End of the Project Evaluation

Strengthening Approaches for Improved Maternal, Neonatal and Reproductive Health in Myanmar: Lashio Township, Northern Shan State, Myanmar

January 8, 2021

Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
AMW	Auxiliary midwife
ANC	Ante-natal care
CHW	Community health worker
GBV	Gender based violence
GSK	GlaxoSmithKline
HIV	Human Immunodeficiency Virus
MW	Midwife
PNC	Post-natal care
RHC	Rural health center
SRMH	Sexual Reproductive and Maternal Health
STI	Sexually transmitted infection
TB	Tuberculosis
VHC	Village health committee

Executive Summary

GSK and CARE Myanmar have been working together in the country since 2012 to provide better health services. The project was expanded from 45 villages to 60 villages in northern Shan State, based on successes and lessons learned in 2012-2015. The project goal is to contribute to the reduction of maternal and neonatal mortality through increased access to, and quality of, sexual and reproductive health, and maternal and child health services.

The overall objectives of the end of project evaluation is:

1. To determine the project achieve its objectives and outcomes and

2. To identify intended and unintended outcomes, best practices, lessons learned and recommendations to improve future programming in terms of sustainability.

Cross-sectional study design using mixed method of desk review, quantitative data collection and qualitative data collection methods was used. A total of 252 women and 125 men participated in quantitative interviews and 39 key informant interviews were conducted with staffs, volunteers and health staffs.

Main findings were as follows:

Safe delivery: Delivery by skilled birth attendants in evaluation was 65.2% which overshoot the target of 20% increase from mid-term. Most of the participants from qualitative interview also responded the pregnant women delivered with AMW, MW or doctors, and mostly at health centers and hospitals.

Emergency referral: More than 90% of women who need emergency obstetric care received emergency referral service. Emergency referral fund played a significant role in receiving referral services, as reported by the qualitative interviews.

Ante-natal care (ANC): Most of the pregnant women received at least one ANC, reported as 84.3% in evaluation and overshoot the target of 20% increased from baseline. More than half (51.5%) reported receiving 4 or more time of ANC during last pregnancy. Qualitative findings also supported as women received ANC mostly from the auxiliary midwives (AMW) from their villages.

Post-natal care (PNC): Women reported receiving post-natal care within three days of delivery was 78.9% which was more than double in compare with baseline. AMW and volunteers at village level provided PNC as reported from qualitative findings.

Child disease prevalence: Disease prevalence of under one and five year old children was decreased and about one third of the children got illness. The children illness were taken care firstly by the AMW with referral to health centers and hospitals for severe cases, as reported by AMW and mother group interviews.

Family planning: Men perception on family planning was changed as health education sessions were provided to both men and women. The use of contraceptive methods was increase at the time of evaluation which were overshoot the target, 54.1% in men and 61.4% in women. Women decision making regarding family planning was also increased to 81.2% in evaluation which was 47.8% in baseline.

Child Immunization: More than 90% of the mothers reported their last child had immunization in evaluation, which was 31% increment in compare with baseline. The qualitative findings also agree with the increase in immunization service for children due to more support from AMW, and MW visit to villages as well as community acceptance for immunization increase.

HIV and STI testing: HIV and STI testing among men was increased in compared with baseline in both men and women. Nearly 60% of pregnant women received voluntary confidential counselling and testing for HIV.

Breast feeding: Breast feeding immediate or within half hour after delivery was reported as 88.9% in evaluation with was twice the percentage of baseline. The midwives and volunteer also supported that finding in interview and they said most of the delivery are with health care providers and it was also told by the government health staffs.

Knowledge about complication of pregnancy: About three fourth of men and women have the knowledge about complication of pregnancy and women had the higher percentage of knowledge, reported as 72.0% and 75.8% in men and women respectively.

Knowledge about HIV: Men reported the higher percentage of awareness of ways of preventing HIV. Among age group, 14-30 year-old age group showed higher percentage of knowledge. Interview with youth group members also reported they have received HIV and SRHR health education messages from Care Myanmar.

SRMH and GBV related positive behavior change among men: Most of the male and female participants reported that there was increase in - men involvement in development of birth plan (95.2%), support their pregnant wife to eat balance diet (91.2%), support their pregnant wife to seek health care 994.4%), help in household chores for the pregnant wife (96.8%), attend health education sessions regarding SMRH and GBV (87.2%). The qualitative findings also supported that there was an increase in men involvement in helping their pregnant wife to seek health care and helping at home.

The following table demonstrates the changes in the percentage of outcome indicator values in baseline, midterm and final evaluation.

