TECHNICAL BRIEF:

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

Lessons for Policy and Programming in Myanmar

LIFT

Livelihoods and Food Security Fund

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INTRODUCTION

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

In Myanmar, LIFT has funded Maternal and Child Cash Transfer (MCCT) programmes since 2014, initially supporting MCCT projects led by Save the Children International (SCI) and partners in the Delta, Dry Zone and Rakhine. In March 2017 LIFT started to support the government-led MCCT Programme in Chin State and in 2019 support was extended to Kayin and Kayah States. The funding and technical support package to the Ministry of Social Welfare, Relief and Resettlement includes cash (for Chin transfers only), operational costs, baseline and M&E support. Currently the most robust programme evidence in Myanmar is the LIFT-funded Dry Zone MCCT, implemented by Save the Children.

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

This Technical Brief is accompanied by a full report, Social and Behaviour Change for Nutrition in Maternal and Child Cash Transfer Programmes: Lessons Learned for Policy and Programming in Myanmar, that can be downloaded from the LIFT website https://www.lift-fund.org/

1. While many SBC interventions include a communication element (hence the term Social and Behaviour Change Communication- SBCC) this is not always the case, and therefore more often the broader term "SBC" will be used.

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

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

Cash: Food intake pathway. The most direct route from cash to improved nutrition via improved food security in the case of the MCCT programme is through increased food consumption, which is an immediate determinant of child nutritional status. In other words, when the cash transfer is used to purchase a higher quantity of diverse, nutritious food for mothers and children, they are likely to benefit nutritionally.

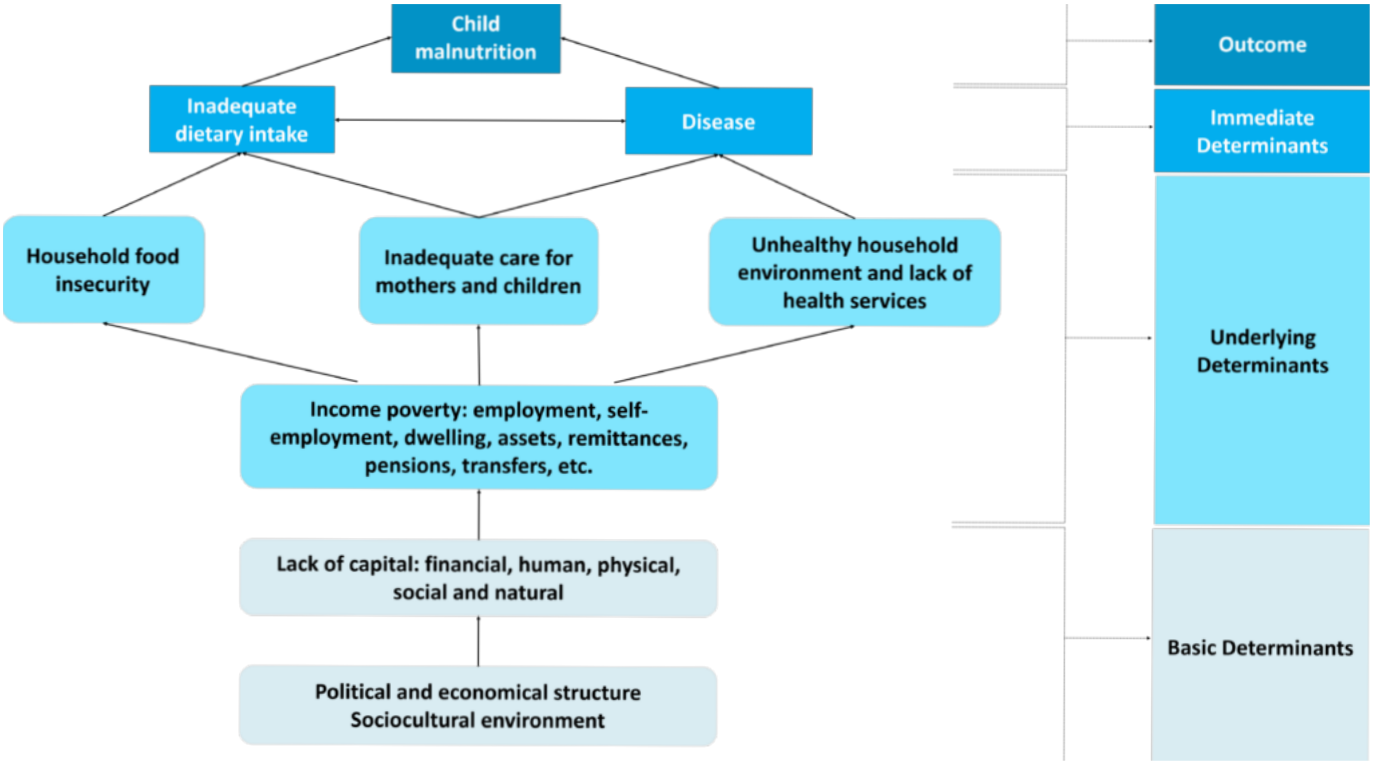
Cash: Health services pathway. When the cash is invested in health expenses, it has been shown to have positive impacts, particularly in the case of conditional cash transfers when receipt of cash is tied to the adoption of certain health-seeking behaviours, such as antenatal care visits and preventive healthcare. It also has been shown to have positive effects on hygiene, and on the probability of using safely managed water and sanitation facilities.[3]

