Chin State MCCT Programme
3rd Post Distribution Monitoring Report
June, 2019

Department of Social Welfare, Ministry of Social Welfare, Relief and Resettlement

Contents

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. The programme rolled out to Rakhine, Naga self-administered region 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

In Myanmar, about 29% of children under 5 are stunted and 19% are underweight. Only 51% of children under 6 months are exclusively breastfed according to the Demographic Health Survey 2015-2016. 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. As the preliminary result of the Myanmar Micronutrient and Food Consumption Survey, 26.7% of under five children were stunted. 19.3% were moderately stunted and 7.4% were severely stunted. As acute malnutrition rate is 19.1%. 15.7% were moderately underweight and 3.4% were severely underweight. In Chin State, the stunting rate of under five children is highest (40.3%) according to the MMFCS 2017-18.

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 in the programme, the pregnant women and mothers receive:

- MMK 30,000 every two months
- Monthly awareness-raising on nutrition, health, hygiene and family planning

To date, MCCT programme in Chin State has registered approximately 35,000 women beneficiaries. The programme has made tenth (10) bi-monthly payments to beneficiaries. The last payment was made to 31,991 beneficiaries.

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 behavioral change)
- Complaints Mechanism (information about process, any complaints or suggestions)
- Beneficiary perceptions on empowerment & effectiveness of the transfer

1.6 Sampling and Data Collection for 3rd PDM beneficiary Survey:

The approved registered beneficiary list was used to select the sample for PDM beneficiary survey. Convenience sampling was applied in this survey, since the DSW Case Managers were 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.

Data collection Training was conducted on Jan 2019 in Hakha and all case managers were trained for data collection with mobile tablet, KOBO tool. Among 9 townships in Chin State, data was collected in only 8 townships. Paletwa township was not included in the actual data collection because of conflicts in that area during data collection time. The PDM survey was conducted during Jan and May 2019 and covered 437 beneficiary women. The interviews were held at the homestead of the beneficiary women.

Kobo toolbox; mobile data collection tool was used to collect 3rd PDM data and it was collected by 11 Case Managers. Data Analysis was done by using Microsoft excel 2016.

The township-wise breakdown of MCCT beneficiary respondents for the 3rd PDM could be seen in below figure.

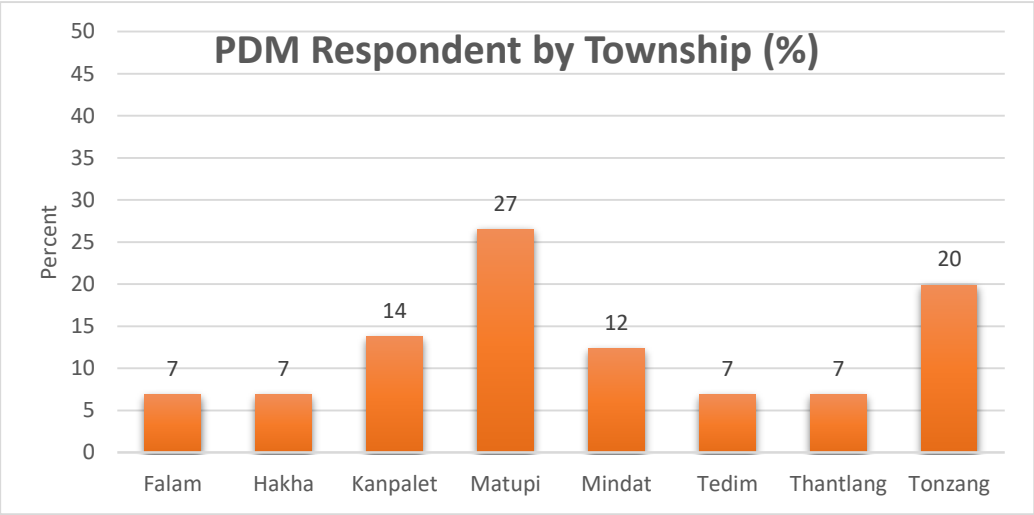

Figure. 1: Percentage of PDM respondent by Township

2. FINDINGS OF THE 3rd PDM

2.1 Profile of Beneficiaries (PDM Respondents)

PDM data was collected from both pregnant and mother of under two children. Although the data was collected in 438 respondents, a mother refused to participate so that there were total 437 respondents.

86% (377) respondents were mother of under two children and 14% (60) were pregnant women. 77% pregnant women were in their third trimester and 23% were first and second trimesters. The minimum age of mothers was 17 and maximum was 48. The average age of the mothers was 28 and the child age was 10.

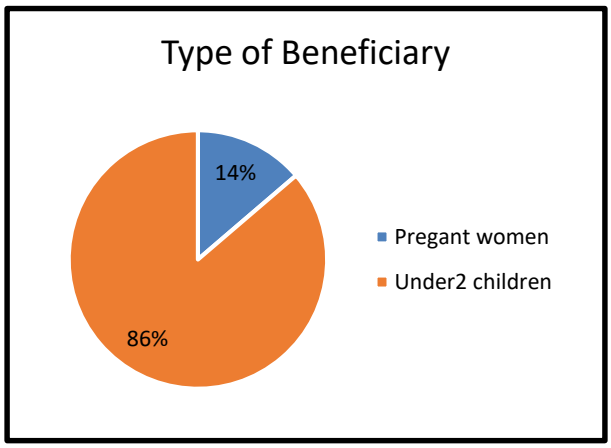

Figure. 2:Type of Beneficiary and pregnant mother

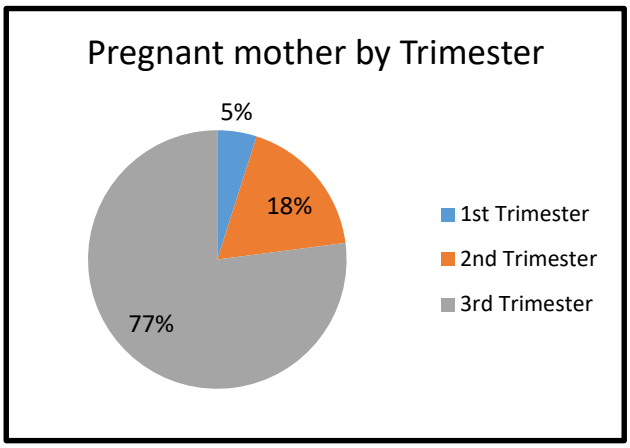

Figure. 3:Type of Beneficiary and pregnant mother

Table (2.1) Age of Beneficiary in PDM

	Pregnant Mother (year)	U2 Child (Month)
Min Age	17	1
Max Age	48	24
Average	28	10

2.2 Cash distribution process

2.2.1 Regular cash payment

Out of the total, 97% of respondents collected regular bi-monthly payments of MMK 30,000 after they registered into the programme. However, 3% of the respondents reported that they missed at least one payment.