Table 1 Indicator values of baseline, midterm and evaluation

	Target	Baseline %	Mid-term %	Evaluation %	Meet Target
Objective 1: To strengthen the quality and sustainability of frontline health services					
% women report last delivery by Skilled Birth Attendant (i.e. Doctor, MW, HA, LHV, Nurse	20% increase	24.80%	48.00%	65.24%	Yes
% women in need of emergency obstetric care receive emergency referral	80%	66.70%	76.00%	93.30%	Yes
% pregnant women receiving ≥1 Antenatal Care (ANC) visit	20% increase	49.60%	85.00%	84.3%	Yes
% pregnant women receiving ≥4 Antenatal Care (ANC) visit	10% increase	16.40%	33.40%	51.47%	Yes
% mother and newborn receiving Post Natal Care (PNC) visit within three days of delivery	20% increase	34.50%	71.80%	78.66%	
% women reporting experience of abortion	10% decrease	18.20%	22.20%	17.46%	
% women receiving post abortion care and counselling after abortion	50% of abortion cases	12.20%	35.30%	65.91%	Yes
Disease prevalence of children under one year of age	20% decrease	13.70%	46.70%	29.03%	

Disease prevalence of children under five years of age	20% decrease	62.40%	58.40%	37.08%	Yes
% of men reported using modern contraceptive methods	20% increase	12.00%	42.40%	54.08%	Yes
% of women reported using modern contraceptive methods	20% increase	21.20%		61.4%	Yes
Objective 2: To enhance the effectiveness of the health system for maternal, new-born and child health					
% of women reported their last child received immunization	NA	62%	93%	93%	
% of measles immunization coverage	5% increase	NA		64.0%	
% of polio immunization coverage	80% coverage	NA		66.70%	
% men receiving Voluntary Confidential Counselling and Testing for HIV	NA	8.7%	12.8%	24.80%	
% men receiving testing for STI	NA	0.0%	31.6%	20.80%	
% women receiving Voluntary Confidential Counselling and Testing for HIV	NA	6.3%	19.7%	38.00%	
% women receiving testing for STI	NA	1.8%	33.6%	23.40%	
% pregnant women receiving Voluntary Confidential Counselling and Testing for HIV	20% increase	NA		59.05%	
Objective 3: To mobilize communities to adopt health services-seeking and health-enabling behavior					
% mothers practicing early initiated breastfeeding (i.e. immediately)	80%	44.60%	38.00%	88.94%	Yes
% men have knowledge to recognize ≥3 complications of pregnancy	80%		9.20%	72.00%	
% women have knowledge to recognize ≥3 complications of pregnancy	80%	2.70%	35.10%	75.80%	
% of youth (14-30) men demonstrate increase awareness of correctly identify ways of preventing HIV	30% increase	NA	NA	80.6%	
% of youth (14-30) women demonstrate increase awareness of correctly identify ways of preventing HIV	30% increase	NA	NA	67.1%	
% men who can correctly identify ≥2 ways of preventing HIV	NA	10.70%	23.30%	71.2%	
% women who can correctly identify ≥2 ways of preventing HIV	NA	2.20%	16.40%	63.50%	

% women reporting improved decision making regarding family planning (i.e. decided alone or decided together with husband)	20% increase	47.80%	69.30%	81.75%	Yes
% increase in positive behavior change among men regarding SRMH and GBV	NA	NA		88.10%	
% of men improve understanding causes of harmful SRHM behaviors and key vulnerabilities	NA	NA		98.50%	
% of women reporting their husbands participating in SRMH activities	NA	NA		74.50%	
% of women reporting men engaged on health-enabling masculinities	NA	NA		72.92%	

The best practices of the project were documented as follows:

- AMW midwives have played a role in providing villagers with frontline health care, especially mothers and children. Capacity-building support and logistical supply support to the AMW, such as basic drugs, have become investments for village health.
- Emergency delivery and under 5 year old child illness can have the support of money from the emergency referral fund, which was a crucial help for mothers and children in the emergency situation and saved lives.
- Staff from Care Myanmar have held regular coordination meetings with government health staff. Mobile clinic activities were enhanced in terms of frequency and area.
- In every step of the implementation of the GSK project, Care Myanmar staff have informed the community. Consultations were conducted by the Community for activities.
- Care Myanmar trained the village saving and loan group on basic accounting. The members of the group said they had learned how to save money.

The following lesson learnt were identified.

- In the targeted villages, youth target groups were not available because most of them had migrated. The project has changed the strategy for reaching young people by collaboration with the school health program.
- Audio-visual techniques and devices such as the use of the projector and role-playing sessions were used during the health education sessions to better understand and pay much more attention to project staff members.
- It was challenging to have proper understanding during the limited training days due to the low literacy level of targeted communities. Flipcharts, local dialogue, posters and group discussion were used during the training made people more interesting.
- Bookkeeping is an important skill in a saving group. Regular bookkeeping monitoring enhances skills.

