It starts with equal

Final Evaluation

Multi-stakeholder Model for Ending Gender-Based Violence Project Kayah

March 2010

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1. List of acronyms

CEDAW - The Convention on the Elimination of all Forms of Discrimination Against Women
CSOs - Civil Society Organisations
DSW - Department of Social Welfare
FGDs - Focus Group Discussions
GAD - General Administration Department
GBV - Gender Based Violence
HH - Household
IGAs - Income Generating Activities
IPV - Intimate Partner Violence
KIIs - key informant interviews
KNWO – Karenni National Women's Organisation
KPBA - Kayah Phu Baptist Association
KSWN - Karenni State Women Network
M&E – Monitoring and Evaluation
MSWRR – Ministry of Social Welfare, Relief and Resettlement
NSPAW - The National Strategic Plan for the Advancement of Women
SPARC – Supporting Partnership and Resilience of Communities in Northern Rakhine
ToRs - Terms of Reference
ToT - Training of trainers
VDOs - Village Development Organisations
VRM - Vulnerable Rural Women
VSLAs - Villages Saving and Loans Associations
WDC - Women Development Center

2. Charts and tables

3. Executive summary and recommendations

The "Multi-Stakeholder Model for Ending Gender-based Violence (GBV)" project in Kayah State involves collaborating with a range of stakeholders to put in place a model designed to prevent and respond to GBV in Kayah state. This new phase of the project, started in 2018, intervened in 92 villages belonging to three townships: Loikaw, Demoso and Phruso, with a total target population of 56.863. The methodology employed a mixed-methods approach, with qualitative data collection through KIIs and FGDs and quantitative data, in the form of household surveys.

The project is highly relevant to the geographical area of intervention and takes into consideration the socio-cultural context in Kayah. It targets key actors in the area when it comes to the prevention and response to Gender based Violence (GBV), while at the same time it works directly with the concerned population, presenting positive alternative role models and practices. The project touches the dual reality on the field. On one hand, it works with those at the center of GBV response in the communities: village administrators; and on the other hand, it works with duty holders: institutions.

One of the major successes of the project is the capacity shown to adjust the activities to the context. CARE staff and partners have been able to deliver in spite of the numerous challenges of the area where the project is implemented. A positive working relationship has been observed with all stakeholders involved in service delivery. CARE staff has been able to confront challenges and has shown to have resources to find strategies and new plans when they faced barriers in the implementation of the planned activities. The fact that many of the activities in the field are being directly implemented by local Civil Society Organisations (CSOs) has positively affected the project in terms of ownership at local level, and has increased mobilisation in the villages.

CARE project team seems to be very well settled in the area and is playing a key role in the referral system, a situation that has it pros and cons. On one side, they have managed to overcome challenges and move the project forward with positive outcomes and; on the other side, they have become key actors with all the expectations and pressure that it involves in the given context.

The evaluators have seen that almost all indicators have been achieved. Quantitative and qualitative information gathered shows big progress in the awareness and response to GBV since 2016. It has been observed that villagers have improved their awareness and knowledge, they have questioned discriminatory traditional practices and changes are being made in community response to GBV.

In what concerns the work done with institutions, progress is being made even if institutional response is still weak and faces numerous challenges at the level of awareness, capacities, resources available and systems in place to respond to GBV that are most of the time difficult to apply, lengthy in time and involves expenses that survivors cannot afford either for travelling or for formal and informal fees that are applied by the different service providers. It is highly appreciated that -through the GBV Coordination Working Group, and mostly through the development of informal nets with key players in the front line of services- advances have been made in spite of the persistent barriers at decision making level that makes institutional improvements in GBV response especially challenging. This is why advocacy actions are to be continued, and work should continue to be made targeting both decision makers and personnel in the front line of service delivery.

In the area of women's economic empowerment, Village Saving and Loan Associations (VSLAs) and Income Generating Activities (IGAs) are highly valued by women and have been effective not only to mitigate financial vulnerability, but also to increase women's self-esteem and indirectly increase their participation in community decision making. It has also facilitated women's access to markets. VSLAs have seem to be solid and in fact they all stated to be running while IGAs need some support to develop business plans that could strengthen their sustainability.

The project is a first step which has reached a number of people in the communities, but concepts are new and they touch long lasting cultural norms and habits. Therefore, it is recommended for the next phase, to work with the same communities further, to ensure that changes are long lasting and actions include hard-to-reach individuals, particularly the young and adolescents.

In what concerns the awareness raising activities, targeting decision makers is essential to increase response at institutional level. Two areas where further work needs to be done in terms of capacities and institutional response have been detected: education and psychosocial support. The first because it seems that survivors are being denied their right to access formal education, and the second because when survivors are facing psychological distress there are almost no capacities to provide support to them.

The efficiency of the project could be further improved by reviewing: the geographical focus, concentrating actions instead of expanding could facilitate long lasting behavioural change; time provided to CSOs to implement actions; and simplification of the monitoring and reporting process. Financial execution, cash flow and balance among budget lines have been positively evaluated.

In the debrief with CARE staff in Yangon held right after the field work, the consultants were told that for the new phase of the project many of the identified challenges, above all regarding the project's efficiency, are already being address in the coming phase starting in March 2020.

Overall it is a comprehensive project that has managed to adjust to the reality in the field. Even if some of the areas of intervention present challenges at the level of sustainability, which is unfortunately the case for social actions when institutions are not fully responsive and have limited capacities and resources.

4. Introduction and background

Gender Based Violence (GBV) is any sexual, verbal, emotional, psychological abuse, threat, coercion, and economic or educational deprivation, inflicted to an individual against their will, on the basis of their gender, and can occur in both their public or private life. GBV is mainly perpetrated against women and girls by men, as it is deeply rooted in the power inequalities between men and women. In Myanmar, GBV contributes to poverty and inequality, limiting women's access to livelihoods, health, education and participation in key peacebuilding and political processes.

Kayah is the smallest state in Myanmar with a population of 286,627. Years of conflict have left the state with ongoing insecurity, weak rule of law and has had long lasting consequences for gender relations and incidences of GBV. The situation is aggravated by the widespread ruling of patriarchal, traditional harmful practices in interpersonal and communal relationships. Although recently Government service provision has started to strengthen, GBV survivors still face obstacles when accessing health, justice and psychosocial support.

Data from the Demographic and Health Survey (2017) of Kayah State, shows that 12.4% of women aged 15-49 have had experiences of physical violence from the age of 15. It is widely acknowledged that GBV in Myanmar is underreported due to the wide acceptance of violent behaviour towards women, and lack of awareness and understanding of GBV. An example of this can be seen from the data collected for the baseline report of the current project, conducted in 2016. Data shows 69.2% of the interviewees agreed with the statement 'violence against women is normal in a relationship'. Furthermore, female respondents agreed with the statement more than male respondents (70.8% females, 66.9% males).

In Myanmar, there is still limited acknowledgement by politicians and decision makers of the importance and degree of incidence of GBV. GBV is being addressed in The National Strategic Plan for the Advancement of Women 2013-2022 (NSPAW). The plan aims to develop and strengthen laws, systems, structures and practices to eliminate all forms of violence against women and respond to the needs of GBV survivors. Notwithstanding, there is neither a legal frame nor consensus to support a dedicated law on the matter. For 5 years now, there is has been an ongoing discussion to draft a law and present it for processing to Parliament. The process, led by the Ministry of Social Welfare, Relief and Resettlement (MSWRR) has involved extensive consultations with CSOs, nevertheless the latest published draft still has great weaknesses (it is not compliant with The Convention on the Elimination of all Forms of Discrimination Against Women, CEDAW) and in spite of this, still faces big resistances

in Parliament. As we write this report, the process the law will take to Parliament is yet to be decided, furthermore, there are divisions in opinion amongst the CSOs. There are those that would like the law to be passed and see it as a starting point towards gender equality and the recognition of women's rights, and there are those that would rather the law was not passed, as they believe it is better to have no law than one that is not up to minimum standards. Supporters of the latter are above all ethnic women organisations that feel misrepresented in consultations at grass root level and think that some definitions included in the law need to be revised.

While institutional response has made some limited improvements with the support of international actors and local CSOs, there is a long way to go for institutions before being able to give appropriate assistance to GBV survivors. Some of these challenges in Kayah State are being addressed by the current project and will be further explored in this evaluation report.

4.1. Project Overview

CARE International Myanmar has been implementing projects in Kayah since 2003 strengthening its gender focus since 2013. The current project is part of CARE's Vulnerable Rural Women (VRW) Programme. The "Multi-Stakeholder Model for Ending Gender-based Violence (GBV)" project in Kayah State started in January 2016, it involves a multi-stakeholder collaboration, with a range of civil society and government partners to put in place a model designed to prevent and respond to GBV in Kayah state.

This final evaluation only covers the second phase of the project that commenced in January 2018 and has been implemented until February 2020. In this new phase, the project covers 92 villages belonging to three townships: Loikaw, Demoso and Phruso. The project started with 50 villages in 2018 and 42 new villages were added in 2019. The total target population is 56.863.

The overall goal of the project is '*to address pervasive gender-based violence that exists in conflict-affected Kayah State in Myanmar*', which is planned to be achieved through the following four outcomes:

1. Karenni State Women Network (KSWN), its member organizations and non-member organizations are an increasingly independent organization who work for longer-term impact and sustainability as they have increased technical and organizational capacity to prevent and respond to GBV.
2. GBV survivors have access to a full range of quality GBV services in a timely and safe manner.
3. KSWN has strengthened support and enabling environment to reinforce GBV prevention and response through their advocacy efforts.
4. The vulnerability of GBV survivors and women in the communities have reduced through increased skills and capacities, access to financial services and economic opportunities.

The main activities of the projects include, among others: capacity building and grant provision to local CSOs working on GBV; awareness raising and sharing knowledge sessions on different GBV topics for key actors and villagers; actions to promote involvement of male community leaders and members in GBV prevention and response; supporting institutions involved in GBV service provision to improve knowledge and response; facilitating coordination of actors involved on GBV prevention and response; putting in place a referral mechanism; development and implementation of a common advocacy plan and support to GBV survivals by providing services, livelihoods skills and community reintegration; and last but not least supporting women's economic empowerment through the constitution of VSLAs and provision of grants to implement IGAs.

Implementation of the activities has been done either directly by CARE or indirectly through the local CSOs (always under strict supervision and support from CARE team in Loikaw).

4.2. Purpose and scope of the evaluation

The overall objectives of the end of project evaluation are:

- To determine the project's achievements of its objectives and outcomes.
- To identify intended and unintended outcomes, best practices, lessons learned and recommendations to improve future programming in terms of sustainability.

In order to attain this, the evaluation is expected to analyse the following key aspects:

1. Relevance: The extent to which the project suited the priorities of the target groups.
2. Efficiency: The extent to which the project was managed, to get value for money from inputs of funds, staff and other resources.
3. Effectiveness: The extent to which the project achieved its objectives.
4. Impact: The extent to what lasting and significant changes have occurred and what the project's contribution to these changes is, the positive and negative, including unexpected impacts
5. Sustainability: To assess whether the benefits of the project are likely to continue after the project ends.

5. Methodology and limitations

The methodology was developed based on the available terms of reference (ToRs) and discussions with CARE staff. The methodological approach was participative, placing the results-based logical framework at the core of the evaluation process. The exercise has been: confidential, participative, constructive, culturally, gender and conflict sensitive. An evaluation matrix was developed linking specific evaluation questions, including a gender analysis and stakeholders (Annex 1).

The methodology used a mixed-methods approach, triangulating qualitative and quantitative data. Quantitative data supported qualitative findings, while qualitative research was used to interpret and compliment the quantitative results. The participatory methodologies were: Household (HH) survey, focus group discussions (FGDs), key informant interviews (KIIs), direct observation, case studies (testimonies of successful project experiences) and rapid use of time surveys (this last used for the baseline survey).

As a first step, the consultants conducted a desk review of existing project documents: project proposal, annual report 2018, previous project phase evaluation (2016-2018), base-line (2016) and end-line (2018) reports, tools and strategies developed by the project. Key stakeholders were identified in collaboration with CARE staff, interview guides were developed by the consultants and an interview schedule was set by CARE staff in Loikaw. At the same time, the survey questionnaire and quantitative methodology was developed.

The second step was the data collection phase. The data was collected across the three townships: Hprusoe, Demoso and Loikaw.

5.1. Quantitative Methodology

The structured questionnaire (Annex 2) was designed to measure performance at outcome level. The questions were taken as much as possible from questionnaires used by CARE in the baseline 2016, endline 2018 and baseline 2020[1] to facilitate comparability and measure progress. Additional

[1] These correspond to: 2016 baseline, situation previous to any intervention; 2018 endline, after implementation of 2016-2018 project; and 2020 baseline, conducted in urban areas previous to the implementation of the new project phase starting in March 2020.

questions have been added to respond to specific project indicators. The 2016 baseline has been used to measure the impact of the project; therefore the progress is measured from the situation in the village/wards previous to any intervention. Given that in the evaluated project, activities were only conducted in Loikaw, Demoso and Hpruso; only the results of the 2016 baseline for these three townships were used.

The consultants have used the same sampling methodological approach as employed in the baseline (2016) and endline (2018) surveys[2]. From a total population of 56.863 (as per the list provided by CARE in the inception phase), the target number of surveys - calculated with a confidence level of 95% and a margin of error of 5 – was estimated to be 382. The sample size was raised to 400 to allow discarding questionnaires with errors; in the end, no questionnaire were discarded.

The selection of the villages participating in the survey was done through calculation of clusters with probability proportionate to size of the population. The number of interviews per cluster was calculated by dividing the total size of the sample 400 by the number of clusters 25, the result was 16 interviews per cluster[3]. The survey was conducted in 24 villages/wards intervened by the project (Annex 3). In every village 16 interviews were conducted apart from Sanpya (6) miles where 32 were done. The selected villages amount to a total population of 22.749, representing 40% of the total population covered by the project.

Out of the 24 villages participating in the survey 5 (Nar Nat Taw, Htay Tha Ma, Nang Kut, Htay Nhar Hlyar, Nwa La Woe San Pya) in Loikaw Township have also participated in the 2016 - 2018 project phase; therefore, they have been involved in 2 phases of the project implementation. The 5 villages represent 31% of the sampling population.

Respondents were selected by random sampling method and gender balance was ensured by strategically alternating between interviewing one male and one female respondent in the selected households. Out of the 400 respondents to the questionnaire 203 were women and 197 were men.

Surveys were conducted by 16 enumerators (15 female and 1 male), all members of partner organisations that were trained over a period of 2 days in Loikaw. On the first day, the enumerators and CARE staff revised and adjusted the questionnaire. On the second day, a practical training session on data collection that included information on ethics, interviewing techniques, and behaviour of enumerators was conducted. Subsequently, the questionnaire was translated to Myanmar. A pilot test was conducted in two wards in Loikaw, which served to refine the wording of the survey and to improve understanding of the questions.

To control for bias, out of the 16 enumerators, 12 were sent to different villages/wards from those where their organisations usually work and implement, while 4 were allocated to the same area because of their knowledge of the local dialect (in Hpruso). They covered 7 villages per day, in teams of 2 enumerators per village, except for Hpruso Township where 4 enumerators were needed per village due to the remoteness of the area and the language barrier. Data collection took place from 12th to 15th February. An evaluation team member closely supervised the trainings, pilot test and data collection phase to ensure its quality. The consultant visited 8 out of the 24 villages to ensure survey questionnaires' quality and provide field support, and checked the completed questionnaires daily to ensure they were completed to a high standard.

The same questionnaire has also been used to gather data for the development of the baseline for the new phase of the project, starting in March 2020. The questionnaire covers relevant outputs and outcomes for the 2020 baseline.

The data analysis has been outsourced with the supervision and quality control of the research team. Brief reports for the endline and baseline are provided together with the data collected in Excel format.

[2] For reference: http://robbresearch.pbworks.com/w/page/23391694/Steps%20for%20Selecting%20Clusters%20with%20Probability%20Proportionate%20to%20Size

[3] Detailed explanation on the sampling methodology can be found in the Evaluation Methodological Plan, included in the deliverables package.

5.2. Qualitative data

Guidelines questions for the FGDs and KIIs were developed based on the evaluation matrix and tailored to the respondent groups (Annex 4). The interview guidelines were intended to be used in semi-structured interviews, taking the form of checklists of themes to be covered rather than actual questionnaires. Semi-structured interviews were held flexible to provide informants more space to voice their ideas, while also leaving room for the evaluators to dig into specific issues raised during the exercise in order to collect more elements to reinforce the lessons learned.

Qualitative data in the form of FGDs and KIIs was collected over a period of 6 days (16th to 21st February). 10 FGDs and 20 KIIs with stakeholders were conducted across the three townships: Loikaw, Demoso, Hpruso. The key stakeholders were project participants, project partners and state actors. They were included but not limited to: Department of Social Welfare (DSW) representatives, State Public Health Department representatives, police, lawyer, VSLA members, male leaders, Village Administrators and safehouse manager. Among the Women's Organisations involved in the project, the consultants have met representatives from: Shining Star, Min Su Community Development Center, Ah Man Thit, Lan Thit Sa, Women Development Center (WDC), Kayah Phu Baptist Association (KPBA) and Karenni National Women's Organisation (KNOW). The list of stakeholders meet per township is in Annex 5.

Two group meetings with the CARE team in Loikaw were conducted at the start and at the end of the mission to gather in-depth project information. In addition, 4 KIIs with members of the staff (M&E officer, VSLA Project Officer and Advocacy/Partnership, Coordinator of Field Office and GBV Project Officer) were conducted to gain a better understanding of the project management and implementation. A debriefing was done by the consultants at the end of the field mission in Loikaw and Yangon to clarify on findings and exchange the main challenges and achievements of the project.

The FGDs and KIIs lasted between 45 minutes to 1h30 minutes. The number of participants per KIIs was 1 to 2, while for FGDs it ranged from 3 to 17 participants. The FGD and KIIs schedule can be found in Annex 6.

Some changes had to be made to the plan as proposed in the evaluation methodology. Originally the consultants selected three villages in each of the three townships to conduct qualitative data collection, however due to government-imposed travel restrictions, the international consultants were restricted to staying within Loikaw and Demoso townships. Instead, FGD and KIIs participants travelled to the two townships to partake in the interviews. This resulted in mixed groups of participants, formed by people from different villages at once. Another change to the schedule was that data from One Stop Service of the General Administration Department (GAD) in Loikaw could not be collected, as the One Stop Service GAD did not want to participate because they have no capacity to provide GBV services.

5.3. Limitations to the Evaluation

Given the security context the International Consultants could not visit the villages. Fieldwork in Hpruso was conducted by the National Consultant who was granted access to the villages. This has limited the exposure of the International Evaluators to the reality in the field, and it represented a disruption on the daily activities of the villagers involved in the evaluation process. Nevertheless, the evaluators have managed to reach a broad representation of actors, thanks to the hard work of the CARE Loikaw team and its project partners. The participation and responsiveness of all actors was highly positive.

