FEASIBILITY STUDY:
Technical options to implement a universal maternal and child cash transfer program in Myanmar
DISCLAIMER: The findings, interpretations and conclusions expressed in this report are those of the authors and do not necessarily reflect the policies or views of UNICEF.
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Executive Summary

This report presents the findings of a feasibility study of technical options for the implementation of the Maternal and Child Cash Transfer program (MCCT) in Myanmar, which is a cash allowance for pregnant women and children to age two. The objective of this report is to advise the Ministry of Social Welfare, Relief and Resettlement (MSWRR) of the best technical options and potential risks of sustainably implementing the MCCT program today, while proposing novel options for the near future in line with international best practices.

The scope of the MCCT is defined in the National Strategy on Social Protection\(^1\) as a universal cash transfer during the last six months of pregnancy until the child is two years old. The transfer targets mothers and their children during a crucial period in the life cycle to optimise future growth and potential by addressing the determinants of malnutrition and poverty. By seizing the ‘window of opportunity’, that is the first 1000 days of a child’s life, and improving maternal and child nutrition, substantial progress is made in the human development of individuals, their communities and the economic development of the nation.

The report consists of two parts. Part I presents global experience and evidence relevant to the MCCT and its impact on nutrition. Part II recommends options specific for Myanmar’s current context and outlines indicative budgetary considerations.

I. Lessons learnt through international case studies

Investments in nutrition during the first 1,000 days can prevent the intergenerational transmission of poverty and improve key determinants of long-term economic growth:

- Well-nourished children do better in school, and as adults, earn 20 per cent more in the labour market and are 10 per cent more likely to own their own businesses (IDS, 2013).
- Countries can lose between 2 to 3 per cent of their potential Gross Domestic Product (GDP) each year (World Bank 2015) as a result of stunting.
- Every dollar spent on nutrition in the first 1,000 days of a child’s life provides a saving of an average 45 USD and in some cases 166 USD (Hoddinott, 2014).

\(^1\) The Republic of the Union of Myanmar (2014)
In Myanmar 35 per cent of children under 5 are stunted, that is 1.8 million children who are not reaching their full potential, have reduced physical and cognitive development, higher risk of disease, leave school earlier, and have reduced economic productivity in the future. As well, women are more likely to have a low birth weight baby, which further perpetuates the cycle of malnutrition.

The direct causes of malnutrition are poor feeding practices and disease. Knowledge, capacity, access to health services, food security and poverty are the underlying reasons which need to be addressed in order to reduce malnutrition.

Maternity cash transfers in the first 1000 days aim to improving the nutrition status of a child, reduce stunting and incidence of illness, thereby increasing the development and economic future of the individual. The additional income can be used to purchase nutrient dense foods during pregnancy, lactation and complementary feeding stage, supplement income for food and non-food expenditure specifically in the final trimester when income opportunities are decreased, and increase health service access. On top of that, it stimulates local markets and economy to improve the availability of nutritious food, and empowers women through resource control.

On a larger scale, MCCT contributes to reduction in malnutrition and increase in human capital through addressing the first 1000 days, provides protection from risks and shocks, addresses economic and social vulnerabilities, promotes economic opportunities, and alleviates social exclusion.

There are a number of interventions that are needed alongside MCCT to address the driving forces of malnutrition and improve nutrition outcomes like the provision of maternal and child services and access to hygiene and sanitation services and improved knowledge and health seeking behaviours.

The main lessons learnt from cash transfer programs all over the world are:

1. The transfer program should be underpinned by long-term commitment and broad coverage.
2. The transfer amount should reflect the cost of a nutritious diet and ability to respond to changing food prices. Understanding the cost of a nutritionally adequate diet and essential expenditure should be used to ensure the size of transfer is sufficient.
3. The delivery needs to be timely and convenient for beneficiaries. The payment delivery mechanisms should be monthly or bi-monthly, nutrition sensitive and minimising disruption and burden on mothers. Providing regular, predictable and adequate transfers to facilitate the purchase of foods and essential services avoids vulnerable households employing harmful coping strategies.

4. Social transfers should be integrated into wider nutrition packages, however, conditionality should not be the default. If an unconditional transfer is made, access to basic services should be available as case studies from South Africa and Zambia show. If conditions are attached to cash transfers, additional administrative costs to implement and monitor these conditions, monitoring capacity, burdens on the recipient and feasibility of conditions should be considered. Soft Conditions can be applied, which encourages participation in an activity (nutrition education sessions or health visits) but non-compliance or non-attendance does not exclude the participant from receiving the transfer.

5. It is essential for the program to be designed with and implemented in coordination with all relevant stakeholders.

6. The rationale for a universal approach to beneficiary selection where all pregnant women are eligible is based on the following considerations:
   - collecting reliable information about income or consumption is costly making targeting by means-testing unfeasible,
   - malnutrition affects all the wealth categories in Myanmar,
   - poverty-based selection methodologies in developing countries are inherently inaccurate at identifying the ‘poor’ and have high exclusion rates,
   - the category of ‘poor’ is arbitrary and flexible and time and resources spent on means-testing women for inclusion in the program would delay inclusion and risk missing the critical 1000 days window.

MCCT Pilots – Myanmar

Save the Children has implemented three maternal and child cash transfer pilots in the Delta, Dry Zone and Rakhine. The current Rakhine Tat Lan Program aims to sustainably increase food and nutrition security and incomes of households in Rakhine through a package of comprehensive, mutually-reinforcing, nutrition sensitive livelihood interventions including livelihoods support, a monthly transfer of 13,000MMK, Mother to Mother Support Groups, Behaviour Change Communication (BCC), and counseling.
Specific information is needed to design and implement the Maternal and Child Cash Transfer program. In order to inform transfer size the Cost of the Diet is a methodology that can be used to calculate the minimum amount of money a typical household would need to purchase their recommended diet (intakes of energy, protein, fat and micronutrients), using locally available foods. In order to inform the nutrition education and BCC approach it is important to understand current and localised IYCF practices and the barriers and opportunities for changing these behaviours through qualitative and quantitative localised IYCF Studies. Monitoring, Baseline and Evaluation including specific, measurable, achievable, relevant and time-bound (SMART) nutrition indicators in the M&E framework are essential to being able to assess the impact of the social transfer program as well as inform program changes and improvements.

II. Technical options for implementation

The study provides technical input to DSW about possible different institutions for a nationwide implementation. The following are the functions that need to be covered:

- Identification and enrolment of beneficiaries;
- Cash delivery and payment;
- Information and communication;
- Exit;
- Complaints/Accountability;
- Data recording; and
- Monitoring and Evaluation.

The study investigates various national institutions and whether their mandate is appropriate to carry out the MCCT and whether their presence on the ground and their reach is sufficient to provide support in the program delivery. The MCCT program, developed as part of the Myanmar National Social Protection Strategic Plan by the MSWRR (2014), is defined as a universal program and monthly transfers are proposed to be 15,000 Kyats per each child.

**Identification and enrolment of beneficiaries**

The program is expected to cover all mothers in the last six months of their pregnancy in the first year of implementation, while also covering all children to age one in year two, and to age two in year three of the program. The study describes advantages and disadvantages of targeting only pregnant mothers to be first enrolled in the MCCT in terms of implementation costs and of political support. The same elements are evaluated for the alternative of providing cash transfers.
to all mothers and all children under two. The Government needs to weigh pros and cons of these two alternatives and decide how to frame the program to the population.

No pregnant woman will receive more than one set of cash transfer payments within the first 1,000 days cycle to incentivise appropriate birth spacing. Mothers of any age can be enrolled in the program: early pregnancy is rare in Myanmar and it is not expected that the small cash allocation of 15,000 Kyats will induce additional births.

The registration process needs to be carried out by the institution closest to pregnant mothers and one that can be an easy point of contact for them. In local communities because of their widespread presence on the ground, two main options have been evaluated: GAD and health workers.

Since midwives are the most accessible institution to pregnant mothers in remote areas, we recommend for them to be the main reference point for the registration process. However, given high transportation costs and high present workload, local NGOs, such as MMCWA, can provide huge support, taking similar responsibilities. Health committees and community leaders, such as ten-household chiefs can also be of additional help.

Cash delivery and payment
Depending on the initial budget allocated and the main scope for a national cash transfer program, considerations about the appropriate amount of the cash transfer and the frequency of payment need to be taken into account. Monthly delivery of 15,000 Kyat seems the best solution, but we suggest the Government to not exclude the possibility of delivering a smaller amount (such as 10,000 Kyats) and/or a less frequent payment (such as once every 2-3 months). These alternatives can be used in case of initial limited budget and to test feasibility of novel payment mechanisms (i.e. mobile money).

As of today, if the program will be implemented at national scale in the next year, GAD seems to be the only candidate for the payment function in rural areas. Homogenous and local presence on the ground and easy accessibility to government funds are among the main advantages for the feasibility of delivering cash at high frequency to eligible individuals in their ward or village tracts.
If the Government decides to rollout a national program immediately, we recommend one of the following options: 1) payment through GAD in both rural and urban areas; 2) payment through a hybrid model (GAD in rural areas and the use of mobile money in urban areas).

Given the technological advances in Myanmar, in the medium to long-run, the mobile money approach may be the best candidate for cash payments not only in urban areas, but also to be extended over time in rural areas. Two options are: (1) to test mobile money in urban areas first and extend it to rural areas later, or (2) to test mobile money both in urban areas and in rural areas, through the use of mobile agents and providing mobile phones.

Myanmar Economic Bank (MEB) is also an option, but huge investment in resources will be needed first. Midwives, supported by local NGOs such as MMCWA and community leaders, can be considered for payment if other approaches are not feasible. However, concerns about an additional burden on the health system and conflict of interest with the midwives’ registration responsibilities in the MCCT program will need to be addressed.

Information and communication
Information and communication have a twofold function in supporting MCCT: firstly, to inform the public about the MCCT and communicate to pregnant women, future beneficiaries, that they are entitled to the program and where they can register. Secondly, behavioural change communication aims to improve their health and nutrition knowledge and practices.

For both, soft advertisement and communication strategies, mass media national campaigns and the use of mobile phone technology is recommended to deliver key messages to communities. For BCC, the messages should be in addition, delivered by those who will have contact with beneficiaries throughout the program – from registration through cash delivery, at both facility level and through face-to-face meetings with midwives and others who will support enrolment and cash delivery (including MMCWA, community leaders, GAD etc.).

Exit
We recommend using a Management Information systems (MIS) to automatise and simplify the exit process, in addition to random checks on the list of participants.
Complaints/Accountability

**DSW is best positioned to receive complaints.** A call centre should be set up to allow direct complaints to DSW. In case of remote and rural areas where mobile phone technology is not common yet, a manual system is recommended and different options are provided (such as mailing complaints, help from local NGOs to fill in forms, and social workers deployed by DSW). In the long run, the call centre is the only option recommended to reduce costs and increase effectiveness.

Data recording

A MIS is of core importance to the design of any quality social protection scheme. Among the many advantages, this system allows easy and constant monitoring of the program implementation, it limits risk of fraud and corruption, and it automatises data collection and the analysis of program indicators. Because the existing infrastructure and technology in Myanmar is limited, a robust MIS should be put in place and uniquely developed for different cash-transfer programs. It is strongly encouraged that the DSW hire an international development consultancy firm and start the MIS development process and testing. Preferably, a digitalised and “open-source” system is developed, so that the final product produced by the consultancy firm can be handed over fully to the government for subsequent implementation and ownership. It is recommended to explore the possibility to link the MIS with the current e-platform for birth and civil registration system.

Monitoring and Evaluation

Constant and attentive monitoring is essential to inform the government about potential issues in the implementation of the MCCT program. On-going monitoring activities are recommended, especially at the beginning of the intervention. Data should be collected before and at different stages after the rollout, to carry on rigorous impact evaluations of the program. Engaging at an early stage with impact evaluation companies, consultants and researchers who can provide expertise is advised.

Budget Considerations

The cost estimates of the MCCT programs starts from the costing exercise developed by ILO: some assumptions made are similar, but we have used up to date estimates given the recent release of the Census 2014.

Estimates are provided for the first year of the implementation, 2016. Discussed are possible initial geographical targeting to a few states (Rakhine and Chin), different cash transfer amounts
(10,000 Kyats and 15,000 Kyats) and a reduction in administrative costs from 20 per cent to 5 per cent in case of mobile money approach or reduced frequency of the payments for manual delivery. Cost estimates for the implementation of a national MCCT program to all years from 2016 to 2020, considering the original program proposed in the 2014 Strategic Plan, are also given. There is a possible reduction in cash transfer to 10,000 Kyats and a reduction in administrative costs.

**Overall, if the government decides to implement the proposed universal cash transfer program at 15,000 Kyats, the costs will reach only 0.37 per cent of GDP by 2020.** Considering the lower expected costs for MCCT compared to other flagship universal interventions and huge expected returns to investments supported by global evidence, nutrition-based interventions should be a top development priority.

**Summary Recommendations for MCCT implementation and Next Steps**

To move forward and be ready when funding will be available in 2016 for the MCCT program, the following actions should be started now:

1. Discussion about feasibility study recommendations during an internal workshop, to finalise which institutions will implement each function.
2. Take key decisions about the most feasible scenario among the ones proposed, given the expected budget availability for next year and respective funding sources.
3. Finalise the operational details for implementation in the initial focus areas and prepare a clear program description to be presented to Governmental pre-budget allocation meetings in October 2015.
4. Establish roles among different institutions, discuss in detail the responsibilities of each actor involved and agree on a mode of cooperation.
5. Start developing an MIS.
6. Identify research partners and start designing the impact evaluation of the MCCT program and the first data collection before any intervention starts.

The implementation of the MCCT program, i.e. the “cash allowance of 15,000 MMK for pregnant mothers and their children under two” in one or two ‘focus’ states for the first year of the implementation is suggested with a scale up of the program to the whole country in the following years. It is recommended to try a novel approach (such as mobile money/MEB) in the delivery of cash to reduce administrative and implementation costs.
Introduction

This report presents technical options for the implementation of a cash allowance for pregnant women and children to age two in Myanmar, henceforth referred to as Maternal and Child Cash Transfer program (MCCT). The objective of this report is to advise MSWRR of the best technical options and potential risks to sustainably implementing the MCCT program today, while proposing novel options for the near future in line with international best practices.

The study was conducted in May 2015 and supported by Save the Children, UNICEF and the International Growth Centre (IGC), with overall support and guidance from the Department of Social Welfare (DSW) at the Ministry of Social Welfare, Relief and Resettlement (MSWR). The research consisted of a desk review of literature related to social transfers to achieve nutrition outcomes, and interviews with key informants from Government Ministries, international organisations, non-government organisations, and potential private sector implementing partners (Annex 1).

The scope of the MCCT is defined in the National Social Protection Strategic Plan². It is a universal cash transfer during the last six months of pregnancy until the child is two years old. The transfer targets mothers and their children during a crucial period in the life cycle to optimise future growth and potential by addressing the determinants of malnutrition and poverty.

The report consists of two parts. Part I presents relevant global experience and evidence on the impact of cash transfers on nutritional outcomes. Specific examples have been identified which will provide a greater understanding of the impact and challenges of various implementation strategies. The experience of other non-governmental maternal and child cash transfers to in Myanmar is also discussed.

Part II presents technical options to implement the MCCT program nationwide. It outlines the roles and responsibilities that need to be covered to deliver the program, and examines different institutions in Myanmar that can perform each of the functions. Part II also provides budget considerations for different implementation scenarios, and more general next steps.

² The Republic of the Union of Myanmar, 2014
Recommendations throughout this report focus on using and strengthening existing government structures in the short run (if the government implements a *nationwide* program in the next few years), while exploring more innovative options for the medium-long run.

The research benefited from the findings of the feasibility study for the Social Pension program supported by Help Age International (Ramkissoon, 2015) by building on its recommendations, while exploring additional possibilities. The system that will be put in place for the first flagship programmes - Social Pension and MCCT - can be in future used for other social transfer programmes of the National Social Protection Strategic Plan\(^3\), and beyond.

\(^3\) Other flagship programmes of the National Social Protection Strategic Plan include: cash allowance for children 3-15, cash allowance for persons with disabilities, school feeding programme, public employment and vocational education programmes, and older person self-help groups.
Part I: Global Evidence: Maternity Cash Transfers and Impact on Nutrition

1. Nutrition Context and Justification for MCCT in Myanmar

A maternal and child cash transfer (MCCT) to pregnant women and their children up to two provides the foundation for a substantial and profound impact on nutrition, health and poverty outcomes. By seizing the ‘window of opportunity’, that is the first 1000 days of a child’s life, and improving maternal and child nutrition, substantial progress is made in the human development of individuals, their communities and the economic development of the nation.

Adequate nutrition early in life, particularly during the first 1,000 days, from pregnancy through a child’s second birthday, is vital to reduce stunting in children. This has enormous benefits throughout the life cycle and across generations (Ruel 2013, Haddad 2014, Gillespie 2013), contributing to building a resilient, healthy and productive future generation.

Investments in nutrition during the first 1,000 days can prevent the intergenerational transmission of poverty and improve key determinants of long-term economic growth (World Bank, 2006). A well-nourished mother gives birth to a healthier baby, well-nourished children have improved cognitive development and a higher chance at doing better at school, and well-nourished people have a better chance of giving birth to health well-nourished babies later in life.

- Well-nourished children do better in school and as adults earn 20 per cent more in the labour market and are 10 per cent more likely to own their own businesses (IDS, 2013);
- An adult who is 1 per cent shorter as a result of childhood stunting is associated with a loss of productivity of 1.4 per cent;
- The economic cost of stunting, in terms of lost national productivity and economic growth, is enormous. Countries can lose between 2 to 3 percent of their potential Gross Domestic Product (GDP) each year (World Bank 2015). In India, the loss of GDP is 2.95 per cent as a consequence of productivity loses resulting from stunting, iodine and iron deficiency and China has a 2 per cent loss of GDP related to obesity and Non Communicable Disease;
- Recent analysis shows there are high benefit cost ratios with every dollar spent on nutrition in the first 1,000 days of a child’s life provides a saving of an average 45 USD and in some cases 166 USD (Hoddinott, 2014).
In Myanmar, 35 per cent of children under 5 are stunted, that is 1.8 million children who are not reaching their full potential. In uterine growth restriction and stunting impacts on the physical and cognitive development of a child and is associated with reduced human capital: higher risk of disease, shorter adult height, less schooling, reduced economic productivity and, for women, lower offspring birth weight (Black, 2013).

The economic benefits of improving nutrition can be understood as saving resources that would otherwise be spent on health care or risk management and increasing productivity and capacity for earning potential (Alderman 2007).

1.1 Causes and Consequences of Stunting and Poor Nutrition in Myanmar

In Myanmar, just over half of all babies born are weighed at birth, of which 9 per cent are registered as low birth weight (LBW) thereby having a higher risk of illness, disease and poor cognitive development. Low weight at birth is often a consequence of undernutrition during pregnancy. Children with low birth weight have an increased risk of obesity and non-communicable diet related diseases (Lancet 2013), which increases the financial burden on households and health services. Another group of children at risk are those stunted at the age of 2 and who are then exposed to a rapid change in diet and lifestyle practices, as is common in the rapidly developing environment in Myanmar.