The following activities are recommend for the further improvement of the similar projects.

- To apply the good practices in other similar projects in the different area with adaptation to the local context.

- Management capacity building of volunteer groups in term of financial management, planning, leadership, coordination and communication with different organizations.
- To provide refresher training to volunteers especially to AMW and village health volunteers to provide up to date information and refresh the knowledge.
- To develop a capacity building plan for project staffs by identifying the training package for the new staffs and refresher training package for the old staffs.
- To provide safe migration message to youth groups to prevent the human trafficking, HIV and STI among migrant youths.

Introduction

Project Background

Since 2011 the Government of Myanmar has acted to implement democratic political reforms, encourage economic liberalization and negotiate an end to long-standing ethnic conflict. More than three quarters of births in Myanmar take place at home. Contraceptive prevalence for modern methods has not increased significantly since 2001. Persistent health disparities among States and Regions.

GSK and CARE Myanmar have been working together in the country since 2012 to provide better health services. The project was expanded from 45 villages to 60 villages in northern Shan State, based on successes and lessons learned in 2012-2015. New and innovative tools and approaches were introduced in the project, such as changing health behaviors and practices, addressing the issue of retaining Community Health Workers (CHWs); improving health surveillance and reporting; improving government responsiveness; and better documenting successful advocacy approaches to influence government policy and practice. The objective of the program is to contribute to reducing maternal and neonatal mortality by increasing access to and quality of, services in the areas of sexual and reproductive health, maternal and child health. The mobilization of communities to adopt health service seeking and health-enabling behavior will be a clear focus.

The target villages of the project are the most remote areas that lack access to health services, and ethnicity is a stigma and a barrier. The difficulty of the Department of Health (DOH) reaching this location was a specific reason for choosing this location.

Scope

Project goal and objectives

Project Goal: To contribute to the reduction of maternal and neonatal mortality through increased access to, and quality of, sexual and reproductive health, and maternal and child health services.

Project Objectives:

1. To strengthen the quality and sustainability of frontline health services;
2. To enhance the effectiveness of the health system for maternal, new-born and child health; and,
3. To mobilize communities to adopt health services-seeking and health-enabling behavior.

ANTICIPATED OUTCOMES

- 20% increase in the number of babies delivered by Skilled Birth Attendants (AMWs or MWs);
- 80% of women who need emergency obstetric care receive emergency referral and care;
- 20% increase in the number of pregnant women receiving at least one ANC visit and 10% increase in receiving recommended four ANC visits from AMWs/MWs;
- 20% increase in the number of mothers and babies receiving least one PNC visit within 3 days of delivery;
- 10% reduction in the number of abortions and 50% of women undergoing abortion receive post-abortion care and counselling;
- 80% of mothers practice early-initiated breast feeding;
- 5% increase in measles immunization coverage.

- 80% of reproductive-age men and women have knowledge to recognize at least three indications of complications in pregnancy.
- 20% increase in the number of pregnant women receiving Voluntary Confidential Counselling and Testing for HIV and STI.
- 30% increase in the number of youth who can correctly identified ways of preventing HIV.
- 20% increase in the number of GBV cases reported and referred for assistance services.
- 50% increase in men's knowledge of SRMH and GBV.
- Number of men engaged on health-enabling masculinities (target to be determined).
- 20% increase in positive behavior change among men regarding SRMH and GBV.
- 20% increase in the number of couples using modern contraceptive method.
- 20% reduction in diseases prevalence among children in the under-five age category.
- 20% reduction in diseases prevalence among children in the under one age category.
- 20% increase in the number of women reporting improved decision-making regarding family planning.

Objective of the Final Evaluation

The overall objectives of the end of project evaluation is:

1. To determine the project achieve its objectives and outcomes

2. To identify intended and unintended outcomes, best practices, lessons learned and recommendations to improve future programming in terms of sustainability.

The evaluation focused on the following:

Relevance: The extent to which the project suited the priorities of the target groups

Effectiveness: The extent to which the project achieved its objectives

Efficiency: The extent to which project was managed to get value for money from inputs of funds, staff and other resources

Impact: The extent to what lasting and significant changes have occurred and what the particular project's contribution to these changes, the positive and negative, including unexpected impacts

Sustainability: To assess whether the benefits of the project are likely to continue after the project ends.

Methodology

Cross-sectional study design using mixed method of desk review, quantitative data collection and qualitative data collection methods was used. The following activities were conducted during the preparatory phase: desk review, work plan preparation, finalization of sample and tools, and inception report. The same methodology as baseline assessment and mid-term evaluation were used.

