Taking pilots to scale in child nutrition: The story of the Maternal & Child Cash Transfer Programme

Throughout the sector staff struggle with the sheer volume and complexity of reports, evaluations and reviews. The LIFT Learning Paper series seeks to provide user-friendly summaries of key learning themes. Drawing on available studies and interviews with stakeholders, this paper is aimed at programme and policy staff, and decision makers in the nutrition, maternal & child health, and social protection fields.

1. Introduction and purpose

This paper looks at the development of Myanmar's government-led Maternal & Child Cash Transfer (MCCT) programme. It traces key factors that have led to a series of pilots being taken to a country-wide scale, and tracks progress to date. Most importantly, this paper seeks to capture not only what progress has been made but why progress has been made, and identify the critical factors that contributed to this. The final section notes the challenges that remain to be addressed in the coming years as the Department of Social Welfare (DSW) seeks to build national coverage. A timeline annex capturing some key moments over the last 10 years on the final page helps visualise the connectivity between the global drives on MCCT, key moments of policy development, and the inputs from various actors on the MCCT projects (and related SP initiatives such as older person's pensions).

2. Why is an emphasis on maternal and child nutrition so important?

The UN Standing Committee on Nutrition summarised very clearly the challenge facing poor families in many countries:

> *Inadequate nutrition during the crucial first 1,000 days of life can stunt the physical and cognitive development of a child, leading to a higher susceptibility to illness, poor physical status, and impaired cognitive ability. These limitations may lead to loss of productivity and contribute to a cycle of poverty. Robust evidence shows that optimal nutrition from conception through a child's second birthday is vital to preventing stunting in children, thereby contributing to building a healthy and productive future generation.*

In Myanmar, according to the 2015-16 Demographic and health survey, 29% of children under the age of 5 are stunted,[1] a key indicator of undernutrition.[2] The frequency of stunting increases significantly in certain poorer areas, such as Chin and Rakhine.

The MCCT programme aims to prevent stunting in children by combining monthly cash allowances for pregnant women and mothers of children up to two years old with Social and Behavioural Change (SBC) approaches focused on improving nutrition and hygiene as well as encouraging positive health-seeking behaviours, supported by local health professionals. The money is intended to be spent on additional, nutritious food for mothers and children and to support better access to health services, but long-term success of the programme is based on behavioural change.

[1] Defined by WHO as "the impaired growth and development that children experience from poor nutrition." https://www.who.int/nutrition/healthygrowthproj_stunted_videos/en/

[2] MoHS, https://dhsprogram.com/pubs/pdf/SR235/SR235.pdf

3. 2014: The Government of Myanmar sets out an ambitious Social Protection Strategy – with a strong emphasis on mothers and children

In 2014 the Ministry of Social Welfare, Relief and Resettlement (MoSWRR) drew up the first ever National Social Protection Strategic Plan (NSPSP) supported by a range of agencies, including UNICEF, the World Bank, World Food Programme, HelpAge and Save the Children. In the years leading up to this, the ILO had been a major technical driver and helped DSW to bring together government counterparts. An ambitious vision was set out for building a comprehensive social protection programme that would over time achieve national coverage. Managed by the Department of Social Welfare, (DSW), the programme was set up to target pregnant women, children, and vulnerable, underserved populations such as the elderly and people with disabilities (box 1). A Technical Support Group, co-chaired by DSW and UNICEF, worked with 16 other agencies including government departments, national research and sectoral associations, UN agencies and NGOs.

Box 1
Myanmar's National Social Protection Strategic Plan 8 flagship programmes

1. Cash transfers for pregnant women and children to age
2. Child allowance for children 3-15 years
3. Cash transfers for Persons with Disabilities
4. School feeding for children attending school
5. Public employment & vocational education
6. Social pensions for those aged over 65
7. Older person's self-help groups
8. Integrated SP system to ensure social worker presence at township level

Myanmar's social protection flagships

Eight flagship programmes were identified and the estimated costs noted.[3] It was recognised that social protection provisions across these areas was at a very low starting point, and together would require a considerable investment of resources (estimated at 5-7% GDP) to achieve national coverage of provisions for targeted groups. Certain initiatives were therefore prioritised to be phased in over time. The cash transfers for mothers and children (MCCT) was one of those prioritised initiatives.