In addition to the 1.8 million children who are stunted, 8 per cent of children under 5 are acutely malnourished (MICS 2009-2010) which demonstrates short-term food insecurity or malnutrition as a result of disease. As many as 41 per cent of children under 2 (MICS 2009-2010) receive an inadequate diet for their age, increasing the likelihood that they are malnourished and increasing their vulnerability. There are geographical disparities and seasonal peaks, with significantly higher rates of malnutrition in rural areas.4

A direct cause of malnutrition during the crucial period of pregnancy and for children under 2 years is inadequate breastfeeding practices; 76 per cent of children under 6 months are not exclusively breastfed, which puts them at a high risk of illness, infection and growth retardation. The reasons for this high figure are complex and can be attributed to a combination of poor information, lack of support, lack of time and requirements to work outside the home. Linked to

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4 Highest percentage of moderately to severely stunted children under five in Chin (58%), Rakhine at (50%) and Northern Shan (47%). Highest prevalence of wasting Rakhine (10.8%), Magway (10.4%), Ayeyarwady delta (9.8%)
this is the limited access and availability of health services to provide both preventative and curative support. Illustratively, there are a high number of pregnant women (71 per cent), who are anemic and do not take iron supplements as per the standard practice. Micronutrient deficiency, or ‘hidden hunger’, namely for iron, vitamin A and Thiamin, is a high concern in Myanmar. It can be addressed through a combination of improving diet quality, access to nationwide supplementation services, and health and sanitation practices.

Income is an underlying factor of food insecurity and vulnerability in Myanmar, where the poverty rate is between 26-38 per cent (LIFT 2014). This, as well as knowledge and awareness of optimal food, hygiene and sanitation practices have a significant impact on a households’ ability to step out of poverty.

Figure 1 demonstrates the causes and consequences of undernutrition. A Maternal and Child Cash Transfer targeted specifically at pregnant women and children under 2 accompanied with appropriate support services will have a direct impact on both the immediate causes of malnutrition - poor breastfeeding practices, diet quality and incidence of disease - as well as the underlying causes of household food insecurity, inadequate feeding and care practices and household environment and health services.

Figure 1. The causes of maternal and child undernutrition

Source: Black et al 2008
1.2 Pathways of impact

MCCT aims to intervene along the causal pathway (see Annex 2) that links malnutrition and long term underdevelopment at the individual and household level:

- Additional income can be used to purchase nutrient dense foods during pregnancy, lactation and complementary feeding stages;
- Supplement income for food and non-food expenditure specifically in final trimester when income opportunities are decreased;
- Increase access to health services;
- Stimulate local markets and the economy to improve the availability of nutritious food;
- Reinforce the importance of the first 1000 days in terms of food and health care prioritisation;
- Empower women through resource control.

The impact of MCCT on the bigger picture:

- Contribute to reduction of malnutrition and increase of human capital through addressing the first 1000 days;
- Protection from risks and shocks;
- Address economic and social vulnerabilities;
- Promotion of economic opportunities;
- Alleviation of social exclusion.

A number of interventions are needed alongside MCCT to improve nutrition outcomes. These can be divided into supply and demand-side interventions:

**Supply Side:**

- Improved provision of maternal and child services, including adequate coverage of supplementations and vaccinations;
- Improved access to qualified midwives or health professionals for information dissemination and support;
- Improved access to adequate hygiene and sanitation facilities.

**Demand Side:**

- BCC strategy to improve nutrition as well as infant and young child feeding knowledge and practices;
- Improved hygiene and sanitation practices through information and education as well as improved services;
Health seeking behaviour for treatment and prevention (checkups, immunisations, supplementations etc.)

### Definitions

- **Stunting** - Being too short for one’s age, this indicates chronic undernutrition and restriction of a child’s growth potential
- **Height for Age Z-Scores** – A Height for Age Z-Score less than -2 is considered stunted
- **Micronutrient Deficiencies** – Low levels of micronutrients such as iron, zinc and thiamine, which can affect growth, immunity, and cognitive development
- **Anemic** – Deficiency in iron, which in pregnancy can cause delivery complications and low birth weight babies
- **BCC** – Any communication (personal, video, mass media, group training) that uses listening, understanding, or negotiation to foster a change in practice
- **Infant and Young Child Feeding (IYCF)** – Nutrition practices and behaviours of pregnant women and children under 2; breastfeeding, maternal nutrition, complementary feeding

#### 2. Global Evidence

##### 2.1 Evidence of Impact – Nutrition Outcomes and Pathways

The evidence discussed under this section draws on programs which have key common features to the proposed Myanmar Maternity Cash Transfer program:

- Target population as close as possible to first 1000 days
- Payments are regular and reliable (not a short term relief payment)
- Nutrition outcomes are measured

The program in Myanmar needs to be designed with common consensus around the overall objectives and the pathways by which those objectives will be reached. This will inform everything from the package of services which support the cash transfer, to the type of monitoring, whether it is conditional or universal and how impact will be measured.
2.1.1 Nutrition Outcomes

The evidence shows that a complete package of interventions during the key window of pregnancy and up to 2 years of age has the greatest impact. Evidence from Mexico, Honduras and Colombia show a significant impact on linear growth and stunting. The impact was greatest the younger a child was and the larger the transfers were (15-20 per cent of household income) (Leroy, 2009).

Results from the South Africa Child Support Grant (CSG) also show that unconditional cash transfers can have an impact on improving nutrition outcomes for children. They also reduce the intergenerational transmission of poverty and malnutrition through improved maternal nutrition, decrease the risk of stunting, and increased wage earning potential as an adult (Aguero 2007).

**Zambia Child Grant Program – Unconditional**
- Blanket coverage of all households within targeted area with child under 5
- Designed to address the determinants of childhood malnutrition
- Reduced intergenerational transfer of poverty in all dimensions: income, education, health, food security and livelihoods.
- Monthly $12 transfer

**Bangladesh TMRI Program - Conditional**
- Program to compare impact of Food, Cash, Food+Cash, BCC+Cash, BCC+Food
- Monthly transfer of $19
- Delivered to women via a new mobile phone cash-transfer system
- Cash conditional on attending nutrition and health BCC sessions
- Measures the impact and cost-effectiveness on key outcomes: household income, household food security, child nutrition

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5 As laid out in the Lancet 2008 and 2013 series
2.1.2 Nutrition Pathways

This section explains how cash transfers have impacted on the underlying and basic causes of malnutrition and stunting as seen in Figure 1.

**Diet quality** - In Mexico and Bangladesh programs improved diet quality, measured as increased expenditure on animal source foods, and fruit and vegetables. In Zambia, although households purchased more micronutrient rich foods, they also included more fats and sugars\(^6\) in their diets, highlighting the need to combine an increase in food expenditure with nutrition information and education. Even though the Zambia program demonstrated increased share of household expenditure on food, an improvement in dietary diversity, an increase in meal frequency, and an overall reduction of number of households considered food insecure, this is not reflected in an overall impact on stunting (Seidenfeld, 2014). This could be attributed to an increase consumption of poor quality food as well as short survey time period and issues over data quality.

**Disease and illness** - The unconditional program in Zambia reduced the incidence of diarrhea (4.9 percentage points), which is on the direct causes of malnutrition for children under 5 years old. The program does not, however, show impact on health seeking behaviours.

**Inadequate care** - The Zambia program also found a significant increase of number children who were exclusively breastfed, by 22 per cent.

**Water, sanitation and the household environment** - The Bangladesh program has had a significant increase in latrine usage (by 33 per cent) and hand washing (by 27 per cent) in just

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\(^6\) Diets high in fats and sugar increase the risk of obesity and diet related chronic disease (heart disease, diabetes, stroke etc)
two years through implementing a BCC approach. This is important because of the symbiotic relationship between nutrition and health causes and outcomes.

**Food insecurity and poverty** - The Mexico program reduced the number of people living in poverty by 10 per cent and the poverty gap by 30 per cent (Skoufias, 2001). In addition to poverty indicators, ownership of productive assets or expenditure on agricultural/livelihood inputs are measured to indicate an impact on overall food insecurity and poverty. The Zambia CSG showed an increase in livestock ownership by 21 per cent (Seidenfeld 2013).

Regular and long-term transfers can have a positive impact on markets, stabilising and increasing demand for goods and services (DFID 2011). Combined with efforts to improve food availability and livelihood opportunities, this can have a positive effect on local economic development.

<table>
<thead>
<tr>
<th><strong>Mexico Oportunidades - Conditional Cash Transfers</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Targeted to reach the poorest communities and households (means-tested)</td>
</tr>
<tr>
<td>• Designed to improve nutrition and health outcomes and school attendance</td>
</tr>
<tr>
<td>• Transfer 33 per cent of household income every 2 months</td>
</tr>
<tr>
<td>• Micronutrient supplementation for Pregnant and Lactating Women (PLW) and under-2-year olds</td>
</tr>
<tr>
<td>• Health and Nutrition Education</td>
</tr>
<tr>
<td>• Conditional on antenatal and 0-5yrs health care visits</td>
</tr>
<tr>
<td>• Stunted reduced by 10% &lt;36m</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>South Africa Child Support Grant – Unconditional</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>• Children up to the age of 18 (this has gradually increased from 7yrs)</td>
</tr>
<tr>
<td>• Objective of poverty reduction and to build, protect and promote human capital and other productive assets while enabling people to more productively manage risks and shocks, as well as promoting social cohesion</td>
</tr>
<tr>
<td>• Monthly transfer of 280 Rand (25 USD) (2012)</td>
</tr>
<tr>
<td>• Payment by specific pay point, electronically or by proxy</td>
</tr>
<tr>
<td>• Use of ‘Road to Health Card’ to record vaccination and weight/health and to encourage the uptake of services</td>
</tr>
</tbody>
</table>
2.2 Evidence Based Design – Linkages, Payments, Objectives

2.2.1 Linkages to Other Services

The range of accompanying services can vary from a full scale supply of health services, to community level health and nutrition information dissemination using a BCC approach, as seen in Bangladesh. The extent of a package depends on the financial resources, however, the cash transfer must be supported by efforts to address the other causes of stunting and poverty (Fig. 1).

In Bangladesh, a study to compare different interventions (see Bangladesh Box) showed that a cash transfer plus a BCC package had the most significant effect for (Ahmed 2015) reducing stunting, increasing food expenditure, increasing diet quality and food intake (calories).

Key features of the BCC package are:

- Key messages including infant and young child feeding (IYCF), WASH, maternal nutrition, nutrition for health, micronutrient dense diets
- Key messages delivered when the cash is collected
- Weekly group meeting of 9-15 mothers
- Delivery of messages to community influencers
- Household visits
- Services provided by NGO staff

Households receiving a cash transfer showed impact on the following malnutrition causal pathways:

- An increase in latrine usage (33 per cent), hand washing (27 per cent) (Bangladesh)
- An increase in expenditure which is a proxy for indicator for income (Latin America) (Leroy 2009)
- An increase in women’s control of resources (Latin America)
- Improvement in knowledge of health practices and practice (in Mexico only).
- South African estimates that 20 months of CSG support during the first 3 years of life can yield a 1.1 per cent gain in adult height, which corresponds with gains in monthly wages of $5.5 - $7.8 / 6050MMK – 8360MMK (R67 to R92) (Centre for Effective Global Action)
The case studies from Latin America demonstrate that health and nutrition services in addition to cash are a key aspect of success (Leroy 2009). These services include access to health services which provide: immunisation and supplementation; health nutrition information and education; and treatment of common illness; and improved water and sanitation provision.

Linkages across departments, ministries and partners are essential to deliver a comprehensive package of health and nutrition education (amongst other services), which will support cash transfers. Ways to build links:

- Policy Coordination
- Joint planning for the delivery of services
- Township planning with multi-sector partners
- Using NGO and Civil Society structures for support
- Joint development of communications materials & campaign using Scaling Up Nutrition (SUN) platform

**Linkages to Other Services:**

- **It is essential for the program in Myanmar to be designed with and implemented in coordination with all relevant stakeholders; DSW, MoH, National Nutrition Centre (NNC) as pivotal partners**
- The Zambia case study shows a significant impact on stunting only when the cash transfer is combined with access to clean water and maternal education level
- The greatest impact on stunting was when cash was combined with BCC Training which included basic nutrition, control and prevention of micronutrient deficiencies, IYCF, health care, maternal nutrition and hygiene (Bangladesh)
- High quality food supplements were given to all children 6-24 months plus free healthcare and nutrition and health education to all households (Mexico)

**2.2.2 Conditional vs. Unconditional**

Overall, the evidence suggests that it is necessary to have health and nutrition services to support the transfer. However, the additional burden of these services and the lack of evidence that a condition improves nutrition outcomes supports the use of unconditional transfers.

No Randomised Control Trial (RCT) has been carried out to establish the cost benefit analysis on nutrition outcomes of unconditional versus conditional transfers. The South Africa and Zambia
programs both demonstrate that an unconditional cash transfer program can have an impact on nutrition outcomes but basic services need to be available and the ‘supply’ side has to be functioning even if compliance is not a condition.

Mexico and Bangladesh included conditionalities and there was an impact on stunting and nutrition related outcomes. However, in Mexico the participants - pregnant and lactating women (PLW) and children up to 2 years - were recipients of food supplantations and all family members received preventative health care. It is thus challenging to determine which intervention had the greatest impact or whether it was a combination. Across the literature the most common conditions are attendance to health and nutrition sessions, participation in growth monitoring and attendance for health checks/vaccinations.

A meta-analysis study did not find significant evidence that conditionalities had an impact on stunting (Manley 2012) and, in fact, found that some conditions might have a negative impact on height for age outcomes. For example, a cash for work scheme which encourages strenuous work during the late stages of the pregnancy, further increasing the nutritional requirements of a woman, or incentivising mothers to be away from their infants, and thus inhibiting breastfeeding.

When considering the feasibility of introducing conditionalities the practicalities and the operational capacity to apply such conditions should also be considered. These are some major challenges to the practicalities and the operational capacity for including conditionalities in Myanmar (Save the Children 2012):

- Additional administrative costs involved with implementing and monitoring;
- Monitoring adherence to conditionality amounts to 26 per cent of the program cost, excluding the cost of the transfers themselves (Mexico Oportunidades);
- Extra institutional capacity to monitor capacity: who monitors it and what are the penalties;
- Beneficiaries may face additional burdens in meeting conditions and those that are most in need of the social transfer may be unable to meet the conditions;
- Conditions will not be feasible in some contexts where supply of services is insufficient.

Implementing a program with the compulsory engagement of a service as a condition of receiving the cash demands the supply of a high quality and affordable service. Soft conditions can be applied as an approach, which encourages participation in an activity (nutrition education sessions or health visits) but non-compliance or non-attendance does not exclude the participant.
from receiving the transfer. Non-compliance or non-attendance could be a result of limitations in the supply of service, employment responsibilities, financial restrictions etc. [see Tat Lan experience below].

2.2.3 A Targeted or Universal Cash Transfer?

The MCCT transfer program in Myanmar should be universal, i.e. all the pregnant mothers and their children under 2 years are eligible for the program, independently of any other characteristic. The main alternative to universal programs are means-testing targeted programs, where individuals are eligible only if another criteria applies, for example, poverty. The rationale for a universal approach to beneficiary selection where all pregnant women are eligible is the following:

- Collecting reliable information about income or consumption is costly, making targeting by means-testing unfeasible. The lack of updated consumption and income data is evident in Myanmar. Without this, a population wide survey would need to be carried out before the roll out and continuously updated.

- Malnutrition affects all the wealth categories in Myanmar, with the wealthiest quintile still exhibiting chronic malnutrition rates of over 20 per cent (MICS 2009-10).

- Poverty-based selection methodologies in developing countries are inherently inaccurate at identifying the ‘poor’ and have high exclusion rates. Even well-known schemes using poverty-based selection have very high exclusion errors. For example, Mexico’s Oportunidades excludes 70 per cent of the poorest 20 per cent of eligible households (Veras 2007) while Georgia’s Targeted Social Assistance (TSA) program, which is described as “among the best-performing similar programs in the world” (World Bank 2009), still excludes 46 per cent of the poorest 10 per cent of the population (UNICEF 2012).

- The category of ‘poor’ is arbitrary and flexible. Poverty lines are inherently political and countries may decide to have a high poverty line and accept a high poverty rate while other countries may choose lower poverty lines. For example, Indonesia has chosen a poverty rate of only 12 per cent while South Africa, a richer country, uses a much higher poverty line of 52 per cent (Kidd 2013). In Myanmar 80 per cent of the population lives on around $2 a day (IHCLA 2010).

- The evidence from Zambia and South Africa demonstrates that receiving the transfer during the critical time of pregnancy and under 2 years will have the maximum impact. Time and resources spent on means-testing women for inclusion in the program would
delay the intervention, risk missing this crucial window and diminish the impact that the transfer may have on nutrition outcomes.

2.2.4 Payment Mechanisms / Frequency of Payments

The payment delivery mechanisms should be nutrition sensitive, minimise disruption and burden on mothers and provide regular, predictable and adequate transfers to facilitate the purchase of foods and essential services.

Social transfers are generally made monthly or bi monthly (Mexico, Zambia). When transfers are not regular, predictable or frequent, vulnerable households are at risk of having to employ harmful coping strategies, like selling assets, etc. For example, in Honduras, the lack of impact on improved dietary diversity and expenditure was attributed to the fact the cash transfer was too small and too low in frequency, twice per year (Leroy 2009).

The size of the transfer should be based on the cost of a nutritionally adequate diet and essential expenditures. In Zambia the transfer was designed to cover one meal per day per household, linked to size of household, and in Bangladesh the transfer was 29 per cent of household income (Ahmed 2015). In Mexico, Honduras and Colombia the amount was between 15-25 per cent of the household income, with strong evidence that the impact was greater when larger transfers were made (Leroy 2009). In Honduras, the transfer was only 15 per cent of household income and too small to have an impact on stunting.

Innovative payment systems, such as mobile phone technology (Kenya), debit cards (Mexico) and smart cards (Malawi and Namibia), were used for 45 per cent of cash transfer programs launched in the last decade.

Advantages of innovative Payment Mechanisms are (DFID 2011):

- Reduced cost to government by leveraging private sector involvement;
- Reduced leakage through fraud and corruption;
- Increased use of bank accounts and access to financial services
2.2.5 A Nutrition Sensitive Transfer: Setting the Objectives

It is imperative that the objectives of the MCCT are clearly defined and established to ensure that the program has maximum positive impact. The design of the program, accompanying package, delivery mechanism, targeting, and amount and evaluation criteria must be designed to be nutrition sensitive in order to have a positive impact on the first 1000 days.

Key learning points from previous programs:

- Detailed assessment of the underlying theory of change and expected impacts should be aligned with the intended design (DFAT 2015);
- Clear nutrition objectives and better defined nutrition actions (Leroy 2009);
- Implementation and integration plan grounded in a strong program theory framework;
- A nutrition sensitive transfer that is big enough to have an impact on the diet quality;
- Effective monitoring system in order to assess impact.

