SOCIAL AND BEHAVIOUR CHANGE FOR NUTRITION IN MATERNAL AND CHILD CASH TRANSFER PROGRAMMES

Lessons for Policy and Programming in Myanmar

Livelihoods and Food Security Fund

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ACRONYMS

A2H	Access to Health Fund
AMW	Auxiliary Midwife
ANC	Antenatal care
Bright SUN	Building Resilience, Synergy and Unity for Nutrition Project
CHW	Community Health Worker
CHV	Community Health Volunteer (AMWs and CHWs)
COS	Community Outreach Support
DoH	Department of Health
DRC	Danish Red Cross
DSW	Department of Social Welfare
ECT	Electronic Cash Transfers
GAD	General Administration Department
GoUM	Government of the Union of Myanmar
HLPU	Health Literacy Promotion Unit
IPA	Innovations for Poverty Action
IRC	International Rescue Committee
LEGACY	Learning, Evidence Generation, and Advocacy for Catalysing Policy Project
LIFT	Livelihoods and Food Security Fund
MAM	Moderate Acute Malnutrition
MCCT	Maternal and Child Cash Transfer
MMK	Myanmar kyats
MNMA	Myanmar Nurses and Midwives Association
MoHS	Ministry of Health & Sports
MS-NPAN	Multi-Sectoral National Plan of Action for Nutrition
MoSWRR	Ministry of Social Welfare, Relief & Resettlement
MtMSG	Mother to Mother Support Group
MW	Midwife
NNC	National Nutrition Centre
NSPSP	National Social Protection Strategic Plan
PDM	Post distribution monitoring
PGMF	Pact Global Microfinance
PNC	Postnatal care
RCT	Randomised Controlled Trial
SBC	Social and Behaviour Change
SBCC	Social and Behaviour Change Communication
SBCC-NPAN	Social and Behaviour Change Communication – National Plan of Action for Nutrition
SCI	Save the Children International
SHD	State Health Department
Tat Lan Project	Tat Lan Sustainable Food Security and Livelihoods

TEAM MCCT	Technical Assistance to the Ministry of Social Welfare, Relief and Resettlement's Maternal and Child Cash Transfer
THD	Township Health Department
VDC	Village Development Committees
VCSW	Volunteer Community Social Worker

EXECUTIVE SUMMARY

Using available data and insights from LIFT-funded programmes as well as global evidence, this paper examines how the provision of cash and social and behaviour change (SBC) interventions, alongside the provision of routine health services can be leveraged for positive nutrition outcomes in maternal and child cash transfer (MCCT) programmes. Targeted to pregnant and breastfeeding women and children under two years old, Myanmar's MCCT programmes are social protection programmes that transfer cash to pregnant and breastfeeding women to support positive nutrition and health outcomes during the critical window of opportunity known as the First 1,000 Days. By design, women are provided not only with a monthly financial stipend, but are also supported through social and behaviour change approaches to adopt positive health and nutrition behaviours.

One important finding of a number of cash transfer intervention studies in Myanmar and elsewhere is the fact that cash alone has some impact on nutrition, but unreliably so. This important fact reveals that something more than cash is required to ensure that these programmes 'work' for nutrition. While cash is certainly a versatile and useful intervention tool for improving child nutrition, accumulating evidence reveals that certain other programme design elements, including an SBC element, must be in place for it to work.

Cash distribution-- even if highly targeted to a vulnerable population such as women and children during the First 1,000 Days-- is not necessarily sufficient to have an impact on nutrition. It is critical to enhance the ways that cash supports nutrition. This is done by (1) pairing cash with innovative, culturally-relevant and effective SBC approaches, (2) ensuring that strong linkages exist connecting beneficiaries with health services, and (3) ensuring that programme design characteristics enable women to adopt positive behaviours and use the cash productively.

LIFT-funded programmes, particularly the MCCT project in Myanmar's Dry Zone, have contributed to the global evidence base for 'what works' in MCCT programmes. We know, for example, that MCCT programmes that combine cash distribution during the First 1,000 Days with SBC and improved access to health services can improve a number nutrition behaviours and achieve meaningful reductions in stunting.

Despite a number of successes, there remain opportunities for improvement. Upon reviewing available evidence, including global research, programme data from LIFT-funded interventions, and in-depth interviews with key stakeholders, ten key areas have emerged as priorities for joint action and programme improvement. The following

recommendations are relevant to the Ministry of Social Welfare, Relief and Resettlement (MoSWRR), the Ministry of Health and Sports (MoHS), LIFT, the Access to Health fund, donors, supporting UN agencies and civil society. They relate to improving collaboration and coordination, strengthening programme strategy, improving the effectiveness of SBC modalities, harnessing cash for nutrition outcomes, and improving monitoring and learning:

Improving collaboration and coordination

1. **Foster broader participation and investment in SBC work by multiple partners to support nutrition-specific and nutrition-sensitive behaviours.** Nutrition-sensitive approaches both in and outside the health sector are critical to addressing the problem of undernutrition in Myanmar. Increase the MCCT programme emphasis on nutrition-sensitive behavioural domains related to WASH, women's empowerment/decision making, financial literacy and other priority areas identified in formative research. Partners have unique and complementary roles to play in addressing the multiple factors contributing to undernutrition.
2. **Engage in, and provide resources to support, the forthcoming community health volunteer policy.** In addition to strengthening capacity nationally in SBC approaches, ensure that MCCT linkages to health services are sound and that the health workforce is sufficient and has the capacity to support the delivery of nutrition interventions. Community health volunteers, which include community health workers and auxiliary midwives, are the government's frontline healthcare workers. This volunteer cadre is foundational in providing the interpersonal communication needed for behaviour change to happen in the Myanmar MCCT context.
3. **Work with the government to agree upon a common government-led model with standard operating procedures or protocols, standard job aids and learning tools with a training curriculum, guided by a central MCCT strategy and inter-ministerial coordination mechanism.** Current State/Region-led 'action plans' are important, but insufficient. In light of a common government-led model, these action plans can be adapted to the geographic, social, and political realities of different states and regions. However, overall guidance from the central level is critical.

Strengthening programme strategy for improving nutrition outcomes

4. **Identify opportunities for synergy and collaboration between the forthcoming development of the Social and Behaviour Change Communication National Plan of Action for Nutrition (SBCC-NPAN) Strategy and the national MCCT programme.** The MCCT is an important platform for national SBCC efforts and should be

included in the national SBCC-NPAN Strategy; likewise, the SBCC-NPAN Strategy should take the MCCT programme's needs, progress, and delivery platforms into account in order to develop a stronger strategy.

Improving the effectiveness of SBC modalities for better programme quality

5. **Align the methodology of SBC approaches with global best practices in order to implement high quality SBC.** This includes following the required steps of the SBC process in order to conduct meaningful SBC. Use national platforms, including the Multi-Sectoral National Plan of Action for Nutrition (MS-NPAN) and the SBCC-NPAN Strategy, to promote higher standards for SBC programming. Partners should agree upon common definitions of SBC terminology and approaches.
6. **Facilitate the use of formative research to develop strategies and inform future programme design.** Many programmes are lacking in formative research to inform their approaches. This is a critical step in the design of effective SBC programming. Government and partners should collaborate to agree on common, acceptable research methods and processes that are streamlined, as well as options for fast-tracking approval.
7. **In addition to targeting the beneficiary population in MCCT programmes, support meaningful involvement of those who influence them (such as husbands, grandmothers, religious leaders, etc.).** Civil society plays a valuable role in collaborating with the government to reach keasdfhe community.

Harnessing cash for nutrition outcomes

8. **Capitalise on mobile technology and other innovative platforms to allow SBC approaches to be implemented at scale.** Mobile payment and the use of mobile phone as an SBC modality should not be considered separately, but rather should be part of an integrated package. Diversifying interventions to reach mothers and their children through multiple, layered channels is crucial to achieving behaviour change. While mobile technology can not replace human interactions, it is a powerful tool

Improving monitoring and learning

9. **Continue to engage in operational research, particularly to better understand the strengths and weaknesses of various modalities for behaviour change.** Questions related to activity quality, frequency, exposure, effectiveness and value for money need to be explored in order to understand the comparative advantages of different modalities. The paucity of evidence on specific behaviour change modalities for nutrition in Myanmar presents a rationale for larger investments and advance planning for research, with key indicators to measure effectiveness. To support positive nutrition outcomes in the First 1,000 Days, adhere to those lessons that have already been learned from Myanmar and global evidence: pair cash with SBC for maximum nutrition impact, link cash

distribution to health services, distribute cash unconditionally in the Myanmar context where supply services are inadequate, and deliver cash in small, monthly payments to ensure they are used by women for health and nutrition expenses, among other lessons learned. These are outlined in the following two sections: LIFT-Funded MCCTs: What Have We Learned About SBC Programming? and The impact of cash + SBCC on nutrition outcomes: Evidence from Myanmar MCCT Programmes

10. **MCCT programmes have a strong track record of monitoring the cash distribution component of the programmes; the SBC component should be monitored with the same rigour.** Because behaviour change is a process that is incremental, measuring the target population's progress along behaviour change pathways is critical. Post-distribution monitoring needs to be strengthened to track the uptake of key behaviours, following the example of the 2018 Chin State MCCT monitoring round. Pathways to priority behaviours should be identified and tracked in order to monitor their adoption.

INTRODUCTION

While Myanmar has seen a number of improvements in maternal and child health and nutrition over the past ten years, a number of the country's women and children continue to suffer from poor health and nutrition. Child stunting rates have dropped from 2010, but are still high at 29 per cent nationally. In certain pockets of the country, and among certain vulnerable groups, rates are much higher. For example, the average rate of stunting among children under five in Chin State is 41 per cent. Six in ten children in Myanmar (58 per cent) and just under half of women (47 per cent) are anaemic, and one in ten children does not live until the age of five.[1] Finding ways to maximize the impact of limited resources for better maternal and child health and nutrition is critical.

Evidence from Myanmar and elsewhere tells us that greater impacts on child nutrition are seen when cash transfer interventions are paired with behaviour change interventions.[2] Using available evidence and insight primarily from LIFT-funded programmes, this paper reviews social and behaviour change (SBC) approaches and interventions within the context of maternal and child cash transfer (MCCT) programmes. This paper will subsequently explore how these SBC interventions in MCCT programmes can best link to Myanmar's nutrition and social welfare initiatives, strategies and services in order to impact on nutrition outcomes in Myanmar. While many SBC approaches and modalities include a communication element (hence the term social and behaviour change communication- SBCC) this is not always the case, and therefore the broader term SBC will be used throughout this paper.

Social and behaviour change (SBC) is an apporach to programming that applies insight about why people bahave the way they do, and how behaviours change within wider social and economic systems, to affect positive outcomes for and by specific groups of people (SPRING 2017). Nutrition SBC aims for social and individual bahaviour changes that improve nutrition outcomes for priority groups.

Nutrition social and behaviour change communication (SBCC) is a set of interventions that combines elements of interpersonal communication, social change and community mobilisation activities, mass media, and adovcacy to support individuals, families, communities, institutions, and countries to adopts and maintain high-impact nutrition-related practices. Effective nutrition SBCC seeks to increase the factos that encourage these behaviours while reducing the barriers to change (USAID 2017).

1. DHS 2015/6
2. IPA 2019, Ahmed 2019

The objectives of the paper are two-fold. The first objective is to present existing evidence and results of MCCT interventions, including cash distribution and SBC activities, on nutrition outcomes in Myanmar. The second objective is to analyse the nutrition components of the MCCT, drawing on lessons and evidence to inform a sustainable model for future government-led MCCT programmes. This involves identifying key recommendations that will both inform the overall strategy for supporting the rollout of the government-led MCCT in new regions; and support relevant departments at the state/regional level (Department of Social Welfare, State Health Department, Township Health Department) and at the national level (Department of Social Welfare, National Nutrition Centre, Health Literacy Promotion Unit), as well as development stakeholders collaborating with the government.

Methodology

This report draws conclusions from both local and global secondary data and reports, as well as primary data collected through interviews with key stakeholders. A series of reviews were first conducted to understand the landscape of the issue.

Most of the information is derived from a review of models and available evidence, including programme design and strategy documents, materials, post-distribution monitoring data, mid-term reports, endline reports, mid-term project evaluations and final project evaluations from LIFT-funded projects in Myanmar's Ayeyarwady Region (Delta), Rakhine State, Chin State, and the Central Dry Zone. In particular, this includes a review of the LIFT-funded Dry Zone MCCT randomised controlled trial (RCT). Additionally, the author reviewed meeting minutes from Monitoring, Evaluation and Learning (MEAL) & SBCC Committee and Task Force meetings. The SBCC Committee is led by the Department of Social Welfare housed in the Ministry of Social Welfare, Relief and Resettlement (MoSWRR) and the technical Task Force is led by the Health Literacy Promotion Unit (HLPU), housed in the Ministry of Health and Sports (MoHS).

Additionally, this report is informed by interviews conducted with key stakeholders, participants and experts including National Nutrition Centre (NNC), Health Literacy Promotion Unit (HLPU), the Township and State Health Departments (THD and SHD) in Chin, the Department of Social Welfare (DSW) national and Chin State teams, MCCT NGO implementing partner Save the Children International, programme participants, World Bank, Alive & Thrive and UNICEF. Please see Annex 3 for a list of interviews and meetings with key informants and stakeholders.

Myanmar MCCT background

Maternal and child cash transfer programmes in Myanmar are social protection programmes that transfer cash to pregnant and breastfeeding women of children aged under two to support positive nutrition and health outcomes during the critical window of opportunity known as the First 1,000 Days. The period from conception until a child's second birthday, which lasts approximately 1,000 days, is one when the body and brain of a child develop at an incredibly fast pace. As a result, humans are most vulnerable to any nutritional deficits during this period.[3] By design, women in the MCCT programme are provided not only with a monthly financial transfer, but are also supported through social and behaviour change interventions to promote the adoption of positive health and nutrition behaviours.

This paper reviews SBC for nutrition approaches and outcomes of MCCT programmes fully or partially funded by the Livelihoods and Food Security Fund (LIFT), a multi-donor fund in Myanmar managed by UNOPS, which has received funding from 15 international donors since it was established in 2009. LIFT's aim is to strengthen the resilience and sustainable livelihoods of poor households by helping people to reach their full economic potential. This is achieved through increasing incomes, improving the nutrition of women and children, and decreasing vulnerabilities to shocks, stresses and adverse trends. After piloting MCCT programmes in Myanmar with NGO implementing partners, LIFT has strategically shifted towards financially and technically supporting the Government of the Union of Myanmar (GoUM) to conduct MCCT programming.

In Myanmar, LIFT has funded MCCT programmes since 2014. LIFT supported three MCCT projects led by Save the Children International (SCI) in the Delta, Dry Zone and Rakhine, with the aid of implementation partners to improve nutrition outcomes for mothers and children through the delivery of nutrition-sensitive cash transfers to pregnant women during their First 1,000 Days. Since March 2017, LIFT supported the government-led MCCT Programme in Chin State. In 2019, LIFT also began funding operational costs and a baseline survey on nutrition indicators for programmes in Kayin and Kayah States through the Ministry of Social Welfare, Relief and Resettlement.

Currently the Government of the Union of Myanmar (GoUM) is operating public- and donor-funded MCCT programmes in four of Myanmar's 14 states and regions. Programmes are ongoing in Rakhine, Kayin, Kayah and Chin States, in addition to the Naga Self-Administered Zone. Programme expansion in Shan State and the Ayeyarwady Region are planned to

3. Martorell 2017 and Cusick 2016

begin in mid-2020 through the Maternal and Child Cash Transfers for Improved Nutrition Project, which is financed by the MoSWRR through the World Bank/International Development Association credit of US$100 million. The MoSWRR also plans to seek a budget from GoUM to expand the programme into Kachin State by 2020, Sagaing Region by 2021 and Magway Region by 2022.

In 2019, LIFT published Taking pilots to scale in child nutrition: The Story of the Maternal & Child Cash Transfer Programme. This learning paper provides additional information on the development of the government's MCCT programme, including the history of the programme, what progress has been made to date, critical factors contributing to that progress and remaining challenges. Additionally, at the time of writing this paper, UNICEF is in the process of collaborating with the DSW to conduct a formative evaluation on MCCT programmes in Chin and Rakhine States in order to improve the design of the intervention by understanding what works, what does not, and the factors behind performance.

Furthermore, Save the Children, the lead implementing partner for three LIFT-funded MCCT programmes in the Dry Zone, Delta and Rakhine, developed a comprehensive paper that draws on lessons learned from their three LIFT-funded MCCT programmes: ***Social and Behaviour Change Communication with Maternal and Child Cash Transfers in Myanmar:***

MCCT INITIATIVE & POLICY CONTEXT IN MYANMAR

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Lessons **Learned from Tat Lan, LEGACY and Bright SUN Programmes.**

The MCCT fits under the country's broader nutrition programming and objectives, outlined in both the Multi Stakeholder-National Plan of Action for Nutrition (MS-NPAN) and under the National Social Protection Strategic Plan (NSPSP). Explicit support from the highest levels of government, donor financing and a proactive MoSWRR have contributed to the particularly rapid pace of programme expansion.

The MCCT programme is part of the GoUM's National Social Protection Strategic Plan (NSPSP) as one of the eight flagship programmes designed to ensure social protection throughout the life cycle. Rooted in the principle of universality and equity, these programmes support the delivery of benefits to "all citizens or inhabitants falling into a specific category of the population." In the case of the MCCT, the programme supports all pregnant women and mothers of children under two years of age (during the First 1,000 Days) to have improved practices on nutrition, Infant and Young Child Feeding (IYCF) and health seeking behaviours in order to achieve improved nutritional outcomes for mothers and children during the First 1,000 Days. The provision of cash allows beneficiaries to improve their dietary diversity, afford basic healthcare during pregnancy (antenatal care) and birth, improve feeding of young children, and afford basic healthcare during early childhood (newborn care, postnatal care, immunisation, well-child care, and sick-child care). By design, the monthly stipend of MMK 15,000 (USD 10) is sufficient in size to facilitate ongoing health and nutrition purchases, but small enough not to be diverted for other uses. Alongside cash, an SBC approach has been promoted to support the adoption of nutrition, health and hygiene behaviours. The purpose of this is to ensure that women and children receive the care and nutrition they need, and to enhance their access to available services.