4. Testing MCCT through projects

A range of projects, led by Save the Children and IRC, with LIFT funding, started up in 2014 to develop and test the MCCT approach in Myanmar, aimed at providing evidence to guide policy and practice in this national social protection programme. A government-led pilot on MCCT was also tested in the 2014-2015 fiscal year in Phyapone Township of the Ayeyarwaddy region by DSW.

The projects aimed to:

- Provide financial and SBC support to pregnant women and mothers of children up to two years old so they can improve their nutritional outcomes and increase household expenditure on, and consumption of, nutritious foods;
- Promote positive health-seeking practices and behaviours amongst families, including encouraging greater linkages to, and use of existing and available health services (e.g. support in Antenatal and Postnatal care);
- Generate and disseminate evidence on performance in order to contribute to the national government strategic plan on social protection. In this case, the focus was on nutrition outcomes, but learning could also contribute to the design of other social protection initiatives

There were four LIFT-supported MCCT projects over a five year period, plus the government pilot. These were designed to test various approaches and means of delivery, and gradually take interventions to a larger scale. These experiences were critically important for providing learning that informed the ongoing evolution of the DSW MCCT programme.

[3] https://www.social-protection.org/gimi/RessourcePDF.action?ressource.ressourceId=50377

Tat Lan I: Rakhine

MCCT was a small component of the multi-sector Tat Lan I programme. This was carried out by Save the Children over 2014-16 in 15 villages in Rakhine. MCCT was designed as a specific pilot project, that was relatively small in scale with cash delivery and SBC components, both done by Save the Children themselves. Cash delivery through IPs was the simplest process, with the least possibility for 'leakage' (ie. part of the payments being withheld by proxies). However, it allowed for only limited local capacity building.

Bright SUN: Ayeyarwaddy

The project was part of LIFT's Delta III programme, and over three years delivered cash and Social & Behavioural Change Communication (SBCC) to over 5,773 women in Labutta township in the Ayeyarwaddy region. Implemented by Save the Children, this project sought to involve the Ministry of Health and Sports (MoHS) in the process as cash and SBC were delivered through Village Health Committee volunteers, set up with the assistance of the Three Millennium Development Goals programme.[4] This project also piloted electronic cash transfers (ECT) for the first time through Wave Money starting in November 2017.

Tat Lan II: Rakhine

The second phase of Tat Lan saw a scale-up for MCCT from a small pilot to a larger MCCT project with over 10,000 beneficiaries in Rakhine. Reach grew significantly from Phase I, as Save the Children implemented in 80 villages and IRC implemented in 102. Cash and SBC was still carried out through Implementing Partners (IPs), with the additional involvement of Village Development Committees and community volunteers.

LEGACY: Magway and Mandalay

More than other projects to date, Legacy sought to develop robust evidence on MCCT's effects on nutrition and stunting, including investing in a randomized control trial. This project had over 11,500 beneficiaries in Magway and Mandalay Regions and was implemented by Save the Children, with the Myanmar Nurses & Midwives Association (MNMA) involved in registration of beneficiaries and cash delivery through Pact Global Microfinance (PGMF) agents over 2016-19. An additional pilot tested cash delivery through MNMA and local midwives registering beneficiaries and delivering cash in their routine village visits (MNMA transferring cash to midwives on a monthly basis). This encouraged mothers to actively participate, as SBC was incorporated in the cash delivery. While this method showed promise and received strong feedback, it also placed a large workload on midwives.

While not an MCCT project, and not having an SBC component, HelpAge's social pensions and disability payments also delivered cash payments to beneficiaries during this period and tested one of DSW's flagship programmes as laid out in the NSPSP. This project was also the first to deliver cash through the General Administrative Department (GAD), the government department with the greatest national village-level coverage. Working through GAD meant that cash channels and village-level administrators were already in place. This project also piloted ECT, involving Wave Money and M-Pitesan.

Over five years, LIFT-supported MCCT projects covered 722 villages and over 28,000 women beneficiaries in Rakhine, Ayeyarwaddy, Mandalay and Magway.

The learning and experience from these projects was extremely valuable in giving confidence and direction to the DSW-led Chin MCCT programme which began in 2017 (see section 6). The Chin State programme covered more than 30,000 beneficiaries. It was also the first MCCT programme that sought to reach universal coverage state-wide.