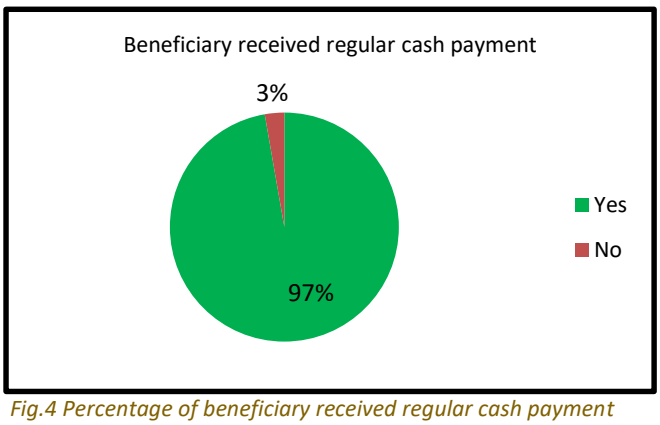

Fig.4 Percentage of beneficiary received regular cash payment

2.2.2 Details of missing payment

Most of the respondents who did not received the payment regularly (30000 per two month) answered that they had received only 15,000 kyats although they had registered. Respondents of missing payment were from three townships (7 in Tonzang, 3 in Matupi and 2 in Kanpetlet).

Table (2.2) Reasons for missing payment

Missing cash payment	Reason	No of respondent	Township
Only received for one month	Not in the payment list of township	6	2-Kanpetlet; 3-Matupi; 1-Tonzang
Received **1st time: 15000** **2nd time: 30000** **3rd time: 15000**	Person distributing cash said he/she had not received the full amount of cash due beneficiaries in the village	1	Tonzang
Don't understand		1	Tonzang
Received **1st time : 20000,** **2nd + 3rd times : 30000** **4th 20000**	Deducted from the office	1	Tonzang
Received **1st time: 15000** **2nd time: 30000** **3rd time: 20000**	Person distributing cash said he/she had not received the full amount of cash due beneficiaries in the village	1	Tonzang

2.2.3 Pre-disbursement information/communication:

More than 96% (419) were informed pre-disbursement information on MCCT cash transfer. Mother who had not received the information in advance of the time and place to receive cash transfer was 4% (16).

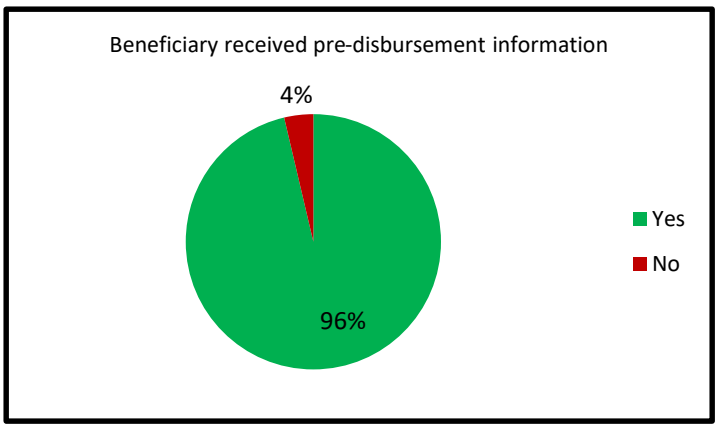

Figure.5 Percentage of beneficiary received pre-disbursement information

2.2.4 Waiting/Queuing time at Payment Point/Site:

One third of the respondents said that they were paid in less than 15 minutes. 35% of beneficiaries took between 15 to 30 minutes in order to collect the last cash payment. 21% beneficiaries reported that it took 30 minutes to 1 hour to receive the payment at the disbursement site. Only 11% took more than 1 hour to collect the payment.

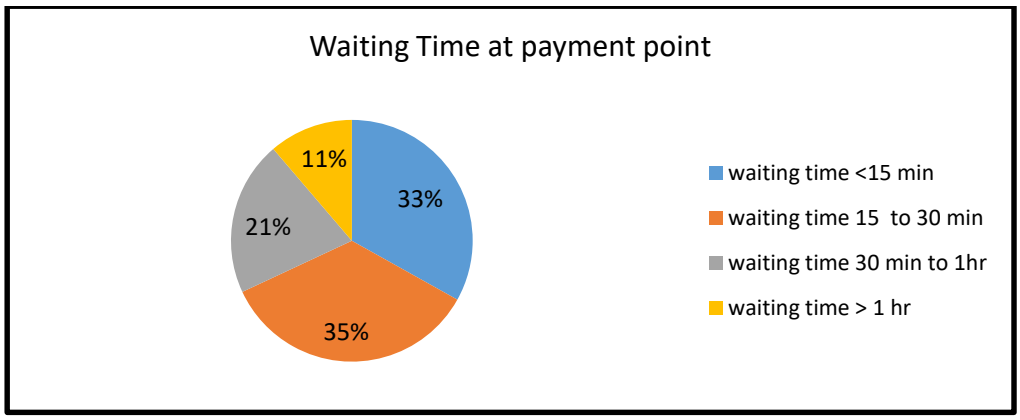

Figure.6 waiting time at the payment point

2.2.5 Amount of last payment received

93% reported that they received full bi-monthly amount of MMK 30,000. However, 5% of respondents informed that they received MMK 15,000. There were a beneficiary who received 60000 MMK and a mother who received 3000 Kyats. Mother who did not receive cash in last payment was only 0.2% (1).

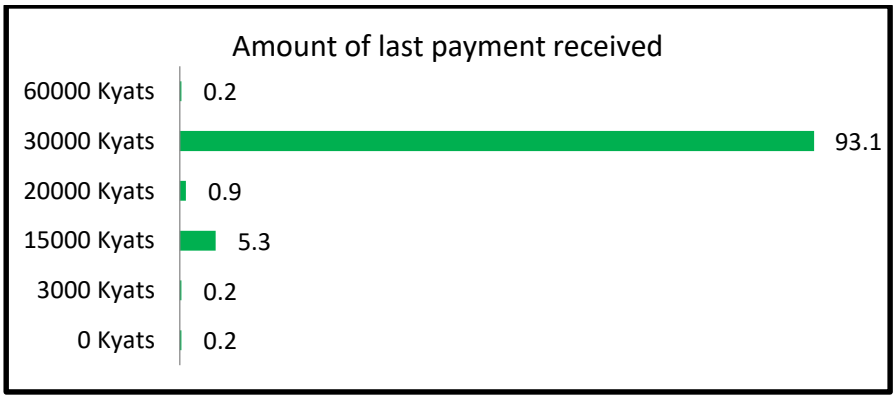

Figure.7 Percentage of mother received cash of last payment by amount

2.3 Use of Cash

2.3.1 Decision on spending MCCT payment

Almost all (99%) the mothers said that they made the decision how to use the received cash of MCCT. Only 1% of the mother reported that the person who decided to use cash transfer was their husband.