The MoSWRR's NSPSP, endorsed in December 2014, outlines eight flagship programmes that aim to provide support through the lifecycle to break the cycle of poverty. The child-sensitive strategy, citing international evidence, points out that the return on financial investments is highest at the youngest ages, as meeting children's basic needs sets a foundation for later success in life. The first of these eight flagship programmes is the MCCT. The MCCT's primary outcomes are nutritional, with strong global justification for the investment in nutrition during the First 1,000 Days as a smart economic investment. Global evidence shows that sub-optimal nutrition during the first 1,000 days can lead to stunting, which is largely irreversible after a child turns two. This, in turn, leads to an

intergenerational cycle of poor growth and development where women who were themselves stunted in childhood go on to have stunted children. As a result, future generations are at a disadvantage from the start of life.[4] The First 1,000 Days are referred to as the 'window of opportunity' when good nutrition can help a child attain their full physical, cognitive and behavioural potential. According to the 2018 Global Nutrition Report, all forms of malnutrition cost the global economy an estimated USD 3.5 trillion per year, or USD 500 per individual due to losses in economic productivity and higher health costs. Experts participating in The Post-2015 Consensus assess that stunting costs Myanmar somewhere between USD 2 billion and USD 6 billion every year due to lost opportunities and high health costs.

The MoSWRR is the lead agency managing the MCCT Programme in Myanmar, though their success depends on successful collaboration with partner ministries MoHS and the General Administration Department (GAD), now housed in the Ministry of the Union Government Office. With the exception of the World Bank/ International Development Association (IDA)- funded Ayeyarwaddy and Shan States, the GAD is responsible for regular cash distribution to beneficiaries through their national network of village administrators at the village level. In areas that are not under government control as in Kayin and Kayah States for example, as well as in some parts of Kachin and Shan States, ethnic health organisations (EHOs), rather than the GAD, support the rollout of the MCCT. The MoHS—through the Department of Public Health (DoPH) and the HLPU—is the implementing partner responsible for provision of routine health and nutrition services and for supporting **the delivery of nutrition information and counseling**; at the community level this includes community-based health and nutrition sessions in most MCCT areas. The MCCT's nutrition objectives and activities are consistent with the MoHS' Community Infant and Young Child Feeding (CIYCF) efforts, which includes a package of tools for programming and capacity development on community based IYCF counselling. Additional activities include IYCF support groups.

The MCCT, though led by the MoSWRR, also features in the MoHS-sponsored Multi- Sectoral National Plan of Action for Nutrition (MS-NPAN), which is a collaborative plan that recognises the contribution of different sectors to nutrition through their relevant line ministries. The overall goal of the Myanmar MS-NPAN is: "to reduce all forms of malnutrition in mothers, children and adolescent girls with the expectation that this will lead to healthier and more productive lives that contribute to the overall economic and social aspirations of the country." The MS-NPAN focuses particularly on improving the nutritional well-being of the most vulnerable groups in the First 1,000 Days in order to have the greatest eventual impact

4. Smith 2000

on the nation's economic and developmental goals. Under the MS-NPAN, MoHS commits to leading counselling sessions targeted to recipients of the MCCT to complement social protection efforts. Also included are monthly awareness-raising sessions led by midwives or auxiliary midwives, on a number of topics related to improved nutrition outcomes, including health, WASH and early childhood care and development.

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LINKAGES WITH THE HEALTH SYSTEM: THE ROLE OF HEALTH SERVICES PROVISION

MYANMAR'S MCCT PROGRAMME COMPONENTS: HOW THEY WORK

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MCCT programmes in Myanmar include two main components: monthly cash distribution and nutrition SBC alongside government provision of basic health and nutrition services. In both government and NGO-implemented programmes, these cash and SBC components are linked to health services provided by the Ministry of Health and Sports. **Over time, conditions which link the programme to the health system have been shifting from soft (encouraged practices) to hard (required practices in order to receive the transfer).** In a context where families have a number of competing needs, the Myanmar MCCT programmes were designed to encourage beneficiaries to spend the cash stipend on expenses that will improve the health and nutrition of themselves and their children. The decision to target women and their children during the First 1,000 Days as programme beneficiaries, the registration process (requiring beneficiaries go to a midwife for antenatal care to get an ANC card), the quantity of the cash transfer, and the frequency of cash transfer, are all programme design characteristics intended to increase the likelihood that **beneficiaries will seek health services** and that cash will be spent on nutrition, health and hygiene expenses for the beneficiary pair.

Annex 1 includes a table with descriptions of programme components in past, current and forthcoming MCCT programmes in Myanmar.

Cash component – Myanmar modalities

The modalities for cash distribution differed slightly across programmes in Myanmar. Save the Children first began delivering cash to beneficiaries in Rakhine State for nutrition security through the Tat Lan I Project (pilot version) and Tat Lan II to subsidise the purchase of diverse and nutritious food and health care for the mother-child pair. Cash was distributed by programme staff with the involvement of village development committees and community volunteers. The monthly transfer amount of MMK 10,000 (USD 7) was informed by a cost of diet analysis to assess affordability of a nutritious diet. Later, following the government's lead, all LIFT-funded MCCT programmes increased the cash benefit to MMK 15,000 (USD 10) per month.

Due to the logistical challenges of cash distribution in remote and mountainous areas when the Department of Social Welfare started its first MCCT Programme in Chin State, they distributed MMK 15,000 (USD 10) per month to each beneficiary pair. However, the cash was

distributed once every two months. Kayin and Kayah have bi-monthly distribution for the same reason. The government proposed transitioning the frequency of all cash distribution to beneficiaries to once every three months (as is happening currently in Rakhine State and the Naga Self-Administered Zone) for logistical ease, however beneficiaries in Chin, Kayah and Kayin requested that the government maintain the two month frequency of distribution.

The LIFT-funded LEGACY Project in the Dry Zone, implemented by Save the Children, distributed cash through PACT Global microfinance (PGMF) agents; each mother had an MCCT account and mothers choose how much they wanted to withdraw from the account. An additional pilot tested cash delivery through Myanmar Nurse and Midwife Association (MNMA). MNMA transferred cash to the township health department, which would distribute the cash through its network of midwives on a monthly basis.

The LIFT-funded Bright SUN Project in the Ayeyarwady Region in Myanmar's Delta agro-ecological zone piloted electronic cash transfers through WAVE Money. In this pilot, 63 villages were piloted for mobile cash transfer while the remaining 139 villages continued to conduct manual cash transfers through volunteers. In e-payment villages, the Delta MCCT provided low-cost phones to about 20 per cent of mothers who did not have access to a phone. Enrollment and cash distribution was first delivered through Village Health Committee volunteers at Rural Health Centers, but then MCCT-Focal Groups were created to supervise the MCCT programme in villages.

In contrast to the above-mentioned models implemented by Save the Children in the Dry Zone, Delta and Rakhine State, government MCCT programmes in Chin, Naga, Rakhine, Kayin and Kayah distribute cash through the GAD. In order to fulfill the DSW's commitment to universality and to reach all eligible beneficiaries, Ethnic Health Organisations (EHO) distribute cash instead of the GAD in those areas under ethnic armed organisations' (EAO) control.

The government plans to adopt electronic cash transfers in those areas where it is feasible. Given the limitations of national banking and telecommunications infrastructure, much of the country, however, will continue to receive manual payments through the GAD in the near future. The future of Myanmar's MCCT will likely involve shifting payment to third party vendors, however, and where possible these will certainly involve mobile payments.

There are a number of benefits of shifting to mobile payments, however inevitably there will be challenges in the transition to an electronic system. Lessons can be learned from the challenges faced by the Delta MCCT

when it piloted Wave Money in place of physical cash distribution. Some of the main challenges included the fact that some participants did not own or have access to a phone, limited telecommunications infrastructure, low penetration of shops which serve as mobile cash payout points, and reduced participation in SBCC sessions, which were held at cash distribution points. The potential benefits of electronic cash distribution include greater system efficiencies, eliminating risk to those carrying large amounts of cash, transparency, flexibility for beneficiaries to pick up the cash at a convenient time, and a platform for innovative communication for behaviour change.

Understanding the SBC Process

Achieving optimal maternal and child nutrition depends upon people adopting certain evidence-based positive behaviours. Understanding why people do or do not practice a certain behaviour creates challenges and opportunities for nutrition programming. Many maternal and child nutrition interventions fail to improve nutrition because they are based on incorrect assumptions about why people do or do not not practice a certain behaviour, whether it be exclusive breastfeeding for the first six months of a child's life, or eating food from the four government-recommended food groups every day (energy-giving foods, protective foods, body-building plant-based foods and body-building animal-based foods). Often programmes operate with objectives including "increasing awareness" or "increasing knowledge on" certain topics, assuming that as long as one knows something, this will lead to positive behaviour change. Unfortunately, behaviour usually does not change this easily. Evidence suggests that simply increasing knowledge and awareness of good nutrition practices does not necessarily lead to sustained behaviour change.[5] Rather, a successful intervention needs to address the most important factors, including knowledge, attitudes and beliefs and/or the social, economic, and political environment, that influence behaviours. Because these factors are not the same for every behaviour, each behaviour must be examined independently. Additionally, individuals may have different reasons for adopting a given behaviour or not. For this reason, formative research such as barrier analyses and focus group discussions are useful in detecting and understanding common themes in communities.[6] With this information, programmes can work to implement interventions that minimise common barriers and amplify common motivators for behaviour change.

While changing behaviour includes increasing knowledge and awareness, the work does not end there. We know from years of development

5. Lamstein 2014
6. Ibid

practice that we must do more than create information, education and communication (IEC) materials and educate people to facilitate behaviour change. Instead, programmes that seek to change behaviour rely on a comprehensive social and behaviour change approach that explores the factors that drive behaviours – both barriers and motivators – at multiple levels: individuals, families, influential community members, service providers, and policy makers. For a basic overview of SBC theory and practice, please see Annex 2.

An SBC strategy is a map, of sorts, to guide the behaviour change intervention process. This strategy is developed based on evidence. Evidence may include formative research, or some type of formal or informal research gathering exercise in order to better understand the motivators and barriers to practicing behaviours, as well as who in the community supports or hinders the adoption of behaviours among the targeted group. In some cases, this information is already available through secondary data, which can be used to inform the programme. However, in cases where information is insufficient or unavailable it needs to be collected. Types of formative research, which can either be qualitative or a mix of qualitative and quantitative, include focus group discussions, key informant interviews, barrier analysis, and trials of improved practices, among others.

An SBC strategy usually outlines the behaviours that the intervention will prioritise, based on various factors; these include considerations such as: Which behaviours have the biggest impact on child nutrition? Which behaviours does the programme have the ability to change? What does the data tell us about which behaviours are a priority? Once behaviours are prioritised, SBC programmes then consider and plan how the programme will bring about sustained changes in priority behaviours through a theory of change. As part of this process, the priority group (or target group) and main influencing groups (also known as key influencers) are identified.

The next step is selecting the best available approaches, channels or delivery platforms and the most appropriate methods, media and materials for reaching the proposed target population(s). A comprehensive SBC strategy includes details such as who will deliver these interventions, when, and how? and with what frequency? **Where interventions with a communication element (SBCC interventions) are taking place,** message development and resource creation is a creative process that comes from the strategy. While many partners take this work on themselves, communications is a special skill that is often best left to experts, when possible. There are a number of available resources for developing high quality materials and effective messages that are relevant to the target audience. One such resource is FHI 360's C-modules.

Monitoring and evaluation is also an important part of SBC programming. Because SBC programming is responsive and solutions-oriented, it is important for programmes to be willing to adapt when one approach is not working, or when new information is discovered. Because there are multiple stages of behaviour change, according to the transtheoretical model of behaviour change, an individual may make progress along the pathway towards adopting a behaviour[7] without yet actually adopting the behaviour. For this reason, it is important to monitor pathways to behaviour adoption to better understand what interventions work and how.

Steps in SBC Programme Process (Adapted from USAID)	
	Select behaviours related to programme objectives
	Gather data to understand the behaviours and their context, including reviewing primary or secondary data and conducting formative research
	Define and prioritise behaviours that will be promoted based on evidence
	Consider and plan how the programme will bring about sustained changes in priority behaviours (theory of change)
	Identify priority group and main influencing groups
	Select the best available approaches, channels, or delivery platforms and the best methods, media, and materials for reaching the proposed target population(s)
	Monitor progress along pathway to behaviour change

A few useful SBC/C resources and tools for practitioners are:

1. FHI 360's C-Modules: https://www.fhi360.org/resource/c-modules-learning-package-social-and-behavior-change-communication
2. The Compass: https://www.thecompassforsbc.org/
3. SPRING: https://www.spring-nutrition.org/publications/tools/nutrition-social-and-behavior-change-strategy-library
4. CORE Group and Food Security and Nutrition Network: https://www.fsnnetwork.org/designing-behavior-change-agriculture-natural-resource-management-health-and-nutrition

7. Prochaska 1997

Nutrition SBC component – Myanmar MCCT approach and modalities

In low-income communities, lack of access to cash is often one of several barriers to good nutrition. For example, in Chin State 59.9 per cent of women 15-49 years reported having serious problems getting money for treatment when they were sick, according to the 2015/2016 Myanmar Demographic and Health Survey (DHS). This lack of financial resources at the household level for nutrition and health is addressed, at least in part, by putting cash in the hands of pregnant women and mothers of children aged under two through a monthly cash transfer. However, lack of access to cash is not the only barrier to good nutrition.

Additional interventions and approaches are needed to address those non-financial barriers to the adoption of positive nutrition, health and hygiene behaviours. For example, lack of access to cash is not the only reason why women in Chin State do not access health care, even when they are sick. In the 2015/16 DHS, 53.1 per cent of women in Chin revealed that their second biggest problem in accessing health care was not wanting to go alone, followed by distance to the health facility (52.1 per cent). Because linking women to the health system is critical to the success of the 1,000 Days period, the MCCT programme uses a design feature to support a behavioural change and get women in the doors of the clinic: requiring that women confirm their pregnancy at their first antenatal care session in order to enroll in the programme. This condition is most likely why Myanmar MCCT programmes have seen impressive increases in the percentage of women accessing antenatal care since these programmes have been operating, thereby connecting women to the health system at the start of their 1,000 Day journey.

The fact that there are multiple barriers to adopting those behaviours that safeguard nutrition requiring different approaches provides a logical justification for linking cash and a nutrition SBC approach for better nutrition outcomes; the effectiveness of linking cash and nutrition behaviour change is reinforced by evidence from Myanmar and nearby Bangladesh.[8] In addition to design features, such as requiring that women enroll with midwives, a number of activities and approaches support behaviour change. LIFT-funded MCCT programmes use multiple modalities, which fall under the following broad categories of SBC interventions: (1) interpersonal communication (either individually or in groups); (2) social change and community mobilisation; and (3) advocacy. The second and third categories relate to creating an enabling environment which can facilitate behaviour change.

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8. IPA 2019 and Ahmed 2019

While smaller-scale LIFT-funded programmes included a diverse array of SBC modalities, the larger government-led programme in Chin, Kayin and Kayah has tended to focus mostly, if not exclusively on a few key modalities. These are Mother Support Groups or community nutrition sessions (often these are combined into a broader SBCC Session which does not separate beneficiaries from community members), individual counseling through the health system, and mobilisation of village authorities and local government. Resource constraints, combined with challenges associated with implementation in hard-to-reach areas, highlight the need to capitalise on mobile technology and other innovative solutions to support the delivery of SBC approaches at scale.

In addition to the following, more information can be found in Save the Children's learning paper.[9]

Interpersonal Communication Modalities in Myanmar MCCT Programmes

SBC Modality 1 - Mother Support Groups

Modality description: While each model differs slightly, LIFT-funded programmes in Myanmar all include some version of a monthly mother support group, sometimes called 'mother-to-mother support group', 'nutrition awareness session' or 'SBCC session'. This is considered to be the key SBC mechanism or activity across the LIFT-Funded MCCT programmes. For the purposes of this paper, this particular modality will be referred to as **Mother Support Groups.**

In some cases the groups are limited to beneficiaries, while in others they are open to all pregnant women and mothers of children aged under five. In others, men and other community members are encouraged to attend. However, they are generally designed to be targeted to pregnant women and mothers. One of the 'soft conditions' of receiving cash was that the beneficiary attend these sessions; it is a soft condition because women were encouraged, rather than required to attend the sessions in order to receive the cash, as would be the case with a 'hard condition'. The SBCC strategy for LIFT-funded MCCT projects in the Delta, Dry Zone and Rakhine indicates that the sessions would be held once monthly on non-cash transfer days. However, in most cases—particularly in government-led models— the sessions were tied to the cash distribution event.

In Save the Children's programmes, these sessions are described as "a vehicle for disseminating information, discussing and sharing experiences, and trialing new practices" (Dry Zone Project). Groups are intended to be composed of 10-20 members, all of whom are pregnant women and/

9. Social and Behaviour Change Communication with Maternal and Child Cash Transfers in Myanmar: Lessons Learned from Tat Lan, LEGACY and Bright SUN Programmes.

or mothers of children aged under two. According to the Delta MCCT project documents: "The format of meetings includes time for mothers to share any problems they may be having in feeding their children, for example, and hearing advice from other mothers about the problem." Sessions covered the following topics: (1) Health Seeking for Women and Young Children; (2) Breastfeeding; (3) Improved Nutrition for Women and Young Children During First 1,000 Days; and (4) Hygiene and Sanitation. In the LIFT-funded Rakhine and Dry Zone MCCT projects, other community members, including older women and all mothers of children younger than five years of age attended sessions.

Provider: In government-led programmes, sessions are mainly led by midwives, or in their absence community volunteers—either auxiliary midwives (AMWs) or community health workers (CHWs). Midwives are given MMK 5,000 (USD 3.30) to lead each session in order to cover their travel expenses and to act as an incentive. In programmes led by Save the Children, sessions are led mainly by community volunteers or volunteer 'mother leaders' and Save the Children project staff join volunteers on a quarterly basis to offer support and tutoring during sessions.

Frequency of exposure: In LIFT-funded programmes, sessions are designed to be held monthly according to various project records. However, in many cases they are held every one to two months, and in some cases less frequently. Project records reveal that attendance varied significantly. For example, when electronic cash distribution was introduced through Wave Money in the Delta MCCT the number of mothers attending sessions reduced significantly as they no longer had to convene in person to collect their cash. From January 2018 to April 2019, 80 per cent of mothers in villages where cash was distributed manually attended mother support group sessions while only 64 per cent of mothers in the Wave Money villages attended sessions. According to the Dry Zone MCCT mid-term evaluation, the level of participation of beneficiary women in at least one SBCC session/topic between January and June 2017 was high with 96 per cent of women attending. However, only one-third (36 per cent) of women attended all sessions in that six-month period. Later monitoring data from the Dry Zone MCCT indicated that in villages where mothers received cash and SBCC, 99 per cent of enrolled mothers attended SBCC sessions; of these, 18 per cent attended four times or less in a year and 81 per cent attended five times or more in a year.