[4] Now the Access to Health Fund, which strengthens national health systems and improves health access for poor and vulnerable people.

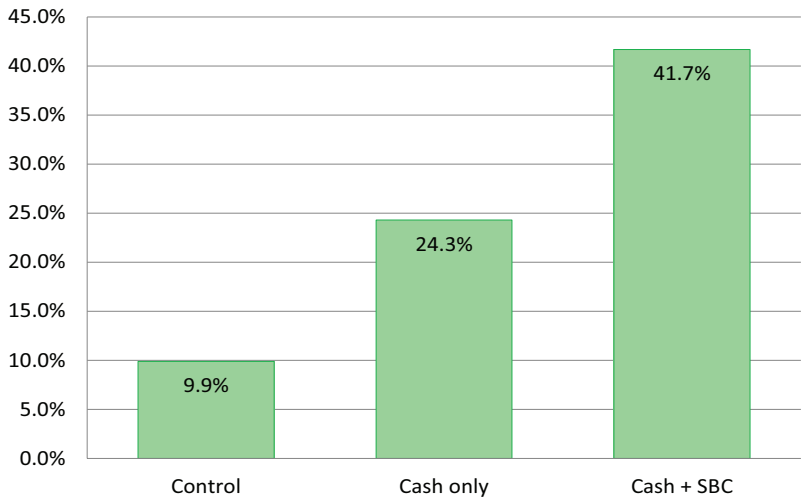
5. A snapshot of progress to date from LEGACY

Save the Children's Legacy project supported over 11,500 women with monthly cash payments of 15,000 MMK over a two year period. The findings from a midline study[5] of this project assessed critical areas such as improvements in knowledge, dietary diversity for pregnant and lactating women, and the number of children aged 6-24 months who were receiving an acceptable diet. This study stands out as an important contribution to learning on the effectiveness of this approach to date. The study compared mothers and children from a control group (untouched by the MCCT), those receiving cash and Social & Behavioural Change (SBC) support, and those receiving only the cash payments with little or no additional support provided.

The findings showed marked improvements in those groups of mothers receiving assistance compared with control groups. It is also notable that **cash plus SBC support showed larger positive effects** compared to those only receiving cash. Figure 1 shows the recorded differences in children aged 6-24 months meeting Minimum Acceptable Diet standards.

The report noted: "In general…the marginal effect in Treatment 1 (cash + SBC) is larger than in Treatment 2 (cash only), indicating that SBC has augmented the impact of cash transfers on health outcomes. This finding could have important implications for ongoing policy discussions."

Figure 1: Percentage of children (6-23 months) meeting Minimum Acceptable Diet



The full Randomised Control Trial (RCT) to assess end-line progress is currently being carried out with results due to be available in mid-2019 and this will contribute to the growing evidence base on the MCCT approach.

6. Taking the MCCT programme to state-wide level steps in Chin State

Chin MCCT was the first MCCT programme implemented with a universal, inclusive approach at a state-wide level. With high poverty and child stunting rates (plus difficulties in accessing remote, scattered populations) it was a challenging choice for taking the approach to a larger scale. This was a major development, scaling up from small scale projects to universal coverage of all pregnant women and children under 2 within a state or region.

LIFT had developed a new strategy for 2014-2018. Within this, nutrition assumed a much greater focus than it had been in the previous phase with specific emphasis being placed on reducing child undernutrition and increasing household spending on food.

During August-September 2016, DSW approached LIFT for financial assistance to start up the Chin MCCT programme. UNICEF supported this engagement, helping draw up the initial concept note, operational guidelines and the project proposal, with Save the Children's technical support, and based on their previous project operations. LIFT was able to organise the funding commitment quickly (and the later addition of two Programme support staff) and DSW began implementation of the Chin MCCT project in early 2017, reaching over 18,000 women by early 2018, with an eventual number over 30,000 across all Chin townships. TEAM MCCT – a consortium comprised of Save the Children, IRC and the Danish Red Cross, and funded by LIFT – was formed to provide technical support for the monitoring and implementing of the SBC components of the DSW Chin MCCT. Through this there was also the development of the SBCC technical task force and committee. This sought to create a bridge between MoHS and MSWRR to link with the MoHS's routine service delivery and draw upon expertise in nutrition and social behaviour change. The group managed to approve the SBCC action plan for Chin State.

