MINISTRY OF SOCIAL WELFARE, RELIEF AND RESETTLEMENT

SOCIAL ASSESSMENT FOR AYEYARWADY REGION AND SHAN STATE

INVESTING IN NUTRITION FOR GROWTH AND DEVELOPMENT

Draft Social Assessment

Myanmar: Maternal and Child Cash Transfers for Improved Nutrition

December 2018

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Ministry of Social Welfare, Relief and Resettlement

December 2018

TABLE OF CONTENTS

EXECUTIVE SUMMARY

Introduction:

The Social Assessment and **Community Participation Planning Framework** are required for projects that receive World Bank financing. The social assessment aims to make the project more responsive to stakeholder concerns, including seeking to enhance the benefits for poor and vulnerable people. Community participation planning framework sets out procedures to ensure that people affected by the project receive culturally appropriate benefits and that the project reaches out to people who are hard to reach. After social assessment and community participation planning framework are completed the Department of Social Welfare (DSW) will organize consultations on the findings and framework to solicit stakeholder views.

Methodology and Limitations:

The social assessment was conducted as a mixed method study that utilized existing quantitative data & extensive qualitative data collection from interviews, focus group discussions, formal and informal consultations and a desk review of reports, studies, existing cash transfer manuals for Myanmar and international best practice.

Research questions focused on:

- Key social factors most likely to facilitate or inhibit the development and implementation of the project in Shan State and Ayeyarwady Region
- Key cultural differences related to ethnicity, tradition and language that need to be considered
- To what extent gender, ethnicity, religion, political affiliation and disability impact inclusion and increase marginalization
- Critical issues about literacy and education levels, poverty status and location of households
- Potential unintended risks of proposed project and how these can be minimized in the context of individuals, households and communities

Limitations focused on the broadness of the social issues and themes of enquiry related to the proposed project in a large and diverse area of Ayeyarwady Region and Shan State. The sample size was relatively small. Representation was limited and the selection of townships and villages was not fully representative of all the eventual stakeholders. The assessment team did not visit any conflict affected areas in Shan State. In Ayeyarwady, majority of places selected were Bamar villages.

Institutional Roles and Responsibilities:

Findings related to roles and responsibilities highlighted that currently DSW has limited capacity in numbers of offices and staff at the state/region and township levels. DSW aims for an accelerated institutional scale up to implement the project. The Ministry of Health and Sports (MOHS) assigns midwife in all villages in Ayeyawardy and Shan but some remote areas have no regular visits. In addition, not all villages have auxiliary midwives as an alternative (both in Shan/Ayeyarwady). General Administrations Department (GAD) has personnel down to all villages (in government-controlled areas)

proving a clear line of communication. The activeness or existence of relevant village level committees and volunteers differ by area. Village social protection committees which have a role in existing MCCT programs have not yet been formed in Ayeyarwady and Shan.

Key recommendations center on the development of strategic preparation, planning and budgeting to open township offices in large scale (e.g. office space; hiring; procurement of furniture; MIS internet etc), the enhancement of DSW and partner awareness raising and communication on cash transfers. In addition, coordination with line departments (GAD, Department of Public Health) at all levels needs to improve. It is recommended that a grievance mechanism be set up at the onset including clear case management procedures, simple and centrally manageable Management Information System (MIS), initial investment in communications and training to beneficiaries and staff.

Nutrition:

Findings on nutrition indicate that family nutritional norms depend on what is locally grown and available and, depending on family's level of poverty, what they can afford to buy at the market. In Ayeyarwady the primary food source is fish paste and rice; in Shan, primary food source is chili paste and rice. Access to vegetables is limited; access to meats/seafood is extremely limited. The remoteness of villages and accessibility by transport has a major impact on family nutrition. In Shan, the assessment team visited a village with no cash economy for purchasing food where most women did not have information on nutrition. Even if midwives provide information, cultural and traditional beliefs tend to be more influential. In communities where nutrition programs were implemented with trained volunteers (Labutta, Kyangin), women were more aware of food groups and nutritional value.

Key recommendations focus on the use of trained volunteers at the community level for effective communication on nutritional norms, taking into account traditional beliefs in different areas. The DSW will need to coordinate with MOHS, since information currently available on nutrition comes from midwives. The project would be more effective by linking with other livelihoods programs, demonstration farms, seed programs to ensure food diversity. In addition, beneficiaries should be communicated on the usage of cash provided through the project not limiting it with food but to include cost for transport or access to health.

Pre and Post-Natal Care:

Findings indicate that the quality of advice on pre and post-natal care is highly dependent on availability and outreach of midwives. More remote and poorer families rely on family members for pre and post-natal care knowledge and advice. In Shan state, the midwives have faced challenges in access to certain villages due to safety and security concerns, and due to midwives not speaking the language of the community. In some cases, households even refuse vaccinations because they do not understand why vaccinations are needed.

To overcome these challenges, it is recommended to involve local volunteers from communities (to be trained and incentivized) to ensure that communications are effective. The project should also consider different models to reach out to particularly remote areas. In relation to Shan state, the project also needs to have models for tailored and culturally appropriate support. DSW should map out and engage existing providers of maternal and child services and interventions in both Ayeyarwady and Shan.

Behavioral Change and Communications:

The assessment points out that currently, almost all behavioral change communication comes from midwives in both regions.

Although smart phone user rate in Myanmar is reported to be 80% (2017), this may not be representative in rural areas of Shan and Ayeyarwady. In Ayeyarwady, most households have cell phones (not smart phones) but men mostly manage them, and almost no women use them for on-line information. In rural areas in Shan, most women do not own or use cell phones for any purpose. This should be considered when developing a communications strategy for the project and the use of mobile phones as potential communication tools.

More broadly for project implementation in general, it is recommended that DSW hires a communications consultant/dedicated staff at the union level to develop a communication strategy taking into account different languages, different education levels of mothers to effectively reach out to the beneficiaries. There must be a clear distinction between general project communication and behavioral change communication and the development of appropriate approaches and modalities should consider the objective of specific and tailored communications for the dissemination of general information and behavioral change. The link and collaboration with community organizations and specific groups such as the Women's Association, Health Committee, Volunteers and Mothers Circles needs to be factored in to any social and behavior change communication (SBCC) strategy. Where these groups exist and are active, there is potential for cooperation but there will need to be incentives in the form of training and expenses.

There is a need to assess targeted communities from a cultural, educational and social perspective in each township that the project plans to operate in, in order to design suitable strategies, approaches and modalities that factor in literacy, awareness levels, age profiles and ethnic diversity before deciding on any particular behavioral change approach.

Cash Transfer Modalities:

Findings indicate that the majority of beneficiaries, midwives, and village leaders find it more realistic that cash transfers to be handed out to them directly in person rather than through mobile mechanisms. In more accessible villages closer to towns, there is some use of mobile and agents, but more often, cash transfers, such as remittances, are received through an informal network of people. In areas where mobile banking money transfer exist, it is the men in the households who collect the money by travelling to nearby towns. In addition, the availability and affordability of safe transport is a concern for women, as well as provision of child care when they travel. For bank transfers and other formal mechanisms, lack of a National Registration Card (NRC) may be an obstacle. Currently, DSW partners with GAD to provide cash transfers directly to pensioners. Potential risks around cash transfers and household spending on nutrition due to lottery gambling by women, alcohol use among men, and domestic violence in the household is undeniable but the existing cash transfer programs have not encountered much of these cases in Myanmar. Key recommendations suggest that given remoteness of certain areas and geographical variation in Ayeyarwady and Shan, one modality of cash transfer will not work in all areas. The project must have multiple modalities for transferring cash based on locations of the beneficiaries. Accompanying communication should address the risks noted above on households using the funds for purposes other than nutrition. Community volunteers, civil society organizations and ethnic organizations should be used as project facilitators. A grievance redress mechanism and a monitoring mechanism should be designed to ensure that cash transfers are reaching the targeted

beneficiaries. Piloting and scaling in a gradual manner may be necessary to understand and manage risks.

Ethnic Minorities and Vulnerable Groups:

Findings outline that when people do not fully understand Burmese or other main ethnic language in the region, they face layers of barriers (receiving information, embarrassment, fear etc.) in fulfilling their service entitlements. Often government services are dependent on individual civil servants' skills in speaking ethnic languages. Poor households, single mothers, women with abusive husbands, people living in conflict affected areas and remote areas, people without NRC are also identified as groups who have the potential to be left out of government services.

Recommendations focus on the establishment of a system to capture the ethnic languages used in each village and identify ways to communicate to ensure outreach to all mothers who are entitled to the program. The recruitment of DSW township staff locally in ethnic townships and to make sure the project volunteers cover different ethnic representation. Project materials should be simple with limited or no text so that it is accessible for none-Burmese speakers and illiterate people. Selection criteria should not exclude people from the program based on NRC status. Including personal information in the project MIS (ethnicity, religion, spoken language, educational background) will enable the project to monitor trends of outreach or dropouts of the program.

Conflict:

There is ongoing conflict in Northern Shan State, with low acceptance and mistrust of government. There are also people displaced in Internally Displaced Population (IDP) camps and settlements but also integrated in communities. Situation in Southern Shan has improved since 2011 with improved accessibility.

Recommendations focus on conducting township-specific conflict assessments prior to determining the implementing townships to identify area-specific potential risks and to map out the key stakeholders. The project is recommended not to be implemented in areas where the DSW and World Bank staff are not able to conduct due diligence monitoring. The project in conflict affected areas should have some flexibility in the design and to consider how to operate in IDP camps or settlements. The DSW staff in ethnic townships should be hired locally. There is a need to conduct continuous stakeholder engagement and regular monitoring during project implementation in conflict affected areas.

LIST OF ABBREVIATIONS

AMWs	Auxiliary Midwives
CHWs	Community Health Workers
CSO	Civil Society Organization
CBO	Community Based Organizations
COSS	Communications, Outreach and Social Support
DHS	Demographic and Health Survey
DoPH	Department of Public Health
DSW	Department of Social Welfare
EAO	Ethnic Armed Organization
GAD	General Administration Department
GDP	Gross Domestic Product
GOM	Government of Myanmar
ICT	Information and Communication Technologies
MCCT	Maternal and Child Cash Transfers
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MIS	Management Information System
MNCH	Maternal, Newborn and Child Health
MOHS	Ministry of Health and Sports
NRC	National Registration Card
NSPSP	National Social Protection Strategic Plan
RHC	Rural Health Center
SBCC	Social and Behavioral Change Communication
SP	Social Protection
SPC	Social Protection Committee
TA	Technical Assistance
UN	United Nations
VCSWs	Voluntary Community Social Workers
WASH	Water, Sanitation and Hygiene

LIST OF TABLES

LIST OF BOXES

A. INTRODUCTION AND BACKGROUND

1 Objectives of the Social Assessment

Social assessment is the instrument used to analyze social issues and solicit stakeholder views for the design of World Bank supported projects. Social assessment helps make the project responsive to social development concerns, including seeking to enhance benefits for poor and vulnerable people while minimizing or mitigating risk and adverse impacts. It analyzes distributional impacts of intended project benefits on different stakeholder groups, and identifies differences in assets and capabilities to access the project benefits

A social assessment is made up of analytical, process, and operational elements, combining (a) the *analysis* of context and social issues with (b) a participatory *process* of stakeholder consultations and involvement, to provide (c) *operational* guidance on developing a project design, implementation, and monitoring and evaluation (M&E) framework.

A social assessment as input to a Community Participation Planning Framework (CPPF) (in order to fulfill the requirements of the World Bank Operational Policy 4.10) will evaluate the project's potential positive and adverse impacts on ethnic minorities.

The CPPF, which is a complement to the social assessment, sets out the measures through which the implementing agency will ensure that (a) peoples affected by the project receive culturally appropriate social and economic benefits and (b) when potential adverse effects on ethnic minorities are identified, those adverse effects are avoided, minimized, mitigated and compensated for.

2 Project Description

The Myanmar Maternal and Child Cash Transfers for Improved Nutrition project will focus on tackling some of the many remaining challenges to implement priority nutrition interventions at scale in the right way, to the right people, at the right time with the right dose/ frequency in a sustained and consistent manner. The project will benefit pregnant and lactating women, infants and young children up to age two, and their families and communities in prioritized nutritionally vulnerable geographic areas. Based on wide consultations and technical input, Shan State and Ayeyarwaddy Region were selected as geographic focus based on the following criteria: burden of under-nutrition (e.g., in terms of stunting prevalence among under-five children), local capacity, stability (security and access), and current level of coverage by key nutrition services.

The principle of the proposed operation is to support evidence-based interventions at the community level to overcome binding constraints to optimum nutrition in the first 1,000 days of life. The intent is to improve the coverage of nutrition-related interventions, while simultaneously motivating women to seek care and improve nutrition/caring practices for themselves and their children. The proposed interventions align with the recently endorsed Multi-Sectoral National Plan of Action for Nutrition and are packaged as two components:

Component 1: Stimulating demand for good nutrition in the first 1,000 days in selected priority areas

Component 1 will finance the delivery of cash transfers to pregnant mothers and mothers with children under two, accompanied by community outreach and social support sessions (COSS) to improve nutrition-related behaviors in selected priority areas: Shan and Ayeyarwady. The MCCT conditional cash transfer program- will enable the consumption of more diverse and nutrient-rich foods (which are often more expensive), and improved uptake of health and nutrition services in the selected areas. The expansion of the MCCT in new geographic areas will benefit from global good practices, and lessons learned from the implementation of the MCCT program to date in Myanmar. To enhance the program, a series of implementation innovations will be introduced.

Subcomponent 1.1: Investing in the MCCT delivery system in Shan and Ayeyarwady. This subcomponent will support the implementation of delivery mechanisms to introduce and effectively implement the MCCT program in Shan and Ayeyarwady. Under this sub-component, the project would finance activities related to beneficiary identification and enrollment, verification of compliance, feedback and grievance redress in the selected areas. More specifically it will support operational costs to implement these mechanisms, and service fees to deliver cash transfers to pregnant women and households with young children aged 0-2 years (see figure 3 on sequencing of activities for MCC implementation) in the priority geographic areas.

Subcomponent 1.2: Conditional Cash transfers for pregnant women and mothers of children ages 0-2 in Shan and Ayeyarwady. This subcomponent will finance cash transfers to pregnant women and children under two in the selected areas. Cash transfer amounts will be set at MMK 15,000 per beneficiary household per month (around US$10),[1] which is about 9 percent of household consumption for the poor.[2] This will ensure, on the one hand, that transfers can have a sufficient impact on consumption and service utilization and, on the other hand, that they do not distort labor market incentives. Cash transfers would provide the additional income that would contribute to greater consumption of more diverse and nutritious foods and/or for covering transportation and other costs to access health and nutrition services. Cash transfers will be conditional on attending monthly COSS sessions and soft conditionalities on health and nutrition services (AN visits for pregnant mothers, full immunization and birth certificate for children).

Subcomponent 1.3: Communications, Community Outreach and Social Support (COSS) in Shan and Ayeyarwady. The sub-component would finance activities at the community and household levels to raise awareness, increase knowledge, and mobilize communities and families to support women in adopting nutrition-promoting behaviors, especially among pregnant and lactating women and women with children under two in Shan and Ayeyarwady. The activities would include community outreach and social support (COSS) sessions for pregnant women, women with young children, husbands, mothers/mothers-in law, and community meetings and events. The voluntary community social workers (VCSW) at the village level will be responsible, with the support of the V-SPC, for organizing community outreach sessions, facilitate scheduled outreach health visits by the basic health providers, and transportation of beneficiaries to access facility-based health and nutrition services. VCSWs would also facilitate active participation of basic health staff in the COSS sessions, assist mothers to seek timely health care and nutrition services, and support outreach and social behavioral change communication. The COSS sessions would also include communication of messages that could help the vulnerable communities cope with the risks posed by climate change and its impacts. To enable smooth implementation and inclusiveness of these activities, this sub-component would provide funds not only to the Union but also directly to the State/Region and District Social Welfare Departments, which together with Union DSW would be responsible for building knowledge and skills of VCSWs (not only on the content but also on facilitation, communication, and problem-solving). It would also finance purchase of mobile phones and monthly top-ups for VCSWs, and operating costs for supporting COSS

[1] The benefit value is expected to be adjusted for inflation on a regular basis.
[2] It is equivalent to 13.7% of the food expenditure of the poor based on the latest household survey in 2015.

implementation and supervision.

In areas not under control of Government, community-based organizations with the trust of EAOs will be tasked with the same responsibilities assigned to DSW. The skills building, key messages and communications materials to be used in COSS would be adapted from existing materials that have been tested and implemented in Myanmar[3] or elsewhere. Quality communication material and innovative approaches will be critical in the success of community activities. The subcomponent will therefore finance continued evaluation of the material and identify needed adaptations, including investing in innovative ICT-based and other methodologies to deliver messages and induce behavior change. The use of ICT will also enhance such messaging, including early warning systems, information about shelters or other protective facilities in the case of severe weather events.

Component 2: Enhancing capacity to implement social protection *programs*

Component 2 will focus on strengthening the capacity of the MOSWRR to effectively deliver, monitor and evaluate social protection programs and services across Myanmar. In order to do that, the project will invest in: (i) strengthening the physical and human infrastructure of MOSWRR to deliver its flagship social protection programs both at national level and in priority states and regions; (ii) developing key building blocks for effective and inclusive implementation of the country's flagship cash transfers programs; and (iii) monitoring and evaluation and overall project management.

Subcomponent 2.1: Enhancing MOSWRR capacity to deliver social protection programs. The sub-component would support national, and selected S/R, districts, and township-level Departments of Social Welfare to improve the physical and human capital infrastructure of DSW to deliver protection programs. This will involve financing costs associated with building new climate-resilient offices and renting offices in the interim and improving infrastructure of the existing ones[4]; ensuring adequate office equipment and vehicles; hiring additional social welfare staff and building their skills. This sub-component will also support participation and engagement in the national level coordination mechanisms, including financing the operating costs for meetings of the National Social Protection Committee, the Nutrition Sector Coordination Group, and national technical groups, such as on Social and Behavior Change Communications, At S/R and township level, it would provide financial support to the functioning of the Social Protection Committees (SPC) in priority geographic areas for scale up of flagship programs.