Cash: Care pathway. Using resources for care is a third pathway through which cash transfers have the potential to positively affect child nutritional status. Care (of children and mothers) is an underlying determinant of undernutrition; there is evidence for the relationship between caregiver feeding practices and nutrition outcomes, as well as psychosocial care and nutrition outcomes. However, further evidence needs to be gathered to understand this relationship in the context of cash transfers, specifically. Evidence that cash alone changes caregivers' behaviours is not strong. A more likely pathway with some evidence

2. de Groot et al. 2017
3. ibid

to support it is that cash transfers could improve beneficiaries' mental health, autonomy and reduce mothers' and children's levels of stress. This can lead to better maternal and child nutrition outcomes. Transfers may also decrease intimate partner violence, also reducing stress, which has positive implications for maternal and child health.[4]

Causal Framework for Cash and Undernutrition



Source: UNICEF's causal framework adapted by de Groot 2016

Women's empowerment as an important cross-cutting factor. While it has not yet been fully understood how to measure and test this pathway, we do know that there is value in putting cash in the hands of women and that it leads to better child nutrition. Evidence reveals that major global reductions in child stunting can be attributed to improvements in women's status between 1970 and 1995.[5] While there is a need to further investigate and understand the ways that cash empowers women, and how this directly benefits the health and nutrition of their children, there are some known ways that cash empowers women; these include increased self-esteem, increased status in the community, increased

4. ibid
5. Smith & Haddad 2000

ability to care for themselves and their families, the opportunity to speak in public and share their experiences with other women, and increased bargaining power in the household through control of movement and resources.[6]

ENHANCING THE IMPACT OF CASH

A number of cash transfer intervention studies have revealed that cash alone does not necessarily have an impact on nutrition. This is consistent with results from LIFT-funded randomised controlled trial (RCT) in Myanmar's Dry Zone. The success of a cash transfer project is highly dependent upon a variety of other factors; positive impacts on nutrition may be limited by behavioural factors as well as physical access to services. There are programme design features that can increase the likelihood that cash will be used for better nutrition outcomes:

Put cash in women's hands. When put in the hands of women, not only is money more likely to be used on food and other household expenses according to global research, but it also empowers women. We know from global research that empowering women—most often measured as women's decision-making or women's control over resources— in and of itself leads to better maternal and child health outcomes.[7]

Target the transfer to the economically vulnerable and children under two. Transfers have higher impact when given to poor and at-risk populations, as well as the young (children under two). This is consistent with findings in the Myanmar Dry Zone RCT. In other words, when it is given to those who need it most, the impact of the cash is greater, and we know that women and children in the crucial First 1,000 Days period—particularly those in low-income areas and with poor access to health services— are among the most nutritionally vulnerable.[8]

'Right' amount in the 'right' frequency. The importance of regular, monthly payments is important for having positive nutrition impact. Global evidence from Mercy Corps and ODI points to the fact that one-time or less-frequent and larger payments tend to be invested in livelihoods, while ongoing monthly smaller payments are more likely to be used on basic household needs, such as food and medicine.[9]

Longer duration increases the effects on nutritional status. Evidence shows that children who are exposed to cash transfers for longer periods