[5] Save the Children and Innovations for Poverty Action 2017

The scaling up to state-wide coverage in Chin was a significant step forward. The Chin MCCT programme was driven by a strong momentum which propelled activities forward even while many critical factors were not in place at this time. An opportunistic approach was adopted by DSW, donors and partners to capitalise on the energy and momentum that had been built up; this opportunism and willingness to take risks and accept mistakes as learning became a marked characteristic of the whole MCCT story.

7. The planned expansion to other states and regions

DSW has an ambitious mid-term plan to expand the programme's geographic coverage, which started with government-funded initiatives in Rakhine and Naga. The intended expansion is summarised below and extends through to 2023.

Table 1: The planned expansion of MCCT in Myanmar states and regions by year

State/region	Fiscal Year	Funding & other contributions
Rakhine state-wide, Naga Self-Administered Zone	2017-18	Fully DSW led and funded. SBC strategy to be developed. Technical reference group involving UNICEF, Save the Children and IRC contributed to learning and recommendations from Tat Lan. Planned DSW staff exchange visit to Chin requested from LIFT to learn from experiences there.
Kayin State	2018-19	Fully DSW funded, and cash transfers have started. LIFT supporting M&E and baseline. Social behaviour change strategy for MCCT to be developed.
Kayah State	2018-19	Fully DSW funded, and cash transfers have started. LIFT supporting M&E and baseline. Social behaviour change strategy for MCCT to be developed
Shan State	2019-20	DSW contributions 20%-40%-60%-100% in coming 4 years, balance from World Bank*.Social behaviour change strategy for MCCT to be developed.
Ayeyarwaddy Region	2019-20	DSW contributions 40%-60%-80%-100% in coming 4 years, balance from World Bank*. Social behaviour change strategy for MCCT to be developed
Kachin State (possibly Sagaing & Mon)	2020-21	Fully DSW Funded. Social behaviour change strategy for MCCT to be developed. Timing for Sagaing and Mon to be confirmed
Magway Region	2022-23	Fully DSW Funded. Social behaviour change strategy for MCCT to be developed. Timing for Magway to be confirmed

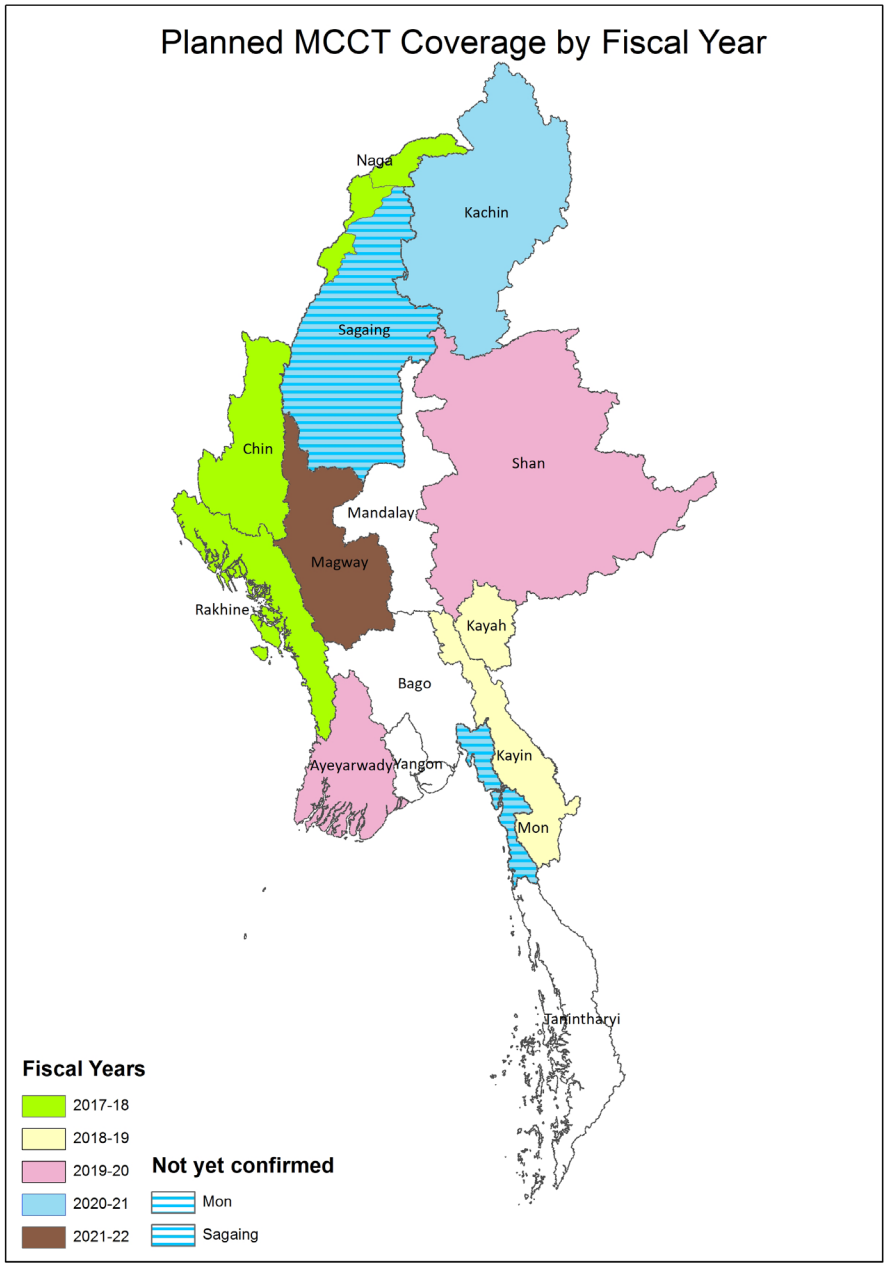
*At the time of writing discussions are ongoing with the World Bank on finalising loan funding contribution agreements for the coming years.