Review of the secondary information/desk review

The project log frame, monitoring and evaluation framework, proposal documents, periodic achievements, and progress of the project were reviewed thorough available project documents. The secondary data review of the baseline report and mid-term evaluation reports were also conducted. Research on causes and consequences of Young Parent's sexual, reproductive and maternal health behaviors, Northern Shan State, Myanmar report was reviewed.

The following reference documents were reviewed:

- Myanmar Demographic and Health Survey (2015-2016)
- Lashio Township Report, Department of Population, Ministry of Labor, Immigration and Population, October 2017
- Five-year Strategic Plan for Reproductive Health (2014-2018), Ministry of Health and Sport, Myanmar.
- National Strategic Plan for Newborn and Child health Development (2015-2018), Ministry of Health and Sport, Myanmar

Primary data collection

Cross-sectional quasi-experimental study design with quantitative and qualitative data collection methods was used.

Quantitative data collection

A cross-sectional survey of face to face interviews with household members using structured questionnaires was conducted. The structured questionnaire explored the topics related to the project log frame indicators. Questionnaire used during the baseline assessment and mid-term review were reviewed and amended as necessary in order to response the questions for relevance of the project. KOBO toolbox was used for the quantitative data collection.

Sampling

Sample size was calculated based on 95% confidence level and margin of error of 8 for female and 12 for male from the total of target population of 6,943 women and 6,712 men from 60 target villages. Clustered random sampling method, probability proportionate to size was applied for the villages. The number of clusters to be used in the evaluation is 20 cluster which is the recommended number for the cluster sampling method, and moreover, the situations of current pandemic was also considered. In baseline, samples were took from 30 villages and in mid-term evaluation, 30 clusters were used to select samples.

Sample size was calculated according the following formula.

$$Sample\ Size = \frac{\frac{z^2 \times p(1-p)}{e^2}}{1+(\frac{z^2 \times p(1-p)}{e^2 N})}$$

N=Total Population Size of 60 villages – women = 6,943, men = 6,712

Z=Confidence Level – 95%

e=Margin of Error – 8% for women; 12% for men

Standard Deviation = (p) =50% =0.5

Sample Size – 147 for women; 66 for men

Design effect – 1.5 x 147 = 221 women, 1.5 x 66 = 99 for men

Total of 320 male and female samples will be needed in evaluation from 20 clusters. Therefore, for each cluster, 12 women and 6 men need to be interviewed. In order to compensate the non-response rate and better results for statistical tests, 252 women and 125 men were interviewed.

Households from the villages were selected through road walk method. Starting from the prominent land mark or house of village leader, the survey team walked to the right and count the numbers. When the first 10th household is reached, the supervisor asked whether respondents with inclusion criteria are available to participate the evaluation or not. If the respondents were not present, not free, refuse, or vacant households were skipped and the household that exit right to the selected household was asked. If both male and female respondents were present in the same household, both persons were interviewed, and if not the survey team took the walk to get the planned number of respondents per cluster.

The inclusion criteria for the interviews was –

- Women who are 14-40 years old and married.
- Men who are 14-40 years old and married.

The exclusion criteria for the interviews was -

- Vacant households
- Persons who refuse to partake in the study

Data Management

Quantitative data collection was conducted through KOBO software, using tablets. Logic and skip pattern were included in the data entry platform. Supervisors checked the cases and questions through the KOBO platform in a supervisor role. Data quality checkers from Yangon checked the data from the KOBO software at the same time and provided the feedback to the field team daily. The consultant performed the data analysis using excel analysis.

Qualitative data collection

Key informant interviews were conducted. FGDs were planned to conduct but according to the travel restriction, the consultant team could not travel and conduct FGD. Therefore the consultant and assistant consultant conducted the KII through the phone according to the appointed schedule. For 2 respondents, who did not speak Myanmar language, Shan language translator from the Lashio Township assisted the consultant to conduct the interview. The coding and analysis of KII findings were conducted by using the N Vivo software version 12. The following table showed the number of qualitative interviews conducted in the final evaluation.

Table 2 Qualitative interview

No	Respondent type	Plan B (The consultant could not travel, data collection took place through phone)		Disaggregation
		FGD or KII	Number	
1	Township Health Department	KII	1	None
2	Rural Health Center	KII	1	None
3	Village Health Committee (VHC) leaders	KII	3	By implementation status
3	Auxiliary Mid Wife (AMW)	KII	6	By RHC
4	VHV	KII	5	By RHC
5	Mother group	KII	6	By implementation status
5	Village Saving and Loan Group (VSLG)	KII	6	By implementation status
6	Youth Groups	KII	5	By implementation status
7	Project Staffs	KII	6	None
	Total		39	

Challenges

As data collection was conducted at the time of Covid 19 pandemic restrictions, and also reinforced by the fear of community to the outsiders, some of the villages selected in the samples were not allowed to conduct the evaluation. Reselection of village samples was taken.