Another limitation is that there are other on-going interventions by CARE and different NGOs in the same intervened areas, hence it is difficult to isolate changes that are a result of the current project alone. In particular, the consultants could not isolate the impact of the activities of this project from those of the Supporting Partnership and Resilience of Communities in Northern Rakhine (SPARC) project who's funds were transferred from Rakhine to Loikaw. The consultants were told that the

additional funds helped provide support for GBV survivors such as access to justice, health care, capacity building and others.

Some notes concerning the methodology:

- The impact was measured using 2016 data as a baseline, due to the fact that for the majority of the villages this project was the first GBV intervention. Nevertheless some of the villages had been involved in the project phase I (2016 - 2018). This was the case for 5 of the villages included in the sampling.
- The 2016 baseline was calculated for 7 townships in Kayah, while the current project is just focusing on 3: Loikaw, Demoso and Hpruso. When reading the section on effectives, it is important to take into account that while for the achievement of targets the data is taken from the logframe, for the analysis of progress and impact, the quantitative data used by the consultants in their analysis is the result of the baseline in the 3 townships where the project has been implemented.
- Some challenges mentioned by the enumerators: a) they found some resistance in the participation of male respondents; notwithstanding, they all managed to reach the male /female ratio. b) language challenges that were easily overcome. c) For some of them it was their first experience as enumerators and they needed some support, which was granted on the spot by CARE team and the consultant. Despite the challenges, the survey exercise was successfully achieved as proven by the 400 surveys passing the quality check.

6. Evaluation findings

This section is organised in accordance with the five evaluation criterias defined by the Organizations for Economic Co-operation and Development / Development Assistance Committee (OECD/DAC) as required in the ToRs.

6.1. Relevance

The project is highly relevant to the geographical area of intervention, and takes into consideration the socio-cultural context in Kayah. It targets key actors in the area when it comes to the prevention and response to GBV, and at the same time it also directly works with the concerned population presenting positive alternative role models and practices.

As the baseline report conducted by CARE in 2016 shows, the incidence of GBV in the area is higher than officially reported. This is due to the lack of awareness of GBV, and the high degree of GBV acceptance by society, including by the parties involved in GBV prevention and response. GBV seems to be normalized and only reported when cases are “severe”. It is the consultants’ understanding – following the exchanges with key stakeholders - that a case is considered as “severe” when it involves sexual violence (rape), children abuse or extreme violence.

The project is trying to change this reality by increasing awareness and challenging traditional norms and practices, while at the same time, working with all the actors involved in GBV prevention and response. The project involved a high range of stakeholders, from key village members to decision makers, passing through village administrators, CSOs and institutional service providers (Health, Police and Court).

Interestingly enough, the project touches on the dual reality in the field. On one hand, it works with those at the centre of GBV response in the communities: village administrators; and on the other hand, it works with duty holders: institutions. Village administrators are key when dealing with GBV cases in the communities. They are in charge of the mediation between offenders and survivors when GBV cases arise in their villages. As explained by a Village Tract Administrator in Demoso, when asked:

What does the community do when there is a GBV case?

There are different ways of dealing with GBV cases. Sometimes the person runs to her parents. Other times they go to the Village Administrator and sometimes they come to me. When they come to me, I invite both parties to my place: wife, offender and offender's family. I try to get an agreement and ask the husband to sign on it. It works in most cases but sometimes it is difficult…. if I am not able to work it out, I now ask for help from KNWO and CARE, sometimes a lawyer comes to help to settle the agreement.

The Village Tract Administrator said he knew the referral system but avoided officially reporting as often the survivor preferred to deal with it informally, only going to health providers if their intervention was required.

Another male Village Administrator from Demoso township said:

I liked the legal awareness training. Traditionally, compensations were not given to the survivor and now, in line with the recommendations of a lawyer, they get compensation. Things have changed for the better in the community. I now see how much I should ask to the offender to require compensation in line with their options. I also call WDC and I am aware of the referral system…. in an on-going case, my main difficulty is that the survivor doesn't want to start the legal process and says that she just wants a chicken as compensation.

The fact is, that given the context and the challenges faced by institutional service providers (discussed further later in the report), cases are mostly dealt with at village level. The project staff is well aware of this, and has accordingly focused to the current on-going coping mechanism, challenging it by promoting the involvement and training of Village Administrators, to improve the communities' response to the survivors. While at the same time, working on the institutional response and supporting better practices.

The action has promoted a positive strategy, working with local CSOs and WOs, allowing for the actions to be implemented at grassroot level to thoroughly reach the communities. While simultaneously, coordinating all actors involved in the GBV coordination working group, who's advocacy strategy targets decision makers. In general, the project has contributed to establishing more positive dynamics among the involved actors in the field.

The project also supports the survivors, by offering: protection through the safehouse, justice through facilitating access to specialised lawyers, and reintegration by providing assistance for income generating activities. For the women at village level, there are actions that increase their resilience and reduce vulnerability through the establishment of VSLAs and supporting group IGAs.

When it comes to evaluating the participation of men and women in the design of the project, given the fact that the project represents a second phase of a long-term planned initiative, lessons learnt from the first phase have contributed to better address peoples' needs. Even if, as it will be further discussed later in the evaluation, given the timing and broad geographical scope of the actions, there were some challenges in reaching some of the actors. Nevertheless, efforts were made to address people's needs, and some extra contribution and funds from other projects have helped satisfy immediate survival requests (medical care, legal assistance, capacity building, etc..). The capacity to provide immediate support was highly appreciated by all actors, but it is the evaluators' opinion that it might raise expectations that will be difficult to fulfil with no continuation of the actions in future projects.

With regards to the wider policy frame, the project contributes to SDG 5 on gender equality and it is aligned with CARE's Gender Strategy for Myanmar. In the national context, it is perfectly in line with the priority area Violence Against Women of the NSPAW in all the four areas that it covers: research and studies, awareness raising, implementation and budget, and policy making.

Lastly, the CSOs involved in the project, have contributed to the discussions on the on-going drafting of a Law on the Prevention of Violence Against Women. Which is a key issue given that in Myanmar up until now there is no comprehensive legal frame in this area.

Overall, the project is comprehensive, and has managed to adjust to the reality in the field. Even if some of the areas of intervention present challenges at the level of sustainability, which is unfortunately

the case for social actions when institutions are not fully responsive and have limited capacities and resources.

FGD with male peer group in Demoso

6.2. Efficiency

One of the major successes of the project is the capacity in adjusting the activities to the context. In spite of the numerous challenges of the area where the project has been implemented, CARE staff and partners have been able to deliver all activities. A positive working relationship has been observed with all actors involved in service delivery. CARE is working either together or parallel to institutional actors, CSOs, decision makers and key players in the villages and communities.

CARE staff is composed of people local to the area, most of whom have been working together for years and who have established a positive, dynamic of cooperation and trust with all the actors involved in GBV response. CARE staff was able to overcome challenges, and had the resources to tailor activities to the context when they faced barriers during their implementation. CARE is facilitating dialogue between CSOs and the government, by supporting both sides in their actions targeting GBV in the communities, and is acting as an interlocutor between parties when discussions are complicated.

Furthermore, the fact that many of the activities in the field are being directly implemented by local CSOs, has positively affected the project in terms of ownership at local level and has increased mobilisation in the villages. Most of the CSOs are either faith or ethnic based organisations, with strong connections in the area. Being part of the community, they are trusted and have the capacity to reach key players at village level. At the same time, for many of them this is an opportunity to strengthen their institutional capacities and acquire new knowledge that will contribute to their sustainability. Nonetheless, there are still many challenges to be overcome for most of the CSOs to be able to operate independently in the management of funds and projects. It should be noted that the organisations are diverse, some of them are more consolidated and have experience in the implementation of projects while others have been recently established. Out of the CSOs participating in the project, the consultants found only one that still does not have the capacity to directly assume the management of grants, therefore it is only implementing activities in the villages with the support of CARE.

It should be noted that all but 3 of the organisations have been involved in the previous project phase (2016 – 2018) therefore there were already positive cooperation dynamics in place; those organisations that continued did so because they were committed to the project and eager to continue its implementation under the established rules. It's worth noting, the materials that in the previous phase took longer than expected delaying the implementation of the actions, were ready from the beginning of the project in this new phase.

However, the efficiency of the project has been affected by several factors, some are internal to the project itself and others are linked to the local context.

In what concerns the **internal** challenges, the consultants would like to highlight the following:

- Activity dispersion in the two phases of the project. Out of the 97 villages of the project, 44 were involved in the first phase of the implementation (2016-2018). For this new phase an effort was made to narrow down the number of townships from 7 (participating in the previous project) to 3, but still more efforts are needed to concentrate actions and be able to move on from a phase of awareness raising, to long lasting behavioural change. All parties involved acknowledged that the efforts required to be present in that many villages are enormous. It was also acknowledged by all actors (including the villagers), that to increase impact, more actions involving a variety of other actors that have still not been tapped by the project, needed to be carried out.
- Finance, monitoring and reporting processes, in the consultants' opinion, could be simplified. The impression is that the current system of reporting implies duplication of work, as the reports do not build on one another; this was especially noticed in the case of M&E reporting. Simpler reporting with links between the activity track system, the monthly and quarterly reports will save the field team precious time and efforts. The consultants have been told that measures are being taken by the country office to address this, by elaborating simpler reporting tools and formats.
- Regarding the grants implemented by CSOs:
    - The call for proposals was launched in 2019, and funds for the implementation were only available in May 2019. After proposals and budgets were reviewed, what was envisaged to be implemented in one year was finally implemented in 8 months. Despite this, all planned activities were delivered, but were compressed in time.
    - As the actions were implemented starting in May (beginning of farming season) it affected the participation of young members of the communities, as they were busy in the fields. To overcome this challenge, CSOs and CARE implemented activities either in the evenings or weekends, this was demanding for all involved (villagers and CSOs) and should be taken into account when planning future actions. Preference was shown for activities to be conducted preferably during school breaks, to make it possible for the youngest and the farmers to partake. It was pointed out in the Yangon debriefing session, that this matter seems to be a general challenge for all projects in rural areas, and it affects above all upland farmers as they work in the farms all year round.
    - The lack of experience of the CSOs partners has made that the reporting, financial management and general administration of the project has been complex and required a lot of extra-effort by CARE staff. Particularly challenging were the following factors:
        - The budget of the grants underestimated operational cost, a situation that caused some distress to all involved parties: CSOs had to struggle to cover running costs, and CARE staff had to find viable solutions so the situation did not affect the implementation of the activities. The main concerns were linked to expenses such as rental of premises, and compensation for staff involved in the implementation of the activities.
        - The lack of experience and difficulties faced by the CSOs in reporting and financial management, has greatly increased the workload of two key staff in CARE Loikaw: the Admin/finance/HR officer, and the M&E officer that had to follow the CSOs closely and provide individual support. This has affected other tasks under their responsibility; for instance, the M&E officer had less time to do monitoring in the field. The consultants believe that it was particularly challenging to follow the actions implemented in Hpruso given that the township is more isolated and touched by conflict. On the up side, the on-the-job learning process has helped the CSOs improve their management skills.

- The difficulties with reporting were aggravated by the high turnover of volunteers in the CSOs. The CSOs face difficulties retaining young, capable individuals as there is no-salary for the work, just the provision of facilitation fees to those involved in the implementation of activities. Therefore, retention of knowledge has also been a big concern.
- It should be noted, great effort has been made to train the personnel of the CSOs on the areas of GBV, and on the project tools to pass knowledge to the communities. Nonetheless, some minor challenges have been noticed by the consultants regarding the delivery of the messages to the communities in a culturally aware and sensitive manner. Above all, this applies to Hpruso township, which presents higher language and cultural barriers. Trainings should be continued in following phases of the project, so CSO members gain more confidence and skills.

Some **external factors** have also been identified - linked to the context, policies and regulations in place - that have had an impact on the implementation of the project. These factors cannot be changed by the project as they overpass their capacity of influence, but nevertheless have affected its implementation. The consultants would like to highlight the following:

- Weak institutional capacities of the key 3 institutional actors involved in the referral systems due to limited awareness, knowledge and resources. During the fieldwork, the consultants could appreciate the difficulties institutions face in being able to provide adequate assistance to GBV survivors. Firstly, not all front-line workers have been trained on GBV, and they face numerous challenges when confronted with cases. Secondly, standard operating procedures (SOPs) in place are difficult to implement, in some cases they are new, and sometimes they involve too many steps. Thirdly, there is a general lack of financial and human resources on all fronts; for instance, DSW does not have enough resources to cover the personnel of the safehouse, health department only have one psychiatrist (recently assigned), and police frontline workers interviewed by the consultants never received gender training (it is the supervisor who attends the training and he does not have the time to share the acquired knowledge).
- The project has to undergo a monthly approval for their activity plan by the GAD, which is a very sensitive, time consuming process for CARE team in Loikaw. They have to be careful and make sure that actions and messages are written in a way that can be approved; all awareness raising speeches are also subject to approval. For instance, it was mentioned that last year some organisations implemented actions without approval, and it has had a negative effect tightening control also for other organisations. Concerns were also raised regarding GBV not being a likeable topic at State level, as it gives light to 'problematic' issues. For example, the State Government does not allow GBV signs boards regarding child sexual abuse in Mese,The impression of the evaluators is that in Demoso, cooperation with the GAD was easier thanks to the involvement of the president of the Women's Affair Federation (which is the wife of the township's GAD) on GBV activities and to the lessened political weight of the township.

- The effectiveness of governance and rule of law have been revealed to be central concerns for all actors. Issues such as having to pay small fees to have medical reports, and to progress things in court, were mentioned on several occasions as failures in the system. Concerns were also raised about not having guarantees of getting a fair deal in court. This, coupled with the cost (emotional and economical) of having to go testify on numerous occasions, makes it so that both institutional actors and villagers prefer to solve things in the traditional way (mediation at village level) which is considered to be easier, faster and less traumatic.

  Women Police officer in Loikaw:

  "Most of the people do not have the money to attend the hearing, that is why most of the cases do not want to go to Court…. in the police station we explain that if they do not want to close the case they have to proceed to the legal system and most choose reconciliation that involves the

Village Administrator, the survivor and the families. Only the most important cases, such as rape, proceed to court "

- Being Kayah an ethnic conflict affected state, and a sensitive context, there is a general mistrust between institutions and the population. It is particularly challenging for ethnic people to go to services offered by the central state to present cases that occur in their communities. There is still much resistance and pressure from non-state armed actors present in the field. Therefore, the preference is to sort things within the community using traditional mediation. As many of the people interviewed said, the general feeling is that:

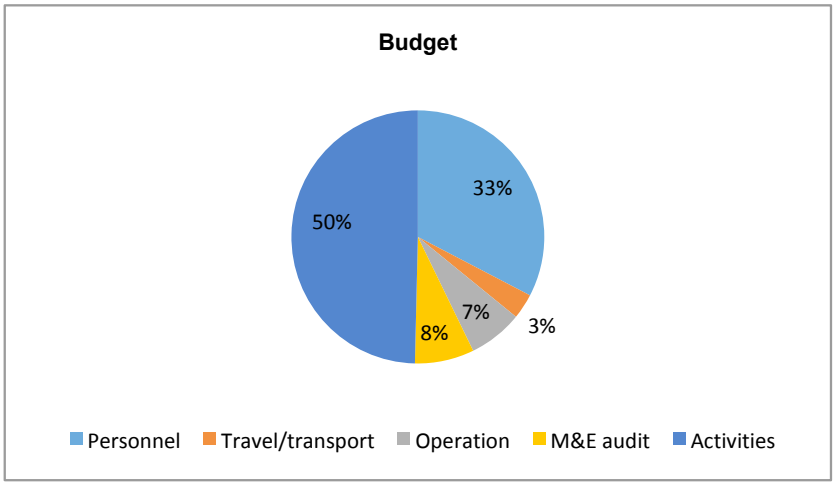
"*Police and court are not good places to be".*

- Communication between CSOs and institutions is not always fluid, many of the CSOs involved in the project are not registered and therefore not accepted as valid interlocutors by institutional actors. This has consequences, mostly regarding the coordination of actors in the field and has put the CARE team as a mediator between the parties. A clear example of the impact of this is the concerns that were raised during the interviews, that since DSW took the lead in the GBV Coordination Working Group, the representation of CSOs has been severely affected, as only registered CSOs are being invited to attend the meetings.

The CARE project team seems to be very well settled in the area, and is playing a key role in the referral system, which has its pros and cons. On one hand, they have managed to overcome challenges and move the project forward with positive outcomes and; on the other hand, they have become key actors with all the expectations and pressure that it involves the given context.

Regarding CARE personnel, continuity on the GBV trainings is desirable as it would support the performance and confidence of the staff in the field. Challenges were revealed regarding the management of psychosocial support for GBV survivors (challenge common to all the actors in the field). Other areas to be strengthened are: leadership skills to improve talking in public, methodology and pedagogical skills (implementing sessions of training to civil servants is still very challenging for CARE staff). It is advisable to include a budget line for continuous capacity building of staff. It is important to note that in spite of the highlighted challenges, trainings were welcome and very well valued by all the interviewed actors in the field research.

Figure 1 - Budget Lines



According to the budget shared with the consultants, by the end of December 2019, 91% of the budget was spent. Considering that only 2 months of implementation were left, it shows a positive degree of financial execution. The budget shows some underspending in the resources allocated to the activities meant to strengthen coordination through the GBV working group, and those crosscutting for programme learning. They have mainly been reallocated to rehabilitation and reintegration support of GBV survivors.

Given the needs in the field, the resources allocated to the activities aiming at supporting GBV survivors were exhausted before the end of the project. Particularly, resources to cover safehouse expenses and other needs in health care, capacity building and supporting IGAs for GBV survivors. This is reasonable given that there is no-allocation of funds by state institutions for them. This is deemed positive as CARE is addressing actual needs; but in the long term could be counterproductive, as the institutions may be failing to fill the funding gaps due to the fact CARE is supporting them. This is particularly the case of the DSW safehouse.

Overall, the budget seems to be balanced and in line with the activities foreseen by the project. Cash-flow has been managed efficiently to ensure availability of funds at Loikaw office.

6.3. Effectiveness

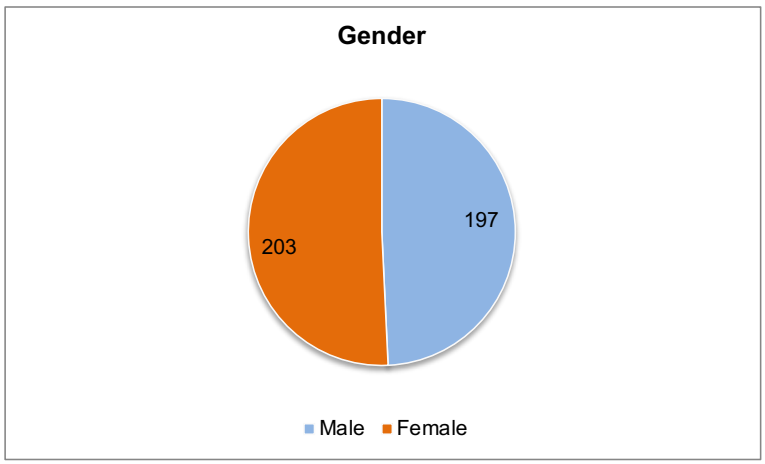
Outcomes	Level of achievement
1. KSWN, its member organizations and non-member organizations are an increasingly independent organization who work for longer-term impact and sustainability as they have increased technical and organizational capacity to prevent and respond to GBV.	Successfully achieved all outcome indicators
2. GBV survivors have access to a full range of quality GBV services in a timely and safe manner.	Successfully achieved all outcome indicators
3. KSWN has strengthened support and enabling environment to reinforce GBV prevention and response through their advocacy efforts.	Successfully achieved all outcome indicators
4. The vulnerability of GBV survivors and women in the communities have reduced through increased skills and capacities, access to financial services and economic opportunities.	One of the two indicators has not been achieved.