Effectiveness: The quality of these sessions are by many accounts highly variable, and appear to have improved in LIFT-funded programmes over time, particularly in those cases where ongoing supervision and support was provided. A Save the Children SBCC learning paper (*Social and Behaviour Change Communication with Maternal and Child Cash Transfers in Myanmar: Lessons Learned from Tat Lan, LEGACY and Bright SUN Programmes*

accessed at: bit.ly/sbc4mct) reported that the most challenging skills for facilitators included participatory adult facilitation skills (an approach to facilitating adult learning which is focused on the needs and experiences of participants).[10] According to the LIFT-funded Rakhine MCCT final evaluation, "it was difficult to tell how didactic or participatory these sessions were. In 2018, the project developed a new strategy using the Designing for Behavior Change[11] approach and identified new topics of emphasis." Unfortunately, this revised approach came rather late in the project implementation stage. The quality of sessions also seemed to vary significantly based on who was leading the session. The Rakhine MCCT final evaluation found that volunteers often simply repeated sessions delivered by Save the Children staff, rather than covering new health and nutrition topics.

According to the Delta MCCT's mid-term evaluation, the execution and format of mother support group sessions differed between villages. The decision made by most programmes, including the government-led models, to tie the nutrition sessions to the cash distribution events was presumably for the convenience of staff as well as beneficiaries. However, the disadvantage of this approach is that by all accounts cash distribution days were rather busy and did not afford a calm, dedicated time and space for open discussion among women. Often non-beneficiaries were present, as in many cases beneficiaries sent someone else to collect cash on their behalf. Again according to the Delta MCCT's mid-term evaluation, one village simply divided women into temporary groups on the day of the cash transfer. In other cases where sessions were conducted on separate days from the cash transfer, the groups were far too large, comprised of 30-40 women per group in one village and 50 women in each group in another village.

Whether or not such large group sizes – or the presence of men or other non-participants—afforded mothers the opportunity to "share experiences, ask questions, resolve their concerns about new behaviours, to discuss barriers to improved practices and come up with solutions, and to share their experiences adopting recommended behaviors" is questionable and varies within and across projects. The Delta final evaluation did, however, describe the mother support groups as having "a renaissance" in 2019 after Mother Leaders received additional training. After this training, the format of meetings included time for mothers to share any problems they were having in feeding their children, for example, and hearing advice from other mothers.

One of the greatest advantages of this SBC modality is that it is in line with the Ministry of Health and Sports' Community Infant and Young

10. SCI 2019
11. TOPS 2013

Child Feeding (C-IYCF) support groups model. While midwives are officially tasked with this responsibility, they are overburdened with their existing workload to deliver basic health services. Therefore, it was suggested by some stakeholders that AMWs or CHWs who are based in communities would be better placed to lead these sessions. In this case, midwives could serve a supervisory or monitoring role, rather than being responsible for leading the delivery of the sessions.

Many midwives and project staff mentioned the need for additional and higher quality participatory learning materials. While there are some flip charts, brochures, and posters available, there is a need to adapt these to the mother-support group context, and also to ensure that they are available in relevant local languages. Furthermore, these materials are based on the government C-IYCF materials, so though they are consistent with government-endorsed behaviours and messages, they have not been tailored to the programme, cultural or geographic context.

Modality 2- Influential Caregiver Group Sessions

Modality description: Starting in 2017 the Rakhine MCCT project started holding separate sessions for men, mainly fathers. The rationale for having sessions for men is that they are considered to be 'key influencers' of the target population, which is women who are pregnant and breastfeeding. The Dry Zone Project also had some sessions for men and older women.

Provider: Project staff (Rakhine MCCT); MNMA (Dry Zone MCCT)

Frequency of exposure: Initially quarterly, then varied

Effectiveness: In both Rakhine and Dry Zone projects these influential caregiver group sessions were to some degree ad-hoc, and there is little documented information on their frequency, the content of the sessions, or measures of attendance or effectiveness. However, global evidence supports the importance of engaging with key influencers and this should be further explored in the Myanmar context, particularly as some internal formative research (barrier analyses) conducted to inform the MCCT projects indicated that fathers and grandmothers were influential figures for mothers of children aged under two.

Modality 3 – Home visits with individual counselling for mothers

Modality description: The Dry Zone MCCT project started delivering counselling to pregnant and breastfeeding women in March 2018, according to their annual report. During these home visits, the Assistant Field Coordinators (AFC) would discuss set topics and both listen to the current practices and challenges of the mothers while also giving suggestions for improvements. Staff focused on small, feasible behaviours (such as adding vegetables to their child's porridge). AFCs counselled

mothers, encouraging them to commit to changing practices including discussion of the timeline for those changes. When relevant, other family members were invited to support the mother to follow through on the behaviours. Volunteers would also join the counselling sessions to record the agreements in a follow-up form. Using this form, the volunteer monitored and recorded the progress on changing practices at agreed-upon periods (usually 1-2 weeks). The AFC then collected the information on the volunteer's follow up forms. When the volunteer's monitoring indicated that the mother was able to change her practice, the AFC would meet with her to confirm the behavior change. In 2018, the Dry Zone MCCT reached an impressive 58 per cent of all women enrolled in cash + SBCC intervention villages with individual counselling. In the Delta MCCT, 16 per cent of mothers received individual counselling from project staff with follow up by SBCC focal volunteers in 2018. The Delta and Rakhine MCCT programmes targeted fewer women for counselling than the Dry Zone programme simply because they had fewer frontline paid staff to conduct home visits. In those cases, the most vulnerable women, such as those who were not attending mother support group sessions, were targeted for counselling.

An additional target group for individual counselling was pregnant women in their third trimester, who were prioritised for counselling sessions to discuss preparing for immediate and exclusive breastfeeding. In particular, they focused on preparing to feed colostrum to their child after delivery. In order to better understand the current practices of newly enrolled pregnant and breastfeeding women and how to better target and support them in counselling, the Dry Zone MCCT Project conducted assessments in February and June 2018. Targeting of women in their 8th and 9th month of pregnancy (with follow up visits) is timely for introducing a number of key nutrition behaviours.

Although home visits and individual counselling does occur within the health system, the government-led MCCT programme does not include this explicitly as an MCCT activity.

Provider: Assistant Field Coordinator and volunteers (project staff in Dry Zone, Delta and Rakhine were trained in counselling techniques); midwives and auxiliary midwives(government)

Frequency of exposure: The programme aimed to provide counselling at six key times during the First 1,000 Days period, including soon after programme enrolment, later during pregnancy, after delivery, and when complementary foods were introduced.

Effectiveness: There is significant global evidence on the effectiveness of interpersonal communication and its role in nutrition behaviour change, including adoption of positive breastfeeding practices[12], but evidence of

impact in this particular Myanmar MCCT context is limited. Because it is a resource-intensive activity, having evidence to support its impact would be useful in justifying broader use in Myanmar nutrition programmes. Nevertheless, there was limited data gathered from LIFT-funded MCCT programmes utilising this modality, which are useful and promising. According to Save the Children's SBCC learning paper referenced above, project staff considered home visits to be the most effective activity to change behaviours. Reasons they cited included the fact that it was in the mother's home, it involved other family members, and was individualised to the mother's needs and reality. According to project records, an average of 2-4 visits were required to improve dietary diversity, complementary feeding and hygiene issues; on the other hand, convincing women to attend ANC sessions or support breastfeeding were usually addressed in 1-2 sessions.

According to anecdotal evidence cited in the Rakhine MCCT's final evaluation, many women particularly liked the individual counselling because they could ask specific questions they did not feel comfortable asking during group nutrition sessions.

In the government system, there are some concerns about the quality of counselling and the extent to which it occurs, given the shortages that exist in the health workforce.

Social Change and Community Mobilisation Modalities in Myanmar MCCT Programmes

Modality 4- Community wide SBCC information campaigns

Modality description: This particular modality largely includes the annual Nutrition Promotion Month (August) activities and annual Global Handwashing Day campaign activities. For Nutrition Promotion Month, in the Dry Zone MCCT Project activities have included games and competitions, including a painting competition for very young children, a group trivia game, and a role-play competition. For Global Handwashing Day, the Delta MCCT project campaign activities included soap distribution, hand washing demonstration sessions, and awareness sessions about the importance of hand washing with soap at critical times. Projects also distributed hand washing reminder stickers to post at home to remind people to wash their hands.

Additionally, in Chin the government and Save the Children through the support of the LIFT-funded TEAM MCCT project piloted a mobile cinema

9. WHO 2018

roadshow in mid-2019 with the aim of targeting two large events per township. In total, 21 mobile cinema shows with pre-hype activities were completed.

Provider: Project staff in collaboration with volunteers and health staff

Frequency of exposure: The project design intended for community-wide SBCC information campaigns to be held intermittently. Nutrition Promotion Month is once per year in August; Global Handwashing Day is once per year in October

Effectiveness: While participation was reported to be high for August and October events, according to the Delta MCCT mid-term evaluation: "The extent to which participants have subsequently engaged in transmission of these messages at the village level is unclear."

Modality 5 - Cooking demonstrations or competitions

Modality description: Originally a cooking demonstration, this activity shifted to cooking competitions where groups competed to cook the most nutritious meal for a child of a given age group. In some cases these were conducted in small groups (in a Mother Support Group session) while in other cases they were used in community sessions with large groups (50 or more people). Key messages revolved around cooking daily meals with foods from all four food groups, good hygiene practices, frequency of feeding, and appropriate texture and quantity of foods for complementary feeding by age group. The LIFT-funded MCCT programmes provided MMK 3,500 (USD 2.30) to each Mother Support Group to purchase food for cooking demonstrations or competitions.

Provider: Project staff and volunteers. Township Health Department involved in cooking competitions during Nutrition Month Campaign.

Frequency of exposure: Twice per year

Effectiveness: Though a popular SBC modality in Myanmar, evidence of impact is limited and should be studied. This is the case globallym as well; in a number of studies, cookingdemonstrations are one of multiple activities in a project and evidence of their specific contribution to nutrition outcomes is lacking.[13] Project staff, however, reportedly consider this to be an effective modality for changing behaviour. Reasons cited in Save the Children's SBCC learning paper include that it gives mothers the opportunity to observe and practice recommendations, and is an opportunity for staff to introduce new foods to mothers.

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13. WHO 2018

However, effectiveness reportedly depended heavily on a number of factors, including group size (which impacted on how participatory the sessions were), logistics related to finding space for the demonstrations/competitions, varying quality of recipes, and whether the recipes were relevant to the life stage of the participants' families.

Modality 6 – Community SBCC Sessions

Modality description: These nutrition sessions were targeted to the broader community. Like the mother support group sessions, these sessions cover a variety of topics. According to the Rakhine MCCT final evaluation, several villages reported that a few men might attend a session. Of the 31,499 people who attended nutrition sessions over the course of the project in Rakhine, 14 per cent were men.

Provider: In LIFT-funded MCCT projects, these were often led by project volunteers or staff. In government-led projects, these are led by a government midwife, auxiliary midwife or community health worker.

Frequency of exposure: Varied, but usually bi-monthly

Effectiveness: According to the Rakhine MCCT final evaluation: "While some men attended nutrition sessions, it is unclear how many men attended and how much they learned. The project had an opportunity to give men skills in child care practices, like child feeding, and raising their awareness about helping their wives who are overburdened with child care, housework, and other work. It is unclear if men were reached with this information and advocacy". According to the Delta MCCT mid-term evaluation, it was unclear whether sessions for husbands and other community members were part of women's sessions, and it was also unclear whether they were recorded as mother-to-mother support groups or community sessions in project monitoring data. Overall, these sessions were not consistently or strategically tailored to a specific group--whether it be to men or to general community members-- and is an area that needs improvement in future programming.

Modality 7 – Community Nutrition Champions

Modality description: Each township in Chin State nominated two individuals to serve as 'Community Nutrition Champions' (CNC). These are 'natural' community/village leaders (elders, religious leaders, respected members of the community)—men or women— who show an interest in the topic of nutrition, want to be involved, and are vocal advocates for nutrition. These 'champions' received a one-day training at the township level on key nutrition messages about women and children during the First 1,000 Days. In some cases, these CNCs lead awareness sessions in the community.

A second type of CNC, known as Mother Champions, are beneficiaries who adopted positive nutrition and health-seeking behaviours, such as attending antenatal care sessions and practicing exclusive breastfeeding for six months. These individuals received additional incentives from the programme, such as blankets.

Provider: Project staff and volunteers

Frequency of exposure: One training per group

Effectiveness: This modality, which was only operating in Chin State, included about 1885 individuals, as of mid 2019. Of these, 50 were beneficiary CNCs. There is very little documentation on the role of Community Nutrition Champions, and no information on their effectiveness. In terms of anecdotal evidence from an interview, Senior Reverend Ni Tin Par, who attended the Community Nutrition Champion Mobilisation Workshop, reported that the workshop itself was useful and she would like ongoing opportunities to engage, including an annual refresher training, as well as materials such as posters to display and share. In terms of her network, she is the leader of a church of about 400 people and holds four church services per week. After the mobilisation workshop, Reverend Ni Tin Par started mainstreaming some of the nutrition messages that she learned into her sermons on Sundays. After church services, she also coordinated with the village administrator and midwife to participate in sharing some of the nutrition messages she had learned at a cash distribution.

Advocacy Modalities in Myanmar MCCT Programmes

Modality 8–Advocacy Meeting with Shopkeepers

Modality description: This modality involved working with shopkeepers to help facilitate the purchase of healthy foods by programme beneficiaries. This included asking shopkeepers to sell a variety of pulses, giving advice to consumers, grouping products according to food groups, and putting up a promotional four-star diet poster in their shops. This involved educating shopkeepers on the benefits of a four-star diet, and listing seasonal food that was available and encouraging programme beneficiaries to consume it.

Provider: Project staff and volunteers

Frequency of exposure: Quarterly

Effectiveness: While the modality is innovative, evidence of the success

of this approach has not been documented. However, it is a good example of an intervention aimed at creating a supportive, enabling environment for behaviour change.

Modality 9- Mobilisation of village authorities and local government

Modality Description: Mobilisation of village authorities and local government, including quarterly meetings with township and village administrators and regular meetings with basic health staff. The purpose of these meetings was to engage authorities, resolve problems, and to ensure that activities were being implemented as planned and that volunteers were being supported.

Provider: Project staff and volunteers

Frequency of exposure: Quarterly meetings with township and village administrators; monthly meetings with basic health staff

Effectiveness: The success of this modality in Myanmar needs further exploration and documentation. Community engagement is critical to ensuring transparency and to supporting advocacy to ensure delivery of high quality government health services.

Linkages with the health system: the role of health services provision

All LIFT-funded MCCT programmes link to the provision of health services. Women are enrolled in the programme after having their pregnancy confirmed by their midwife (who gives them an antenatal care card) which, along with being a resident of their village, was for a time the only 'hard' or absolute conditionality for participating in the programme. SBC interventions and cash create demand for health services and the Ministry of Health supplies these services to the population. This linkage is critical in order for the MCCT programme to sustainably safeguard women and children's nutrition and health. Although there are a number of challenges that the health system faces in terms of infrastructure, supplies and workforce capacity, finding opportunities to connect women and young children to the health system is critical, particularly in poor, remote areas of the country like Chin State where access to health services are limited. For example, the most recent data from the 2015/2016 Myanmar Demographic and Health Survey prior to the DSW implementation of the MCCT in Chin State, reveal that only 15 per cent of women in Chin State

had an institutional delivery and only 21 per cent of mothers received a postnatal check-up in the two days after delivery (compared to a high of 92 per cent in Magway Region). In Rakhine State, another area where the government is implementing the MCCT, only 30 per cent of births were assisted by skilled providers (compared to 83 per cent nationally).

To date, LIFT-funded projects have operated with soft conditions to encourage recipients of cash to practice certain positive health-seeking behaviours. While participation in mothers group sessions and practicing health-seeking behaviours are encouraged, cash delivery is not subject to conditions other than having an antenatal care card, which confirms pregnancy. Soft conditions include:

- Receive eight antenatal and 4-6 postnatal care contacts
- Immunise the child according to the national immunisation schedule
- Attend mother-to-mother support group meetings
- Attend community-based growth monitoring and promotion (Rakhine MCCT)

Some current and future MCCT programmes, including those in Shan State and the Ayeyarwady Region, financed by the MoSWRR through the World Bank IDA loan, tie conditions to the cash transfer. These are still being determined, however they will likely include a requirement to participate in community outreach sessions (conducted by volunteer social workers), in addition to conditionalities on health and nutrition services, such as antenatal care, immunisation and birth certificate for children.

CASH TRANSFER PROGRAMMES FOR NUTRITION IMPACT: WHAT WE KNOW FROM GLOBAL EVIDENCE

HOW CASH CAN LEAD TO BETTER CHILD NUTRITION: MAPPING THE CONCEPTUAL PATHWAYS

CASH TRANSFER PROGRAMMES FOR NUTRITION IMPACT: WHAT WE KNOW FROM GLOBAL EVI-DENCE

CASH TRANSFER PROGRAMMES FOR NUTRITION IMPACT: WHAT WE KNOW FROM GLOBAL EVIDENCE

While global evidence has shown that tying conditions to cash transfers have had an impressive impact on the adoption of positive health- and nutrition-related behaviours—especially when practicing health seeking behaviours are part of the condition for receiving cash—this is only the case in countries where the supply side of the healthcare system is sufficient, functional and accessible to programme beneficiaries.[14] In contexts like Myanmar, where health infrastructure and capacity is still being built, **setting hard conditions could present an ethical dilemma resulting from withholding much-needed benefits from those beneficiaries who are unable to meet the conditions, but who are likely most in need of cash.** Because cash and behaviour change are designed to create demand for health services, enforcing hard conditionality in places where the supply side of health care is not ready for the influx in demand could potentially undermine programme objectives.