Map: MCCT planned expansion

As can be seen from table 1 and the map, planned growth of the MCCT is significant. The Myanmar government (through DSW) is also making substantial contributions to funding with rapid growth in their commitments.

Conclusions on achievement so far

- The global evidence on the importance of mother and child nutrition up to 24 months has been strong, along with growing acknowledgement of the importance of social protection provisions for specific groups in society.
- Multiple actors have worked in pushing for the same objectives and formed a critical mass to drive this.
- An ambitious government strategy was created, and strong leadership emerged on social protection where child nutrition featured strongly.
- The ILO was involved in the early stages in helping DSW develop and cost out the national social protection strategy. UNICEF then picked this up and along with Save the Children provided technical support to DSW in developing the strategy and providing technical guidance.
- Save the Children and IRC brought significant experience of cash transfers and stunting campaigns and successfully carried out pilot initiatives in different locations around the country and at sufficient scale to gain experience and foster confidence in this approach.
- Funding for scaling up to new states and regions has been secured from government and donor sources.
- DFID's inputs included sectoral technical expertise, a strong commitment to nutrition, plus connections with key decision makers and funding.
- LIFT provided technical expertise and a large pooled fund that was applied with flexibility and adaptability at key moments.
- Robust evidence drawn from several different contexts in Myanmar is gradually being generated and this will be critical in the coming years for continuing to improve the programme and make the case for further investment.



The next section, and the main purpose of this paper, attempts to understand what critical factors underpinned this progress. A final section looks ahead to the opportunities and challenges that remain in realising this vision.

8. What critical factors have underpinned MCCT and the drive to take it to scale?

It is important to note that whilst certain factors may only get a brief mention, many of the key steps identified often resulted from a significant investment of time and engagement by stakeholders on all sides. Reaching agreement on a shared vision for the way forward, priority setting, planning, developing systems and tools, and securing resources all took months of significant commitment and time from those actors involved.

"Pushing at an open door": Meeting national priorities

An impressive aspect of the MCCT initiative is the relative speed that a number of significant project initiatives were taken up in helping stimulate policy change and taking to scale. Typically, aid agencies set out a stepped process (at least that is how it is planned, in practice it is rarely linear and certainly not predictable). Steps often include:

1. **Identifying needs** and priorities in a particular sectoral area, as well as the most appropriate government and non-government partners to work with
2. **Designing an appropriate intervention pilot** to address this, often drawing on established learning from other contexts. This is usually at relatively small scale but with high set-up costs and is closely monitored. The intention is to test the approach, adapt and refine from learning arising, and use this to make the case for wider adoption
3. **Gathering, analysing and disseminating evidence** on performance through evaluations, research, and studies. A variety of approaches to dissemination is used to publish findings – print and online resources, key stakeholder engagements, working with the media
4. **Lobbying and advocacy** with government and other stakeholders to make the case for policy and practice changes, taking to scale and attracting further investment. The adoption of the approach in policy (and emergent practice) change is a significant success indicator

Principle government departments are often viewed as a "target" for advocacy with considerable effort expended to build relationships with key decision makers and influence government policy and practice. The MCCT initiative was more a case of "pushing at an open door," with strong drive and leadership coming from within high levels of the government, particularly from DSW.