Subcomponent 2.2: Developing key building blocks for more effective and inclusive poverty reduction programs. This sub-component would finance technical support to develop key building blocks for effective social protection programs nationally. This sub-component will finance the development at the national level of a management information system (MIS), a modern G2P payment system, and a grievance redress system for the MCCT program. ICT would be used to communicate with beneficiaries and non-beneficiaries, obtain community feedback, and support independent verification of the effectiveness of the program. The component would finance setting up a call center for community feedback and the use of mobile technology to send and gather information from beneficiaries. This

[3] The project team is working in close collaboration with DPs that have also developed behavioral change communication material. The project team will be assessing the material to determine the support needed for enhancing the material and to identify needs for further investment to ensure successful implementation of the COSS activities.

[4] In the construction of new buildings, the project will take into account potential risks posed by climate change, especially landslides and floods, using soil testing and other engineering measures, specific to each site. Offices where possible will include investments in energy efficiency and renewable energy such as rooftop solar systems.

subcomponent will also finance the development of applications for mobile devices, for facilitating enrolment and compliance verification. The experience from implementation under component 1.1. would help to refine these national processes. The development of these national social protection tools would have positive impact in the implementation of the MCCT nationwide, as the systems developed will be used in all S/R where the MCCT is operational Chin, Rakhine, Naga, Kayin, and Kayah, in addition to the Shan and Ayeyarwady. Beyond the MCCT program itself, such systems would provide the foundations of a modernized national SP system which would be used by other programs such as the social pension[5] and child grants.

Subcomponent 2.3: Project Management, Monitoring and Evaluation. This sub-component will finance: the operational costs needed to manage, coordinate, monitor and evaluate project implementation; the personnel costs for managing the project at the Union, State/Region, and district levels in the areas of contract management, financial management, procurement, and planning; and operating costs to undertake regular supervision and monitoring, and facilitate implementation of the project. In areas in which DSW will not be able to support implementation and monitoring and evaluation, the sub-component will provide resources for hiring a third party tasked with the same roles and responsibilities[6].

Component 3: Contingent Emergency Response (CERC)

This zero-dollar subcomponent would allow rapid reallocation of IDA credits proceeds to respond to unanticipated eligible crises or emergencies.

3 Relevant Country and Sector Context

3.1 Country Context

Myanmar, with a population of about 51.4 million, has been undergoing multiple transitions—political, economic and social—from authoritarian military rule to a nascent democracy, from isolation to greater connectedness, from a closed-economy to a more open one, and from neglect to re-establishing of government's stewardship and accountability to ensure universal access to basic social services. Gross Domestic Product (GDP) growth over the past five years has been exceptional compared to its peers. Between 2011 and 2016 GDP grew by 7.3 percent per year on average, or 6.4 percent in per capita terms.

Despite remarkable economic progress in recent years, this has not translated into expected poverty reduction and progress in human capital. While the economy grew at an average 7 percent a year between 2011 and 2017, poverty declined from 48 percent in 2005 to 32 percent in 2015. Myanmar is nonetheless growing below potential, and growth has not been as pro-poor or inclusive as it could have been. Reforms in the early years of the transition have unleashed greater growth among those with capital, land and education, typically those in urban areas. Myanmar's agricultural sector has lacked the momentum needed to support broad based rural poverty

[5] Social pension is also rapidly expanding its coverage from targeting over 90 until 2017, to over 85 in 2018 (covering approximately 165,000 beneficiaries) and for next year moving the age to 80 year.

[6] A number of civil society organizations and NGOs operates in those areas and have the trust of the community and of EAOs. Further consultation during implementation will be needed to identify suitable third parties that will have the trust of all the stakeholders.

reduction, and structural transformation remains slow.

The victory for the National League for Democracy (NLD) in 2015 in the first general democratic election marked a momentous milestone in Myanmar's political and economic transition. In addition to efforts to end conflict and securing peace, the Government of Myanmar (GOM) has begun to reverse decades of severe under-spending and institutional neglect in the social sectors—health, education, and social protection. The senior leadership of the government recognizes the importance of investing in human capital, in terms of better health and nutrition status, to stimulate economic growth and overall development of the country.

Despite this progress, the country's political and economic situation remains fragile. The country faces an immense crisis in Rakhine State, with a massive outflow of Muslim population into Bangladesh, forming one of the world's largest refugee populations in history. Moreover, the broader peace process remains tenuous: ongoing conflict in many regions, such as Shan and Kachin, has led to an increasing number of internally displaced populations.

3.2 Sectoral and Institutional Context

Myanmar has seen substantial progress in improving health and human development outcomes over the past decades. The country, however, was not able to meet the Millennium Development Goals (MDG) targets on maternal and child health. The Demographic and Health Survey (DHS) of 2015-2016 estimated an infant mortality of 40 per 1,000 live births, under-five mortality rate of 50 per 1000 live births, and neonatal mortality rate of 25 per 1,000 live births, and maternal mortality ratio of 200 per 100,000 live-births. The mortality rates are significantly higher than the Southeast Asia region's averages (Table 1). Difficult terrain, conflict in border areas, and health systems challenges related to health financing, human resources, state of physical infrastructure, and information contributed to low utilization of essential services, constraining progress towards achieving the Maternal, Newborn and Child Health (MNCH) MDGs.

Table 1. Selected Human Development Indicators

Indicator	Status	Data source
Total Population	51,400,000	Myanmar Census 2014
Total Fertility Rate	2.29	Myanmar Census 2014
Life expectancy at birth (2015)	66.4 years	Myanmar Census 2014
Infant mortality rate	40/1000 live-births	DHS 2015-2016
Maternal mortality ratio	200/100,000 live-births	DHS 2015-2016

Myanmar also continues to suffer from a high prevalence of maternal and child under-nutrition (Table 2). While stunting among under-five children has declined from around 50% in the 1990s, DHS (2015-16) indicates that 29.2% of children under five (equivalent to 1.4 million children) are stunted. Wasting remains elevated at 7% of children under five years of age. Micronutrient deficiencies are also a cause for concern: 57.4% of children of 6-59 months and 46.6% of women of reproductive age are anemic.[7] These deprivations at a young age are carried over into adulthood and have been shown to have important implications for the cognitive and physical capacity of the adult workforce. Simultaneously, the burden of overweight/obesity among adults is growing, though it remains a less acute public health

[7] A national food consumption and micronutrient survey is underway to provide additional details on micronutrient status and the causes of anemia.

concern. Further, the prevention of early life under-nutrition may serve as protection against later life metabolic disorders which are associated with overweight.

Table 2. Prevalence of under-nutrition in children (<5) and women of reproductive age (15-49) in Myanmar, 2015-2016

	Level of Public Health Significance
Under five stunting, (% children 0-59 months)	Medium
Under five wasting, (% children 0-59 months)	Poor
Low birthweight	--
Anemia* (% children 6-59 months)	Severe
Thinness, (BMI<18.5 kg/m^2), (% women 15-49)	Medium
Anemia, (% women 15-49) **	Severe

Note: + *Myanmar has borderline 'high' stunting prevalence, with a 95% confidence interval (27.2-31.2) exceeding the public health cutoff for 'high' stunting of 30%.* *Defined as hemoglobin <11 g/dl. **Defined as hemoglobin <12 g/dl in non-pregnant women and <11 g/dl in pregnant women.*

The origins of human capital limitations begin in early life—the first 1,000 days from conception through a child's second birthday. The consequences of early life under-nutrition are lifelong and far reaching. The persistence of high levels of under-nutrition in the face of strong economic growth and poverty reduction represents a staggering, yet avoidable, loss of human and economic potential. Under-nutrition elevates the risk of child morbidity and mortality, increases expenditure on health care and social safety nets, lowers the efficiency of investments in education, and decreases lifelong income-earning potential and labor force productivity, with the potential to be transmitted across generations. In addition to being a major contributor to maternal and childhood deaths, early childhood under-nutrition contributes to an increased risk of non-communicable diseases later in life.

Early life under-nutrition is, therefore, a key human capital constraint to further poverty reduction, competitiveness, and the creation of a vibrant private sector in Myanmar. The current cohort of young workers who have grown up in a period of very high maternal and child under-nutrition rates face avoidable challenges in reaching their full potential, and these developmental handicaps continue to affect the present generation of young children. Fortunately, there is a window of opportunity, and intervention in the first 1,000 days period can lock in human capital for the next generation. Good nutrition – especially during the earliest years of life – underpins the very future of Myanmar and can be a catalyst for growth (Horton and Steckel, 2013, Caulfield et al. 2004).

Maternal endowments (health, nutrition and education) as well as agency and empowerment are also determinants of stunting.[8] Consuming an optimal diet and accessing quality, appropriate healthcare can improve birth outcomes and interrupt the intergenerational transmission of under-nutrition. The process of stunting begins even before birth, and maternal under-nutrition is associated with impaired growth in utero. Maternal stature[9] continues to be the strongest predictor of child stunting in Myanmar, with children born to mothers of short stature 6 times more likely to be stunted. Nationally, 6.4% of women age 15-49 are of short stature, with the prevalence as high as 14% in Chin. Other

[8] *See* Kamiya et al. Mothers' autonomy and childhood stunting: evidence from semi-urban communities in Lao PDR. BMC Women's Health 2018 18:70.

[9] Maternal short stature (defined as height <145 cm) is often a sign of a mother's own exposure to malnutrition in early life and a significant risk factor for delivering low birth weight babies. Poor dietary intake and low pregnancy weight gain can also contribute to adverse pregnancy outcomes, including low birthweight and low iron stores.

maternal factors, such as socio-economic status, level of education, age of pregnancy, and access to maternal care are determinants of stunting. Mothers' level of education, for example, is significantly correlated with stunting: stunting prevalence is 39 percent in households were the mother had no education, compared to 17 percent in households where the mother had more than secondary education. Access to adequate care in pregnancy and delivery is also low: only 51 percent of women attend at least 4 antenatal care visits, and 60 percent of deliveries were assisted by a skilled birth attendant.

There is wide geographic variation in the prevalence of under-nutrition across States/Regions. The national averages mask disparities across geographical areas (Figure 1). Overall, nutrition outcomes in rural areas are significantly poorer than in urban areas, as are outcomes in States/Regions affected by conflict. Yangon is an exception when it comes to wasting (12.6%) and has the second highest wasting prevalence after Rakhine (13.9%). Stunting rates vary from 41 percent of under 5 children in Chin State to about 20 percent in Yangon. The States/Regions with the highest rates of stunting prevalence are: Chin, Kayah, Rakhine, Ayeyarwady, Shan, Kachin and Mon, while stunting is considerably lower in Yangon, Nay Pyi Taw, and Bago[10]. These geographical disparities in stunting prevalence emphasize the need for effective geographic targeting of more intensive efforts to leverage existing platforms to address the problem in the near term, while strengthening routine systems and nationwide programs to address the issue in a sustainable manner over time across the whole country.

3.3 Context for the DSW Maternal and Child Cash Transfer Program

The Maternal and Child Cash Transfer (MCCT) Program is one of the eight flagship social protection programs 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 the aims to promote human and socio-economic development, strengthen resilience to cope with disasters, enable productive investments and improve social cohesion. Rooted in Myanmar's context, the NSPSP endorses the principles of universality (everyone is entitled to social protection) and integrated approach (addressing multiple vulnerabilities in a coordinated manner that maximizes linkages with other services). Taking into account the country's vulnerability profile, the eight 'flagship' programs are intended to address vulnerabilities along the life cycle, and four of these programs are cash transfer programs (see table below for the objectives and description of each). To ensure the implementation is technically and financially feasible, the flagship programs are expected to be progressively rolled out. The MCCT Programs is set to be the first of the flagship programs to start being implemented by the government, initially in Chin State only[11] and also being implemented in Kayah and Kayin, with funding from LIFT.

Table 3. Four Social Protection Cash Transfer Programs of Eight NSPSP Flagship Programs

Flagship Program / Intervention	Objective	Description
Maternity and child benefits	To improve nutritional outcomes for all mothers and children during the critical first 1,000 days of life	Cash benefit from the last 6 months of pregnancy to 2 years of age

[10] Additional analysis is underway to understand the true significance of these regional variations.

[11] It should be noted that although this will be the first government-implemented statewide MCCT Program, MCCT program are already being implemented, on a limited scale, in Rakhine, Dry Zone and Delta region by Save the Children, and the learning from these programs has informed the design and operationalization of the Chin MCCT Program.

Child allowance	To support families in accessing services that promote children's all-round development	Every caregiver of a child aged 3-15 years receives an allowance
Social pension	Income security for all of the elderly	Cash benefit to those age 65 and over
Disability allowance	To ensure that their needs are adequately met and to facilitate their social inclusion and access to services	Cash benefit to children and adults with disabilities

Nutrition indicators for mothers and children in Myanmar are worrisome. As per the preliminary results of the 2016 Demographic and 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 Program 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.

Apart from being a deprivation in itself, poor nutritional status in early childhood is associated with:

- Higher morbidity and mortality in childhood;
- Suboptimal cognitive, motor and socio-emotional development;
- Suboptimal school performance and learning capacity;
- Suboptimal work capacity and productivity in adulthood;
- Lower wages in adulthood;
- Higher vulnerability to obesity and non-communicable diseases in adulthood.

For all these reasons, poor maternal and child nutrition is a very serious problem and requires urgent policy attention. The MCCT program promises to be an effective new tool to improve maternal and child nutrition, complementing policies and program already being implemented in the health, nutrition and WASH (Water, Sanitation and Hygiene) sectors to achieve the same[12].

The promise of the MCCT Program lies in empowering pregnant and lactating women with: 1. additional purchasing power (MMK 15,000 per month, which would be paid out as MMK 30,000 every two months for administrative ease) to meet their unmet needs during the first 1,000 days; 2. Nutritional information and SBCC. It is expected that this cash transfer will enable pregnant/lactating women to:

- Improve their dietary intake;
- Improve their dietary diversity;
- Afford basic healthcare essential during pregnancy, delivery and post-delivery;
- Improve feeding and caring for their young children;
- Afford basic healthcare essential during early childhood of their children.

[12] Refer to the nutrition casual framework in the Social Behavior Change Communication Strategy for the MCCT Program for details on how health and WASH contribute to nutrition outcomes.

Participating pregnant/lactating women enrolled in the MCCT program will be provided monthly awareness-raising sessions on a range of topics related to improved nutritional outcomes will also participate in awareness raising sessions relate to improve nutritional outcomes, health, nutrition and hygiene. These awareness-raising sessions will be delivered by the local auxiliary midwife in the local language and will be as interactive as possible, adapting to the needs and interests of the local women and building on their existing knowledge and practices in the areas of health, nutrition, and hygiene. The graphic below summarizes the components of the MCCT program and the expected outcomes at various levels.

4 Key Issues and Key Research Questions for the Social Assessment

The objective of the social assessment is to complete an investigation of the socio-cultural, institutional, historical and political context and the key related social issues that are likely to impact tackling some of the many challenges to implement the proposed priority nutrition interventions at scale. Historically Ayeyarwady has been partly devastated by severe storms like Nagris that initiated a long post Nagris dependency on aid. In Shan conflict has been an historical problem for generations and although peace has been reported in many areas there are still a number of ongoing conflicts that restrict access to certain areas while inhibiting development support. The social assessment through identifying the key challenges will provide focused insights into the social processes and inter-cultural relationships that will potentially impact the inclusion of targeted beneficiaries such as pregnant and lactating women, infants and young children, and their families in prioritized nutritionally vulnerable areas in Shan State and Ayeyarwady Region. In addition, the social assessment will identify a social development strategy that strengthens social inclusion ensuring that the poor and excluded groups and intended beneficiaries are meaningfully included and empowered through their participation in the design and implementation of the project. The identification of key social factors that facilitate and inhibit optimal inclusion and participation will be vital to achieving these important research objectives focusing on Cash Transfers; Social and Behavior Change Communication; and System Strengthening /Multi-sectoral Collaboration.

Accordingly, the following key research questions were proposed to guide the social assessment.

Box 1. Research questions

- What are the key social factors most likely to facilitate or inhibit the development and implementation of the project in Shan State and Ayeyarwady Region?
- What are the important cultural differences related to ethnicity, tradition and language that need to be considered?
- To what extent do gender, ethnicity, religion, political affiliation and disability impact inclusion and increase marginalization?
- What are the critical issues about literacy and education levels, poverty status and location of households
- What are the potential unintended risks of the proposed project and how can these be minimized in the context of individuals, households and communities?

Based on these key research questions, the following areas of inquiry were identified:

1. **Institutional Roles and Responsibilities:** DSW and possibilities for collaboration with MOHS, GAD, Education and other relevant departments and actors.
2. **Existing Norms on Nutrition:** Existing norms and factors influencing norms, including challenges at household and community level.
3. **Existing Norms on Pre and Post Natal Care:** Existing norms and factors influencing norms, including challenges at household and community level.

4. **Behavioral Change and Communications:** Existing pre and post natal care and nutritional awareness communications. Social factors impacting communications, good practices.
5. **Cash Transfers and Preferred Modality:** Existing cash transfer models, concerns, challenges. Social factors impacting cash transfers, potential risks with different modalities.
6. **Ethnic Minorities and Inclusion:** Inclusion of ethnic minorities at community, local and regional level.
7. **Additional Vulnerable Groups:** Poor households, single mothers, widows, mothers with abusive partners, families with alcohol dependencies, migrants etc.
8. **Conflict in project area:** Incidences/impacts of armed conflict and community conflict.

5 Methodology

This is a mixed method study using existing and local quantitative data supplemented by extensive qualitative data collection from interviews, focus group discussions, formal and informal consultations and observations. As outlined in the Inception Report there is extensive access to related reports, studies, MCCT manuals focusing on interventions in Myanmar and international best practice.

The main units of enquiry are local departments / authorities, selected and representative individuals and groups and a good cross-section of targeted households. The table below provides more detail. There is also a calculation of additional discussions that is calculated at one per village and based on the discretion of the team and need for additional information. The main instruments used were Focused Group Discussions (FGD) with community members and women, Semi-structured Interviews that included regional and township local authorities, Key Informant Interviews with village leaders and health care staff and finally household (HH) Interviews that focused on families with pregnant women and mothers with children under two.