How cash can lead to better child nutrition: mapping the conceptual pathways

There are many contributing factors to poor child nutrition. According to the widely-cited UNICEF causal framework for undernutrition they are immediate, underlying and basic. Using the lens of the UNICEF causal framework as our basis for conceptualising child nutrition, there are three main pathways through which cash transfers have the potential to positively affect child nutritional status. These pathways, supported by global evidence, are by making additional financial resources available for: 1) Food security (quantity, frequency & quality), 2) Health, and 3) Care.[15]

Cash: food intake pathway. In the first pathway, cash tranfer programmes improve household food security. The most direct route from cash to improved nutrition via improved food security in the case of the MCCT programme is through increased food consumption, which is an immediate determinant of child nutritional status. In other words,

14. de Groot 2017
15. ibid

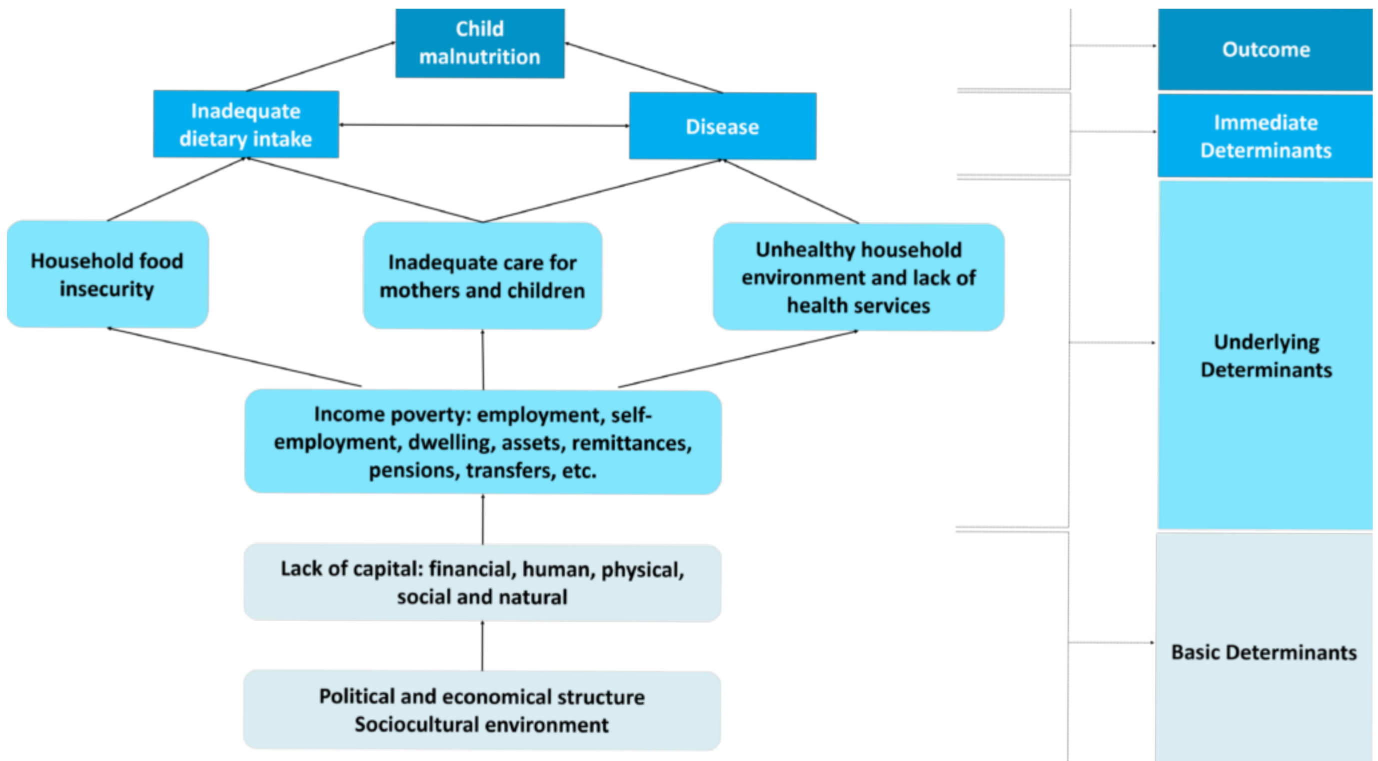
when the cash transfer is used to purchase a higher quantity of diverse, nutritious food for mothers and children, they are likely to benefit nutritionally.

Cash: health services pathway. Poor health is another immediate cause of undernutrition, which is why the second pathway involves health spending to improve nutrition. When the cash is invested in health expenses, it has been shown to have positive impacts, particularly in the case of conditional cash transfers when receipt of cash is tried to the adoption of certain health seeking behaviours, such as antenatal care visits and preventive healthcare. It also has been shown to have positive effects on hygiene, and on the probability of using safely managed water and sanitation facilities.[16]

Cash: care pathway. Using resources for care is acknowledged as a third pathway through which cash transfers have the potential to positively affect child nutritional status. There is evidence for the relationship between nutrition outcomes and caregiver feeding practices, as well as nutrition outcomes and psychosocial care. Care (of children and mothers) is an underlying determinant of undernutrition; there is evidence for the relationship between caregiver feeding practices and nutrition, as well as psychosocial care and nutrition However, further evidence needs to be gathered to understand this relationship in the context of cash transfers specifically. Evidence that cash alone changes caregivers' behaviours is not strong. A more plausible pathway with some evidence to support it is that cash transfers could improve beneficiaries' mental health, autonomy and reduce mothers' and childrens' levels of stress, which then leads to better maternal and child nutrition outcomes. Transfers may also decrease intimate partner violence, also reducing stress, which has positive implications for maternal and child health.[17]

16. ibid
17. ibid

Causal Framework for Cash and Undernutrition



Women's empowerment as an important cross-cutting factor. While it has not yet been fully understood how to measure and test this pathway, we do know that there is value in putting cash in the hands of women and that it leads to better child nutrition. Evidence reveals that major global reductions in child stunting can be attributed to improvements in women's status between 1970 and 1995.[18] While there is a need to further investigate and understand the ways that cash empowers women, and how this directly benefits the health and nutrition of their children, there are some known ways that cash empowers women; these include increased self-esteem, increased status in the community, increased ability to care for themselves and their families, the opportunity to speak in public and share their experiences with other women, and increased bargaining power in the household through control of movement and resources.[19]

The LIFT-funded MCCT programmes in Myanmar put cash directly in the hands of women, and the vast majority of them report that they decide how to spend the cash, despite this being a departure from traditional norms, according to some. According to findings from interviews that took

18. Smith and Haddad 2000
19. Leroy 2009

place in early 2018 with mothers and influential caregivers (mainly fathers and grandparents) in the MCCT programme in Chin State, only about one-fifth of influential caregivers interviewed reported that women made decisions alone over food purchases for children. This amount increased to 41 per cent by August 2018. In the August 2018 PDM round, nearly all respondents (94 per cent, n=320) reported that women exercised control over the cash transfer. Consistent with other post-distribution monitoring findings from other LIFT-funded MCCT programmes, this is significant as it is perceived by many influential caregivers as a departure from traditional household practices.

ENHANCING THE IMPACT OF CASH

WHY CASH ALONE IS NOT ENOUGH: CASH + SBC PATHWAYS:

ENHANCING THE IM-
PACT OF CASH

ENHANCING THE IMPACT OF CASH

One important finding of a number of cash transfer intervention studies to date globally is the fact that cash alone has some impact on nutrition, but unreliably so. This is consistent with results from LIFT-funded randomised controlled trial (RCT) in Myanmar's Dry Zone, which is discussed in further detail under the section: The impact of cash + SBCC on nutrition outcomes: Evidence from Myanmar MCCT Programmes. This important fact reveals that something more than cash is required to ensure that these programmes work for nutrition.

The success of a cash transfer project is highly dependent upon a variety of other factors; positive impacts are limited by behavioural factors as well as physical access to services, in some cases. Cash is certainly a versatile and useful intervention tool for improving child nutrition, however certain programme design elements must be in place for it to work. Programme design features that can increase the likelihood that cash will be used for better nutrition outcomes include:

Put cash in women's hands. When put in the hands of women, not only is money more likely to be used on food and other household expenses according to global research, but it also empowers women. We know from global research that empowering women—most often measured as women's decision-making or women's control over resources— in and of itself leads to better maternal and child health outcomes.[20]

Target the transfer to the economically vulnerable and children under two. Transfers have higher impact when given to poor and at-risk populations, as well as the young (children under two). This is consistent with findings in the Myanmar Dry Zone RCT. In other words, when it is given to those who need it most, the impact of the cash is greater, and we know that women and children in the crucial First 1,000 Days period—particularly those in low-income areas and with poor access to health services— are among the most nutritionally vulnerable. Cash can address some of the determinants of child nutrition through the pathways mentioned above (food, health expenses and care).[21]

'Right' amount in the 'right' frequency. The importance of regular, monthly payments is important for having positive nutrition impact. Global evidence from Mercy Corps and ODI points to the fact that

20. ibid

21. Leroy 2009, Lagarde 2009, Manley 2012, DeGroot 2017, IPA/SCI 2019

one-time or less-frequent and larger payments tend to be invested in livelihoods, while ongoing monthly smaller payments are more likely to be used on basic household needs, such as food and medicine.[22]

Longer duration increases the effects on nutritional status. Evidence shows that children who are exposed to cash transfers for longer periods of time have better nutrition outcomes.[23]

Integrate with existing health systems. Supporting linkages to health service platforms is critical, particularly during the First 1,000 Days period when important health interventions, including antenatal care, facility delivery, postnatal care and child immunisations have the potential not only to improve nutrition outcomes, but also to be life-saving. A number of cash transfer programmes, particularly in Latin America, have linked to health systems either by requiring participants through hard conditionalities or encouraging them through soft conditionalities to make contact with, or seek, health services. The placement of hard conditions on cash transfers, however, is only appropriate where supply-side services are adequate. If they are not adequate, such as in geographically remote or underserved areas, this approach risks unfairly penalising those most in need of the cash benefit. Due to these supply side challenges, many countries in Sub Saharan Africa have instead elected to implement unconditional cash transfers.[24] Though the programme is unconditional, in order to foster critical linkages with the health system, Myanmar's MCCT programmes require that mothers enroll in the programme by visiting the midwife and encourage beneficiaries and community members to attend education and support sessions led by government health staff or volunteers.

Why cash alone is not enough: Cash + SBC pathways:

Not only can cash have positive nutrition impacts when certain design elements are in place (put it in women's hands, target the vulnerable, right amount, right frequency, etc.) but it affords women the dignity and flexibility to make decisions about their cash spending, based on the underlying assumption that they can best decide how cash can benefit their children's nutrition. Even if mothers have cash, mothers have different levels of knowledge about nutrition and health, varying levels of confidence about whether they can practice good nutrition and health behaviours, and different understanding of how serious (or not) the threat of undernutrition is.

While the provision of cash eliminates an important barrier to some positive child nutrition practices in economically disadvantaged communities, cash alone is not a silver bullet to improving nutrition. Access to cash

22. Mercy Corps 2017, Hagen-Zanker 2017, IPA/SCI 2019
23. de Groot 2017, IPA/SCI 2019
24. de Groot 2015

is not necessarily the only barrier to certain optimal nutrition practices. While evidence from LIFT-funded programmes in Myanmar demonstrate that distributing cash alone to beneficiaries during the 1,000 days period had some benefits, far greater benefits were seen when combined with SBC approaches. A study conducted by IFPRI in Bangladesh also had extremely positive results. To test the value of adding a behavioural element to cash programming, IFPRI conducted a randomised controlled trial with four treatment arms (a cash transfer; a food ration; a half cash payment and half food ration; and a cash transfer plus nutrition behavior change communication (BCC), as well as a control group) to understand the impact of adding BCC to the cash intervention. The study found that cash plus nutrition behaviour change communication (BCC) was the only intervention in the study that led to a significant improvement in height for age (0.25 standard deviations) and a greater reduction in child illness than the other three treatment arms.[25]

At the same time, for those behaviours for which cash inputs are most immediately relevant, when one is given money there are, of course, more than the three choices mentioned above (food, health and care) for spending cash. One can imagine that in resource-poor settings, in particular, women are presented with a complex set of choices and economic and social pressures after receiving the cash transfer. For example: Does she use the money to repay a loan that keeps growing? Does she pay for a non-beneficiary child's urgent visit to the clinic? In a household where members eat together, does she feed meat to herself and her beneficiary child but not the rest of the family? There are a number of competing interests for cash. Action Against Hunger and partners' Refani Project visually demonstrated how complex this web of choices were by mapping beneficiaries' options upon receiving a cash transfer and their potential impact on reducing undernutrition (Please see Annex 4). According to their model, beneficiaries have the option to spend the cash, save the cash, or reduce their own economic production (work less). Should the beneficiary choose to spend the cash on nutrition, health and hygiene expenses, the causal pathway between women and children's nutrition status and cash is shorter and more direct.

The fact that there are many available options for spending cash is one reason why Myanmar MCCT programmes include an SBC approach or component. Its purpose is, among other objectives, to support beneficiaries to choose to spend their money on expenses that will improve nutrition; this includes health, hygiene and food items and services. According to available programme monitoring data in Myanmar, the vast majority of beneficiaries do indeed spend their money on health, hygiene and food.

25. Ahmed 2019

Design elements of the MCCT can encourage the cash to be used for nutrition purposes, but may not be enough to reach maximum potential impact. SBC not only has the potential to enhance the success of the pathways leading from cash to better child nutrition, but it also has the potential to add additional pathways through which the programme can have an impact on child nutrition. In other words, integrating an SBC approach into a cash transfer programme may both reinforce and also open up additional pathways through which cash can have an impact on nutrition.

SBC can enhance the cash□food intake pathway for better nutrition. We can refer to this as the cash + SBC: food intake pathway. Findings from an RCT of a LIFT-funded MCCT in Myanmar's Dry Zone illustrates this point.[26] In the study, those children in the cash plus SBCC arm saw greater changes in food intake measures than those in the cash only arm, relative to the control group. While the cash alone group saw some increase in iron-rich food intake, the cash plus SBCC arm saw an even greater increase in iron rich food intake. Furthermore, there were additional changes in the cash plus SBCC arm that did not occur in the cash only group. For example, the study measured a 0.444** unit (food group) increase in Women's Dietary Diversity Score among those who received a combined cash plus SBCC interventions compared to those in the control group. Children's dietary diversity scores also increased by 0.661** units (2.89 in control group vs. 3.55 in the group receiving a combined cash and SBCC intervention). While there were increases in food intake measures between the control group and the cash alone group, the increases were smaller than those in the cash + SBCC group. Furthermore, none of the food intake findings for the cash alone group were statistically significant. The findings from the Dry Zone RCT that dietary diversity is higher are consistent with the fact that women assigned to the cash plus SBCC arm of the intervention spent significantly more money on food relative to the control group. Post-distribution monitoring reports from LIFT-funded MCCT programmes in Chin, Delta and Rakhine reveal that women receiving the Myanmar MCCT also reported increased spending on food. For more information and evidence from LIFT-funded programmes, see The impact of cash + SBCC on nutrition outcomes: Evidence from Myanmar MCCT Programmes section below.

The way that SBC approaches can enhance this pathway is by supporting strategies, opportunities and messages to address non-cash barriers to diet quality, quantity and frequency. For example, a programme could engage shopkeepers to sell vitamin-A rich fruits and vegetables at the cash distribution site where the mothers have just received cash from the programme, which can save time for busy mothers. Or, an SBC activity could target men to encourage their wives not to spend their

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26. IPA 2019

cash transfer money on sugary snack foods, which have little nutritional value for children. There are countless possibilities—both major and minor—which could help foster an environment where it becomes easier for women and their children to eat sufficient and healthy foods with adequate frequency. See Nutrition SBC component – Myanmar MCCT approach and modalities section above for a description of the SBC modalities used in Myanmar's LIFT-funded MCCT programmes.

SBC can also enhance the cash health services pathway, or the cash + SBC: health services pathway. Beneficiaries' engagement in peer groups led by midwives or other health professionals may help women develop a stronger or more trusting relationship with their midwife, for example. She may find her more approachable and be more likely to ask her questions or for advice. As another example, a woman may learn at the monthly nutrition session that the midwife will be coming to the village to give immunisations next week, so she can plan to attend with her child. Alternatively, an advocacy activity could highlight a gap in the health system in a given part of the country, drawing resources to that area. In Myanmar, LIFT-funded MCCT programmes have seen an increase in the uptake of health services since the programmes began. In particular, there was a statistically significant increase in antenatal care visits with skilled health providers among women who were in the cash plus SBCC arm of the Dry Zone RCT compared to the cash only group as well as the control group. Women in the cash plus SBCC arm of the intervention were also more likely to attend at least four antenatal visits.[27]

SBC can also enhance the cash care pathway, or the cash + SBC: care pathway, giving caregivers tools, support and information to make healthy decisions and practice positive behaviours.

In addition to enhancing the above three pathways, SBC also has the potential to forge additional pathways for better nutrition. These are:

Cash + SBC: Women's knowledge, skills and self-efficacy pathway. When women are exposed to more information about health and nutrition, this may lead to increased self-efficacy. Increased self-efficacy and personal sense of control can lead to behavious change. Maternal self-efficacy has long been considered an important determinant of success for breastfeeding and is an important overall predictor of behaviour change.

Cash + SBC: Family and community members' knowledge,

27. IPA 2019

awareness and ability to support women pathway. Targeting key influencers, for example, such as husbands and elder women to support women—whether it be to help reduce her workload while she is pregnant or breastfeeding, or understanding how to be sympathetic to a woman who has just endured a difficult child delivery, for example—is important to creating an enabling environment for practising positive behaviours. Educating community members on the objectives of the programme, for example, may minimise any negative sentiment or jealousy towards mothers who are receiving the MCCT stipend and increase community understanding about the needs of women and children during this vulnerable life period. Finding ways to support women in all aspects of the First 1,000 Days journey—whether it relates to child feeding practices, mental health issues, or health-seeking behaviours—can reduce women's stress, increase their confidence, and make them happier and better able to deal with the challenges of being a mother in their family and community.

EFFECTIVE SBC

LIFT-FUNDED MCCTS: WHAT HAVE WE LEARNED ABOUT SBC PROGRAMMING?

E-Payment Potential For Behaviour Change

EFFECTIVE SBC

EFFECTIVE SBC

In terms of behaviour change in the context of maternal and infant and young child nutrition programmes, there are a number of key lessons that practitioners have learned over the years, which can inform SBC efforts in Myanmar. For a basic overview of SBC theory and practice, please see Annex 2.

Effective behaviour change programmes in nutrition rely on evidence to change behaviour through formative research. According to a study reviewing complementary feeding behaviour change interventions in 29 developing countries, the authors found that effective programmes used formative research to identify cultural barriers and enablers to optimal feeding practices, to shape the programme implementation strategy, and to develop messages and identify avenues for their delivery.[28] This also helps ensure that the intervention is culturally sensitive, integrated with local resources, and whether the intervention strategies are appropriate and feasible for local families.

Not only do successful behaviour change programmes rely on evidence to shape their programmes at the outset, but they **map out the conceptual pathways to change targeted behaviours, assessing intermediary behaviour changes in order to learn what worked.**[29] Behaviour change is a process that takes time, and although an individual may not change her behaviour fully within the given timeframe of an intervention, she may make substantial progress. Understanding whether and how far the targeted population is moving forward in the process of behaviour change is important to understanding the effectiveness of different intervention approaches.

Many projects use a limited set of behaviour change techniques; often, they are overly dependent upon education-focused change techniques. Some behaviours can be addressed through education-focused interventions—particularly if the target population is not aware of the importance of a behaviour or how to practice it. In many cases, however, people know what they should do, but for various reasons do not or cannot practice the behaviour. Therefore, interventions that create opportunities for social support, that create enabling physical environments and that improve problem-solving skills and self-efficacy are promising alternatives or supplements to education-focused change techniques.[30] There is also significant room to explore behaviour change

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28. Fabrizio 2014
29. Ibid
30. Girard 2019
31. Lamstein 2014
32. Ling Shi 2011 and Lamstein 2014

approaches for nutrition that are outside the health sector.