"*This was a political decision. The previous government had made the commitment and the new government seemed to have seen this as a relatively affordable investment, and one that would be both a valuable investment in Maternal & Child health, and popular with citizens.*" Partner specialist.

Compared to the "normal" stepped approach, the MCCT drive did not wait for all findings before scaling up (most of the evidence sought from the projects is still being gathered). While this may seem surprising, there was significant global evidence and tried-and-tested experience to draw on from other countries. Ideally, specific evidence would have preceded the scale up, but this was the correct moment to act in order to capitalise on the high level momentum from both government and non-government actors.

Compelling evidence on the damaging effects of poor nutrition on mothers and infants and clear recommendations on how this should be addressed were published in the UK medical journal The Lancet in 2008. This was followed by the launch of several initiatives; notably, the global 1,000 Days campaign in 2010, the Scaling Up Nutrition (SUN) movement in 2011, and the World Health Organisation targets on mother and child nutrition in 2012, all powerful sources of inspiration. In 2013 the Transfer Modality Research Initiative was tested in Bangladesh and found a 7.3% decrease in child stunting was observed when cash transfers were combined with nutrition behaviour change support.

Leadership and high-level endorsement

Senior DSW staff, in particular the Director General and the Director of the Social Protection Section, under the leadership of the Union Minister, undoubtedly played the most important and critical roles in driving the programme forward and establishing the right conditions. Both these leaders brought strong personal interest in MCCT and a commitment to engage with stakeholders to take it to scale.

In early 2017, the strategy received a major boost. That January the State Counsellor chaired the first ever National Coordination Meeting on Nutrition in Pakokku, Magway. The meeting brought together senior stakeholders to discuss how nutrition issues could be addressed with a more coordinated, national approach across sectors. This was attended by five government ministers (Health and Sports, Social Welfare, Relief and Resettlement, Education, Religious Affairs, and Agriculture, Livestock and Irrigation), six donor countries, six UN agencies, the World Bank and Non-Government Organisations. This meeting would eventually lead to the development of the Multi-sectoral National Plan of Action on Nutrition (MS-NPAN 2018-2023). The State Counsellor also visited the MCCT project in Kyee Village on 25 January 2017 (part of the LEGACY project), facilitated by DFID, LIFT and Save the Children, and spent time with beneficiary women. At this visit she stated:

"*Nutrition is the lifeblood of children. According to research, under-twos will see more brain development when they have had better nutrition. Nutrition helps make stronger children and boosts development. Ministries, regional governments and philanthropic organisations help child nutrition programmes. But participation is a must for both parents. The government has the responsibility to help parents in developing their offspring. Today I told the health minister to educate people on how to find affordable protein.*"[6]

Resource contributions at critical points

The NSPSP noted that to deliver the full range of planned initiatives would take 5-7% of GDP, a significant increase from previously available resources. It is not unusual for government departments in any country to develop thoughtful and ambitious strategies on a particular issue and find that despite the strength of their case, the realities of funding limitations frustrates the initiative, leaving the strategy under-funded and unable to meet its objectives. The ability of the MSWRR to secure significant increased government funding for MCCT (amongst multiple priorities for the government) is a major success. It appears there was growing awareness that Myanmar's work in this area was lagging behind regional neighbours and that there was sufficient confidence built up on the effectiveness of MCCT interventions to make the case for further investment. This was helped at a critical time by funding commitments (and two support staff positions) made by LIFT to enable the Chin scale up. At the time of writing, the World Bank is planning loan commitments for MCCT expansion into other states. The successful securing of resources appears to not only have met funding needs and filled gaps in provision, but built confidence and provided reassurance to stakeholders on all sides that the drive to scale up MCCT was not being shouldered by donors or by DSW alone.