Use of Representative / Purposive Sampling. The criteria and rational for the selection of social assessment sites and stakeholders was as representative as possible and considered ethnic, post-conflict, socio-economic and geographical variables. The township selection process was based on consultation with the DSW. In Ayerarwady the three townships selected (Chaung Tha, Labutta and Kyan Kin) were particularly representative of the three main geographical areas in the region and included villages that were diverse in location and socio-economic status. In Shan because of the division of the state into three distinct areas there was a selection of one township in South Shan (Hopong), one township in East Shan (Kengtung) and one in North Shan (Lashio). The ethnic and locational diversity of villages in Shan were difficult for the social assessment team to represent in sampling because of logistical, access issues and time constraints. However, with continual consultations with DSW and GAD a relatively representative group of villages was selected. These in some cases were not the original villages suggested by DSW and GAD and were in a few instances more remote than those originally selected by DSW. Time limitations, weather conditions and logistics were also factors.

Limitations. The main limitations of this study center on the broadness of the social issues and areas of enquiry related to the proposed project in two large and diverse areas (Ayeyarwady Region and Shan State). Each individual community in each of the thousands of villages that will

be supported by this proposed project is unique with particular social issues and dynamics that can affect the design, development and implementation of a culturally sensitive MCCT project. Representation was seen as key and the selection of townships and villages may not have been as representative of all the stakeholders particularly the vulnerable and marginalized in these two areas as first imagined. Village selection was mainly done by DSW and in some cases more accessible places were chosen. In other instances, after reaching the Townships, GAD allowed the SA Team to modify the travel schedule to visit more remote areas in order to improve representation. In Ayeyawaddy the majority of places selected were ethnically Bamar. After submitting travel authorization for Lashio there were conflict issues but eventually the social assessment team were permitted by GAD to visit one village, Nam Pawng. Initially there were three villages selected to visit in Lashio. To compensate for this the team visited two urban Wards one of which has a relatively large migrant community. This in the end was something that broadened the initial scope of the social assessment.

Concerns for safety and wellbeing of the social assessment team needed to be considered and particularly in disputed areas and locations where transport is limited, and weather conditions hinder access. The language used in interviews and focus group discussions needed to be the language that is used by the majority of participants and this was not always Burmese. The prior identification of locations that needed support from indigenous facilitators and translators was factored into planning but there were still difficulties in relation to some areas because of the number of ethnic groups and languages involved.

Piloting. It was agreed to conduct the pilot data collection in Chaung Tha coastal sub- township with the selection of three villages (Ou To; Seik Kyee and Aung Minglar) and Shan in Hopong Township with the selection of the following three villages (Nam Hkoke, Loi Aun and Par Pant). This took place from August 27 to September 9, 2018 and helped to split responsibilities and roles through the division of team members at township and village levels. After piloting there was a revision of procedures, guidelines and instruments. Observation played an important role at this phase and the organization of teams based on how best to facilitate local understanding of questions and discussion themes. For example a local Pa O interpreter was used to good effect in Hopong. After the piloting and analysis of data there was a decision to use one single team instead of two teams that worked in Ayeyarwady and Shan in September, so that data could be collected and analyzed in an efficient and standardized manner.

Overall Number of Interviews, Discussions and Consultations. This was a calculation based on the pilot and was adjusted based on logistics and availability and permission to interview targeted stakeholders. The main units of enquiry were local departments / authorities, CSOs, NGOs and selected and representative individuals and groups and a good cross-section of targeted households. The table below provides more detail. There was also a calculation of additional discussions that is calculated at one per village and based on the discretion of the team and need for additional information.

Table 4. Number of Interviews and Focus Group Discussions

Interview Types	Location Unit of Analysis and Participants	Number of Interviews
Semi-Structured Interviews	Regional, township levels focusing on local departments in Ayeyarwady and Shan Note: 3 Townships in each area	24 (12 x2)
Key Informant Interviews	Village tract / leader (18), Mid-wife (18) Note: 3 villages per Township	36 (18x2)
Focus Group Interviews	Village Group 1. Women's Group Village (18) Village Group 2. Mixed Group Village (18) Note: 3 villages per Township	36 (18x2)
Household Interview	Village: Focusing on families / mothers expecting or with young children under two. Representation of economic status / ethnicity and distance from village / township (72) Note: 3 households per village	72 (36x36)
Additional discussions	Dependent on issues in particular areas. This can be flexible and based on observation and interviewers judgment. Note: 1 per village INGOs, CSOs, Ethnic Groups	18 (9x2)
TOTAL		**186**

Table 5. Overview of Final Interviewees by Gender and Ethnicity

Townships	Semi – Structured Interviews with Line departments	Key Informant Interviews	FGDs	HH	M	F	ETHNICITY											
							Bama	Kayin	Chin	Pa-O	Shan	Nepalese	Akha	Lahu	Rakhine	Lisu	En	Mixed
Ayeyarwady (Pathein)	2				4	2	6											
Pathein TS Chaung Tha Sub-TS	3	2	7	10	27	44	59								1			1
Labutta	4	4	7	9	13	35	43	3							1			1
Kyangin	3	6	6	9	28	32	59	1	1									
Shan (Taunggyi)	2				1	2	1				1							
Hopong	3	3	6	8	15	38	5			45	1	1						1
Kengtung	3	4	6	11	37	60	1				20		4	54			18	
Lashio	6	3	0	6	7	7	4				5					1		
Total	26	22	31	53	127	216	171	4		45	27	1	4	54	2	1	18	3

B. DETAILED SOCIAL ASSESSMENT FINDINGS

1 Institutional Roles and Responsibilities

This section will summarize the administrative structure of the government departments and none-governmental organizations including ethnic organizations and community organizations that has potential relevance to the project implementation. It will also touch upon grievance redress mechanism that will be essential for World Bank funded projects.

1.1 Administrative structure and demography

Ayeyarwaddy Region comprises of 6 districts, 26 townships, 279 wards and 1,926 village tracts covering 35,964 km^2, and the population of the Region ranks second in the country after Yangon Region. Shan is the largest State in land area (155,458$km^{2,}$), almost a quarter of the total country area, comprising of 19 districts, 55 townships, 498 wards and 1,815. In terms of population, Shan is the 5th biggest of all States and Regions. Due to the large size, the State is administratively divided in three areas (North, East and South).[13]

Table 6. DSW Administrative and Human Resources Structure

Region/State	Ayeyarwady Region	DSW office and No. of Staff	Shan State	DSW office and No. of Staff
Region		17 staff (8 vacancies)		18 staff (6 vacancies)
# of Districts	6	2 district offices: Pyabon and Myaung mya 8 staff each (5 vacancies each)	19 (North 5, East 11, South 3)	2 district offices: Lashio 13 staff and Kengtung 9 staff (5 vacancies)
# of Townships	26	0	55 (North 24, East 10, South 21) – 15 townships are under self-administered areas	0
# of Towns	40	0	111 (North 54, East 23, South 34)	0
# of Wards	279	0	498 (North 77, East 187, South 234)	0
# of Village Tracts	1,926	0	1,815 (North 1168, East 225, South 422)	0
# of Villages	12,696	0	17,767 (North 8,223, East 3,699, South 5,845)	0
Population[14]	6,184,829	NA	5,824,432	NA

1.2 Implementing agency: Department of Social Welfare

The DSW will have the overarching responsibility for overseeing and coordinating the implementation of the project and monitoring progress toward achievement of MCCT and overall

[13] 2011 HMIS data. Population refers to 2014 Census.
[14] 2015 census data

project goals. The department currently has 3 offices in each of the State and Region. In Ayeyarwady, the regional office is in Pathein, with two district offices in Myaungmya and Pyapon. Two new district offices are scheduled to open in Labutta and Maubin in FY 18/19. DSW Shan State office is in Taunggyi (Southern Shan) and the two district offices in Lashio (Northern Shan), and Kengtung (Eastern Shan). Additional district offices are scheduled to open in Kyaukme and Muse (both in Northern Shan) in FY 18/19. Currently, most DSW offices in Shan State and Ayeyarwady Region are understaffed with 5-8 vacant positions.

DSW's activities are largely divided into 11 areas described in table 8. These are managed by the regional and district offices, and though some of these programs are at community levels, regular monitoring and interventions at the village level are not in the staff's current work plan. DSW has plans to establish offices at the township level starting in FY 19/20. Currently, staff below Assistant Director level also have a quite limited knowledge of the MCCT program.

Table 7. Types of Services Currently Delivered by DSW

Early Childhood Care and Development Services: Nurseries (3 to 5 years old); Orphanage; Self-help schools; Mothers' training program on care taking and nutrition (mother's with 3 months to 6 years olds); Early childhood care intervention - assessment of disability; mental health care for the pregnant women
Child and Youth Welfare Services: Juvenile justice rehabilitation center (under 18); Nargis orphanage hostel (remaining 30. New children under different criteria); Support funding to voluntary organizations including ministry (for girls boys); Regional Youth policy drafted
Women Welfare Services: School for home science (vocational training)
Care of the Aged: Home for aged, Care giver training; Service of elderly (with no family bathing, speaking), Awards the oldest person in region one male; one female
Rehabilitations of people with disabilities: Schools for blind people; Vocational training (partnership with NGO) in-kind donation and provide DSW volunteers; Blind massage service (send to Yangon); school for deaf
Rehabilitations of ex-drug addicts
Grants in aid to voluntary organizations: Train volunteers at Home for Aged; Child Youth Care services), Humanitarian volunteers (train the volunteers; technical support).
Public services
Repatriation, Reintegration, and Rehabilitation of victims of human trafficking
Social Protection Program: Social Pension; Food support through Mother's Circle
Policy development: Inputs to policies including Law Violence against women; Child protection law; Law for elderly: Law for disabled.

1.3 Multi-Sector Collaboration for Project Implementation

General Administration Department. Township GAD office led by the Township Administrator is responsible of coordinating the line departments and their interventions at the township level as well as playing a key role in ward and village tract level administration. At the township level, GAD typically has 34 positions regardless of the size of the township. In addition, GAD hires clerks who

are assigned to specific ward/village tracts to support the local administrators.[15] Based on the recent amendment of the 2012 Ward and Village Tract Administrators Law, the local administrators are directly elected by the household representatives. Ward/village tract administrators are the lowest level of the GAD administration structure though they are technically not civil servants. Ward and village tract administrators attend regular meetings held at the township with government departments and cascades the communication down to village heads, 100 household heads, 10 household heads and individual households. These local level administrators will be the key messengers to share the project information to the people living in their ward and village tract. Currently DSW relies on the GAD structure for the Social Pension program and for MCCT program, tasking them to carry cash from the GAD township office and distribute them to elderly people over 90 years old in their respective areas (10,000MMK per month per person).

Department of Public Health. Under the Township Health Department there are Urban Health Centers, Rural Health Centers and its sub-centers, which provides maternal and child health services. Midwives are stationed at these facilities and are in the frontline providing antenatal care services, delivery of babies and postnatal care services, which includes immunization, growth monitoring, basic nutrition advice and birth registration assistance. These services are provided to all mothers and children regardless of holding National Registration Cards (NRC). The number of assigned villages per midwife varies from around 5 to 25. In both Ayeyarwady and Shan, hard to reach remote villages had less or no visits by the midwives. In places that are distant from the health facilities alternatively had Traditional Birth Attendants (TBA) or retired midwife assisting the delivery of the babies. The age and experience of the midwives were also factors for the beneficiaries to choose to receive their assistance or not. Inexperienced midwives tend to be assigned to new or remote areas. While in Ayeyarwaddy, most visited villages had access to midwives, in Shan mothers from one remote visited village gave birth at home by support from their family members. In Shan there are many villages located in mountainous areas where accessibility becomes challenging especially in the rainy season. Secondly, there were safety and security concerns. Some midwives assigned to post-conflict or conflict affected area felt unsafe to visit the respective villages alone and instead called pregnant and lactating mothers to visit them. Another factor is the education level of mothers, villager's education level in Shan is perceived to be low and with the combination of limited exposure to external communities, they are more rooted to their tradition norms.

Health Committee and Volunteers. The Public Health Department forms health committees in cooperation with the GAD at the village level. This committee includes influential people in villages such as: monks, better-off people, citizens with good communication skills. The assigned midwives or basic health staff (BHS) to the village takes the role of secretaries in this committee. However, it was not evidential that the committees exist in all villages, instead, there were more active incentive-based volunteers such as malaria volunteers, integrated community health volunteers. In some areas there are voluntary Auxiliary Midwives (AMW) supporting the mid-wives who are trained to perform similar tasks to the mid-wives except for immunization, unfortunately however, the number of AMW is limited and although it is a lengthy process to train AMWs, the continuity of the AMWs are often unreliable.

[15] https://asiafoundation.org/wp-content/uploads/2014/10/Administering-the-State-in-Myanmar.pdf

Department of Education

The Department of Education (DOE) has presence in both township and at village levels. In urban areas almost all wards have at least one government school (Ayeyarwady 162%, Shan 97%) while in rural areas the ratio of government schools per village stands at 32 % in Shan State and slightly over 50% in Ayeyarwardy Region.[16] The Ministry of Education (MOE) has committed to a national scale up of around 1,000 new schools and 4,000 to 5,000 upgrading of schools to accommodate higher grades every year. Nurseries are under the management of DSW although there are some nurseries supported by organizations such as UNICEF, which are directly managed by DOE. Nutrition education is included in the new primary school curriculum. Teachers particularly in areas close to town were encouraged to find donors to conduct cooking demonstrations for primary school students, however, this was not found in rural areas.

In addition to teaching at schools, teachers in rural villages are in responsible of reaching out to young children who dropped out of schools and have positions in various village committees or activities. School teachers are one of the signatories witnessing the delivery of cash to beneficiaries. In urban areas they collaborate with line departments, for example in health care provision to students under DOPH; awareness raising of human trafficking and drug abuse with police department and so on. Students from small number of households and conflict affected villages are often left out from the education system. As per Minority Inclusion Project under the MOE introduced in 2018, teachers from nearby villages reaches out to 10 household heads from villages without schools to promote education.

Language is not seen as an issue in delivering the school curriculum in Ayeyarwady but in Shan State, since majority of the government school teachers are Burmese, students face some challenges in the first few years of education. Recently, teaching of ethnic language has also been incorporated in the curriculum. The literacy rates in rural villages in Shan state perceived to be just around 60% only or less.

Table 8. Literacy Rate

	Township	Literacy Rate (GAD Data)	Perceived Literacy Rate by DoE during interview
Ayeyarwady Region	**Kyan Kin**	99%	> 90%
	Labutta	98.71%	90 – 95%
	Pathein	94.87%	100% (no illiterates)
Shan State	**Hopong**	89.75%	90% (in non-conflict affected villages)
	Kengtung	92.74%	60% (in Urban areas) 40% (in rural areas)
	Lashio	98.93%	-

Parents and Teachers Association and Education Committee

PTAs are set up by the villagers (or school parents and ward administrator in urban wards) at the establishment of schools. The members include school teachers, ward/village head, village elders, respected person (influential person), and active parents. They promote education; mobilize funding

[16] Data from World Bank Education team. The data counts all types of government schools.

for renovation, maintenance of schools; and coordinate between teachers and parents. Education committees are separately set up for MoE programs but formed with similar members to PTA.

Ethnic Administration. In Shan State there are 4 Self-Administered Zones (SAZ) namely, Danu, Pao, Palaung, and Kokang, and one Self-Administered District (SAD), Wa. These areas have parallel administration system in place. According to the Constitution and the 2010 Self-Administered Zone/Division Law the head of the GAD is the secretary of the SAZ and district leading body and working committee. Besides the SAZ and SAD, there are multiple ethnic organizations particularly in Shan State.

Women Affairs Associations and Mother and Child Welfare Associations. Women Affairs Association and Mother and Child Welfare Association are state-sponsored groups established on the instruction of township authorities through 1988-2010. The associations are considered semi-government associations, by organization structure; for example, the wives of township administrator and village tract administrators normally are the leaders of the associations. Previously the village level women affairs association had nominal members only. Their main activities are to attend ceremonial events, but some have donation-based activities including nutrition education. Under the current government, there were budget cuts for these actives. The activeness of the associations depends on the township administrator's wife's network.

Social Protection Committees. In Chin State where MCCT has been implemented, Ward/Village Social Protection Committees (SPC) are supporting the implementation of the MCCT program tasked to undertake identification and enrollment of pregnant women and women with children under two in their respective village.

In Shan State and Ayeyarwaddy Region, SPCs are not formed yet. In all visited villages, the SA team did not come across any DSW affiliated volunteers, apart from Pathein**.** The table below identifies types of positions at the community level of the people who may be opinion leaders and/or potential members of the SPC. It is not rare to see active individuals in rural villages, wearing different hats and holding multiple positions.

Table 9. Community level positions and potential members of SPC

Positions at ward/village	Ayeyarwady	Shan	Strength/ Weaknesses
Ward/Village tract administrator	In every ward/village	In every ward/village. SAZ/District has a separate administrator.	Well established communication system in place with TS and individual HH level.
Village head	Majority male	Majority male.	
Midwife	Based in places where RHC and sub-centers are located. All Female	Based in places where RHC and sub-centers are located. All Female	Best knowledge of the pregnant and lactating mothers
Auxiliary midwife	Supports Midwives but still limited coverage. Depending on funding situation.	Supports Midwives but still limited coverage. Depending on funding situation. Female	Useful source in areas where there are no midwives.

Positions at ward/village	Ayeyarwady	Shan	Strength/ Weaknesses
	Female		
Health volunteers	Most villages have someone assigned on paper. Activeness depends on existing programs/incentives	Some villages had local ethnic AMWs	Network with DoPH and other health related projects
Headmasters/teachers (Data includes government and monastic schools)	Exist in all areas where schools are. Urban: 454 schools in 279 wards (162 %)[17] Rural: 6,533 schools in 12,696 villages (51%)	Exist in all areas where schools are. Urban: 488 schools (North 185, East 72, South 231) in 498 wards(North 77, East 187, South 234) (97%) Rural: 5,604 (North 2,179, East 782, South 2,643) in 17,767 villages (North 8,223, East 3,699, South 5,845) (32%)	One of the most educated people in rural areas. Established relationship/ communication line with parents. Respected people
Religious leader	In most villages Male	In most villages Male	Respected people
Village elder	In every ward/village there are several elders Majority are male	In every ward/village there are several elders Majority are male	Respected and educated
Women's group	Not in all village	Not in all village	Knowledgeable and experienced in women's affairs
Community Social Service group (funeral service; ambulance service; red cross)	Most villages have someone assigned on paper.	Most villages have someone assigned on paper.	