This section is built on the triangulation of the data analysis, from the survey -quantitative data- and the qualitative data gathered in KIIs and FGDs.

As a first step and to give a brief out-line of the characteristics of the population who participated in the survey we are including some demographic data.

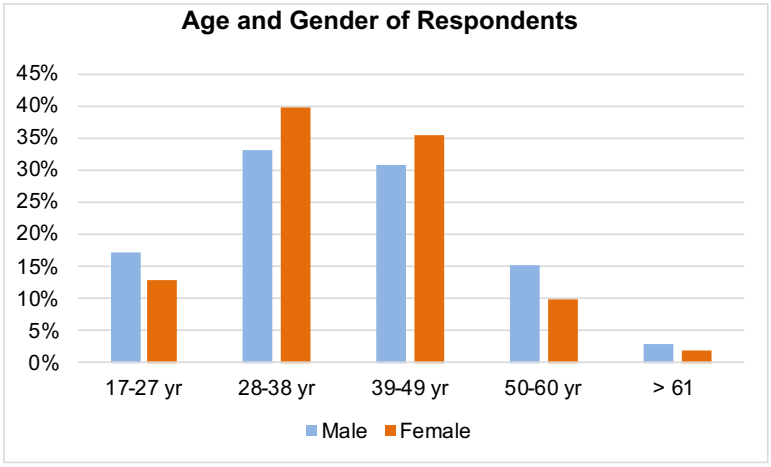
Concerning the gender: 51% of the respondents were female and 49% male.

Figure 2– Number of respondents by gender.



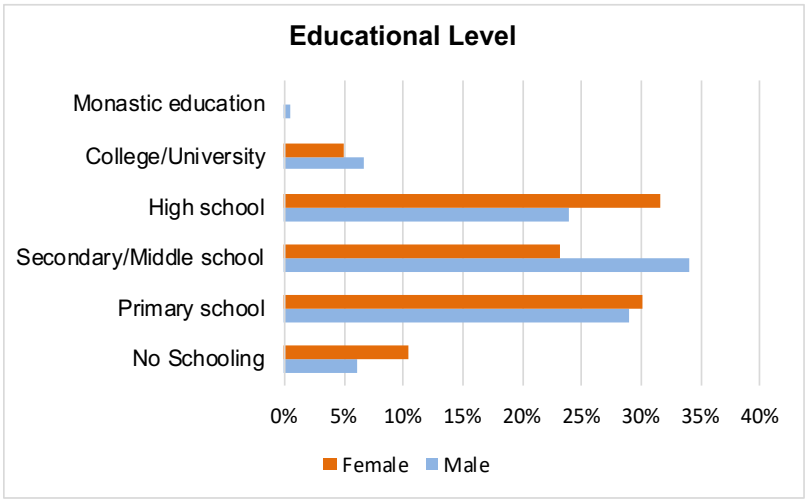
Around 70% of the participants were between 28 and 49 years old. There were more middle age female than male participants. This could be due to the fact that men were working at the time the survey was conducted, and to the resistance the evaluators faced to involve male villagers.

Figure 3 - Age and Gender of the Respondents



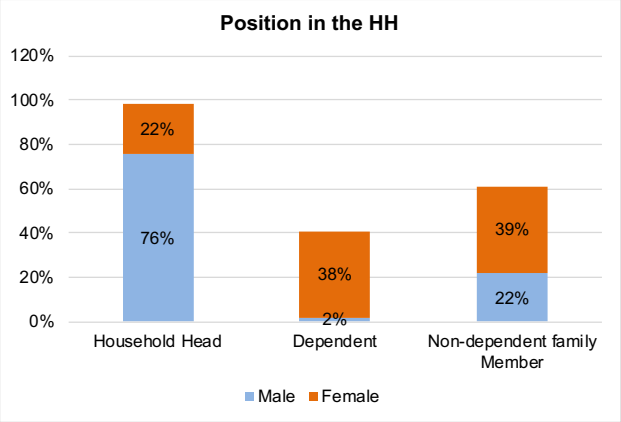
Concerning the educational level of the respondents, data shows that more women than men have achieved High School level education, however, there are also more women that did not go to school.

Figure 4 - Educational Level by Gender



76% of males declared to be Head of Household (HH), while 38% of women declared to be a dependent and 39% to be a non-dependent family member.

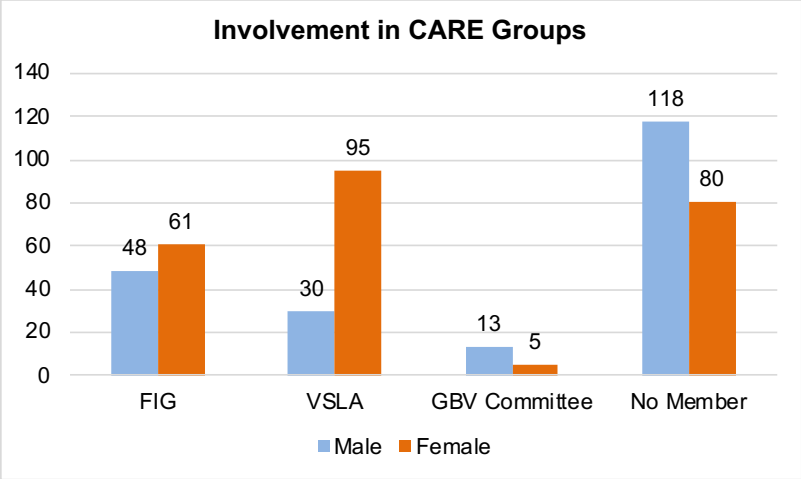
Figure 5– Position in the HH by Gender



80% of both males and females declared being married. The ethnicities of the participants were: 39% Kayah, 22% Kayaw, 19% Kayan and 10% Bamar. Regarding religion, the majority were Christian 60%, followed by 30% Buddhist and 7% Animist.

Finally, concerning participation in the CARE project group activities: 60% of males and 40% of females were not involved. Many of them were members of VSLAs (30% males and 95% female), and around 25% of respondents were participating in Farmer Interest Groups from another projects working on livelihoods.

Figure 6– Number of People Involved in CARE Groups



In the following section, for each of the outcomes, a table is presented, with the indicators and the results as per the endline survey. It is followed by an analysis of the quantitative data gathered in the survey informed by the main findings of the qualitative field research.

6.3.1. Project Outcome 1: KSWN, its member organizations and non-member organizations are an increasingly independent organizations who work for longer-term impact and sustainability as they have increased technical and organizational capacity to prevent and respond to GBV

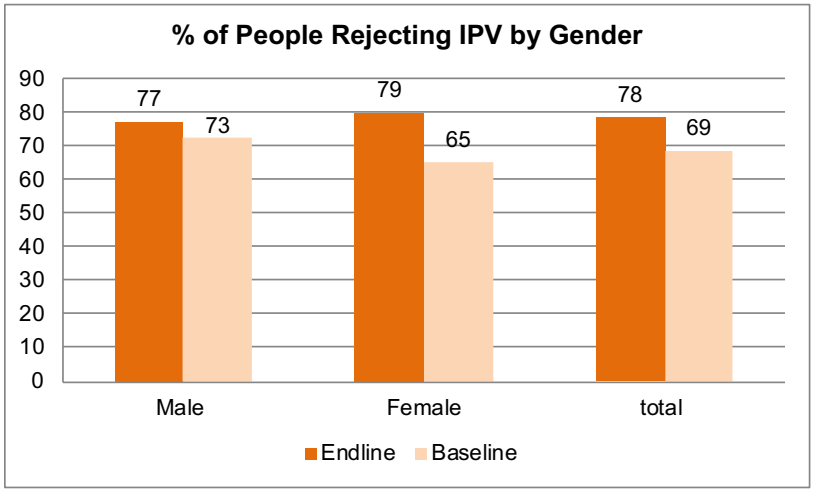
Indicator	Baseline - 2016	Target	Endline – 2020
1. % of people (male and female) who reject intimate partner violence (IPV)[4]	**11.7%** (Male 9.8% and Female 12.9%)	20%	**80%** (Male 79% and Female 81%)
2. % of people (male and female) demonstrating understanding of IPV[5]	**24%** (Male 20.2% and Female 27.5%)	35%	**73%** (Male 71% and Female 76%)
3. % of community responders who report having provided GBV services and information about other available GBV services	**5%**	30%	**Provided GBV services: 33%** (Male 35% and Female 31%) **Provided information on available services: 85%** (Male 90% and Female 79%)

The results of the comparison between baseline and endline responses to the questions measuring progress in the **% of people who reject IPV**, shows positive trends towards the endline.

The results from the 3 townships, taking into account only positive responses to 13 statements (Table 1) were analysed. Figure 7 shows the results of this analysis, where there was a change from 69% of respondents rejecting IPV in the baseline 2016 to 78% rejecting IPV in the endline 2020. Bigger advances were made in the case of women, as the percentage of changed from from 65% in 2016 to 79% in 2020; while for men, it changed from 73% in 2016 to 77% in 2020.

[4] Calculated as per the baseline: agreeing to all 5 (41, 42, 43, 46, and 49) questions of the questionnaire.
[5] When asked: What does the words" Partner Intimate Violence" mean to you? They recognised at least two of the listed manifestations of IPV.

Figure 7- % of people who reject IPV. Comparative baseline – endline.



The table shows that 10 out of the 13 questions/ statements measured in the survey show positive trends. In particular, the total number of respondents who agreed with the following statements decreased:

- There are times when a woman deserves to be beaten, from 46% in 2016 to 18% in 2020.
- A wife should tolerate being beaten, from 74 % in 2016 to 38% in 2020.
- It is natural to beat a wife, from 22% in 2016 to 7% 2020.

On the other hand, there are 3 questions that show limited change:

- Women should choose whom they want to marry, from 90% in 2016 to 88% in 2020.
- If a man sees another man beating a woman he should stop him, from 89% in 2016, to 82% in 2020.
- Violence against women is a community concern, from 82% in 2016 to 77% in 2020.

In 2016, 96% of respondents agreed with the statement “family problems should only be discussed with people in the family” while in 2020 the percentage of people agreeing went down to 71%.These changes suggest some degree of advancement in raising awareness of GBV to the public, nevertheless there is still a long way to go. Men are still more likely to justify making use of violence, however the differences in findings between genders is not enormous; for instance, 7% of women still justify being beaten if they burn the food whereas only 4% of men justify it.

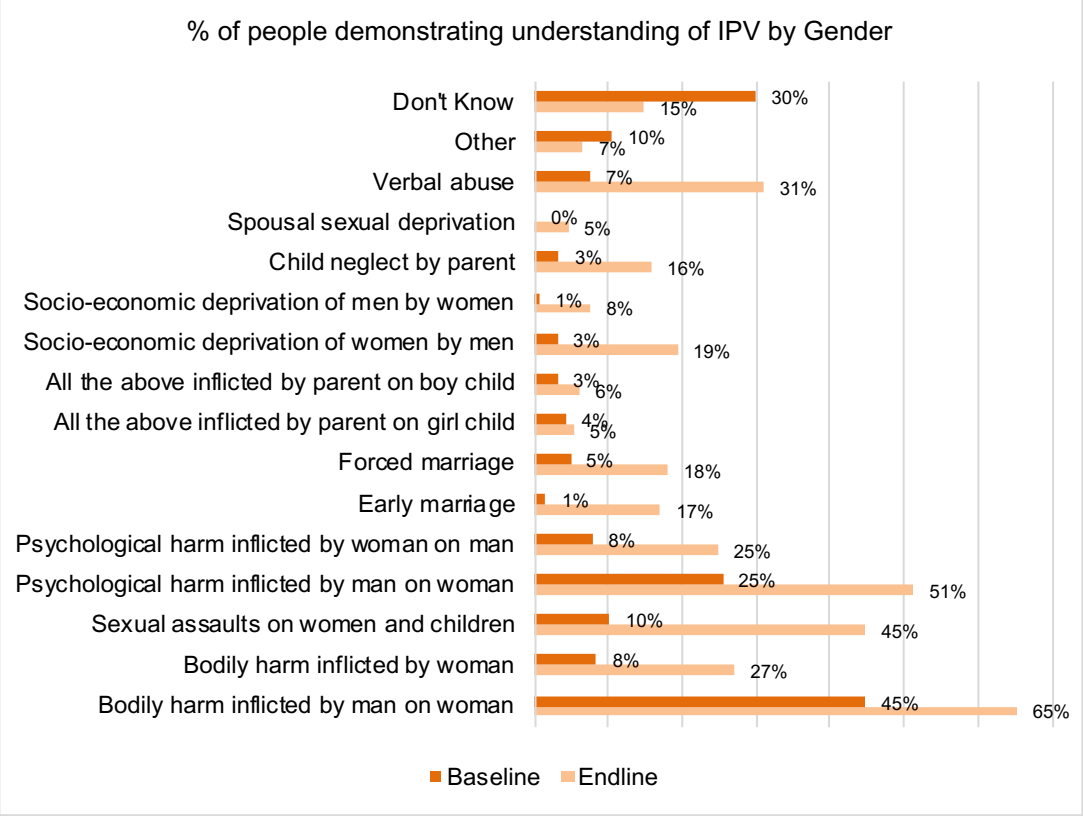
Figure 8– People rejecting IPV by gender. Results per each of the statements measured. Comparative baseline – endline.

% of people (male and female) who reject intimate partner violence (IPV) by Gender						
	Endline-2020 (n=400)			Baseline-2016 (n=335)		
	Male	Female	Total	Male	Female	Total
	%	%	%	%	%	%
Q11.There are time when a woman deserves to be beaten.						
Agree	20%	16%	18%	42%	49%	46%
Q12 A wife should tolerate being beaten by her husband to keep the family together.						
Agree	44%	33%	38%	75%	74%	74%
Q13 It is natural to beat a wife who to have sex with her husband						
Agree	6%	8%	7%	22%	21%	22%
Q14 If a suitable groom is found even though a girl is young, she should marry him.						
Agree	8%	8%	8%	17%	16%	16%
Q15 It is wrong to say that a wife is justified in refusing to have sex with her husband/partner when she is tired or not in the mood.						
Agree	15%	12%	14%	17%	19%	18%
Q16 If a wife goes out without telling her husband/partner, he is justified in hitting or beating her.						
Agree	10%	16%	13%	28%	37%	33%
Q17 Women should choose themselves whom they want to marry.						
Agree	88%	88%	88%	92%	89%	90%
Q18 It is better to send a son to school than it is to send a daughter.						
Agree	12%	10%	11%	19%	15%	17%
Q19 If a wife burns the food, it is only proper that her husband/partner discipline her by hitting or beating her.						
Agree	4%	7%	6%	5%	11%	8%
Q20 If a woman was raped, in most cases that means she must have done something to provoke it.						
Agree	12%	7%	10%	28%	19%	23%
Q21 Violence against women is a community concern.						
Agree	77%	77%	77%	80%	84%	82%
Q22 If a man sees another man beating a woman, he should stop it.						
Agree	82%	81%	81%	88%	89%	89%
Q23 Family problems should only be discussed with people in the family.						
Agree	76%	67%	71%	97%	96%	96%

The results from the analysis of the second indicator, % of people demonstrating understanding of IPV, as for the first indicator show progress has been made, and the target has been achieved.

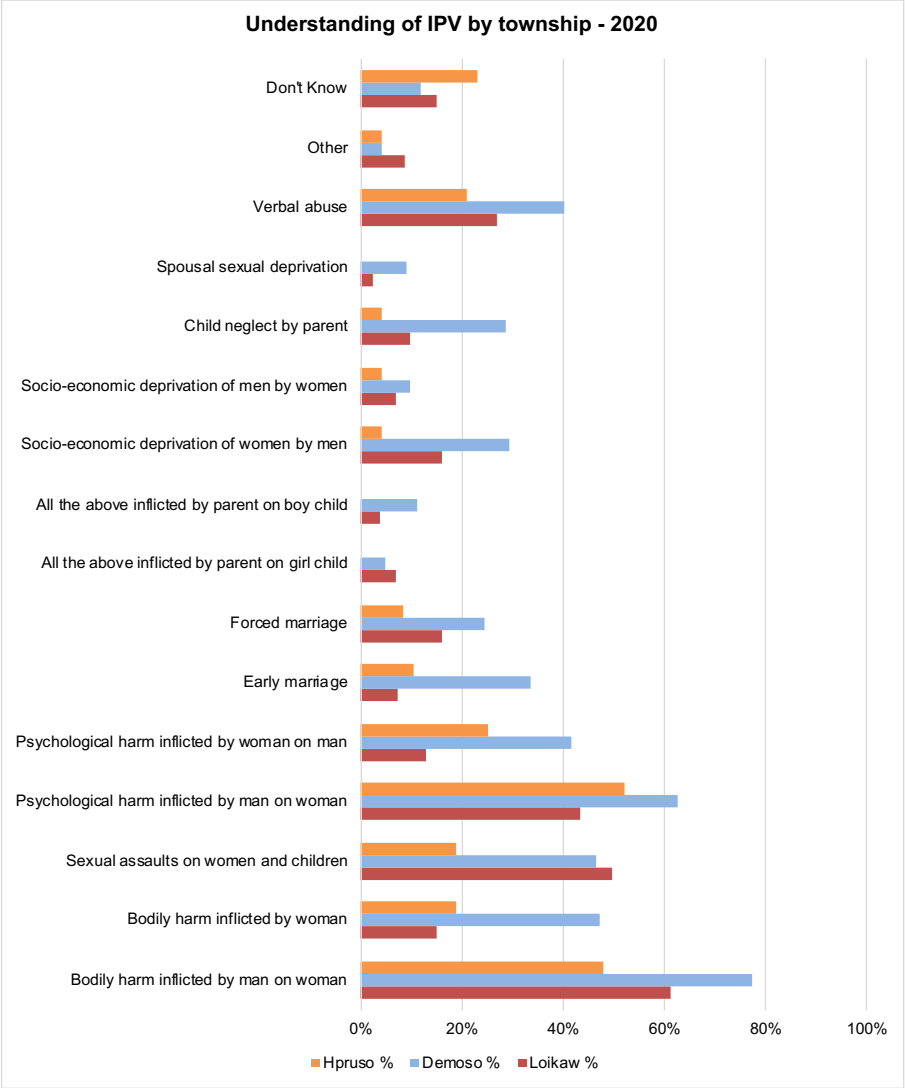
When the respondents were asked: *What does the word "violence" mean to you?* there was a significant decrease in endline respondents who answered 'Don't know' compared to the baseline (Figure 9). The most commonly identified form of violence remains physical and sexual assault; nevertheless, in the endline there has been a positive change with an increasing number of respondents also recognising socio-economic deprivation and psychological harm as forms of IPV.