At the village level, some of the community members' fear of participating in interview (afraid of transmission of Covid 19), the village leaders and staffs member have to explain thoroughly to get the permission. In some villages, actual sampling method of road walk was not done and participants were selected randomly as per the inclusion criteria.

Consultant travel was restricted due to pandemic and the actual plan of evaluation was postponed for one month to wait for the clearance of restrictions. However, the restrictions were still present so that FGD from the qualitative data collection were replaced with KII. The field team training was replaced with virtual training.

Approach to ethical and child safeguarding

All of the evaluation team members were trained about informed consent and confidentiality as part of the training. All of the respondents were explained about project, their voluntary participation, confidentiality requested to sign the informed consent. If the respondents were younger than 18 year old, informed consent were sought from both respondents and their caregivers. Ensuring confidentiality and privacy during the interview were also considered as important issues.

Findings and analysis

Accessing Project's effectiveness through Impact and Outcomes

Objective 1. To strengthen the quality and sustainability of frontline health services

% increase in the number of babies delivered by Skilled Birth Attendants (AMWs or MWs) - APPROXIMATELY 20%

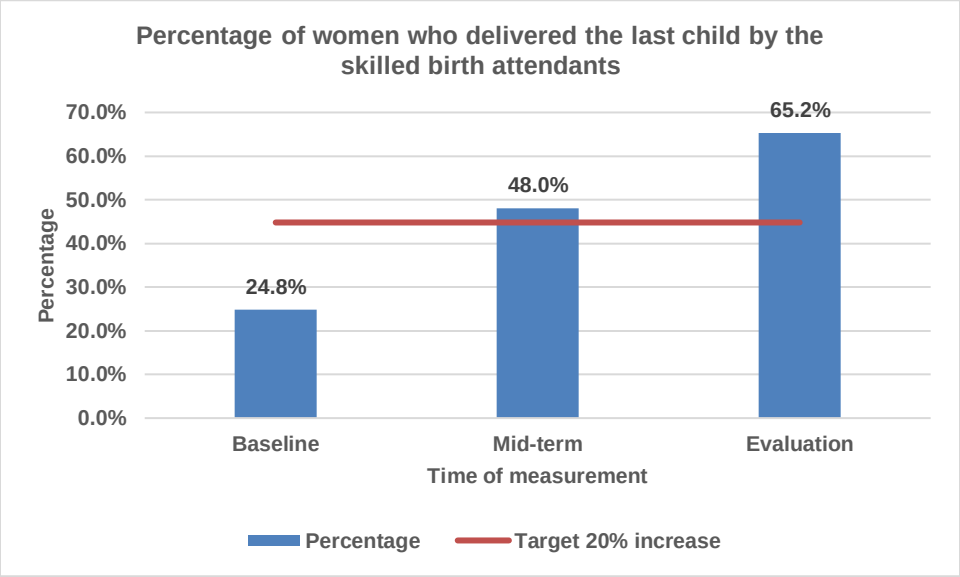

Figure 1: Percentage of women who delivered the last child by the skilled birth attendants

Figure 1 showed the comparison between baselines, mid-term and final evaluation on the number of babies delivered by skilled birth attendants (AMWs or MWs). The figure indicated that around 40% increase in final evaluation comparing with the baseline evaluation and 17% increase than mid-term evaluation. The final evaluation results showed that it is double the targeted program increment shown in Figure 1 with the red line which means the number of babies delivered by skilled birth attendants (AMWs or MWs) are increased a lot than the baseline evaluation.