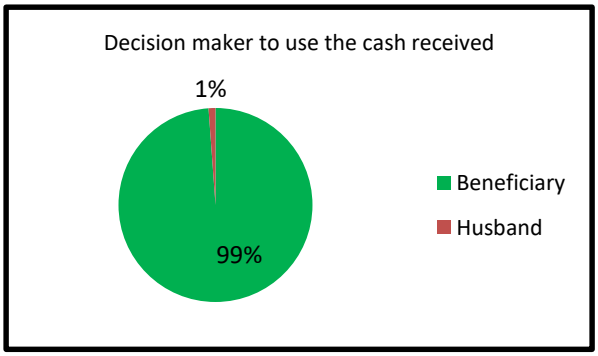

Figure.8 Decision maker to use cash received

2.3.2 Spending of MCCT Cash Transfer

About 60% of the respondent said they bought more food for them and 53% spent the received cash on more food for their children. 30% of the respondent mentioned that they had spent the MCCT cash on buying more food their families and 32% used the cash for their business. About 25% of the beneficiaries bought milk and baby formula for the children. 10% of the mothers used cash to purchase clothes, shoes and blanket for their children.

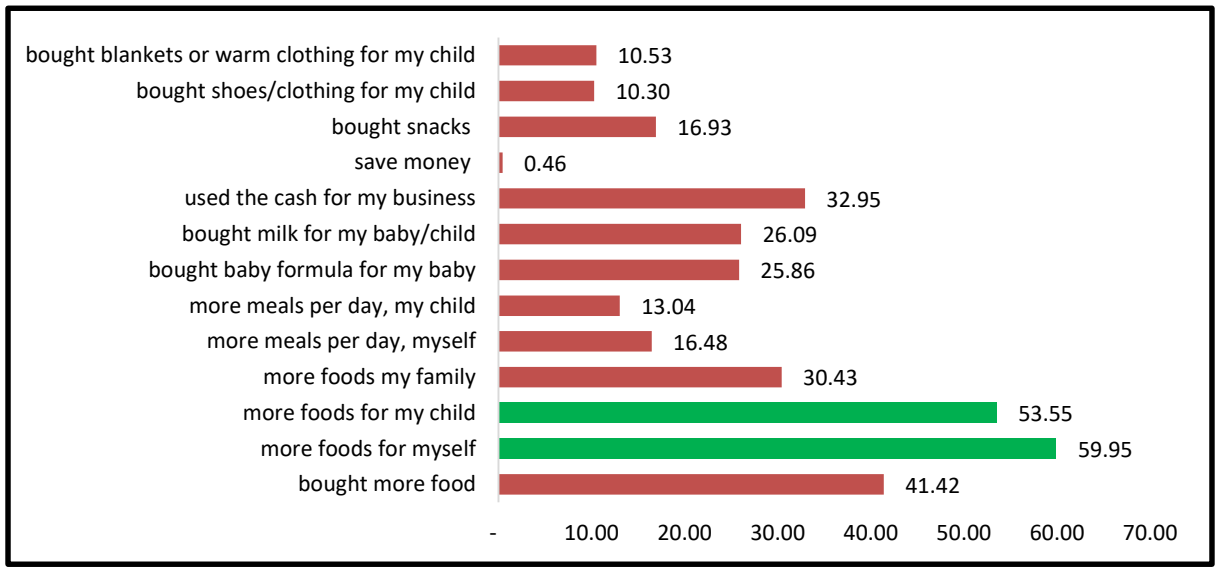

Figure.9 Percentage of respondent spent the received cash by item/category

The mothers who reported that they ate more meal per day were asked how many more meals per day they had eaten. 62% responded that they ate three more meals per day and 6% said that they had two more meals per day. Mothers who had one more meal per day were 32%.

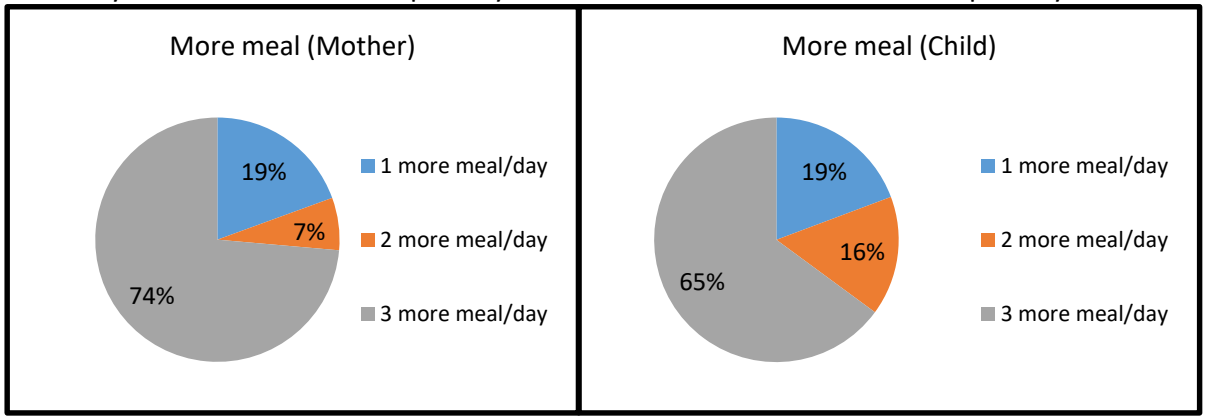

Figure.10 Percentage of mother and child who eat more meal by number of more meal per day

2.3.3 Status of sharing cash with other household members

25.6% responded that they share the cash or food with others whereas 72.8% said that they do not share with other family members. Those who share cash/food with others were asked to specify, 15% indicated that they share with husband and remaining 83% informed that they share with other household members. However, 3% told that the cash/food bought from MCCT were shared with non-household members.