Figure 9 – Understanding of IPV. Comparative baseline – endline.



When comparing the results between townships, Hpruso still showed less awareness than Loikaw and Demoso. Notwithstanding, it is important to highlight that Demoso's respondents were those who showed the most progress in the understanding of IPV (Figure 10).

Figure 10– Understanding IPV by township in 2020.



Women show higher awareness of the forms of violence that do not involve physical abuse, nevertheless, it is worth noting significant progress of IPV awareness has been made by males since baseline 2016 (Figure 11).

Figure 11– Understanding IPV by gender in 2020

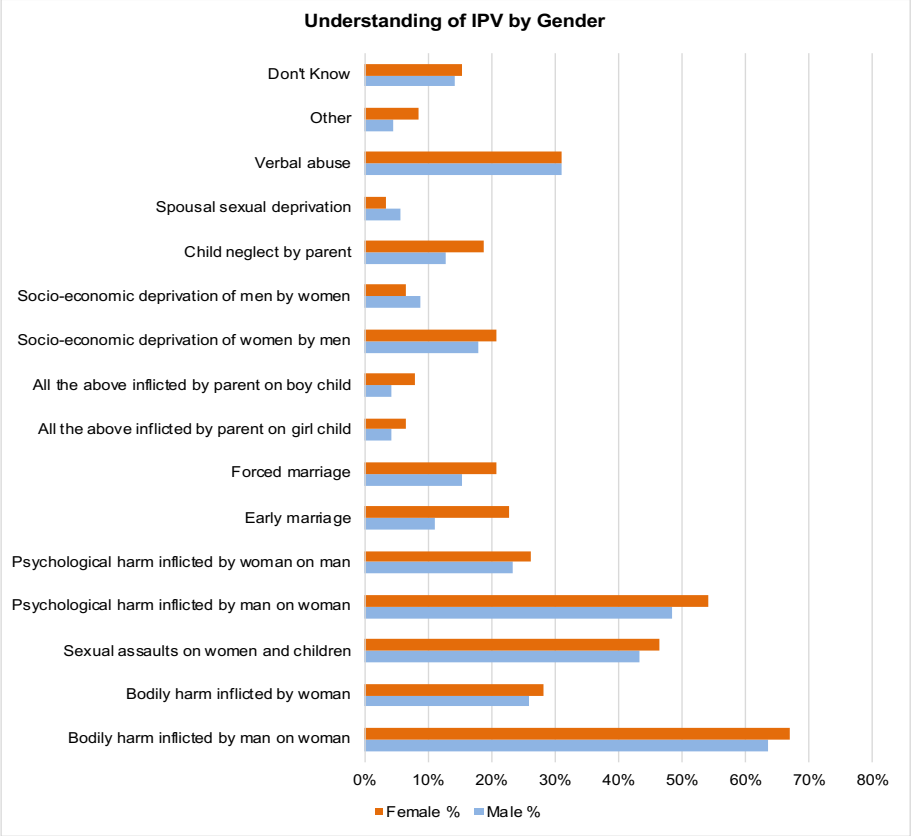
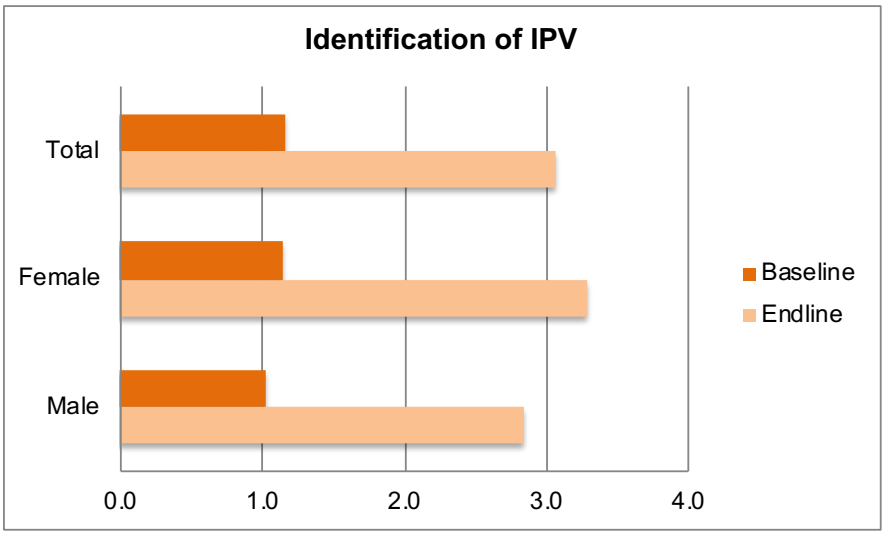


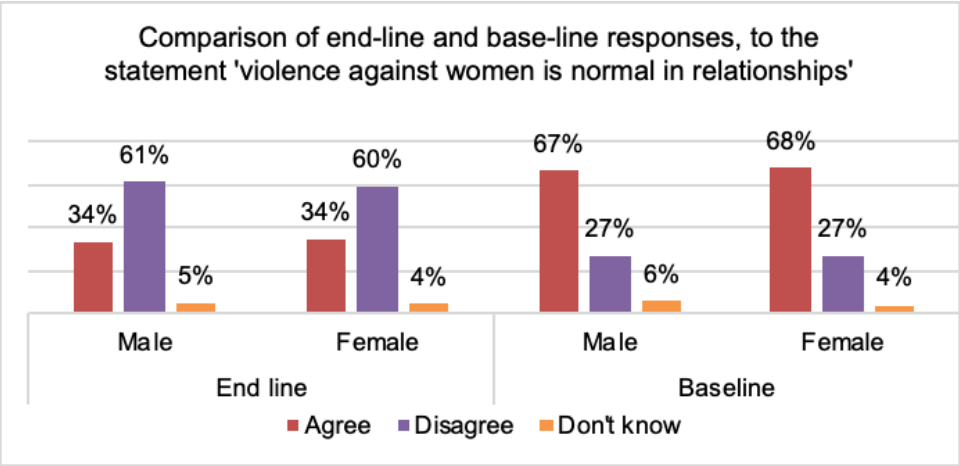
Figure 12 shows the progress of IPV awareness in the last four years. In 2016 the average number of causes of violence identified per individual was just one, while in 2020 the average is 3. Women still show higher awareness, but men show higher progress; suggesting that the actions which have been targeting male community members have been successful.

Figure 12– Understanding of IPV by gender. Comparative baseline – endline. Number of cases of IPV that an individual is able to identify.



Progress can also be observed regarding respondent's perception of violence. As shown in Figure 13, in the endline survey, 61% of males and 60% of females believe violence is not normal in a relationship, whereas in the baseline, 67% of males and 68% of females believed it was.

Figure 13 – Violence against women is normal in relationships. Comparative baseline – endline by gender.



Results from the survey also show that almost all respondents, male and females, are aware that: women have legal rights to protect themselves from violence (93%); there is legal punishment for perpetrators (96%) and; violence harms the whole family (95%). Interestingly enough, men score slightly higher in knowledge than women.

Community awareness and male peer approach activities were evaluated positively by the participants in FGDs and KIIs. They specially appreciated activities that involved community interactions; such as: family talks and male peer groups. The positive results are clearly seen in the achievement of the indicators. The consultants have very much appreciated the involvement of key community influencers, in particular the Village Administrators who are the first point of contact when GBV cases arise in their communities. It was observed that the communities with a Village Administrator who was proactively involved in the project, have had a higher degree of change in attitudes and perception. It was found that community leaders used their influence to "motivate" participation of villagers in awareness activities.

When asked about participation and motivation to be involved in male peer groups, a 'male champion' who was also happened to be the Village Administrator said:

As Village Administrator I went to the community leaders, I invited them and requested their participation. One or two were resistant but I included them anyway. Later on, they changed their attitude and partook in activities.

For the most part, trainings were considered relevant and easy to understand, the methodology that included interaction and role-playing facilitated assimilation of new concepts. The training modules and materials to share knowledge were reported easy to use. Nevertheless, it was reported that at times it was hard to address issues that challenge traditional cultural practices, this was the case especially in Hpruso (where one of the male champions disengaged from the training and was not able to form the peer group). WOs also mentioned encountering more challenges when conducting awareness raising sessions in Hpruso given the cultural taboos in the area; for instance, it was mentioned that traditional norms do not allow to openly talk about sexual related issues and if done the offender is punished by offering a chicken to the community. In Hprusoe, communication is also a barrier as the local dialect is widely spoken and people have more difficulties to understand and communicate in Burmese.

During the FGDs in Hpruso participants communicated similar concerns, clearly stating their difficulties in assimilating concepts and transmitting them to the rest of the community. They acknowledged the importance of awareness raising activities in their area given the high incidence of GBV in their communities, and requested more materials to support assimilation of new concepts and facilitate knowledge sharing.

Family talk sessions that involved husband and wife were particularly appreciated by the communities, and every time the consultants enquired about them a big smile appeared on the participants' faces. Those who attended the sessions enjoyed them very much and said it has helped them have a happier family life, and recommended running more sessions with more community members. According to CARE staff, this methodology was welcomed among Christian communities. as it particularly fits their cultural practices.

For other trainings, the participants requested further sessions for those that have been involved, particularly in legal awareness because concepts were new and difficult to assimilate in just one session. WOs that were providing the legal awareness sessions have also found it challenging to convey the legal knowledge from a non-confrontational (women against men) perspective.

A general comment regarding the awareness raising activities was the fact that they reached a limited number of people in the communities. In fact, the consultants noticed that those participating in the FGDs and KIIs were involved in many of the project's activities. The participants acknowledged that there were many others from their villages, who for a variety of reasons, were not involved and requested for a next phase to have further reach out within communities; particularly to involve young people and adolescent.

Demoso Village Tract Administrator statement in KIIs:

We have some cases in the community, we need more awareness. One session is not enough… no all community members are aware.

This very same person has acknowledged that he has personally changed how he deals with GBV cases due to the project. Given his position his change in behaviour has had an important impact in the whole community. When asked what he has changed, he said:

Personally, in our culture we give priority to boys, but now I support equally boys and girls. In community meetings I raise awareness. When there is a GBV case, I am now aware that there are laws that protect women; I now call KNWO, CARE and the Women's Federation of Demoso to support me. At community level, committees are now 50/50 or at least 1/3 are women. Village Administrators are mainly males, but there are women in Village Development Organisations (VDOs) and Education Committees. Women are faster learners and are more pro-active.

KIIs notes with Male activist from Saung Du (New), Demoso Township

U Domenico is a young male activist (31 years old) and a village administrator, who has been very active in sharing GBV, referral, legal and gender awareness knowledge within his community after receiving trainings from CARE. He organises weekly peer group meetings where he shares knowledge using CARE's modules and activities. He uses his influencing power as a Village Administrator to make sure people attend the peer group trainings.

U Domenico has shown a lot of self-awareness of the changes in his mindset since receiving the trainings and recognises issues with his past behaviour.

Before, he says, he used to catcall and harass women with his peers with no regards for the women's feelings, he used to have a victim blaming approach when trying to solve GBV cases within his community.

However, since the trainings, he has been conscious of his behaviour towards women, applying what he has learned to his day to day life, and has moved away from victim blaming when dealing with GBV cases to a survivor centred approach.

U Domenico has also seen significant changes within his community, where there is increasing participation and willingness to learn about GBV, including from village leaders. Furthermore, his village has been moving away from traditional means of resolving GBV cases to an increased use of the referral system.

He says there have been changes in behaviour towards children as well, and more awareness of violent forms of child abuse. U Domenico has found the trainings very useful, in the future he hopes that more women in his community can raise their own awareness of their rights and the protection available to them.

Regarding the 3rd indicator: % of community responders who report having provided GBV services and information about other available GBV services, the number of respondents helping other community members suffering from GBV has more than doubled since the baseline, men being more pro-active than women in providing support to survivors (Figure 14). There is also a surprising increase in the numbers of people who are referring survivors to the available services in the community, changing from 12% in 2016 to 85% in 2020 (Figure 15).

Figure 14 – Have you ever helped someone who suffers from GBV? Comparative baseline - endline

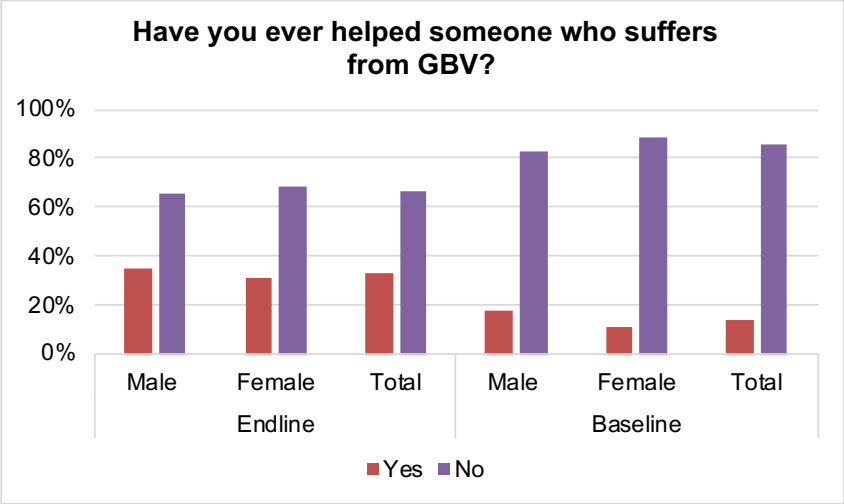
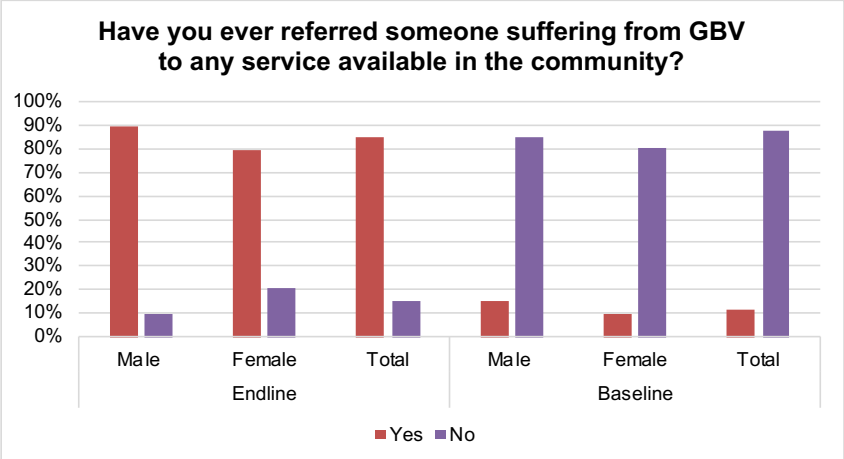


Figure 15 – Have you ever referred someone suffering from GBV to any service available in the community? Comparative baseline - endline



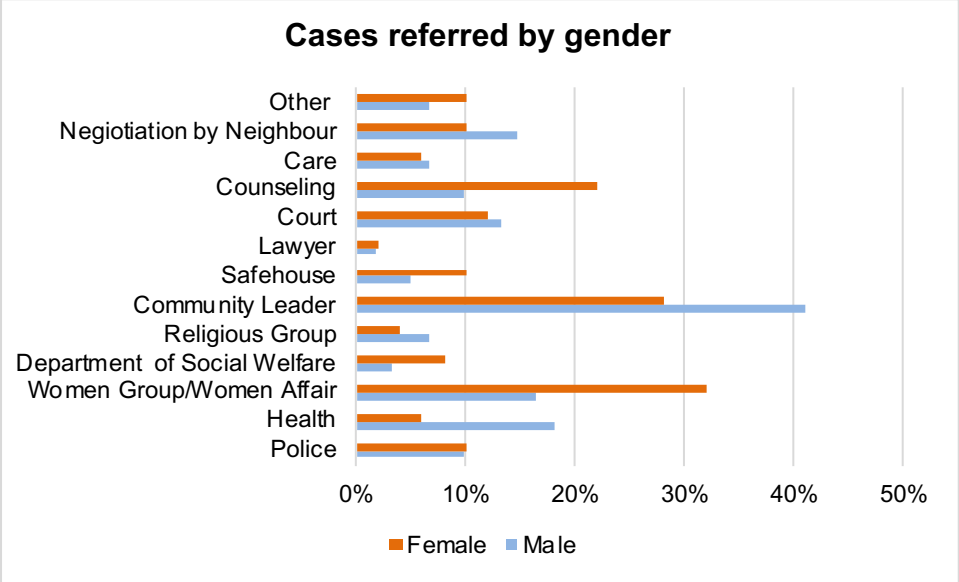
Those that have referred GBV survivors mainly call for the intervention of Community Leaders, usually the Village Administrator. When compared with the baseline, we can see that people are increasingly referring cases to WO's and there is a big decrease of the cases referred to neighbours for negotiation. There is also a difference between the three townships with regards to who the most active and sought out actors are: in Loikaw and Demoso they are the Community Leaders, while in Hpruso are the WOs (Figure 16). This fact might be linked to the more resistant, traditional dominant culture of Hpruso, where there are conversations that cannot be had in public and are still taboos.

Figure 16 – Those that have referred someone towards what service are referring them. Comparative baseline -endline.

	Endline				Baseline			
	Loikaw	Demoso	Hpruso	Total	Loikaw	Demoso	Hpruso	Total
Police	7%	13%	18%	**10%**	8%	0%	0%	**5%**
Health	13%	10%	18%	**13%**	12%	0%	0%	**8%**
Women's Group/Women affair	23%	20%	36%	**23%**	4%	0%	0%	**3%**
Department of Social Welfare	9%	0%	0%	**5%**	0%	0%	0%	**0%**
Religious Group	4%	3%	18%	**5%**	0%	0%	0%	**0%**
Community Leader	29%	53%	27%	**35%**	8%	0%	0%	**3%**
Safehouse	6%	0%	36%	**7%**	0%	0%	0%	**0%**
Lawyer	1%	0%	9%	**2%**	0%	0%	0%	**0%**
Court	7%	13%	45%	**13%**	0%	0%	0%	**0%**
Counselling by neighbour	19%	13%	0%	**15%**	32%	17%	0%	**23%**
Care	4%	0%	36%	**6%**	0%	0%	0%	**0%**
Negiotiation by Neighbour	16%	10%	0%	**13%**	28%	67%	67%	**43%**
Other	10%	7%	18%	**8%**	12%	33%	22%	**18%**

There are differences between the actors that male and female respondents seek out to refer the cases to, as shown in Figure 17, women refer more to WO's and men go to the community leaders.

Figure 17– Cases referred by gender. Endline.



Between the three townships, there is a change in the actors that are sought out when a case of violence arises in the communities, as shown in Figure 18. Village Chiefs remain the most called upon, but NGOs and WOs come second, while in 2016 they were not even reported as actors in the area of GBV. When analysed by township, it looks like in Demoso the NGOs and WOs are stronger actors than in the other 2 townships.