**Key Criteria for Success (Save the Children 2012):**

1. The transfer program is underpinned by long-term commitment and broad coverage
2. The transfer amount should reflect the cost of a nutritious diet and ability to respond to changing food prices.
3. The delivery needs to be timely and convenient for beneficiaries
4. Integrate social transfer into wider nutrition packages. However, conditionality shouldn’t be the default.
3. MCCT Pilots – Myanmar

Save the Children has implemented three maternal and child cash transfer pilots in the last five years. They have been different in purpose and design and the collective learning has informed the recommendations mentioned above. Pilots implemented by Save the Children in the Delta and the Dry Zone, 2009-2012, were designed as part of wider recovery programs to address existing cases of acute malnutrition and for preventative. The outcomes and learning from these programs informed the design of the Tat Lan MCCT program, which started in 2013, and is still being implemented as part of a longer term development approach.

3.1 Tat Lan MCCT Program Key Features:

Tat Lan aims to sustainably increase food and nutrition security and incomes of households in Rakhine through a package of comprehensive, mutually-reinforcing, nutrition sensitive livelihood interventions, including a Maternity Social Protection Program. Its key features are:

Activities:
- Mainstreaming BCC for Improved Nutrition and Infant and Young Child Feeding (IYCF) Practice activities;
- Cash Transfer to pregnant and lactating women and children under two;
- Mother to Mother Support Groups;
- Individual Counseling.

Program details so far:
- Monthly transfer of 13,000 Kyat;
- Universal coverage in 15 villages;
- 395 mothers enrolled and receiving cash transfers;
- Initial enrolment is for pregnant mothers and mothers with children up to 6 months old to ensure each recipient receives up to 24 months of transfers;
- The transfer will last for a maximum of 24 months from the last 6 months of pregnancy (assuming that most mothers will go for first ante-natal care around this time);
- Enrolment and verification will be led by the Tat Lan staff with support from Mother to Mother Support Groups, Nutrition focal points and Village Development Committees;
- Soft Conditionality: Receipt of the transfer will be conditional on attendance at nutrition education and Mother to Mother Support Group sessions, attendance at ANC services and immunisation of their child according to the national immunisation schedule. While SC
promotes these activities, there will be no penalty for women who do not attend these sessions.

- Evaluated using a control group for comparison, results expected early 2017.

### 3.2 Behaviour Change Communication (BCC) component

Tat Lan has been designed based on the evidence that financial support to improve diet quality and practice has to go hand-in-hand with changes in key IYCF and health practices amongst pregnant and lactating women and their children. An in-depth BCC component has been incorporated to achieve those changes, and includes:

- Mother to Mother Support Groups;
- Peer Mothers providing breastfeeding counselling;
- Parent Education Support Group;
- Village Wide Communication and Mobilisation;
- Mass media;
- Print media;
- Prevention of widespread promotion of breast milk substitutes.

The approach aims to address six IYCF behavioural objectives and three nutrition sensitive behavioural objectives such as health seeking behaviour and WASH practices.

Initial monitoring from the Tat Lan project shows impact in the following areas (Save the Children 2015):

- **Money used for food & healthcare**
  
  There was a demonstrated understanding that the intention was for the cash to be spent on food and healthcare specifically for the mothers and young children.

- **It is not an income substitute but does cover food costs in last trimester**
  
  Mothers reported that the cash transfer does not compensate for the loss of income during the last trimester when pregnant women often were unable to work but that it did support food costs.

- **Good/improved knowledge on IYCF**
  
  Women were able to demonstrate their knowledge and understanding of key IYCF practices, but there is still reluctance to exclusively breastfeed and water is still commonly given.
Mothers seek out support from a skilled healthcare professional
Although health seeking behaviour has improved, many women reported that midwives only visit every quarter and, therefore, women have to travel in order to visit a midwife or a doctor, thereby incurring additional costs.

Money is a motivator for behaviour change
The money is motivating women to seek out healthcare and attend health and nutrition sessions, as it is a condition of the transfer.

3.3 Review of Tools
Information required for informing the design or implementation of the Maternal and Child Cash Transfer program:
- Cost of a nutritionally adequate diet to inform transfer size;
- Identify barriers to optimal nutrition practices to inform key BCC messaging;
- Up to date data on pregnant women for targeting and administrative planning;
- Robust monitoring system to ensure adequate mechanisms are in place;
- Effective evaluation design to ensure the design allows for impact evaluation.

The MCCT pilots carried out in Myanmar by Save the Children and partners have relied on three methodologies to inform the design of the program and provide the necessary information: cost of the diet assessment, qualitative IYCF studies and monitoring, baseline and evaluation.

1. Cost of the Diet Assessment: The Cost of the Diet is a method developed by Save the Children to calculate the minimum amount of money a typical household needs to purchase their recommended diet (intakes of energy, protein, fat and micronutrients) using locally available foods. The cost of food grown and consumed at home is included in the calculation by applying market prices (Save the Children 2014). This tool can be used at the program design phase to inform the size of the transfer and as a monitoring tool to understand the purchasing power of the transfer.

Methodology: Seasonal market price and availability data is collected within a specific livelihood zone. In addition interviews and focus group interviews carried out with mothers who represent the wealth groups within a target community, there is a specific focus on pregnant and lactating women and young children.
2. **Qualitative IYCF Studies** In order to inform the nutrition education and BCC approach it is important to understand current and localised IYCF practices and the barriers and opportunities for changing these behaviours.

**Methodology**

A combination of different methods can be used to collect the information required:

- Focus Group Discussions
- Key Information interviews
- Qualitative surveys
- Secondary Data Review

3. **Monitoring, Baseline and Evaluation**

Including specific, measurable, achievable, relevant and time-bound (SMART) nutrition indicators in the M&E framework is essential for assessing the impact of the social transfer program and to inform any changes that may need to be made. Ideally, this data is collected using existing systems or by strengthening the existing mechanisms although additional systems for nutrition specific data may need to be set up and this should be budgeted for (DFAT 2015). Some illustrative indicators are listed:

**Quantitative:**

- Duration and exclusive breastfeeding: Individual survey;
- Dietary diversity score;
- Anthropometry: Birth weight, weight, height, maternal BMI;
Micronutrient status: Iron, Vitamin A.

**Qualitative:**
- Nutrition and hygiene practices;
- Women's work load;
- Child care practices;
- Health care access.

### 3.4 Institutional Support

The importance of tackling malnutrition as an integral part of addressing economic and human development in addition to the recent success of social protection programs in Latin America, Africa and Asia has meant an increased push from some key institutions. UNICEF, UK AID (DFID), Australia DFAT and the World Bank are just some of the international organisations endorsing social protection as a mechanism for impact on nutrition.

Both ‘Zero Hunger Challenge’ and ‘Scaling Up Nutrition’ are multi-sector platforms which have gained a lot of traction in Myanmar. They can be used to enable many partners across government departments, private sector, UN and civil society, to work towards common goals, impacting on the complex determinants of malnutrition. These networks can be used to develop materials, key messages and communications channels when implementing the package of services.

#### Recommendations:

1. The program should be designed with clear objectives and pathways/theory of change.
2. The transfer should be large enough to have an impact (i.e. approximately 1/3rd of household income).
3. A universal coverage to all pregnant women and their children under 2 rather than a means-testing approach.
4. A regular monthly (or bi-monthly) transfer, which is easily accessible.
5. Investing in supply of services, which address other determinants of nutrition outcomes; antenatal, vaccination and supplementation, and child health care.
6. Aligning efforts among Ministries and international and local organisations to provide good coverage of essential nutrition, health and wash BCC and health services to pregnant women and their children under 2.
Implementing a MCCT program at national scale requires different institutions and actors in Myanmar to fill in different functions in a coordinated manner for a more effective delivery of the program. The following are the main roles and responsibilities necessary for the implementation of the MCCT program:

- **Identification and enrollment of beneficiaries:** Clear eligibility criteria need to be established, and eligible women identified and enrolled in the program. A simple and clear procedure needs to be developed.

- **Cash delivery and payment:** A cash delivery mechanism should be able to easily access all the recipients, in particular mothers and children in remote areas. Part II will discuss the most common methods used in other countries in light of the recent technological advances happening in Myanmar and the expected evolution over the next few years.

- **Information and communication:** First, the whole population should be aware of the MCCT program: information about its existence, the purpose, universal eligibility, and how the program works should be communicated widely. Secondly, international experience shows that the cash transfer should be combined a BBC component (see Part I) to have significant results on nutrition outcomes. Actors for this function should be locally present and accessible, and a trusted source for the program’s recipients.

- **Exit:** Timely exit of individuals from the program needs to be assured when eligibility is over. Monitoring will need to be in place for the correct implementation of this function.

- **Complaints/Accountability:** A grievance mechanism through which anyone can file complaints against the program is necessary to ensure accountability. The mechanism should be accessible to both beneficiaries and non-beneficiaries, anonymous and responsive in a timely manner.

- **Data recording:** A MIS should be set up monitor, such as by checking the time and the amount of the cash transfers, provide updates on the list of beneficiaries after any new enrollee and after any exit, in line with programs in other countries and as recommended for the Social Pension program.
- **Monitoring and Evaluation:** Monitoring mechanisms should be put in place to make sure the program is implemented correctly in all its aspects (eligibility, amount, frequency of the transfer, exit, etc.) and inform any necessary adjustments. The evaluation, done on a sub-sample of beneficiaries, will provide evidence about the effectiveness of the program.

2. Stakeholders' Map for Social Protection

The following institutions are reviewed for their potential involvement in the delivery of the MCCT program:

- Ministry of Social Welfare, Relief and Resettlement (MSWRR);
- General Administration Department (GAD);
- Health System
  - Infrastructure
  - Health workers
  - Local Professional Organisations and INGOs
  - Health Committees;
- Myanmar Economic Banks (MEB) and other banks;
- IT Companies
  - Myanmar Mobile Money
  - Oredoo and Telenor.

Annex 3 describes the mandate and structure of these institutions. In particular, we focus on whether their mandate is appropriate to carry out the MCCT and whether their presence on the ground and their reach is sufficient to provide support in the MCCT program delivery. Table 1 summarises that information and it describes what the institutions' potential strengths and weaknesses.
Table 1: Stakeholders Map for Social Protection

<table>
<thead>
<tr>
<th>INSTITUTION</th>
<th>MANDATE</th>
<th>STRUCTURE/PRESENCE ON THE GROUND</th>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
</tr>
</thead>
<tbody>
<tr>
<td>MINISTRY OF SOCIAL WELFARE, RELIEF AND RESETTLEMENT (MSWRR)</td>
<td>Dept. of Social Welfare: Welfare of vulnerable groups, including children, women, elderly and persons with disabilities. Ministry responsible for the National Social Protection Strategic Plan</td>
<td>Two main Departments: Dept. of Social Welfare and Dept. of Relief and Resettlement Recent deployment of social workers to township level</td>
<td>Most appropriate mandate and accountability for MCCT program Initiated development of additional in human resources on the ground</td>
<td>Homogenous presence only at state/region level Presence in district, townships or at lower level limited at this stage</td>
</tr>
<tr>
<td>GENERAL ADMINISTRATION DEPARTMENT (GAD)</td>
<td>Local governance and administration Ensure the rule of law, peace and prosperity of villages and townships, regional development and people's welfare Carry several activities, such as tax collection, land management, information dissemination, data recording, etc.</td>
<td>Hierarchical and geographically defined Presence on the ground at all geographical levels, down to Village Tract/Wards.</td>
<td>Homogenous presence on the ground locally</td>
<td>Burden of existent administrative responsibilities</td>
</tr>
<tr>
<td>INSTITUTION</td>
<td>MANDATE</td>
<td>STRUCTURE/PRESENCE ON THE GROUND</td>
<td>STRENGTHS</td>
<td>WEAKNESSES</td>
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<tr>
<td><strong>HEALTH SYSTEM</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>A) INFRASTRUCTURE</td>
<td>Health services</td>
<td>Health centres</td>
<td>Significant presence</td>
<td>Gaps in infrastructures and human resources</td>
</tr>
<tr>
<td>B) HEALTH WORKERS</td>
<td>Health services</td>
<td>Presence on the ground is widespread (directions from MoH to have presence in every village)</td>
<td>Homogenous presence on the ground; midwives travel to remote villages</td>
<td>Travel costs are high to reach villages and workload is very high</td>
</tr>
<tr>
<td>C) LOCAL NGOS AND INGOS</td>
<td>Education, community engagement, basic health services</td>
<td>Locally active in some areas in the country, but not everywhere</td>
<td>Potential role of support in certain areas for MoH</td>
<td>Not homogenous presence in all townships</td>
</tr>
<tr>
<td>D) HEALTH COMMITTEES</td>
<td>General support for health system and village health volunteers</td>
<td>Present down to Ward/Tract level</td>
<td>Homogenous presence on the ground locally</td>
<td>No role in providing services</td>
</tr>
<tr>
<td>MYANMAR ECONOMIC BANK (MEB) AND OTHER BANKS</td>
<td>Provide financial services</td>
<td>MEB branches present at state/region level, but not in all townships yet</td>
<td>Sector is growing and the country is opening also to international banks</td>
<td>No reach in rural areas and below township level</td>
</tr>
</tbody>
</table>
### Table 1 (continued): Stakeholders Map for Social Protection

<table>
<thead>
<tr>
<th>INSTITUTION</th>
<th>MANDATE</th>
<th>STRUCTURE/ PRESENCE ON THE GROUND</th>
<th>STRENGTHS</th>
<th>WEAKNESSES</th>
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<tbody>
<tr>
<td><strong>IT COMPANIES</strong></td>
<td></td>
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</tr>
<tr>
<td>A) MYANMAR MOBILE MONEY</td>
<td>Provide network coverage in the country and phone services</td>
<td>Present in all states, but with huge variation of agents</td>
<td>Already providing mobile money services</td>
<td>Investment needed in the next few years</td>
</tr>
<tr>
<td>B) OREDOO AND TELENOR</td>
<td>Provide network coverage in the country and phone services</td>
<td>Expected to cover 90% of areas in next 3-4 years</td>
<td>Expected full network coverage in the country</td>
<td>Regulation ready, but still need to be approved by Central Bank (expected soon)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Invested agents and retailer stores in the country</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Use of feature phones and smart phones</td>
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<td></td>
<td>Providing health information through phone applications</td>
</tr>
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<td></td>
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<td></td>
<td></td>
<td>Investment needed in the next few years</td>
</tr>
</tbody>
</table>
This section investigates different options to implement each of the functions described above. Strengths and weaknesses of different institutions are evaluated for the implementation of the MCCT program.

The MCCT program was developed as part of the Myanmar National Social Protection Strategic and is defined as universal. Monthly transfers are proposed to be 15,000 Kyats per each child. It is expected to cover all mothers in the last six months of their pregnancy in the first year of the implementation; the allowance will cover all children to age one in year two and all children to age two in year three of the program.

### National Social Protection Strategic Plan (2014)

“Flagship program: “Cash allowance for pregnant women and children to age two”

A nationwide, universal cash allowance for all mothers in the last six months of their pregnancy will be established in 2015. In 2016, the allowance will cover all children to age one, and in 2017, all children to age two.

The goal is to provide expecting mothers and young children with additional resources they can use to provide for their basic needs, including nutritional needs. The impact on the well-being of children during these critical formative years is expected to be substantial.

Each beneficiary would be provided an allowance of MMK 15,000 per month. The cost to the budget of full coverage is estimated at 0.14 per cent of GDP in 2015 and gradually phases in to reach 0.32 per cent of GDP by 2024.

The program will be implemented nationwide. MSWRR will be the leading agency. By 2017, some 2.25 million women and children will be covered. The mothers receiving benefit will be expected to participate in antenatal and postnatal health assessments.”

### 3.1 Eligibility Criteria

The program in the National Social Protection Strategic Plan (2014) defines the target population as “pregnant women and children to age two”. As explained above, only pregnant women, starting from the last six months of their pregnancy, are eligible for the program and their children will receive cash transfers until they turn two. No children already born will be covered in the first
year of implementation. The full period of cash transfer is between 24-30 months, depending in which month of pregnancy the registration happens.

Defining only pregnant women as the targeted population has advantages. The eligibility criteria seem to be very simple and clear; however, disseminating the information about eligibility criteria in a timely manner before the rollout of the program is essential to avoid any confusion and tension about who can or cannot participate. It is recommended to frame the program as ‘for pregnant women only’ in the initial stage. Framing it as it is done now as ‘pregnant women and children to age two’ could create confusion.

The potential concern might be that it would be very easy for the Registration Officers (discussed in detail below) to circumvent these criteria. As an example, they can easily pre-date the registration forms to allow mothers who already gave birth to participate in the program and allow them to receive transfers for some period of time. There is no immediate and easy solution to solve this concern, and it might be an initial concern that the government simply needs to be aware of.

Another concern is political, in that it will be difficult to justify to mothers with children under 2, who delivered the baby during the first year of the program implementation, that they are not eligible for the program because they did not register when pregnant. Allowing all women pregnant and women with children under two to receive some support might be more politically acceptable and receive wider support from the community. Also, costs of monitoring are expected to be lower.

Under this scenario, providing the transfer to mothers only for a limited amount of time, for example when the child is nearly two years old, is expected to have limited impacts on nutrition outcomes. Secondly, there is a potentially very high operational burden of identifying, registering and implementing a payment process for just for a few months given the current capacity in place.

Overall, both options have implementation and monitoring costs and might present political concerns. The Government needs to weight pros and cons of these alternatives and decide how to frame the program to the population. Eligibility criteria will need to be clearly communicated, not least in the name of the program.
The eligibility rules should clarify that no pregnant woman will receive more than one set of cash transfer payments within the first 1,000 day cycle (multiple sets of cash transfers will be provided in the case of twins). This rule will further promote appropriate birth spacing that is recommended based on studies showing that birth intervals of less than two years are associated with adverse perinatal and maternal outcomes (WHO, 2005).

The program is universal: all mothers can participate. The program does not seem to create risk of any negative incentives. Firstly, teenage pregnancies do not seem common in Myanmar: fertility rate among 15-19 years old women is only 0.02 children (Census, 2014). Secondly, the cash transfer each month does not seem big enough to incentivise women to have additional children. Because of these two main reasons, we recommend the delivery of the program to all pregnant women, independently of their age. However, we suggest that other policies and programs accompany the MCCT to promote education about the health risks associated with early pregnancy.

3.2. Registration: Identification, Verification and Enrolment

The registration process consists of three main steps: identification of all potential eligible individuals, verification of the eligibility criteria and official inclusion in the program. In the case of the MCCT program, pregnancy status needs to be verified before the registration in the program. The study evaluates which is the most suitable option for a smooth and easy registration process.

Identification, verification and enrolment need to be carried out by the institution most close to pregnant mothers and an easy point of contact also in remote areas. In local communities, because of their widespread presence on the ground, there are two main options.