Using multiple SBC approaches and channels to change behaviours is more effective than using one approach or channel, according to a review of 91 studies on preventing and reducing stunting and anaemia by USAID's SPRING initiative.[31] Yet an informal review of SBC interventions being implemented by members of the Scaling Up Nutrition Civil Society Alliance (SUN CSA), many of which are LIFT-funded partners), conducted by Alive & Thrive, LIFT and the World Bank in Myanmar found that "few partners are using an integrated approach that encompasses interpersonal communication, community mobilisation and mass media, as well as rigorous M&E."

Targeting multiple audiences has a greater effect than reaching beneficiaries alone. In SBC programming it is important to reach out to those individuals who influence the target population (in this case, women who are pregnant and breastfeeding); these so called 'key influencers' (whether they be men, religious leaders, grandmothers, or others) have an important role to play in supporting behaviour change among women.[32]

Human contact is important to achieving behaviour change. Behaviour change programme approaches should employ frequent interpersonal contact. Not only does targeting the right people matter in behaviour change programming, but focusing on achieving a higher number of visits and contacts with the target population can lead to greater change.[33]

LIFT-Funded MCCTs: What have we learned about SBC programming?

LIFT-funded programmes have had impressive successes, despite facing numerous challenges, in implementing SBC interventions. However, many SBC interventions seem similar to health promotion or health education interventions; in some cases SBC and nutrition promotion are treated as interchangeable. Imparting knowledge to programme beneficiaries about recommended health and nutrition behaviours seems to be the focus of many interventions, despite the fact that in many cases beneficiaries already know what they need to do, but face barriers to practising the behaviour.

Effective behaviour change programming requires:

1. A strong contextual analysis through formative research and/or secondary data;
2. A basic understanding of behaviour change theory to support programme design;

33. ibid

3. A strategy or plan on how to change identified priority behaviour that speaks to the cultural context, barriers, motivators, key influencers that were discovered in the contextual analysis;
4. A monitoring system with a spirit of learning that adapts to lessons or changes in the programme context; and
5. Sufficient investment in creative approaches and modalities for a sufficient period of time to see behaviour change.

With respect to contextual analysis and formative research, there are major constraints to evidence-generation in Myanmar that have hindered the SBC work of partners. In many cases, the long lead time needed for government ethical approval has made gathering information to inform programme design or implementation nearly impossible. Most LIFT-funded MCCT programmes conducted formative research at later stages of the project, or in the case of the government not at all. In Chin State, the government determined that formative research and an SBC strategy were not necessary, despite donor funds being available for these activities through TEAM MCCT. While some barrier analyses studies were conducted in Save the Children's LIFT-funded MCCT programmes, unfortunately the studies took place towards the end of the programmes, which limited the extent to which they could inform the project.

With respect to an understanding of behaviour change theory to support programme design, there is a need to build the capacity of LIFT implementing partners to conduct high quality SBC programming. The Designing for Behaviour Change Framework, developed by USAID's TOPS and translated and adapted by Save the Children's LEARN Project is a particularly useful framework for designing interventions to meaningfully change behaviour. Noticeable progress was seen in Save the Children's MCCT projects after nutrition advisers and project staff received this training.

In terms of strategy, unfortunately most LIFT-funded programmes with SBC elements have either developed strategies in the very late stages of implementation, or do not have a strategy at all. The Dry Zone RCT report highlighted SBC activity protocol consistency issues, stating that interventions were not consistently implemented across all villages; this is perhaps a result of not having a documented strategy in the early stages of implementation. However, over time, activities became more comprehensive and targeted key behaviours. In lieu of formative research, a desk review of nutrition, health and hygiene practices in Chin State was conducted at the beginning of the project to inform activities. The desk review, along with other secondary data, eventually fed into an SBCC strategy for Chin State. Later, 'rapid community assessments' were conducted as an alternative to formative research, since the government did not grant approval for formative research. Rather than develop a comprehensive SBCC strategy document, the government developed an

SBCC Action Plan, while the TEAM MCCT project developed an internal interim SBCC Strategy, based on the available evidence. The strategy included a variety of useful information, including proposed creative themes, key messages in response to behavioural priorities, and activities adapted to the Chin context. Due to a variety of constraints, however, this internal interim strategy was not adopted by or developed with the government. The SBCC Action Plan in Chin, which the government did endorse, is not a traditional SBCC strategy document, but rather one which focuses more on activities, logistics and resources. The Chin SBCC Action Plan, which was developed by the government, under the leadership of MoHS, includes three key approaches:

1. **Coordination/Advocacy:** This mainly involves coordination with and between DSW, GAD and Public Health Division at State, Township and village levels in order to promote clarity with respect to roles, approach and engagement in implementation, largely focused on data collection related to beneficiary lists and Mother Support Group sessions. Responsible actors include Township GAD, Village/Ward Administrators, village leaders, State DSW, Township DSW, SHD and THD. Other development actors, including international and local NGOs, and UN agencies are also included as partners, particularly for coordination purposes at State and Township levels.
2. **Capacity building and enhanced job aids:** This approach relates to delivering cascade-style SBCC and cIYCF trainings to BHS and CHVs, as well as printing and distributing IEC materials (namely cIYCF key message flip charts). The state-level cIYCF and SBCC training of trainers (ToT) for township training teams are led by the NNC, HLPU and the State training team, comprised of the Health Education Officer, State Nutritionist and DPHN. Township training teams then train BHS and CHVs at the township level. Alongside training, this approach includes developing or revising BCC and other support tools where necessary. Overall, NNC is primarily responsible for cIYCF. The NNC provides technical support for job aids, such as the cIYCF flipchart, while the HLPU supports content design of IEC materials and standardization of health education messages. They are developed and disseminated with the support of the LIFT-funded TEAM MCCT.
3. **Community Engagement/ Social mobilisation:** The third and final approach outlined in the Chin SBCC Action Plan includes community mobilisation workshops for village and religious leaders, Fathers Group Sessions led by BHS or VHWs, combined Mother and Father Group Sessions, rapid community assessments (focus

group discussions, trials of improved practices and recipe creation) to explore current behaviours and practices, and finally the maintenance of ongoing nutrition promotion activities. These are listed in the strategy as cooking demonstrations or competitions, nutrition promotion activities, joint supportive supervision visits to Mother Support Groups, and Village Social Protection Committee meetings. State and Township Health departments are key players in the implementation of SBCC field activities while case managers from DSW and village tract/ward administrators from GAD are responsible for facilitating arrangements of SBCC sessions in villages or wards; they are supported by Village/ward Social Protection Committees. Save the Children (through the LIFT-Funded TEAM MCCT) was mentioned as a support actor for the rapid community assessments.

After a joint learning meeting organised in July 2019, Kayin and Kayah States followed a similar approach to Chin, endorsing State-level 'SBCC Action Plans'. The multi-sectoral workshops were led by State Health Department officials in collaboration with Township Health Department, DSW, UNICEF, LIFT and ethnic health organisation partners. Kayin and Kayah State action plans are similar to that of Chin, with the addition of some recommendations, the adaptation of certain activities (such as less frequent sessions in harder to reach areas) and adding certain partners, such as Ethnic Health Organisations participants. Another difference is that Kayin and Kayah did not yet have the support of a LIFT-funded capacity building project, as was the case in Chin with TEAM MCCT. In Kayah, community engagement/social mobilization activities are simplified to include only: health education session, cooking demonstration, and mothers groups. In terms of recommendation, they make valuable recommendations, including HLPU and DSW developing a MCCT cash usage component and leveraging the use of the MCCT Facebook page as a potential communication channel to share programme information and receive complaints, and assigning state and township level focal persons for DSW, DoPH and GAD to facilitate SBCC activities, and to utilise radio as a communication channel. In Kayin, community engagement/social mobilisation activities include health education, counselling, family conversations, school health and youth activities. Furthermore, in Kayah, EHO partners plan to develop an SBCC action plan for non-government controlled areas.

Though it is important to individualise action plans to individual states and regions, the SBCC Action plan process may have been overly simplified, particularly in Kayin and Kayah, and would benefit from more

comprehensive overarching guidance on strategy development and standard activity protocols. Most tasks related to SBCC are assigned to MoHS, however the budget for the MCCT is housed in the MoSWRR, which leads to practical challenges in implementation.

Monitoring systems, though generally strong in LIFT-funded MCCT programmes, were relatively weak when it came to SBC monitoring. Using behaviour change monitoring tools, such as the lot quality assurance sampling (LQAS) or periodic focus group discussions would facilitate implementing partners to make sure that interventions continued to be relevant and responsive to the needs of beneficiaries throughout the life of the project. In Chin, TEAM MCCT supported 'rapid community assessments' in lieu of formative research since research was not approved by the government. This assessment yielded rich data which could be used to strengthen behaviour change efforts in Chin.

E-payment potential for behaviour change

Particularly as the national MCCT programme expands and cash distribution shifts from manual to electronic, the use of mobile technology platforms for SBC will be necessary. Given the current level and growth of the use of mobile phones in Myanmar, practitioners will need to look to mobile technology for efficient and far-reaching information-sharing solutions.

While the opportunities to gather and educate beneficiaries at cash distribution points will be eliminated, as the programme shifts to electronic cash distribution, there will be opportunities for innovative use of mobile phone technology for nutrition education and promotion through games, reminders, text messages, voice memos, videos, and more. However, even as things progress with mobile technology, it will continue to be of critical importance to link with health care platforms. Mobile technology can enhance behaviour change efforts, but is not a suitable replacement for interpersonal contact with health service providers.

THE IMPACT OF CASH + SBCC ON NUTRITION OUTCOMES

THE IMPACT OF CASH + SBCC ON NUTRITION OUTCOMES

THE IMPACT OF CASH + SBCC ON NUTRITION OUTCOMES

Evidence from Myanmar MCCT Programmes

To date, the most robust programme evidence in Myanmar is from the Dry Zone MCCT, which was implemented by Save the Children. They collaborated with research partner IPA to conduct an RCT. Villages were randomly assigned to one of three groups: Treatment Group 1 (Cash plus SBCC), Treatment Group 2 (Cash only) and a Control Group that received neither cash nor SBCC interventions. Researchers collected survey and biomarker measures of programme impact around 30 months after the start of the program, including height and weight of children and mothers, dietary diversity, antenatal and postnatal care practices, delivery and newborn care practices, infant and young child feeding, child illness and general health, WASH measures, and other economic indicators. Other data sources, which though not as powerful statistically are nevertheless valuable, include final project evaluations and reports. LIFT-funded MCCT projects also regularly collected post-distribution monitoring data (self-reported) to monitor the receipt and use of cash, attendance at mother support group sessions, behavioural patterns, knowledge about health and nutrition behaviours, among other information.

The above-mentioned sources of evidence reveal a number of important findings that confirm global evidence, and contribute towards deepening the evidence base for MCCT programmes that seek to have a positive impact on nutrition outcomes during the First 1,000 Days.

A monthly delivery of cash paired with SBCC interventions significantly reduces childhood stunting. The headline finding of the Dry Zone intervention is that there is a statistically significant reduction in the proportion of stunted children among those covered by the cash plus SBCC arm of the intervention. After two years of programme delivery, the project achieved a 4.4 percentage point reduction (13 per cent reduction from 24 per cent to 19.6 per cent, $p < 0.05$) in the proportion of moderately stunted children.

Cash plus SBCC reduces stunting, especially among female and poorer children. According to the Dry Zone RCT findings, significant effects on the proportion of stunted children are greater among children from lower socio-economic households. Female children tended to be less stunted than their male counterparts, particularly girls in the oldest age category who received longer treatment exposure. Data indicate that compared to their male counterparts, girls who were exposed to the full

treatment of cash plus SBCC experienced a lower rate of stunting (10.2 percentage point reduction for girls vs. 5.4 for all children, $p<0.1$)

Cash alone, however, is less effective in reducing stunting when SBCC is not delivered alongside it. After two years of programme delivery through the Dry Zone MCCT, there were no significant effects observed in stunting among those children whose mothers received cash alone compared to the control arm.

Treatment exposure matters. Another headline finding from the Dry Zone RCT is that the reduction in the proportion of stunted children was greater for those children who received maximum exposure to cash plus SBCC. A reduction in the proportion of stunted children is more pronounced for children covered by the programme for the greatest number of months (24-29 months).

Cash may reduce moderate acute malnutrition (MAM). A 2.8 percentage point ($p < 0.1$) reduction in the proportion of children suffering from MAM in the cash plus SBCC arm (similar findings for the cash only arm) suggests that cash transfers may help reduce wasting.

In MCCT programmes, women report being the main decision makers on the use of the cash. Nearly all beneficiary respondents in post-distribution monitoring (PDM) surveys across programmes indicated they were in charge of spending their cash transfers. In the Delta MCCT, 99.6 per cent of beneficiaries reported controlling decisions regarding the use of the MCCT cash transfers according to 2018 post-distribution monitoring. In the first and second PDM rounds from the government programme in Chin, 95 per cent and 94 per cent of beneficiaries, respectively, reported being the main decision-maker in the household on the use of MCCT cash. In the Rakhine MCCT 99 per cent of women reported managing the cash they received (Tat Lan MCCT Brief) and in the Dry Zone MCCT that figure was 99 per cent according to 2018 PDM data and 99.6 per cent according to RCT data. The fact that 99 per cent of women in the Dry Zone MCCT reported managing the cash is impressive given that in the project baseline survey only 46 per cent of women reported that they had control over some income and did not have to ask their husbands how to spend that cash.

The fact that women are able to control the cash is particularly important given that global research indicates that when women are given money, it can function as a safety net. Also, it may improve a mother's physical and mental state, reduce levels of stress, increase confidence, which could lead to more positive parenting and better child nutrition outcomes.

Programme monitoring reports[34] indicate that beneficiaries are using cash for its intended purposes—food and health care expenses

to promote maternal and child wellbeing. Women spend the cash transfer on buying food for themselves and, increasingly, for their children. In the Dry Zone MCCT, 93 per cent of mothers spent the transfer on food. Sixty-four per cent spent money on food for themselves (down from 69 per cent at baseline) and 51 per cent for their children (up from 8 per cent at baseline). According to the most recent round of PDM in Chin (October 2018), nearly all respondent beneficiaries when asked how they spent the transfer reported spending money on buying quantity and variety of food items for themselves, children and family. Of the beneficiary respondents, 46 per cent also spent money to pay for health care costs (transportation, drugs and consultation).

In the Delta MCCT, according to PDM data the majority of women reported using cash to buy more food (72 per cent), a greater variety of food for themselves (73.1 per cent) and a greater variety of food for their child (43.3 per cent). More than one-third reported using some of the MCCT payment to cover costs related to health care (36.5 per cent).

There is still room for improvement, however, in supporting positive spending habits. According to Delta PDM data, a small percentage of women reported purchasing baby formula (5.4 per cent) or milk for their children (2.8 per cent). However, approximately 21.5 per cent of women reported purchasing snacks with limited nutritional value (e.g. biscuits, cake and sweets). In Chin State, this number was higher; 27 per cent of beneficiaries reported that they spent money on buying snacks (sweets/ cakes/biscuits etc.) Also, 18 per cent of respondents used part of the money on buying formula milk, which is more expensive and less nutritious than a mother's own breast milk. Concerns related to increased spending on infant formula and unhealthy packaged snacks should be addressed in future behaviour change programming.

Comprehensive MCCTs with cash + SBCC components improve nutrition and health knowledge. There is evidence to suggest that those who participate in MCCTs have improved nutrition and health knowledge. While acquisition of knowledge does not automatically or necessarily lead to behaviour change, it can contribute to the process of adopting positive behaviours. According to the April 2018 post-distribution monitoring (PDM) data analysis report in Chin State, women who attended mother-to-mother support group sessions reported increased knowledge in the areas of diet diversity, infant and young child feeding, the importance of seeking antenatal care, immunisation schedules, the importance of child health care, and maintaining good hygiene in the household. Delta MCCT PDMs highlight that on average, more than half of beneficiary respondents reported greater nutrition knowledge when pregnant and breastfeeding, avoiding dietary restrictions and practicing optimal IYCF behaviours.

Beyond knowledge acquisition, there is evidence that beneficiaries receiving cash plus SBCC are adopting improved behaviours. When receiving cash plus SBCC, the infant and young child feeding practices improved among programme beneficiaries. In the Dry Zone MCCT RCT, relative to the control group, the proportion of children who met the minimum dietary diversity score is about 19 percentage points higher and the proportion of children receiving a minimum acceptable diet is over 20 percentage points higher among those whose mothers received cash plus SBCC.

Evidence also suggests that SBCC plus cash has a positive impact on mother's dietary intake. For the Minimum Dietary Diversity Score for Women, there was a 0.444 unit increase ($p < 0.01$) in the number of food groups consumed by women in the cash and SBCC intervention relative to the control group. Beneficiaries receiving cash plus SBCC are also 14.8 percentage points more likely to meet the minimum dietary diversity score threshold relative to the control group.

In terms of WASH, those in the SBCC plus cash group demonstrated an increase in hand washing behaviour over those in the control group and also were 1.4 percentage points more likely to use soap for hand washing compared to the control group.

Maternal health was also positively impacted. According to a study of the Rakhine MCCT, the provision of cash plus SBCC increased utilisation of antenatal care services compared with SBCC alone. In fact, 43 per cent of women receiving cash and SBCC attended four antenatal visits compared to only 25 per cent of those women who received SBCC but no cash. Also in the Rakhine MCCT, minimum meal frequency, minimum dietary diversity, and minimum adequate diet were higher among children at 12 months whose mothers received SBCC and cash than those whose mothers received SBCC alone.

In an analysis of several monthly rounds of PDM (December 2017 to July 2019) from the Delta MCCT, when asked what impact the MCCT had on them, more than two-thirds of respondents (69%) said that they were accessing regular antenatal care from a health provider.

Behaviours that did not see a major change in the Dry Zone RCT between the cash only group and the group receiving cash and SBCC include those related to safe water treatment and water storage. There were also no major changes in self-reported rates of child illness and postnatal care with skilled health providers, relative to the control group. There are a

34. Respondents are purposively selected in PDMs, which means that the data is not representative. The data provides general insight on major findings and where necessary tries to point to township level differences.

number of possible reasons why this could be the case; one could be that these behaviours were not prioritised and promoted by the project as much as other behaviours, or perhaps a longer intervention would have been required to detect change.

Women start antenatal care earlier. One important behaviour is seeking antenatal care as soon as a woman knows she is pregnant. Early antenatal care can serve as an entry point to the health system and its services. Because women need to have a confirmed pregnancy to receive the MCCT, women started antenatal care much earlier, which is a major benefit of MCCTs, according to the Rakhine MCCT's final evaluation.