When disaggregated by gender, there are no big differences in responses, aside from the fact that women tend to seek help from WOs more than men (43% of women, 37% of men).

Figure 18– If there is a case of violence, who do people report to? Endline.

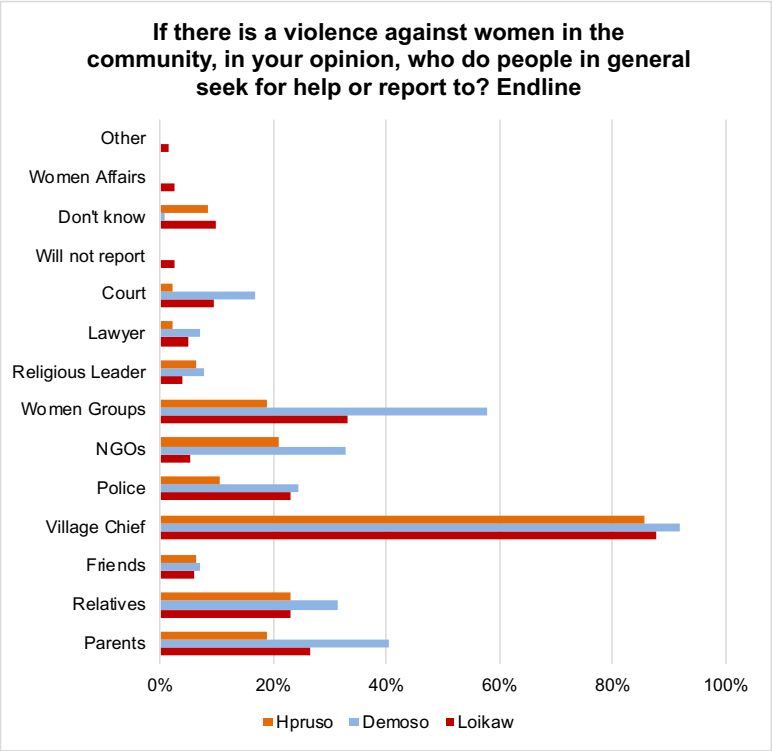
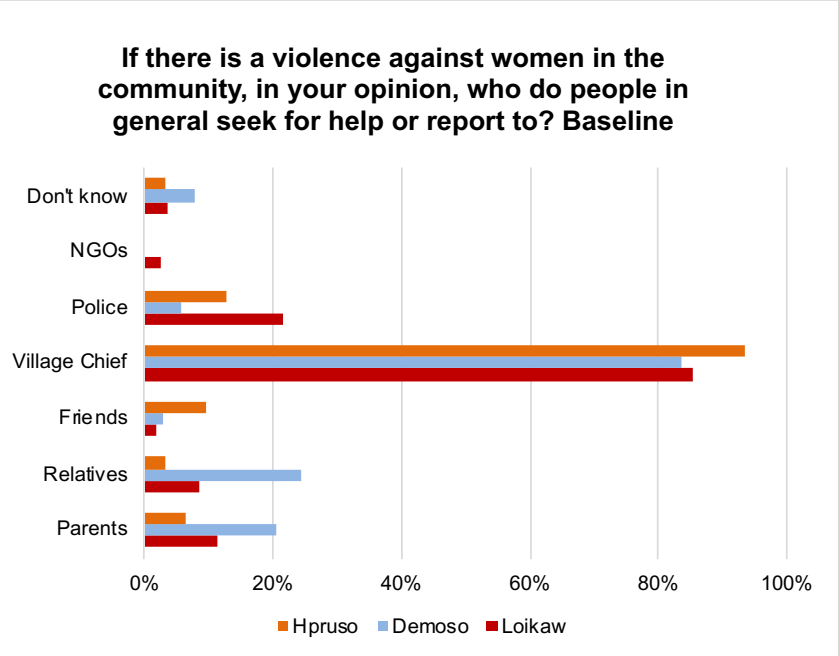


Figure 19- If there is a case of violence, who do people report to? Baseline.



The interviewees showed awareness of the referral services in place, however, given the context, formal institutional actors in the referral system are mostly avoided; this is mainly the case for the police and judicial system. The preference for all stakeholders, including the institutions, and survivors to sort out things at community level.

One police officer said:

If a survivor does not want to proceed, we close the case. Most of the people prefer to reconcile by doing a mediation with the involvement of the Village Administrator. Minor cases are settled and only most important cases go to court. Rape cases must go to court.

'Important' cases involve extreme violence or rape according to the understanding of the consultants.

When the villagers were asked what happens when there is a case of GBV in their communities, with some variations, in most of the cases they said:

Some women run to their parent's house. Some cases arrive to the Village Administrator and he (they are almost all men) uses the traditional system to deal with it and if doesn't manage he refers it to the Village Tract Administrator. Both Village Administrator and Village Tract Administrator use mediation between the survivor and perpetrator with the active involvement of the perpetrator's family. The mediation exercise involves a written agreement between parties with the perpetrator signing as signal of engagement to do what was agreed.

Those involved stated that it mostly works but sometimes it is difficult. The difficulties expressed are, among others: lack of engagement of the men and psychological instability of the survivor. The latter was recognised as a big issue, which causes a lot of distress to all of the actors involved in the GBV response.

Proactive and committed Village Administrators involved in the project activities have changed the way they deal with the cases. They disclosed that now, they call the active CSO/WO in their area and sometimes CARE. If this is the case, in some occasions they have the support of a lawyer that assists the actors to reach a fair agreement.

This is a clear example of the project's adaptation to the context. Implementing partners have actively tried to involve key actors on the ground, and when they managed they have disclosed changing their way of proceeding to suit them. Interviewed Village Administrators felt that they have better tools and support to fulfil this duty for the community.

Lastly, activities contributing to the achievement of this outcome included actions aimed at strengthening the CSOs/WOs in charge of the implementation of many of the awareness raising actions. The consultants have found that trainings were highly appreciated, and the CSOs' preference was to continue the implementation of actions through the provision of small grants as it has contributed to their strengthening and has increased ownership. They all stated that they have received additional support on ad hoc basis from CARE staff.

Participant from a WO in Loikaw:

After getting the grants the CSOs have gained in accountability, ownership and leadership skills. We have participated in trainings on project cycle management, finance, proposal writing, M&E, project planning, advocacy, etc.

Given the challenges mentioned under the efficiency section, and in spite of the success of the action, all the CSOs are still struggling to be sustainable. This project represents a first step for them that needs follow up for consolidation and possible future sustainability. In fact, the consultants found that among those interviewed only two CSOs have the capacity and experience to acquire funds from other sources. Among other skills, they need to improve report writing, computer skills, budget making and financial management. The WOs representatives that participated in the exchanges with the consultants acknowledged their need for further trainings and reinforcement of skills.

FGD in Hpruso

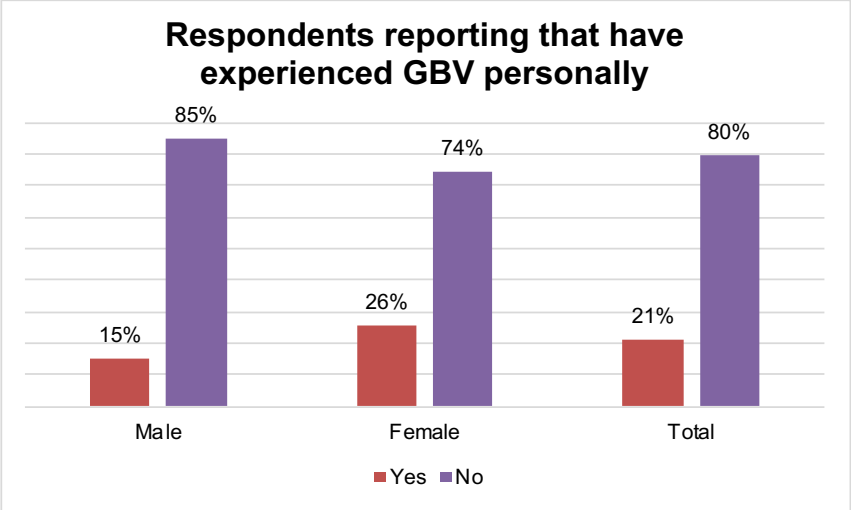
6.3.2. Project Outcome 2: GBV survivors have access to a full range of quality GBV services in a timely and safe manner

Indicator	Baseline - 2016	Target	Endline – 2020
1. % of GBV cases reporting satisfaction and responsiveness of the referral systems[6]	**60%**	66%	High Satisfaction - **65.2%** Medium Satisfaction - **34.8%**
2. # of GBV cases received services (health, psycho-social, legal)[7]	**46**	30 Cumulative target	15 (in 2018) + 38 (in 2019) **53**

According to the quantitative data, a total of 21% of the respondents have personally experienced violence (Figure 20,15% of males and 26 % of females).

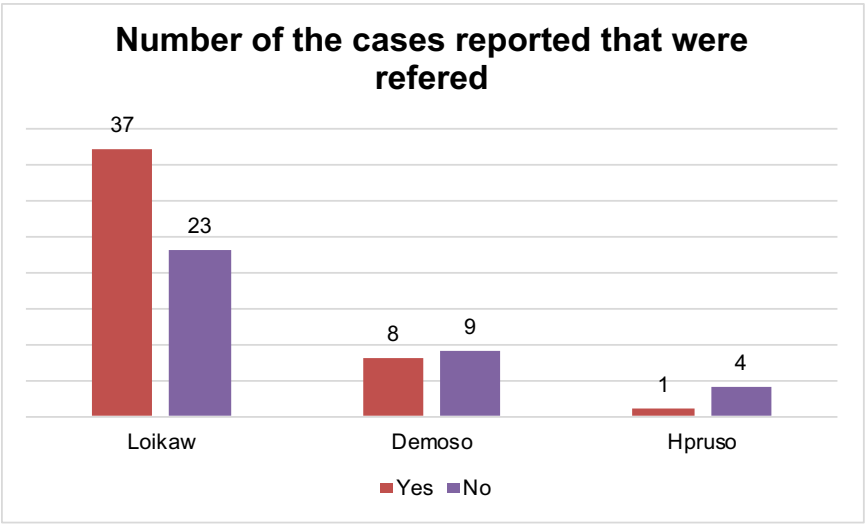
[6] Given the limited number of cases reported during the survey the qualitative data analysis presented here below is, on the view of the consultants, more relevant than the statistical analysis.
[7] Information provided by M&E Officer in Loikaw: 21/02/2020

Figure 20 – Respondents that have experienced GBV personally by gender. Endline.



Respondents who experienced violence were asked if their case was referred. It was found that there was a differences in the number of cases that were between the townships (Figure 21). In Loikaw 62% of the cases were referred, in Demoso just 47% and in Hpruso only 20% (1 out of the 5 that have been acknowledged).

Figure 21 – Number of the cases that were referred by township. Endline.



There are obvious variances in the services that GBV survivors were referred to. Mainly, the respondents were accessing counselling, especially in Loikaw. Counselling is done at community level by community members, it is an established local system of self-help. When looking at the gender breakdown, it seems that males tend to go more to legal and police services than women (Figure 22)

Figure 22 – To what services are the declared cases addressed. Endline.

What of the referral services?				
	Loikaw	Demoso	Hpruso	Total
Health	0	2	0	2
Legal	2	0	0	2
Social Services	5	1	0	6
Police	3	2	0	5
Safehouse	0	0	1	1
Counselling	23	3	0	26
Other	4	0	0	4
Total	37	8	1	46

Concerning the level of satisfaction with the different referral services used by GBV survivor respondents, given the small number of individuals participating in the survey who has made use of the institutional services (legal, health, police and social), the consultants believe that the qualitative data collected is more suited to assess their quality. For the quantitative data, on average, 65.2% of users expressed high satisfaction and 34.8% an average degree of satisfaction.

During qualitative data collection, the consultants were able to gain insight into the challenges faced by all those involved in the referral system. It is important to note, that all actors highly appreciated the project and have acknowledged that since its implementation there have been some positive changes; at the same they are also highly aware of their limitations in responding to GBV.

Regarding training sessions, the consultants noted that most of the key interviewed stakeholders had participated in the sessions, however, the trainings did not always reach the front-line workers. This was particularly true with the police, although in the health and social sectors, it seemed to be easier to reach front-liners. Given the vertical structure of the public institutions, invitations had to be addressed to the person in charge of the institution. Most of the times, those individuals attended meetings and trainings, but there was not a system in place to pass on the knowledge to their staff.

Another challenge regarding the training sessions, was the mobility of civil servants in some of the service providers, especially those linked to security. There were also restrictions by the administration on the trainings that can be provided to civil servants, trainings for health staff have not been authorised and other actors in the judicial system or education have restrictions on their participation in trainings and awareness raising activities.

When asked about the referral system, DSW informants had knowledge of it and used it, but the interviewed health worker officer and police officers had limited knowledge. All the institutional stakeholders seemed to have standard operational procedures to follow, but they all faced challenges in applying them, as they are considered too complicated given the limited capacities of the services available on the field. However, it should also be noted that not all actors received adequate training for the implementation of their own procedures.

Other concerns linked to privacy, confidentiality, availability of female officers or specialised trained staff where common challenges to all the service providers. Dealing with individuals' mental health issues and lack of psychosocial support was one of the main concerns raised by all. In the health system a psychiatrist has recently been assigned, thanks to the advocacy efforts, however, it will not be enough to cover the needs.

Generally, it felt that it was faster and more effective for stakeholders to sort out GBV cases at the community level. Health workers and DSW are cooperating with the WOs and CARE, with a clear informal cooperation system in place. CARE staff and WOs are sometimes called in the middle of the night to help when emergencies occur.

There are other important concerns with regards to the accessibility of services by survivors. During the interviews, their high costs is a point that was raised in several occasions . Survivors are required to travel and pay tips in order to advance in processing the cases, this is a concern particularly for cases going to court. For example, it seems the issuing of medical reports was blocked if a tip was not given to the forensic doctor. Survivors are put under a lot of stress having to recount their experience several times to different actors that are not always appropriately trained on GBV. Adding to this, in the case of legal procedures there is no guarantee of having a fair ruling. “Going by the books” was stated to be cumbersome by all stakeholders, and therefore the preference was to make use of community mechanism, unless cases involved “very serious offenses”, such as rape and child sexual abuse.

Furthermore, given the context in a conflict affected area, there is a variety of actors with influence in the communities, and mistrust from the local population towards the representatives of the central government. In fact, all interviewed villagers agreed that the police and court are places to be avoided, while there was less resistance towards the health care system.

CARE staff mentioned that they do not feel confident when doing training sessions for the institutional actors. They feel that they need further skills and a different approach to convey the knowledge, as expectations are completely different than when working at community level.

Legal support is highly appreciated by all the informants, cooperation with the Loikaw Royal Firm has been very productive to survivors and also to other services involved in the referral system. Mainly WOs and Village Administrators as the lawyer assists in the mediation process. The lawyer revealed that when processing cases, they face a lot of resistance from the police. Nonetheless, he also said that recently in the courts, things have improved due to two factors: a) a regulation from 2019 that states that ruling of cases cannot take over 9 months and b) a certain degree of awareness together with an informal network he has, that gives priority cases and does not require the payment of tips for GBV cases.

The DSW safehouse has been equipped, is being supported and the personnel has been trained by the project. Currently, the main concern is that DSW is counting on the support of CARE to keep the safehouse open and has still not allocated a budget to it. This leaves the personnel in a difficult situation, as they have been contracted to be integrated into the DSW structure but it has not yet been approved by the Ministry. On these grounds, sustainability in the long run will be problematic. The consultants have been made aware that CARE has been in negotiations with DSW to make effective the handover of the premises and its operations since 2018, however by the end of 2019 DSW was still not ready to take over the management of the house. Concerning the safehouse services provided, it was highlighted by the personnel that they are facing difficulties in providing counselling to the survivors, this is particularly problematic to them because they have a user with mental health problems.

Coordination of actors is happening through the GBV Coordination Working Group but mostly and more effectively, though the informal networks created by the different stakeholders. Previously, the coordination working group was led by CARE and KNOW, and involved a wide range of participants from CSOs and institutions which were meeting monthly. Leadership has been passed on to the DSW who depend on the support from CARE to organise the work. Meetings are now held every two months, and since the leadership passed to the DSW the participation of CSOs has decreased, as only those that are registered are invited to meetings.

It should be noted that in conflict affected areas, and given the procedures and control to which registered CSOs are subject, there is no interest from the part of the CSOs to be registered. As such, CARE has found itself in a difficult position; on one hand they support the DSW to assume the lead of the working group and gain ownership of it, while on the other hand, they are acting as representatives of CSOs that do no longer participate in meetings. In spite of the pressure, CARE seems to be managing well and all actors appreciated the work CARE is doing.

In the meetings of the GBV Coordination Working Group, the consultants were told by a Key Informant that:

The main objective is to give response to on-going cases from the different actors involved. They also present updates on the work they are doing; their successes and challenges; future plans for the upcoming next 2 months and advocacy activities that will be implemented are shared.

It seems to be a good mechanism to call for cooperation among services and also to raise concerns on common challenges and needs. The new system led by the DSW is positive on the ground of sustainability but presents challenges on inclusivity. Concerns were raised to the fact that the mechanism is becoming more vertical and invitations are sent to the chefs of services at state level, therefore actors in the field are no longer involved.

Overall, services have improved thanks to the support of CARE; nevertheless, for reasons that go beyond CARE's capacity, satisfaction of users continues to be limited. CARE, together with its CSOs partners are doing their best to improve the institutional response, and by doing so they have placed themselves at the centre of the service provision covering the faults of the system as much as they can.

DSW Demoso

6.3.3. Project Outcome 3: KSWN has strengthened support and enabling environment to reinforce GBV prevention and response through their advocacy efforts

Indicator	Baseline - 2016	Target	Endline – 2020
1. # of decisions taken to improve GBV prevention and response promoted by KSWN's advocacy efforts at community or state level [8]	-	4	**5 decisions**
2. # of state level leaders participated at advocacy activities[9]	-	10	Total: **140** (50 male and 90 female)

[8] Information provided by M&E Officer in Loikaw: 21/02/2020
[9] Information provided by M&E Officer in Loikaw: 21/02/2020

3. Average rating of the level of support of influential leaders targeted through KSWN's advocacy efforts	-		Positive: **61%** Neutral: **31%** Negative: **1%** Don't know: **6%**

A five years advocacy plan has been developed (2018-2023) by the GBV Coordination Working Group in November 2018, an operational plan to implement it was agreed for 2019. In the plan were included non-registered CSOs that are not attending the coordination meetings. Out of the actions included in the plan, the consultants were told that most of them were implemented, including: lobbying to decision makers to increase the allocation of resources to respond to GBV, collecting GBV data, evidence based policy papers development, legal awareness raising activities, awareness on the referral system and special events in key dates . Challenges were faced in some of the activities to raise awareness among ethnic leaders so they are able to deliver messages against harmful traditional practices to their communities and using radio messaging to advocate for a better response to GBV in ethnic languages. These activities will be conducted in 2020.