**GAD:** As described in Section 2, the GAD is the only governmental institution present in each geographical level down to village/community level. The GAD has the administrative capacity to identify, verify and enroll pregnant mothers in the program. However, we think registration needs to be carried out by institutions that pregnant women trust given the sensitivity of the situation and the fact that pregnancy status needs to be verified through a pregnancy test. As well, since pregnant women will have to contact these institutions to be registered in the program, it would be easier to opt for an institution to which pregnant mothers already refer to for their pregnancy period and newborn babies.
Health Workers: In the health sector, the lack of infrastructure and health personnel is the main concern. At the current state, NGOs and midwives are the only workers present on the ground at village/community level. However, both international and local NGOs (MMCWA, MNMA) do not yet have homogenous coverage of the country. Since midwives at the sub-RHC level are the most accessible institution to pregnant mothers also in remote areas, we recommend the use of midwives as the main reference point for the registration process in the program. However, midwives may not be able to implement this function by themselves only because midwives at Sub-RHCs usually provide health services in more than one village – they cover on average seven villages. On the one hand, mothers need to travel to Sub-RHCs to get services. On the other hand, even though midwives are expected to visit villages every month, transportation costs are very high (MERLIN, 2012). If travel costs for both midwives and mothers are too high, we might have limited take-up of the program only because midwives and mothers cannot be in contact, especially in the most remote areas.

On top of that, since posts are often vacant at Sub-RHCs, midwives usually also perform functions of other personnel. Other responsibilities for the MCCT program might represent an additional burden to them. Even though the enrollment process should not take too much of their time since it can be performed when mothers refer to the centre for antenatal, postnatal care or delivery, their workload is already very high.

Local NGOs, such as MMCWA, could support the midwives’ activities for the MCCT program as much as they can. Community leaders, such as ten-household chiefs, can also be of help. While midwives remain the focal point for the MCCT program registration function, local NGOs and institutions at the community level can help them in many steps of the process.

The following activities are recommended:

1. Public Information Campaign: a media campaign to inform the general public about the MCCT program. It is recommended that local and international NGOs, GAD7, village health committees and leaders all participate in the campaign. The involvement of the Ministry of Information and Communication can also be considered. Especially because some rural areas are very remote and no media access is possible, the role of all these institutions is crucial. During their activities, they should disseminate information about the existence of the program, clarify eligibility criteria and required document for the verification, explain the registration process, and the delivery of the

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7 As they do for immunisation campaigns for example.
cash mechanism. The linkage between MoH, DSW, NGOs and community leaders should be strengthened to combine efforts for the delivery of the program. DSW should provide detailed instructions and material to each of the institutions involved to support this process.

2. Identification: midwives act as the main Registration Officers, but local NGOs have a role of supporting this function. To identify eligible mothers, midwives need to visit or to be visited by eligible individuals. A registration form should be provided to midwives at health centres. As shown in Annex 4, basic socio-demographic information is collected. Verification of pregnancy status needs to be made through a urine test. Additional information about proxy recipients is also collected.

Transportation costs and the current workload for midwives are the main concerns. For a manual identification process, a suggestion is for the midwives to delegate some of the work to local NGOs such as MMCWA: local NGOs can also be provided with forms and pregnancy tests to identify eligible individuals. Community leaders and committees can also be considered as an option. Helping with this function, they can limit transportation costs for both midwives and mothers to get in contact, and help lower the midwives’ workload to identify any possible participant. Once these institutions identify individuals, forms need to be delivered to midwives as they act as main focal points for the identification function.

In the long run, a more technological option is recommended. Midwives, and local NGOs, need to be provided with mobile phones or asked to use their phones and fill in similar digitised forms. IT companies such as Koe Koe Tech are experts in delivering these types of services and they can provide immediate support: the technology necessary is simple, accessible and relatively cheap. The main cost is that of mobile phones if they need to be provided as part of the program. In densely populated areas clustered around urban/city hubs where technology and network coverage is present this approach is strongly recommended but also in rural areas it should be tested. Even if network coverage is not widespread yet, midwives and local NGOs can submit the digitised list of recipients once a month/bimonthly when they travel to places where a (better) connection is available. As part of the MIS (details below), this would allow midwives to submit the list of enrolled people in a timely manner to DSW and that way DSW will have constant and immediate access, or with a minor time gap, to the list of eligible individuals. This approach eliminates the costs of mailing forms to DSW, the possibility of losing them and the costs of storing them.
It is key that midwives and local NGOs automatically enroll any pregnant mother they encounter. This can either be done when a mother comes just for the registration in the program, when the pregnant women refer to the midwife for antenatal/postnatal care or in case of delivery, when local NGOs encounter pregnant mothers during their activities. INGO and health workers in clinics and hospitals will also be of help to make sure any eligible individual is registered in the program, incentivising mothers to go for registration along with other health services.

The immediate advantage of using midwives as main Registration Officers is the creation of a strong link between mothers and the health system. Given the initial access of mothers to midwives, their first contact for the registration in the program can incentivise mothers to go for other services such as antenatal and postnatal care and it can build stronger relationships between the health system and those in need. Relationships with local NGOs and community leaders will also be strengthened.

It is essential that, during the identification process, mothers are assigned to an identification number in the program and that this is linked to their children’s information. In the program database, it should be easy to identify each mother and link her to her child. We suggest requiring mothers to bring the National Registration Card (NRC) identification number\(^8\) to be registered in the program. Each mother has to be linked to the NRC number in the database.

In addition, as soon as the child is born, it should be encouraged to register the child, provide a birth certificate and add information about the date of birth of the child in the MCCT program database to link the information.

In Myanmar, birth registration coverage of children under 5 is only at 72 per cent in 2010 (MICS 2009-2010). There are multiple registration systems issuing different documents, causing confusion among parents and birth registration masks large disparities between different states and regions, urban and rural areas, and wealth quintiles. UNICEF recently focused on three areas of intervention to improve the current situation in the country: policy advocacy for building a comprehensive system for civil registration and vital statistics; increasing coverage of birth certificates through a campaign mobilising parents and service providers to register the children.

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\(^8\) The national registration card contains the important personal information of holder such as face photo, name, date of birth and place; fingerprint image, iris image, signature, nationality, date of issue authority and so on. The ID card is very useful for authorised person confirmation. Generally, face image and fingerprint image are used for identification.
who still did not receive a certificate; and supporting the permanent recording of births through setting up an electronic platform, as the foundation of a civil registration system. The intervention was extremely successful, leading to better coordination among government agencies, an increase of 21 per cent in the coverage of birth registrations for children aged under 1 since 2010, and the establishment of an electronic platform which is expected to be fully operationalised in 2015. The system has equipment and support to be operational in every part of the country: records entered by Central Statistical Organisation (CSO) staff in district offices can be accessed at state/region and central levels and the data can be used to automatically generate statistical reports and analysis (UNICEF, 2015). It is encouraged that DSW link this new platform placed within the CSO to the MCCT program database through the mother’s identification number. Since the CSO platform creates and keeps a permanent record of births anywhere in the country, linking this information to a MIS for the MCCT program would allow having constant on-time information about any new child born from mothers in the program. MCCT can incentivise even further the childbirth registration if correctly promoted or encouraged as part of the MCCT program.

In addition, any of the documents, such as Household Registration Form Number 66/6 and Birth Certificate, can also be provided to Registration Officers to identify the eligible individuals and help filling in the enrollment forms with information about name, residency status, age, etc. of the recipient.

3. Verification: Midwives, and local NGOs, are responsible to verify the eligibility of the individual, mainly their pregnancy status. A pregnancy test is recommended to verify the status. In case, for any reason, verification with a urine test is not possible, Registration Officers can visit the individual’s household/neighborhood or they can discuss the case at the village/community Health Committee at which a midwife resides as a member.

4. Enrolment: After midwives and local NGOs identify and verify eligible individuals, with possible help of community leaders and/or Health Committees, they have to notify beneficiaries of the result. This can happen right at the moment of identification and verification, or after consultations at the village level once all the criteria for enrollment are verified.

The entire process of registration is delegated to midwives, and local NGOs, and the final list of beneficiaries of the program is sent to DSW, this would happen immediately if the process happens through mobile phones. No further verification at higher governmental levels will be necessary, since no additional documentation/information can be provided about beneficiaries.
However, it is essential that random checks will be performed by DSW to monitor that all the beneficiaries on the list respect criteria of age, pregnancy status and number of children enrolled.

Fake participants might be the main concern. However, we limit this problem by asking recipients to provide NRC documentation and thorough pregnancy status testing. Community leaders and GAD can also easily enforce this process following-up with mothers about their pregnancy.

5. Data Entry: Midwives, and local NGOs, are responsible to register participants of the program. In case DSW decides to opt for manual registration, midwives and local NGOs need to fill in and collect hard copies of the registration forms from the participants. We suggest that forms are copied and kept at the Sub-Rural Health Centre as a reference for midwives. Original forms need to be sent to DSW, where the final list of beneficiaries will be created, and all data entered through a MIS (Please see section 4 for details). Alternatively, a list of beneficiaries is created by midwives and local NGOs, collecting data through the use of mobile phones, because of the simplification in data collection and reduction in costs. The final list of beneficiaries can be shared with other authorities such as Medical Health Townships Offices, DSW Region/State Offices, and GAD at different levels. Overall, there is no need for an initial round of mass registration at the start of the program, because pregnant women qualify to become beneficiaries on an ongoing basis.

Recommendations:
The registration process, including identification, verification and enrolment of the beneficiaries, needs to be delegated to midwives at Health Centres. Local NGOs, such as MMCWA, can provide critical support to midwives during this process by taking similar responsibilities.

It is recommended to simplify the data collection through the use of mobile phones, because it reduces costs and coordination problems in managing hard copies of the forms and it helps with the timely submission of the list of beneficiaries to DSW. The database needs to uniquely identify mothers and link the participants to their children’s information. Random checks need to be carried out to verify that no fake beneficiaries exist. Community leaders, Village Health Committees, and GAD can be of help in this process.
Engaging with MoH

Given the important role played by the health system (midwives and local NGOs that provide health services) during the implementation of the MCCT, it is necessary that DSW engage early with representatives of MoH to understand their willingness in taking responsibilities in the program, as recommended in this study.

MoH, with support of WHO/GAVI Alliance, is already involved in the delivery of a Maternal and Child Health Voucher Scheme for maternal, pre and postnatal care and nutrition. The pilot started in May 2013 in the Township of Yadarshey and covers about 1,346 beneficiaries. The Health Planning Unit of the Department of Health took care of the entire implementation process and has developed experience in the delivery of this type of program. In particular, they were involved in the registration process also in most remote areas, in communication campaigns for voucher distributions (and they will also try to promote the use of health services), in the use of midwives to deliver health services to children and mothers as part of the program and in monitoring and evaluation processes (GoM, 2015). All the experience they developed is very meaningful in collaborating with DSW for the implementation of the MCCT. Partnering with MoH is definitely necessary and a point of strength for the effectiveness of the MCCT program implementation.

3.3. Cash Transfers: Amount and Frequency of Payment

For the feasibility of a national MCCT program, considerations need to be made about the amount of the cash transfer and the frequency of payment.

DSW is evaluating the amount of 15,000 Kyats for the cash transfer. If this is implemented, the cash allowance program, will be unprecedented in Myanmar in its amount of benefit. Even if the amount is small per individual, given the total number of children born per year, 906,493 children in the year before the Census 2014, the absolute cost will be high and a substantial budget allocation will need to be made for the program. The introduction of a conditional cash transfer to mothers in the last six months of pregnancy and children until two years old of 15,000 Kyats per month is estimated to entail an additional cost of 0.32 per cent of GDP and 1 per cent of government expenditure by 2024 (ABND, ILO report 2014).

It is important to keep in mind the main purpose of the transfer to determine the right amount. The cash transfer program in Zambia, for example, aimed to provide at least one meal per person per day in the household and linked the size accordingly. In other countries, the goals were
eliminating the poverty gap, eliminating the food poverty gap, or providing a percent of the food poverty line. Most national programs have food security as a key objective: the food poverty line or cost of a typical meal is the most common point of reference used to set the transfer size.

Overall, as a rule of thumb, the amount of the transfer (at least in studies from Sub-Saharan Africa) is shown to have positive impacts on outcomes of interest if above 20 per cent of the pre-intervention consumption. The lack of data in Myanmar does not allow us to provide precise and detailed calculations at this point.

The most recent estimates to evaluate the right amount of a potential maternal and child cash transfer are done by Tan (2015). The author uses the World Bank’s revision of the Integrated Household and Living Conditions Assessment Survey II to estimate the level of food-poor households in each state/division in Myanmar. These estimates suggest that the proposed benefit of MMK 15,000 per beneficiary per month may be too high: MMK 15,000 is more than twice as much as the highest food poverty gaps in Rakhine and Chin States (i.e. poorest and with the highest levels of malnutrition). However, these calculations do not take into account the costs of transport for health services, the lost income from a break in employment during pregnancy, the costs of a nutritious diet, etc. The author concludes that since the cash allowance program has the scope of reaching as many food-poor households as possible, there is limited budget and there is a large difference between the food poverty gap and the proposed benefit, the program benefit should be scaled down to allow more households below the food poverty line to receive the allowance. The average food poverty gaps imply that the benefit could be reduced by one third to MMK 10,000 or scaled down further to MMK 5,500 per beneficiary per month—the closest number to the average food poverty gaps in the three poorest states. Based on previous studies’ calculations of the right cash transfer amount (see Part 1 for examples in Myanmar), the latter amount proposed might actually be too small to have any impact on nutrition outcomes. Thus, 10,000 Kyats is recommended as the lowest possible amount for the MCCT program.

It is essential that the government clarify what is the main goal of the program before settling on a final amount for the program. The Government should also consider the available budget amount to be allocated, who to reach first: highest number of recipients, poorest states first, etc. and political concerns and acceptance by the general population.

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9 Food poverty is defined as households whose total expenditure is lower than the cost of purchasing food with 2300 Kcal per adult equivalent per day.
Estimates should be re-visited when the Myanmar Poverty and Living Conditions Survey (MPLCS) conducted by the World Bank with the Ministry of National Planning and Economic Development is released in mid-2015. In the meantime, this feasibility study considers scenarios under different cash amounts and focuses mainly on 15,000 Kyats and the smaller amount of 10,000 Kyats only. The DSW is evaluating the frequency of payment to be set on a monthly basis. Previous studies in nutrition literature (see Part I) show that a constant inflow of cash is important for food security of households and constant intake of nutritious food is essential to improve child nutrition outcomes. Anecdotal evidence from the Tan Lan study in Myanmar also shows that it is easier for women to retain a small amount of cash each month from their husbands to be used for their children. Larger amounts of cash can end up being used for different reasons than just food or health expenses. On the other hand, feasibility is also an important criterion for the implementation of a national MCCT program and there is no rigorous evidence that a less frequent payment, than monthly, has worse nutritional outcomes.

Even though a monthly delivery of cash is recommended, the possibility of providing cash at a lower frequency should not be excluded, especially during the rollout phase of the program. It might be valuable to compare delivery of payment at different frequencies to test the feasibility of the payment mechanism, in particular in the most remote rural areas.

**Recommendations:**

Depending on the initial budget allocated and the main scope for a national cash transfer program, decisions about the amount of the cash transfer and the frequency of payment will need to be made. A monthly delivery of 15,000 Kyat may be the best solution, but the Government should not exclude the possibility of delivering a smaller amount and/or a less frequent payment per each enrolled individual. The desired cash transfer might not be feasible in the first stage of the program and alternatives can be used in case of initial limited budget and to test feasibility of novel payment mechanisms.

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10 MPLCS contains modules on household demography, consumption, access to credit, and other topics relevant to household welfare and it will allow calculating poverty measure per each state/region.
3.4. Cash delivery and payment

Payment options depend on who is involved in the delivery of cash, the delivery agents, and the delivery method.

In the context of Myanmar, potential delivery agents we will be considering are:

- Government Ministries/Departments;
- Banks;
- Mobile phone companies; and
- Local health personnel.

A combination of these may be used for some interventions.

Delivery methods, whereby cash, vouchers or e-money is delivered, include:

- Direct delivery (cash in envelopes);
- Delivery through banking systems (either over the counter, from ATMs or other mobile banking technologies);
- Delivery using smart cards, debit cards, prepaid cards and Point of Sale devices and/or mobile phone technologies.

To decide who should deliver cash and how the payment should take place considerations of both the supply and demand-sides need to be made. On one hand, limited access to, or long distances to branches of financial institutions represents a supply-side constraint, which translates into transaction and opportunity costs for clients. On the other hand, low-income households’ inability to pay the fees attached to the use of formal financial services limit the demand for such services.

The review of recent experience shows that the agency directly delivering cash in envelopes using its own staff remained a common mechanism. This was used, for instance, by Save the Children in Myanmar, Southern Sudan and Vietnam (2009), and by Concern in DRC (2009). In several contexts, including Niger, agencies had partnered with local traders to assist in the direct delivery of cash. Agencies worked with banks and post offices in several contexts including Chechnya, Kenya, Gaza and Pakistan. In some contexts they opened bank accounts for beneficiaries and in others agencies distributed checks that could be cashed at branches. The use of new technologies such as smart, prepaid or debit cards and mobile phones remains relatively rare, but examples from Kenya, Malawi and Haiti show that they are starting to be used.
The following payment systems to deliver MCCT payment, both in a short or long term, are assessed below, following the fast technological changes that Myanmar is experiencing:

1. MEB (or other banks)

2. Manual Payment via:
   a. GAD
   b. Local personnel (health workers, health committee members)
   c. DSW
   d. Others (NGOs, international organisations, security companies, Microfinance institutions, etc.)

3. Mobile money

3.4.1. MEB or other Banks

Myanmar Economic Bank (MEB) has previous experience managing Social Pensions for civil servants, military and political personnel and it has also been considered for the Social Pension Flagship Program as a good candidate to deliver cash transfers. Possible advantages in using MEB as a delivering cash provider are:

- Previous experience with smart card system introduced in 2012 for the Social Pension scheme for civil servant, military and political personals;
- MEB branches in most of the townships: they can be used as a payment method for recipients living close to them;
- Existing technical system for Government to People (G2P) payments.

On the other hand, potential risks are:

- MEB branches exist only at township level (and not yet in all the townships) and it is impossible to reach the whole population at village/community level, making it especially difficult to reach remote and rural areas homogenously.
- The ‘mobile outreach’ model using MEB staff at temporary locations is still under-developed: it would need to be developed and used for the first time to deliver cash transfers.
- In addition, when proposed for the Social Pension cash transfer programs, difficulties in transferring budgets from DSW to MEB and the lack of human resources at MEB were presented as substantial challenges in using this as a feasible delivery option.
Overall, to use MEB as a unique delivery method, in particular in rural areas, there is a clear necessity of investment in opening new bank branches or engaging new staff for mobile outreach in rural areas, finding resources to cover the additional administrative and implementation costs and clarifying how to transfer budget from DSW to MEB given the present legislation.