CSOs in Northern Shan. In Northern Shan, local CSOs including Northern Shan Women Network who has 14 sub-groups; Wa Women's Network; and Ta-ang Women Organization are actively taking roles in delivering services of larger NGOs or Ethnic Administrations in conflict affected areas.

1.4 Accountability and Grievance Redress Mechanism

The Social Assessment did not observe any functional accountability mechanism under DSW's current programs to complement the government's formal financial auditing process. DSW runs several programs disbursing cash to beneficiaries including the Social Pension Program and the Mother's Circle Program. The cash transfer part of the Social Pension Program is handled by GAD. The GAD township office manages the accounting in coordination with the existing DSW district or regional office. Mother's circle program also disburses cash to beneficiaries, but the project does not have a systematic monitoring process to review the finance flow and to measure the satisfaction of the beneficiaries.

[17] Data from World Bank Education team. The data counts all types of government schools

The Bright Sun Project, a MCCT program implemented by Save the Children in Labutta Township has a feedback mechanism in place. The operations manual clearly states the scope, intake modalities, categorization and resolution processes but the implementing team noted the limited experience of receiving complaints because the beneficiaries are uncomfortable in creating tensions with the staff and volunteers. Normally, core issues are raised through midwives and volunteers who monitors and engages with the beneficiaries and implementing agency staff.

1.5 Recommendations

Strategically plan and budget up front for institutional arrangements, including additional staff hiring, staff training, township offices establishment (physical location, hiring office space, connecting internet for MIS, procurement of furniture and other equipment, procurement of vehicles/motorcycles). Current situation of the shortage of DSW offices with the department's lack of presence at the township level with limited outreach experience and staff capacity are key risks to the project implementation and disbursement of funds.

Strengthen internal and external communications about the project. This will be crucial to the DSW's successful scale up and project implementation. This will require DSW to assign one communication officer and set up internal launch events at all levels for all staffs.

Plan good collaboration and coordination with GAD and MOHS who have people down to the village level. Ensure that the extent and scope of this collaboration is understood by staff at all organizations and at different levels. This will require extensive training, and understanding from GAD and MOHS that additional work may be required of their staff. Collaboration with GAD and MOHS should be structured and agreed on through an official agreement.

Focus on training, paying and incentivizing selected community volunteers at the village level, rather than establishing social protection village committees. The project will need to mobilize thousands of village volunteers who will need to be trained and to be well informed. Ways to incentivize the volunteers who are not project beneficiaries are also important factors to be considered. There is evidence that village committees usually consist of the same members of the village for different purposes (electrification committee, micro-credit committee etc) and do not convene unless there is ongoing incentivization and facilitation. It is not clear if the project can maintain such continuous facilitation for committees without significant allocation of resources to village-level facilitation.

Establish a grievance redress mechanism at the onset of the project. Some of the key elements for a successful grievance redress mechanism are to have: a clear case management procedure, technically simple and centrally manageable MIS system, and initial investment in communications and training to beneficiaries and staff. The grievance redress mechanism will require budgeting from project funds.

DSW project management should have stated accountability and transparency principles from the beginning of the project and this should be reflected in all communication materials.

2 Existing Dietary Norms

2.1 Findings

This section will examine the existing norms related to nutrition from a Regional / State, Township, Village and Household perspective. These were the main areas visited and units of analysis were based on interviewing regional and township government departments and authorities, village administrators, community groups and targeted households. In addition and when active in selected study areas, CSOs, CBOs and NGOs directly supporting pregnant women and mothers with young children were contacted and interviewed.

- *Family nutritional norms depend on what is locally grown and available and, depending on family's level of poverty, what they can afford to buy at the market.*
- *In Ayeyarwady, primary food source is fish paste and rice; in Shan, primary food source is chili paste and rice. Access to vegetables is limited in some remote villages depending on accessto water and access to water; access to meats/seafood is extremely limited.*
- *Remoteness of villages and accessibility by transport has big impact on family nutrition; only villages in peri-urban areas have access to markets.*
- *In some areas in Shan, there is no cash economy in villages for purchasing food.*
- *Most women do not have any information on nutrition. Even if midwives provide information, cultural and traditional beliefs are stronger. In Shan, there is also a mistrust of information provided by midwives.*
- *In communities where nutrition programs were implemented with trained volunteers (Labutta, Kyan Kin), women are more aware of food groups and nutritional value.*

Ayeyarwady Region. The geographical spread of the three townships visited showed that nutrition varied depending on location, with areas close to the coast like Chaung Tha having an availability of other seafood that are important nutritional sources for pregnant women and mothers with young children. In Labutta and Kyaingin, there was more of a dependency on meat (chicken, pork and beef) than on fish but with an availability of fish and fish products to supplement the meat. All three locations have access to fresh vegetables, pulses and beans as well as fruit. From a regional perspective nutrition depends, among other things, on availability of a variety of food including, fish, sea food, fish products, meat, vegetables and pulses, and ability of individual families to produce or purchase in local markets. The location of individual communities and families and access to food markets plays an important nutritional role across all socio-economic groups.

In Chaung Tha, which is a coastal township, seasonal variations in the availability of sea food was highly dependent on the monsoon and weather conditions. In addition to this there is an increase in the population during the fishing and tourist season that has a knock-on effect on the availability and price of food. In Labutta, which is a township located in the delta, soil erosion was identified as a factor in the restrictions of livelihoods directly related to food production. In addition, the availability of fish has been reduced and families are more dependent on buying from the market than before. Home grown vegetables are less of a possibility now because of the population density in some areas as well as the above-mentioned quality and availability of land and fresh water. Transport is a key issue in relation to nutrition in Labutta as many communities are dependent on a good combination of road and waterway transport to transport food products to markets and

homes. In Kyankin, which is an upland township, the assessment found that the township has better land that is less affected by soil erosion and salt water compared to the other two townships. The possibility to grow and produce fresh vegetables and graze domestic animals is better than in the two other areas. In addition, Kyankin is supported by the ARD CDD project in all villages that has improved agricultural and transport infrastructure within the township that has had probable positive impacts on food production and transportation.

Shan State. Shan is a landlocked state, therefore there is a limited supply of freshwater fish / products. There is more incidence of subsistence farming due to the climate and geography. This impacts what can be bought in markets. The availability of food varies and is dependent on location of the community and household, ability of the family to purchase or produce food themselves, and possibility of bartering or exchanging food and food products within subsistence farming communities.

While it is probable that nutritional norms vary in the three townships visited in Shan (Hopong, Kengtung and Lashio), there were certain similarities based on the availability of a similar variety of vegetable, beans and pulses as well as common animal husbandry traditions that contributed to the availability of chicken, pork and beef. In Hopong, the villages visited had decent access to locally grown food and there was a tendency to be self-sufficient. In Kengtung, in the more isolated areas that are occupied by small ethnic minority groups like the En, Akha and Lahu, there is limited access to markets and limited use of cash to purchase food. This is balanced somewhat by the ability to produce vegetables at home, but the poverty level of most villagers and dependency on selling chickens and other domestic farm animals to purchase rice and other foodstuff creates a nutritional deficiency and reliance on vegetables. In Lashio, the sample included more accessible and urban communities. Good quality food is readily available in the numerous markets in Lashio, but price and ability to pay are the constraining factors.

The diversity of villages and the geographical spread, ethnic groups and socio-economic status make the villages in Kengtung some of the most diverse in the assessment. In terms of nutrition and nutritional norms, there is a contrast that can be clearly linked to the location of the village, ethnicity, food availability and awareness. The contrast between Kat Taung Village (almost urban) and Na Li Village (extremely remote and takes 3.5 hours to reach) demonstrates that different attitudes to nutrition are impacted by many factors. Living in a remote village may be compensated by having good land in some cases and the possible availability of home-grown food, but without the outreach and service provision / advice from a midwife, this relative advantage from a nutritional perspective can lead to a severe wellbeing disadvantage. In addition, inability to access markets for selling and buying food products and other items inhibits not only nutrition but also access to information and communication. In cases like Na Li and En Village cash transfers alone will be ineffective in supporting improved nutritional intake for women and children, unless women are to diversify gardening practices or spend the cash transfer on transportation costs for access to better health care.

At the household level, the assessment found that most households consume what is readily available, without much consideration to nutritional diversity. In some locations supported by midwives and INGOs, while pregnant women may know about nutritious food, there is not much change in diet due to inability to pay. Better-off mothers in general consume Milk, Ovaltine, Obimin

(multi-vitamin supplement) and fruits during their pregnancy in addition to consuming more meat than before. Villages where NGO projects are being implemented have better awareness on nutrition. They were fully aware of the three food groups. However, in practice, households do not seem to be using what they have learnt due to income and time constraints, and a lower level understanding about the consequences of malnourishment.

In Ayeyarwady, households have more postnatal nutrition norm changes than prenatal changes. After birth, both well-off and vulnerable households reported to consume more vegetable soup to increase breast-milk supply. In addition, well-off households consume more meat and drink Ovaltine while poorer households rely mainly on dry fish. Although they do not avoid much food during their pregnancy, food avoidance was seen after giving birth. The main foods avoided are bamboo shoot, sweet potato, djenkol beans, mushroom and vegetables with advice mostly coming from older family members.

For child after birth, in most villages interviewed, breastfeeding was exclusively practiced until the child is 6 months old. Those who did not have sufficient breast milk or mothers who had to go for work reported feeding their child boiled condensed milk. This was particularly the case with poorer mothers and more prevalent in the villages of Chaung Tha. After 6 months of age, children are fed locally made rice powder and chewed-and-then-spitted rice to supplement breastfeeding. Sometimes, mothers add soft fish or meat. Some well-off families fed their children Dumex milk powder and Nestle baby food.

In Shan, the assessment covered thirty households in two urban wards and nine villages. These households represented Shan, Bamar, Pa O, Akhar, Em, Wa, Nepalese, Chinese, Bamar, Larhu and Kachin ethnic groups. The ethnic diversity had a diverse number of socio-economic groups, education levels, urban and rural families as well as livelihood dependencies. This makes for very interesting cases for culturally appropriate and flexible support based on the understanding of individual community and household understanding, attitudes and emphasis on nutrition with a focus on pregnant women and mothers with young children. Shan is a diverse and complex state with a large land area and in many cases communities are separated by geographical, social and political barriers.

Many of the interviewed women said they do not consider about nutritional benefits when they cook, as they have to cook what is available in the fields. The staple food in Shan state really depends on the income of the households and the distance from the market. In rural households, the main staple food is rice, boiled vegetable/vegetable soup and pounded chili. Almost all households interviewed eat rice three times a day. Houses can afford to eat vegetables in Shan state because many of the rural households plant vegetables in their gardens and fields. Access to vegetables depends on the season. During winter and in the monsoon seasons most households do not have difficulties in getting vegetables, but during summer months they have limited access to vegetables. Urban households eat a variety of food including vegetable and meat. Meat and milk are not easily accessible in rural areas. In low-income urban households, non-nutritious food such as spicy pickled tealeaf, ready-made fake meat products from China, instant noodles and low-priced snacks are also foods consumed on a normal basis.

In general, rural poor households do not change their diet habits for pre-natal nutrition, while middle class women are seen to be able to afford to eat more meat, fruits and take vitamin tablets like Obimin. Most women receive nutrition related information from their mothers and relatives and they don't avoid too many food items during their pregnancy.

However, women are very careful about their post-natal diet. Households claim to avoid eating vegetables from outside that may contain a lot of pesticides and chemical fertilizers and try to eat vegetables from their garden. Some villages even reported avoiding meat that is sold by outsiders and not killed in the village. The common food items eaten in most households after giving birth are boiled chicken/chicken soup, dog meat or egg. While chicken and eggs are mostly eaten by people of Shan ethnicity, eating dog meat is traditionally more common amongst En and Lahu people and linked to post-natal diets. The only vegetables eaten by some households are as soup, such as mustard leaf or drum stick leaf after giving birth. Although many mothers start eating some food items after one month, they still avoid majority of the food items such as bamboo and mushroom for at least 6 months. Exclusive breastfeeding is more common in towns or villages that are close to the town as they meet the midwife often and get information about exclusive breastfeeding from the midwife.

In most remote villages, there were cases of mothers feeding the child water from the first month and other supplements such as chewed rice from three months of age. This results from not trusting midwives from outside the area, not using midwife services after birth, not getting vaccination because they give birth using the local TBA, language difficulties in understanding the midwife, and a dependency on casual labor work to earn daily income necessitating leaving the child at home with grandparents/elder child.

Table 10. Factors influencing Nutrition/Dietary Norms at Different Levels

Level	Factors Influencing Norms
Region	• Regional Strategy • Land use • Transport and Market Conditions • Demand and price
Township	• Traditional crops • Location of Township • Transport and Markets • Demand and price
Village	• Location of village • Number of HHs • Livelihood linked to food • Traditional diet • Health and Midwife service • Active NGO/donor programs on nutrition
Household	• Awareness of HH on nutrition • Direct advice from Midwife • Economic status • Education level of mother • Support from family / husband • Availability of cash • Capacity to produce food at home

Level	Factors Influencing Norms
	• Size of the family • Occupation of family • Location of household in relation to market • Influence of tradition and older family members (female) • Ethnicity and tradition • Information from social media (limited)

2.2 Recommendations

- Use of trained volunteers at the community level is key for effective communication on nutritional norms, taking into account traditional beliefs in different areas.
- DSW will need to coordinate with MOHS at the township level, since information currently available on nutrition comes from midwives (though info booklets are too complex).
- The project should link with other projects, livelihoods programs, demonstration farms, seed programs etc. to ensure food diversity; improved eating, feeding and caring practices, better sanitation and hygiene, and better access to health services; otherwise, increased cash will not lead to better nutrition.
- Communication should also note that cash transfers can be used for transport, access to health.

3 Existing Norms on Pre and Post-Natal Care

3.1 Findings

This section will examine the existing norms related to pre and post-natal care from a Regional / State, Township, Village and Household perspective. These were the main areas visited and units of analysis were based on interviewing regional and township government health departments and RHC / Sub-center staff, midwives, TBAs, village administrators, community groups and targeted households focusing on pregnant women and mothers with young children under two. In addition, and when active in selected study areas, CSOs, CBOs and NGOs directly supporting pregnant women and mothers with young children were contacted and interviewed.

- *Quality of advice on pre and post-natal care is highly dependent on availability and outreach of midwives.*
- *More remote and poorer families rely on family members for pre and post-natal care knowledge and advice.*
- *In Shan state, the MOHS midwives have faced challenges in access to certain villages due to safety and security concerns, and due to midwives not speaking the language of the community. In some cases, households even refuse vaccinations because they do not understand why vaccinations are needed.*

Ayeyarwady. Pre and post-natal care in Aweyarwady is in general standardized where the healthcare system is developed in a systematic manner with the provision and availability of hospitals, RHCs, Sub- Centers and outreach led by Midwives. The three townships in the assessment all had at least one hospital and RHCS provision that was supplemented with SHCCs and an outreach system that is tailored for supporting pregnant women and mothers with small children. The total

number of hospitals and RHCs in the region and number of health staff specifically responsible for supporting pregnant women and mothers and young children is seen as a commitment to, and a prioritization of health and wellbeing advice for families and individual mothers.

The provision of health care institutions is supplemented with a complex outreach system that in general seeks to do outreach to all levels. However, because of the geographical location of remote communities and individual households that includes islands, delta and uplands areas, there are pockets with limited outreach.

Interviews with health personnel at the township levels, highlighted the following challenges for effective mother and child care support:

- There are not enough staff in the department because some villages have around a population of 6000 and they can only assign one midwife for the whole village. Normally the recommended ratio is one midwife per 3000 people.
- The RHC has to refer mothers to the hospital in some cases as they cannot handle too many births at the same time. They have requested more RHCs to improve outreach.
- Approximately one tenth of the population don't see any midwives and just give birth with TBA close to their homes. These are mainly the people who live in very remote areas and who do not get the information about midwives coming to the village.

In Labutta township, SAVE Bright Sun Project is active. The project support pregnant women and mothers with children under 2 years of age. The project works in 5 RHCs out of 16 in Labutta and trains 5 volunteers in each village where they reach out. Most of the volunteers are auxiliary midwive and community health workers. They have allocated one project officer for two RHCs. Cash support to the mothers is given based on a registration book and the endorsement/registration from GAD. The health department invites the volunteers in their RHC meetings. The volunteers receive travel allowance from Save the Children. Initially Save the Children considered providing in-kind support, such as pulses, eggs and bananas, to avoid risks with carrying of cash, but decided against this due to complexity of in-kind support itself.

In Ayeyarwaddy, almost all of the villages covered in the assessment (including remote villages) had access to midwife or TBA services. The main exception is in Kyan Kin among people who live in upland villages and work in areas where their employment necessitates long periods away from home. Pregnant women in this area reported to be likely to have less access to pre and post-natal services and are also more likely to be poor and disadvantaged. One constraint is that, the midwives allocated in some villages are young and less experienced and therefore, the people from these village have less trust in these young midwives to deliver babies. In such cases, the use of TBAs or retired midwives was observed. The villages with experienced midwives use their services, but this depends on the distance from the sub-center/RHC because if it is remote, families do not seem to call the midwife for birth and use TBA. In addition, there is a common fear about the midwife referring them to the hospital for delivery, so women try to give birth with a TBA first and only when that is not possible, they call the midwife. This is sometimes connected to the expense related to hospital referral and possibly traditional beliefs and availability of family members to support mothers while in hospital.

Generally, pre-natal care available to villages in Ayeyarwady include urine test, blood tests (for HIV, sexually transmitted infections, checking hemoglobin levels, diabetes), measuring weight, measuring blood pressure, womb check-up, provision of iron, folic acid and vitamin B1 tablets. In general, post-natal care available in villages include continuous provision of vitamin B1 after 3 months of giving birth, encouraging mothers to immunize their infants on time, encouraging mothers to do exclusive breastfeeding for the first six months. The midwife also plays an important role in giving nutritional information to women. In most cases, the midwife asks the women to eat more diverse foods and avoid certain food after child birth. Midwives do not seem to explain sufficiently on the consequences of malnutrition. In addition, the midwives provide women with booklets about pre and post-natal care and most in Ayeyarwaddy can read this book since at least one household member is usually literate.