All activities are subject to authorisation at State level and messages have to pass censorship. Resistances at State level have been barriers, for example, if the Loikaw GAD does not like the subject as in his view does not pass positive messaging, therefore billboards are not allowed, furthermore he has not been pro-actively involved in the big events organised. The situation – as far as the consultants observed- was different in Demoso, where the wife of the GAD was present in meetings and involved in GBV response through the Demoso Women's Affairs Federation[10]. In Loikaw, the GAD's wife has a full time job and therefore less availability to participate in events that are not directly organised by the Women's Affairs Federation, such as Myanmar Women's Day.

According to CARE Loikaw, the main successes of the Advocacy Strategy were materialised in the following decisions:

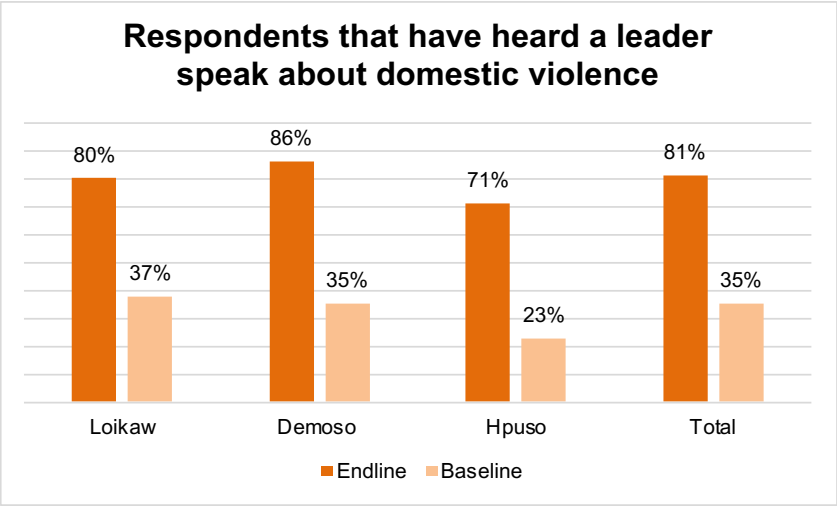
- The appointment of a psychiatrist at Loikaw hospital, increased responsiveness of the health system and police which have increased the number of female police officers in Kayah State.
- The delivery of GBV clinical care and management training to health senior staff from the whole state (7 townships) using the guideline developed by the Health and Sport Ministry in 2018. Training was delivered by the staff of the Ministry.
- The availability of emergency contraceptive pills in Hoya cottage hospital for GBV
- The land provision by state government to build the safe house under the ownership of Department of social welfare.
- One rape case committed by military soldier was transferred to civil court from military court for justice for the first time. The perpetrator was sentenced to 7 years of prison.

The consultants were also told that the evidence-based advocacy papers have been very useful to advocate to the State Parliament and to other decision making actors, as there is still a high denial of the incidence of GBV and giving numbers and evidence helps to sustain advocacy efforts.

Figure 23 shows that the number of respondents who have heard their leaders talking about GBV in their communities has drastically increased in all the townships since 2016.

[10] Wives of the GADs are given the role of Presidents of the Women's Federation of the township.

Figure 23 – Respondents that heard their community leaders speak about GBV. Comparative baseline – endline.



When asking respondents from whom they have heard GBV messages, the project's influence can clearly be seen, as WOs have been the common response (Figure 24). Most of the other leaders have increased their messaging on GBV from 2016, with a significant increase of Ward Leaders speakers. Although, there has been a decrease of Village Administrators speakers, which decreased from 38% in the baseline to 27% in the endline. On the view of the consultants, the fact that the project is being implemented through local women's CSOs has a direct impact in the number of women leaders sending GBV messages. It is also true that women leaders are the female most pro-active members of their communities and they tend to attend trainings and be involve in activities that are conducted in the villages. On the other hand, with regards to the decrease of Village Administrators, even if the project has achieved considerable progress in many male leaders the survey shows that there are still resistances among them above all in rural areas.

Figure 24 – From what community leader have you heard? Comparative baseline – endline.

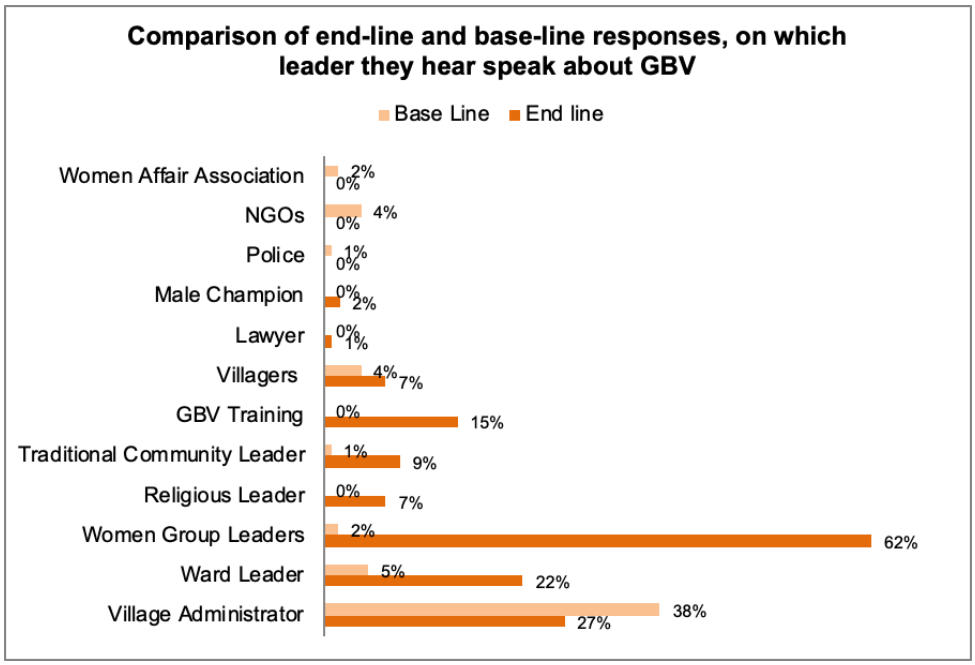


Figure 25 shows that most respondents rate the level of support from the community leaders to GBV survivors as positive, with women scoring slightly higher than men (58% men, 64% women). 82% of respondents reported changes in their village leadership in the past year (Figure 26).

Figure 25– Rating of the level of support from community leaders to GBV survivors by gender. Endline.

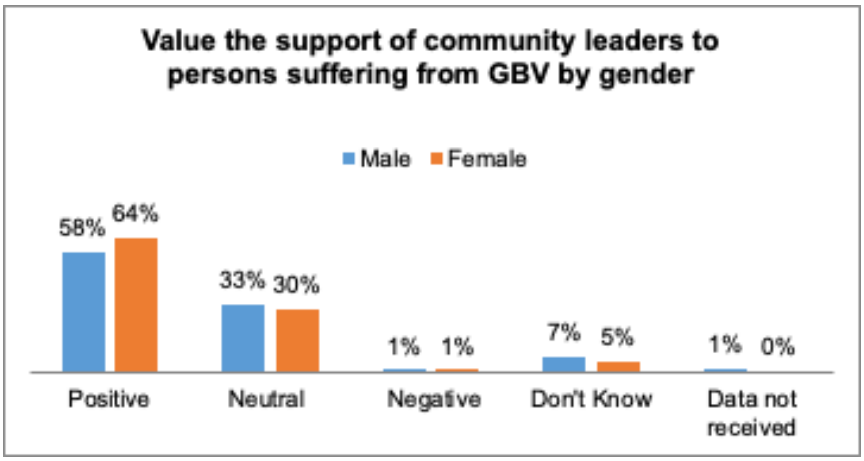
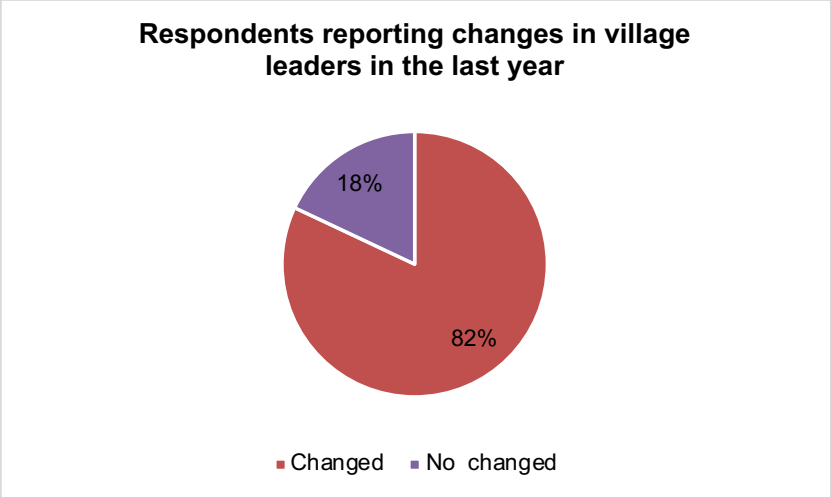


Figure 26– Changes reported in leadership in the last year. Endline.



As shown from the data of the endline survey, and previously explained under Outcome 1, the project has successfully managed to engage some Village Administrators and other community leaders. This, together with the increased advocacy efforts and empowerment of local WOs and CSOs, has contributed to bringing GBV into public community discussions.

6.3.4. Project Outcome 4: The vulnerability of GBV survivors and women in the communities have reduced through increased skills and capacities, access to financial services and economic opportunities

Indicator	Baseline - 2016	Target	Endline – 2020
1. Repayment rate all loans (in %)[11]	**75%**	80%	**100%**
2. # of VSLA members participated in training on GBV awareness, psycho-social counseling, community referral guideline[12]	**182**	420	Total: **358** (42 male and 216 female) 234 – VSLAs from the evaluated project 124 – VSLAs from other CARE projects

Under this Outcome, the project has supported the creation of 15 VSLAs. During the FGDs, the consultants have found a high degree of satisfaction with the system in place. Many VSLA members recognised that they had their doubts in the first year of the VSLAs, and therefore bought limited shares, but after observing the system working well, in the second year they increased their level of contribution. The funds were mainly used for education and health related expenses. Women felt they had gained negotiation power within the household, by being able to gather funds and contribute to the family's wellbeing.

VSLA rules seemed to be clear and easy to apply, especially after members had followed a whole year cycle and had participated in buying capital, borrowing, returning loans and doing the annual balance. According to the internal evaluation conducted by CARE staff, 7 of the VSLAs are doing very well, 6 are doing OK and 2 groups are facing challenges. Most of the challenges are due to the limited capacities and confidence of the members who are having trouble keeping the records, remembering the rules or they still do not trust the system. For almost all of the VSLA members, it was their first experience participating in a saving scheme and it has helped empower them, and allowed them to acquire skills on financial management. It should be noted that in spite of the challenges on the bookkeeping, out of the 80 active VSLA groups already functioning, none had experienced failures in the return of the borrowed amounts by the VSLA members.

[11] Information provided by M&E Officer in Loikaw: 21/02/2020
[12] Information provided by M&E Officer in Loikaw: 7/4/2020

FGD - VSLA members Demoso

During the FDGs, the VSLA members requested further capacity building in accountancy, communication, organising and leadership. It was found that among VSLA members, there were female community leaders, and their membership and received trainings has helped them strengthen their position within the community.

The VSLAs performing well have been supported to undertake IGAs (13 out of the 15), supported by CARE and partners to identify market opportunities within their communities and elaborate a proposal and budget. The average investment provided by CARE was between 25 and 30 thousand kyats with a contribution of around 20% either in cash or in kind. Given the lessons learnt from the project phase 2016 -2018, CARE has recommended the groups to focus on trade rather than animal breeding or farming (in the previous phase, some IGAs failed due to animal pests and market failures). The individuals partaking in the income generating committee were chosen among the VSLA members out of their interest and capacity, and they received trainings in bookkeeping, report writing and accountancy.

When asked by the consultants, all the groups reported a high level of support and presence of either CARE staff or CSOs implementing the project in their villages. The activities are highly appreciated, and they do not only support direct needs of the women but also increased their financial management skills, facilitated access to markets, mobility and increased their negotiation power in the community.

The consultants believe that for the future, given that all activities are up and running they need to develop business plans. When consulted, participants revealed that they did not have a clear idea of what will happen after the 5 years commitment to cooperate and re-invest all the profit. Another risk regards sustainability, as only one of the members in the IGAs is getting a small cash contribution either for their work, or/and for the space rented within their HHs to conduct the activity. All the rest are contributing to the IGA for free without any prospect of profit for at least 5 years. This situation in the medium term could lead to the disengagement of the participants. It was also noted that capacity building in financial management needs to be strengthened[13].

Lastly, the project has also contributed to supporting GBV survivors in their reintegration in the communities, through capacity building and facilitating access to resources through small IGAs (examples of IGAs are piglets breeding, sewing, beauty salon...). When asked the GBV survivors interviewed, were enormously grateful as this support had allowed them to go back home (mainly those who had stayed in the safehouse), with something that could help them make a living with. Capacity building and supporting with IGAs are essential for the re-integration of survivors.

In the KIIs the consultants recognised the challenges faced by both the survivors and the project. The level of education of the women in many cases was low and the assimilation of financial management

[13] The consultants have been made aware that this concern is planned to be addressed in the new project phase.

principles challenging, furthermore, there is an important number of GBV survivors who are under distress, with no access to local capacities to support them psychologically. Another identified barrier to survivor's reintegration is the resistance shown by the education system in allowing survivors to re-join the system, in addition to failure to provide additional support for them. The consultants have been made aware that the local education facilities are denying access to girls that have under-gone traumatic GBV experiences, even if they are ready to continue with their formal education. This is a challenging new front to be addressed in the future through advocacy and awareness raising.

CARE, together with partners (especially Good Shepard Foundation), have struggled to find additional funds to support survivors' reintegration, the same as for helping them access health care and legal support. Unfortunately demands are too big to be just covered by one project. Thanks to the additional fund of the SPARC project, they have managed to cover the needs of more survivors but it is limited, as stated by CARE, at around 3 cases per month.

GBV survivor testimony from Hpruso

The survivor is a 40 years old woman with three children. She became a VSLA member in June 2018. She contacted CARE for support after GBV awareness trainings made her to realise she herself was in an abusive relationship.

She had previously tried to file for a divorce, however, the community ward leader prevented her, claiming that she "should be patient with her husband as you are a woman". With CARE's support, she opened a legal case and filed for a divorce in June 2019. She also used her knowledge and awareness of GBV to encourage and support another woman to report the abuse they were experiencing and leave the situation.

She feels empowered, confident and is happier. CARE has helped her a lot with income generating activities. She received sewing training from KNWO supported by CARE and received 1.5 lakh for piglets to raise. In the past three months, she sold the piglets, and made 1.9 lakh which she used to buy a sewing machine. She also borrowed 1 lakh from the VSLA, which she used to buy traditional pieces of fabric and sewed traditional bags to sell. Because of this, now she has started a sewing activity which is generating income for her so she can support her family.

Concerning the achievement of the indicators, the second indicator regarding the number of VSLA members trained in GBV. The evaluators have the impression that the target was set to cover all VSLA members, while the reality is that only 2 to 3 per VSLA has been trained. Additional numbers have been added because VSLA members from other project have been also trained on GBV

6.4. Impact

The project has had very positive impacts in the communities for both men and women.

The population of the villages where the project implemented its activities has acquired knowledge on GBV, and those who have participated in awareness raising activities have stated that they have changed behaviour. Participants have reported having healthier and happier families thanks to the project. Long-lasting behavioural change is a long-term process and further actions need to be taken to ensure it occurs.

In the villages where there is engagement of local leaders, a change has been reported in the way communities are dealing with GBV cases. Most importantly, traditional discriminatory practices have been questioned and new actors (CSOs, CARE and local lawyers) are reported to be called to support mediation.

New topics and ideas have been introduced into the communities' exchanges. Male peer groups and Family Talk have successfully brought GBV and gender inequalities into the community dialogue.

Institutional service providers have acquired new knowledge and awareness of GBV. Services are reported to be more responsive, in spite of the challenges and resistance at decision making level. The project has managed to establish informal networks among key actors in the different services involved in GBV response.

Coordination among actors is in place in spite of the challenges between unregistered CSOs and institutional actors. CARE has filled this gap, bridging the two to coordinate and represent unregistered CSOs' interest in the GBV working group. DSW has gained ownership of the coordination mechanisms even if it still depends on CARE to prepare meetings.

Advocacy actions are important even if the acquired results are limited due to the resistance by decision makers. Some concrete achievements in the improvement of service delivery have been acquired: psychiatrist in Loikaw hospital, involvement of Demoso GAD, faster track in legal processing and increased numbers of female police officers in Loikaw.

VSLAs and IGAs have increased women's self-esteem, negotiation power and financial skills. Consultants have appreciated that women are requesting further skills in leadership to strengthen their role in community decision making. There have been identified cases of women that have become community leaders coming from CSOs that are supported by the project.

GBV survivors that have been supported by the project are grateful, and in spite of the challenges some have reported feeling more optimistic for the future. However, survivors under mental distress are still not able to reach support, neither from CSOs nor institutions given the lack of capacities. This generates great frustration to all those involved in GBV response and to the survivors themselves.

Overall, the consultants evaluate that the project has had positive impact for all actors involved. There are obvious limitations given the difficult of the context where the project is implemented, other factors affecting the impact – as mentioned before- were the geographical dispersion of the activities and the limited time CSOs had to implement the actions covered by CARE grants.

FGD - Village Group Loikaw

6.5. Sustainability

The project represents an important step to questioning established and well-accepted harmful practices by the communities and service providers to respond to GBV cases. As previously discussed, the activities have targeted key actors that have the potential to become agents of change in their communities; nevertheless, further work with key stakeholders to empower them to transmit to others the new values and knowledge acquired is needed, in order to make the changes long lasting.

Two important factors could contribute to sustainable behavioural changes. First, targeting key village leaders (which the consultant could see is being done) as they have the capacity to change the traditional way of doing things, are key actors in the "real referral system" and also set the example for the rest of the community to follow. Second, the project should not broaden its geographical focus but rather consolidate the achievements of the first and second phase. To do so, the project should involve the same individuals to consolidate understanding and promote change, while also aiming to expand to the wider community and hard-to-reach individuals, focusing on the youngest of the communities. This was a clear demand from most of the interviewed participants, particularly the Village Administrators.

In what concerns the sustainability of the services provided to GBV survivors, there are 3 main actors considered:

- Institutional service providers that face enormous challenges to provide services up to minimum standards. They lack sufficient economic resources, have big capacity gaps and lack of awareness among their personnel. These, together with high mobility of staff makes relying just on institutional response is not realistic yet. Notwithstanding, the project is correctly addressing the challenge, by supporting capacity building of service providers and advocating decision makers for better response and services.

  One specific mention should be given to the newly established DSW safehouse, whose insertion within the structure of the DSW is still to be approved by the Ministry at the level of Naypyidaw and it is currently relying on CARE support to cover salaries and running cost.