Women in the MCCT programmes did not change fertility, desired fertility, or use of family planning. According to the Dry Zone study, women who receive the cash transfer do not appear more likely to be currently pregnant and do not have a higher number of pregnancies since the start of the programme relative to the control group. The study also did not find any statistically significant results on the desire of women or their husbands to have an additional child. This suggests that there are no fertility effects of the programme. The reason for this is unknown, but study authors observe that this is unsurprising due to the relatively small size of the cash transfer.

There are benefits to electronic payments, including that they are a more secure way of delivering cash to beneficiaries, however it comes at a cost to the nutrition SBC component as the programme is currently structured. According to the Bright Sun's final evaluation, during manual distribution women had higher attendance at nutrition sessions (to collect the cash) and thus greater exposure to messages. It is crucial to pursue other innovative ways to reach women with important messaging through alternative channels or to find other ways to encourage mothers to attend nutrition education sessions and seek interpersonal contact with health care professionals. There are questions about the quality of nutrition sessions being held at cash distribution points, when attendees are likely distracted by the cash distribution process. The MCCT will need to explore alternative, innovative SBC approaches as it transitions to electronic payment systems.

LOOKING FORWARD: PROPOSING A COMMON MODEL

THE CORE ELEMENTS OF
A SUCCESSFUL MCCT
PROGRAMME FOR NUTRITION

LOOKING FORWARD:
PROPOSING A COM-
MON MODEL

LOOKING FORWARD: PROPOSING A COMMON MODEL

The core elements of a successful MCCT programme for nutrition

MCCT programming is still an evolving area of implementation research in the development and social sectors. While there is data now to affirm the relevance and importance of an MCCT model with both cash and SBC components, the next step is to gather more comprehensive data on the effectiveness and feasibility of different SBC modalities. Where cash is distributed, what packages of interventions and approaches work best to improve nutrition outcomes? To date, there is insufficient data from MCCT programmes in Myanmar to indicate what elements of modalities in programmes with SBC approaches work best and why.

There is also limited evidence on individuals' exposure to the programme activities, and a lack of behaviour change process indicators that measure individuals' progress towards behaviour change. While there is certain global and regional data that can be accessed to indicate what strategies tend to work best in similar settings, operational research and learning in Myanmar is critical to better understanding the most effective mechanisms for behaviour change for better nutrition.

Drawing on the available evidence and lessons learned, however, we can conclude that there are a number of core elements of a successful MCCT programme for nutrition, which are illustrated in the table below:

Cash should...	Linkages to health services should ...	SBC should...
• Be paired with SBC in order to have maximum impact on nutrition **(1, 2)** • Be given to women, who decide how to spend it **(3, 4)** • Be distributed regularly (monthly) in modest quantities – small enough not to create conflict in the home; but large enough to make meaningful food and health care purchases **(5, 6)** • Be an efficient process that does not take too much of women's time **(7)** • Target mothers of children aged under 2 **(3, 7, 8, 9)** • Be of sufficient duration to see impact **(1, 7)**	• Be recommended, facilitated and encouraged but not required to receive cash in systems with supply side issues **(10)** • Be facilitated by linking the registration process with midwives providing antenatal care **(1)**	• Be based on formative research to identify cultural barriers and enablers to optimal feeding practices, to shape the intervention strategy, and to formulate appropriate messages and mediums for delivery **(11)** • Use diverse platforms and techniques **(12, 13)** • Target key influencers (husbands, grandmothers, etc.) in addition to program beneficiaries in order to increase the social support from family and community to boost behaviour change. **(14)** • Employ frequent interpersonal contact **(13)** • Outline impact pathways and assess intermediary behaviour changes **(11)** • Be monitored regularly **(15, 16)**

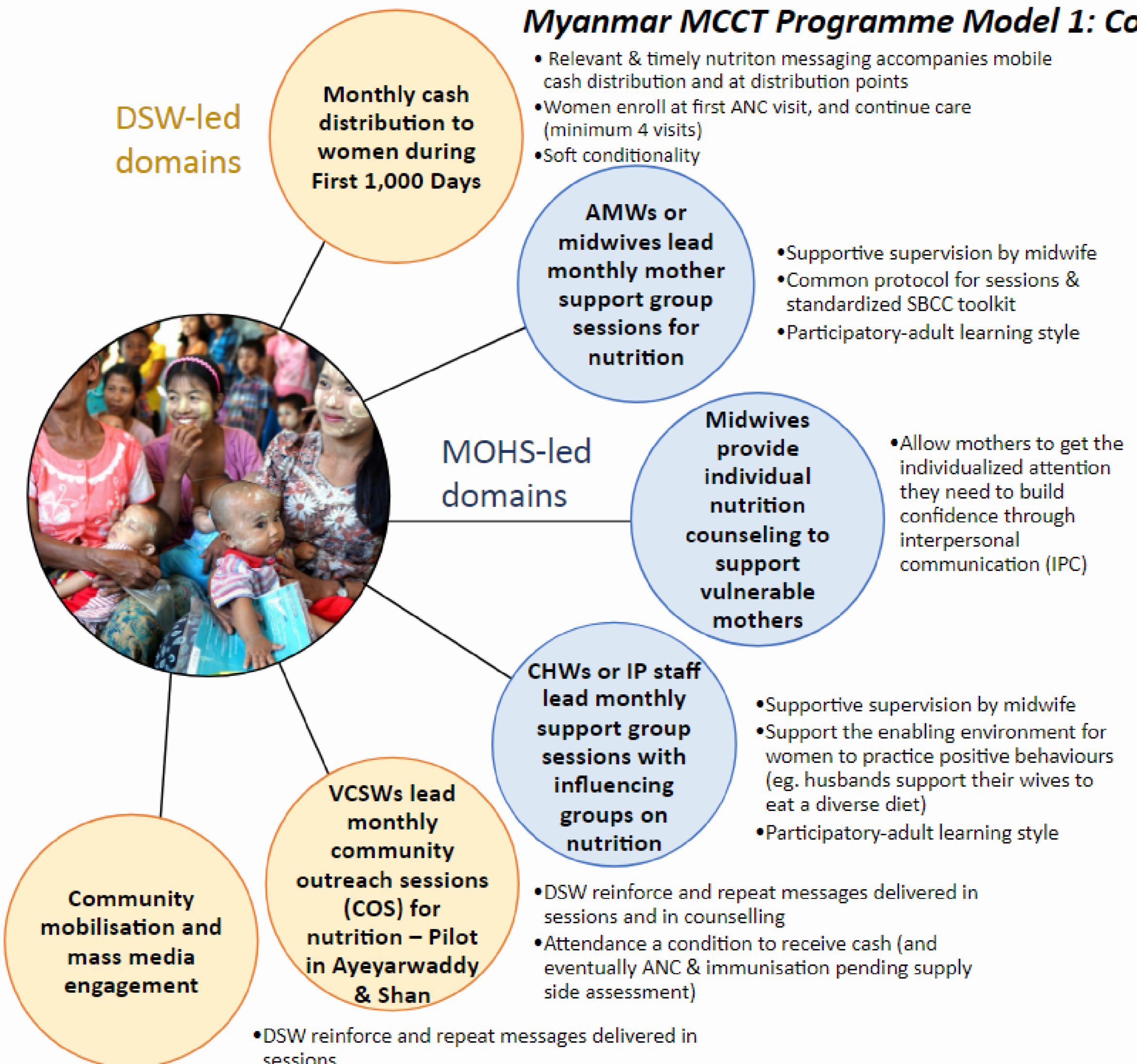
(1) Dry Zone MCCT
(2) Ahmed 2019
(3) Leroy 2009
(4) Myanmar MCCT PDM data
(5) Mercy Corps 2017
(6) Hagen-Zanker 2017
(7) de Groot 2017
(8) Lagarde 2009
(9) Manley 2012
(10) de Groot 2015
(11) Fabrizio 2014
(12) Girard 2019
(13) Lamstein 2014
(14) Ling Shi 2011
(15) USAID & SPRING 2017
(16) UNICEF 2018

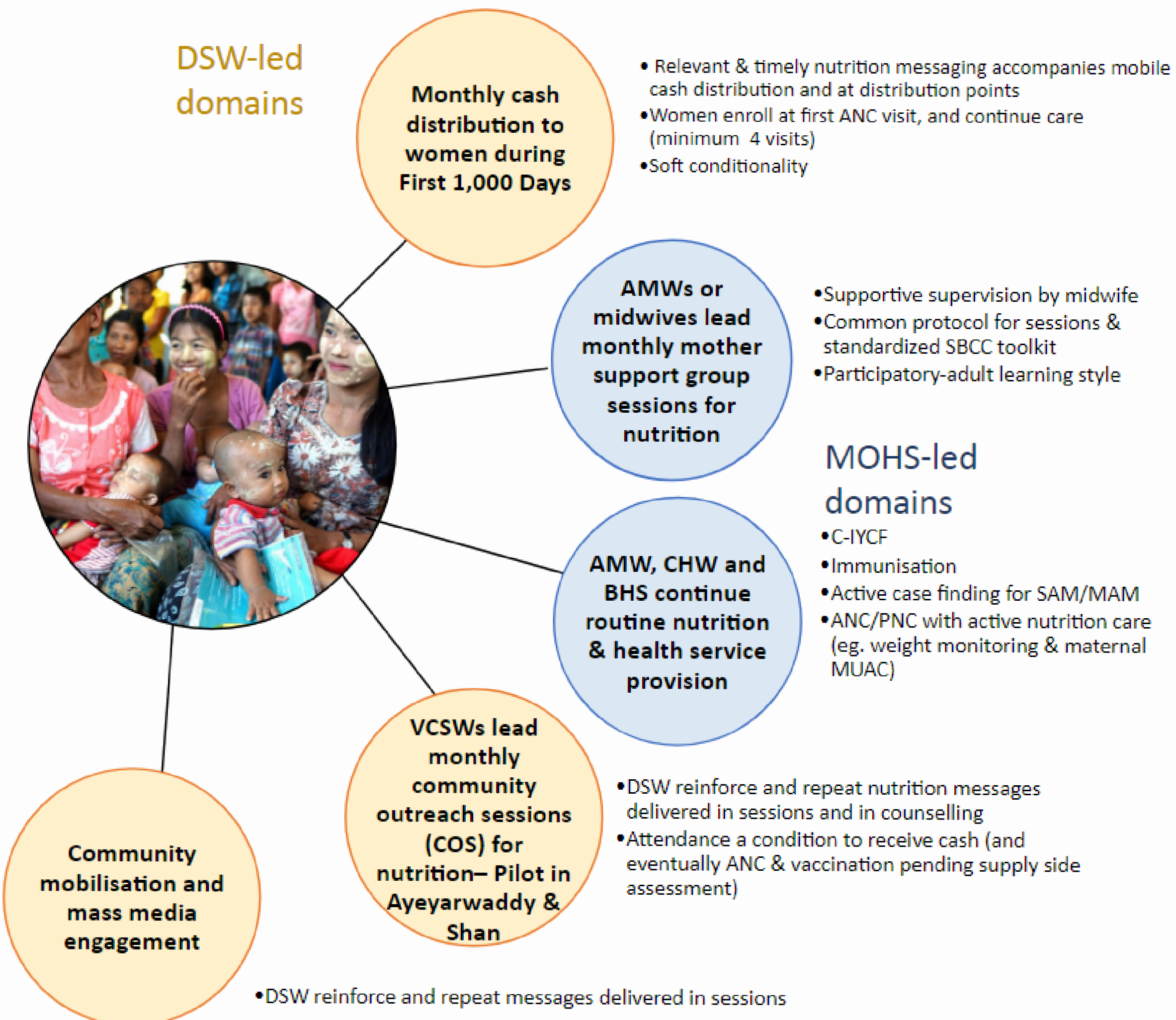
Taking into consideration the core elements of a MCCT programme, global evidence on the characteristics of a successful MCCT programme, as well as Myanmar's unique operational context, two potential designs for Myanmar's MCCT programme emerge. The first model demonstrates an ideal comprehensive design, while the second model demonstrates a simpler design better suited to a leaner funding context. The graphics also represent the important but separate functions of the DSW and MoHS; in both models, the DSW as well as the MoHS are responsible for key domains of programme implementation. While DSW can support behaviour change through nutrition-sensitive and programme-related messaging and community mobilisation, the MoHS staff and volunteers have a unique role to play in delivering counselling and health services.

The models reflect the fact that in Ayeyarwaddy and Shan States the government is piloting a MCCT model, funded by the World Bank, which includes a cadre of DSW staff known as Community Outreach Support (COS) volunteers to lead monthly community outreach sessions. These COS workers would share information relevant to the MCCT programme, as well as support health care workers in the delivery of important nutrition messages.

One difference between the comprehensive and minimum functional models is that in the first model, health staff facilitate two types of nutrition sessions. One set of sessions is led by MWs or AMWs and targeted towards MCCT beneficiaries while the other is led by Community Health Volunteers (CHVs) towards key influencers and other non-beneficiaries. This model requires some task-shifting from basic health staff to CHVs in order to share the burden of work; in the past, often these groups have been combined. This audience segmentation of nutrition support group sessions, however, is designed to support more effective messaging. In the comprehensive model, mothers have a safe space to openly discuss questions and concerns with highly tailored and targeted messaging in an intimate context while non-beneficiaries have a separate forum within which to learn how to support mothers and children. While the majority of AMWs and MWs are women, both men and women serve as CHVs.

Another difference between the two models is that the first model places a greater emphasis on individual counselling, which is highly effective but time consuming. While individual nutrition and health counselling is a component of the Myanmar health care system, in a context where health resources are constrained, the extent to which this occurs varies.


Myanmar MCCT Programme Model 1: Comprehensive Design
DSW-led domains
Monthly cash distribution to women during First 1,000 Days
• Relevant & timely nutriton messaging accompanies mobile cash distribution and at distribution points
•Women enroll at first ANC visit, and continue care (minimum 4 visits)
•Soft conditionality
AMWs or midwives lead monthly mother support group sessions for nutrition
•Supportive supervision by midwife
•Common protocol for sessions & standardized SBCC toolkit
•Participatory-adult learning style
MOHS-led domains
Midwives provide individual nutrition counseling to support vulnerable mothers
•Allow mothers to get the individualized attention they need to build confidence through interpersonal communication (IPC)
CHWs or IP staff lead monthly support group sessions with influencing groups on nutrition
•Supportive supervision by midwife
•Support the enabling environment for women to practice positive behaviours (eg. husbands support their wives to eat a diverse diet)
•Participatory-adult learning style
VCSWs lead monthly community outreach sessions (COS) for nutrition – Pilot in Ayeyarwaddy & Shan
•DSW reinforce and repeat messages delivered in sessions and in counselling
•Attendance a condition to receive cash (and eventually ANC & immunisation pending supply side assessment)
Community mobilisation and mass media engagement
•DSW reinforce and repeat messages delivered in sessions


Myanmar MCCT Programme Model 2: Minimum Functional Design
DSW-led domains
Monthly cash distribution to women during First 1,000 Days
• Relevant & timely nutrition messaging accompanies mobile cash distribution and at distribution points
•Women enroll at first ANC visit, and continue care (minimum 4 visits)
•Soft conditionality
AMWs or midwives lead monthly mother support group sessions for nutrition
•Supportive supervision by midwife
•Common protocol for sessions & standardized SBCC toolkit
•Participatory-adult learning style
MOHS-led domains
•C-IYCF
•Immunisation
•Active case finding for SAM/MAM
•ANC/PNC with active nutrition care (eg. weight monitoring & maternal MUAC)
AMW, CHW and BHS continue routine nutrition & health service provision
VCSWs lead monthly community outreach sessions (COS) for nutrition– Pilot in Ayeyarwaddy & Shan
•DSW reinforce and repeat nutrition messages delivered in sessions and in counselling
•Attendance a condition to receive cash (and eventually ANC & vaccination pending supply side assessment)
Community mobilisation and mass media engagement
•DSW reinforce and repeat messages delivered in sessions

KEY FINDINGS AND RECOMMENDATIONS

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The key findings related to SBC in Myanmar's MCCT programmes have led to a series of recommendations for the GoUM and its supporting partners to support nutrition outcomes. The findings and recommendations are based on a review of models and available evidence, including programme design and strategy documents, materials, post-distribution monitoring data, mid-term reports, endline reports, mid-term project evaluations and final project evaluations from LIFT-funded projects. In particular, this includes a review of the LIFT-funded Dry Zone MCCT RCT. They also draw from meeting minutes from MEAL & SBCC Committee and Task Force meetings, led by the DSW and HLPU and interviews conducted with key stakeholders, participants and experts. Meetings and interviews were held with National Nutrition Centre (NNC), Health Literacy Promotion Unit (HLPU), the Chin Township and State Health Departments, the Department of Social Welfare (DSW) national and Chin State teams, MCCT NGO implementing partner Save the Children International, programme participants, World Bank, Alive & Thrive and UNICEF. Please see Annex 3 for a list of interviews and meetings with key informants and stakeholders.

The following table provides a series of concrete recommendations for the GoUM and the UNOPS multi-donor funds (LIFT and A2H), based on extensive consultations with stakeholders. While the recommendations are formulated for LIFT and A2H, most recommendations to UNOPS are relevant to all stakeholders supporting government-led MCCTs.

1. Improving collaboration and coordination for programme implementation

<table>
<tr><td colspan="2">Finding 1.1- SBC has become seen as the work of MoHS, exclusively. However, SBC is a tool that can be used in any sector in order to challenge norms and promote the adoption of positive nutrition behaviours. Nutrition challenges are multi-sectoral, and therefore require the involvement of multiple stakeholders.</td></tr>
<tr><td colspan="2">Recommendations 1.1</td></tr>
<tr><td>UNOPS</td><td>Government</td></tr>
<tr><td>LIFT/A2H FMO: Educate stakeholders and ensure there is broad ownership of SBC, where possible.

Frame DSW's work as 'nutrition-sensitive' SBC, which according to the MS-NPAN requires the involvement of other ministries.

Collaborate with DSW and World Bank to prioritise behaviours related to gender, making healthy and wise shopping decisions, joint decision making, providing support to pregnant women and mothers, sharing work loads, and increasing the demand for health services, etc.