6. Leroy 2009
7. ibid
8. Leroy 2009, Lagarde 2009, Manley 2012, DeGroot 2017, IPA/SCI 2019
9. Mercy Corps 2017, Hagen-Zanker 2017, IPA/SCI 2019

of time have better nutrition outcomes.[10]

Integrate with existing health systems. Supporting linkages to health service platforms is critical, particularly during the First 1,000 Days period when important health interventions, including antenatal care, facility delivery, postnatal care and child immunisations have the potential not only to improve nutrition outcomes, but also to be life-saving. A number of cash transfer programmes, particularly in Latin America, have linked to health systems either by requiring participants through hard conditionalities or encouraging them through soft conditionalities to make contact with, or seek, health services. The placement of hard conditions on cash transfers, however, is only appropriate where supply-side services are adequate. If they are not adequate, such as in geographically remote or underserved areas, this approach risks unfairly penalising those most in need of the cash benefit. Due to these supply side challenges, many countries in Sub Saharan Africa have instead elected to implement unconditional cash transfers.[11] Though the programme is unconditional, in order to foster critical linkages with the health system, Myanmar's MCCT programmes require that mothers enroll in the programme by first visiting the midwife and encourage beneficiaries and community members to attend education and support sessions led by government health staff or volunteers. By linking with the health system, Myanmar has seen increases in antenatal care services in MCCT programme areas.

WHY CASH ALONE IS NOT ENOUGH: CASH + SBC PATHWAYS

While the provision of cash eliminates an important barrier to some positive child nutrition practices in economically disadvantaged communities, cash alone is not a silver bullet to improving nutrition. While evidence from LIFT-funded programmes in Myanmar demonstrate that distributing cash alone to beneficiaries during the 1,000 days period had some benefits, far greater benefits were seen when combined with Social and Behaviour Change Communication (SBC) approaches. Cash is not necessarily the main barrier to certain optimal nutrition practices.

There are a number of competing interests for cash. Beneficiaries

10. de Groot 2017, IPA/SCI 2019
11. de Groot 2015

have the option to spend the cash, save the cash, or reduce their own economic production (work less). Should the beneficiary choose to spend the cash on nutrition, health and hygiene expenses, the causal pathway between women and children's nutrition status and cash is shorter and more direct.

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

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

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

Integrating an SBC approach into cash transfer programme may both reinforce and also open up additional pathways through which cash can have an impact on nutrition.

SBC can enhance the **cash: food intake pathway** for better nutrition. This can be done by supporting strategies, opportunities and messages to address non-cash barriers to diet quality, quantity and frequency. SBC can help create an environment where it becomes easier for women and their children to eat sufficient and healthy foods with adequate frequency.

SBC can also enhance the **cash: health services pathway,** facilitating beneficiaries' connections to health services, promoting health-seeking behaviours and building the capacity of health care workers. through individual, community-level and advocacy interventions.

Beneficiaries' engagement in peer groups led by midwives or other health professionals may help women develop a stronger or more trusting relationship with their midwife, for example. She may find her more approachable and be more likely to ask her questions or for advice. As another example, a woman may learn at the monthly nutrition session that the midwife will be coming to the village to give immunisations next week, so she can plan to attend with her child. Alternatively, an advocacy activity could highlight a gap in the health system in a given part of the country, drawing resources to that area.

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

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

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

Cash + SBC: Family and community members' knowledge, awareness and ability to support women pathway. Targeting key influencers to support women is important to creating an enabling environment for practicing positive behaviours. Whether the support relates to child feeding practices, mental health issues, or health-seeking behaviours, it can reduce women's stress, increase their confidence, and make them happier and better able to deal with the challenges of being a mother in their family and community.

EFFECTIVE SBC

In terms of behaviour change in the context of maternal and infant and young child nutrition programmes globally, there are a number of key lessons that apply to the Myanmar MCCT programme:

Effective behaviour change programmes in nutrition rely on evidence to change behaviour through formative research. According to a study reviewing complementary feeding behaviour change interventions in 29 developing countries, the authors found that effective programmes used formative research to identify cultural barriers and enablers to optimal feeding practices, to shape the programme implementation strategy, and to develop messages and identify avenues for their delivery.[12] This also helps ensure that the intervention is culturally sensitive, integrated with local resources, and whether the intervention strategies are appropriate and feasible for local families.