- WOs/CSOs. Thanks to this project they have placed themselves at the centre of the referral system and together with CARE are supporting institutional service providers to fulfil their duties. Service providers refer to them as key actors in the local support for GBV survivors, and call them to help and support those in need. The services they provide are highly linked to the availability of cooperation funds, and their sustainability as service providers at this point in time is not yet ensured. In spite of this, there are two factors that should be mentioned: a) this project is working on the organisations' capacity building and its objective is to strengthen the organisations to ensure their sustainability. b) women organisations are community based, so the knowledge acquired by the organisations will remain in the community even if the project finishes.

  It was quite obvious during the interviews that the capacity and degree of professionalism of the WOs is diverse. Some of them have managed to have other sources of funding, but the majority are relying solely on the project. Change in the implementation modality from direct implementation in 2016 to small grant making, is contributing to capacity building and improving the chances of sustainability for the WOs.

- Village Administrators seem to be key actors and front liners in GBV response. They are in many occasions the first point of referral, and they pay a central role in case management (referring cases when needed) and above all facilitating mediation. Working with them has proved to be effective, sustainable and also very useful in addressing unequal treatment. It has been particularly effective when they have act as male champions in their communities as they set the example to follow and they have been very effective to mobilise male community members. Bearing in mind that the project is implemented in an ethnic conflict affected area, and relations with centrally managed institutions (above all police and court) are complicated. As explained before, dealing

with law and order institutions is considered as negative by the villagers and it's avoided as much as possible.

Most cases are resolved the traditional way. In the field research it was also pointed out that other actors such as the police, lawyers and WOs also preferred it to the institutional response, as it is considered to be faster and less cumbersome. The survivors also show preference to solve cases locally not escalating them to the legal system, given that police and court are 'not good places to go', legal processes are time consuming, costly and involve a lot of unaffordable travel, while rule of law is not guaranteed (corruption seems to be widespread).

Concerning the GBV coordination group, there seem to be some challenges since the process has been led by DSW, nevertheless institutional involvement is an essential factor for its sustainability. Higher ownership of the process needs to be developed, as up until now DSW is relying on the assistance of CARE and KSWN for the preparation of meetings. Good dynamics seem to be built and should be maintained in spite of the challenges to ensure sustainability. At this point, the consultants believe that without the advocacy and pushing eagerness of CARE, DSW could drop the initiative for lack of resources and capacities to organise the meetings.

The advocacy strategy has helped promote changes that could be long lasting; notwithstanding, big advocacy efforts and achievements are too often lost when there is a change in the staff of the involved institutional departments and decision makers.

Last but not least, in what concerns the actions aimed at women's economic empowerment: VSLA and support to income generating activities. VSLAs seem to be sustainable and performing well. The consultants could see the satisfaction and higher reliance of the members after the first year running. All of the members interviewed could see the positive impact in their lives, in terms of contributing to their families' wellbeing in times of need and being able to put some money together at the end of the year. It was also reported that all 35 VSLA created during the different phases of the project are still up and running. Furthermore, VSLA members are assisting in the referral system as some of the participants have been trained to identify GBV cases and have gained some basic skills in the guiding principles and social counselling.

Concerning IGAs activities, it is still too early to evaluate their sustainability. Nevertheless, it was noted that there is a high level of satisfaction from the women involved. They have facilitated women's access to markets and increased knowledge in financial management. In the long run, to facilitate sustainability it is advisable to assist the women in developing basic business plans that give them a route to follow for the future. It is also the opinion of the consultants that the fact that for the first 5 years the members do not benefit from the profit as they have the engagement to re-invest all the income generated could imply a disengagement in the activity in the midterm.

7. Key lessons learned and good practices

Overall, the project learnt from the challenges of its first phase (2016-2018). When asked about the actions, CARE staff in Loikaw made reference to changes in order to address the challenges faced in the first phase.

An important lesson learned (already highlighted in the relevance section) is the fact that you need to adjust your response to the context where you work. In this sense, the project has shown great capacity to adjust, and has targeted the key actors in the field. It should be noted that Village Administrators have been considered from the beginning as key service providers in the communities; by doing so the project has multiplied the impact in both awareness raising and better response to GBV survivors.

Materials for trainings should be developed at the very beginning of project implementation, this matter which had a great negative impact in the previous phase of the project, has no longer been an issue in the evaluated phase.

Timing is important, in two senses. It is needed to adjust the actions to the availability of actors (try to avoid, when possible, farming season) and planning should take into account capacities of implementing partners to avoid compressing implementation of actions in a limited time.

Informal strategies and networking with key front-line workers is essential to respond to on-going GBV cases. The consultants observed that in spite of the challenges at decision making level, good strategies of cooperation were developed with those that are on the front line of the institutions.

Men's participation to change things is key, nevertheless, it should be noted that efforts should still be placed on involving women. Interestingly enough, the survey has shown that men are performing better in some of the indicators.

It is important to be realistic and acknowledge the limits of the support you can provide. CARE has placed itself in the centre of service delivery and this is creating high expectations from all actors involved in GBV response and from the survivors, overstretching staff capacities.

8. Conclusions and Recommendations

Main recommendations with regards to the efficiency, grants management:

- For the future phases, the focus should be placed in consolidating the achievements in the villages that have participated in the 2018-2020 phase. This will facilitate shifting from awareness raising to long lasting behavioural change. This aspect should be clearly stated in the call for CSOs implementation.
- Grants to CSOs should be the preferred implementation modality. The timing for implementation of grants should be longer to avoid accumulation of activities, overstretching staff, and to be able to reach villagers that were not involved in the 2018-2020 phase. It is also advisable to avoid the implementation of activities on the farming season.
- Budgets for CSOs grants should review the allocation of resources for current expenses and personnel. In the current phase these budget lines have been a challenge that generated frustration for all sides- CSOs and CARE.
- CSOs need support to develop and consolidate their internal rules. Diverse degrees of development has been observed among them but they all seemed to have weakness in their organisational capacities and management of human resources.
- Budget for further capacity building should be allocated for:
    - CARE staff. Particularly, in the areas of GBV psychosocial support, public speaking (leadership skills to strengthen advocacy capacities) and pedagogy skills to work with civil servants.
    - CSOs training in proposal writing, budget making, reporting and financial management needs to be consolidated and supported by fundraising skills; adding to that, the allocation of resources to facilitate access to computers and computer skills will be needed. Other areas to be improved are leadership and communications skills that will help them gain confidence when working with the communities. It might be a good strategy to focus the trainings on those people who are stable in the organisations (young people fastly move on to better paid jobs) and provide them with Training of trainers (ToT). This, given the level of education, could be challenging but more effective in the long run.
- M&E and reporting processes could be simplified to avoid duplication of work by the field office. By reducing and simplifying the reporting, the person in charge will be able to allocate more of their time to monitoring field visits.

With regards to the work with service providers and institutions:

- Advocacy plans are to be continued, there are great challenges, but achievements even if limited are being obtained.

- Awareness raising and advocacy should target the education system. It was identified that big challenges are faced by survivors to continue with formal education. The consultants acknowledge that individual efforts are being done (mainly the Good Shepard Foundation), but a more structured approach targeting key actors will help better address the challenges. It might be a good area to include in the GBV Coordination Working Group Advocacy Strategy.
- Another area that needs to be tackled is psychosocial support. There are no resources available to support survivors with mental health issues, either due to trauma or due to previous conditions. If feasible, the front-liners should be equipped with skills on how to deal with those cases. All interviewed actors have mentioned this as one of their major handicaps in their service provision.
- It is important for CARE to lower expectations of institutions in their responsibility to respond to GBV. Message should be passed to institutions that CARE facilitates their work but it is not responsible for GBV response.

Activities at community level:

- Activities in the new phase should seek to reach young and adolescents. If needed, the materials or the methodology used should be adjusted to the new audience. One strategy that could work is to provide ToTs to those already involved in the project activities, so they develop skills to pass the message to the younger members of the community.
- Work with Village Administrators and other key community leaders has probed to be very effective and is to be continued. For those involved they could follow a ToTs to gain skills to pass messages to their communities, those that are resistant should be targeted through advocacy and awareness raising.
- Male approach together with Family Talk has been successful and is to be continued and expanded. Women should also be targeted, through awareness raising actions. It has been noted that men in many of the indicators are now performing better than women, and key actors in the GBV response still report high resistance of women to confront and acknowledge GBV behaviours.
- IGAs need further support to develop business plans that will help them have a clearer strategy of growth for the future and could set the basis for their sustainability.

It should be added that when conducting the de-briefing in CARE Yangon office the consultants were made aware that many of the identified challenges have already been addressed in the new project phase, above all those regarding the efficiency of the project. In particular, the reporting system is being simplified, timing for implementation reviewed, support for permanent staff and current expenses for local CSOs is preview and further training will be provided.

9. Annexes

Annex1 – Evaluation Matrix

Criteria	Evaluation Questions	Doc Analysis	CARE	Participants (men and women)	CSOs	Stakeholders
Relevance	Were the underlying project theories and assumptions valid?	X	X	X	X	X
	To what extent does the provision of the planned outputs meet the needs of the project participants?		X	X	X	X
	To what extent is the project relevant to the current and long-term development needs and government priorities of Myanmar?	X				X
	To what extent is the project aligned to the needs of women and men affected by GBV?		X	X	X	X
	Was gender integrated into programmatic goals and objectives?	X				
Efficiency	To what extent is the relationship between inputs and outputs timely, cost-effective and to expected standards?	x	x			
	To what extent did the project successfully adapt to constraints and challenges occurring during the implementation of the project?		X	X	X	
	Is the monitoring & evaluation system in place efficient?	X	X		X	
	Was a gender perspective reflected in the delivery of outputs?		X	X	X	X
	Did the project counted with appropriate human and economic resources to implement the activities? In concrete, the gender components of the project?	X	X		X	
Effectiveness	To what extent has the project achieved its objectives?	X	X	X	X	X
	What are the main factors influencing the achievement and non-achievement of the project objectives?		X	X	X	X
	To what extent have the activities listed in the proposal contributed to		X	X	X	X

	the achievements of the outcomes and outputs?					
	To what extent are community group members satisfied with the results of the project?			X	X	X
	Is gender properly integrated into the log-frame (objectives and indicators)?	X	X			
	Does the project have gender targets measurable by appropriate gender indicators?	X				
	Was gender mainstreamed in job descriptions and project products (studies, reports, etc..?)	X				
	Is the project gender sensitive, responsive or transformative?	X		X		
Impact	What are the unintended positive and negative impacts of the project?		X	X	X	X
	To what extent has the project led to positive support for GBV victims?		X	X	X	X
	What were the benefits for the men and women of the affected communities?		X	X	X	X
	Has the project contributed to long lasting behaviour change in the beneficiaries relating to gender equality and GBV?		X	X	X	X
Sustainability	What are the "drivers" (positive forces) and threats that may affect the sustainability of the observed changes / impacts.		X	X	X	X
	Can the knowledge and skills obtained through the project be maintained over time?		X	X	X	X
	Is the project financially sustainable over time without external financial support?		X	X	X	X
	What is the project stakeholder's level of ownership of the project activities?				X	X
	What is the level of ownership of gender equality achievements?			X	X	X
	What gender norms hindered the project and how they have been addressed?		X	X	X	X

Annex 2 – Questionnaire[14]

CARE INTERNATIONAL'S ENDLINE SURVEY ON GENDER-BASED VIOLENCE IN KAYAH STATE, MYANMAR

ENDLINE SURVEY (2020)

Mingalarba! My name is _____ and I am working with Care Myanmar.

If you don't mind, I would like to ask you some questions about your thoughts about men and women relationships and your attitudes towards violence against women.

This should not take much of your time, and you can choose to stop the interview at any time, or to skip any questions if you like. Your responses are confidential, and your name will not be written down. We will use the information that you provide to plan our activities, and to see how well we are doing in our work.

Are you happy to proceed with the interview? Would it be possible to talk with you in private?
☐Yes ☐No

RESPONDENT AGREES TO BE INTERVIEWED → Proceed to the survey.

RESPONDENT DECLINES TO BE INTERVIEWED → Thank the person, fill out the table below, and go to the next house.

Question Code	
Date	
Interview Name	
Village Name	
Village Tract Name	
Township Name	
Results of the Interview	Result of interview: 4.4550 Completed 4.4551 Respondent not at home 4.4552 Respondent refused 4.4553 House not found/locked/destroyed 4.4554 Others, specify _____

1. Respondent information

Q1	Age	1.---------- 2. Don't Know
Q2	Gender	1. Male 2. Female 99. Other(Specify)……
Q3	Position in HH	1.Household Head 3.HH member 99.Other (Specify)……..
Q4	Who is income earner in your family? (multiple choice)	Husband

[14] Myanmar version in the deliverables package.

		2. Wife 3. Chidren 99.Other (Specify)….....
Q5	Are you involved in Care oriented committee or group?	1.FIG 2. VSLA 3.GBV committee 4. No member (Skip to
Q6	What is your role?	1.Leader 2.Member
Q7	What is your religion? CIRCLE ONLY ONE ANSWER.	1.Buddhism 2.Christianity 3.Dagundaing 4.Hinduism 5.Islam 6.Animist 99.Others, specify……..
Q8	What is your ethnicity? CIRCLE ONLY ONE ANSWER.	1.Kayah 2.Kayin 3.Kayan 4.Kayaw 5.Shan 6.Pa-O 7.Bamar 8.Gaybar 9.Ma Naw 99/Others, specify_____
Q9	What is the highest educational level that you reached?	1.No Schooling 2.Primary school 3.Secondary/Middle school 4.High school 5.College/University 6.Monastic education 99.Others, specify…….
Q10	Marital Status	1.Single 2.Married 3.Seperate/Divorce 4.Widow/Widower 99.Other(Specify)…….

2. Attitude toward GBV

Statements	Agree	Disagree	Don't know	No response
Q11.There are times when a woman deserves to be beaten.	1	2	3	4

Q12.A wife should tolerate being beaten by her husband to keep the family together.	1	2	3	4
Q13.It is natural to beat a wife who refuses to have sex with her husband.	1	2	3	4
Q14.If a suitable groom is found even though a girl is young, she should marry him.	1	2	3	4
Q15.It is wrong to say that a wife is justified in refusing to have sex with her husband/partner when she is tired or not in the mood.	1	2	3	4
Q16.If a wife goes out without telling her husband/partner, he is justified in hitting or beating her.	1	2	3	4
Q17.Women should choose themselves whom they want to marry.	1	2	3	4
Q18.It is better to send a son to school than it is to send a daughter.	1	2	3	4
Q19.If a wife burns the food, it is only proper that her husband/partner discipline her by hitting or beating her.	1	2	3	4
Q20.If a woman was raped, in most cases that means she must have done something to provoke it.	1	2	3	4
Q21.Violence against women is a community concern.	1	2	3	4
Q22.If a man sees another man beating a woman, he should stop it.	1	2	3	4
Q23.Family problems should only be discussed with people in the family.	1	2	3	4

Q24	What does the word “violence” mean to you? *(Do not read the following options. Encircle the number of the respondent‘s answer. Give hints if the respondent does not understand the question and circle the closest response.) CIRCLE ALL THAT APPLY.*	1.Bodily harm inflicted by man on woman 2.Bodily harm inflicted by woman on man 3.Sexual assaults on women and children 4.Psychological harm inflicted by man on woman 5.Psychological harm inflicted by woman on man 6.Early marriage 7.Forced marriage 8.All the above inflicted by parent on girl child 9.All the above inflicted by parent on boy child 10.Socio-economic deprivation of women by men 11.Socio-economic deprivation of men by women 12.Child neglect by parent 13.Spousal sexual deprivation 14.Verbal abuse 15.Others, specify …… 16.Don’t know

Statements	Agree	Disagree	Don't know	No response
Q25.Women in Myanmar have legal rights to protect themselves from violence.	1	2	3	4
Q26.There is a legal punishment for violence against women in Myanmar.	1	2	3	4
Q27.Violence against women is normal in relationships.	1	2	3	4
Q28.Violence against women harms the whole family.	1	2	3	4

Q29	If there is a violence against women in the community, in your opinion, who do people in general seek for help or report to? (Multiple Choice)	1.Parents 2.Relatives 3.Friends 4.Village chief 5.Police 6.NGOs 7.Women's group 8.Religious leader 9.Lawyer 10.Court house 11.Will not report 12.Don't know
Q30	Have you ever helped someone who suffers from GBV?	1.Yes 2.No
Q31	Have you ever referred someone suffering from GBV to any service available in the community?	1.Yes (Continuous ask Q32) 2.No (Q33)
Q32	If yes, to what service?	1.Police 2.Health 3.Women group 4.Ministry of social Development 5.Religious group 6.Community leaders 7.Safehouse 8.Lawyer 9.Court 99.Other(Specify)……..

Q33	What kind of services are available for GBV in your community?	1.Referral services for health 2.Referral service for legal 3.Referral social services (Health/ legal/ material/ food/ drug) 4.Referral services for safety 5.Safehouse 99.Other, (specify)…..
Q34	Have you ever experience any GBV episode personally?	1.Yes (Continuous ask Q35) 2.No (Skip ask Q 37)
Q35	Has anyone supported you when or if you needed assistance / services on GBV in this field?	1.Yes 2.No 3.N/A
Q36	What of the referral services have you used? (multiple answers possible)	1.Referral services for health 2.Referral service for legal 3.Referral social services (Health/ legal/ material/ food/ drug) 4.Referral services for safety 5.Safehouse 99.Other, (specify)…..

Q37.How will you be rating your satisfaction of the services received when you faced with GBV case?

	High	Medium	Low
1.Referral services for health	1	2	3
2.Referral service for legal	1	2	3
3.Referral social services (Health/ legal/ material/ food/ drug)	1	2	3
4.Referral services for safety	1	2	3
5.Safehouse	1	2	3
99.Other, (specify	1	2	3

Q38	Have you heard a leader speak out about domestic violence?	1.Yes (Continuous ask Q38) 2.No (Skip ask Q41)
Q39	If yes, which leader (village tract/ward administrator, ward leader, women's group leader, others, specify)	1. Village tract/ward administrator 2. Ward leader 3. Women's group leader 4. Religious leader 5. Traditional community leader 6.Others,specify……
Q40	How would you value the support of community leaders to persons suffering from GBV?	1.Positive 2.Neutral (they don't care) 3.Negative – no intervention, it's is family business
Q41	Has there been any change in community leaders in the last year	1.Yes 2.No
Q42	Are you currently using any financial service?	1.Yes 2.No
Q43	If yes, which one? (Multiple Choice)	1.Commercial bank 2.Micro-credit institution 3.VSLA 4.Private creditor 5.Family member 6.Trader/Merchant 7.Community Fund 8. Employer 99.Other (specify) ----------
Q44	Are you and your family member an entrepreneurship?	1.Yes (Continues ask Q45) 2.No (Skip ask Q 47)
Q45	What is your average daily income per day? FOR ENTREPRENEURS ONLY	1. 0-1500 i. i. 4.4550-6000 5.6050- 7500 6.Above 7550
Q46	Q46.What was your average daily income per day before entrepreneurship?	1.0- 1500 2.1550- 3000 3.3050- 4500 i. 5.6050-7500 6.Above 7550

Q47	Who do usually decide at home how to use the HH income with regards to mayor purchases (inputs for agriculture, motorbike, TV…)?	1.Men 2.Women 3.Jointly
Q48	Who do usually decide at home how to use the HH income with regards to health and education?	1. Men 2. Women 3. Jointly
Q49	Who do usually decide at home how to use the HH income with regards to daily consumed food?	1. Men 2. Women 3. jointly

Q50.I would like to ask you about all the different foods that your household members have eaten in the last 7 days. Could you please tell me how many days in the past week your household has eaten the following foods?
(for each food, ask what the primary source of each food item eaten that week was, as well as the second main source of food, if any)

Food item	Days eaten in past week (0/7 days)	Sources of foods	
		Primary	Secondary
1. Maize			
2. Rice			
3. Bread/wheat			
4. Tubers			
5. Groundnuts and pulses			
6. Fish (eaten as main food)			
7. Fish powder (only flavor)			
8. Red meat (sheep, goat, beef)			
9. White meat (poultry)			
10. Vegetable oi, fats			
11. Eggs			
12. Milk and dairy products (main food)			
13. Milk and tea in small amounts			
14. Vegetables (including leaves)			
15. Fruit			
16. Sweets and sugar			

Food source codes:

Purchase =1

Own production =2

Traded goods/services, barter =3

Borrowed = 4

Received as gift= 5

Food aid =6

Other (specify) =7

Q51	What practices or techniques do you use in your farming activities?	1.Traditional techniques 2.Good agricultural practices 3.Mix both

Measuring unpaid work: We are interested in your unpaid work: household work, care work and unpaid community work.