A Pragmatic Approach

The pressure to take the programme to scale brought obvious capacity, planning, logistical and fund management challenges. There was a greatly increased caseload expanding into new areas of the country (in Chin this meant reaching more remote areas and scattered populations). The number of available DSW staff was limited – particularly at field level – as was experience with an MCCT approach. The same challenges of reaching remote areas extended to the MoHS as well, as some villages covered by the programme had no access to health professionals or volunteers to support SBC. Systems had not been developed to manage budgets and staff and provide effective direction, coordination and monitoring between union, state/region, township and field levels. These were critical concerns amongst stakeholders as the programme expansion started gaining pace. There was only limited learning available from the project experiences at the time. Several stakeholder experts mentioned that a pragmatic and risk-tolerant approach was adopted. There appeared a general feeling of "going with the energy" and opportunities emerging from the DSW drive from the supporting organisations, such as LIFT, Save the Children and UNICEF. One former LIFT staff member felt that in order to maintain momentum, partners "positioned themselves as practical and positive support providers, and built on the strong ownership and political momentum, rather than applying a technically pessimistic lens to the programme…" despite concerns about the pace of expansion and capacity to carry it out successfully (see next section).

This combination of a clear national strategy, political commitment, available resources (funding and technical assistance), the appetite for risk-taking, and a pragmatic approach proved to be the correct set of factors to drive the progress of the programme so far. If any of these factors had not been in place, progress would in all likelihood not have happened, or at the very least would have been considerably slower.

[6] https://scalingupnutrition.org/news/aung-san-suu-kyi-launches-campaign-to-tackle-malnutrition-in-myanmar/

9. Looking ahead: key issues for consideration

There are some significant challenges for DSW and its collaborators that will need careful consideration in the coming years.

Determining Programme Priorities
The global evidence and the emergent available evidence from Myanmar demonstrates the value of a combined package of SBC and cash support to achieve an impact on nutrition outcomes. There is an opportunity for the MCCT programme to leverage the existing investments and technical expertise of both DoPH and DSW to improve SBC initiatives in both departments to achieve maximum impact on nutrition outcomes. A clear commitment to nutritional outcomes requires collaborative efforts across ministries specifically involving the National Nutrition Centre and the Health Literacy Promotion Unit (both part of the DoPH) together with DSW, as is laid out within the Multi-Secotr National Plan of Action for Nutrition. Identifying clear roles, potential funding allocations, resources and the sharing of expertise and skills will go a long way towards ensuring that nutrition goals are met.

Making sure we can walk before we run
MCCT has seen rapid expansion in a short period of time. However, staffing and systems capacity, along with communication and coordination mechanisms, have not been developed at the same pace. In order to see the development of an effective scaling up to national level, there are several factors that need urgent attention.

a. Ensuring long term investment and staff capacity to successfully run the growing programme

DSW capacity at the Nay Pyi Taw level in programme management remains stretched by other demands and limited by staff and budget constraints. State/Region and Township level capacity and coverage are not yet at a required level either. There will be a continuing need to build managerial, financial and technical capacity to manage service delivery. The limited financial management capacity to handle significantly increased funding flows, along with internal ministry rules, do not make it easy to devolve responsibilities to the field. This creates delays and difficulties for local teams.

Field level capacity: Experience from the HelpAge projects on social pensions showed that a considerable level of voluntary assistance was provided by community and local administrators to ensure payments were made to the older people (eg. family and friends travelling to receive payments for older people unable to travel, and GAD administrators taking payments to villages for collection). Despite this, evidence from the projects so far showed that leakage was very low. These are laudable contributions, but an approach that relies heavily on volunteer contributions would be severely tested to take such initiatives to a much larger scale. MCCT has faced similar shortages of dedicated staff at field level allocated for the programme. The Chin MCCT programme also showed that there is a strong need for greater field level coverage from MoHS. Limited resources have resulted in some villages not having access to any suitable health facilities, midwives or even health volunteers.

One of the planned flagships of the NSPSP is to build an integrated Social Protection system to ensure **social worker presence** at township level. This could be an important step going forward as DSW has limited numbers of township level staffing. DSW Case Managers in the Chin State programme were intended to take on a social worker role. In practice, however, these staff were involved mainly with cash transfers, but a pragmatic decision was made to make use of this capacity to get MCCT work moving.