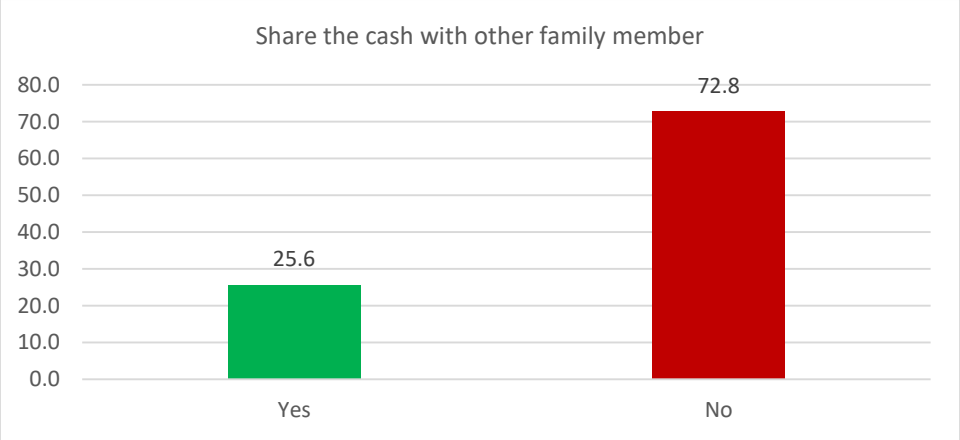

Figure.11 Percentage of respondent who share the cash with other family member

2.3.4 Adequacy of Size of Cash Transfer

MCCT is not intended to cover all household food costs but is only to supplement normal income. The beneficiary were asked if they think MCCT cash transfer is enough to cover nutritious food for them and their children. 12% responded that the cash transfer is sufficient for nutritious food for them and their children. 64% said that the cash amount is adequate to cover most of nutritious food requirements. 20% informed that it covered some nutritious food needs, however 3% said that it is not sufficient to cover for nutritious food for them and their children.

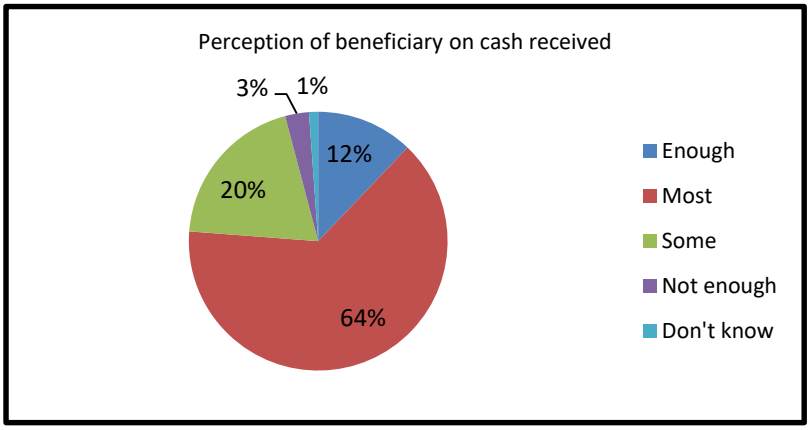

Figure.12 Perception of the beneficiary on received cash

2.4 SBCC Awareness Sessions

2.4.1 Awareness Sessions

72% of the respondents reported that they know about awareness session of MCCT and two third of the respondents had attended those sessions. However, the mother who attended the awareness session regularly was only 53% of the total respondent.

All respondents knew about the SBCC sessions and most of them joined those sessions in Mindat and Tedim. About one third of the respondents did aware and attended the SBCC sessions in Tonzang. More than two third of the respondents knew and participate in the awareness sessions in other townships.

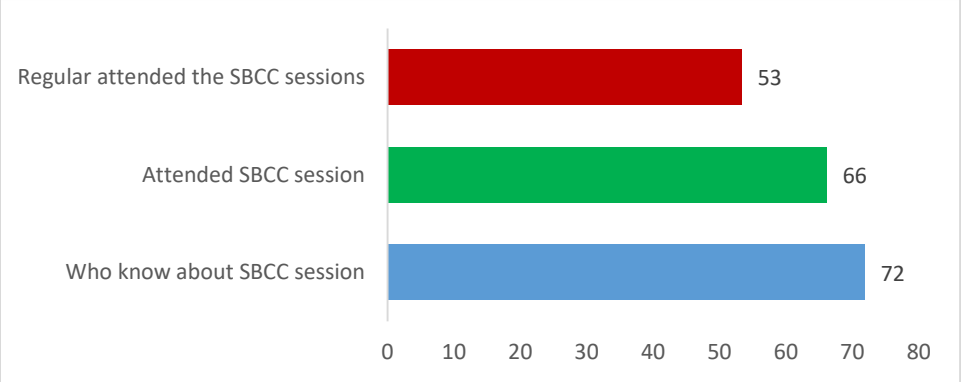

Figure.13 Percentage of mother who knew and attended the SBCC session

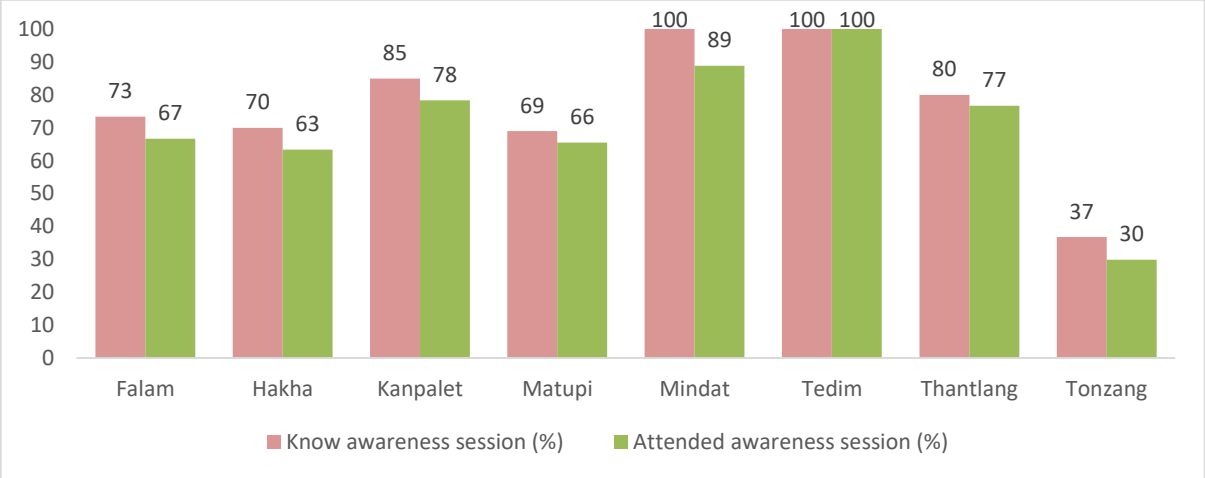

Figure.14 Attend the awareness sessions by township

2.4.2 Reasons for not attending the SBCC sessions

The beneficiaries who could not attend the awareness sessions shared the reasons for not attending the sessions. 17% of the respondent shared that the awareness sessions were not organized, one third of the respondents informed that they did not know the time and venue for the awareness session and 44% told that they could not attend the awareness session due to traveling, job, illness etc.