DSW is considering MEB as way to deliver Social Pension cash transfer and wants to be consistent among different cash transfer programs the use of this method cannot be excluded here. However, the use of MEB is not currently a feasible option in Myanmar without a huge investment in resources. Investments are expected to take too much time and to be too costly in order to be able to rollout a national MCCT soon. If the DSW is considering building capacity and provide financial services to the population while exploring new approaches in long run, MEB (and other banks) might be considered as one option for payments. However, the use of MEB will need to be evaluated in comparison to other alternatives, such as the use of mobile money, which might be more promising in term of cost-effectiveness (See details in section 3.4.3.) and it will need to be tested on a smaller scale first.

3.4.2. Manual Payments:

**General Administration Department**

GAD should be considered by MSWRR to carry out manual payments not only in urban areas, but also more specifically in rural areas (70 per cent of the country, Census 2014). There are many important advantages to using the GAD as a delivery mechanism:

- GAD has a presence down to the village level, with both a Village Administrator in each Village (VA), and a Village Tract Administrator (VTA) and Clerk at the Village Tract level (VTAC): it is the only governmental institution with national presence;
- GAD structures have strong, established lines of supervision in place, with instructions and data flowing regularly from the Central level to the Region/State, District, Township and Village Tract/Village levels;
- GAD Region/State and Township Offices have established working relationships with the DSW Region/State Office;
- There would not be any conflict of interest between GAD and Registration Officers (we recommended Midwives at Health Centres, local NGOs such as MMCWA and community leaders). Accountability would not be a concern in this case;
Direct budget transfers can be made through bank accounts from DSW budget to GAD offices at Township levels. VTAs can have withdrawal rights on these bank accounts and deliver cash transfers in their Ward or Village Tract.

On the other hand, some issues to consider are:

- Given the strength and importance of the GAD structure throughout the country, there is a risk that individuals would find it difficult to complain against the GAD about payment-related issues. Even with an anonymous complaints channel, the number of beneficiaries in some Villages or Village Tracts is so low that anonymity could be compromised. The existence of a call centre, and the possibility to complain directly to DSW, can be a good solution to this concern. However, the risk might still exist with manual complaint mechanisms if not directed to DSW only. See Section 3.5. for details on complaints mechanisms.

- There is a need to formalise the agreement between MSWRR and GAD:
  - A letter of agreement between MSWRR and GAD is defined with the details about roles and responsibilities of GAD as part of the delivery mechanism.
  - The letter of agreement is approved by the Government.
  - An order is issued by the Government to GAD about functions to perform at Township, District, and Village levels.

- There are political considerations to be taken into account, since the DSW does not have direct control over GAD activities and monitoring can be compromised.

Overall, we think the possible risks are very minor, and GAD might be the unique feasible option at present in the country to deliver cash transfers in rural areas. This is especially true if the MCCT needs to be delivered at national scale immediately, i.e. both in urban and rural areas. However, concerns might exist in terms of their current workload to take on this responsibility as well. Discussion with GAD will be necessary to understand their opinion about this potential role in the MCCT program implementation.

If the DSW is willing to implement a small-scale MCCT first and scale up a national program in the following years, it is recommended to test alternative payment mechanisms, such as mobile money, especially in urban areas with the goal of extending a similar mechanism in rural areas. Given the current infrastructure in place, GAD can always remain the solution in case other options are not feasible for a national program in the medium-long run in rural areas as well.
Local health personnel

Health workers at the village level that have direct contact with eligible recipients may also play a role in delivering cash payments. We suggest considering midwives supported by local NGOs such as MMCWA and community leaders, as an alternative to the GAD and if novel methods cannot be tested first.

Midwives at Health Centres, however, might not be the best candidates for this function because, firstly, they do not have experience in managing large amounts of cash. Secondly, there is no easy and direct access to government bank accounts for them, especially if they may be volunteers not registered officially as midwives. They have other important duties to carry on for the recipients and may not have capacity in taking care of this responsibility as well. Their workload is already high, especially if they will be identified as Registration Officials for the MCCT program. Also, it is not recommended that the same institution implement both the functions of enrollment and cash delivery because of concerns of accountability and fraud. There would be huge conflict of interest and monitoring costs will be very high.

Because of the reasons above, and especially the potential conflict of interest and the additional burden on the health system, this option should be considered only as a last resort. DSW should evaluate pros and cons of other novel payment approaches, and the use of GAD and investment in MEB first.

Department of Social Welfare

Given the current infrastructure, it seems that DSW does not have the capacity to deliver payment to recipients: DSW structures reach Regions/States, but only 12 Districts out of 68, and no other lower geographical levels. DSW is under-staffed and positions at local level are vacant. To consider DSW as a possible candidate for the delivering of cash, a huge investment in terms of recruiting new personnel is required. Even if DSW is committed to deploy more than 6,000 social workers in the next year, a delay in the process and under-staffing to perform this function are still a concern. DSW could engage in the monitoring and data collection function of the MCCT program, but not more direct responsibilities for program implementation.

Others

None of the alternatives, such as the use of local NGOs, international organisations, security companies, microfinance institutions, etc., seem to have a structure in place at local level in the
whole country. None of these are recommended for a unique cash delivery function, but they can be used for support in certain areas of the country.

3.4.3. Mobile Money

Given the recent fast technological development in Myanmar and the expected changes in the next few years (Asian Development Bank, 2012, 2014), it is recommended to consider more innovative technologies for the cash transfer program implementation. We do strongly recommend taking into consideration the development and use of mobile money to deliver cash in local communities. International examples from Kenya, Malawi and Haiti and the movement from manual transfer to electronic ones in other countries such as Mexico, shows that Myanmar can be a pioneer in the use of mobile money for nationwide cash transfer delivery.

Mobile Money Transfers allow the GoM to electronically disburse funds through a Mobile Network Operator. The funds are transferred to the recipients through their mobile phones. This method works like an ‘e-wallet’ where the transfers happen instantaneously at very low cost per transaction and the funds can be cashed out by the recipient whenever she wants (Figure 2).

The main components of mobile money transfers are sending and receiving transfers. The GoM, DSW, has a special account with operators, such as Telenor, Ooredo, MPT, where it can deposit and transfer funds specifically for the MCCT program. From this account, e-money needs to be transferred to individual accounts of the recipients, so that the DSW remains accountable for the program. When that happens, the recipient receives a confirmation SMS alerting them of the deposit and the operator (and DSW) receives a report of all e-money disbursed.

Each participant in the program receives notification of the funds transferred and must cash out the money or make payments at a Mobile Money Agent. These agents are generally independent entrepreneurs who operate as a Mobile Money Agents as a side-business and generate revenue by charging a withdrawal fee for every time a recipient cashes out.

Recently, many organisations are moving away from manual cash transfers due to the high operational costs, security costs to counter theft by those delegated to disburse the funds and for fraud with manual disbursements, both within the organisation's offices and field operations.
‘Going electronic’ offers a number of benefits:

1. **Low operational costs**: cash transfers are often sent to groups of people in multiple locations in just one moment and it can be easier to reach them via mobile than to bring them together in one place;

2. **Increased outreach**: Mobile Money does not require the recipient being ‘financially included’ as in the case of bank transfers, but just that they have a SIM card with which they have a registered mobile money wallet;

3. **Reduced cash handling (costs, theft and fraud)**: relying on a network of mobile money agents who already handle cash will increase security over creating new systems for transporting cash. There is no need to handle large amounts of cash manually anymore;

4. **Back end and administration savings**;

5. **Transparent and traceable audit trail**: it is easier to track payments if they are sent electronically, which can reduce corruption and increase confidence that the right amount of money ends up with the right individuals;

6. **Quicker and more accurate management reports**: the recording of transfers is immediate through an electronic platform, so checking and monitoring is more accurate;

7. **Reduction of costs and freedom for recipients in cashing out money**: even though individuals might pay some fees for cashing-out money, fees are generally low and there might be higher opportunity costs in paying a low fee than travel to pay points at certain dates/times.

To consider Mobile Money as a feasible option to deliver cash, the following elements should be evaluated:

- Scale of mobile money usage and awareness in both general public and target population;
o Functionality of mobile money web platform (to be able to make disbursements);
o Agent coverage and liquidity;
o Network (signal) coverage;
o All associated operational costs and fees of using mobile money i.e. transfer fee, withdrawal fee and other fees (if applicable).

Myanmar is making rapid progresses in providing network coverage. IT companies in Myanmar are developing a network of retailer stores that can act as mobile agents in the whole country and they are also developing partnerships with banks.

These changes are expected to happen fast and enable the start of the implementation of mobile money in urban and rural areas in the next 2/3 years\textsuperscript{11}. If a short-term solution will be implemented, it is recommended to plan a move to a system based on mobile money as soon as:

- Mobile phone coverage and use increases;
- Beneficiaries are comfortable using mobile phone technology;
- IT companies, retailer stores or other general stores have local presence; and
- Presence of bank branches and ATMs are widespread in the country.

The roll-out of the program and mobile money cash transfers could start in urban areas first, where all these conditions are already satisfied or very likely to be satisfied soon, and gradually extend to rural areas as soon as there is availability of phones, bank branches, and retailer stores. At the same time, mobile money can be tested on a smaller scale in rural areas by providing mobile phones as part of the MCCT. The cost of mobile phones has dramatically declined in Myanmar.

\textsuperscript{11} There are official agreements between the Government and IT companies that need to be respected, describing the network expansion plan for next years. The possibility to carry out m-money business might generate an additional incentive to IT companies to expand coverage and money transfers reaching more remote areas as well. In fact, the cost of the towers is financed through commissions on two services: calls and money transfers.
Recommendations:

As of today, if the program is implemented on a national scale in the next year, GAD seems to be the only candidate for the payment function in rural areas. Homogenous and local presence on the ground and easy accessibility to government funds are among the main advantages for the feasibility of delivering cash at high frequency to eligible individuals in their ward or village tracts. Thus, if the Government decides to rollout a national program immediately, one of the following options is recommended:

- GAD in both rural and urban areas, or
- A hybrid model, GAD in rural areas, while mobile money is used in urban

Given the technological advances in Myanmar, in the medium to long-run, the mobile money approach may be the best option for cash payments not only in urban areas, but also to be extended over time in rural areas. Two options are: (1) to test mobile money in urban areas first and extend to rural areas later, or (2) test mobile money both in urban areas and in rural areas through the use of mobile agents and providing mobile phones.

MEB can also be considered as an option, but huge investment will be needed.

Midwives, supported by local NGOs, such as MMCWA, and community leaders, are an option only as a last resort because of (1) concerns about additional burden on their work and (2) potential conflict of interest with their recommended registration function.

3.4.4 Proxy or Representative Payees (PP)

Regardless of which payment system option is selected, it is strongly recommended to include a mechanism through which beneficiaries can designate a Proxy Payee (PP) or Representative to collect benefits on their behalf. Other similar cash transfer programs commonly use this type of mechanism when beneficiaries might have difficulty in collecting their benefits due to mobility challenges or remoteness and this is especially necessary for mothers around the time of delivery. The PP or Representative can be defined during the registration process.

Concerns arise if PP appropriate cash transfers resources for other reasons that are not within the scope of the MCCT program. A growing literature suggests that income or assets in the hands of women are associated with larger improvements in child health and larger shares of household
spending on nutrients, health, and housing than are resources in the hands of men (Duflo, 2003; Thomas 1990, 1994). To avoid other individuals in the household, often men, taking over the control of the cash transfer resources, it might be necessary to place some restrictions on the use of PP. Solutions can be limiting the use of a PP just around the delivery period or limitations on the number of times that PP can be used over the 24-30 months of participation in the program.

3.4.5 Notifications and Records of Transfers

When manual payments, or cash-out from mobile agents in case of mobile money, are implemented notifications about the pay-point location and the days to cash-out money are crucial. The following should be implemented:

- Each eligible person should be notified about the day of the cash delivery at a certain pay-point. Notifications at least two weeks in advance should be made through GAD/Midwives and/or mobile phone calls/text messages to the participants.
- Some routine should be in place: transfers should be made the same week of each month, so that recipients can remember easily and make consumption decisions expecting cash inflow at the same moment each month.
- Pay-point locations should be defined before the beginning of the program. They should be calculated based on similar average walking distance for all the households in a certain areas. A maximum feasible by foot distance should be defined to ensure beneficiaries do not have to walk too far or have too high transportation costs to get to the Pay-point.
- More than one day and a maximum number of three days should be allowed to collect cash. More than one day allows some flexibility in collecting cash in case of time constraints for the recipients. A maximum number of three days avoids other implementation challenges in the delivery mechanism. In case the recipients miss the window of delivery in a certain month, the unclaimed cash amount should be automatically transferred to be picked-up during the next available date. Flexibility needs to be allowed, especially for recipients in remote areas. Unclaimed benefits are not lost.

Secondly, if a manual system is implemented especially in rural areas, each cash transfer needs to be recorded through appropriate forms. The following data needs to be collected:

- Who received the transfer (participant or proxy recipient);
- Day of the delivery;
Amount of the cash delivered; and
Problems at the moment of the payment.

All this information needs to be sent to DSW and added through MIS to the main program database. Since this process is not time-effective, it is recommended to implement more innovative and technological ways to deliver cash as soon as possible in the context of Myanmar.

3.4.6 Considerations about Smart Cards

In many countries, such as Brazil, Kenya, South Africa, etc., cash transfer programs use the biometric smart card as a way to deliver cash, while verifying the recipient's identity in a smoother way. Smart cards, which operate as simple debit/credit cards, are personal cards usually linked to biometric information of individuals, mainly finger prints. In the context of cash transfer programs, they are used as 'electronic wallets': smart cards are loaded each month with funds from the program and used by recipients at different locations to withdraw or cash out money. This electronic delivery system, however, needs private sector participation where a private sector company, typically a bank, smart card platform, or cellphone operator, partners with the program implementer. Smart cards can be used at bank branches, ATMs, or any store or mobile agents with a POS (Point of Sale) machine that can read the card to cash out money.

The advantages of providing and using smart cards in the MCCT program are several:

- This system is clearly more cost-effective: the smart card provides lower transaction costs per transfer, especially compared to manual payments;
- Identification and authentication of the recipients is very easy at each location with POS machines;
- Through the electronic system, data about each transfer and cash withdraw are recorded;
- It avoids duplications of cash transfers;
- It allows flexibility to recipients to cash-out money whenever they want;
- Reduces concerns of corruption and ensures transparency.

On the other hand, disadvantages are:

- There is a clear need of some infrastructure in place: private sector participation is essential. Unfortunately in Myanmar, accessibility to banks, cellphone operators or private agents is still not common everywhere.
- Smart cards need to be produced and delivered to recipients: other international programs experience delays in the delivery of cards to individuals and thus of the cash
payments, followed by many complaints about inefficiency of the program.

- It needs some initial investment in POS machines, in particular if the retail stores channel is used as a way to have access to cash transfers.

At the moment, smart cards are not feasible to use in the context of Myanmar, but they are definitely a possibility in the medium-long run. It is not worth the Government investing in setting-up a smart card only based system. On the other hand, we do recommend investing in promoting financial access or mobile money. In case MEB will be used, ATM cards can be provided and they will be linked to individual bank accounts. If mobile money will be developed as a payment mechanism, smart cards are not necessary because each recipient will own a phone and a mobile money account. For manual delivery, documentation such as NRC is enough to identify cash recipient of the program.

3.5. Nutrition interventions and linkages

As demonstrated in Part I of this study, achieving impact on stunting, improving nutrition outcomes and overall reduction in poverty requires not only cash support but also provision of, or access to, other services which address specific determinants of malnutrition and poor development. The critical window of 1000 days for child development is the main focus across several GoM Ministries and therefore opportunities for collaboration should be maximised to improve nutrition outcomes.

The following minimum essential package is necessary:

- The purpose of the MCCT and the reasons as to why the 1000 days is the focus, should be communicated effectively to the recipients and the wider community.

- It is necessary to identify the entry points (the delivery of the cash, monitoring visits, registration) for the delivery of key messages by trained public health and health professionals. Specifically, links should be made between the NNC / MoH / UNICEF. The key health messages are standard and probably already developed and ready to use nationally. Those responsible for registering and delivery of cash should be adequately trained to deliver messages.

- These key messages should include IYCF practices, and essential available health services for antenatal care and childhood health care (including supplementation and vaccinations), and hygiene and sanitation practices.

- It is necessary to work with the MoH, NNC, development partners and the SUN platforms to coordinate, and collaborate on materials, resources and efforts.
If possible, given financial and human resources, an additional BCC Package (see Part 1 for details on the characteristics of the BCC package and example of activities) would increase the impact of the cash transfer by providing a nutrition and health education service to mothers and the wider community using a BCC approach linked with existing NNC/MoH programs. Ideally, the roll out of the MCCT overlaps with NNC/MoH initiatives also focusing on 1000 days to maximise impact and resources.

In the long term and for maximum impact, the Government should also aim to improve in the following:

- Provision of basic services;
- Improve midwife coverage including antenatal services, supplies and childhood health services;
- Address access to clean water and sanitation services;
- Access to quality education services for all children.

**Recommendation:**

As part of the MCCT program key messages not limited to nutrition, but including health, hygiene and sanitation practices and health care services, should be delivered to communities. Right from the beginning of the MCCT implementation, efforts and resources should be combined between MoH, local and international organisations and other current programs to maximise impact.

3.6. Information and communication

Information and communication have a twofold function in supporting MCCT: firstly, to inform the public about the MCCT and communicate to pregnant women, future beneficiaries, that they are entitled to the program and where they can register. Secondly, BCC aims to improve their health and nutrition knowledge and practices. A potential pilot Save the Children may conduct in the Dry Zone, planned to start in late 2015, will provide rigorous evidence about the impact of a BCC strategy in addition to the provision of cash transfers compared to providing a cash only option.
For both, soft advertisement and communication strategies, mass media national campaigns and the use of mobile phones can be used. For BCC, the messages should also be delivered by those who will have contact with beneficiaries throughout the program – from registration through cash delivery, at both facility level and through face-to-face meetings with midwives and others who will support enrolment and cash delivery technology (including MMCWA, community leaders, GAD).

More innovative solutions can also be used for a national scale MCCT program in the medium-long term. Mobile phone technology and/or mobile phone applications can provide additional information to mothers about nutrition, pregnancy, and childcare. Even though this is feasible in urban areas where phone coverage is present and everyone have smartphones/feature phones, Myanmar would need to wait a few years to have this applicable in rural areas as well. These technological solutions are very promising in reducing costs and reaching a higher number of individuals.

**Recommendation:**

In the short term, advertisement and communication strategies, mass media national campaigns and the use of mobile phone technology is recommended to deliver key messages to communities. In the medium-long term, a BCC approach can be of additional support to achieve nutrition outcomes.