Not only do successful behaviour change programmes rely on evidence to shape their programmes at the outset, but they **map out the conceptual pathways to change targeted behaviours, assessing intermediary behaviour changes in order to learn what worked.**[13] Behaviour change is a process that takes time, and although an individual may not change her behaviour fully within the given timeframe of an intervention, she may make substantial progress. Understanding whether and how far the targeted population is moving forward in the process of behaviour change is important to understanding the effectiveness of different intervention approaches.

Many projects use a limited set of behaviour change techniques; often, they are overly dependent upon education-focused change techniques. Some behaviours can be addressed through education-focused interventions—particularly if the target population is not aware of the importance of a behaviour or how to practice it. In many cases, however, people know what they should do, but for various reasons do not or cannot practice the behaviour. Therefore, interventions that create opportunities for social support, that create enabling physical environments and that improve problem-solving skills and self-efficacy are promising alternatives or supplements to education-focused change techniques.[14] There is also significant room to explore behaviour change approaches **for nutrition that are outside the health sector.**

Using multiple SBC approaches and channels to change behaviours is more effective than using one approach or channel, according

12. Fabrizio 2014
13. Ibid
14. Girard 2019

to a review of 91 studies on preventing and reducing stunting and anaemia by USAID's SPRING initiative.[15] Yet an informal review of SBC interventions being implemented by members of the Scaling Up Nutrition Civil Society Alliance (SUN CSA), many of which are LIFT-funded partners), conducted by Alive & Thrive, LIFT and the World Bank in Myanmar found that "few partners are using an integrated approach that encompasses interpersonal communication, community mobilisation and mass media, as well as rigorous M&E."

Targeting multiple audiences has a greater effect than reaching beneficiaries alone. In SBC programming it is important to reach out to those individuals who influence the target population (in this case, women who are pregnant and breastfeeding); these so called 'key influencers' have an important role to play in supporting behaviour change among women.[16]

Human contact is important to achieving behaviour change. Behaviour change programme approaches should employ frequent interpersonal contact. Not only does targeting the right people matter in behaviour change programming, but focusing on achieving a higher number of visits and contacts with the target population can lead to greater change.[17]

NUTRITION SBC COMPONENT - MYANMAR MCCT APPROACH AND MODALITIES

MCCT programmes supported by LIFT use multiple modalities to support behaviour change. These modalities fall under the following broad categories of SBC interventions: (1) interpersonal communication (either individually or in groups); (2) social change and community mobilisation; and (3) advocacy. The second and third categories relate to creating an enabling environment which can facilitate behaviour change.

Interpersonal communication modalities in Myanmar MCCTs include Mother Support Groups, Influential Caregiver Group Sessions with key influencers such as fathers and grandmothers, and home visits with

15. Lamstein 2014
16. Ling Shi 2011 and Lamstein 2014
17. ibid

individual counseling for mothers. **Social change and community mobilisation** modalities in Myanmar's MCCTs include community wide SBCC information campaigns (including mobile cinema, as well as the #6la exclusive breastfeeding campaign), cooking demonstrations or competitions, community SBCC Sessions, and the identification and training of Community Nutrition Champions. The range of advocacy modalities used in LIFT-funded programmes include providing tools and technical assistance to the government to begin a national MCCT programme, meeting with community-level shopkeepers to help facilitate the purchase of healthy foods by programme beneficiaries as well as the mobilisation of village authorities and local government.

While smaller-scale LIFT-funded programmes included a diverse array of SBC modalities, the larger government-led programme in Chin, Kayin and Kayah has tended to focus mostly, if not exclusively on a few key modalities. These are Mother Support Groups and/or community nutrition sessions, individual counseling through the health system, and mobilisation of village authorities and local government. Resource constraints combined with implementation in hard-to-reach areas are challenges for the government provides an opportunity to capitalise mobile technology and other innovative solutions to allow SBC approaches to be implemented at scale. While useful information and insights can be taken from project documents and reports, there is a great deal more evidence to gather about which modalities work, how, and why.

Further description and analysis of the various SBC modalities can be found in the full report accessed at https://www.lift-fund.org/. Additionally, Save the Children published a learning paper on the SBCC modalities under LIFT funded programmes: *Social and Behaviour Change Communication with Maternal and Child Cash Transfers in Myanmar: Lessons Learned from Tat Lan, LEGACY and Bright SUN Programmes.* This can be accessed at: bit.ly/sbc4mct.

THE IMPACT OF CASH + SBCC ON NUTRITION OUTCOMES: EVIDENCE FROM MYANMAR MCCT PROGRAMMES

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

The RCT from the Dry Zone[18] compared three groups: Cash + SBCC, Cash only and a Control Group which received neither cash nor SBCC interventions. The findings from this and other studies in Myanmar support global evidence, and contribute towards deepening the evidence base for MCCT programmes which seek to have a positive impact on nutrition outcomes during the First 1,000 Days.

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

18. IPA & SCI 2019

Cash plus SBCC reduces stunting, especially among female and poorer children. Significant effects on the proportion of stunted children are greater among children from lower socio-economic households. Female children tended to be less stunted than their male counterparts, particularly girls in the oldest age category who received longer treatment exposure. Data indicate that compared to their male counterparts, girls who were exposed to the full treatment of cash plus SBCC experienced a lower rate of stunting (10.2 percentage point reduction for girls vs. 5.4 for all children, $p<0.1$)

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

Treatment exposure matters. The reduction in the proportion of stunted children was greater for those children who receive maximum exposure to cash plus SBCC. A reduction in the proportion of stunted children is more pronounced for children covered by the programme for the greatest number of months (24-29 months).

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

In MCCT programmes, women report being the main decision makers on the use of the cash. Nearly all beneficiary respondents in post-distribution monitoring (PDM) surveys across programmes indicated that they were in charge of spending their cash transfers. In the Delta, Rakhine, and Dry Zone 99% of women interviewed reported controlling decisions regarding the use of the MCCT cash transfers. In the government-led Chin programme it was still high at over 94%.

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

Programme monitoring reports[19] indicate that beneficiaries are using cash for its intended purposes—food and health care expenses

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

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

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

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

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

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

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

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

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

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

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

Women in the MCCT programme did not change fertility, desired fertility, or use of family planning. According to the Dry Zone study, women who receive the cash transfer do not appear more likely to be

currently pregnant and do not have a higher number of pregnancies since the start of the programme relative to the control group. The study also did not find any statistically significant results on the desire of women or their husbands to have an additional child. This suggests that there are no fertility effects of the program.

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

LOOKING FORWARD: PROPOSING A COMMON MODEL

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

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

Myanmar is critical to better understanding the most effective mechanisms for behaviour change for better nutrition.

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

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

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

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

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

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

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

Myanmar MCCT Programme Model 1: Comprehensive Design

DSW-led domains

Monthly cash distribution to women during First 1,000 Days

- Relevant & timely nutriton messaging accompanies mobile cash distribution and at distribution points
- Women enroll at first ANC visit, and continue care (minimum 4 visits)
- Soft conditionality

MOHS-led domains

AMWs or midwives lead monthly mother support group sessions for nutrition

- Supportive supervision by midwife
- Common protocol for sessions & standardized SBCC toolkit
- Participatory-adult learning style

Midwives provide individual nutrition counseling to support vulnerable mothers

- Allow mothers to get the individualized attention they need to build confidence through interpersonal communication (IPC)

CHWs or IP staff lead monthly support group sessions with influencing groups on nutrition

- Supportive supervision by midwife
- Support the enabling environment for women to practice positive behaviours (eg. husbands support their wives to eat a diverse diet)
- Participatory-adult learning style