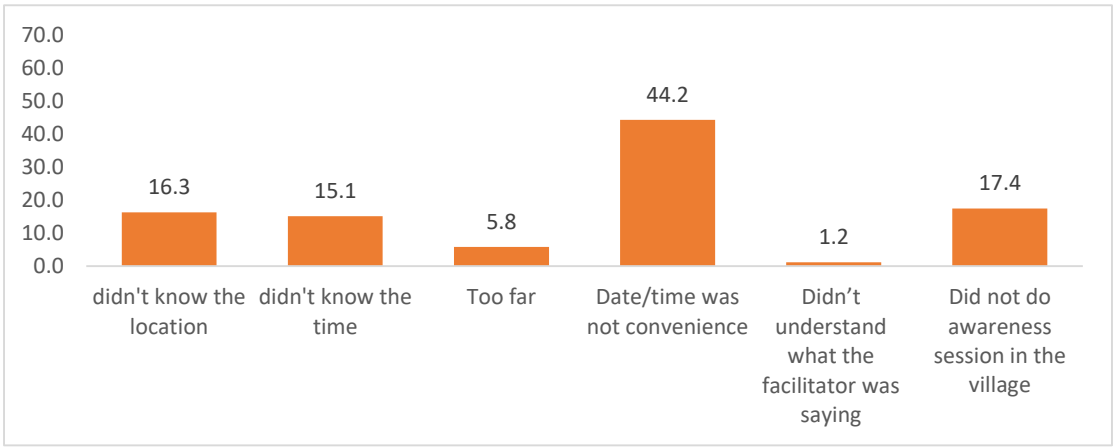

Figure.15 Reasons for not attending the awareness sessions

2.5 Complaints Focal Person and Payment Eye-witness

2.5.1 Know the eye-witness and complaint focal

28% of the respondents shared that they knew about the complaints focal person in their ward/village. The respondents were asked if they knew who is responsible for witnessing the bi-monthly payment of MCCT beneficiaries. 62% reported that they know about the eye-witness responsible person.

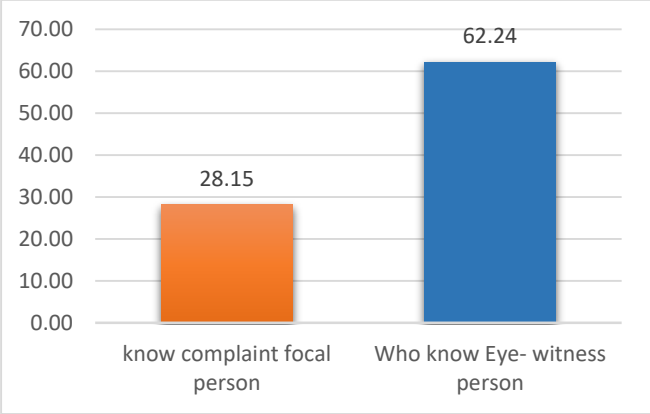

Figure.16 Percentage of mother who know the responsible person for compliant and eye-witness

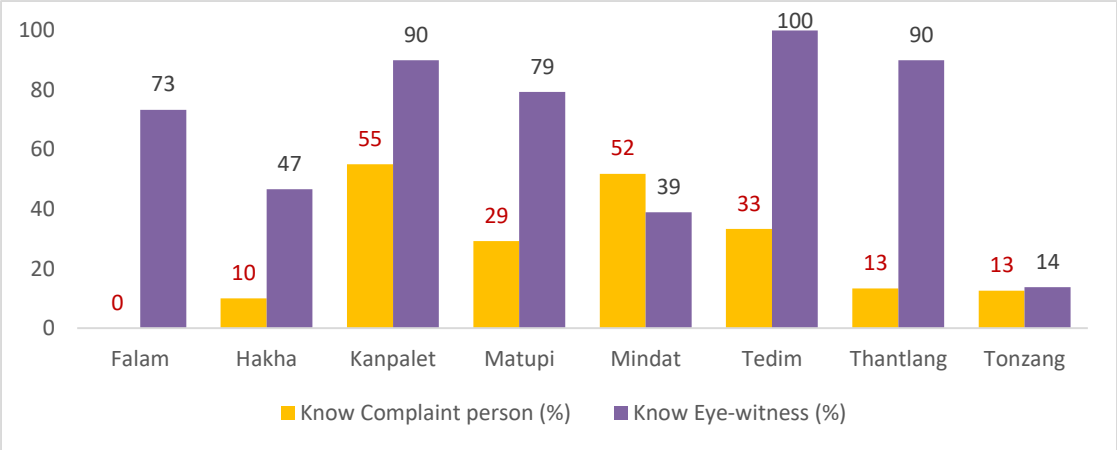

Figure.17 Percentage of mother who know responsible person for compliant and eye-witness by Township

2.5.2 SBCC sessions and Know the eye-witness and complaint focal

Those who know the complaint focal person of MCCT in their area, 89% joined SBCC sessions of MCCT and 3% did not attend those sessions. Among the mothers who know their eye-witness for MCCT cash payment, 76% were participated in the awareness sessions. It shows that mother who attended SBCC sessions had more aware about MCCT program.

2.6 Health Care Provider for ANC/PNC in the village

About two third of the respondents mentioned midwife were the main health care provider for their villages. 37% said that in their village, auxiliary midwife provide health care.