3.7. Exit

If a comprehensive database exists with basic information about the mothers and date of birth of the child, then the exit procedure should be immediate. The MIS should signal every day who is still a beneficiary of the program and who is not, derived from the date of birth of the child or the enrollment of the mother in the program. The list should be updated automatically and the updated list should be provided ahead of each payment cycle. The requirements for this to happen are:

- At the time of registration information about month of pregnancy of the mother needs to be collected. The enrollment information needs to be updated with the date of birth of the child.
- The MIS flags automatically any person who should exit the program based on the record of these dates.
- Recipients need to be notified either through mobile phone technology, Registration Officers, or payment provider before the last monthly transfer that they will soon exit the program.

There might be cases of miscarriage or when children die before turning 2 years (infant mortality at 62 per 1000, and mortality for children under 5 at 72 per 1000, Census 2014), and cash delivery should be stopped. One or two extra months of cash support can be provided to cover medical and burial expenses. In case the mother dies but the child survives, the benefit needs to be transferred to a new caregiver. DSW should monitor the list of beneficiaries every six months through contacting midwives, GAD local offices or village committees, or performing field-visits.

**Recommendation:**

Use a MIS to automatise and simplify the exit process, in addition to random checks.

### 3.8. Complaints Mechanisms

A complaints mechanism is extremely important for accountability. During the program implementation, there can be complaints about several elements of the program. Among others, examples are:

- Additional requests for information or clarification about the program in general and related services;
- Eligibility criteria and program exit;
- Cash delivery; and
- Quality of services.

It would be best if the institutions responsible to receive complaints about the program are separated by the function of registration in the program and cash delivery to avoid conflict of interest among the actors involved. If the same institutions covered all these responsibilities, this would limit recipient's ability to raise issues related to the institution that enrolled them in the
program and provided the cash transfers. Thus, this reasoning should immediately exclude midwives, suggested for registration, and other agents, suggested for cash delivery, as candidates.

Since the DSW is accountable for the MCCT program, it seems to be the best candidate to fill this position.

A call centre should be set up at DSW to receive complaints: the phone number should be advertised through mass media and provided to recipients at the moment of the registration in the program. In remote and rural areas where mobile phone technology is not common yet, a manual system is recommended.

Three options can be explored by DSW:

1. Recipients can mail complaints directly to DSW (where possible);
2. Local NGOs can help recipients especially in remote areas to fill in complaint-forms and send them to DSW;
3. If DSW invests and deploys social workers in the communities, these case managers can be considered as a feasible option to help recipients with the complaints in remote and rural areas.

A call centre is the only option recommended for any program-related complaint mechanism to reduce costs and increase effectiveness. If a mobile money approach is chosen, the complaint mechanism will also be easier to implement: the DSW can directly communicate via SMS/calls with the individuals and receive complaints through the same system in real time.

If the workload for DSW escalates quickly during the national program, for example, if people start calling the call centre to complain about problems not directly related to the program, call centres should be set up at different geographical levels, such as one per township or district. The DSW will remain responsible for implementing this function.
3.9. Monitoring and Evaluation of the MCCT program

3.9.1 Monitoring

Constant and attentive monitoring is pivotal to inform the government about potential issues in the implementation of the MCCT program. First, the main database (and the MIS) will provide the implementers with the possibility of checking the following information at any time:

1. List of program recipients:
   - Number of actual recipients
   - Socio-demographic of the recipients
   - Date of enrollment
   - Date of birth of the child/children
   - Exits
   - Number of applicants
   - Number of rejected applicants
   - Reasons of rejection

2. Records of payments
   - Amount and dates of each payment
   - Number of recipients that collect payments
   - Number of recipients that did not collect payments
   - Expected dates at delivery point
   - Expected location at delivery point

Secondly, it is recommended that DSW carry out field monitoring, especially at the beginning of the rollout of the program by random operational spot checks to determine whether the program is being implemented correctly. Also, regular field visits to conduct key informant interviews and

Recommendation:

DSW is best positioned to receive complaints. A call centre should be set up to allow direct complaints to DSW. In case of remote and rural areas where mobile phone technology is not common yet, a manual system is recommended. In the long run, the call centre is the only option recommended to reduce costs and increase effectiveness.
meetings, to remain informed of perceptions of the program and other issues not captured by the MIS or spot check monitoring, should be conducted.

Third, depending on which institution will carry out the service of payment provision, additional monitoring will need to be done for the amount of cash used for the payment at different institutional levels. This will entail checking re-conciliation among payment records in the database and money received/withdrawn from GAD townships bank accounts and re-conciliation among payment records in the database and money cash out from IT companies retailer stores, mobile agents and bank branches (Mobile money system/MEB or other banks).

Finally, DSW should evaluate and respond promptly to grievance mechanisms with follow-up interviews with recipients. These complaints can flag important weaknesses of the program that should be addressed as soon as possible in the MCCT program roll-out.

3.9.2 Evaluation

It is strongly recommended to collect data from a sub-sample of eligible recipients before any enrollment in the program and intervention (baseline). Comparing baseline data with follow-up data collection after the program is rolled out and cash transfer delivered, will allow for the rigorous investigation of the effects of the intervention in the short, medium, and long run.

This first data collection is really important: it should be planned in advance and in detail. The roll-out of a national program represents a unique opportunity to provide evidence to the country and international community about the feasibility, validity and positive effects of the model of MCCT program implemented in Myanmar. Comprehensive data collection should be carried out to study the effects of the cash delivery on children and mothers' health and anthropometrics, household dynamics, consumption, labor, fertility, and other behavioural and economic outcomes.

Engaging at an early stage with impact evaluation companies, consultants and researchers who can provide expertise in designing the evaluation, collecting data, and do the analysis and results dissemination is recommended.
4. Establishing a Management Information System (MIS)

MISs are core to the design of any quality social protection scheme. The majority of cash transfer programs implemented internationally use a MIS-based operational system to manage and update the beneficiary database and automate most of the processes. MIS also makes monitoring smoother, reducing the risk of fraud and possible corruption. MIS can vary from simple standardised forms to more digitised systems. The more the system is digitised and made automatic, the easier the possibility of doing routinised checking and monitoring. The system can be set up to flag possible incongruences in the data and worrying situations during the program implementation.

Unfortunately, the existing infrastructure and technology in Myanmar is limited. Thus, a robust MIS should be put in place, especially with the long-term objective that other cash transfers program will be delivered. As suggested in the Social Pension Feasibility Study, the database should be developed in a way that associates participants in the program with their households, by assigning a unique ID number to each household. This way, the household database would be a starting point for a comprehensive picture of all recipients of different cash transfer programs inside each household.

A digitised MIS can be used to create a digital database of registered participants and continuously update new beneficiaries’ information. Targeting and registration can be accomplished on a real time or near real-time basis avoiding the costs of data entry and potential errors. Moreover, registered applicants’ details can be transferred quickly using existing telecommunication systems. It can also keep records of each payment transaction and reconcile amounts recipients

**Recommendation:**
It is recommended to define on-going monitoring activities, especially at the beginning of the intervention as well as collecting data before and at different stages after the roll-out, to carry on rigorous impact evaluations of the program. It is beneficial to engage impact evaluation companies, consultants and researchers who can provide expertise at an early stage.
receive with amounts the service provider delivers. Additional checking on frequency of the payment, amount, and delays in the delivery can be monitored constantly to assess the efficiency of the program in cash delivery. Digital MIS can track and flag recipients that should exit the program. The targeting process is very efficient, given the notification reports that can be produced and that provide information on deviations from the service standards on real-time processes. The system can also continuously monitor and check the most sensitive and important information. The automatic creation of indicators, always up to date, will help in establishing the cost-effectiveness of the program. Fast and accurate processing of complex program processes can be set up through MIS, for example, computation of proxies and determination of eligibility.

It is recommended that an international development consultancy firm, specialised in Social Protection MIS is hired. The MIS to be developed has to be ‘open-source’, so that the final product produced by the consultancy firm can be handed over fully to the government for subsequent implementation and ownership. The MIS has to be modeled on similar examples, drawing on lessons from other programs, within Myanmar and internationally. In addition, the MIS should be uniquely developed for different cash-transfer programs, so that the GoM can easily manage all the cash-transfer programs in a similar manner.

Especially for the MCCT, it is suggested to link the MIS to the already existing e-platform for birth and civil registration system (See details in Section 3.2 - Identification).

In the Social Pension feasibility study a description of the organisational structure and an estimation of the costs is provided. Since the development of the MIS requires at least four months, its implementation should be started as soon as possible.

**Recommendation:**

A robust MIS should be put in place and uniquely developed for different cash-transfer programs. We recommend the development of an “open-source” MIS. We strongly encourage the DSW to hire an international development consultancy firm, specialised in Social Protection MIS as soon as possible and start the MIS development process and testing.
5. Budget Considerations

Annex 5 considers different scenarios for the implementation of the MCCT program. The model followed for the estimates is based on “Social Protection Assessment Based National Dialogue (ABND): Towards a nationally defined social protection floor in Myanmar”, report developed by International Labour Organisation (ILO) in consultations with government ministries and a wide range of development partners. Some assumptions and data are taken from this report, while some initial estimates are updated with new released Census data (2014).

5.1 Data

Budget scenarios are based on the following sources of information:

**Census data 2014:** Estimates of the number of recipients, mothers and children, are taken from Census data for the whole country and from some states (Rakhine and Chin States), when geographical targeting is evaluated. As done in the ILO ABND report, note that the estimates consider pregnant women AND the total number of children 0-2 years old starting from the first year of the implementation. Thus, the budget considerations might over-estimate the costs in the first three years of implementation.

In fact, as proposed in the Myanmar Social Protection Strategy Plan (2014), in the first year of implementation, only pregnant mothers will be enrolled and receive a cash transfer for the last six months the pregnancy. In the second year of the implementation, children under 1 will also be included in the program, while in year 3 children under 2 will be included. Thus, in the first three years of implementation, not all children aged 0-2 will be part of the program.

Unfortunately, we need to assume that all children aged 0-2 will be receiving the transfer in addition to pregnant mothers starting in year one of the program. To provide correct estimates, we would need dates of birth of children. However, we do not have information for in which months how many children are born in the first year, how many will turn one in the first year of implementation, and so on. Similar figures are missing for children under 2. Overall, the cost estimates provided are the best estimate given the existing data.

- **International Monetary Fund (IMF):** macro-economic data about GDP, state expenditure and inflation. This data is taken from the ILO ABND report.
- **UNDESA population estimates:** We started from an ILO costing exercise to derive the population growth for years 2014-2020, based on UNDESA projections of the population.
The growth rate is necessary for our calculations to project mothers and children recipients in the following years of the program. However, our projections are based on 2014 Census data.

5.2. Assumptions
The following assumptions are derived here from the ILO ABND report:

- An initial 20 per cent take-up rate and additional 20 per cent per year for the following years.
- Administrative costs are estimated around 20 per cent if the program is universal, but only 5 per cent in case of reductions of implementation costs, such as the use of mobile money approach to deliver cash or less frequent payment.

5.3. Scenarios
An estimate is given for the first year of the implementation: which is the most interesting for DSW for next year’s budget allocation under different scenarios. It is based on the recent Census estimates of eligible mothers and recipients projected in 2016, which will most likely be the first feasible year for implementation when DSW will have governmental funding for the MCCT program. The amount of the transfer is set at 15,000 or 10,000 Kyats in 2016. See description below for all scenarios A-H presented.

A projection of cost estimates is also given for the implementation of a national MCCT program for all years from 2016 to 2020. This exercise shows the Government potential future costs depending on the chosen implementation option. The population, and thus recipients, is projected over the years and the cash amount is adjusted for inflation. An additional 20 per cent take-up rate is added each subsequent year. Unfortunately, it is not possible to provide the same exercise for specific States, because of a lack of population projections from UNDESA data source. (See Scenario A, B, G in Annex 5).

For the costing exercise, in term of geographical coverage, the following is considered:

- National MCCT program, i.e. in all the country.
- Geographical targeting, i.e. starting from one or two states (the poorest and with high malnutrition levels such as Rakhine and Chin State).
- For the cash transfer amount 10,000 Kyats and 15,000 Kyats are considered.
In terms of cash delivery method, a possible reduction in administrative costs (from 20 per cent to 5 per cent) is taken into account in two cases, namely, reduced frequency of payment in case of manual payments, especially in rural areas where manual delivery is very expensive, and the use of mobile money as the main cash transfer approach.

Thus, the following scenarios are presented:

- **Scenario A:** Universal cash transfer of 15,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old.

- **Scenario B:** Universal cash transfer of 10,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old.

- **Scenario C:** Universal cash transfer of 15,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old for Rakhine State.

- **Scenario D:** Universal cash transfer of 10,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old for Rakhine State.

- **Scenario E:** Universal cash transfer of 15,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old for Chin State.

- **Scenario F:** Universal cash transfer of 10,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old for Chin State.

- **Scenario G:** Universal cash transfer of 15,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old, with lower implementation costs (for example, using mobile money).

- **Scenario H:** Universal cash transfer of 15,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old, for Rakhine and Chin State with lower implementation costs (for example, using mobile money).

To make a decision, DSW will need to take into consideration how much budget it is expected to have allocated from next year’s budget specifically for the MCCT program. Figure 3 shows the
costs for each scenario in million Kyats and Figure 3 as a percentage of GDP in the first year of implementation (2016). While Scenario A refers to the original MCCT program proposed by DSW, 

**Scenario H** is the recommended scenario for the first year of implementation.

*Figure 3. Costs of scenarios A-H in million Kyats*

**Cost of Scenario (Kyats Million) in 2016**

*Figure 4. Costs of scenarios A-H as share of GDP*

**Cost of Scenario as % of GDP in 2016**
It is advised for DSW to evaluate the funding necessary for the MCCT program compared to the costs for other cash-transfer programs presented in the National Social Protection Strategic Plan, especially looking at the costs in the long-run. Providing cash support for the first 1,000 days is the most cost effective strategy in the life cycle.

Recent analysis (Hoddinott and Horton, 2014) shows that there are high benefit cost ratios with every dollar spent on nutrition in the first 1,000 days of a child’s life, providing a saving of an average 45 USD and in some cases 166 USD. Overall, there is a very strong economic argument for investing in the first 1,000 days (see Part 1 for additional evidence).

Estimates from ILO ABND report suggest that other universal interventions outlined in the National Social Protection Strategy would cost significantly more. For example, from ILO ABND report, costing exercises suggest that universal child allowance for 0-15 children at 8,000 Kyats per month per child costs 1.58 per cent of GDP by 2020 and a universal social pension of 25,000 Kyats per month for people 65 years old and over costs 1.09 per cent by 2020. On the other hand, the MCCT program costs only 0.32 percent of GDP by 2020, three to four times less than other universal cash interventions (see calculations in Scenario G).

Thus, considering the lower expected costs for MCCT compared to other flagship’ universal interventions, and with such expected returns to investments supported by global evidence, nutrition-based interventions should be a top development priority. The MCCT program should be considered the priority among other flagship programs in next year budget allocation.

**Figure 5** shows the expected costs for Scenario A, i.e. original MCCT program proposed by DSW (universal for all the country at 15,000 Kyats per month) until 2020, while **Figure 6** shows similar cost estimates as a percentage of GDP.
Overall, the original MCCT program proposed by DSW (Scenario A) will cost up to **0.37 per cent of GDP in 2020**. Possible cost reductions are proposed in Section 6.2. Budget estimates done by UNICEF in July 2015 (UNICEF SP Costing Model) provide similar results.
6. Summary Recommendation for MCCT implementation and Next Steps

6.1 Moving Towards the Implementation

To move forward and be ready for when funding will be available in 2016 for the MCCT program, the following actions are recommended:

1. Discussion about feasibility study recommendations

A workshop to discuss the feasibility study recommendations and finalise which institutions will implement each function is crucial. In particular, the DSW and all the actors involved should provide feedback on the recommendations in the feasibility study. Final decisions will need to be made about the program implementation.

2. Key decisions and funding sources

It is important to identify which is the most feasible scenario among the ones proposed, given the expected budget availability for next year. DSW needs to decide whether to start from a small scale MCCT program in the first phase, rather than trying to obtain pre-budget allocations for a national scale program that requires a substantial budget allocation (See Section 5 for different scenarios and recommended scenario H).

3. Finalise program design of the small-scale program in the first phase

It is necessary to finalise the implementation details of a small-scale program in the first phase and prepare a clear program description. The feasibility study and a detailed program proposal can be presented to Governmental at pre-budget allocation meetings in October 2015. See Section 6.2 for suggestions for the first phase implementation.

4. Establishing roles among different institutions

Once the plan for the MCCT is clear (about the initial phase at small-scale and the scaling up of the program in following years), meetings between DSW and MoH and GAD representatives, stakeholders from IT companies and MEB are recommended, as well as further discussions with MMCWA, MNMA and international NGOs to finalise the roles of each institution for the MCCT program delivery. DSW needs to discuss in detail the responsibilities of each actor involved and agree on a mode of cooperation. It is essential, as highlighted in the study, that efforts from different partners involved are put together for the effectiveness of the MCCT. Contracts, term of references, etc. will need to be put together in time before any roll-out of the program.
5. Developing MIS

In preparation for the implementation of the MCCT program, along with the Social Pension, the DSW can start making arrangements for the development of a MIS, such as recruitment of new personnel for the MIS, and developing operational manual, etc. See social pension feasibility study for further details on financial and human resources necessary and a detailed plan for moving forward (Ramkissoon, 2015).

6. Impact evaluation

Before any intervention, consultants, researchers and impact evaluation companies should be identified that can help with designing the program evaluation and collecting baseline data. The impact evaluation design and the first data collection do require time and need to be implemented before any intervention. DSW can start immediately working with research partners to design the impact evaluation of the MCCT program.

6.2 Next Steps: The Initial Phase

It is recommended to start implementing the program on a small scale in the first phase, with the main scope of testing novel cash delivery mechanisms.

Overall, the Government should take into account the following considerations to implement a small-scale program in the first phase:

- Geographical targeting;
- Administrative and implementation costs of manual delivery; and
- Amount and frequency of the transfer.

It is suggested to start from a small-scale MCCT program in the first phase, considering the following criteria in order of importance:

1. Geographical targeting: start from 1 or 2 states only and plan to extend to other states in following years.
2. Test new models of cash delivery: in particular, implementing mobile money both in urban and rural areas (if budget is limited, testing in urban or rural areas only). This would reduce current and future administrative costs; it would ensure the country is a global leader in this new approach of delivering cash transfers, which is still rare in international experience; it also has the potential to improve financial services in the country, if banks or banking mobile agents will be used as cash-out agents.
**Scenario H** represents implementation on a smaller scale next year and how much funding will be necessary to start in 2016 (Section 5).

If a different approach is chosen and manual delivery will be implemented, such as through GAD or using the banking system agents, implementation and administrative costs could be reduced by reducing the cash transfer amount to 10,000 Kyats and/or reducing the frequency of the transfer. This alternative would not reduce costs of the transfers, but would reduce implementation and administrative costs, especially in rural and remote areas.

**Recommendation:**

- The implementation of a *small-scale MCCT program in the first phase*, i.e. the ‘cash allowance of 15,000 MMK for pregnant mothers and their children under two’ in one or two states.

- Testing a novel approach in the delivery of cash to reduce administrative costs.

- **Scenario H** shows how much funding will be necessary to start in 2016.
Annex 1: Interviews and meetings with stakeholders

Interviews took place mainly in Yangon and in Nay Pyi Taw. The consultant Elisa Maffioli with Andrea Smurra (IGC), Lena Nguyen (UNICEF), Nandar Aung (UNICEF), and Mathew Tasker (Save the Children) conducted interviews with the following stakeholders:

**Government officials and representatives of governmental organisations from:**
- Department of Social Welfare at the Ministry of Social Welfare, Relief and Resettlement (MSWRR)
- Department of Health at the Ministry of Health (MoH)
- Department of Budget at the Ministry of Finance and Revenues (MFR)
- Myanmar Economic Bank
- Myanmar Maternal and Child Welfare Association (MMCWA)

The consultant also attended a workshop on the feasibility study for the Social Pension Scheme with senior officials of Myanmar Economic Bank, and representatives of the General Administration Division, MoH and MSWRR.

The objective of the interviews was to gather views on the main issues around the feasibility of a national, universal maternal and child cash transfer (MCCT) program. A whole day workshop to present the feasibility study about the Social Pension program has been fundamental to understanding the technical options for the MCCT program implementation.

**Representatives of international organisations and NGOs:**
- UNICEF
- Save the Children
- International Growth Centre
- World Food Programme (WFP)
- BRAC
- DFID
- UNDCF
- The Asia Foundation
- International Labor Organization (ILO)

These interviews sought information about similar cash transfer programs in Myanmar, their management, advantages and disadvantages, implementation features and the problems faced. Meetings with BRAC, a microfinance organisation, provided information on managing large transfers of cash. Meetings with The Asia Foundation provided information about different governmental actors on the ground at state/region, district, township, and village level.

**IT companies**
- General Manager of Planning Department at Myanmar Mobile Money
- Founder of KoeKoe Tech
- General Manager at Telenor

These interviews helped gauge the possibility of developing mobile money strategies in Myanmar over the coming years, and to better understand their expansion plans, expectations, and the potential to use mobile application technology for health information delivery.
Annex 2: Pathways of Impact

Essential services & inputs for maximum impact
- Access to clean water
- Access to adequate sanitation
- IYCF & WASH information & support
- Access to supplementation / immunisations

Basic Inputs
- Regular access to midwife / healthcare
- Market access and infrastructure
- Geo-political stability

Improved Childhood nutrition outcomes
- Improved schooling attendance
- Increased earning potential
- Increase in GDP
- Reduced vulnerability to risks

Cash Transfer
- Maternal diet quality
- IYCF practices
- Access to healthcare
- More strategic livelihood management
- Prioritisation of time to allow for improved childcare
Annex 3: Detailed description of institutional arrangements in Section 2

Ministry of Social Welfare, Relief and Resettlement (MSWRR)

Mandate
Department of Social Welfare (DSW) of the Ministry of Social Welfare, Relief and Resettlement (MSWRR) is responsible for all social protection initiatives among the Ministries. The MCCT programme is among these initiatives. See Section 3 for more details on the MCCT programme as part of the National Social Protection Strategic Plan (GoM, 2014).

Structure
The MSWRR is divided into two Departments:

   - Relief and Resettlement
   - Social Welfare

The DSW is further divided into 5 Divisions:

1. Children and Youth
2. Physical Rehabilitation
3. Women’s Development
4. International Relations
5. Administration and Finance

Issues related to mothers and children are the responsibility of the Division of Children and Youth.

DSW has an established State/regional presence, but not such an established presence at the township level. District-level offices exist only in 12 Districts out of 67. The Director of Social Welfare at the State/Region level is the head of DSW for the State/Region. The organisational structure also includes an Assistant Director, Staff Officers, Grade 1 and 2 Social Workers, Branch Clerks, Divisional Clerks, and Lower Divisional Clerks.

DSW recently committed to investing in social work case management with its own resources (Save the Children, 2015), which will help DSW to play a role in the implementation of the National Social Protection Strategic Plan. This strategy, adopted by the GoM in December 2014, articulates the need for an integrated approach to social services with 330 township level social service centres, housing 6,000 social work case managers in all townships. Even though the investment in social workers is high, this requires time and resources. Unfortunately, the deployment of social workers has been delayed: social workers will only be deployed in the first 27 townships starting beginning of June 2015, and initially only a small number of case managers will be sent out (three per office and 81 in total).

At this point in time, there are insufficient numbers of DSW personnel. There is a clear need to invest in building existing capacity on the ground.

General Administration Department (GAD)

Mandate
The General Administration Department (GAD), under the Ministry of Home Affairs (MoHA), manages the country’s public administrative structures and plays an important role in local governance and administration. The GAD official mandate is to ensure the rule of law, peace and prosperity of villages and townships, regional development and people’s welfare. It carries out such activities as tax collection, land management, information dissemination, data recording, etc. At the village tract level, clerks support administrators and keep records of administrative, economic and social statistics (population figures, migration, birth and deaths, etc.). GAD is also
in charge of reporting back to Nay Pyi Taw relevant information about the local population (The Asia Foundation, 2014).

**Structure**
The GAD structure is very hierarchical and geographically defined. The Executive Secretary is the senior civil servant in each state and region. In each district, there exists a District Administrator. Below districts, GAD has a Township Administrator in each township. Below townships, there exist Ward or Village Tract Administrators (VTA) per each ward or village tract. Within villages, there is a "household heads" system, where groups of 10 households select representatives to participate in Village Tract committees, along with other elected people from the villages (GoM, Ministry of Home Affairs, 2012).

Overall, the GAD structure includes units at the Region/State, District, Township, Village Tract and Village levels (In Myanmar there exist 63,938 villages according to GAD statistics, with 3,133 wards and 13,620 village tracts). GAD Administrators up to the Township level are appointed; at the Village Tract and Village levels households elect Administrators. An appointed clerk also sits at the Village Tract level. While Village Tract Administrators are not GAD staff (even if they receive a small subsidy from them), the Village Tract clerk is a GAD employee. Different committees with specific responsibilities exist at district, township and ward/village tract level (The Asia Foundation, 2014).

Among all the institutions in Myanmar, the GAD is the only institution that has physical office space allocated up to the Village level. Thus, it is the only institution with local and homogenous presence in the country, with the possibility of reaching the more remote areas.

**Health System in Myanmar**

**Mandate**
The overall mandate of the Ministry of Health (MoH) and of all the actors involved in health care provision is to achieve an equitable, efficient and effective health system in the country. In Myanmar, the health system presents a wide range of actors. However, an active collaboration and alignment of resources and efforts are needed to make improvements. Even though there have been some important developments in health and health care in Myanmar over the past decades, the country is still far from reaching the global standard of 2.28 health workers (doctor, nurse and midwife positions) per 1000 population. Health care public and private infrastructure is insufficient, and health insurance is practically absent.

**Structure**
The MoH is the main player in the health sector as a governing agency as well as a provider of health care. However, many key organisations have played an increasing role in this space as political and administrative circumstances have evolved. The present health system comprises a pluralistic mix of public and private systems both in financing and provision of health services.

**Health Care Infrastructure**
The following health care infrastructure composes the health system (Than Tun Sein et al., 2014; Department of Health, Ministry of Health, Myanmar, 2014; MERLIN, 2011.):

**Rural areas:**
- **Sub-Rural Health Centres (Sub-RHC):** Midwives are normally based at the Sub-RHCs and they supervise VHVs - auxiliary midwives and community health workers, that provide delivery of, and linkages to, health services at the village level. The policy of the MoH is for each midwife to cover on average 7 villages and 3000-4500 individuals.
Midwives are responsible for conducting outreach to villages on a monthly basis mainly to provide EPI and ANC services. Otherwise individuals need to travel to Sub-RHC to get services. Distance and travel time from villages to a Sub-RHC vary widely, but can be several hours by foot, vehicle or boat depending on the local context. Travel costs are crucial elements to consider when we investigate Midwives as an institution for the delivery of an MCCT program. Historically and to the present day most Midwives have insufficient funds for transport to deliver services, but this might soon be improving with increased government health funds for operational costs.

- **Rural Health Centres (RHC)** are where ambulatory services including delivery care are provided by the basic health staff (BHS). One Health Assistant, one Lady Health Visitor, five Public Health Supervisors Grade I and five Midwives (MWs) should staff each RHC.

- **Hospitals** in the rural areas are 16-bed station hospitals with 17 health staff, headed by a Station Medical Officer, who provides emergency care alongside general medical care.

- **Township Hospital**, will be headed by the Township Public Health Officer and a Township Medical Care Officer under new MoH re-construction. Usually a 25-bed operated by 55 staff, which provides emergency care and treatment, primary care for prevalent diseases, general administrative and auxiliary services, and clinical care such as general medicine, surgery, obstetrics and gynecology and pediatric care.

**In urban areas:**

- **Urban Health Centres** provide ambulatory care and dental care for general patients and also a Maternal and Child Health (MCH) Centre that takes care of pregnant mothers and children under five years old.

In the public sector, RHCs, Sub-RHCs, MCH Centres and Urban Health Centres provide ambulatory care and are patients’ first point of contact with health staff. Both public health centres and private clinics are available through the country, but further investment in health infrastructure and health personnel is necessary. Myanmar had indeed 0.6 hospital beds per 1000 population in 2010 to cover inpatients for both acute and chronic care available in public and private, general and specialised hospitals. In contrast, other similar developing countries, such as Timor Leste, Nepal, Viet Nam and Thailand had more than two hospital beds per 1000 population.

**Health Workers**

- **Doctors, Nurses and Midwives** per 1000 population increased from 1.27 in 2006–2007 to 1.49 in 2010–2011, but this is still far below the global standard of 2.28 health workers (doctors, nurses and midwives) per 1000 population. In particular, the number of doctors in Myanmar from both public and private sectors gradually increased from 0.1 per 1000 in 1990 to 0.5 in 2010. Density of nursing is also increasing, but is less than 1 per 1000 population. Among all health workers, midwives are the first point of contact for mothers. Since posts are often vacant, they usually also perform functions of other personnel. Their current workload is a second element of consideration when we will be evaluating Midwives as a possible option to deliver an MCCT program.

- Several thousand voluntary community-level health workers, namely Community Health Workers (CHWs) and Auxiliary Midwives (AMWs), introduced in 1980s to support the work of RHCs, remain active in their own villages. While some refresher courses and other supportive mechanisms were usually program specific, a national policy for retraining and retaining volunteers in the health workforce for the whole
country\textsuperscript{12} has not materialised yet. In recent years, as part of regional poverty-reduction initiatives, a few regional governments have launched the training and deployment of new AMWs with the objective of deploying one AMW per village. However, a more consistent national strategy is necessary to use these health workers as additional workforce for health care delivery.

Local NGOs and INGOs

- **Local NGOs** – Myanmar Maternal and Child Welfare Association (MMCWA), Myanmar Nurse and Midwife Association (MNMA) and Myanmar Red Cross Society (MRCS), etc. The two main NGOs, which are covering some share of service provision on the ground, are MMCWA and MNMA. However, many others can be taken into account similarly for the implementation of the MCCT program.

- The **Myanmar maternal and child welfare law** (1990 – revised in 2010) established MMCWA, as a non-profit-making, non-governmental organisation. As of now, the MMCWA functions with 330 township associations, and 22,063 branch associations formed to undertake health and welfare activities nationwide. It now has over 2,000,000 volunteer workers serving the organisation throughout Myanmar. As service delivery points, they have 134 maternity homes to deliver maternal and child care; 11 maternity waiting homes in 11 townships; 740 Early Childhood Care and Development Centres, i.e. community-based day care centres, preschool centres as well as the provision of parenting education (December 2013).

- MNMA is an independent, professional and non-governmental association founded in 1948, working for the nursing and midwifery profession and the improvement of health services in the country. There are 216 association branches throughout the country with a membership of 18,026 Nurses, including Licensed Nurses, Midwives and Lady Health Visitors. The MNMA provides various services such as conveying updated nursing education, emergency preparedness, sports and fitness and active involvement in social support networking inside and outside the organisation. The MNMA also provides a maternity shelter for women who cannot afford to deliver at a private clinic. In collaboration with other NGOs, the MNMA implements a Community Home-Based Care Project (CHBC through the guidance and support of the authorities, MoH and the Department of Health and State/Division, District and Township Nurse and Midwife Association. MNMA has operated the CHBC since 2001 to help improve the continuum of prevention, treatment and care available to those who are in need.

Even though both are non-governmental institutions, both have strong links with MoH, and they can be considered part of the governmental health system. This is definitely an advantage in developing the process of collaboration with DSW and MoH.

- **INGOs**, e.g. PATH, Marie Stopes International, Save the Children, World Vision, Oxfam, Médecins Sans Frontieres, AMDA, ADRA, CARE International, Burnet Institute, Malteser, etc. These INGOs are formally separated from the country health system and they are working separately to finance specific health-development programs that fall within their expertise. Collaboration with government health system is often common. The majority of these INGOs came into Myanmar as part of their collaborative efforts for relief and rehabilitation of Cyclone Nargis in 2008.

Overall, there are over 60 registered INGOs, 82 local NGOs and 455 Community-Based

\textsuperscript{12} GoM is scaling up AMWs across the country (approx. 6000 to be recruited/trained in 2015). The current government guidance is 1 AMW and 1 CHW per village.
Organisations actively working in the health sector, and the majority of local NGOs and community-based social groups are implementing partners for donor-supported projects. Given their presence on the ground and their investment in the health system, local organisations and international NGOs need to be considered by the Government as an important point of support for the delivery of an MCCT program.

Health Committees

Health committees have been established at various administrative levels down to the Ward/Tract. Health committees are composed of a Village Leader, assigned Midwife for the village, ‘village leaders’ and health volunteers. The most senior person at the administrative level of the committee heads these committees, and members are drawn from senior managers in government and NGOs. Heads of the health departments are designated as secretaries of the committees. The Village Health Committees’ role is to support the BHS and Village Health Volunteers (AMWs/CHWs). They coordinate environmental health/sanitation activities; coordinate mothers and children to come for vaccination days, and also facilitate emergency referrals to health facilities. Even if these committees do not have any role in delivering health care services, their presence on the ground is widespread in the country and they represent a good reference point for the knowledge and information they have about their communities.

Health workers and local committees have homogenous presence in the country, especially at village tract or ward level, while INGOs and local NGOs still do not cover all townships. Investments in the health care system are necessary from the GoM and through this process of improving and developing better infrastructure and services, local and international NGOs can provide support for health care delivery in the areas where they are currently active.

Myanmar Economic Bank and others

Structure

Myanmar Economic Bank (MEB) is a government agency and sits under the Ministry of Finance and Revenue (MFR). MEB mainly conducts commercial banking services to both the private and state sector in Myanmar through its network of 307 bank branches at the township level, 14 State and Divisional Banking Offices and 6 Head Office Departments. MEB Head Office opened in Nay Pyi Taw in 2006 and the Administration Department and respective sections of the Head Office Departments were also moved from Yangon to Nay Pyi Taw in May 2006. Nay Pyi Taw Bank Branch commenced its banking operations in 2008. The presence on the ground is however still limited because of the low number of bank branches.

Overall, financial services and bank presence are increasing in Myanmar, but it is still not widespread especially outside the big cities. As of September 2014, 24 banks (4 wholly state-owned and 11 partially state-owned or managed) had a total of 863 bank branches. Very few people are using financial services (about 6% of the population). Myanmar is also welcoming foreign banks (A Japanese bank just opened a branch in Yangon in April 2015), but more investment is needed to reach the population, especially in rural and remote areas.

IT Companies (Telenor, Ooredo, Myanmar Mobile Money)

Telenor and Ooredo

Structure

At present, Telenor and Ooredo are the two main IT companies in Myanmar. Telenor signed a nationwide telecommunications license agreement with the GoM on 30 January 2014. They launched in Myanmar starting with Mandalay on September 27, 2014 and expanded to Nay Pyi Taw (October 3, 2014), followed by Yangon (October 26, 2014). Telenor plans to rapidly roll out
to other cities and rural areas. The company has 620 employees and 3.406 million mobile subscriptions (Q1 2015). The plan is to cover 90% of the country in the next 3/4 years, starting from the most densely populated areas.

From discussions with stakeholders, Telenor is ready to launch in Kachin and Shan states. It is also creating a joint venture with Yoma Bank with the goal of using mobile money upon governmental approval of regulations\(^{13}\). The system will work through a network of cash distributors linked to Yoma bank branches (53 in total now). Each Telenor retailer store or general store can be a potential agent of the network. As part of the Know Your Customer procedures necessary to have a sim card and a mobile banking account these procedures will not be any different than the ones to open a bank account, and they are expected to be even lighter in terms of administrative costs for clients. Monitoring will be crucial to avoid problems with sim cards that can be exchanged between individuals. Overall, it seems that the networks of agents will be able to deal with several types of transactions since they will be based on a bank system.

Ooredo has a similar strategy of coverage and expansion. In addition, Ooredo is already using mobile phone applications to develop additional services other than just communication technology: these are related to agriculture, health, education and women specifically in collaboration with international and local organisations. Unfortunately, Ooredo do not provide these services on feature phones.

**Myanmar Mobile Money**

**Structure**

Myanmar Mobile Money (MMM) is the First Mobile Money Platform Service Provider in Myanmar. It started its activities 2 years ago with Mobile Money and Technology: MMM is now offering not only basic Mobile Money services such as Cash In, Cash Out, Remittances, but also a huge range of value added services that enable the Mobile Money user to take advantage of the same services provided by traditional banks and more (saving, pop-ups, e-commerce, bill payment, etc.). Future developments also focus on micro-finance and insurance. MMM mobile agents system is present in all 15 states/divisions: while Yangon has the highest number of agents employed (207), there is still huge variation among different areas with 7 states/divisions having less than 10 agents. Expansion of MMM mobile agents is necessary to provide a homogenous service in Myanmar: the investment in agents’ deployment in low-covered states/divisions seems to be the current main goal of MMM. However, clear projections have not been shared.

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\(^{13}\) The regulations are ready to be approved and approval is expected before the 2015 national elections.
Section A: Basic Applicant Information
Please copy the information directly from official document, if available

1. First Name:
2. Middle Name:
3. Last Name:
4. Father's Name:
5. Date of Birth (DD/MM/YYYY):
6. Village:
7. Township:
8. District:
9. Region/State:
10. House Number and Street:
11. Age:

Section B: Main Criteria for Registration

B.1 PREGNANCY: Only pregnant women starting from 2nd trimester can be registered

12. Is the woman pregnant at the moment of the registration?
   ☐ Yes, in 1st trimester. The woman CANNOT be registered for the program.
   ☐ Yes, in 2nd trimester.
   ☐ Yes, in 3rd trimester.
   ☐ No. The woman CANNOT be registered for the program.

13. Did the woman get a pregnancy test?
   ☐ Yes.
   ☐ No, but pregnancy is visible. Please ask question 16.
   ☐ No and pregnancy is NOT visible. Please ask question 16.