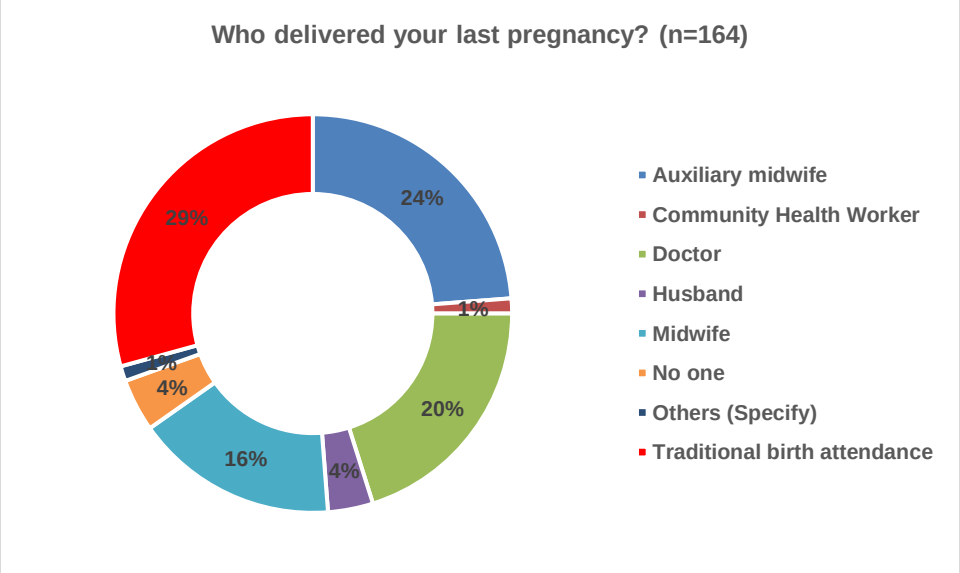

Figure 2: Who delivered your last pregnancy?

As shown in Figure 2, 60% of the respondents from evaluation responded that their last pregnancies were delivered by the Auxiliary midwife, Doctor and Midwife. 29% of the respondents were delivered their last pregnancies with traditional attendance and very few respondents were delivered their last pregnancies with husband (4%) and community health worker (1%) according to Figure 2.

Qualitative findings

Most of the respondents from the qualitative study said the pregnant women went to health center for the delivery. The role of AMW are different, deliver the pregnant women by herself to assisting the pregnant women to go to rural health centers. Most of the pregnant women delivered at clinics and hospital and a few respondents said home delivery with AMW and traditional birth attendants. Members of village health committee and mother group also reported that they also assist the pregnant women to go to the clinics or hospitals for delivery.

% of women who need emergency obstetric care receive emergency referral and care - approximately 80%

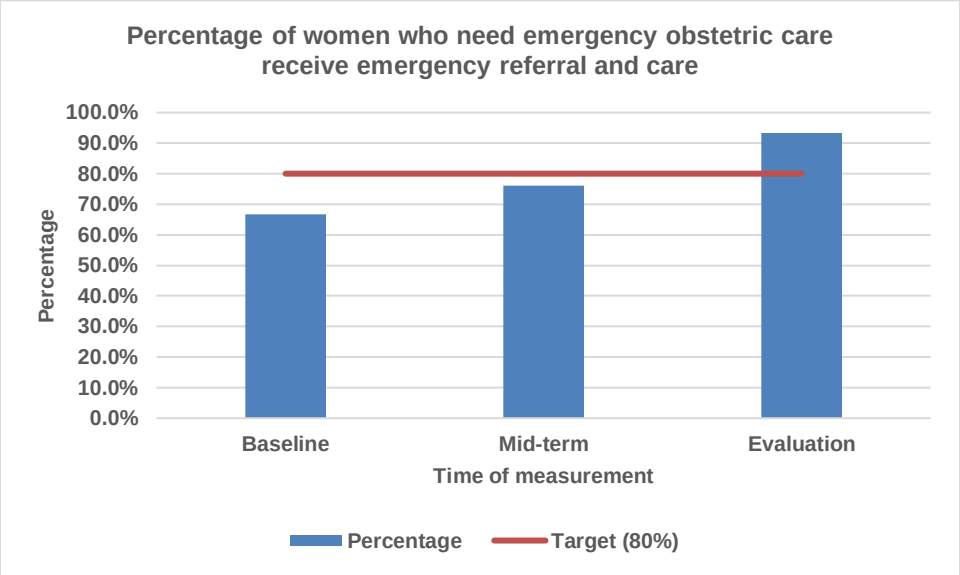

Figure 3: *Percentage of women who need emergency obstetric care receive emergency referral and care*

In Figure 3, the program targeted to reach 80% of women who need emergency obstetric care receive emergency referral and care. The final evaluation results showed that over 90% of women received emergency referral and care which was over 10% higher than the program target. However, the study found that 2 cases did not receive emergency referral because the services are far from home and the service provider is not known.

Qualitative finding

All of the AMW, mother group members, village health committee members and village health volunteers said that if women faced the difficulty during the delivery, they assist the women to go the rural health centers or hospital. The community members from the village also helped in referral cases. In the villages where cars are available, the pregnant women were sent by the car, and in some cases motor cycles were used. The rental fees for the car during the emergency referral cases was supported by the village emergency referral fund. The health staff from rural health center also reported that in case of emergency, Care Myanmar assisted the travel of pregnant women to come to the rural health center.

% increase in the number of pregnant women receiving at least one ANC visit – approximately 20% increase

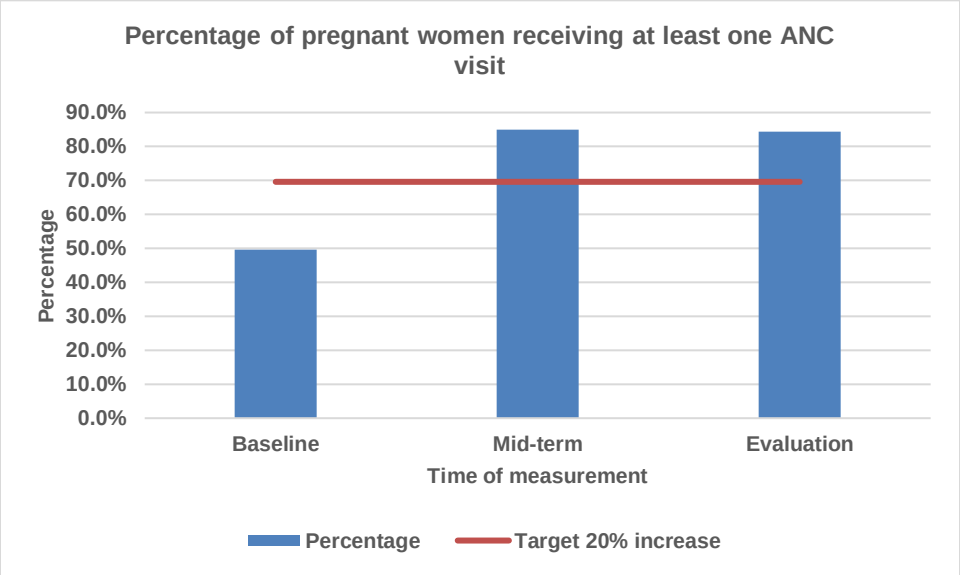

Figure 4: Percentage of pregnant women receiving at least one ANC visit

Figure 4 showed the comparison between baselines, mid-term and final evaluation on the pregnant women receiving at least one ANC visit together with program target. The results showed that it is over 10% higher than the program target and the final evaluation was over 30% higher than the baseline evaluation even there were no differences between mid-term and final evaluation.

% increase in receiving recommended four ANC visits from AMWs/MWs – approximately 10%

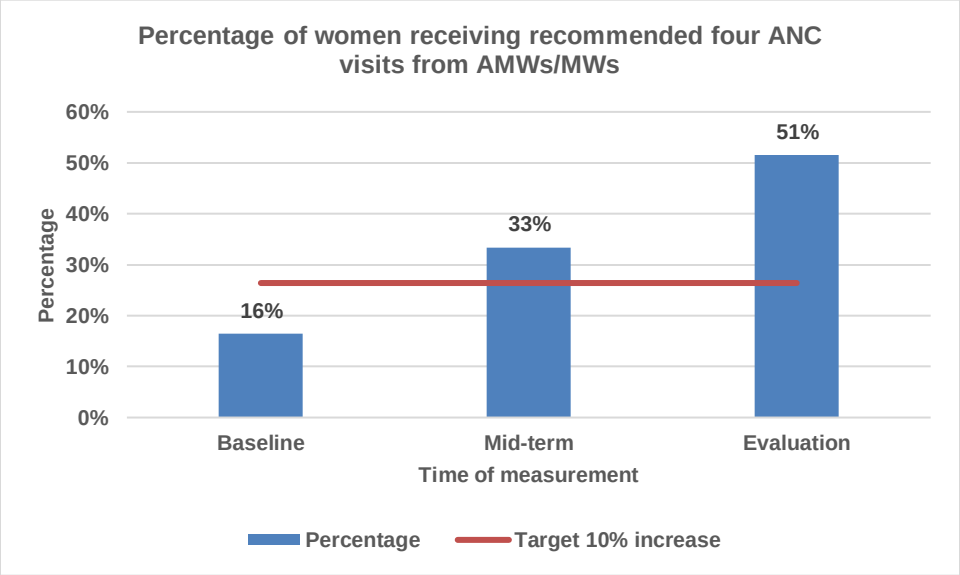

Figure 5: *Percentage of women receiving recommended four ANC visits from AMWs/MWs*

In Figure 5, the final evaluation results showed that 51% of the pregnant women received recommended four ANC visits from AMWs/MWs which was 25% higher than the program target and 35% higher than the baseline evaluation. The results also indicated that the final evaluation results also 18% higher than the mid-term evaluation results.

