MCCT Learning Paper: Mobile Money Pilot – Labutta Township

Save the Children

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SUMMARY

Since December 2017, Save the Children has been working with Wave Money to pilot mobile money in place of physical cash distribution for MCCT recipients in select villages in Labutta Township.

This learning paper presents key findings from Post Distribution Monitoring (PDM) surveys conducted on a monthly basis from December 2017 until July 2019. The PDM covered 1,484 beneficiary respondents from all 64 Wave Money pilot villages.

KEY FINDINGS:

- **Accessing and controlling mobile money:** Access to a mobile phone has increased from 65% to 79% of respondents. Most respondents control the MCCT payment process (86.4%), and 87.3% fully control the use/expenditure of the monthly MCCT cash transfer.

- **Accessing Wave Money agents:** More than half the respondents can reach a Wave Money agent within 15 minutes, and the majority within 30 minutes. Most respondents incurred either no cost or 1,000 MMK or less to reach Wave Money agent (77.8%).

- **Ease of Wave Money transfer:** On average, 30% of respondents received their MCCT cash transfer from a Wave Money agent within 5 minutes, and 44% within 10 minutes. However, an average of 30% of respondents are waiting over 20 minutes – with approximately 9% of respondents waiting between 30 and 60 minutes.

Only 95 respondents (6.4%) reported having difficulties accessing their MCCT cash transfers through Wave Money agents.

- **Use of MCCT cash transfers:** Most respondents used the MCCT cash transfers to buy food for themselves, their child and family. Beyond purchasing food, 43% of respondents used some of the MCCT cash transfer to cover healthcare costs (e.g. transport etc.). Only 4.9% of respondents were buying baby formula, and very few respondents used the MCCT cash transfer for alcohol/betel etc. (<1%). However, an average of 25% of respondents are using MCCT cash transfers to buy unhealthy snacks.

- **Mother-to-Mother Support Group (MtMSG) attendance:** Only 11.6% of respondents had not attended all MtMSG sessions. However, nonattendance increased over the PDMs (from 7% to 17%). This may reflect less incentive to join sessions now that beneficiaries do not need to physically collect their MCCT cash transfers.

- **Knowledge and practices:**
  - **Food Taboos and IYCF:** More than half reported greater nutrition knowledge and avoiding harmful food taboos when pregnant/breastfeeding and practicing better IYCF.
  - **ANC:** Two thirds (69%) of respondents were accessing regular ANC.
  - **Exclusive breastfeeding:** Nearly all respondents (97.6%) with children under 6 months had breastfed in the last 24 hours, and only (5.6%) reported providing something other than breastmilk to their child.
  - **Dietary diversity:** Pregnant respondents and children 6 to 24 months old still have low dietary diversity (an average of 3.6 and 3.4 food groups respectively).

BACKGROUND

Since December 2017, Save the Children has been working with Wave Money to pilot mobile money in place of physical cash distribution for MCCT recipients in select villages in Labutta Township.

This learning paper presents findings from Post Distribution Monitoring (PDM) surveys conducted on a monthly basis from December 2017 until July 2019. The PDM covered 1,484 beneficiary respondents from all 64 Wave Money pilot villages. Just under half (45%, n=675) of the respondents were surveyed more than once over this duration. This analysis presents the data across four PDM rounds (each covering a 5-month period) (Table 1.).[1]

Table 1: PDM rounds

PDM round	Timeframe	Total number of respondents	Avg. duration enrolled in MCCT
1	Dec 2017 - April 2018	504	13.8 months
2	May - Sept 2018	875	15.3 months
3	Oct 2018 - Feb 2019	659	17 months
4	Mar - Jul 2019	175	19.6 months

ACCESS AND DECISION-MAKING

Mobile phone access

Access to a mobile phone through the household or personal ownership has increased over the last three PDM rounds from around 65% to 79%. While this is a positive trend, as of the last PDM round, there are still an estimated 20% of MCCT recipients who do not own a mobile phone and are unable to access one within their household.

Table 2: Access to mobile phones (HH and personal)

PDM round	HH member(s) own a mobile phone	MCCT recipient can access a HH member's mobile phone	MCCT recipient has access to own mobile phone
1	85.5% (n=431)	N/A[2]	N/A
2	68.7% (n=601)	65% (n=514)[3]	66.6% (n=527)[4]
3	75.2% (n=496)	75% (n=487)[5]	74.6% (n=485)[6]
4	80% (n=140)	79.4% (n=139)	78.9% (n=138)

Decision-making and control of MCCT cash transfers

Most respondents specified they control access to a mobile phone (even if it is a person's phone outside their household) for MCCT payment processes (averaging 86.4% across the PDM rounds).

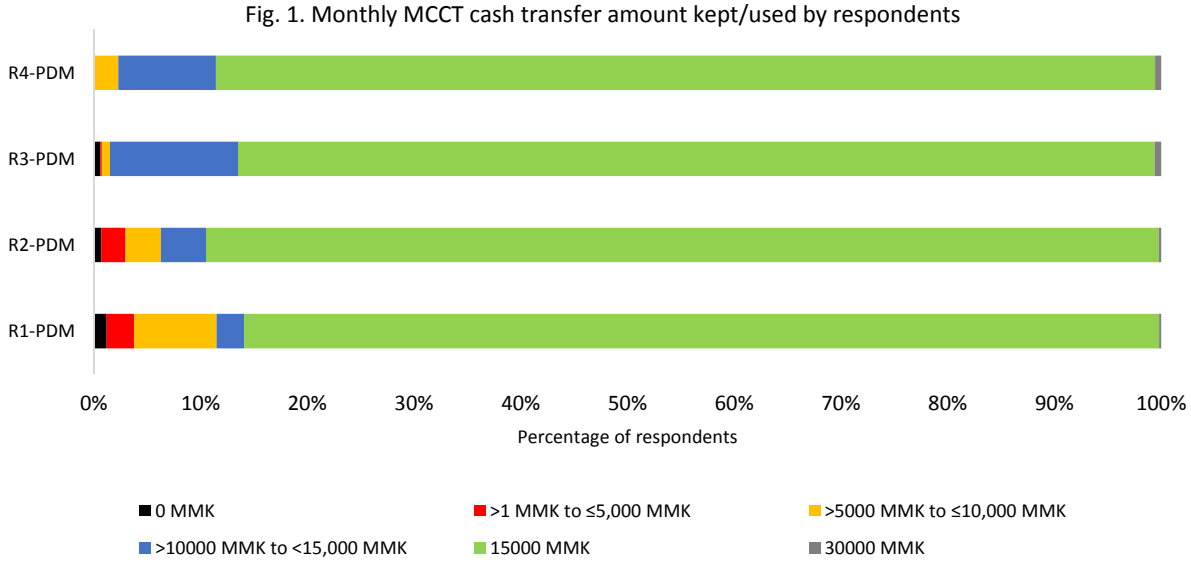
Table 3: Control of MCCT payment on third party mobile phone

PDM round	Recipient controls access to a mobile phone for MCCT payments
1	89.9% (n=453)
2	80.7% (n=706)
3	85.9% (n=566)
4	89.1% (n=156)

[1] While some recipients were interviewed multiple times, they are only represented once in each PDM round.
[2] Data was not properly collected for these questions in the first PDM round.
[3] Out of 791 responses
[4] Out of 791 responses
[5] Out of 650 responses
[6] Out of 650 responses

Only 11 (0.7%) MCCT recipients across the PDM rounds said they did not control decisions regarding the use of the MCCT cash transfers. When asked how much of the monthly MCCT cash transfer they can use, on average 87.3% of respondents reported being able to use the full monthly 15,000 MMK MCCT cash transfer. Only 2% of respondents reporting only being able to use 10,000 MMK or less.

Fig. 1. Monthly MCCT cash transfer amount kept/used by respondents



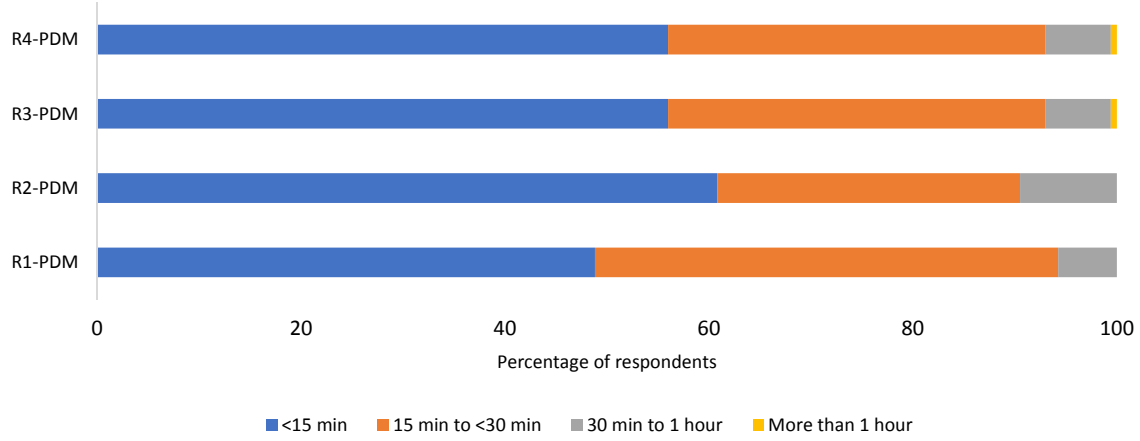
Most respondents directly collected the MCCT cash transfers from Wave Money agents (ranging from 84.3% in the first PDM round to 97.7% in the last PDM round). Only 3 respondents reported providing some of the MCCT cash transfer to another non-household member (MCCT focal person in each case), and 6 respondents reported providing some of the MCCT cash transfer to another household member.

MCCT PROCESS

Travel time and cost

Travel time for a one-way trip to reach a Wave Money agent/shop is reasonable, with half or more respondents able to reach the Wave Money shop/agent within 15 minutes, and the majority within 30 minutes (over 90% in all PDM rounds).

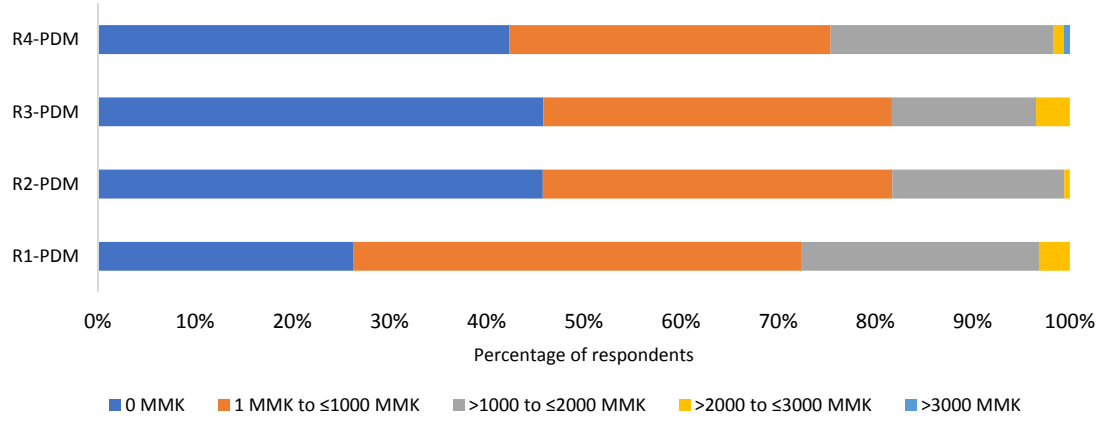
Fig.2. Travel time to Wave Money agent (one-way trip)



Due to the proximity of the pilot villages to the township, travels costs are quite low. However, the costs do highlight the need for expansion of what is a very new Wave Money agent network. The penetration of agents into areas beyond the township will be a key determinant for lowering transaction costs of receiving an MCCT through an electronic payment system.

Between 26% to 46% of the respondents across the PDM rounds could reach a Wave Money agent without having to pay for transportation. Out of those respondents who incurred some cost, most spent less than 1,000 MMK per one-way trip (an average of 37.6% of respondents across the PDM rounds). This would equate to 2,000 MMK or less for a return trip – or up to approximately 13% of the MCCT cash transfer. On average, 20% of respondents across the PDM rounds were spending between 1,000 and 2,000 MMK per trip (or between 2,000 MMK and 4,000 MMK for a return trip). Very few respondents spent more than 2,000 MMK per one-way trip to a Wave Money agent.

Fig. 3. Cost of one-way trip from village to Wave Money agent

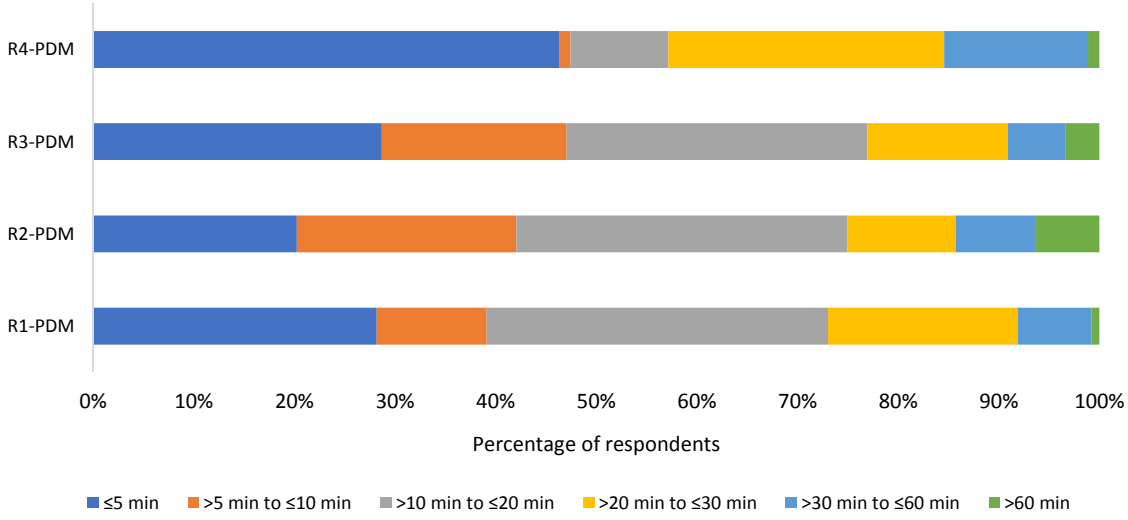


While these costs are on the low side, for villages further from the township, these costs could quickly become a barrier for accessing Wave Money shops/agents. The Wave Money network will need to expand and be present (even if periodically), in more remote rural areas to ensure it can effectively cover respondents as physical money distribution is replaced.

Wave Money transaction duration

Across the PDM rounds, an average of 30% of respondents were able to collect their MCCT payment from a Wave Money agent within 5 minutes – for the last PDM round this accounted for nearly half of the respondents (46%, n=81). The collection of an MCCT payment within 10 minutes was reported by an average of 44% of respondents across the PDM rounds. While this is a positive trend, an average of 30% of respondents are waiting over 20 minutes to collect their MCCT payment – with approximately 9% of respondents waiting between 30 and 60 minutes. The expansion of mobile money agents will hopefully alleviate what appears to be congestion due to supply-side constraints.

Fig. 4. Time taken to collect cash from Wave Money agent



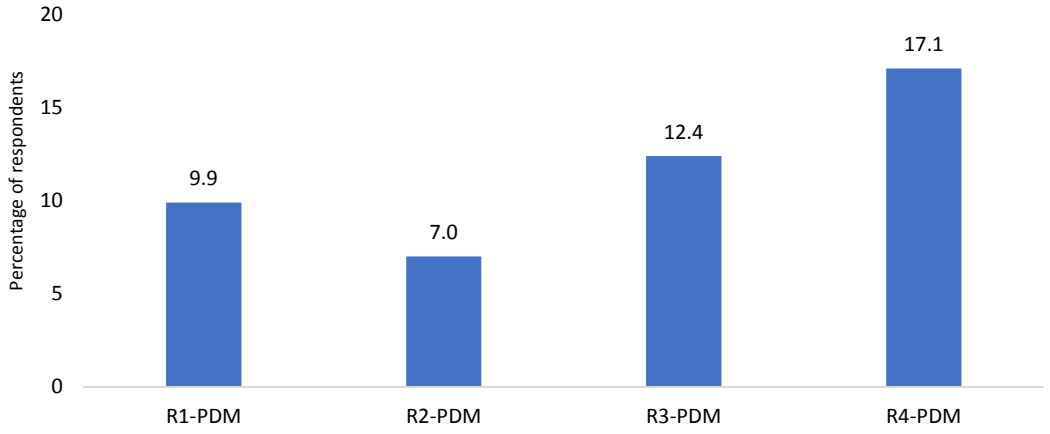
Ease of Wave Money transactions

Only 95 respondents (6.4%) across the PDM rounds reported having difficulties accessing their MCCT cash transfers through Wave Money shops/agents. Most of the issues were related to receiving the SMS MCCT notification, remembering pin numbers or having to wait in line for a long time. Only 3 recipients reported Wave Money agents collecting a fee for the service – 500 MMK in each case.

MOTHER TO MOTHER SUPPORT GROUP ATTENDANCE

Over the four PDM rounds an average of 11.6% of respondents had not attended a Mother to Mother Support Group (MtMSG) session – the majority had missed 1-2 sessions. Most of the reasons were due to lack of awareness of when or where the session(s) were held or due to other commitments. While these numbers are low, the trend was increasing over the last 3 PDMs (ranging from 7% to 17.1%). This may reflect an unintended negative impact of introducing mobile payments, where respondents are less incentivised to attend sessions now that they can receive the payment remotely on a mobile phone.

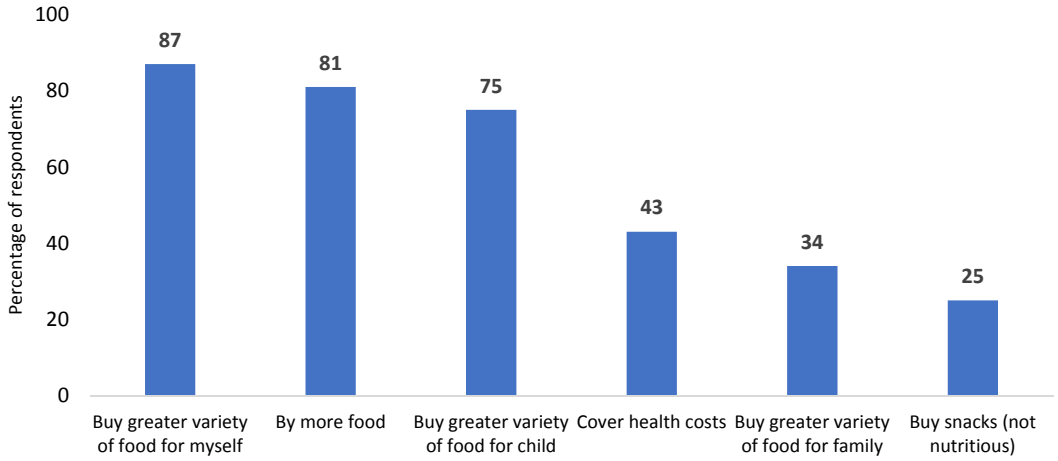
Fig. 5. Missed MtMSG sessions



USE OF MCCT CASH TRANSFER

Most respondents across the PDM rounds used the MCCT cash transfers primarily to buy food for themselves, their child and family. Beyond purchasing food, 43% of respondents are using some of the MCCT cash transfer to cover costs associated with accessing healthcare (transport etc.). Only 4.9% of respondents mentioned buying baby formula, and very few or no respondents used the cash for general household, business or other financial purposes (debt repayments/savings) or to buy alcohol/betel etc. (<1%). However, on average, 25% of respondents across the PDM rounds specified using MCCT cash transfers to buy snacks with limited nutritional value (e.g. biscuits, cakes, sweets etc.).

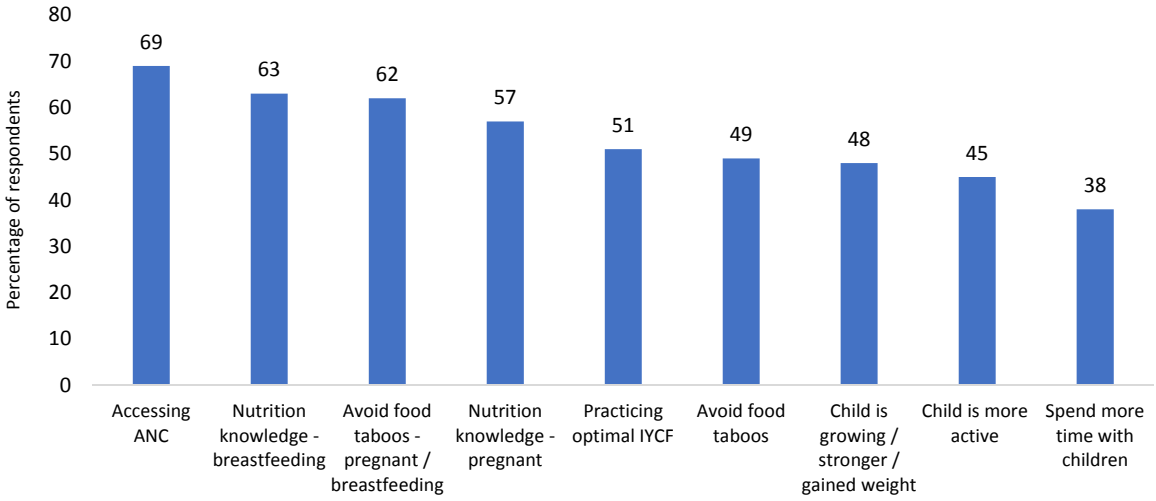
Fig. 6. Main use of MCCT cash transfers



KNOWLEDGE AND PRACTICES

When asked what impact the MCCT has had on them, on average more than two thirds (69%) of the respondents specified that they were accessing regular ANC from Midwives or health centres. More than half reported greater nutrition knowledge when pregnant and breastfeeding, avoiding food taboos when pregnant/breastfeeding, and practicing optimal IYCF.

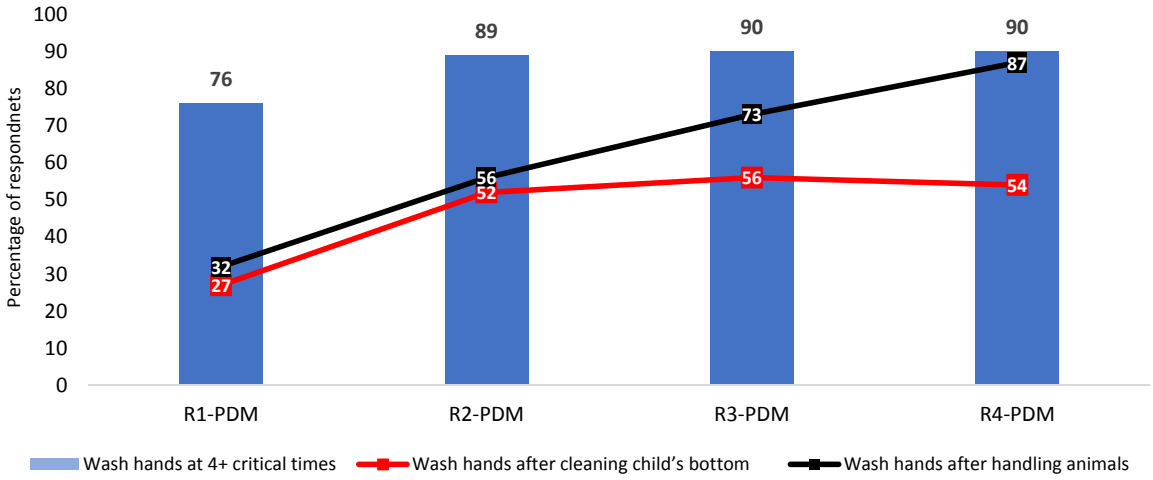
Fig. 7. Main changes due to the program: Knowledge and practices



Handwashing

Handwashing practices are high across all the PDM rounds, with most respondents 'always' washing their hands at 4 or more critical times.[7] The average number of critical times a respondent 'always' washes their hands went from 4.6 to 6.1 across the PDM rounds. For two of the weakest handwashing times (after 'handling animals' and 'cleaning a child's bottom'), there has been a positive trend over the PDM rounds – although the latter is still only practiced by around half (54%, n=95) of respondents interviewed in the last PDM round.

Fig 8. Handwashing practices

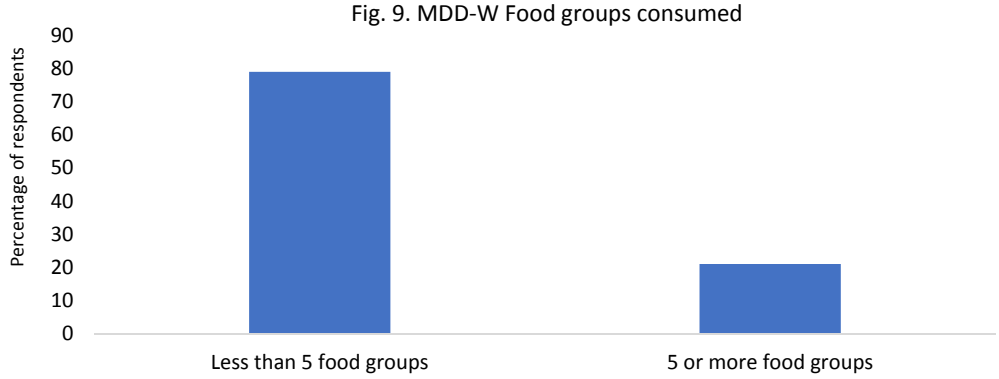


Minimum Dietary Diversity for Women

Minimum Dietary Diversity for Women data was collected from 263 pregnant respondents.[8] The proportion of respondents who reach the minimum of 5 food groups in a population can be used as a proxy indicator for higher micronutrient adequacy, an important dimension of diet quality.

The average was low at 3.6 food groups, with only 21% (n=56) consuming five or more. However, the average enrolment was only 3.8 months, so many had limited programme exposure. Most respondents (94.7%, n=249) were consuming 'grains and tubers' (rice), and 'meat/fish/poultry' (including organs/offal) (86.3%, n=227), just over half (52.1%, n=137) were consuming 'dark green leafy vegetables', and 32.3% (n=85) were consuming 'vitamin A rich fruit and vegetables'.

Fig. 9. MDD-W Food groups consumed



[7] Out of a total of 7 critical times listed.

[8] Minimum Dietary Diversity for Women is a dichotomous indicator of whether or not women 15–49 years of age have consumed at least five out of ten defined food groups the previous day or night. Due to limitations on the PDM survey length, only pregnant respondents were asked these questions.

Exclusive Breastfeeding

A sub-group of 359 respondents with children between 0-5 months were asked if they had breastfed in the last 24 hours. Across the PDM rounds this was consistently high, averaging 97.6%. Only 20 (5.6%) respondents reported providing something other than breastmilk to their child in the last 24 hours – the most common liquids were 'any vitamins, mineral supplements, medicines, ORS,' 'plain water' and 'traditional medicines'.

Dietary diversity – child (6-24 months)

A sub-group of 181 respondents with children 6 months and older were asked about dietary diversity for their children in the last 24 hours. Of the 7 food groups, the average across this sub-group was 3.4 food groups (ranging from 3.1 to 3.9 across the PDM rounds). The majority of children received grains, roots and tubers (rice) (97%), and flesh foods – meat, poultry, fish, organs etc. (78%), half consumed 'other fruit and vegetables', and 42% consumed 'vitamin A rich fruit and vegetables'. There were only 4 infants between 2 to 5 months of age that had received the following: 'diary' (2 infants, both 5 months old), 'grains, roots and tubers' and 'other fruit and vegetable' (1 infant, 3 months old); and 'grains, roots and tubers', 'other fruit and vegetable' and 'flesh foods' (1 infant, 2 months old).

Fig. 10. 4 or more food groups consumed