13. If pregnancy test was not taken, please verify the applicant’s pregnancy status by checking with community members.

Please list community members with who you verified applicant’s age:

Member 1
NAME:
FUNCTION:
Member 2
NAME:_______________________________
FUNCTION:___________________________

Member 3
NAME:_______________________________
FUNCTION:___________________________

Section C: Designated Recipient
If the applicant wishes to designate a trusted person (e.g. family member, neighbour) to collect payment at (TBD) on his/her behalf, please complete this section. Please explain to the applicant that the person should be trustworthy, and that if they wish to change their Designated Recipient or make a complaint against them they can do so via (TBD). Please complete the details of the Designated Recipient:

12. First Name: ____________________________
13. Middle Name: ____________________________
14. Last Name: ____________________________
15. Father’s Name: ____________________________
16. Date of Birth (DD/MM/YYYY): __/__/______
17. Village: ____________________________
18. Township: ____________________________
19. District: ____________________________
20. Region/State: ____________________________
21. NRC Number (if available): ____________________________

Section D: Midwife Information

22. First Name: ____________________________
23. Middle Name: ____________________________
24. Last Name: ____________________________
25. Date: ____________________________
26. Signature: ____________________________

Section E: Registration Receipt (retained by applicant)

NRC number ____________________________

Applicant First Name: ____________________________
Date (DD/MM/YYYY): ____________________________
Applicant Last Name: ____________________________
NRC Number: ____________________________

Midwife signature: ____________________________
### Annex 5: Budget Scenarios

**Scenario A:** Universal cash transfer of 15,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old

**Scenario B:** Universal cash transfer of 10,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old

**Scenario C:** Universal cash transfer of 15,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old for Rakhine State

**Scenario D:** Universal cash transfer of 10,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old for Rakhine State

**Scenario E:** Universal cash transfer of 15,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old for Chin State

**Scenario F:** Universal cash transfer of 10,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old for Chin State

**Scenario G:** Universal cash transfer of 15,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old, with lower implementation costs (for mobile money)

**Scenario H:** Universal cash transfer of 15,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old, for Rakhine and Chin State with lower implementation costs (for mobile money)

<table>
<thead>
<tr>
<th>PARAMETERS</th>
<th>SCENARIO A Myanmar 15,000 Kyats</th>
<th>SCENARIO B Myanmar 10,000 Kyats</th>
<th>SCENARIO C Rakhine 15,000 Kyats</th>
<th>SCENARIO D Rakhine 10,000 Kyats</th>
<th>SCENARIO E Chin 15,000 Kyats</th>
<th>SCENARIO F Chin 10,000 Kyats</th>
<th>SCENARIO G Myanmar 15,000 Kyats Lower implementation costs (5%)</th>
<th>SCENARIO H Rakhine+Chin 15,000 Kyats Lower implementation costs (5%)</th>
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</thead>
<tbody>
<tr>
<td>Total female population aged 15-49</td>
<td>13,531,491</td>
<td>13,531,491</td>
<td>564,243</td>
<td>564,243</td>
<td>114,388</td>
<td>114,388</td>
<td>13,531,491</td>
<td>678,631</td>
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<tr>
<td>Total number of births 15-49</td>
<td>914,655</td>
<td>914,655</td>
<td>37,250</td>
<td>37,250</td>
<td>14,205</td>
<td>14,205</td>
<td>914,655</td>
<td>51,455</td>
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<tr>
<td>Total population aged 0-2 (under 1 &amp; 1)</td>
<td>1,574,502</td>
<td>1,574,502</td>
<td>59,010</td>
<td>59,010</td>
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<td>Maternal benefit</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Target group</td>
<td>914,655</td>
<td>914,655</td>
<td>37,250</td>
<td>37,250</td>
<td>14,205</td>
<td>14,205</td>
<td>914,655</td>
<td>51,455</td>
</tr>
<tr>
<td>Take-up rate (%)</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
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<td>20%</td>
</tr>
<tr>
<td>Target group covered by this scenario</td>
<td>182,931</td>
<td>182,931</td>
<td>7,450</td>
<td>7,450</td>
<td>2,841</td>
<td>2,841</td>
<td>182,931</td>
<td>10,291</td>
</tr>
<tr>
<td>Benefits per head per year (Kyat) - last 6 months pregnancy</td>
<td>90,000</td>
<td>60,000</td>
<td>90,000</td>
<td>60,000</td>
<td>90,000</td>
<td>60,000</td>
<td>90,000</td>
<td>90,000</td>
</tr>
<tr>
<td>Total cost of providing maternal benefits (Kyat million)</td>
<td>16,463,788,822</td>
<td>10,975,859,214</td>
<td>670,500,000</td>
<td>447,000,000</td>
<td>255,690,000</td>
<td>170,460,000</td>
<td>16,463,788,822</td>
<td>926,190,000</td>
</tr>
</tbody>
</table>

Total female population aged 15-49: 13,531,491, 13,531,491, 564,243, 564,243, 114,388, 114,388, 13,531,491, 678,631

Total number of births 15-49: 914,655, 914,655, 37,250, 37,250, 14,205, 14,205, 914,655, 51,455

Total population aged 0-2 (under 1 & 1): 1,574,502, 1,574,502, 59,010, 59,010, 23,730, 23,730, 1,574,502, 82,740

Maternal benefit:

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Scenario A Myanmar</th>
<th>Scenario B Myanmar</th>
<th>Scenario C Rakhine</th>
<th>Scenario D Rakhine</th>
<th>Scenario E Chin</th>
<th>Scenario F Chin</th>
<th>Scenario G Myanmar</th>
<th>Scenario H Rakhine+Chin</th>
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<tbody>
<tr>
<td>Target group</td>
<td>914,655</td>
<td>914,655</td>
<td>37,250</td>
<td>37,250</td>
<td>14,205</td>
<td>14,205</td>
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<td>20%</td>
<td>20%</td>
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<tr>
<td>Target group covered by this scenario</td>
<td>182,931</td>
<td>182,931</td>
<td>7,450</td>
<td>7,450</td>
<td>2,841</td>
<td>2,841</td>
<td>182,931</td>
<td>10,291</td>
</tr>
<tr>
<td>Benefits per head per year (Kyat) - last 6 months pregnancy</td>
<td>90,000</td>
<td>60,000</td>
<td>90,000</td>
<td>60,000</td>
<td>90,000</td>
<td>90,000</td>
<td>90,000</td>
<td>90,000</td>
</tr>
<tr>
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<td>670,500,000</td>
<td>447,000,000</td>
<td>255,690,000</td>
<td>170,460,000</td>
<td>16,463,788,822</td>
<td>926,190,000</td>
</tr>
<tr>
<td>Children's benefit</td>
<td></td>
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<td>Target group</td>
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<td>1,574,502</td>
<td>59,010</td>
<td>59,010</td>
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<td>23,730</td>
<td>1,574,502</td>
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<td>Take-up rate (%)</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
<td>20%</td>
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<tr>
<td>Target group covered by this scenario</td>
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<td>314,900</td>
<td>11,802</td>
<td>11,802</td>
<td>4,746</td>
<td>4,746</td>
<td>314,900</td>
<td>16,548</td>
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<tr>
<td>Benefits per head (Kyat)</td>
<td>180,000</td>
<td>120,000</td>
<td>180,000</td>
<td>120,000</td>
<td>180,000</td>
<td>120,000</td>
<td>180,000</td>
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<tr>
<td>Total cost of providing children’s benefits (Kyat million)</td>
<td>56,682,086,348</td>
<td>37,788,057,565</td>
<td>2,124,360,000</td>
<td>1,416,240,000</td>
<td>854,280,000</td>
<td>569,520,000</td>
<td>56,682,086,348</td>
<td>2,978,640,000</td>
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<tr>
<th>Total Benefit</th>
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<th></th>
<th></th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Total cost of benefit per year (Kyat million)</td>
<td>73,145,875,170</td>
<td>48,763,916,780</td>
<td>2,794,860,000</td>
<td>1,863,240,000</td>
<td>1,109,970,000</td>
<td>739,980,000</td>
<td>73,145,875,170</td>
<td>3,904,830,000</td>
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<td>Admin cost per year (Kyat million) - 20%</td>
<td>14,629,175,034</td>
<td>9,752,783,356</td>
<td>558,972,000</td>
<td>372,648,000</td>
<td>221,994,000</td>
<td>147,996,000</td>
<td>3,657,293,758</td>
<td>195,241,500</td>
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<tr>
<td>Cost of Scenario</td>
<td>87,775,050,203</td>
<td>58,516,700,136</td>
<td>3,353,832,000</td>
<td>2,235,888,000</td>
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<td>887,976,000</td>
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<td>4,100,071,500</td>
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<table>
<thead>
<tr>
<th>Cost of Scenario (Kyats Million)</th>
<th>87,775</th>
<th>58,517</th>
<th>3,354</th>
<th>2,236</th>
<th>1,332</th>
<th>888</th>
<th>76,803</th>
<th>4,100</th>
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</thead>
<tbody>
<tr>
<td>Cost as % of GDP</td>
<td>0.11%</td>
<td>0.07%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.00%</td>
<td>0.09%</td>
<td>0.00%</td>
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<tr>
<td>Cost as % of Govt. expenditure</td>
<td>0.38%</td>
<td>0.25%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.01%</td>
<td>0.00%</td>
<td>0.33%</td>
<td>0.02%</td>
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### Scenario A: Universal cash transfer of 15,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old (Myanmar)

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<tr>
<th>PARAMETERS</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total female population aged 15-49</td>
<td>13,531,491</td>
<td>13,558,852</td>
<td>13,588,645</td>
<td>13,620,896</td>
<td>13,655,631</td>
</tr>
<tr>
<td>Total number of births 15-49</td>
<td>914,655</td>
<td>916,504</td>
<td>918,518</td>
<td>920,698</td>
<td>923,046</td>
</tr>
<tr>
<td>Total population aged 0-2 (under 1 and 1)</td>
<td>1,574,502</td>
<td>1,530,842</td>
<td>1,488,392</td>
<td>1,447,120</td>
<td>1,406,992</td>
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</table>

**Maternal benefit**

<table>
<thead>
<tr>
<th></th>
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<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target group</td>
<td>914,655</td>
<td>916,504</td>
<td>918,518</td>
<td>920,698</td>
<td>923,046</td>
</tr>
<tr>
<td>Take-up rate (%)</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>Target group covered by this scenario</td>
<td>182,931</td>
<td>366,602</td>
<td>551,111</td>
<td>736,559</td>
<td>923,046</td>
</tr>
<tr>
<td>Benefits per head per year (Kyat) - last 6 months pregnancy</td>
<td>90,000</td>
<td>95,519</td>
<td>94,793</td>
<td>94,208</td>
<td>94,208</td>
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<tr>
<td>Total cost of providing maternal benefits</td>
<td>16,463,788,822</td>
<td>35,017,358,716</td>
<td>52,241,679,089</td>
<td>69,390,004,619</td>
<td>86,958,695,418</td>
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**Children’s benefit**

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<tr>
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<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Target group</td>
<td>1,574,502</td>
<td>1,530,842</td>
<td>1,488,392</td>
<td>1,447,120</td>
<td>1,406,992</td>
</tr>
<tr>
<td>Take-up rate (%)</td>
<td>20%</td>
<td>40%</td>
<td>60%</td>
<td>80%</td>
<td>100%</td>
</tr>
<tr>
<td>Target group covered by this scenario</td>
<td>314,900</td>
<td>612,337</td>
<td>893,035</td>
<td>1,157,696</td>
<td>1,406,992</td>
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<tr>
<td>Benefits per head (Kyat)</td>
<td>180,000</td>
<td>191,038</td>
<td>201,212</td>
<td>210,621</td>
<td>220,470</td>
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<tr>
<td>Total cost of providing children’s benefits</td>
<td>56,682,086,348</td>
<td>116,979,353,162</td>
<td>179,689,669,569</td>
<td>243,834,980,459</td>
<td>310,198,851,293</td>
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**Total Benefit**

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<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total cost of benefit per year</td>
<td>73,145,875,170</td>
<td>151,996,711,878</td>
<td>231,931,348,657</td>
<td>313,224,985,078</td>
<td>397,157,546,711</td>
</tr>
<tr>
<td>Admin cost per year - 20%</td>
<td>14,629,175,034</td>
<td>30,399,342,376</td>
<td>46,386,269,731</td>
<td>62,644,997,016</td>
<td>79,431,509,342</td>
</tr>
<tr>
<td>Cost of Scenario</td>
<td>87,775,050,203</td>
<td>182,396,054,254</td>
<td>278,317,618,389</td>
<td>375,869,982,094</td>
<td>476,589,056,054</td>
</tr>
<tr>
<td>Cost of Scenario (Kyats Million)</td>
<td>87,775</td>
<td>182,396</td>
<td>278,318</td>
<td>375,870</td>
<td>476,589</td>
</tr>
<tr>
<td>Cost as % of GDP</td>
<td>0.11%</td>
<td>0.19%</td>
<td>0.26%</td>
<td>0.31%</td>
<td>0.37%</td>
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<tr>
<td>Cost as % of Govt. expenditure</td>
<td>0.38%</td>
<td>0.69%</td>
<td>0.92%</td>
<td>1.09%</td>
<td>1.23%</td>
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<tr>
<td>Scenario B: Universal cash transfer of 10,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old (Myanmar)</td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
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</tr>
<tr>
<td><strong>PARAMETERS</strong></td>
<td>2016</td>
<td>2017</td>
<td>2018</td>
<td>2019</td>
<td>2020</td>
</tr>
<tr>
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<td>13,620,896</td>
<td>13,655,631</td>
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<tr>
<td>Total number of births 15-49</td>
<td>914,655</td>
<td>916,504</td>
<td>918,518</td>
<td>920,698</td>
<td>923,046</td>
</tr>
<tr>
<td>Total population aged 0-2 (under 1 and 1)</td>
<td>1,574,502</td>
<td>1,530,842</td>
<td>1,488,392</td>
<td>1,447,120</td>
<td>1,406,992</td>
</tr>
</tbody>
</table>

### Maternal benefit

| Target group | 914,655 | 916,504 | 918,518 | 920,698 | 923,046 |
| Take-up rate (%) | 20% | 40% | 60% | 80% | 100% |
| Target group covered by this scenario | 182,931 | 366,602 | 551,111 | 736,559 | 923,046 |
| Benefits per head per year (Kyat) - last 6 months pregnancy | 60,000 | 63,679 | 63,196 | 62,806 | 62,806 |

Total cost of providing maternal benefits

| 10,975,859,214 | 23,344,905,811 | 34,827,786,059 | 46,260,003,079 | 57,972,463,612 |

### Children's benefit

| Target group | 1,574,502 | 1,530,842 | 1,488,392 | 1,447,120 | 1,406,992 |
| Take-up rate (%) | 20% | 40% | 60% | 80% | 100% |
| Target group covered by this scenario | 314,900 | 612,337 | 893,035 | 1,157,696 | 1,406,992 |
| Benefits per head (Kyat) | 120,000 | 127,358 | 134,142 | 140,414 | 146,980 |

Total cost of providing children's benefits

| 37,788,057,565 | 77,986,235,441 | 119,793,113,046 | 162,556,653,639 | 206,799,234,196 |

### Total Benefit

| Total cost of benefit per year | 48,763,916,780 | 101,331,141,252 | 154,620,899,105 | 208,816,656,719 | 264,771,697,808 |
| Admin cost per year - 20% | 9,752,783,356 | 20,266,228,250 | 30,924,179,821 | 41,763,331,344 | 52,954,339,562 |

| Cost of Scenario | 58,516,700,136 | 121,597,369,503 | 185,545,078,926 | 250,579,988,063 | 317,726,037,369 |
| Cost of Scenario (Kyats Million) | 58,517 | 121,597 | 185,545 | 250,580 | 317,726 |
| Cost as % of GDP | 0.07% | 0.13% | 0.17% | 0.21% | 0.24% |
| Cost as % of Govt. expenditure | 0.25% | 0.46% | 0.61% | 0.73% | 0.82% |
Scenario C: Universal ash transfer of 15,000 Kyat per month for all pregnant women in the last 6 months of pregnancy and children until 2 years old (Myanmar)

<table>
<thead>
<tr>
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<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
<th>2020</th>
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<tbody>
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<td>13,620,896</td>
<td>13,655,631</td>
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<tr>
<td>Total number of births 15-49</td>
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<td>916,504</td>
<td>918,518</td>
<td>920,698</td>
<td>923,046</td>
</tr>
<tr>
<td>Total population aged 0-2 (under 1 and 1)</td>
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<td>1,530,842</td>
<td>1,488,392</td>
<td>1,447,120</td>
<td>1,406,992</td>
</tr>
</tbody>
</table>

Maternal benefit

| Target group                           | 914,655    | 916,504    | 918,518    | 920,698    | 923,046    |
| Take-up rate (%)                       | 20%        | 40%        | 60%        | 80%        | 100%       |
| Target group covered by this scenario  | 182,931    | 366,602    | 551,111    | 736,559    | 923,046    |
| Benefits per head per year (Kyat) - last 6 months pregnancy | 90,000 | 95,519 | 94,793 | 94,208 | 94,208 |
| Total cost of providing maternal benefits | 16,463,788,822 | 35,017,358,716 | 52,241,679,089 | 69,390,004,619 | 86,958,695,418 |

Children’s benefit

| Target group                           | 1,574,502  | 1,530,842  | 1,488,392  | 1,447,120  | 1,406,992  |
| Take-up rate (%)                       | 20%        | 40%        | 60%        | 80%        | 100%       |
| Target group covered by this scenario  | 314,900    | 612,337    | 893,035    | 1,157,696  | 1,406,992  |
| Benefits per head (Kyat)               | 180,000    | 191,038    | 201,212    | 210,621    | 220,470    |
| Total cost of providing children’s benefits | 56,682,086,348 | 116,979,353,162 | 179,689,669,569 | 243,834,980,459 | 310,198,851,293 |

Total Benefit

| Total cost of benefit per year         | 73,145,875,170 | 151,996,711,878 | 231,931,348,657 | 313,224,985,078 | 397,157,546,711 |
| Admin cost per year - 5%              | 3,657,293,758  | 7,599,835,594  | 11,596,567,433 | 15,661,249,254 | 19,857,877,336 |

| Cost of Scenario | 76,803,168,928 | 159,596,547,472 | 243,527,916,090 | 328,886,234,332 | 417,015,424,047 |
| Cost of Scenario (Kyats Million)      | 76,803       | 159,597       | 243,528       | 328,886       | 417,015       |
| Cost as % of GDP                        | 0.09%         | 0.17%         | 0.23%         | 0.27%         | 0.32%         |
| Cost as % of Govt. expenditure          | 0.33%         | 0.60%         | 0.80%         | 0.96%         | 1.07%         |
References

Introduction


Part 1


Part 2


Additional References for Background


Completed for:
Ministry of Social Welfare, Relief and Resettlement
International Growth Centre
Save the Children
UNICEF

Completed by:
Jennie Hilton, Public Health Nutrition, Consultant
Elisa Maffioli, Department of Economics, Duke University
August 2015