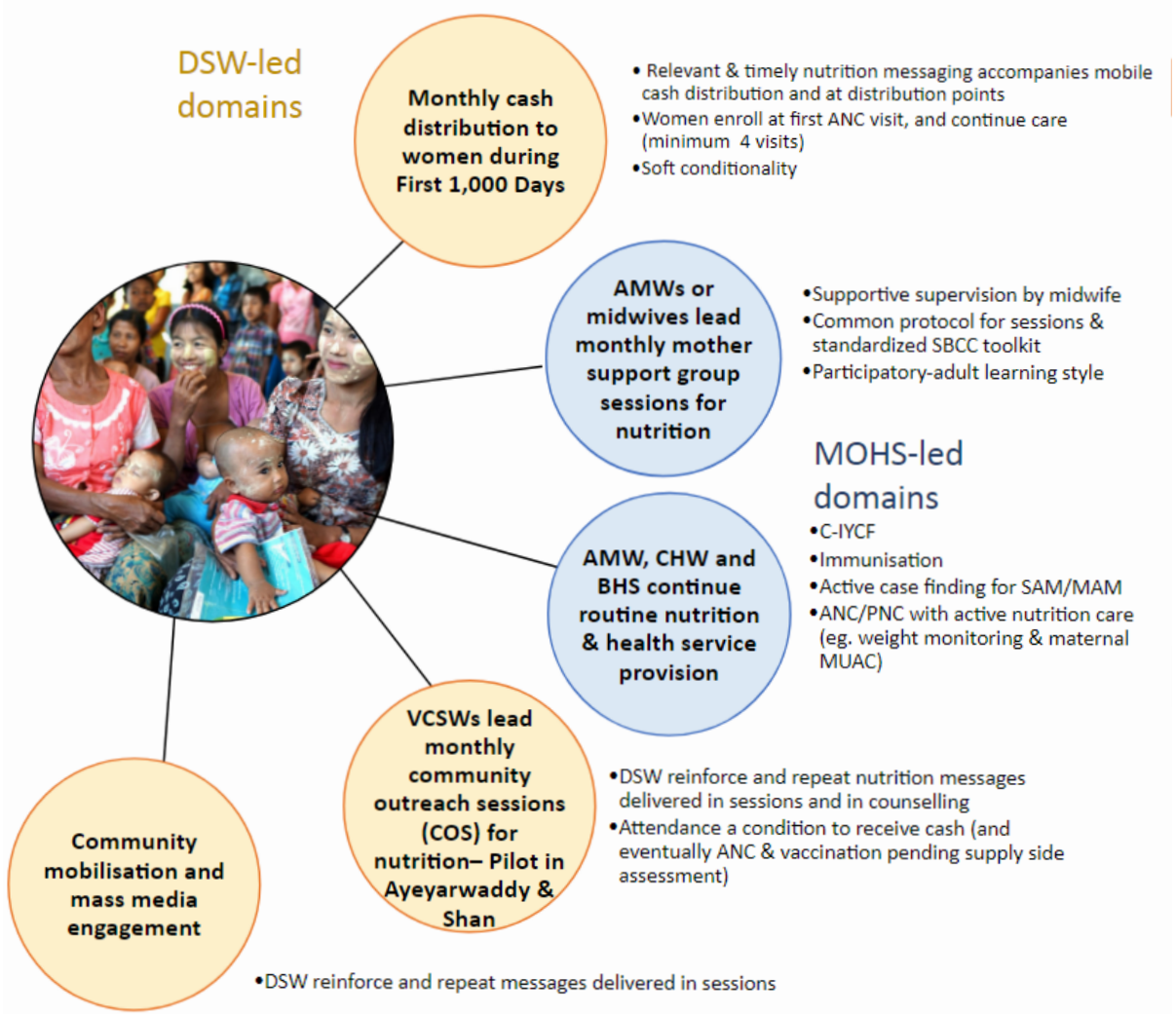
VCSWs lead monthly community outreach sessions (COS) for nutrition – Pilot in Ayeyarwaddy & Shan

- DSW reinforce and repeat messages delivered in sessions and in counselling
- Attendance a condition to receive cash (and eventually ANC & immunisation pending supply side assessment)

Community mobilisation and mass media engagement

- DSW reinforce and repeat messages delivered in sessions

Myanmar MCCT Programme Model 2: Minimum Functional Design



Despite a number of successes, there remain opportunities for improvement. Upon reviewing available evidence, including global research, programme data from LIFT-funded interventions, and in-depth interviews with key stakeholders, ten key areas have emerged to prioritise for joint action and programme improvement. The following recommendations are relevant to the Ministry of Social Welfare, Relief and Resettlement (MoSWRR), the Ministry of Health and Sports (MoHS), LIFT, the Access to Health fund, donors, supporting UN agencies and civil society:

SETTING PRIORITIES

Improving collaboration and coordination

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

Strengthening programme strategy for improving nutrition outcomes

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

Improving the effectiveness of SBC modalities for better programme quality

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

Harnessing cash for nutrition outcomes

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

Improving monitoring and learning

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

Key findings and a series of concrete recommendations for the GoUM and the UNOPS multi-donor funds (LIFT and A2H) are in the full report, Social and Behaviour Change for Nutrition in Maternal and Child Cash Transfer Programmes: Lessons Learned for Policy and Programming in Myanmar, that can be downloaded from the LIFT website https://www.lift-fund.org/. Recommendations to UNOPS are relevant to stakeholders supporting government-led MCCTs.

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