Q52	What unpaid work have you done yesterday?	○ I have done none. (go to Q56) ○ I have done the followings(Continuous ask53)
Q53	What did you do? (activities: household, care work, community)	Average hours
Household activities		
	• Cooking	
	• Washing clothes	
	• Cleaning house	
	• Buying household items	
	• Water fetching	
	• Home gardening	
	• Farm animal breeding	
	• Others(specify)	
Care's work (taking care of your children, parents, others' children etc)		
	• Child care (own)	
	• Parents care	
	• Care to other children	
	6.Others(specify)	
	7.Others(specify)	
Community work (attending meeting, voluntary work for community etc)		

	• Attending meeting	
	• Voluntary work for community	
	• Others (specify)	
Q54.	How many hours do you spend on unpaid work in a day?	……..…..hours
Q55.	How many hours do you spend on unpaid work in a week? Note: It may be difficult to ask hours spent per week	……..hours

Question Number	QUESTIONS AND FILTERS	CODING CATEGORIES		
	Please tell me the extent to which you agree or disagree with each statement:	Disagree	Neither agree or disagree	Agree
Q56	Raising the children is only women's responsibility	1	2	3
Q57	Men should participate in raising his children	1	2	3
Q58	Decisions at home should be taken jointly	1	2	3
Q59	If there is a disagreement at home men should have the last word.	1	2	3
Q60	A man when insulted should fight to command respect	1	2	3
Q61	A woman when molested should fight back	1	2	3

If Respondent is a man,finish this interview therefore you must be says Thank You Very Much for your take a time for us.

(Only Women respondents)

Q62	Do you participate in a community decision making body?	1.Yes 2.No
Q63	Are you usually attend in meetings?	1.Yes (Ask to Q64) 2.No (Question End)
Q64	When you talk and express your opinion in meetings do they listen to you?	1.Yes 2.No 3. Don't know

Annex 3 - Quantitative data: villages surveyed

In green those villages that have participated in two phases of the project (2016-18 and 2018-19).

	Township	Village Tract	Village	Organization	Population	Interviews
1	Loikaw	Min Su	Min Su Ward (9,10,11,12)	Min Su (Community Development Center-(CDG)	3345	16
2	Loikaw	Noe Koe	Daw Lo Shay	Min Su (Community Development Center-(CDG)	388	16
3	Loikaw	Pan Kan	Htu Du Ngan Tha	Min Su -(CDG)	721	16
4	Loikaw	Nang Kut	Nang Kut	Min Su (Community Development Center-(CDG)	1891	16
5	Loikaw	Chi Kae	Htay Tha Ma	Min Su (Community Development Center-(CDG)	2473	16
6	Loikaw	Nwa La woe	Nwa La woe san pya	Lan Thit Sa	636	16
7	Loikaw	Nar Nat Taw	Nar Nat Taw (word 15)	Ah Man Thit	391	16
8	Loikaw	Daw Paw Ka Lae'	Htay Nhar Hlyar	Shining Star	1664	16
9	Loikaw	Law Pi Ta	Law Pi Ta	Shining Star		16
10	Loikaw	Nwa La woe	Htay Pa Law Khu	Shining Star	545	16
11	Loikaw	Pan Kan	Daw San Bone	Shining Star	376	16
12	Loikaw	Nayng Yah (Ka)	Nar Nat TawWard (8)	Ah Man Thit	453	16
13	Loikaw	Pankan	Pankan	KWA	1583	16
14	Demoso	Htee Pho kaloe	Phae Lyar	KN WO	615	16
15	Demoso	6 Mile sun Pya	Daw Poe Si	Maw Moh	652	16
16	Demoso	Ngwe Taung	Aung Tha Pya(Village or Ward)	Women Development Center(WDC)	422	16
17	Demoso	Saung Du (Ywa Thit)	Done Ka Mee	Women Development Center(WDC)	572	16
18	Demoso	San Pya Chauk Maing	Zee Phyu Kone	Ka Yaw	390	16
19	Demoso	Daw Ngan Kha	Daw Ngan Kha 4	Ka Yaw	323	16
20	Demoso	Wan Ban Palo	Lwe ka Hti	KBAWD	708	16
21	Demoso	Demoso	Sanpya (6) mile	KWA	2661	32
22	Hpruso	Moso	Moso	KWA	444	16
23	Hpruso	Do Mo Saw	Khar Bae	KWA	364	16
24	Hpruso	kyae Pho Gyi (kay Lyar)	Htee Thae Khu	KPBA	477	16
	Total				22.749	400

Annex 4 – Interview guides

Management Team

1. Who was involved in designing the project? To which extent communities, CBOs, Local authorities have participated in the project design?
2. What staff is involved in the project implementation? What is they background and how do you organise your work in the field?
3. How do you work and communicate with Yangon office?
4. How actual target areas were selected? Please describe the identification process of villages and beneficiaries.
5. Which problems have you encountered with the design of the project and what solutions have been applied?
6. What problems have you encountered in implementing the Work Plan, why? How did you address them?
7. Can you give examples how the project has been flexible in adapting to actual (local) circumstances and constraints?
8. What monitoring system and tools have been used? What field monitoring has been implemented?
9. What problems have you encountered in the budget expenditure (e.g. unspent budget or increase in beneficiaries)? What solutions have been put in place?
10. What practices and innovations have been applied to ensure best cost/quality ration? What synergies have allowed increases in efficiency?
11. What coordination mechanisms (including decision making) have been organized with field staff? how information has been disseminated to/from partners, what benefits and limitation have you encountered?
12. What has been the key challenges encountered in implementation by your organization?
13. How have you addressed these challenges within your organization and with your partners?
14. Looking back at the project design, what changes would you have done in retrospect?
15. What is your experience of the implementation structure, positive and negative aspects?
16. Do you think there have been more difficulties with staff turnover and reassignments than usual, and in that case why?
17. Which are the main factors facilitating and limiting the realisation of the objectives? (internal and external)
18. What would you say has been the main impact of the project for men and women?
19. What would you say has been the main shortfall of the project?
20. Which would you say are the priorities for the second half of the implementation?
21. What can be improved? What is most needed?
22. Could you please evaluate the sustainability of the project?

Field Project Staff

1. How many staff in the field? Men, women? Age group?
2. Please explain your role in the project and job description.
3. What is your background?
4. What capacity building and trainings have been provided to the project staff? Quality?
5. Do you think there are other needs in terms of capacity building?
6. What is your experience in the implementation of the project? (Field work and cooperation with partners)
7. What have been the key challenges? Which are the main factors facilitating and limiting the realization of the objectives? (internal and external)
8. How have you addressed these challenges within your organization and with your partner?
9. What do you think of the work of the WOs? Are there strengths or weaknesses? How do you think challenges can be overcome?
10. Evaluate your work with institutions – Separate response for Health, police and DSW.
11. Level of coordination of the different actors involved in the project (governmental and CSOs)?
12. Any coordination with other development partners?
13. Please evaluate participation of men and women in the activities

14. What would you say has been the main impact of the project?
15. Could you evaluate the impact for men and women? What do you think the project have changed in the dynamics between men and women?
16. To what degree do you think you have addressed population needs with regards to GBV prevention and response?
17. What would you say has been the main shortfall of the project?
18. Do you think that the activities in the project promote long lasting change of behaviour?
19. Will there be sustainable after the project ends?
20. Looking back at the project design, what changes would you have done in retrospect?
21. What would you see as the main priorities if the project was to have a new phase?

CSOs/ Women's Organisations

1. Have you participated in the design of the project? How?
2. What is your organization's main area of work?
3. What is your involvement in the project?
4. Have you attended trainings?
5. Which trainings have been the most useful? How have you used these trainings in your work?
6. How has the project supported the organisation? What has it changed after the project?
7. What kind of services are you providing for men and women?
8. What are the main challenges your organisation faces?
9. What has been the impact of the project for men and women? Do you think the project has changed dynamics between men and women?
10. Do you think the project has improved support for GBV victims?
11. Have you used the referral system? Have there been any challenges?
12. Have you been working with male activists? What are the main challenges?
13. Have you been working with VSLAs? What are the main challenges?
14. Do you have an advocacy strategy? What have you done so far?
15. How is your organisation's communication and collaboration with state actors (police, health department etc.)? What are the main challenges?
16. How is your organisation's communication and collaboration with the community? What are the main challenges?
17. How has your organisation's communication and collaboration with CARE been? What are the main challenges?
18. Do you have any other source of funding?
19. How can CARE further support you?

Safe house

1. Have you participated in the design of the project? How?
2. What was your involvement in the project?
3. Have you attended trainings?
4. Which trainings have been the most useful? How have you used these trainings in your work?
5. How has the project supported the organisation? Is your capacity better than before?
6. Do you have any protocol of intervention in place? How does it work?
7. Has the number of referrals to your safe-house changed?
8. Do you notice any difference since the project started in 2016?
9. Do you think the community is aware of the support available for GVB victims?
10. Have you used the referral system? What are the main challenges?
11. Have your received any new equipment and supplies for your work?
12. How is your organisation's communication and collaboration with state actors (police, health department etc)? What are the main challenges?
13. How is your organisation's communication and collaboration with the community? What are the main challenges?
14. How has your organisation's communication and collaboration with CARE been? What are the main challenges? What are the main challenges your organisation faces?
15. What are your priorities for the future? For the safe-house and in general on GBV?

Male village member

1. Age? Position? Single/ Married
2. Did you attend any project activities and trainings? Which ones?
3. What did you learn?
4. What did you change at home?
5. Do you think the project has changed any dynamics between men and women in your community? Which one?
6. Have you been engaged with male activists in your village?
7. If someone asks you for advice regarding a GBV case what would you do?
8. Do you know what services are available for GBV in your community?
9. Do you think GBV is a problem in your community? Why?
10. What support do you need? Who could provide it?
11. Are the services (police, health department, DSW) responding to GBV in your village? What are the main challenges?
12. What did you like about the project?
13. What do you think are the main priorities on GBV for the community? For men? For women?

Female village member

1. Age? Position? Single/ Married
2. Did you attend any project activities and trainings? Which ones?
3. What did you learn? Have you used what you have learned in your everyday life?
4. What did you change at home?
5. Do you think the project has changed any dynamics between men and women in your community? Which one?
6. If there is a case of GBV in your family what would you do?
7. Do you know what services are available for GBV in your community?
8. Has you used them? If yes, ask her how has the experience been.
9. Have you been engaged in activities with VSLA? If yes ask how and in what capacity.
10. Do you think GBV is a problem in your community? Why?
11. What support do you need? Who could provide it?
12. Are the services (police, health department, DSW) responding to GBV in your village? What are the main challenges?
13. What did you like about the project?
14. What do you think are the main priorities on GBV for the community? For men? For women?

GBV survivor

1. Age? Position? Single/ Married
2. What do you know about the project?
3. Did you attend any project activities and trainings?
4. Which trainings have been the most useful for you?
5. Could you explain where did you go for assistance when you were in trouble?
6. Do you know what services are available in your community?
7. How was the support you were given? Ask about police, health, social and legal advice.
8. Have you been engaged in activities with VSLA? How does it work?
9. Have you received support?
10. What do you think is most needed to support women facing the same challenges as you?

Religious leader / village administrator

1. What do you know about the project?
2. Is GBV a problem in your community? Explain
3. Did you attend any project activities and trainings?
4. What did you learn?
5. Do you often come across GBV cases?
6. How do you handle them?
7. Do you know what services are available for people suffering from GBV?
8. Do you know of the referral systems available to GBV victims?
9. Please evaluate the services available to GBV survivors.

10. Do you think the project has been useful, what is the best? Any weakness?
11. What in your opinion is most needed in your community?

Department of Social Welfare

1. What do you know about the project?
2. Have you participated in the design of the project? How?
3. What is your organization's main area of work?
4. What was your involvement in the project?
5. Have you attended trainings?
6. Which trainings have been the most useful? How have you used these trainings in your work?
7. What are the main challenges your organisation faces?
8. How has the project supported the organisation? Is your capacity better than before?
9. Has your procedure to respond to a GBV case changed?
10. What are your thoughts on the referral pathway? What are the main challenges?
11. How is your organisation's communication and collaboration with other state actors (police, health department etc)? What are the main challenges?
12. How is your organisation's communication and collaboration with the community? What are the main challenges?
13. How is your organisation's communication and collaboration with CSOs? What are the main challenges?
14. How do you coordinate with other actors? What are the main challenges? Do you have a commo action plan?
15. How has your organisation's communication and collaboration with CARE been? What are the main challenges?
16. What do you think are the priorities in the near future?

Medical social departments and midwifes

1. What do you know about the project?
2. Have you participated in the design of the project? How?
3. What is your organization's main work in relation to GBV?
4. What was your involvement in the project?
5. Have you attended trainings?
6. Which trainings have been the most useful? How have you used these trainings in your work?
7. How has the project supported the organisation? Is your capacity better than before?
8. Has your procedure to respond to a GBV case changed? Do you have standard Operations procedures?
9. What are your thoughts on the referral pathway? What are the main challenges?
10. How is your organisation's communication and collaboration with other state actors (police, DSW etc.)? What are the main challenges?
11. How is your organisation's communication and collaboration with the community? What are the main challenges?
12. How do you coordinate with other actors? What are the main challenges? Do you have a common action plan?
13. How has your organisation's communication and collaboration with CARE been? What are the main challenges?
14. What are the main challenges your organisation faces?
15. What do you think are the priorities in the near future?

Law home

1. What is your organization's main area of work?
2. What do you know about the project?
3. Have you participated in the design of the project? How?
4. What was your involvement in the project?
5. Have you attended trainings?
6. Which trainings have been the most useful? How have you used these trainings in your work?
7. Has your procedure to respond to a GBV case changed?

8. What are your thoughts on the project's legal awareness training? What are the main challenges?
9. How is your organisation's communication and collaboration with CSOs? What are the main challenges?
10. How is your organisation's communication and collaboration with state actors (police, health department etc)? What are the main challenges?
11. How is your organisation's communication and collaboration with the community? What are the main challenges?
12. How do you coordinate with other actors? What are the main challenges? Do you have a commo action plan?
13. How has your organisation's communication and collaboration with CARE been? What are the main challenges?
14. What are the main challenges your organisation faces?
15. What do you think are the priorities in the near future?

Police

1. What do you know about the project?
2. Have you participated in the design of the project? How?
3. What is your organization's main work in relation to GBV?
4. What was your involvement in the project?
5. Have you attended trainings?
6. Which trainings have been the most useful? How have you used these trainings in your work?
7. How has the project supported the organisation? Is your capacity better than before?
8. Has your procedure to respond to a GBV case changed? Do you have standard Operations procedures?
9. What are your thoughts on the referral pathway? What are the main challenges?
10. Have you noticed a difference in reporting of GBV cases since the implementation of the project?
11. How is your organisation's communication and collaboration with other state actors (police, DSW etc.)?
12. How do you coordinate with other actors? What are the main challenges? Do you have a common action plan?
13. How is your organisation's communication and collaboration with the community? What are the main challenges?
14. How has your organisation's communication and collaboration with CARE been? What are the main challenges?
15. What are the main challenges your organisation faces?
16. What do you think are the priorities in the near future?

VSLAs

1. What is your role/objective?
2. When were you formed?
3. Explain who is leading, who are members, how it works.
4. Do you have written rules and procedures?
5. Have you received any trainings? Please evaluate.
6. Which trainings have been the most useful?
7. Who are they lending for what purposes? Ask for a register of loans and reimbursements process.
8. Is GBV a problem in your community?
9. What do people usually do when there is a GBV case?
10. What is your role with regards to GBV.
11. What did you learn from the project?
12. Do you know what services are available in the community? Please evaluate.
13. What are the priorities for the future.

Annex 5 – List of Informants FGDs and KIIs per township

FGDs			
Stakeholders	Loikaw	Demoso	Hpruso
CARE team	x		
Male group	x	x	
KSNW, WO	x	x	
VSLAs	x	x	
Project Participants	x	x	
DSW	x		

KIIs			
Stakeholders	Loikaw	Demoso	Hpruso
Police	x		x
Community Leaders (village administrator, village leader)	x	x	x
GBV Survivor	x	x	x
Project Participants			x
Health Department	x	x	
Male activists and group		x	
Safe house (x 2)	x		
GBV Working Group			
Lawyer	x		
WOs	x	x	

Annex 6 – Interview schedule / agenda

Date	Township	9-10:30	10:30 – 12:00		13:00-14:30	14:30-16:00
16/02/2020	Loikaw	Meeting with CARE Kayah team				
17/02/2020	Hpruso	KIIs Police	KIIs Key community leader		KIIs GBV survivor	
	Demoso	KIIs Male Activist	KIIs x2 GBV survivors	KIIs DSW	KIIs Village Tract leader	KIIs Health care nurse
18/02/2020	Hpruso	FGD Project participants			FGD Male village group	
	Demoso	FGD Male peer group & activist	FGD Women Organisations		FGD VSLA (6 villages)	FGD Project Participants (Family Talk)
19/02/2020	Loikaw-	KIIs Women Organisation	KIIS DSW		KIIs GBV Working Group member- Min Su	KIIs Safe-house (DSW)
	Loikaw	KIIs Safehouse (Good Shepard Myanmar Foundation)	KIIs State Health Department Representative	KIIs CARE Staff – VSLA & income generating activities Officer	KIIs GBV Working Group member – KSNW	KIIs Legal Representative
20/02/2020	Loikaw	KIIs GBV Survivor	KIIs Village Administrator		FGD Male village group	
	Loikaw	KIIs Police	FGD Project Participants (Family Talk)		FGD Women Organisation	FGD VSLA
21/02/2020	Loikaw	CARE Kayah team	CARE Staff – M&E Officer	CARE Staff- Advocacy Officer	CARE Kayah team debrief	