Shan. There is little difference for state level institutional arrangements for pre and post-natal care. What complicates Shan in comparison to Ayeyarwady is the division of the state into three distinct administrative areas which creates slight variations in health care including pre and post-natal care. In some places, it is difficult for midwives to get to remote villages and areas affected by conflict. To add to this, the ethnic diversity of the three areas in Shan affects the human resource strategy as it is necessary to have midwives who speak local languages and understand local traditions and customs.

In Hopong township, village health committee were present in some villages. The health department organized these in cooperation with the GAD, including influential people of the village such as monks, better-off people, and people who are good at communicating. The Health Department's midwife takes the role of a secretary in this committee where it exists. These committees are sometimes geared for emergency response. In most cases it is the same active community members and administrators who participate in all other committees in the village. In contrast in Kengtung township, there were no village health committees or social protection committees.

Health complications reported by health care services for pregnant mothers were due to hypertension, having a lot of children without much break, young pregnancies, older (over 40) pregnancies, using TBAs to give birth and using of traditional herbal steam and sauna inside the house.

Lashio township provided a wealth of information for the assessment, given conflict, difficult outreach to remote areas, and a volunteer system with local civil society participation. Northern Shan needs a lot of volunteers, because there are a lot of areas that the health staff cannot even get access to. In such hard to reach areas (mainly conflict affected), health volunteers are the main people delivering midwife services.

Compared to Ayeyarwaddy, the villages in Shan State have less access to the services of the midwife for the following reasons:

- Remoteness: Many villages are located far up on the mountainous areas and therefore, they are difficult to access even by motorbikes especially in the rainy season.
- Safety and Security: Some villages are post-conflict villages and therefore, the midwife may not feel safe to cover all villages assigned to her and calls the pregnant women/lactating mothers to visit her instead. Safety wise, Northern Shan (Lashio is affected the most).

- Education: The level of education amongst villages in remote areas of Shan is reported to be very low and therefore, they are more rooted to their traditional norms and this is reported as a challenge for the midwife to influence behavioral change. There is also a tendency for remote villagers because of transport and access to markets to have little interaction with the people outside their village and this may have an effect on awareness levels.
- Language: Until recently some of the villages in Shan in townships did not have a local ethnic midwife, making it very hard for the midwife to communicate with the villagers about prenatal and postnatal care. However, now, almost all of the midwives interviewed by the SA team in the area are local indigenous women and can speak at least one ethnic language. The Department of Health is focusing on training more local / indigenous midwives to widen their coverage.

At the household level, there are good practices particularly where households are close to a village with a RHC and midwife. If both are available, the probability of standard medical norms being overly influenced by tradition and taboos decreases. The absence of a midwife (with a good reputation) creates a dependency on TBA. This can be positive depending on the individual TBA. The social status of the households has an influence on norms and particularly the awareness and education level of the mother. The ethnicity of household combined with distance from RHC (particularly in Shan) can impact on practices that may be damaging to mother and child.

In Ayeyarwady, the assessment covered 30 households with pregnant women and mothers with young children under 2 years. These households were selected based on socio-economic means, ethnicity and location in relation to village health services. In general, there was a distinct difference between mothers in households that were financially better off living in villages close to RHC and hospital. In some interviews mothers in Ayeyarwady said that when they had a choice and means they attended the local hospital as well as consulting with the midwife responsible for the village. However, this was not the norm, and the midwife and TBA were used effectively to support women of all socio-economic means and ethnicity. The major factor was not always affordability of services, but sometimes the convenience of the mother and family in relation to home births influenced the decision.

Box 2. En Village, Kengtung Township, Eastern Shan.

This village is located around 30-45 minutes drive form Kengtung city. The village is located slightly high up on the mountain. According to the midwife, the local En ethnic group prefer to just stay in the village area and do not like to venture down to areas close to Kengtung.

There is no school or sub-center in the village but the road to the village is very good. The school is around 5-8 minutes motorbike ride from the village and so is the health sub-center. Therefore, according to the midwife, only 2 children from that village go to school and only the richer households can afford to send their children to school. The villagers indicated they really want school for their children in the village because to send children to school now, they have to rent a 3 wheel car which costs 1000 per person per day.

The village is very poor and isolated. Not many in the village own a motorbike. Although the En community understand and can speak Gon Shan fluently they don't take advantage of this to earn income from casual labor and potential employment in towns. The main occupation of men in the village is focused on making bamboo baskets while women go to the forest and find forest products and firewood.

As in other remote villages, families mainly eat vegetables and forest products. They do not eat so much meat as most animals raised are sold in order to have money to buy other necessities. This money is used to buy oil and food that they do not grow in the village. The dependency on basket weaving impacts the amount of food they produce. Baskets are sold in KT market.

In the village, the husbands are the main people who assist in giving birth. Not many go to KT for birth (although it is close by) but prefer to give birth in the village. Women eat dogs after giving birth because traditionally dog meat is good to keep the women warm after birth.

The old midwife responsible for the village retired 3 years ago and there was a long gap of around 2.8 years before a replacement was assigned. The newly assigned midwife has only been there for around 4 months when the SA Team visited. The midwife reported that the villagers don't have good nutritional habits and are also influenced by tradition and the food they eat after birth. The poverty level inhibits the nutritional intake and the fact that the community chooses to live in relative isolation from markets and food supply creates health issues and increases possibilities of mothers and children being anemic and undernourished.

While the SA team has not visited many 'isolated' villages like 'En Village' it is clear that the challenges faced by an MCCT project to provide nutritional support to villages like this are extreme in comparison to most of the villages visited by the SA team in Ayeyarwady and Shan. In addition to the a lack of food products there is the added reality that many communities like En Village don't use and value cash in the same way as communities where food and related commodities are sold in markets and small retail shops. Where these don't exist money is less valuable than the actual commodities.

The location of the family dwelling is also a key aspect in deciding which service to avail of as are the occupation and livelihood of the mother. Mothers who live and work in remoter areas and who are also key income providers for their family in general use the TBA when available or have the midwife come to their house to deliver the baby. When other siblings are young in such families there is a possibility that an additional young child will create additional responsibilities for these young children as the mother needs to get back to work soon.

In areas where there is a combination of support from the standard health services and specific mother and child focused projects (SAVE and World Vision), there is an increased level of choice, support and awareness at household level. This indicates that pre and post-natal care is significantly improved at the household and community level when a specific project focusing on mother and child care works effectively with the community and health care services to support all mothers at household level. Vulnerable and disadvantaged families benefit greatly from such targeted support.

For households in Shan state, service level is somewhat different than in Ayeyarwady. In Shan the assessment covered different households based on ethnicity, livelihoods and access to mother and child care. The more remote the household, the greater the probability that the family was disadvantaged, and in some cases disconnected from the support system. The En and Lahu village in Kengtung is highlighted below as an example. A combination of remoteness and ethnic minority status generally correlates to poorer economic means, less education and less access to basic services.

On the other extreme in Shan were household located in urban or peri-urban areas, whose pre and post-natal care choices and standards increase significantly. Migrant women living is designated urban compound areas in Lashio township were exceptions to the better off urban households. These women largely do not have access to services. Migration has also severed some community links that would enable them to rely family and community informal support when pregnant and after giving birth.

Table 11. Factors influencing Pre and Post-Natal Care Norms at Different Levels

Level	Factors Influencing Norms
Region	• Number of hospitals, regional health centers and sub health centers • Number and qualifications of health staff • Ability to reach all areas including remote villages • Outreach arrangements in SAZ and areas of conflict (Shan) • Important to have indigenous staff and culturally sensitive awareness (Shan)
Township	• Hospital and Health Care facilities • Reputation and condition • Location of township in relation to villages • Transport and hospital service costs • NGO Support (SAVE / WV / Malteser / Care)
Village	• Location of village in relation to RHC • Professional training and reputation of midwife • Ethnicity of Midwife • Outreach ability • Transport and weather conditions • Relationship between TBA and Midwife • Community support • NGO Support (SAVE / WV / Malteser / Care)

Level	Factors Influencing Norms
Household	• Location of household • Socio-economic status of household (poorer families more dependent on TBAs) • Education and awareness of mother • Influence of tradition v outreach of Midwife • Age, ethnicity and professional knowledge of TBA. • HH cohesion and domestic issues • Support of father and greater family (alcohol, drugs, gambling etc) • Community facilitation of pre and post-natal care.

3.2 Recommendations

- Project needs to include local volunteers from communities (to be trained, paid and incentivized) to ensure that communications are effective.
- The project should consider different models to reach out to particularly remote areas, specifically using active local civil society institutions.
- Especially for Shan state, the project also needs to have models for tailored and culturally appropriate support. DSW must map out and engage existing mother and child care service providers.

4 Behavioral Change and Communications

4.1 Findings

This section will examine the existing norms related to Behavioral Change and Communications from a Regional / State, Township, Village and Household perspective. These were the main areas visited and units of analysis were based on interviewing regional and township government DSW, GAD, Education and Health Departments, RHC / Sub-center staff, midwives, TBAs, village administrators, community groups and targeted households focusing on pregnant women and mothers with young children under two. In addition, and when active in selected study areas, CSOs, CBOs and NGOs directly supporting pregnant women and mothers with young children were contacted and interviewed.

- *Currently, almost all behavioral change communication comes from midwives. Women in Shan rarely take advice from midwives.*
- *In Ayeyarwady, most households have cell phones. Men carry them, and very few women use them for internet.*
- *In rural areas in Shan, most women do not own or use cell phones for any purpose.*

DSW's insight into SBCC with a focus on MCCT is limited at this time. For effective and relevant SBCC interventions, DSW would need to collaborate with the Health and Education sectors, relevant localized civil society, volunteer community-based committees and specific and tailored Mother and Child Care (MCC) support projects like Save the Children, (Labutta), World Vision (Kyankin), Maleser (Kengtung) and Care (Lashio) programs.

Ayeyarwady. While the understanding of SBCC focusing on MCCT is limited from the perspective of DSW, there is a distinct advantage in Ayeyarwady, in that the health care services and specific MCCT projects such as SAVE and World Vision are actively involved in a variety of SBBC activities.

The limited presence of DSW in Townships is a disadvantage when considering SBCC in project activities. Questions related to SBCC and MCCT were comprehensively answered only by health officials who understand the medical and nutritional issues involved. In all health centers visited in Ayeyarwady, there was an understanding of the importance of scientific and medical information for standardized support. Many health centers had charts, graphs and awareness raising material on display and a visual health monitoring board that indicated numbers and trends for specific conditions.

SBCC outreach and community involvement in SBCC needs the support of midwives, auxiliary midwives and TBAs. How to involve theses important MCCT professionals has been piloted by Save and World Vision and lessons can be adapted. The link and collaboration with community organizations and specific groups such as the Women's Association, Health Care Committee, MCCT Volunteers and Mothers Circles needs to be factored in to any SBCC strategy. Where these groups exist and are active, there is potential for cooperation but there will need to be incentives in the form of training and expenses. Labutta has a distinct advantage for SBCC interventions because of SAVE Bright Sun MCCT project and to a certain extent Kyankin because of World Vision. The challenge is how to set up active volunteer and civil society groups at community level where they don't exist or have only a nominal presence.

In Ayeyarwady, apart from villages contacted who were part of either SAVE or World Vision support in Labutta and Kyankin, villages knew little outside the standardized awareness raising activities and material focusing on pre and post-natal care provided by midwives and RHCs. In three villages in Chaung Tha, there was no visible material apart from a nutritional chart seen in the sub-township RHC. At village level, midwives reported that they help with awareness on nutrition but only through verbal advice based on general information related to basic do's and don'ts. Even this can be limited because of time constraints and work and responsibility overload. Village involvement and community support was recognized as vital, but because of limited experience there were few practical examples to refer to in villages that had not experienced specific and focused MCCT SBCC.

Shan. In Shan interviews at state level with DSW were similar to Ayeyarwady in that the specific insight into tailored SBCC focusing on MCCT was limited and informed by experience with various modalities of SBCC that were used for other social protection issues associated with child protection or substance abuse. Collaboration between health care and specific MCCT projects (Malteser and Care) exists in Shan in Kengtung Township and with Care in Lashio. As in Ayeyarwady, there is a possibility for DWS to work with UNICEF and civil society active in Shan to adopt and possibly replicate SBCC modalities to the project needs.

Shan is more complex in relation to SBCC because of the diversity of ethnicities, traditions and languages. While a universal approach to SBCC may be possible in Ayeyarwady, in Shan any approach needs to carefully consider all of the above. In addition, there are clear differences between Southern Shan, Northern Shan and Eastern Shan that includes languages that have no scripts and significant numbers of illiterate mothers and family members. A universal approach to

SBCC is something to avoid in Shan. There is a need for better understanding of the complex community dynamics and further consultation with UNICEF, Malteser, Care and other organizations who are implementing specific SBCC interventions directly related to nutrition and MCCT. See below for Malteser Project's comprehensive and integrated MCCT interventions in Kengtung Township in Eastern Shan that includes nutrition and the promotion of home gardens.

Health education is more under developed in Shan villages due to remoteness, language, trust and education levels. Midwives have indicated that their basic duties are difficult to administer, and that priority is on pre and post-natal care. Nutritional awareness is considered as being secondary to other MCCT issues.

Many in Shan villages have a low literacy level. If they use the internet, the mothers note that they only look at the pictures as they cannot read. Such households cannot read the pre and post-natal care handbook given by the midwives either. However other more image orientated messaging focused on MCCT and SBCC are possibilities.

In Shan, it is suggested that local civil society organizations conduct SBCC seminars using local language speaking volunteers from the village. In addition, as most cannot read or write in any language (Burmese/Shan), it is suggested that SBCC is done using pictures and local language videos.

At household level, the assessment focused mainly on communications. Most households interviewed had mobile phones once, but the continual use depends on means and family occupation. Use of both smart phones and keypad was seen only in the villages nearer to towns and connected to a service provider. In most households, men are the primary owners and users of cell phones.

Internet usage (mainly Facebook and calling applications) was seen amongst interviews but only two out of the over 200 women interviewed used the Internet (Facebook) to read about childcare. Both these women interviewed were well-off and educated women. Women receive most information about nutrition and childcare from the midwife and most mothers, especially younger mothers listen to the midwife.

In Shan, there is extensive use of phones and internet in better-off urban households and households close to urban areas (Hopong, Kengtung and Lashio), in contrast to remote villages where Akha and Em ethnic women have never heard of the internet and only seen phones. These two extremes indicate that any SBCC in Shan needs to factor in language, ethnicity, location, education level / literacy, script and socio-economic status / availability of mobile phone with the women. Experiences from the NGO Malteser below needs to be factored in, and practical aspects such as demonstrations and home gardening support with the facilitation of local ethnic women volunteers are key to successful SBCC interventions.

Table 12. Factors influencing Behavioral Change and Communications Norms at Different Levels

Level	Factors Influencing Norms
Region	• Lack of in-depth knowledge understanding of SBCC as an approach. • Focus on other social related issues associated with child protection. • MCCT SBCC seen as a Health BCC and not linked to social issues • Need to have specific SBCC expertise at Regional level for strategic planning • **Shan:** Same as above with additional complex elements linked to culture, language and tradition. • Cultural understanding of concepts linked to SBCC (may not be universal) • Political hijacking of SBCC approaches may undermine key messages
Township	• Health sector lead in the design and development of MCCT SBCC • Collaboration with Hospitals and Village RHCs • Involvement of Midwives • Support from Village HH heads (Admin) and Health Care committees. • Use of ICT messaging and use of lessons from SAVE, WV, Malteser, Care and UNICEF • Trained, skillful and respected ethnic communicators
Village	• Outreach of health professionals • Availability of RHC or Sub-center staff to support SBCC • Midwife training and reputation in village • Influence of TBAs and willingness to change behavior • Traditional customs and beliefs • Support from community • Ethnic Volunteers / Women's Groups presence
Household	• Awareness of mother • Support of family • Outreach of Midwife • Modality and tools for SBCC • Culturally Appropriate Approach tailored to different categories of households • General understanding of communication from the perspective of targeted groups • Education level of women • Languages used in the households and community • Importance of demonstration and use of role play (creativeness) in SBCC

4.2 Existing Pre and Post-Natal Care Awareness and Communications

Below is a description of the Volunteer approach system used by Save the Children in its acclaimed and well documented Bright Sun MCCT project. Pre and post-natal awareness and communications are an integral component of the project and it is important that the DSW MCCT project learns from some of its successes.

Volunteer Approach for Communications by Save the Children in Labutta

Through a community meeting (inviting village tract administrators and influential people in the villages), they introduce the project and choose volunteers who are active and can work for this project. They explained that the choice of the volunteers should be gender balanced. These volunteers were then elected by the community and they cannot be government staff. The

volunteers could be Community Health Workers (aux. midwife etc.), people who can give their time, people who have good relations with people in the village. They may also be some active members of the health committee/ those who have volunteer experience. They include both young and old people in this volunteer group and 50% of them should be women.

Older volunteers stay till the end of the project, but they are not so active. The young people on the other hand are active but have high turnover rates. The volunteers are separated into two groups: SBC and MCCT. There are more male staff in MCCT. But in general, there are more female volunteers. The volunteers initially get a three-day training and a refresher training whenever needed/whenever there is a change in the program.

The maximum number of pregnant women the program has in a village of 3000 people is 180. In this village, there are 6 volunteers and not 4. The minimum number of pregnant women in a village is 1. This is for a very small village.

Challenges of the program include:

- Sometimes the focal person adds pregnant women form other villages in the list if they are close to them.
- People from nearby villages come to RHC which receives the money instead of their own RHC to get the money.
- Sometimes the volunteer cuts money from the beneficiaries for village contribution (village celebrations and funerals) and also for the transportation costs of the volunteers.
- There is a feedback mechanism and all the beneficiaries have the phone numbers of Save the Children office, but people don't use the mechanism because they are concerned about their relationship with the volunteers. Feedback generally comes through midwives and other volunteers.

The program also conducts post distribution monitoring of how cash is used. During this monitoring exercise, volunteers go to each household and find what challenges they face in achieving good nutrition outcomes. Most people use the money on health and food expenses.

Malteser Project in Kengtung Township

The NGO Malteser project in Shan implements pre and post nutritional awareness interventions in Kengtung Township. The assessment team interviewed project staff and visited a village supported by the project. This is an important intervention in the proposed DSW MCCT project area that can contribute through tried and tested culturally appropriate SBCC approaches.

Malteser International follows a comprehensive approach – working with and supporting government health staff like midwives, while promoting good health, nutrition, sanitation and hygiene within the communities at the same time. The assistance of skilled birth attendants and the availability of medical facilities are crucial requirements for reducing neonatal mortality. Training health volunteers, establishing mother support groups, and constructing additional health centres to increase access to medical facilities in rural areas are an important contribution to this goal.

Measures taken by Malteser include:

- Construction of eight health facilities including staff accommodation
- Equipment of eight health facilities, installation of solar power systems and refrigerated storage for vaccines and medication
- Supporting midwives to undertake immunization programs, health education and growth-monitoring campaigns for children
- Promotion of safe delivery attended by skilled birth attendants
- Encouragement of better practices in food security and nutrition through health Education, 'nutrition days', home gardening promotion sessions and agricultural demo plots
- Provision of 500 education sessions on mother, neonatal and child health, hygiene and sanitation, and nutrition, to increase knowledge and awareness, and promote behavioural change
- Support government training of 40 auxiliary midwives to aid basic health staff in remote villages
- Establishment of 20 community-based mother support groups and provision of volunteer training
- Establishment of a referral system and incentives to encourage safe delivery at health facilities with skilled birth attendants
- Home gardening in villages.
- Mother support groups in villages. Groups interested in home gardening are given seeds and gardening equipment to grow nutritious vegetables.

The project is currently taking place in Kengtung and Mong Phyat townships. The maternal and child health project activities can be broken down into two parts: 1. Activities undertaken by volunteers and 2. Activities under-taken by Malteser staff.

Activities by volunteers: First, Malteser collaborates with MOHS to increase AMWs and community health workers (CHW) by supporting the health department in providing trainings to produce more ANW and CHWs. The AMW training takes 6 months. After being trained, the auxiliary midwife leads group sessions on Infant and Young Child Feeding, focusing on pregnant and lactating women. The CHW leads health talks for the wider group.

Activities by Malteser staff: In addition to the training given by the volunteers, Malteser staff also give Health Education in villages focusing on pregnant and lactating women.

4.3 Recommendations

- The project will need to hire a communications consultant/dedicated staff at the union level and develop a sophisticated communication strategy (taking into account different languages, different education levels of mothers, remoteness, existing service providers). A universal approach will not work in Shan state.
- The communications strategy needs to be costed, with extensive and repeated trainings for all involved (financial and human resources).
- Civil society intermediaries are recommended to deliver behavioral change messages in Shan State.

- The communication strategy should use innovative methods, such as cooking and home gardening demonstrations and other visuals, as well as community level trained and respected volunteers.
- Any communication must also reach out to and involve midwives, auxiliary midwives and traditional birth attendants.

There is limited awareness of behavioral change as an approach and a possible confusion with prescriptive awareness raising approaches.

In areas where communities are isolated and remote with less contact with professional health service staff there needs to be a culturally appropriate targeting of TBAs and influential family and village leaders in any behavioral change strategy. The inclusion of key health practitioners and skilled community communicators and groups will be vital for effective behavioral change in more connected areas where health services are standardized.

Where health services don't exist then alternative behavioral change strategies will be necessary focusing on local women and local support organizations. It is recommended that women are seen as the key to this process and the foundation for sustainable behavioral change interventions. Demonstrations and practical interventions linked to nutrition and child care should be considered ahead of complex messaging.

There is a need to assess targeted communities from a cultural, educational and social perspective in each township in which that the project plans to operate, in order to design suitable strategies, approaches and modalities that factor in literacy, awareness levels, age profiles and ethnic diversity.

5 Cash Transfers and Preferred Modalities

5.1 Findings

This section will examine the existing norms related to Cash Transfers and preferred modalities from a Regional / State, Township, Village and Household perspective. These were the main areas visited and units of analysis were based on interviewing regional and township government DSW, GAD, Education and Health Departments, RHC / Sub-center staff, midwives, Traditional Birth Assistants (TBAs), village administrators, community groups and targeted households focusing on pregnant women and mothers with children under two. In addition, and when active in selected study areas, CSOs, CBOs and NGOs directly supporting pregnant women and mothers with young children were contacted and interviewed.

- *Majority of midwives, village leaders and beneficiaries prefer cash transfers to be handed out to them directly in person rather than through mobile mechanisms.*
- *In more accessible villages closer to towns, there is some use of mobile money and WAVE way, but more often, cash transfers, such as remittances, are received through an informal network of people.*
- *Even where mobile banking money transfer exist, it is the men in the households who collect the money by travelling to nearby town, whereas nutrition project will target*

women with children under 2 years. Availability and affordability of safe transport is a concern for women, as well as provision of child care when they travel.

- *For Bank transfers and other formal mechanisms, lack of a National Registration Card may be an obstacle.*
- *Currently, DSW partners with GAD to provide cash transfers directly to pensioners, and MCCT program beneficiaries in Chin and Rakhine State and Naga region.*
- *The assessment found that there may be risks for cash transfers and household spending on nutrition due lottery gambling by women, alcohol use among men, and domestic violence in the household.*

Ayeyarwady. There is a practice and tradition of dealing with cash transfers in the form of remittances. Preference on cash transfers depends on location of township and proximity to either Bank or WAVE Money agents. Majority of townships in Ayeyarwady have both services. Preference of DSW and GAD varies, but there are clear precedents in Ayeyarwady to consider bank transfers or WAVE money when villages and households are within reasonable distance to services. For remoter villages, there is no choice, but the development a payment mechanism that includes the handing over of cash using designated officials or volunteers. There are risks with all three modalities focusing on technical and logistical for banks and WAVE and on the establishment of a safe and competent mechanism / chain of delivery for cash handover.

DSW currently has limited experience in regard to MCCT and coordinating cash transfers to relatively large number of beneficiaries in a geographically diverse area. The experience with the current Social Pension cash transfer, while relevant, is limited to a low number of beneficiaries. Beneficiaries need to prove that they are over 90 years of age to receive this pension. However, the collaboration with GAD at all levels was seen as important and this was verified by GAD at township and village representative levels.

In Aweyarwady, Labutta stood out as the only township where there is a good understanding of MCCT cash transfer and the various modalities. This is because of the SAVE Bright Sun project that has cash transfer as a key element. Both Chaung Tha and Kyankin have no similar model focusing on MCCT. The World Vision (WV) MCCT intervention in some villages of Kyankin is not a cash transfer project so experience there in relation to financial support is on a case by cases basis and reported to be handed directly through WV staff to beneficiaries. It is important for this particular project to be aware of existing MCCT interventions in targeted townships like Labutta and to ensure that any new intervention is harmonized with these approaches to avoid negative comparison and possible discontent among neighboring villages.

At village level in Ayeyarwardy, there was a general preference for cash transfers that suited the village location and access to banking and telephone services. Areas close to Chaung Tha like Aung Mingular island (10 mins by boat) and the other two villages Seik Eiyi and Oo To have potential to have a flexible modality, but the main consensus of the majority of women was for cash in hand. Travel to receive money from an MCCT transfers to a bank or Wave agent is still a difficulty for women, as well as an additional cost.

Shan. Remoteness is a bigger factor in Shan state for access to Banks or WAVE services**.** In remoter villages, preference for direct cash handover were reported, but close to Hopong, Kengtung and

Lashio townships there are good facilities and services. The Banks require a National Registration Card for opening an account however.

In Shan, in the three Townships visited Hopong, Kengtung and Lashio there were no similar models of MCCT to SAVE identified. A number of civil society organizations have on-going MCC orientated projects, but none support cash transfers and instead provide in-kind support and training. Shan Townships are significantly more complex in the context of MCCT than in Ayeyarwady. The division of Shan into three distinct areas and the difficulties to administer government programs in some of these areas due to conflict and remoteness creates logistical and administrative difficulties that are magnified by a multi-ethnic population with a wide range of languages, education levels and cultural beliefs. While Hopong can be generally seen as more homogeneous (Pa O) and connected, Kengtung and particularly Lashio are complex and from a MCCT perspective extremely challenging.

The Em Village in Kengtung is an example of a community where money is rarely used and trading is limited. In Lashio there are similar villages with the addition of being situated in on-going armed conflict areas where DSW support is not possible without the collaboration of indigenous civil society organizations like the Ta Ang Women's Organization (TWO) who are focusing on MCCT in Man Tong Self- Administered Zone (SAZ).

On the other end of the scale in Township urban areas in Shan (all three areas), there is a potential to implement a number of MCCT modalities that include the conventional (cash) and the more innovative using handheld devices and bank transfers.

In Shan, proximity to township centers is the key and as outlined above there are extremes in relation to the location of villages that indicate that only areas close to townships have any possibility of using bank transfers or Wave. Wave is not as common as in Ayeyarwady, but as in the case of Labutta, a dedicated project that provides the technical support and facilitation of Wave can create a culture of acceptance once the distances are short and the beneficiaries see the benefits. In isolated areas there will be no choice, but the physical handing over of cash. How this can be achieved in areas with on-going conflict, poor communications and transport and different administration systems is complex and necessitates not only multi-sectoral support (GAD, Department of Health etc) but also trusted civil society organizations who are incentivized to work closely with the DSW MCCT project. In Shan, the challenges at village level are many and numerous as outlined above to achieve universal coverage.

To reach all communities with cash transfers in Shan (universal support) will be challenging and will require DSW to be flexible, collaborative and inclusive in its approach to cash transfers. The active involvement of a connected chain of independent agencies and volunteers will be necessary to ensure that all beneficiaries are identified and covered by the DSW MCCT project. The modality of support to households in these areas for all aspects of MCCT and particularly cash transfers needs to be carefully considered and developed with the support of agencies both government and non-government who are active and trusted in these locations.

At the household level, the main preference for more remote households is to have cash delivered in hand in both Ayeyarwady and Shan. This can be positive if there are links to the midwives, registration for pre and post-natal care, vaccinations and attendance at training and talks. Risks

associated with gender-based violence and domestic disputes have been reported due to cash transfers, but the significance is hard to ascertain.

5.2 Existing MCCT Modalities

The DSW Maternal and Child Cash Transfer (MCCT) Program is one of the eight flagship social protection programs 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 Program was first of the flagship program to start being implemented by the government, initially in Chin State only with funding from LIFT.

MCCT program beneficiaries are entitled to:

- MMK 30,000 every two months until the new child reaches the age of 24 months
- Membership in a local Mother Support Group
- Monthly/Quarterly awareness sessions on nutrition, health & hygiene in their community
- MCCT program beneficiaries have responsibilities to:
- Attend the monthly/quarterly awareness sessions on nutrition, health & hygiene
- Collection of cash from ward/village administrator's office every two months until the new child reaches the age of 24 months (they will be informed of the date by the W/VSPC)
- Bringing the new child to ward/village administrator's office for beneficiary verification (as soon as possible after, but no later than 45 days after, the birth of the child)
- Participate in post-distribution monitoring surveys

Save the Children's (SC) MDG program in Labutta Township supports MCCT program to deliver nutrition-sensitive cash transfers and Behavior Change Communication to women from pregnancy through their First 1,000 Days (i.e. from pregnancy through to their child's second birthday). The intervention has been integrated with 3MDG's work to build community health workers capacity to deliver primary health care, and to promote nutrition outcomes through BCC and the distribution of the MCCT.

SC engages with the Township Health Departments to participate in MCCT and nutrition promotion activities. This includes working closely with the Township Medical Officer (TMO), Midwives, Health Volunteers, AMWs and CHWs to ensure the effective program delivery.

202 villages in 5 RHC catchment areas in Labutta were chosen as focal points for this intervention. All pregnant women in the RHC catchment areas are targeted. The 5 RHCs selected cover 30 Sub-Centers.

The Save the Children Bright Sun MCCT model compares in some aspects to the Chin MCCT project but has significant differences particularly in the modality of cash transfers and the use of efficient and effective collaboration between designated project staff, volunteers, health workers and beneficiaries.

5.3 Recommendations

- Given the remoteness of certain areas and geographical variation in Ayeyarwady and Shan, one modality of cash transfer will not work in all areas. The project must have multiple modalities for transferring cash based on location of village in relation to banking and WAVE services, legal status of mothers, availability of safe transport.
- Accompanying communication should address the risks noted above in terms of households using the funds for purposes other than nutrition.
- Community volunteers, civil society organizations and ethnic organizations should be used as facilitators.
- A grievance redress mechanism and a monitoring mechanism should be designed to ensure that cash transfers are reaching the targeted beneficiaries.
- Piloting and scaling up gradually may be necessary to understand and manage risks.

Recommendations based on findings on cash transfers while not representative of all the townships in both regions indicates the need for flexibility in regard to payment modality among households when the conditions are clear and services are available. Findings indicate that remittances from family members are transferred regularly but special consideration should be given to the fact that the targeted group in MCCT projects are pregnant women and women with children under 24 months. There are risks with all three modalities (Bank, Mobile Cash Transfer and Handover of Cash).

Cash in Hand Transfers. Recommendations from the majority of midwives, village leaders and beneficiaries indicated that cash transfer would be best if it could be given directly to MCCT beneficiaries in hand. In such a scenario the midwife, if included by DSW in the process, would have an opportunity to influence beneficiaries if they are given a role in the transfer process. The main recommendation is that direct cash transfers are dependent on women registering for pre and post-natal care and attending talks and courses related to mother and child care and nutrition. This recommendation was in both Shan and Ayeyarwady, and is particularly appropriate for areas that are isolated and remote. This would necessitate a formal partnership between DSW and MOHS at all levels.

Mobile Cash Transfer. There are possibilities in towns and villages close to township centers to avail of Mobile Cash as a mechanism for cash transfers. However, this needs a commitment and determination on the side of the project to promote the positive aspects of Mobile Cash and to ensure that the technical and logistical challenges are well understood and overcome.

It is highly recommended that existing Mobile Cash procedures and support mechanisms can be adapted in Labutta and other suitable areas of Ayeyarwady and Shan. A piloting of an appropriate Mobile Cash modality is seen as a possible solution to determine the technical and logistical challenges for this particular MCCT project.

It is strongly recommended work closely with Save the Children in Labutta and at central level to tailor Mobile Cash to specific project needs.

Key lessons from the consultations with Save the Children and health staff in Labutta hinged on linking Mobile Cash to attendance at pre and post-natal care sessions and behavioral change

interventions as the independence of the Mobile Cash modality can have some negative impacts on other project interventions.

The biggest difficulty with mobile cash transfers would be the need for women to travel to the nearest town or mobile cash agent to retrieve the money. Mobile agents would need to be encouraged, bearing in mind market viability for these private agents and additional fees to be incurred by women.

Bank Transfers. There are some positive experiences from interviewed families receiving remittances through bank transfers. While this is only practical in towns and villages close to towns bank transfers are recommended to be considered where targeted families are legally registered in order to open a bank account. Like Mobile Money the use of banks to receive cash transfers creates independence for beneficiaries and in certain situations mitigates against the possible negative power dynamics within the household that may adversely affect the effective use of funds.

Monitoring

Recommendations related to monitoring of all three cash transfer modalities center on the development of trust and collaboration of local authorities, beneficiaries and involvement of respective health officials, midwife and RHC / SHC staff. This will involve strong partnership between DSW and MOHS (or with other ministries / departments with a strong ground presence, or with community-based organizations) to help alleviate some of the outreach limitations of DSW.

It is recommended that where health staff don't exist because of remoteness or political tension / conflict the Traditional Birth Assistants or a suitable and actively engaged local civil society can be coopted to support effective monitoring. In Shan there are locations where local CSOs support Mother and Child Care and in these locations they often substitute the work of the midwife and health staff.

It is recommended that any monitoring mechanism be carefully tailored to the individual locations. Monitoring is key to mitigating the negative aspects of cash transfers but also to reinforce and report positive community support and engagement.

It is recommended that a flexible system of monitoring will be necessary according to the cash transfer method chosen for each individual area, and be administered by local community members.

6 Ethnic Minorities and Inclusion in Project Area

6.1 Legal and Institutional Framework

While the 2014 census has not released the ethnic disaggregated data, GAD presents the township level ethnic minority sub-group population data which estimates that the Bamar is the largest ethnic group, comprising around two-thirds of the population. The majority Bamar population mainly lives in the central and delta parts of the country divided into seven administrative Regions while the ethnic minorities live mainly, though not exclusively, in the mountainous border areas roughly corresponding to the country's seven States. Main minority groups include Shan, Kayin, Rakhine, Chin, Mon, Kachin, and Kayah. These eight "ethnic races," including the majority Bamar, are

subdivided into 135 officially recognized ethnic groups and belong to five linguistic families (Tibeto-Burman, Mon-Khmer, Tai-Kadai, Hmong-Mien, and Malayo-Polynesian). According to Chapter 1, clause 22 of the 2008 Constitution of Myanmar, the Union Government of Myanmar is committed to assisting in developing and improving the education, health, language, literature, arts, and culture of Myanmar's "national races." The constitution provides equal rights to the various ethnic groups included in the national races and a number of laws and regulations aim to preserve their cultures and traditions. However, the list of recognized ethnic groups has not been updated since 1982 Myanmar Citizenship Law.

6.2 Ethnic groups in Shan and Ayeyarwardy

Overall, the team has reached out to people who belong to 11 ethnic groups and several mixed-race people in the two region and state. The assessment found that people who do not fully understand Burmese or other main ethnic languages spoken in the area faced barriers in accessing government services, including fear to ask questions or to make mistakes or to receive clear information on services in itself is often not straight forward. Besides political or cultural motivation to preserve their own language, the geographical location of village and household is one factor that excludes people from speaking or learning other languages. Often in Myanmar, government services were dependent on individual civil servant skills in speaking ethnic languages. The assessment interviewed midwives and school teachers who were from different areas of the country who were learning the local major ethnic language to be able to perform their duty. In recent years, MOHS has been assigning local midwives who graduated from nearby nursing schools, recognizing the importance of staff's ethnic background that plays a crucial role in reaching out to local women to deliver services effectively.

Table 13. Overview of the Interviewees

Townships	Semi – Structured Interviews	Key Informant Interviews	FGDs	HH	M	F	ETHNICITY											
							Bama	Kayin	Chin	Pa-O	Shan	Nepalese	Akha	Lahu	Rakhine	Lisu	En	Mixed
Ayeyarwady (Pathein)	2				4	2	6											
Pathein TS Chaung Tha Sub-TS	3	2	7	10	27	44	59								1			1
Labutta	4	4	7	9	13	35	43	3							1			1
Kyangin	3	6	6	9	28	32	59	1	1									
Shan (Taunggyi)	2				1	2	1				1							
Hopong	3	3	6	8	15	38	5			45	1	1						1
Kengtung	3	4	6	11	37	60	1				20		4	54			18	
Lashio	6	3	0	6	7	7	4				5					1		
Total	26	22	31	53	127	216	171	4		45	27	1	4	54	2	1	18	3

Ayeyarwady

In Ayeyarwady Region, Bumars and Karens (S'gaw Karens and Pwaw western Karens) are known to form the majority population while there are also Rakhines, Asho Chins, Hindus, and Muslims and other ethnic groups residing in the Region.

. The assessment team was taken to Burma villages but most villages had residents of other ethnic groups such as Asho Chin, Rakhine and Kayin. While in some villages, there were permanent ethnic residences, some villages also had seasonal migrants coming from Rakhine. No religious conflict between village population was reported in visited villages in most of which were Christians and Buddhists. The conducted interviews suggest that large number of ethnic minorities in Ayeyarwady have relatively good understanding of Burmese, however, in most cases, they speak their own languages in their household and amongst their ethnic community.

Table 14. List of visited villages in Ayeyarwady Region

Township	Village	Main ethnicity	Ethnic Minority	Religion
Pathein	Oo Tu	Burmese	Kayin	Buddhist
	Seik Kyi	Burmese	Kayin, Rakhine	Buddhist
	Seik Kyi Hamlet Village	Burmese	Kayin, Rakhine	Buddhist
	Aung Minglar Kyun	Burmese	Rakhine	Buddhist
Labutta	A Hmet	Burmese	Kayin	Buddhist
	Paine Taung	Burmese	Kayin, Rakhine	Buddhist
	Phone Soe Kwin	Burmese	Kayin	Buddhist
Kyankin	Kwin Gyi	Burmese	Kayin	Buddhist, Christian (minority)
	Yay Lel Kyun	Burmese	-	Buddhist
	Kyoet Pin Su	Burmese	Asho Chin, Kayin	Buddhist, Christian (minority)

Shan

The Shan ethnic group is divided into over 30 subgroups under the government's official ethnic categorization while the actual residence in Shan State are not limited to these groups. Ethnic Shan is the majority and other large ethnic groups include Palaung, Wa, Kachin, Danu, Lahu, Akha, Pao, Kokang Chinese and possibly Kayan.

The team visited Hopong, Kengtung, and Lashio townships, where some villages were exclusive to one ethnicity and some had diverse ethnicities residing together. The understanding level of Burmese language was quite limited in most visited areas, so the team worked with local ethnic language translators in conducting the village interviews. Many people spoke more than one language which was learned out of on necessity basis and often Burmese was not prioritized. In

locations that are distant from schools, where the populations who had a lower priority for in sending children to schools also had generations of people had not received formal education. However, the link between low education and access to health service was not evidenced evidential from the field assessment.

Table 15. List of visited villages in Shan State

Township	Village	Main ethnicity	Ethnic Minority	Religion	Major Language
Hopong	Nam Hkoke	Pa-O	Burmese, Shan, Nepalese, Chinese	Buddhist	Pa-O
	Loi Aun	Pa-O	-	Buddhist	Pa-O
	Par Pant	Pa-O	Shan	Buddhist	Pa-O
Kengtung	Kataung	Shan	Burmese	Buddhist	Shan
	Yan Lu	Shan	Burmese, Rakhine, Wa	Buddhist	Burmese
	Nam Waw Awt	Akhar	-	Animism (Nat Sar)	Akhar
	Nar Lei	Larhu	-	Christian	Larhu
	En Wan Lwe	En	-	Buddhist	En
Lashio	Ward 7	Mixed	Kachin, Kayin, Burma, Chin, Rakhine, Shan, Palong, Larhu, PaO, Koekant, Nepalis,	Mixed	Burmese
	Ward 9	Mixed	Kachin, Shan, Chinese and Bamar	Mixed	Burmese
	Wan Mai Pain Non	Shan	-	Buddhist	Shan

6.3 Recommendations

- Establish a system to capture the ethnic languages used in each village and identify ways to communicate to reach out to all mothers who are entitled to the program
- Hire DSW township staff locally in ethnic townships
- Make sure the project volunteers cover different ethnic representation
- Ensure that project materials are simple with limited or no text so that they are accessible to non-Burmese speakers and illiterate people
- Do not to exclude people from the program based on NRC
- Include personal information in MIS (ethnicity, religion, spoken language, educational background); this would enable the project to monitor trends of reach out or dropouts of the program

7 Other Vulnerable Groups

7.1 Description

Below is a short overview of additional groups who were identified as having been left out from basic health services.

Unregistered villages or hamlet villages: These villages are often registered as part of a larger village. In Ayeyarwardy, Chaung Tha sub-township, the team visited this type of village, 40 minutes away on a small boat from the main village. The mid-wives are not obligated to go to this part of the village so it would be the mothers who would have to travel to see them. The team heard of pregnant mothers giving birth on boats.

Rural Poor: People who are living in fields or in forests for their livelihood, or women who had to tirelessly work to buy food for the family, had no flexibility to avail of the midwife's service. This was particularly informed by people in Ayeyarwady.

Urban Poor: Majority of urban poor living in Lashio were migrants from outside Shan State who came with the hope for finding better paid jobs. For the same reason as the rural poor, it is not practical for urban poor pregnant women to queue for long hours to get the basic services at MCH while they had causal casual labor opportunities. Though the medication is free, even the small amounts of informal contribution often required to be made to the hospital and its staff are a burden to them. Most urban poor migrant families do not have NRC and their household registration documents as they are not originally from the area.

Single mothers: Some single mothers for various reasons and combination with poverty or lack of access to information can be left out from basic health care. The assessment team witnessed one case each in Ayeyarwaddy and Shan where mothers felt embarrassed to go to the midwives because they were raped. In both cases, the midwife discovered stories from health workers in the village and therefore went to their house to do necessary check-ups.

Women with abusive or alcohol dependent husbands: Some women face constraints having freedom to move out of the house dealing with abusive, alcoholic husbands. The team encountered a case in Kyangin where the wife was not able to participate in World Vision nutrition sessions due to these reasons.

Post-conflict/conflict affected areas: Unless the individual health provider was from the area, safety concerns made some midwives and heath care providers stay away from the villages. In such areas, people depend on AMW if available.

Bad road accessibility: One remote village in Kengtung township had not had the assigned midwife's visit for three years. The villagers were not aware of the services midwives provides.

Coverage areas/ large numbers of villages: In Shan, the average number of villages per village tract is much higher than that of the nationwide average. Similarly, coverage area of rural sub-centers and schools is higher.

Areas with no phone coverage: Due to limited access to communication services, the midwife could not inform the village head in advance of her visit. Women working in the field often miss the midwife's visit.

NRC: Many of the interviewed people did not have NRCs but this did not show up as an obstacle to access health services. However, to be a recipient for the Social Pension program, NRC is a required document, alternatively, confirmation letters from respective village leaders and village elderly can be used. This process is easier in villages but in urban wards, where ward administer are unfamiliar with the citizens background, it becomes more difficult.

7.2 Recommendations

- To establish a system to capture the ethnic languages used in each village and identify ways to communicate to reach out to all the women who are entitled to the program
- To hire DSW township staff locally in ethnic townships
- To make sure the project volunteers covers different ethnic representation
- Project materials to be simple with limited or no text so that it is accessible for none-Burmese speakers and illiterate people
- To identify ways of transferring cash to remote areas, at the same time to ensure that beneficiaries have access to markets to purchase nutritious food
- Not to exclude people from the program based on NRC
- To include personal information such as ethnicity, religion, spoken language, educational background in MIS will enable the project to monitor trends of reach out or dropouts of the program

8 Conflict in Project Area

8.1 Description

While this section touches upon the general conflict situation in Shan State, it is worth noting that the assessment team did not conduct an in-depth conflict assessment at this stage for several reasons. Firstly, the team did not get permission to visit conflict-affected areas due to security situation. Secondly, when the Social Assessment was designed, the project had not yet discussed the potential coverage area within Shan State. By the end of the field assessment, the national consultants were permitted to visit Lashio township and had meetings with organizations who work in conflict affected areas. Therefore, the information here is mainly based on desk review and secondary information from the interviews conducted in Shan State.

Brief Background of Conflict in Shan[18]

As Shan State was said to have hosted the greatest variety of ethnic militias and insurgent armies than any other place on earth in the last three decades of the 20th century, the sub-national conflict map in the Contested Areas of Myanmar report (2016) still shows its legacy. While access has improved significantly in Southern Shan since 2011 under the quasi-democratic government's

[18] Smith. 1999. Burma: Insurgency and the Politics of Ethnicity; Horsey 2015. Internal analysis for UN.

initiative to resolve the conflict between Tamadaw and EAOs, security situation has deteriorated in recent years in Northern Shan leading to increased numbers of displacement. Due to the armed conflict in Kachin and Northern Shan resumed in 2011, 103,000 people are estimated to be living in camps and settlements today. An additional 30,500 persons have fled their homes in 2017 and 6,500 persons were displaced during January to May 2018 in Shan State alone.[19]

Long history of conflict in Shan State dates to the colonial time when Myanmar government was administered by two separate bodies, Ministerial Burma and Frontier Areas. The Federated State of Shan belonged to the later which the authority remained with the hereditary chiefs, the Shan *saophas*. During the 1947 Panlong Conference, Shan along with other members of Frontier Areas agreed to be part of the Union of Burma on a condition that they would retain full autonomy in internal administration. Under the 1947 constitution of Independent Burma (1948), Shan State was given a notional right to secession after a 10 years trial period. Although the Shan *saopha*, Soa Shwe Theik was inaugurated as the first prime minister of the Union of Burma, the increased threat against secession threw him in prison where he passed away, which also contributed to the military coup in 1962. As counterattack, the Shan State Army (SSA) was the first armed resistance to be formed amongst many other insurgents that were established through 1960s - 70s. During the same period, the Chinese supported the Communist Party of Burma (CPB) who expanded the territory in Wa and Kokang areas. The SSA and Pa-O National Organization (PNO) were ideologically against CPB. However, later on the northern part of SSA split and joined the CPB. In 1989, the CBP collapsed and split along ethnic lines, into United Wa Sate Army (UWSA), the Myanmar National Democratic Alliance Army (MNDAA), the National Democratic Alliance Army (NDCC/Mong La) and the Shan State Army-North (SSA-N). Below table summarizes the ceasefire status of the main armed groups in Shan State.

Table 16. Bilateral Ceasefire Agreement between Government and main Ethnic Armed Organizations in Shan State (2011 to Present)

Armed Groups	Previous Ceasefire Agreement	Current Ceasefire Agreement
United Wa State Army (UWSP)	1989	September 2011
National Democracy Alliance Army (NDAA)	1989	September 2011
Restoration Council of Shan State (RCSS)/Shan State Army South (SSA-South)	No	December 2011
Shan State Progress Party (SSPP)/ Shan State Army-North (SSA-North)	1989	January 2012
Pao National Liberation Organization (PNLO)	No	2012
Kachin Independent Organization (KIO)	1994, broke down in 2011	No
Taang (Palaung) National Liberation Army (TNLA)	No	No
Arakan Army	No	No

Interviews with Care Myanmar and Taang Women's Organization (TWO) explained the low acceptance of government staff and strong resistance to Burmanization in conflict affected areas of Northern Shan and emphasized the importance of assigning locally hired staff with collaborations with local CSOs in implementing projects in these areas (see section B1).

[19] June 2018, OCHA report

8.2 Recommendations

- To conduct a conflict assessment in each township prior to determining the implementing townships to identify area specific potential risks and to map out the key stakeholders. This will help implement a government cash transfer project with proper outreach to the communities in such areas. Since some of the armed groups are non-signatories to the ceasefire agreement, this assessment is recommended to be carried out by the World Bank Group.
- The project is recommended not to be implemented in areas where the World Bank staff would not able to conduct due diligence monitoring.
- To ensure that the project in conflict affected areas has some flexibility in the design.
- To conduct continuous stakeholder engagement and regular monitoring during project implementation based on the risk level.

C. CONSULTATIONS

[THIS SECTION WILL SUMMARIZE THE ISSUES RAISED IN CONSULTATIONS HELD ON THE SOCIAL ASSESSMENT IN JANUARY 2019. IT SHOULD LIST DATES AND INVITEES BROADLY, SUMMARIZE ISSUES DISCUSSED AND SUMMARIZE RESPONSES TO CONCERNS RAISED.]

D. ANNEXES

1 References

Caufield et al. 2004, "*Undernutrition as an underlying cause of child deaths associated with diarrhea, pneumonia, malaria, and measles"*. US National Library of Health

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2 Case Examples from Field Work

Loi Aun Village, Hopong, Southern Shan.

Population: 727 (F 356/M 362); HH: 159 Livelihood: farming (paddy, corn, garlic, variety of vegetables, domestic farm animals)

Loi Aun village is situated off the road from Taunggyi to Hopong in a beautiful location in the hills with good vegetation and an abundance of productive land. The road to the village center is paved and in good condition. The village has a peaceful ambiance and is homogeneous in the sense that the vast majority of is residents are Pa O. There is an old monastery in the center of the village with a collection of golden stupas at the back. Loi Aun may have been an important religious center in the past.

What makes Loi An stand-out in relation to existing nutritional norms is its location, spread of households, livelihoods and the availability of good land. This combination in conjunction with a tradition of home grown vegetable and bean production combined with animal husbandry provides most villagers with ample supplies of food.

According to the FGD, villagers do not think too much about nutrition when they cook and just cook what they have. The households mainly eat vegetables (mustard leaves, watercress, cucumber, pumpkin, potatoes, French beans, butterfly beans, long beans and lentils) fish and meat (chicken, pork, beef). Meat is eaten less regularly but its availability is important. Diet changes when women find out that they are pregnant and eat more fruits such as apples, papaya and bananas which are also grown locally.

Household interviews confirmed that there is an availability of home produced food that is often shared with neighbors and that pregnant women and women with young children benefit from this in a very natural manner. In conclusion the combination of the availability of good land, spread of houses to accommodate gardens and the agricultural knowhow to grow and produce nutritious food provides many advantages for young mothers. Community cohesion and support reinforces the prioritization of mothers and young children because of the traditional values and homogeneous nature of the village.

Peine Taung Village (SAVE), Labutta, Ayeyarwady

Mother is 40 yrs old and lives with her husband (55), 5 children and mother in Peine Taung village which is about 5km from Labutta Township. This Bamar couple has been married for 20 years. They live in a basic bamboo house near to the village. The house has no water supply or electricity and is poorly furnished with an external kitchen.

Both husband and wife attended school up to second grade but cannot read and write. Both parents work but in low-income occupations focusing on domestic service and fishery. The two oldest

children also work, one in prawn farming and the other as a waitress. The remaining three children a girl (8) and two boys (12 and 1) live at home.

Child Care and Support from SAVE Bright Sun Project

She has been registered for the Bright Sun project (Save the Children) since she was 4 months pregnant. In addition to collecting MCCT payments she has also attended all the SBCC sessions which are tailored and focus on pre and post natal care. This includes attending the midwife every month during pregnancy and getting regular treatment and advice. Medical and nutritional advice is delivered in a balanced and complimentary manner.

They family used to buy whatever was sold at the village during the early years of the previous 4 children's development. Now she spends the 15,000MMK from SAVE to buy bananas, potatoes, watercress, green vegetables, condensed milk, oil and rice. Most of the money is spent for groceries but not only for the baby. Although this family is by no means perfect in the way that it adheres to SAVE Bright Sun advice it is clear that the project has made a big difference to the family's attitudes and behavior to child care. What makes this a standout case is the mother's age and her previous experiences with child care. In addition, it highlights the case of a mother who has adapted to the use of WAVE using her SIM card to travel to Labutta to receive her payment. While there she has an opportunity to buy a wider variety of food at a cheaper price.

Seik Eiyi Village, Chaung Tha Township, Ayeyarwady (Pre and Post Natal Care)

This mother is 32 and has four young children aged 6, 5, 3 and 8 months. Her parents died when she was young and she has 6 siblings. She got married at the age of 17 and her husband is 8 years older than her and also from the same village. They both are Bamar and Buddhist. Both mother and husband work for charcoal making business and collect firewood in the forest around Seik Kyi village (Chaung Tha). Her husband cuts the firewood and she make the bundles and takes them to the charcoal production location. The husband earns around 4000-5000 MMK and she earns 3000 MMK per day. The job is highly seasonal.

Child Care and Support:

The mother and her 8 months old baby are extremely undernourished. Prior to giving birth she did not eat properly. The result being detrimental to both the health of the mother and child. She could not regularly visit the midwife prior to the birth as she works in the deep forest and only met the midwife twice during the pregnancy and got some advice and vitamins.

The most recent birth was premature at seven-months and delivered by the TBA. She stopped working one day before she delivered the baby. The standard price for giving birth with TBA is 25000 MMK in her village. She made the payment in installments after delivery as she could not afford to save like other mothers in Seik Eiyi village in advance.

After the birth she met with the mid wife three times and her child has been vaccinated twice. In addition she asked for a contraception injection which last for three months. She could not breastfeed as she had no breast milk due to lack of nutrition during and after pregnancy. Now she

gives condense milk to the child as she can't afford more expensive milk. Although the midwife advises her to eat nutritious food, it is unaffordable and difficult to access.

To add to this difficult situation, her 6 years old daughter looks after three younger siblings including the eight-months-old child while the parents are away for days at a time for work. She is a first-grade student and she cook and washes clothes for her younger brothers and sister. She also mixes the condensed milk for the 8 months old baby. The baby is also fed some rice when the mother comes back from the forest. The couple can be 3-4 days in deep forest for firewood collection at a time.

Kwin Gyi Village, Kyankin Township (World Vision SBCC support)

Kwin Gyi a typical agricultural village is around 20 minutes drive from the main Kyankin road. The houses are well built and including a few solid block houses. There is a Health self-center in the village with two health staff (midwife + PHS2). According to interviews TBAs are no longer common in the village as many mothers avail of the midwife service.

Child Care SBCC Support World Vision

World Vision is very active in the village and this is clear in the answers of the women from different backgrounds and means. World Vision focuses on SBCC activities which includes – giving talks to pregnant women and young children on nutrition. Their model is very impressive as they give health talks to these women and also weigh their children to monitor progress. For women whose children are under the red zone or yellow zone of weight, they get food supplies (eggs, noodles, beans etc.). There is no cash payment from WV in this area. This in-kind approach connects the women to health care services directly with the incentive of health care and support for nutrition. The health and nutrition talks are given by World Vision volunteers and the volunteers are evaluated by the midwife. All awareness and SBCC interventions are developed through a strategic TOT process which involves WV health experts and township and village level health staff. TOT training is conducted up to three times a year.

Community Health Volunteers (CHV) are key to this whole process. Potential CHVs are proposed and merits are discussed at the village level before a decision is made. In general there is one CHV per village but if a village is large there can be two. It takes time for CHVs to adapt to the position and responsibilities and it is important that they gain the respect and confidence of the village mothers. The majority of CHVs are women in Kyan Kin township (92 out of 94) with the majority being between the ages of 20 and 45.

Cooking demonstrations and all year-round Home Gardening support are an important part of the SBCC support by CHVs. The CHVs act as facilitators and links with the parallel WV livelihoods projects and this is seen as an important element of the overall Mother and Child Care program. Some houses are provided with goats which is dependent on the poverty status. This is a Goat Bank approach and the family commits to providing offspring (young goats) to neighbors after one year.

When interviewing women in the village it was evident that they had indebth knowledge related to the importance of the first 1000 days and how nutrition is vital for brain and cognitive development.

They have a good understanding about 3 groups of food items they should consume:

• Vegetables they say helps them prevent disease,

• Meat makes them grow

• Oil makes them strong

World Vision's SBCC activities have reduced avoiding food during and after pregnancy and reinforced the importance of eating nutritious meals. The midwife indicated that although the in-kind food is given for the children to gain weight, it is consumed by the whole family and therefore it has been difficult to sometimes raise the weight of the children. In addition some women because of a combination of poverty, domestic problems and being too busy making ends meet have difficulty to attend some SBCC events.

Pant Village, Hopong Township, Southern Shan

This village is one of the more remote villages in the township located around 25km to the west of Hopong Township on a small rural road with the last part on a dirt track to get to some households. The village does not have many solid block houses, mostly wooden in structure and less dispersed compared to Loi Aun the other Pa O village visited by the SA Team. However, houses are more dispersed compared to the villages in Ayeyarwaddy. The houses are also surrounded by farmland and small household plots. Most houses seem to have al gardening space to grow vegetables. The village has a large monastery but like the previous village Loi Aun there are few monks and monastic activity. There is an overcrowded school that caters for primary and middle school children. There is no RHC in the village and the mid-wife comes to visit from Hopong and uses a sub center (basic hall) to meet with mothers.

Although Par Pant is in general not a poor village and has many of the similar advantages of Loi Aun, the other Pa O village visited by the SA team there are still many traditional attitudes and customs that can be seen as potentially detrimental to the health of mothers and young children. These center on the Pa O belief that after birth the mother should take part in a 'sauna style' ritual that involves periods of time under a warm blanket for up to 9 days. The heating effect is from burning wood which cases the small houses to become smoky.

Traditional beliefs are strong but the education level of younger women and fact that some go to have their babies in the clinic or hospital helps. Only when a baby is delivered in the house are Pa O birth traditions more likely to be imposed. The fact that there is not a resident Midwife or equipped health center is also something that affects behavior and attitudes. A common occurrence that was reported in Par Pant Village was for the midwife or hospital staff to give mothers an injection and asks them to explain that this injection (placebo) can be seen as a substitute for the traditional Pa O 'sauna' custom. Interviewed women in the village indicated that this is in most cases accepted by families and elders.

Of the mothers interviewed in both FGD (women) and HH Interviews the majority preferred to use the TBA. Some of the reason for this is that the TBA is respected and is the grand- daughter of the

previous TBA. In addition to get the hospital in Hopong requires transport, takes time and is more expensive leaving the majority of women with only one choice the TBA. In an interview with the TBA she indicated that she provided nutritional advice (rather restrictive) to mothers and promotes the Pa O traditional practices.

What makes Par Pant a challenging cases for SBCC is the above traditional influence and the TBA. In such cases where the midwife has less influence it will be necessary to target the TBA for inclusion in SBCC TOT and other activities along with key Pa O female elders. This will need a different approach than developing SBCC interventions in villages where there is an active RHC and where the Midwife is in residence or visits regularly. It is assumed that that there are many cases similar to Par Pant in Shan and that a culturally appropriate approach to SBCC will be paramount to sustainably impact SBCC.

In addition to the traditional Pa O customs surrounding births and nutrition there is an added element of risk that was observed and discussed in Par Pant. The village like Loi Aun has a thriving Cheroot cigar production village industry which involves the drying and steaming of Cheroot leaves. This creates a humid and smoky environment which may contribute to potential health hazards for mothers and children / families. When asked, mothers indicated that this was uncomfortable. All houses visited were involved in some way in this production process.

Peine Taung Village (SAVE)

This village is around 30 minutes away from Labutta city and the village is located around 5 minutes' drive from the main road. This village is supported by the SAVE Bright Sun project which has an MCCT emphasis. Previous to the use of WAVE Money in November 2017 Peine Taung mothers in the SAVE project received cash directly from the project volunteers. The project provides Telenor Sim Cards to the beneficiaries and opens a Wave Money accounts for them with the facilitation of trained volunteers. To legitimize the process women in the project sign an agreement with Wave Money. This has become popular and the use of Wave Money has increased from 32 to 64 villages in Labutta including Peine Taung village.

To open a wave money account, only two things are needed:

1. **Smart Phone** (Volunteers use their own smart phones to open the account for the beneficiaries by interesting the Sims of the beneficiaries)
2. **Sim**
3. **NRC** (if they beneficiaries do not have NRC, they use the NRC of their husband/ other family members)

Benefits of Wave Money:

It is reported it reduces risk of cash transfer including theft and potential abuse. While many poor families don't have phones the ownership of a Sim is enough to use the system.

Difficulties using Wave Money:

Technical difficulties include the need to use smart phones for optimal service and 30 % of people in the Labutta area don't have this technology but relay on older key pad technology. However, Save the Children is planning to give keypad phones to the beneficiaries and develop a new system, that won't be dependent on Wave. Husbands and other family members can also collect the MCCT money for mothers if they are not available and months can be accumulated if one month is missed.

Other impacts of Wave include:

When mothers get the money through WAVE they have to go to Labutta. They go to Labutta in a group sometimes to collect the funds by travelling in an old truck car or by bike. After collecting the Wave Money they also buy food in Labutta as there are more options there and it is also cheaper than the shops in the village. Transport options also include a bus service which is a bit more expensive. Visits to Labutta from Peine Taung have increased according to mothers interviewed by the SA team. Overall, there seems to be a positive sentiment about using Wave Money and they claim that they can eat a variety of additional food from Labutta due to this Wave Money system. Mothers confirmed that they prefer wave money to giving cash in hand.

While Wave is popular in Peine Taung it is less ideal in areas that are more remote and where access to Wave Money agents are restricted and travel time for expecting mothers and mothers with young children long and possibly risky. The SAVE model however is something that needs to be looked at particularly in Labutta and also in township areas that will be possibly covered in the DSW MCCT project.

Aung Mingular Village (Island), Chuong Tha Township, Ayeyarwady

Aung Mingular is traditional fishing village on an island off Chaung Tha. The island is very close to the mainland and only separated by a short stretch of water. There has been some tourist houses and resort development along the beach and west side of the island. Land was sold to families from outside the island to build holiday homes and because of the prevalence of tourism in the area there is a strong possibility that this small island will be part of additional development.

The tiny island has 125 HH and a population of 395 people according to the Village head. The main occupation is fishing, and some service provision associated with tourism, small boat building and repairs.

What contributes to Aung Mingular as a challenging location for nutritional norms is a lack of fresh water combined with poor land quality, density of houses and also a negative environmental impact associated with waste and waste management. FGDs indicated villagers mainly eat rice and fish. They don't eat vegetables regularly because of availability and cost. In terms of fish, they just eat the cheapest kind of fish as other more valuable fish, prawns and crabs are sold. There are many pigs on the island indicating that pork in addition to fish is also available, however the environmental impact in such limited conditions may be negative.

While the population is homogeneous for most of the year there is an influx of migrants after the monsoon. This increases the demand for limited food and natural resources. According to one FGD Rakhine migrants have bigger fishing nets and therefore more valuable catches. Because they are

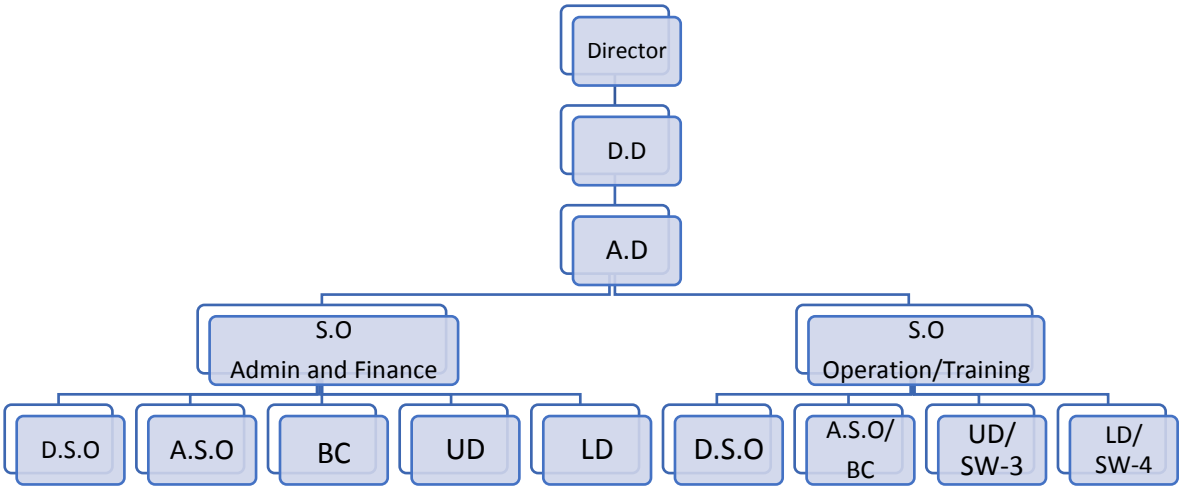
temporary residents they don't contribute to the village and just come during the summer months to earn money and go back to their own villages during the monsoon.

The case of Aung Mingular highlights the negative impact very limited and un- productive land, poor housing conditions and sanitation, a dependency on fish and rice plus additional seasonal population expansion can have on the nutritional norms of relatively poor families. While awareness based on FGD and HH interviews in relation to nutrition is good capacity to grow or buy nutritious food is limited. Seasonal unemployment and poor weather conditions only add to the challenges this community faces. Mothers and young children while prioritized by families and the community and well supported by the respected midwife are vulnerable all year round because of the above-mentioned conditions.

3 Detailed DSW Structure

Ayeyarwady Regional Office

No.	Designation	Structure	Appointed	Vacant	Remark
1	Director	1	1	0	
2	Deputy Director	1	1	0	
3	Assistant Director	1	1	0	
4	Staff Officer	2	2	0	
5	Deputy Staff Officer (Social Worker - 1)	2	1	1	
6	Assistant Staff Officer (same rank with BC and SW – 2)	2	2	0	Attached to others
7	Branch Clerk	2	2	0	
8	Upper Division Clerk (UD)	3	3	0	Attached to others
9	Social Worker – 3 (same with UD)	5	2	3	Attached to others
10	Lower Division Clerk	4	2	2	Attached to others
	Total	**23**	**17**	**6**	



Pyapon District Office

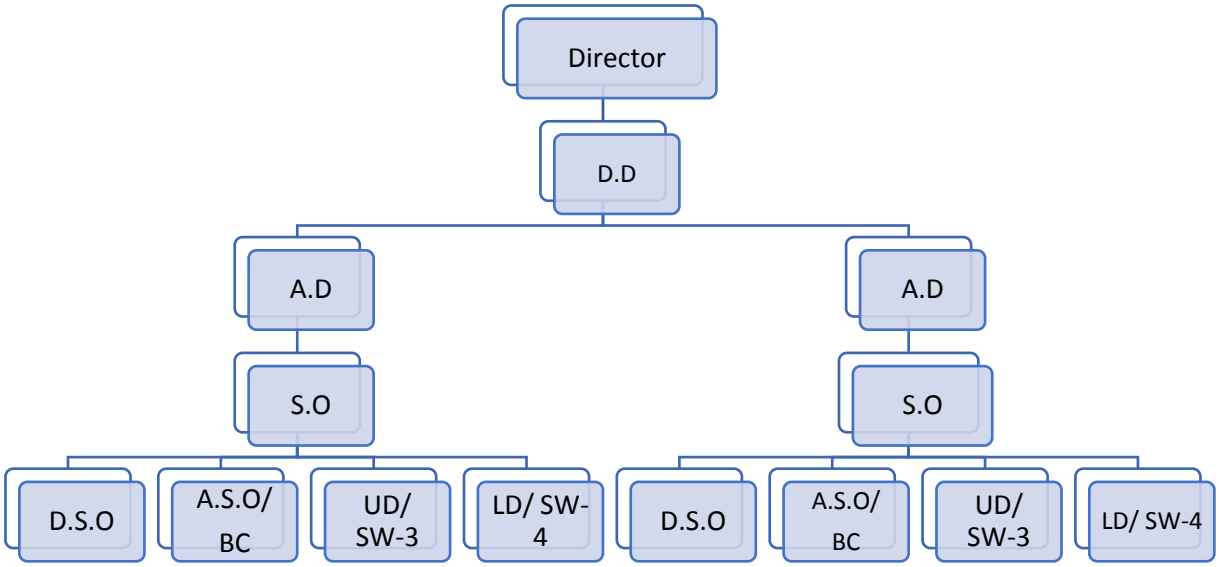
No.	Designation	Structure	Appointed	Vacant	Remark
1	Deputy Director	1	0	1	
2	Assistant Director	1	1	0	
3	Staff Officer	1	1	0	
4	Deputy Staff Officer	1	1	0	
5	Assistant Staff Officer (same rank with BC)	1	1	0	
6	Branch Clerk	1	1	0	
7	Upper Division Clerk (UD)	1	1	0	
8	Social Worker – 3 (same with UD)	2	0	2	
9	Lower Division Clerk (LD)	2	1	1	Attached to others
10	Social Worker – 4 (same with LD)	2	1	1	Attached to others
	Total	**13**	**8**	**5**	

Myaungmya District Office

No.	Designation	Structure	Appointed	Vacant	Remark
1	Deputy Director	1	0	1	
2	Assistant Director	1	1	0	
3	Staff Officer	1	1	0	
4	Deputy Staff Officer	1	1	0	
5	Assistant Staff Officer (same rank with BC)	1	1	0	
6	Branch Clerk	1	1	0	Attached to others
7	Upper Division Clerk (UD)	1	0	1	
8	Social Worker – 3 (same with UD)	2	1	1	
9	Lower Division Clerk (LD)	2	2	0	1 attached from other
10	Social Worker – 4 (same with LD)	2	0	2	
	Total	**13**	**8**	**5**	

Shan State Office

No.	Designation	Structure	Appointed	Vacant	Remark
1	Director	1	1	0	
2	Deputy Director	1	0	1	
3	Assistant Director	2	2	0	
4	Staff Officer	2	0	2	
5	Deputy Staff Officer (Social Worker - 1)	2	2	0	
6	Assistant Staff Officer (same rank with BC and SW – 2)	2	2	0	
7	Branch Clerk	2	2	0	
8	Upper Division Clerk (UD)	3	2	1	
9	Social Worker – 3 (same with UD)	5	3	2	
10	Lower Division Clerk	4	4	0	
	Total	**24**	**18**	**6**	



Kengtung District Office

No.	Designation	Structure	Appointed	Vacant	Remark
1	Deputy Director	1	0	1	
2	Assistant Director	1	1	0	
3	Staff Officer	1	1	0	
4	Deputy Staff Officer	1	1	0	
5	Assistant Staff Officer (same rank with BC)	2	1	1	Attached to Mandalay Deaf School
6	Branch Clerk	1	1	0	
7	Upper Division Clerk (UD)	1	0	1	
8	Social Worker – 3 (same with UD)	2	1	1	
9	Lower Division Clerk (LD)	2	2	0	
10	Social Worker – 4 (same with LD)	2	1	1	
	Total	**14**	**9**	**5**	

Lashio District Office*

No.	Designation	Appointed	Remark
1	Deputy Director	1	Lashio District DSW office
2	Assistant Director	1	Attached to Yangon office
3	Staff Officer	1	Attached to Head Office, Nay Pyi Daw
4	Sub department officer	1	Lashio District DSW office
5	Deputy Staff Officer	1	Lashio District DSW office
6	Deputy staff officer	1	Yangon, Thone Kwa Township office (Attached to Lashio District Office)
7	Upper Division Clerk (UD)		Taunggyi DSW office (Attached to Lashio District Office)
8	Upper Division Clerk (UD)	1	Lashio District DSW office
9	Social Worker – 3 (same with UD)	1	Lashio District DSW office
10	Lower Division Clerk (LD)	1	Lashio District DSW office
11	Lower Division Clerk (LD)	1	Lashio District DSW office
12	Social Worker – 4 (same with LD)	1	Lashio District DSW office
13	Social Worker – 4 (same with LD)	1	Attached to Lashio youth training center
14	Security	1	Lashio District DSW office
	Total	**13**