Support the DSW to work with communications/SBC experts to develop a relevant programme brand, messages and strategy to market prioritised behaviours at cash distribution points or other relevant platforms for programme beneficiaries and key influencers. Coordinate closely with MoHS and partners to ensure that it is coherent with or complementary to the national nutrition SBC strategy.</td><td>DSW: Focus on community mobilisation, organising and educating key influencers, and supporting behaviour change for nutrition-sensitive practices. Work with communications/SBC experts to develop a relevant programme brand, messages and strategy to market prioritised behaviours.</td></tr>
</table>

Finding 1.2- Although inter ministerial collaboration is improving over time, there is insufficient coordination of the SBC component at the Union level and varying levels of coordination at State/Region and Township levels. The differences seen between State/Regions depends heavily on the capacity, interest and commitment of individuals from different departments, demonstrating that coordination mechanisms are not institutionalised. The original SBCC coordination mechanisms, including the SBCC Committee, chaired by the DSW, and SBCC Task Force, chaired by the HLPU in the DoPH, are currently not functional.	
Recommendations for 1.2	
UNOPS	Government
LIFT/A2H FMO & IPs: Support the government to make effective use of meeting time for coordination. Identify and leverage opportunities for collaboration at State/Region and Township levels.	DoPH and DSW (Township and State-level): In areas where MoSWRR and MoHS are coordinating, alternate hosting of ongoing monthly township and quarterly state/ regional meetings by MoSWRR and MoHS. DoPH (Union level): Issue official letters of support to states and regions to sanction specific areas of collaboration (such as alternating hosting monthly meetings).
Finding 1.3- The MoSWRR and MoHS collaborate best when roles are clear and ownership is defined.	
Recommendations for 1.3	
LIFT/A2H FMO: Support structured collaboration at the national level, facilitate fostering complementary domains of ownership where possible. Within the realm of SBC, LIFT can support DSW to implement nutrition-sensitive SBC. A2H can support the MoHS to document activity protocols or guidelines for MCCT-related activities (among others) led by the MoHS, such as mother-to-mother support groups and cooking competitions. A2H can also advocate to the MoHS that AMWs and CHWs have an official role in the MCCT programme, promoting and acknowledging their ability to contribute while helping to relieve the workload of midwives.	
Finding 1.4- Facilitating linkages to the health system are critical, however the health system is currently facing a number of challenges related to HR capacity and service delivery. Midwives are already overloaded with responsibilities, so assigning additional time-intensive nutrition SBC tasks is not realistic, particularly when community-based workers may be better positioned for these tasks.	
Recommendations for 1.4	

UNOPS	Government
LIFT/A2H FMO: Support MCCT task shifting from midwives to AMWs and CHWs by advocating to formalise their role in nutrition behaviour change and MCCT activities. Support MoHS to include community-level MCCT-related responsibilities in AMW and CHW job descriptions, and to formalise this in key policy and strategy documents, including MCCT operation manuals, MS-NPAN, National Health Plan, State/Region health plans, forthcoming national SBCC strategy and forthcoming CBHW policy. LIFT/A2H IPs: Collaborate with AMWs and CHWs to fulfill their responsibilities. Support building the capacity of AMWs and CHWs in counselling services, breastfeeding, and other important skills for nutrition-behaviour change (counselling, communication skills, listening techniques, effective facilitation, etc.).	DoPH and DSW: Coordinate to support MCCT task-shifting from midwives to AMWs and CHWs. DoPH: Formalise the role of AMWs and CHWs in the health system. Assign official responsibilities, including supporting behaviour change for nutrition in communities and activity reporting. To reduce turnover and acknowledge their service, provide minimal payment for their work.

Finding 1.5- LIFT and A2H have strong, productive relationships with government partners in MoSWRR and MoHS, which should continue to be prioritised. At the same time, there is an important opportunity to further collaboration and coordination with the World Bank, particularly on nutrition-sensitive SBC matters.
Recommendations for 1.5
LIFT/A2H FMO: Continue to communicate directly and regularly with government as often as possible. Collaborate with World Bank, UNICEF and relevant partners to provide direct support to DSW to fill current gaps, including supporting building institutional capacity in for nutrition-sensitive SBC. Also, continue to support SBC capacity-building initiatives with MoHS (in collaboration with UNICEF, Alive & Thrive and World Bank).
Finding 1.6- Civil society plays an important role in supporting and amplifying the government's SBC efforts.

Recommendations for 1.6
LIFT/A2H IPs: Support the MCCT in ways that are relevant to LIFT and A2H-funded programming. For example, support social/community mobilisation, prioritisation of behaviours, monitoring uptake of behaviours, identification of innovative communication platforms, dissemination of media and job aids, building the skill and knowledge capacity of community health volunteers in nutrition behaviour change, etc. Also, practice evidence-based SBC programming; develop SBC programme strategy; monitor pathways to behaviour change. LIFT/A2H FMO: Enable IPs through funding and technical support, particularly in MCCT programme areas. Task the LEARN Project and its Master Trainers with continuing to build the skills and knowledge capacity of partners in formative research gathering and nutrition behaviour change programming. Hold partners accountable for evidence-based SBC programming by requiring partners to articulate pathways of behaviour change in their project Theory of Change; hold partners accountable for development of SBC strategy and monitoring pathways to behaviour change. Where geographically and thematically relevant, encourage LIFT and A2H partners to collaborate on behaviour change programming, resource development/ dissemination and evidence generation.

2. *Strengthening programme strategy for improving nutrition outcomes*

Finding 2.1- There is no overarching nutrition SBCC strategy for the national MCCT. Currently, the SBC component of the national MCCT programme faces challenges, and would benefit from a roadmap.	
Recommendations for 2.1	
UNOPS	**Government**

<table>
<tr><td>LIFT/A2H FMO: Support DoPH through funding and technical support (with UNICEF). Propose common SBC vocabulary, a common template for SBC strategy development, a list of recommended formative research methods (and protocols) for collaboration with DoPH, DSW and partners. This would be relevant (but not exclusive to) to the National Nutrition SBCC Strategy.

With these commonly-agreed-upon vocabulary and tools, move forward to support DSW to develop state/regional nutrition SBCC-MCCT strategies. Leverage evidence from LIFT-funded projects, where available, to inform strategy. Support DSW (with the aid of communications/SBC experts) to develop a programme brand and identify and prioritise key nutrition-sensitive behaviours, develop key messages and materials for the target population and key influencers.

Support DoPH to develop relevant activity protocols, resource guides for Mother Support Groups, cooking demonstrations, and other government-supported modalities for nutrition behaviour change.</td><td>DoPH: Ensure that MCCT is complementary with, the forthcoming national Nutrition SBCC Strategy. Engage relevant stakeholders in the process, including DSW and civil society partners.

DSW: Develop a National SBCC-MCCT plan that is consistent with the Nutrition SBCC Strategy and contextually relevant to the MCCT programme.</td></tr>
<tr><td colspan="2">Finding 2.2- The SBC approaches currently used at state levels (SBCC plans of action) are useful, but insufficient. They are essentially implementation plans for rolling out cascade trainings and community engagement activities (health education session, cooking demonstration, mothers group discussion).</td></tr>
<tr><td colspan="2">Recommendations for 2.2</td></tr>
<tr><td>UNOPS</td><td>Government</td></tr>
<tr><td>LIFT/A2H FMO: Upon the development of common SBC vocabulary, a common template for SBC strategies, a list of recommended feasible formative research methods (and protocols), support States to develop adapted strategies with the guidance of communications/SBC experts.</td><td>DSW: Adapt national SBCC MCCT strategy to states/regions.</td></tr>
</table>

Recommendations for 2.3
LIFT/A2H FMO: Develop user-friendly SBC briefs in Myanmar language to share with DoPH and DSW. Support government to come to a consensus with key partners on common terminology and vocabulary for SBC-related terms, template for strategy and recommended feasible formative research methods. Encourage partners to participate in common usage. Seize capacity building opportunities, such as the development of the SBCC-NPAN Strategy. LIFT/A2H invest in high quality international SBC training for national, state and township-level government staff. The Designing for Behaviour Change (DBC) Framework training is a useful and practical resource which has been adapted and translated into Myanmar language by Save the Children's LEARN Project. Invest in heavy revision of SBCC training for frontline workers. Instead of a training generically termed 'SBCC', either create new or revise current trainings for relevant audiences to improve skills to promote behaviour change. For example, midwives, AMWs and CHWs should be skilled in individual counselling, communication skills, listening techniques, effective facilitation, etc. LIFT/A2H IPs: Provide input into process and participate in common usage and seize capacity building opportunities with government—particularly CHWs and AMWs— in project areas.

3. Improving effectiveness of SBC modalities for better programme quality

Finding 3.1- Standard operating procedures or protocols for MoHS-led SBC activities, including mother support groups, home counselling and cooking competitions are outdated (or do not exist) and are not currently used.	
Recommendations for 3.1	
UNOPS	**Government**
LIFT/A2H FMO: Support DoPH to identify and revise or develop SOPs for various activities. Support DSW to adopt SOPs in the MCCT manual. These can be revised periodically.	DoPH: Revise or develop SOPs for activities. DSW: Include revised SOPs in MCCT manual

Finding 3.2- In particular, the way mothers group sessions and SBCC awareness sessions (sometimes called awareness-raising sessions, nutrition awareness sessions, health education sessions, and mother-to-mother support group sessions) are conducted is inconsistent and should be revised. For example, in some settings, non-beneficiaries (including men) are invited, which may hinder women's willingness to speak or ask questions without reservation.
Recommendations for 3.2
DoPH: For mother support groups, create a safe and intimate space for women to discuss relevant issues. Finding alternative times (other than cash distribution) is also important as manual cash distribution will shift to e-payment. Segment audiences for mother support groups, key influencer groups and community awareness sessions. DSW: Consider a more appropriate way to engage with beneficiaries and their proxies at cash distribution time, such as recorded messages, mobile cinema, campaign events, etc. Consider ways to support and educate key influencers (such as men and older women).
Finding 3.3- There are insufficient standard, participatory tools and job-aids for health professionals, to support behaviour change, particularly in local languages.
Recommendations for 3.3
LIFT/A2H FMO: Provide financial and technical support through SBCC-NPAN strategy for MoHS. Provide direct support to DSW. Collaborate with World Bank for DSW COS session tools for VSCW. Partners collaborate to share tools and resources and jointly develop innovative tools where necessary.
Finding 3.4- Platforms for SBC are somewhat lacking in diversity and innovation.
Recommendations for 3.4
LIFT/A2H IPs: Diversify SBC modalities. Consider alternatives to education-focused change techniques/ interventions that create opportunities for social support, that create enabling physical environments and that improve problem-solving skills and self-efficacy. Also consider mobile platforms.

4. Harnessing cash for nutrition outcomes

<table>
<tr><td colspan="2">Finding 4.1- E-payments and mobile messaging are not seen as an opportunity for integration. E-payments provide a natural platform for sharing nutrition relevant nutrition content at scale.</td></tr>
<tr><td colspan="2">Recommendations for 4.1</td></tr>
<tr><td>UNOPS</td><td>Government</td></tr>
<tr><td>LIFT/A2H IPs: Continue to seek partnerships with technology partners for opportunities for innovative platforms for nutrition SBC.</td><td>DSW: Mobile payment and the use of mobile phone as an SBC modality should not be considered separately, but rather should be part of an integrated package. Support integration of mobile payment and messaging platform in future tenders for mobile payment providers.</td></tr>
<tr><td colspan="2">Finding 4.2- Cash payments may be three-monthly in some areas (45,000 MMK instead of 15,000 MMK), which raises concerns about the potential that cash will more likely be used for non-nutrition or health purchases. While it is unlikely that this change in amount would lead to intimate partner violence, it is worth monitoring any potential risks that may be associated with increasing the quantity of cash that beneficiaries will receive at a given time.</td></tr>
<tr><td colspan="2">Recommendations for 4.2</td></tr>
<tr><td>UNOPS</td><td>Government</td></tr>
<tr><td>LIFT/A2H FMO: Support DSW to monitor potential negative impacts of less frequent cash distribution.</td><td>DSW: The negative side effects of delivering cash less frequently than monthly in this context should be examined. It is possible that larger sums of cash will be seen as substantial and therefore less likely to be used on small, regular, nutrition-related household purchases, as is intended. Furthermore, distributing larger sums of cash to women could potentially contribute to intimate partner violence in certain circumstances.

Until cash is distributed monthly electronically, monitor the effect of distributing larger sums of cash on women's control over cash, purchases and intimate partner violence, as these unintended effects could potentially undermine the nutrition objectives of the programme.</td></tr>
</table>

5. Improving monitoring and learning

<table>
<tr><td colspan="2">Finding 5.1- MCCT programmes have developed successful methods for monitoring the cash component of the programme. However, there is little in the way of SBC monitoring, particularly with respect to behaviour change pathways.</td></tr>
<tr><td colspan="2">Recommendations for 5.1</td></tr>
<tr><td>UNOPS</td><td>Government</td></tr>
<tr><td>LIFT/A2H IPs: Integrate behaviour change monitoring tools, such as periodic LQAS or FGDs into programme design</td><td>DSW: Strengthen SBC-nutrition component of PDM tool in order to gather data for SBC programme learning.</td></tr>
<tr><td colspan="2">Finding 5.2- The comparative effectiveness of SBC modalities (including their quality, frequency and exposure) and activities used in MCCT programming have not been sufficiently explored in Myanmar. For example, mothers groups are an often-used modality, though quality and form vary. Evidence of their effectiveness as a channel needs further exploration in Myanmar in comparison to other models.</td></tr>
<tr><td colspan="2">Recommendations for 5.2</td></tr>
<tr><td>UNOPS</td><td>Government</td></tr>
<tr><td>LIFT/A2H IPs: Engage in research or structured programme learning on mother support group model and other commonly used modalities.

LIFT/A2H FMO: Encourage the government to support operational research to test the Volunteer Community Social Worker (VCSW) model pilot and compare to the mother support group model.</td><td>DSW: Engage in operational research or structured learning to test the effectiveness of the VCSW versus the health worker-led model</td></tr>
<tr><td colspan="2">Finding 5.3- There are major constraints to evidence-generation in Myanmar which hinders the SBC work of partners. In many cases, the long lead time needed for government ethical approval has made gathering information such as formative research to inform programme design or implementation nearly impossible.</td></tr>
</table>

Recommendations for 5.3	
UNOPS	Government
LIFT/A2H FMO: Seek guidance from the government on appropriate, recommended, feasible formative research methods. Share this information with partners. Encourage partners to collaborate on research initiatives where possible. Advocate for ethical review processes options that are streamlined and fast-tracked. LIFT/A2H IPs: Use secondary data where available. Engage in joint research initiatives, where feasible.	DoPH: Allow for ethical review process options for formative research that are streamlined and fast-tracked.

Myanmar's MCCT programme, which is a highly dynamic programme, continues to expand to cover women and children in more states and regions. Given the fast pace of programme developments and adaptations and changing contexts, it may be useful to revisit the recommendations in this paper in the future to ensure their relevance.

CONCLUSION

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The findings and recommendations above relate to ten overarching priorities to improve Myanmar's MCCT programmes for positive nutrition outcomes. While the recommendations target specific actors, these priorities have been identified for the larger community of MCCT and nutrition stakeholders to consider. Like the key findings and recommendations above, these priorities are based on programme models, available evidence, and stakeholder interviews. Similarly, they relate to: improving collaboration and coordination, strengthening programme strategy, improving the effectiveness of SBC modalities, harnessing cash for nutrition outcomes, and improving monitoring and learning:

Improving collaboration and coordination

1. **Foster broader participation and investment in SBC work by multiple partners to support nutrition-specific and nutrition-sensitive behaviours.** Nutrition-sensitive approaches both in and outside the health sector are critical to addressing the problem of undernutrition in Myanmar. Increase the MCCT programme emphasis on nutrition-sensitive behavioural domains related to WASH, women's empowerment/decision making, financial literacy, and other priority areas identified in formative research. Partners have unique and complementary roles to play in addressing the multiple factors contributing to undernutrition.
2. **Engage in, and provide resources to support, the forthcoming community health volunteer policy.** In addition to strengthening capacity nationally in SBC approaches, ensure that MCCT linkages to health services are sound and that the health workforce is sufficient and has the capacity to support the delivery of nutrition interventions. Community health volunteers, which include community health workers and auxiliary midwives, are the government's frontline healthcare workers. This volunteer cadre is foundational in providing the interpersonal communication needed for behaviour change in the Myanmar MCCT context.
3. **Work with the government to agree upon a common government-led model with standard operating procedures or protocols, standard job aids and learning tools with a training curriculum, guided by a central MCCT strategy and inter-ministerial coordination mechanism.** Current State/Region-led 'action plans' are important, but insufficient. In light of a common government-led model, these action plans can be adapted to the geographic, social, and political realities of different states and regions. However, overall guidance from the central level is critical.

Strengthening programme strategy for improving nutrition outcomes

4. **Identify opportunities for synergy and collaboration between the forthcoming development of the Social and Behaviour Change Communication National Plan of Action for Nutrition (SBCC-NPAN) Strategy** and the national MCCT programme. The MCCT is an important platform for national SBCC efforts and should be included in the national SBCC-NPAN Strategy; likewise, the SBCC-NPAN Strategy should take the MCCT programme's needs, progress, and delivery platforms into account in order to develop a stronger strategy.

Improving the effectiveness of SBC modalities for better programme quality

5. **Align the methodology of SBC approaches with global best practices in order to implement high quality SBC.** This includes following the required steps of the SBC process in order to conduct meaningful SBC. Use national platforms, including the Multi-Sectoral National Plan of Action for Nutrition (MS-NPAN) and the SBCC-NPAN Strategy, to promote higher standards for SBC programming. Partners should agree upon common definitions of SBC terminology and approaches.
6. **Facilitate the use of formative research to develop strategies and inform future programme design.** Many programmes are lacking in formative research to inform their approaches. This is a critical step in the design of effective SBC programming. Government and partners should collaborate to agree on common, acceptable research methods and processes that are streamlined, as well as options for fast-tracking approval.
7. **In addition to targeting the beneficiary population in MCCT programmes, support meaningful involvement of those who influence them (such as husbands, grandmothers, religious leaders, etc.).** Civil society plays a valuable role in collaborating with the government to reach keasdfhe community.

Harnessing cash for nutrition outcomes

8. **Capitalise on mobile technology and other innovative platforms to allow SBC approaches to be implemented at scale.** Mobile payment and the use of mobile phone as an SBC modality should not be considered separately, but rather should be part of an integrated package. Diversifying interventions to reach mothers and their children through multiple, layered channels is crucial to achieving behaviour change. While mobile technology can not replace human interactions, it is a powerful tool.

Improving monitoring and learning

9. **Continue to engage in operational research, particularly to better understand the strengths and weaknesses of various modalities for behaviour change.** Questions related to activity quality, frequency, exposure, effectiveness and value for money need to be explored in order to understand the comparative advantages of different modalities. The paucity of evidence on specific behaviour change modalities for nutrition in Myanmar presents a rationale for larger investments and advance planning for research, with key indicators to measure effectiveness. To support positive nutrition outcomes in the First 1,000 Days, adhere to those lessons that have already been learned from Myanmar and global evidence: pair cash with SBC for maximum nutrition impact, link cash distribution to health services, distribute cash unconditionally in the Myanmar context where supply services are inadequate, and deliver cash in small, monthly payments to ensure they are used by women for health and nutrition expenses, among other lessons learned. These are outlined in the following two sections: LIFT-Funded MCCTs: What Have We Learned About SBC Programming? and The impact of cash + SBCC on nutrition outcomes: Evidence from Myanmar MCCT Programmes
10. **MCCT programmes have a strong track record of monitoring the cash distribution component of the programmes; the SBC component should be monitored with the same rigour.** Because behaviour change is a process that is incremental, measuring the target population's progress along behaviour change pathways is critical. Post-distribution monitoring needs to be strengthened to track the uptake of key behaviours, following the example of the 2018 Chin State MCCT monitoring round. Pathways to priority behaviours should be identified and tracked in order to monitor their adoption.

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REFERENCES

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ANNEXES

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Annex 2: Understanding Sbc Theory And Practice
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ANNEXES

ANNEXES

Annex 1: LIFT-Funded MCCT Project Components

	Fully funded by LIFT				***Operational costs funded by LIFT (2018 to 2020)***		***Non-LIFT funded***		
Project Title	Tat Lan II (Rakhine MCCT)	"Bright SUN (Delta MCCT)"	"LEGACY (Dry Zone MCCT)"	MCCT Programme (Chin State)	MCCT Programme (Kayin)	MCCT Programme (Kayah)	MCCT Programme (Rakhine)	MCCT Programme (Naga)	MCCT Programme (Shan & Ayeyarwaddy) – forthcoming
Lead implementing partner	SCI	SCI	SCI	Department of Social Welfare in MoSWRR	Department of Social Welfare in MoSWRR	Department of Social Welfare in MoSWRR	Department of Social Welfare in MoSWRR	Department of Social Welfare in MoSWRR	Department of Social Welfare in MoSWRR
Collaborators	MSWRR (DSW), MoHS, MNMA and PGMF	Wave Money, MoHS	MoHS	DoPH, GAD, Save the Children, IRC, DRC, MMRC, UNICEF	"DoPH, EHOs, GAD, UNICEF"	DoPH, EHOs, GAD, UNICEF	"GAD, UNICEF"	"GAD, UNICEF"	World Bank (Donor)
Geographical coverage	Rakhine State (182 villages in Pauktaw, Myebon and Minbya Townships in Rakhine State)	Ayeyarwaddy Region (202 villages within the coverage of 5 rural health centres in Laputta Township: Kyar Kan, Gan Eik, Kan Bet, Thin Gan Gyi, Yae Saing)	Magway Region (380 villages across three townships)	State-wide (1,463 villages)	State-wide	State-wide	State-wide	Area-wide	State-wide
Intervention period	January 2016 to December 2018	December 2015 to September 2019	May 2016 to December 2018	March 2017 to present	October 2018 to present	October 2018 to present	July 2017 to present	July 2017 to present	Beginning 2020

Cash Component	"Maternal and child cash transfers of 10,000 MMK(increased to 15,000 MMK) per month Cash distributed by programme staff with the involvement of Village Development Committees and community volunteers"	"Maternal and child cash transfers of 10,000 MMK(increased to 15,000 MMK) per month. Innovation: Piloted electronic cash transfers (ECT) through WAVE Money starting in November 2017 starting in 32 villages, expanding to 32 additional villages in June 2018. SC purchased low-cost phones for 407 Wave Money beneficiaries (about 20% of mothers) who did not have access to a phone. Enrollment & cash distribution first delivered through Village Health Committee volunteers at Rural Health Centers, but then MCCT-Focal Groups were created to supervise the MCCT programme in villages"	"Maternal and child cash transfers of 10,000 MMK (increased to 15,000 MMK in September 2017) Cash delivery through Pact Global Microfinance (PGMF) agents. Each beneficiary had an MCCT account and mothers chose how much they wanted to withdraw from the account. An additional pilot tested cash delivery through MNMA and local midwives (Department of Public Health) registering beneficiaries and delivering cash in their routine village visits (with MNMA transferring cash to midwives on a monthly basis)."	Maternal and child cash transfers of 30,000 MMK every two months due to logistical challenges of monthly transfer in Chin State, where the terrain is difficult with limited infrastructure	Maternal and child cash transfers of 45,000 MMK every three months due to logistical challenges of monthly transfer	Maternal and child cash transfers of 45,000 MMK every three months due to logistical challenges of monthly transfer	Maternal and child cash transfers of 45,000 MMK every three months due to logistical challenges of monthly transfer	Maternal and child cash transfers of 45,000 MMK every three months due to logistical challenges of monthly transfer	

SBC Component	"Intensive BCC model -Mother Support Groups -Influential Caregiver Group Sessions -Home visits/ Individual counselling -Community wide information campaigns -Cooking Demonstrations/ Competitions -Community SBCC Sessions -Mobilisation of village authorities and local government"	""Light touch" model -Social and Behaviour Change Communication sessions for pregnant women and mothers of children under 2 years of age through Mother to Mother Support Groups (MtMSGs), and for other community members through community SBCC sessions -Home visits/ Individual counselling -Community wide information campaigns -Cooking Demonstrations/ Competitions -Mobilisation of village authorities and local government"	"Intensive BCC model Midwife-led model MNMA organized SBCC activities in 146 villages designed to receive SBCC + cash The project's key behavioural objectives were refined at the start of the final year of the project. These relate to health seeking behaviours (ANC), maternal nutrition, IYCF and WASH. -Mother Support Groups -Influential Caregiver Group Sessions -Home visits/ Individual counselling -Community wide information campaigns -Cooking Demonstrations/ Competitions -Community SBCC Sessions -Mobilisation of village authorities and local government"	"SBCC Strategy & Formative research (internal to SCI) -SBCC Nutrition sessions/ Mother support groups -Key influencer training for church and other leaders to be Community Nutrition Champions -Cooking competitions -Community wide information campaigns"	"Monthly community engagement led by MoHS (BHS and CHVs): -HE session -Cooking demonstration (no budget for this activity) -Mother group discussion -Also: Family conversations, school health and youth activities -Began Dec 2019/ Jan 2020 According to Kayin State Action Plan"	"Monthly community engagement led by MoHS (BHS and CHVs): -HE session -Cooking demonstration (written in the Kayah State MCCT SBCC Action Plan, however there is no budget for this activity) -Mother group discussion -Began Nov/Dec 2019 According to Kayah State MCCT SBCC Action Plan"	No data	No data	Volunter social worker (DSW) to provide awareness sessions

Technical Assistance or Capacity Building Component		"Government integration and capacity building component: Project delivery through existing 3MDG supported government structures, and capacity building of local health staff to take place at national and township level with support from 3MDG."		"TEAM-MCCT includes two technical assistance components. The first component supports the government in the development of an SBCC approach and delivery of related activities The Monitoring & Learning component includes providing technical assistance to the MoSWRR to develop and implement a monitoring and learning support strategy."		"Capacity Building Training (MCCT + SBCC) at State and Township levels, led by DoPH and DSW in collaboration with EHOs and GAD To begin Quarter 4 2019, according to Kayah State MCCT SBCC Action Plan Capacity building component for baseline assessment"	Capacity building component for baseline assessment		

Monitoring & Learning Component	"Intervention cohort study with 30 pilot villages 15 intervention villages (Cash + intensive BCC) and 15 control villages (intensive BCC only) Direct monitoring, post-distribution monitoring, baseline, midterm, final evaluation"	"Control case study Matched case/control households 202 intervention villages (in Labutta) receiving cash + BCC 202 control villages (in Nyabutaw) receiving no cash or BCC Electronic transfer pilot, direct monitoring, post-distribution monitoring, baseline, midterm, final evaluation."	"Randomised control trial with three comparison 'arms': 1. Cash only 2. Cash + BCC 3. No cash or BCC]Direct monitoring, post-distribution monitoring, baseline, midterm, final evaluation"	TEAM-MCCT supports the government on routine PDM activities, as well as project baseline, midterm and final					
Additional research	Barrier analyses were also conducted to examine the constraints families face to exclusive breastfeeding and dietary diversity	Inclusions survey to determine if there were women who were eligible to receive the MCCT but who were not receiving it	Cost of Diet Study to inform cash transfer amount	Unpublished formative research (conducted for TEAM MCCT)					

Annex 2: Understanding SBC theory and practice

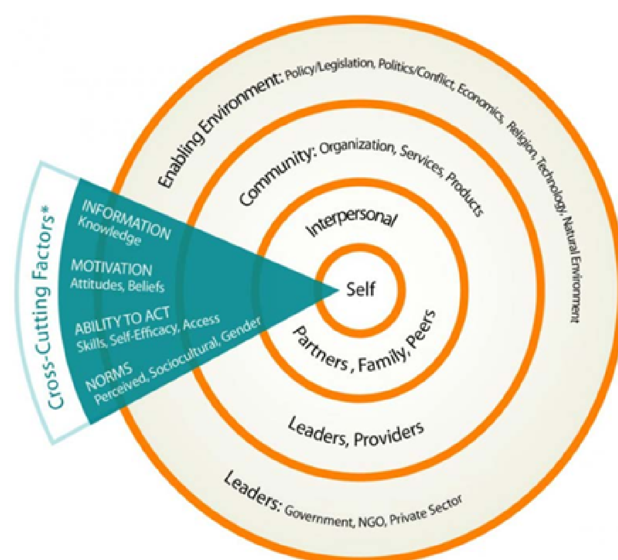
Some of the barriers and factors that contribute to child undernutrition— which vary widely but may be thematically similar in a number of communities— can be addressed through a social behaviour change (SBC) approach. This approach commonly involves a communication element, hence the term Social and Behaviour Change Communication (SBCC).

There are a number of theories of behaviour change. According to one model, the socio-ecological model for behaviour change, whether or not we practice a behaviour is not only controlled by ourselves, but is also fundamentally rooted in the fact that we have interpersonal relationships that influence us, live in a community with institutions that shape and affect us, and policies that govern us.

SBC is an evidence-informed process which seeks to understand why a given target group (women who are pregnant or with children under two, in the case of the Myanmar MCCT Programme) are or are not practicing certain behaviours, and what interventions can help intervene to facilitate the adoption of certain positive behaviours. SBC involves individual strategies including behaviour change communication to address those things that are in the control of the individual, community mobilisation to address communal factors, and advocacy to address relevant policies that either support or inhibit positive behaviours.

The language to describe social and behavior change can vary among institutions and organisations. The following definitions apply to the Myanmar MCCT context.

Figure: Socio-ecological model for SBCC



Source: Spring 2017, Adapted from McKee, Manoncourt, Chin and Carnegie (2000)

BCC, SBCC, SBC: What is the difference?

Behaviour Change Communication (BCC) is an evidence- and research-based process of using communication to promote behaviors that lead to improvements in health outcomes. ... A growing understanding that behaviors are grounded in a particular socio-ecological context and change usually requires support from multiple levels of influence resulted in an expansion of the approach to become S**ocial and Behaviour Change Communication (SBCC)**.... The addition of an 'S' to BCC aims to bring the field closer to the recognition of the need for systematic, socio-ecological thinking within communication initiatives. Individuals and their immediate social relationships are dependent on the larger structural and environmental systems: gender, power, culture, community, organization, political and economic environments. (The Manoff Group 2012)

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SBCC is a set of interventions that combines elements of interpersonal communication, social change and community mobilisation activities, mass media, and advocacy to support individuals, families, communities, institutions, and countries to adopt and maintain high-impact nutrition-related practices. Effective nutrition SBCC seeks to increase the factors that encourage these behaviours while reducing the barriers to change. (USAID 2017)

Social and behaviour change (SBC) is an approach to programming that applies insight about why people behave the way they do, and how behaviors change within wider social and economic systems, to affect positive outcomes for and by specific groups of people (SPRING 2017). Nutrition SBC aims for social and individual behavior changes that improve nutrition outcomes for priority groups.

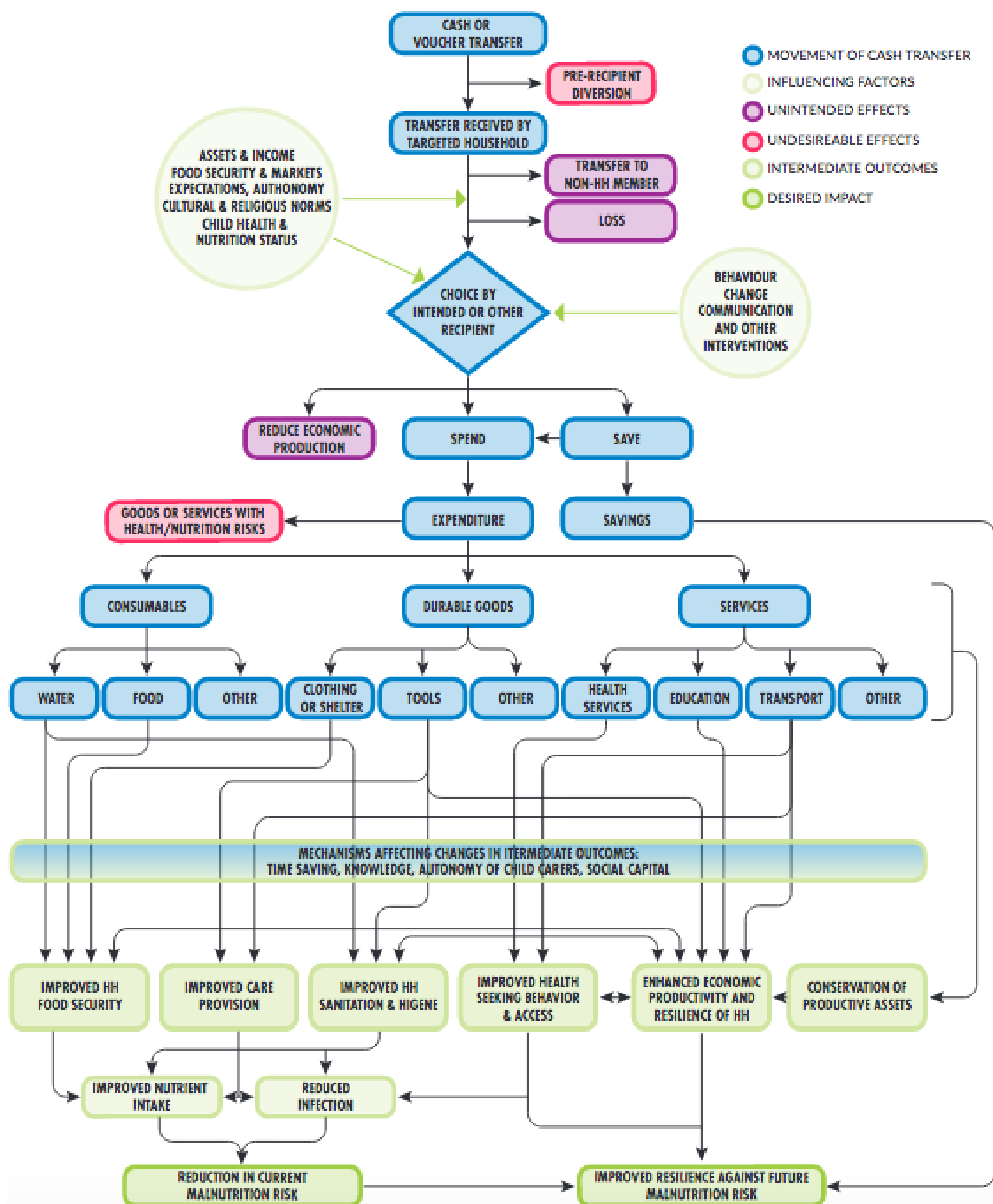
SBC activities focus on changing the behavior of individuals and communities, as well as the social norms and environmental factors that affect those behaviors. (Spring 2017)

Annex 3: List of Interviews/Meetings with Key Informants and Stakeholders

Name	Position	Affiliation
Dr. San San Aye	Director, Department of Social Welfare	MoSWRR
U Kyaw Linn Htin	Assistant Director, Department of Social Welfare	MoSWRR
Aye Min Nyunt	Director	Chin State Social Welfare Office
Ohn Mar Swe	MCCT State Assistant Director	Chin State Social Welfare Office
Joseph Sumpi & Hri Tar	Case Managers - Falam	Chin State Social Welfare Office
Daw Sang Rem	Midwife, Hakha	Township Health Department
Emily Dung Boi	Health Assistant 1	Township Health Department
Daw Tum Cing	Township Health Nurse	Township Health Department
Dr. Zin Ko Ko Aung	Hakha Township Medical Superintendent	Township Health Department
Dr. Mang Biak Kong	Hakha Township Deputy Medical Superintendent	Township Health Department
Daw Sang Rem	Hakha Maternal and Child Health (MCH) Focal person	Township Health Department
Dr. Tin Maung Swe	Chin State Health Director	Chin State Health Department
Dr. Sharun Par	Chin Assistant State Health Director	Chin State Health Department
U Bwai Faa Lin	Chin State Nutritionist	Chin State Health Department
Dr. Phyu Pyu Aye	Director, Health Literacy Promotion Unit	MoHS
Dr. Than Naing Soe	Acting Director, Health Literacy Promotion Unit	MoHS
Dr. Lwin Mar Hlaing	Director, National Nutrition Center	MoHS
Ni Tin Par	Senior Reverend and Community Nutrition Champion	Hniarlawn Baptist Church – Chin State
Lum Bang Mother Support Group members	Participants	Community members—Chin State

Zaw Naing Oo	Programme Officer, LIFT	UNOPS
Paing Soe Kyaw	Project Support Officer, LIFT	UNOPS
Pyae Phyo Aung	Health Team Leader, Access to Health	UNOPS
Hnin Weatherson	Head of Programs – Nutrition	Save the Children
Swe Lin Maung	Senior Nutrition Advisor	Save the Children
Dr. Saw Eden	Senior Nutrition Advisor	Save the Children
Cherry Soe	Head of Programs – Child Poverty	Save the Children
Dr. Sanda Lin	Sr. Program Manager, TEAM MCCT Program	Save the Children
Mira Delmo	Thematic Advisor - Child Poverty	Save the Children
Sui Hnem Cuai	Project Manager, MEAL, TEAM MCCT	Save the Children
Naing Aung	Project Manager, SBCC, TEAM MCCT	Save the Children
Nang Mo Kham	Senior Health Specialist	World Bank
Dr. Theingie Han	Nutrition Program Consultant	World Bank
Francesca Lamanna	Senior Economist	World Bank
Dr. Ye Naing Win	Project Manager	World Bank
Jennifer Cashin	Regional Technical Specialist, Southeast Asia, Alive & Thrive	FHI 360
Nangar Somroo	Social Policy Specialist (Social Protection)	UNICEF
Hnin Su Mon	Communication for Develop-ment Specialist	UNICEF

Annex 4: Theory of Change for REFANI child nutrition programme testing cash-transfers vs. fresh food vouchers alongside BCC



Source: Action Against Hunger, Concern Worldwide, ENN and University College London (2017). REFANI Research on Food Assistance for Nutrition Impact Synthesis Report. Action Against Hunger: London.

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