In addition, ensuring staff have the essential support to carry out their work is important for achieving full coverage. For example, it will be important to ensure that field staff have sufficient training and support to carry out their work and cover expenses. Some stakeholders also suggested that an approach of rolling training (not one-offs) be adopted to acknowledge the realities of staff turnover, redeployments and IT refreshers.

Ensuring **operational costs** for sufficient staffing for MCCT (and other SP initiatives) going forward is also critical. In the short term this looks likely to continue to be supported with matching contributions from donors but in the long term, government resources will be essential for sustainability when donor funds phase out.

Determining the Most Effective Approaches for implementation: A study is needed to compare the approaches and effectiveness of different SBC and cash delivery modalities. This could strengthen understanding of which approaches are likely to have a positive impact on behaviour and household expenditure on nutritious foods and ease of access for beneficiaries. This could also potentially simplify the process for field level staff and mainstream cash and SBC.

b. Adopting technology for strong monitoring and efficient payment systems

Management Information Systems (MIS) development has been slow and this remains a critical shortfall for data collection and management, and informing decision making as the scale of coverage expands. Provision of IT equipment and staff training in systems would also be essential to ensure successful data management.

Even if looking at only MCCT and the intended expansion of older person's pensions and disability payments together, there is potential for system development to improve efficiency at Nay Pyi Taw through to township and local administration levels for the range of planned Social Protection initiatives. An added advantage is in the event of an emergency occurring in a particular area, having a reliable, up-to-date database of groups such as mothers of under-2 children, pensioners and those with disabilities would be a valuable starting point for relief efforts seeking to target community groups likely to be most in need of assistance.

Exploring Mobile Money transfer options: Experience from Save the Children's work in the Delta (plus a HelpAge pilot initiative in older person's pensions) showed that this could be effective at scale. However, one of the key constraints is the lack of available local pay points in the more remote areas. In the short term, there is plenty of scope for testing mobile transfers at scale in certain areas and retaining provision for physical cash deliveries in areas where this is not yet appropriate. Note that any mobile transfer system would benefit greatly in terms of efficiencies from the creation of an MIS system as noted above.

In the course of interviews with MoHS midwives who had been involved in supporting the MCCT project, Save the Children suggested the potential for many advantages of mobile cash transfers, including reducing risks around corruption, and better personal security of staff not having to carry round large sums of cash. However they stressed the importance of ensuring an incentive for mothers to meet face to face with health professionals regularly as this was vital for monitoring progress and providing advice. One suggestion for a way forward was to trigger cash transfers once a regular meeting had taken place, although this would need to factor in cases where women are not able to travel to meet the health professional (eg. due to illness, being in hospital).

Technology for SBC: One underexplored area is the capacity for technology to improve SBC interventions. Appropriate use of technology can reduce costs and complement physical interactions, but importantly should not replace them. Currently the MayMay app by KoeKoe Tech delivers timed communications to mothers about health and nutrition and connects them with local health facilities, but this requires the mother to have access to a smart phone. Media such as radio could be used as another method of communicating positive health-seeking behaviours. These areas should be explored more.

c. Strengthening relationships and cooperation amongst stakeholder groups towards shared goals

Some of these points relate to operational costs and capacity discussed above. Cross-Ministry collaboration in Myanmar is often challenging and would benefit from initiatives that would streamline and facilitate joint action. In the context of MCCT, the principle Ministries and departments where improved engagement should be built are between the MSWRR and MoHS, or more specifically, between the DSW and DoPH. These departments need to collaborate at both a national and field level to best meet MCCT nutrition goals. There is also the Social Protection Committee, chaired by one of the Vice presidents that can support on this. Field staff from the GAD have supported the old age pension initiative and the Chin MCCT and may be well placed to take up a more officially mandated role in supporting administration of social protection payments.

There is also a need for improved coordination between UN organisations and other development organisations working towards the same goals so that support is coherent and maximising efficiencies. (ie. World Bank, Save the Children, UNICEF, LIFT)

Ensuring sensitive planning for expansion into conflict affected states

Planned coverage expansion into states and regions where Ethnic Armed Organisations run the local administration will require some careful thought and planning. Whilst support for mothers and children are amongst the least contentious interventions, there is a risk that non-state actors will see an expansion of MCCT as one of government influence encroaching on their territory. Collaboration with Ethnic Health Organizations will be necessary for areas not directly reachable by Government.

MCCT Timeline: