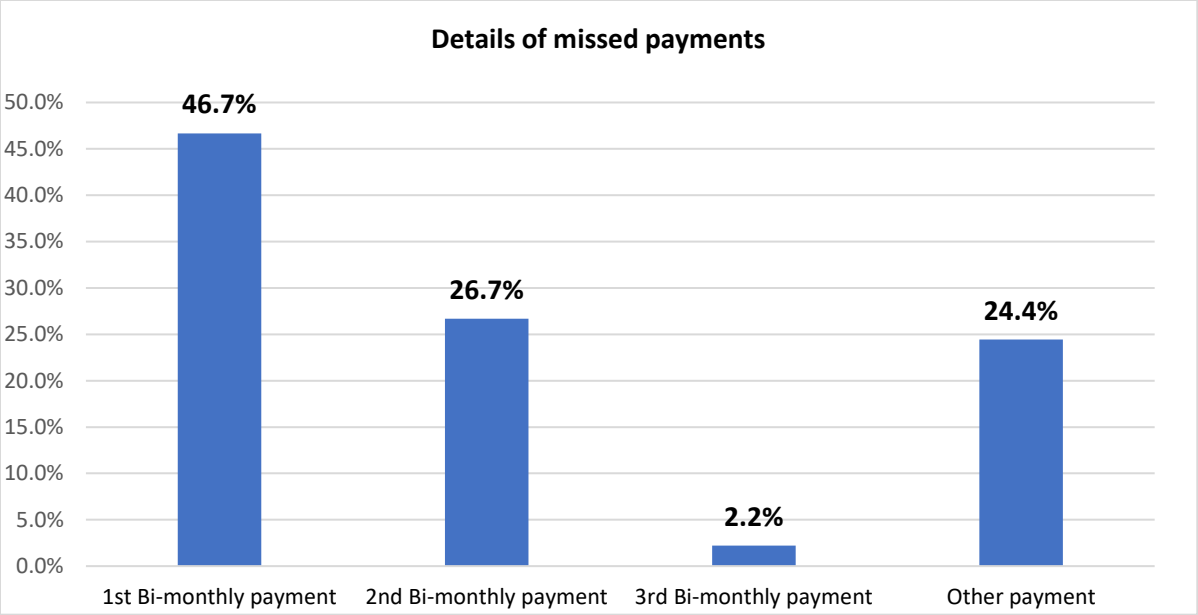

Figure 4: Details of missed MCCT payments

2.2.3 Pre-disbursement information/communication:

The respondents were asked if they were informed about in advance of the time and placed to collect the MCCT cash transfer. 89% of the total respondents shared that they received the advance information/communication about the last payment. Whereas, 10% mentioned that they did not receive pre-payment information and 1% did not answer to this question.

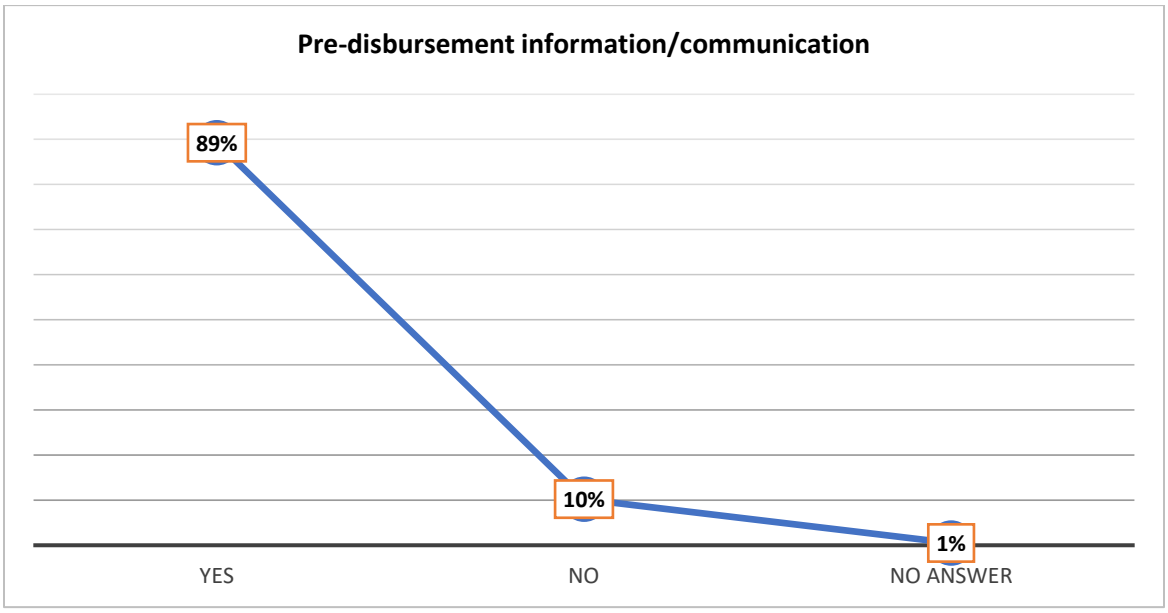

Figure 5: Pre-disbursement information to beneficiaries

2.2.4 Waiting/Queuing time at Payment Point/Site:

Beneficiaries were asked about how long did they have to wait at the payment point to receive the cash transfer. Half of the respondents said that they were paid in less than 15 minutes. 21% of beneficiaries took between 15 to 30 minutes in order to collect the last cash payment. 19% beneficiaries reported that it took 30 minutes to 1 hour to receive the payment at the disbursement site. Only 8% took more than 1 hour to collect the payment.

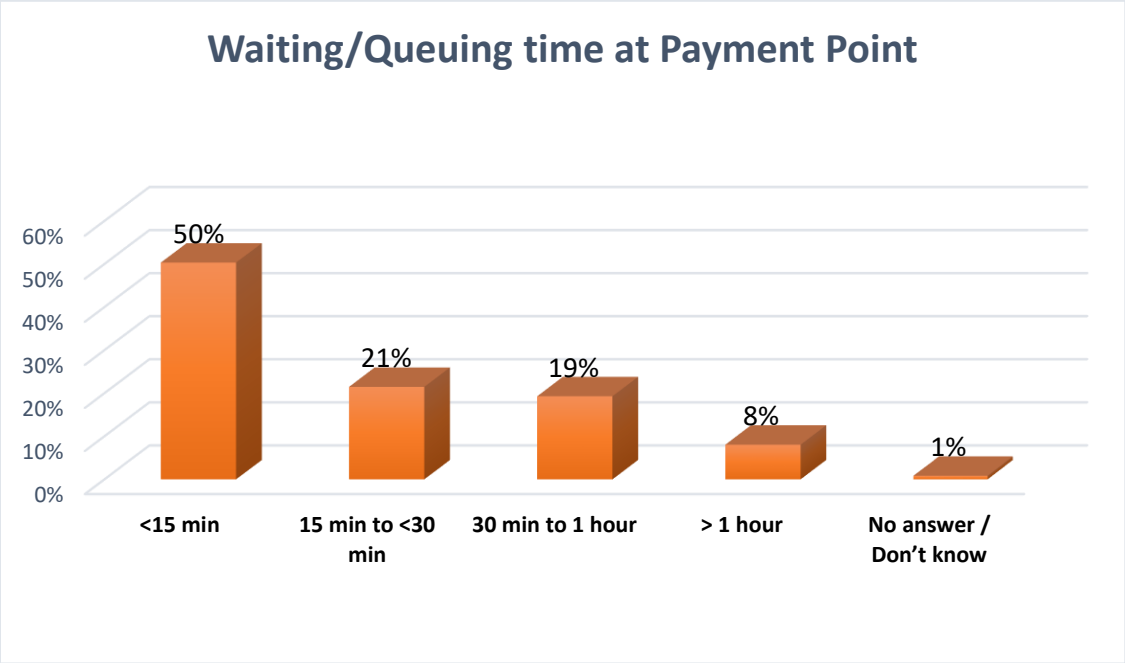

Figure 6: Waiting time at the Payment site

2.2.5 Amount of last payment received

PDM respondents were asked how much amount/Kyats were received in their last MCCT payment. 89% reported that they received full bi-monthly amount of MMK 30,000. However, 8% of respondents informed that they received MMK 15,000. The beneficiaries who received MMK 15,000 were registered a month before the payment generation process so they were only given cash transfer of one month. The beneficiaries who got amount other than MMK 15,000 or 30,000 (3% of the respondents) stated different reasons for receiving other amount i.e a) person distributing cash said he/she had not received the full amount of cash for beneficiaries in the village; b) beneficiary was not on the payment list received by the person distributing the cash; c) beneficiary owed money to the person distributing the cash transfer; d) Person distributing cash kept some of the cash for themselves and d) beneficiaries were charged a tax / fee to get the cash transfer.

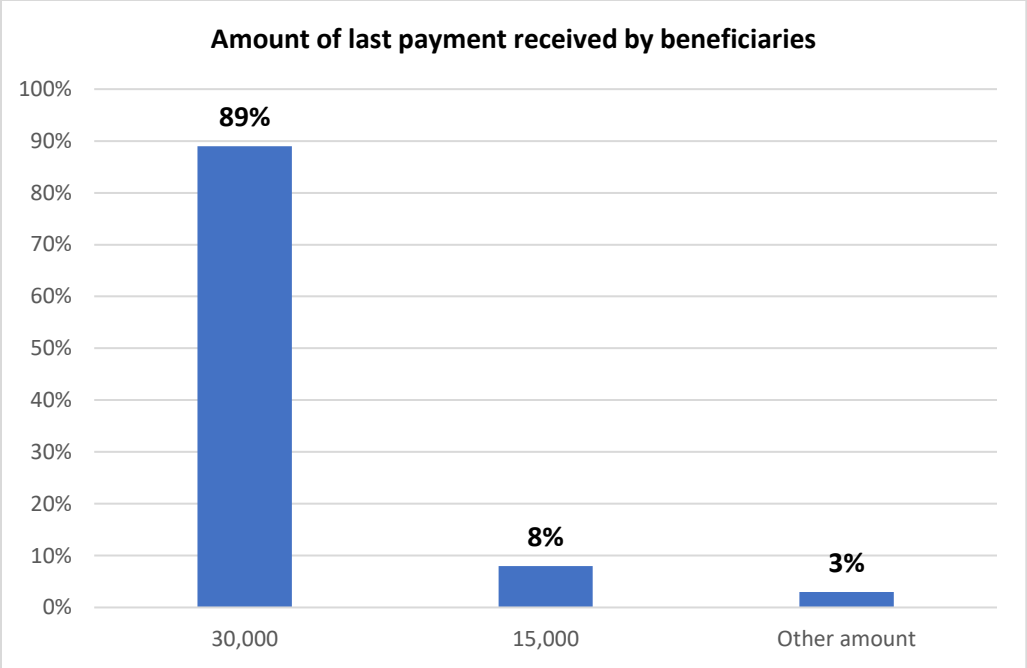

Figure 7: Amount of last payment received

2.3 Use of Cash

2.3.1 Decision on spending MCCT payment

The beneficiary survey respondents were asked who within the household makes the decision on MCCT cash transfer spending. Almost all (94% of beneficiaries) reported that they make the decision on how to use MCCT cash transfer. There were only 3% who said that it is the husband who decides on what to buy from MCCT cash transfer while in remaining 3% of cases mentioned that any other adult male/female member of the household made the decision on the use of MCCT transfer.

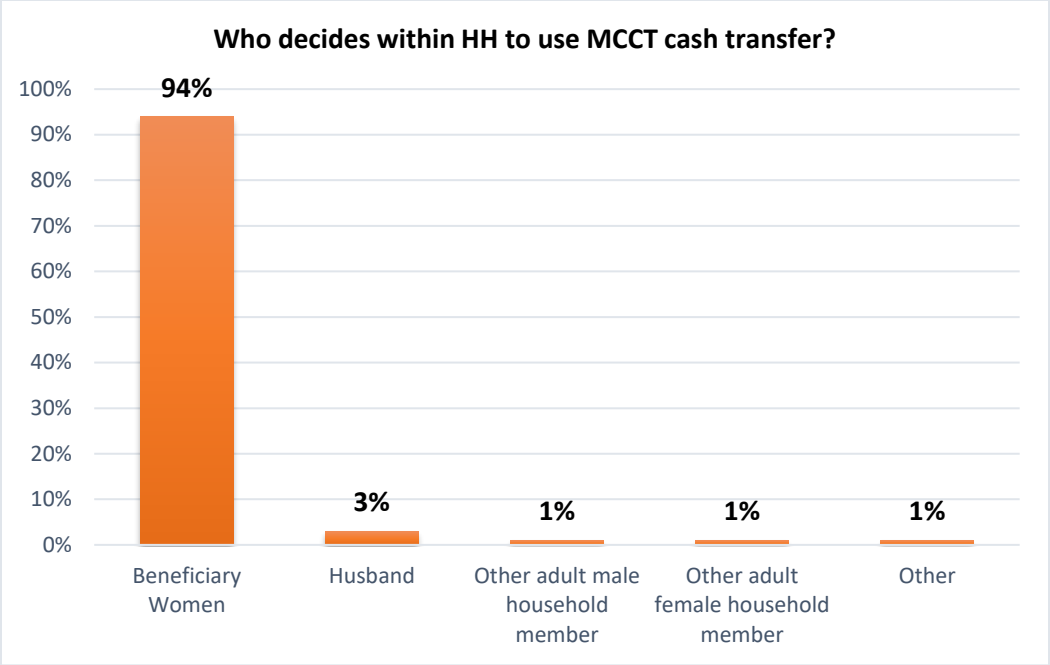

Figure 8: Decision maker in HH on use of MCCT cash transfer

2.3.2 Spending of MCCT Cash Transfer

The MCCT beneficiaries were asked about how they spend cash transfer. Nearly all the respondents shared that they have spent money on buying quantity and variety of food items for themselves, children and family. 46% of the beneficiaries also spent money to pay for health care costs (transportation, drugs & consultation). 18% of respondents also used part of money on buying formula milk for baby. 27% of the beneficiaries reported that they spent money on buying snacks (sweets/cakes/biscuits etc.)

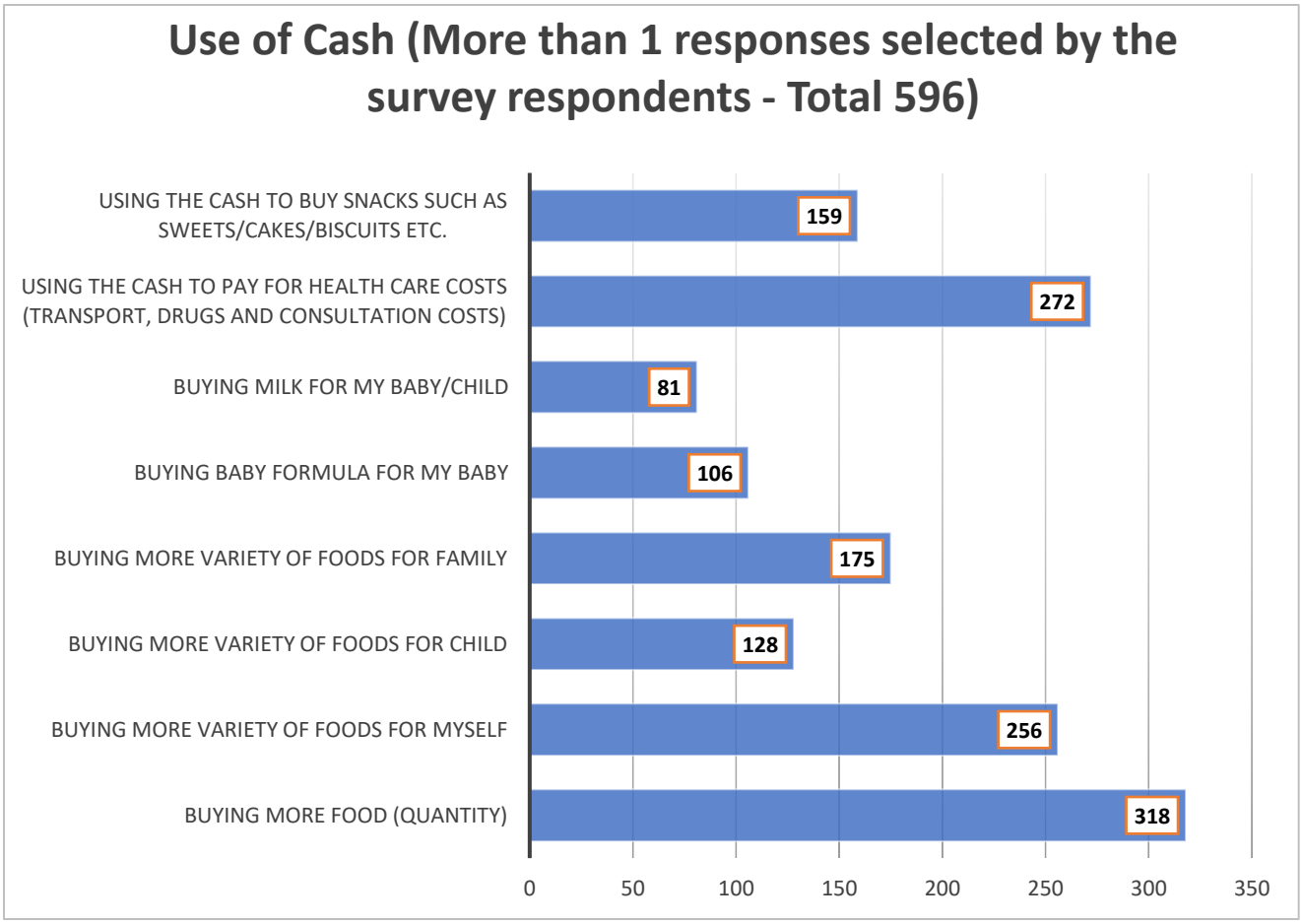

Figure 9: Use of MCCT cash transfer

10% of the respondents also reported that they used cash transfer to buy blankets or warm clothing for children as the last payment disbursed during the winter season of Chin State.

2.3.2 Status of sharing cash with other household members

The Survey respondents were asked if they share cash or food bought with the MCCT cash transfer with other people than them/woman beneficiary or children. 37% responded that they share the cash or food with others whereas 63% said that they do not share with other family members. Those who share cash/food with others were asked to specify, 14% indicated that they share with husband and remaining 84% informed that they share with other household members. However, 2% told that the cash/food bought from MCCT were shared with non-household members.

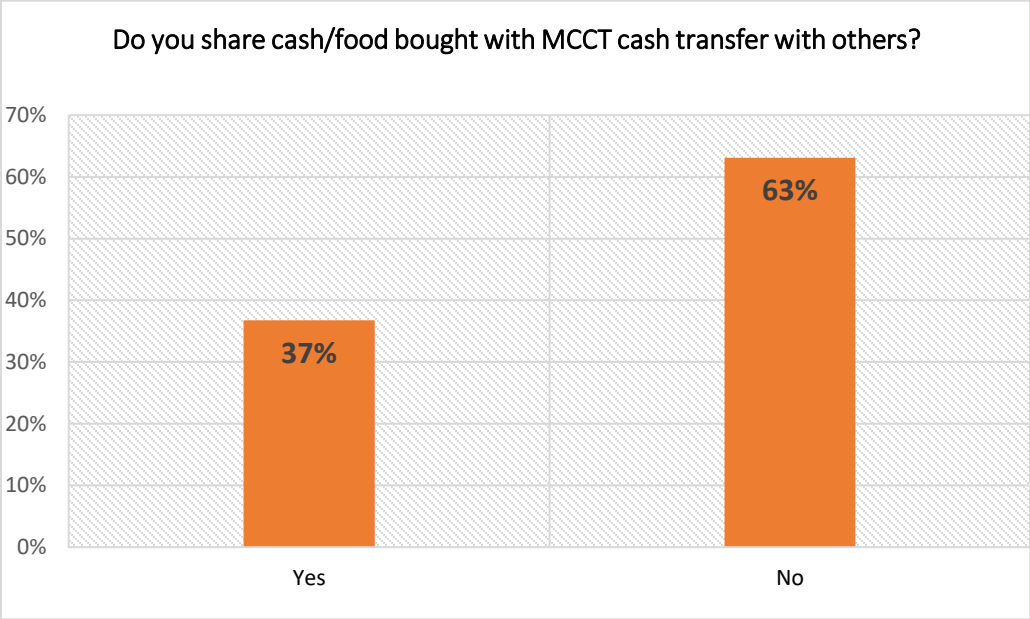

Figure 10: Sharing of MCCT cash transfer

2.3.3 Adequacy of Size of Cash Transfer

Though MCCT is not intended to cover all household food costs and is only to supplement normal income. The PDM beneficiary survey were also asked if they think MCCT cash transfer is enough to cover nutritious food for them and their children. 13% responded that the cash transfer is sufficient for nutritious food for them and their child, 15% of the respondents shared that the cash amount is adequate to cover most of nutritious food requirements, 56% informed that it covers some nutritious food needs, however 15% said that it is not sufficient to cover for nutritious food for them and their children. When they were asked to report what monthly allocation of kyat would be more appropriate, 15% mentioned MMK20,000 per month, 33% said MMK 30,000 per month, rest of the respondents' answer was between MMK 25000 to MMK 60,000.

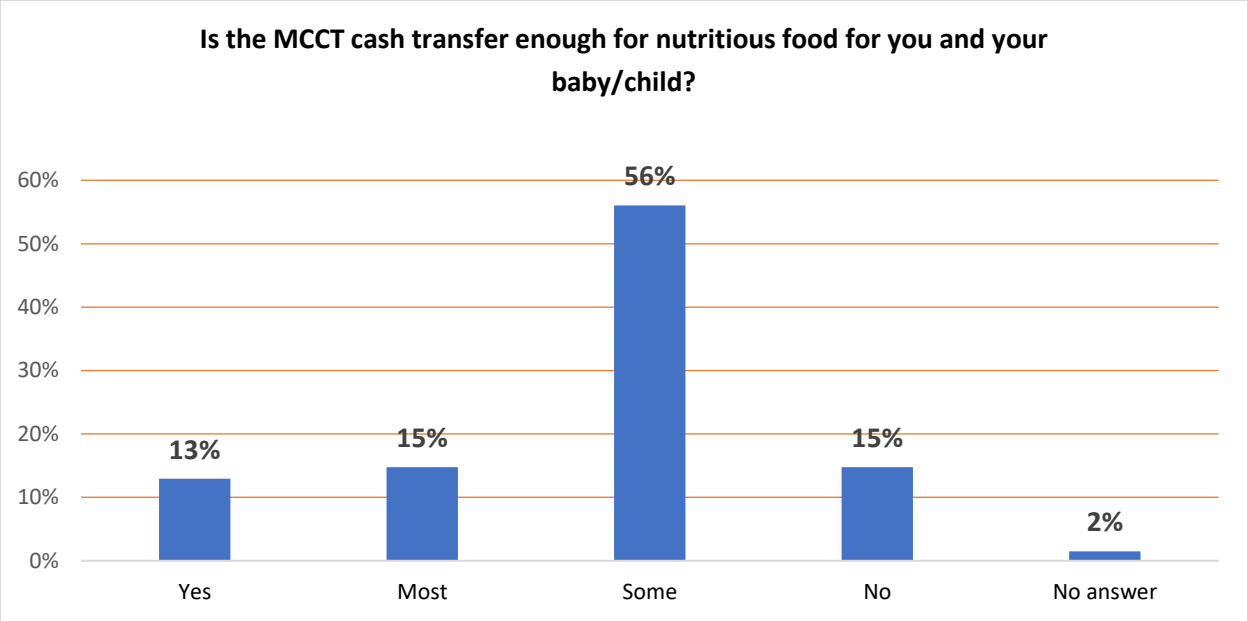

Figure 11: Adequacy of MCCT Cash Transfer

2.4 SBCC Awareness Sessions

2.4.1 Awareness Sessions

Beneficiaries were asked if they have attended regular SBCC Awareness Sessions. Slightly above than one third (36%) of the respondents reported that they have attended regular awareness sessions. However, slightly less than one third (31%) responded that they have not attended regular sessions. Whereas one third of the respondents did not answer to the question.

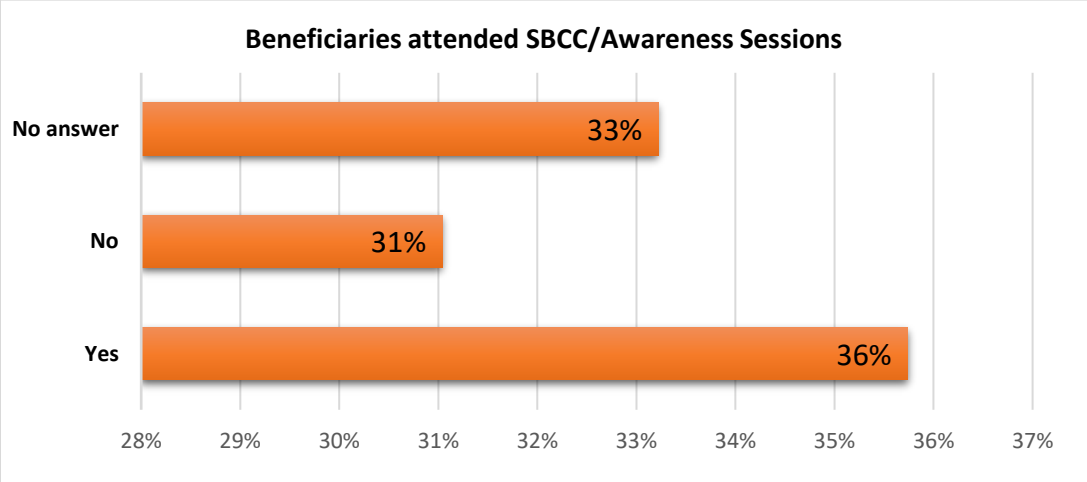

Figure 12: Attendance at Awareness Sessions

The beneficiaries could not attended that awareness sessions shared the reasons for not attending the sessions. 81% shared that the awareness sessions were not organized, 11% informed that they did not know the time and venue for the awareness session and remaining 8% told that they could not attend the awareness session due to traveling, job, illness etc.

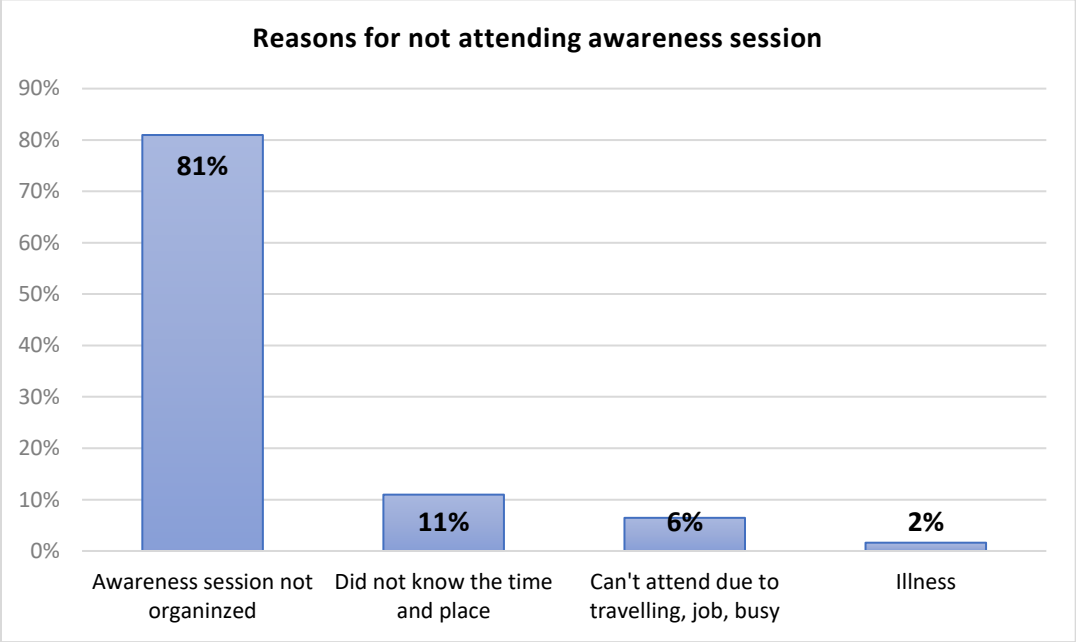

Figure 13: Reasons for not attending Awareness Sessions

2.5 Complaints Focal Person and Payment Eye-witness

The PDM survey respondents were asked if they know who in their village/ward is responsible for registering complaints related to MCCT programme. 29% of the respondents shared that they know about the complaints focal person in their ward/village, However, most of the respondents (69%) did not know about the complaints focal person for MCCT programme. The respondents were also asked if they know who is responsible for witnessing the bi-monthly payment of MCCT beneficiaries. 64% reported that they know about the eye-witness responsible person, and 33% shared that they do not know about the eye-witness.

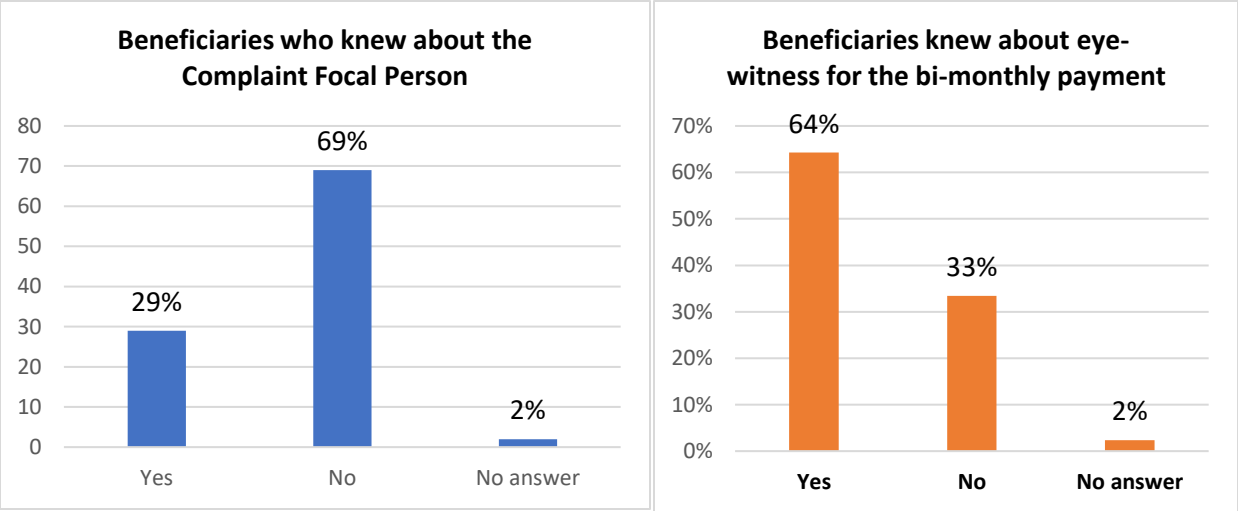

Figure 14: Knowledge about the Complaint focal person and Eye-witness

3. Conclusion & Recommendations

The findings of the second post-distribution monitoring are overall positive and encouraging particularly related to regular bi-monthly cash transfer collection by 91% of the survey beneficiaries, advance information to 89% of MCCT beneficiaries about the payment date and venue, less waiting time at payment site as 71% of the beneficiaries collected their cash within 30 minutes after reaching payment point. Almost all (94%) of beneficiary women make decision themselves on the use of cash transfer. Moreover, there is a clear indication from the post-distribution monitoring that cash is being used on buying quantity and variety of food items for the beneficiary women and children. Global evidence also suggests that giving cash to women has positive impact on wellbeing of women and children as women tend to spend more on the food and immediate needs of the children.

The insights and reflections collected through PDM also provides an opportunity to Social Protection Section/Department of Social Welfare to address few key areas which require immediate course correction i.e programme communication, regularity of SBCC awareness sessions, and raising awareness about the complaints and feedback mechanism among public in general and beneficiaries in particular. There are few additional areas which needs further research/follow up for example use of part of cash on formula milk and snacks etc. which can be looked into in detail when formative evaluation is done (planned in early 2019).

3.1 Key Recommendations (MCCT Programmatic/Implementation):

3.1.1 Programme Communication:

Programme communication needs more attention to sensitize general public, MCCT beneficiaries and stakeholders about the programme, implementation processes and calendar of regular and predictable payments. The information about regular payment cycle will help beneficiaries to predict cash transfer and plan spending related to the immediate and pressing needs related to woman and children nutrition and health care. Information, education, and communication package should include MCCT poster, flyer, banner in Chin language. Further, local innovative means should be used to raise the awareness.

3.1.2 SBCC Awareness Sessions:

SBCC component may be strengthened by developing the mapping of ward/village wise MCCT beneficiaries and linking them with the Mother Support Groups (MSG) being formed to support MCCT programme. All MSGs can identify a focal person from each group who will coordinate the awareness sessions in close collaboration of the DOPH midwives and Auxiliary midwives/community health workers/health volunteers etc. These groups through the focal MSG can coordinate with the DSW township case managers on calendar of regular payments, grievance rederessal and other associated areas of the MCCT programme. In addition to this, there is need to review the agenda of

awareness sessions, timing, venue and devise the strategy to make it more smooth and interactive which maintains beneficiaries' willingness and interest to regularly participate.

3.1.3 Follow up/detailed enquiry on PDM findings through Formative Evaluation:

PDM does raise some of the key areas which needs further and detailed follow up for example: use of cash transfer on formula/baby milk, snacks, adequacy of cash transfer, reasons of beneficiaries not attending SBCC awareness sessions, distance/travel time from beneficiary residence to the registration and payment site, difference of payment amount, assistance received through other flagship programmes etc. This can be done through planned formative evaluation for Chin and Rakhine MCCT in January 2018.

3.2 Recommendation related to next round of PDM:

3.2.1 Review and refinement of PDM instrument:

- Based on the last 2 PDM exercises, It is proposed to review the tool and identify the areas of refinements and further simplify the language, sequence of questions.

- Collect additional demographic information about family, household size, education level of beneficiary pregnant/mothers with new born children, status of her and husband's employment.

- Add question related to distance and travelling time from the residence of the beneficiary women to registration/payment point and idea of related costs.

- Simplify the language of few questions related to use of cash and awareness sessions, this should be done after reviewing all questions with the DSW case managers and identifying which questions were difficult to administer and how those can be simplified.

3.2.2 Sampling:

- Since the first 2 rounds of PDM used convenience sampling which has its risk of biasness as the hard to reach areas and most vulnerable/marginalized households might not sampled. The DSW should consider using probability/random sampling approaches to provide every beneficiary an equal chance of being part of a PDM survey. This approach will draw a sample from the total beneficiary population by random and taking township representative sample. Various statistical software packages including MS Excel can easily help to identify random sample for the PDM.

- The first 2 rounds of PDM survey were administered on different beneficiaries from 1st to 2nd PDM. However, in order to support further analysis and see the variance/change from one quarter/PDM survey to another it is proposed to consider small panel sampling as well.

3.1.3 Data collection through Tablet/Smart devices:

It is recommended to collect all PDM survey data by using tablets/smart gadgets. The second PDM utilized combination of paper based and electronic data collection. The electronic data collection by using an android application will eliminate existing challenges and pitfalls linked to paper based survey and data entry emerged during first two rounds of PDM data collection. The DSW has already developed an android application which should be adopted in all townships. A two-days refresher on PDM Survey android application will support the smooth transition from paper based to fully electronic mode.

3.1.3 Timelines for PDM:

The PDM beneficiary survey is expected to happen regularly/preferably every 3-4 months. Since the MCCT cash transfer is expected to be utilized on the immediate needs of the beneficiary women and children, the PDM survey is to be conducted after 2-3 weeks of MCCT cash transfer payments allowing some time to beneficiaries for spending the money.