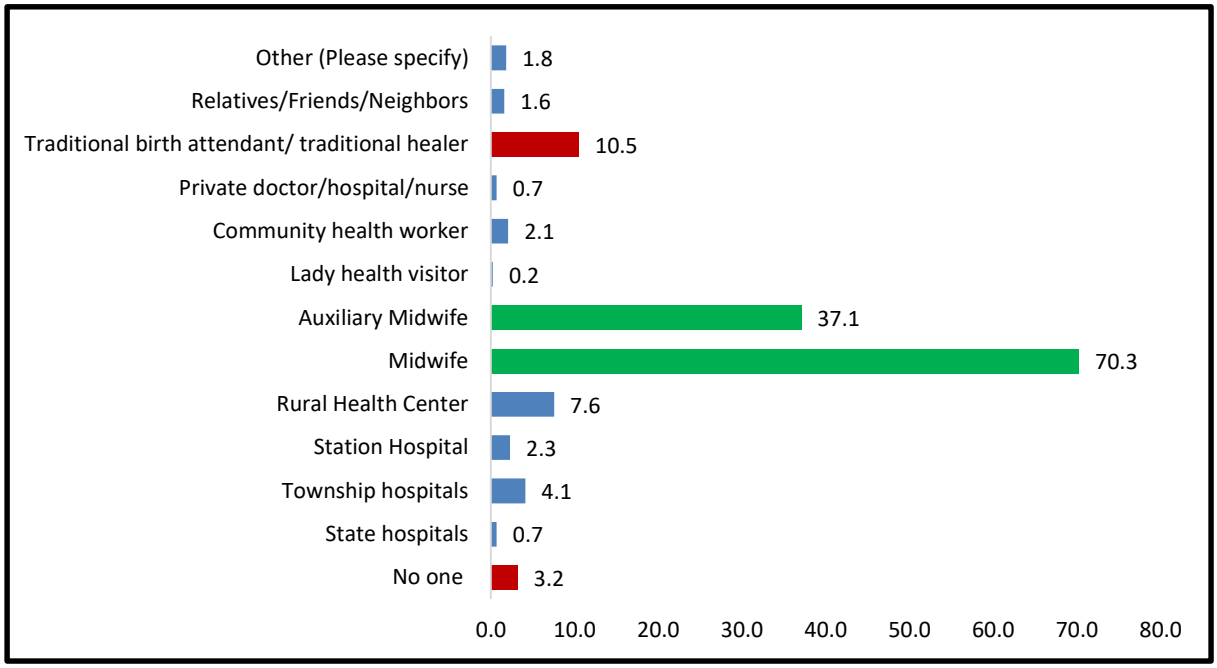

Figure.18 Percentage of mother who received ANC by Health Care Provider

2.6.1 Received ANC and Frequency

More than 83% of the beneficiaries of MCCT program received Ante natal care among 437 respondents. Among those 42% mentioned that they did four ANC visits during their pregnancy time.

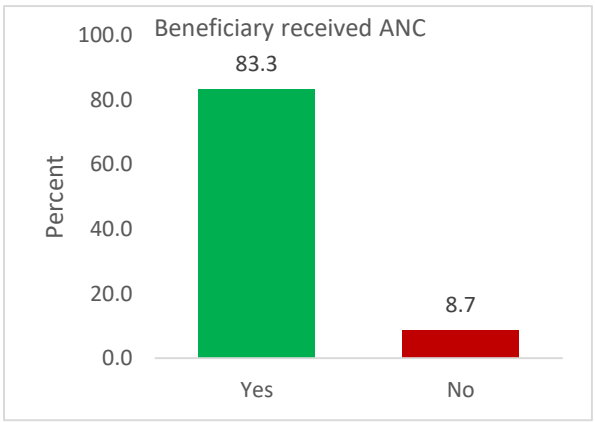

Figure.19 Percentage of Beneficiary received ANC

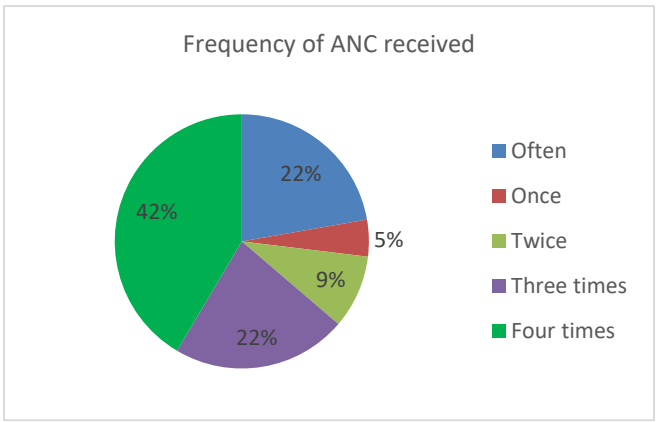

Figure.20 Percentage of Beneficiary received ANC by frequency

2.6.2 SBCC sessions and ANC

There were 232(63.7%) respondent who received ANC four and more times during their pregnancy period. Among those, 73.3% joined SBCC sessions of MCCT and 4.3% did not attend those sessions. It means that mother who attended SBCC sessions had aware about ANC and they followed to take the required antenatal care.

2.6.3 Birth Attendant

More than two third of the respondents delivered their children with the skilled birth attendant at the different health care centers. About 28% of the respondents said that they gave birth their children by midwife. 42.8% of the respondent shared that they delivered their babies with skilled birth attendants.

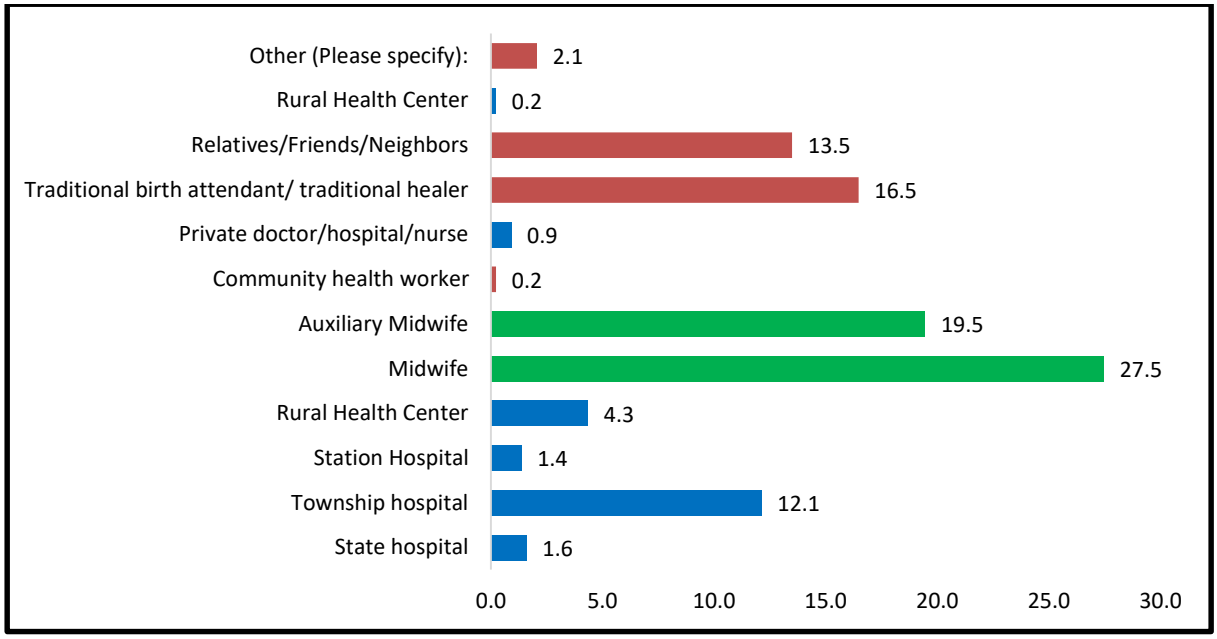

Figure.21 Birth attendant during delivery

2.6.4 SBCC sessions and Skilled birth attendant

There were 187 (42.8%) respondents who gave birth their baby with trained health care personnel. 72% of those mothers attended SBCC sessions of MCCT and 4.8% did not participate those sessions. It showed that pregnant women who participated in the SBCC sessions recognized well the important of skill birth attendant during their delivery.

2.6.5 Frequency of visit by midwife in their village

There were monthly visiting of midwives in the village of 44% of respondents. In the villages of 42% of the respondents, the midwives visited every two month. About 10 percent of respondents said that midwives visited their villages every three month. Only one percent of the respondent said that midwife came to their village every 6 months.

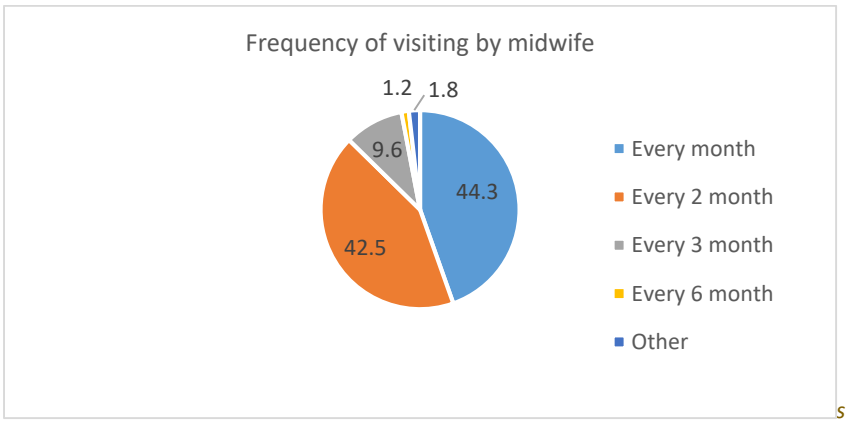

Figure.22 Frequency of visit by midwife

2.7 Increased knowledge and changed behavior

2.7.1 Increased knowledge because of SBCC

Among the mother who attended the SBCC sessions, 60% of the respondents shared that they know more about the importance of eating diverse foods. More than 55% of mothers knew more how to feed the child and exclusive breast feeding.

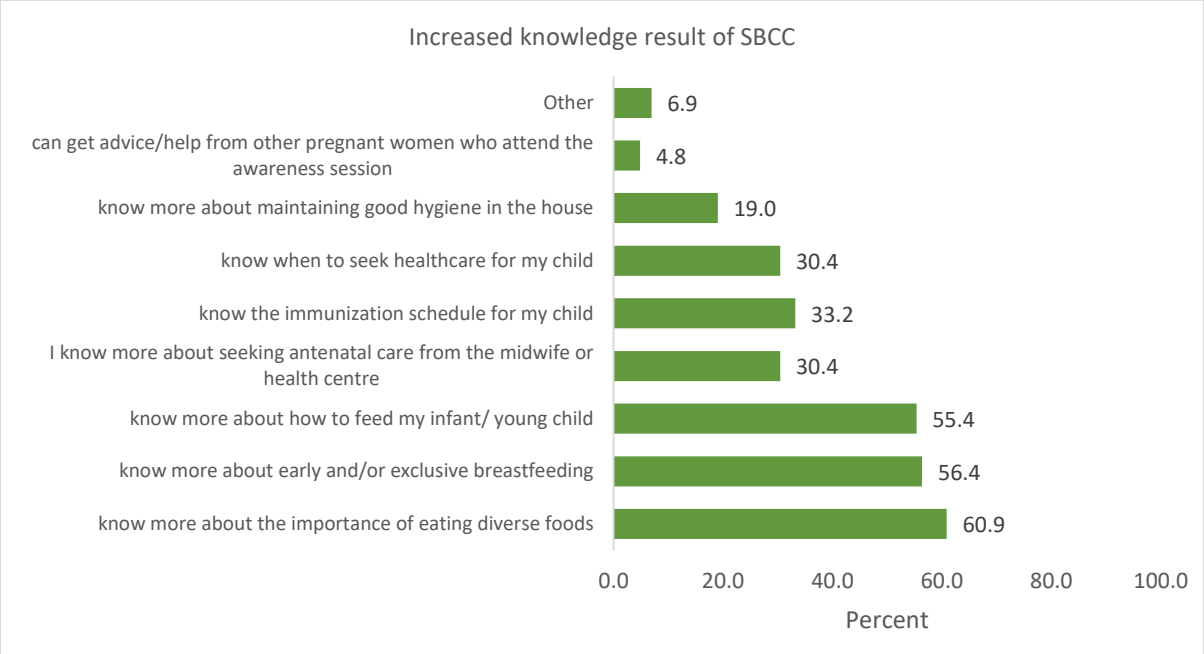

Figure.23 Increased knowledge result of SBCC sessions

2.7.2 Hand washing practices

More than 80% of the mothers responded that they washed their hands after using the toilet and before eating. About 50% of the respondents had practice of hand washing after disposing of baby faces, after cleaning baby bottom and before feeding children. There were 61 % and 72% respondents who washed their hands before cooking/ preparing food and after eating.

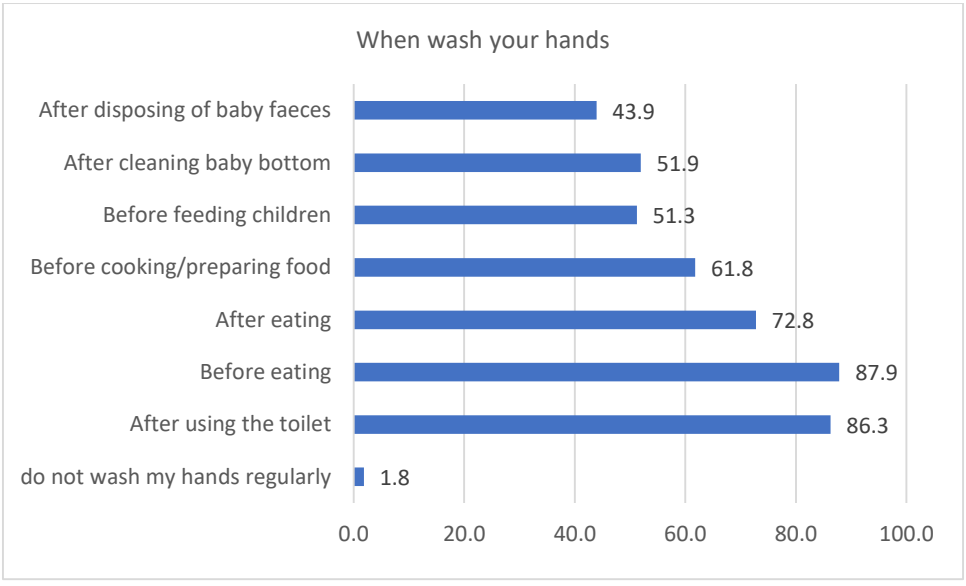

Figure.24 Hand washing practice of the respondents by events

Among the respondents who wash their hands, 92 percent washed their hands with soap and water and 3.2 percent use ash and water to wash the hands and only 1.8 percent use water only for hand washing.

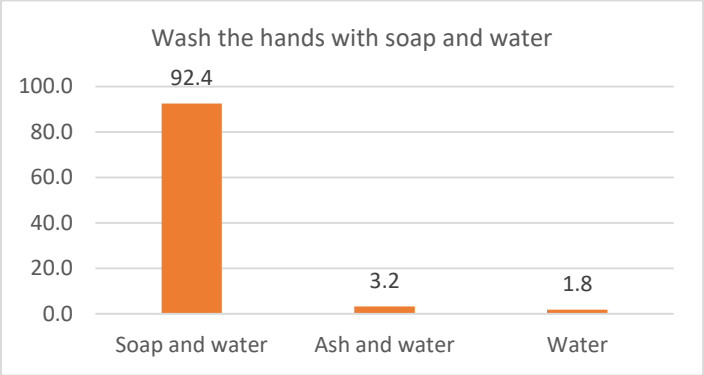

Figure.25 Percentage of mothers who wash their hands with soap and water

2.7.3 Changed behavior because of SBCC sessions

About two third of the respondents shared that they changed feeding and hygiene practice as the result of attending awareness sessions. About half of the participants said that their health seeking practices were changed because of SBCC in MCCT. 18% of the women responded that they had plan to have more children because of MCCT program.

Figure.26 Changed behavior result of SBCC sessions

3. CONCLUSION AND RECOMMENDATIONS

3.1 Conclusion

The objective of the study was 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. The PDM data collection was done from Jan to May 2018 in 8 townships among total 8 townships of Chin State. The number of respondent was 437. The responds were interviewed by using structured questionnaire in mobile data collection tool/ KOBO. There were 437 mothers participated in this study. Microsoft excel 2016/ descriptive statistics was used to present number, percentage, mean and standard deviation. The result of the study showed that 97% of the beneficiary received the regular cash payment and 96% of them were informed the pre-disbursement information on MCCT cash transfer. 93% of beneficiary received 30000 kyat in last payment. Two third of the respondents had to wait less than 30 min to receive cash at the payment point.

Regarding the use of MCCT cash transfer by mothers, 99 % of mothers said that they were the main decision maker how to use the received cash. About 60 percent of the respondents used the cash for more food for them and for their children. 26% of the mothers in this study shared the received cash with other family members.

In social and behavior change communication, although 72 percent of the respondents knew about the awareness sessions, only 66 percent were joined those sessions. Only one percent of the respondents participated in the SBCC sessions regularly.

Half of the mothers responded that there was assigned midwife in their villages and 38 percent of the mothers said that midwife visited their villages for the MCH services. More than two third of the respondents saw midwife for ANC and 37 percent took ANC with auxiliary midwife. 83 percent of mothers received antenatal care and 41 percent of those took ANC four times during their pregnancy.

In this study, it was found that mothers who joined the SBCC sessions were more participated in the ANC, skilled birth attendant and hand washing. Moreover, mothers who joined awareness sessions knew well the responsible person for eye-witness and complaint focal in their villages in MCCT program. About 40 percent of mothers increased their knowledge about eating diverse foods, exclusive breast feeding and infant and young child feeding. It was significant that the behavior change regarding the feeding practice, hygiene practice and health seeking behaviors were improved according to the result of the PDM data.

3.2 Key Recommendations (MCCT Programmatic/Implementation):

3.2.1 Programme implementation and communication:

MCCT implementation in all townships in the Chin State is improved more and more from time to time because of coordination and collaboration of the related departments in MCCT program. However coordination among related departments in the township and state levels should be improved concerning to the monitoring and action plan/response based on the findings of the monitoring activities and reports by each township.

3.2.2 SBCC Awareness Sessions:

- SBCC plan and activities each township should be followed up to monitor the output of the activities.
- IEC distribution in SBCC session have to be monitored so that the availability of the IECs for SBCC sessions might be reported and it could be included in the plan of the township and state level.
- The challenges of the implementing SBCC sessions in the villages should be reported regularly and feedbacks and actions for that issues should be included in the township level implementation

3.3 Recommendation related to next round of PDM:

3.3.1 Review and refinement of PDM instrument:

- Based on the last 3 PDM exercises, It is proposed to review the tool and identify the areas of refinements and further simplify the language, sequence of questions.

- The user manual/ field guidelines should be developed for the PDM process so that it could be applied in the all States and Regions where MCCT program is implemented.

3.3.2 Sampling:

- Samples should be selected from all townships from Chin States in order to represent the whole MCCT program implemented area.

- Probability of sample proportion (PPS) may use next PDM since the size of the study populations are different among townships in Chin.

- The sample size should be calculated according to the method of sampling.

3.3.3 Data collection through Tablet/Smart devices:

- KOBO data collection tool for PDM should be reviewed and revised. It took time to clean data set in 3rd PDM data analysis because of data quality regarding data type and consistency.

- Training on revised data collection tool to all potential data collectors before next PDM

- Assign focal person for the data quality check during and after data collection and role and responsible of assigned person for data quality

3.4.3 Timelines for PDM:

- The complete data collection plan will be shared to all townships prior data collection time.

- It is better to include back up plan for some actions difficult to implement in the data collection in some townships.