Qualitative findings

Some of the village health volunteers and mother group members said they have to do the list pregnant women in the village and work together with AMW. They also assist the pregnant women to get ANC. AMW played the significant role in the ANC of pregnant women in the implementing villages. AMW know who is pregnant in the village and she monitor the pregnant women to have ANC, and necessary medications and immunizations. AMW also help the pregnant women to plan for delivery and assist the women in the delivery and referral. Some of the AMW said they went to the homes of pregnant women to educate them, and help them to get immunization and ANC. Some AMW said they accompany the pregnant women to go for the ANC visits.

Reasons for not receiving ANC

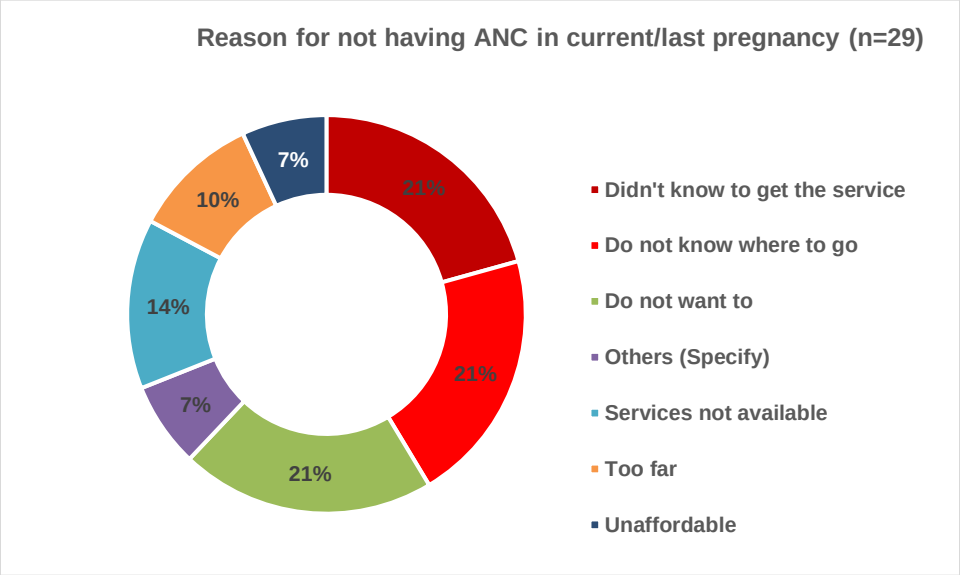

Figure 6: *Reasons for not having ANC in current/ last pregnancy*

However, there were 29 respondents (15% of the respondents) who did not receive ANC visits and Figure 6 showed the reasons why they did not receive ANC visits. The results showed that 63% of the respondents did not know how to get the service, where to go and they did not want to get the service. Only 14% and 10% of the respondents responded that the services are not available in their areas and too far from their home.

Knowledge about danger signs during pregnancy

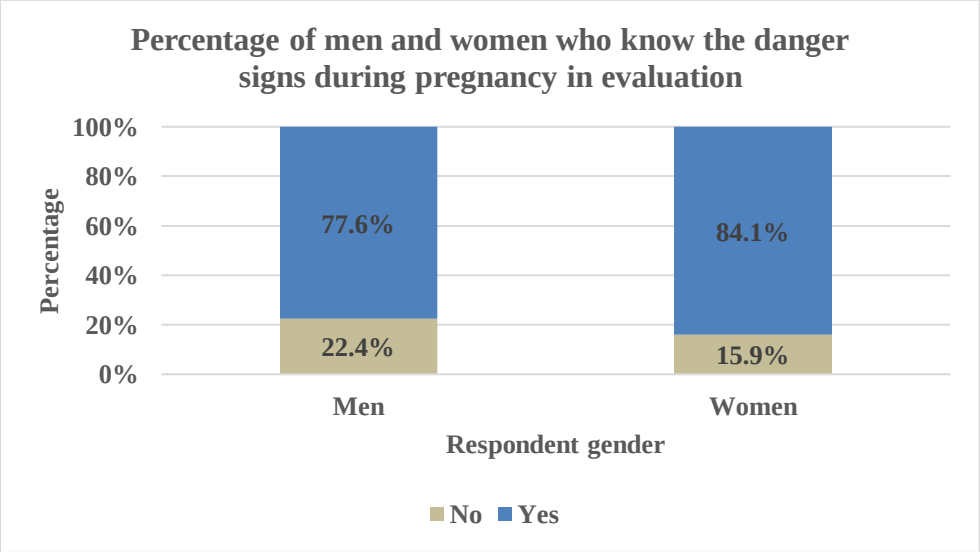

Figure 7: *Percentage of men and women who know the danger signs during pregnancy in evaluation*

Figure 7 showed the knowledge of the danger signs during pregnancy between men and women. The evaluation results showed that over 75% of the male respondents and over 80% of the female respondents had the knowledge of the danger signs during pregnancy.

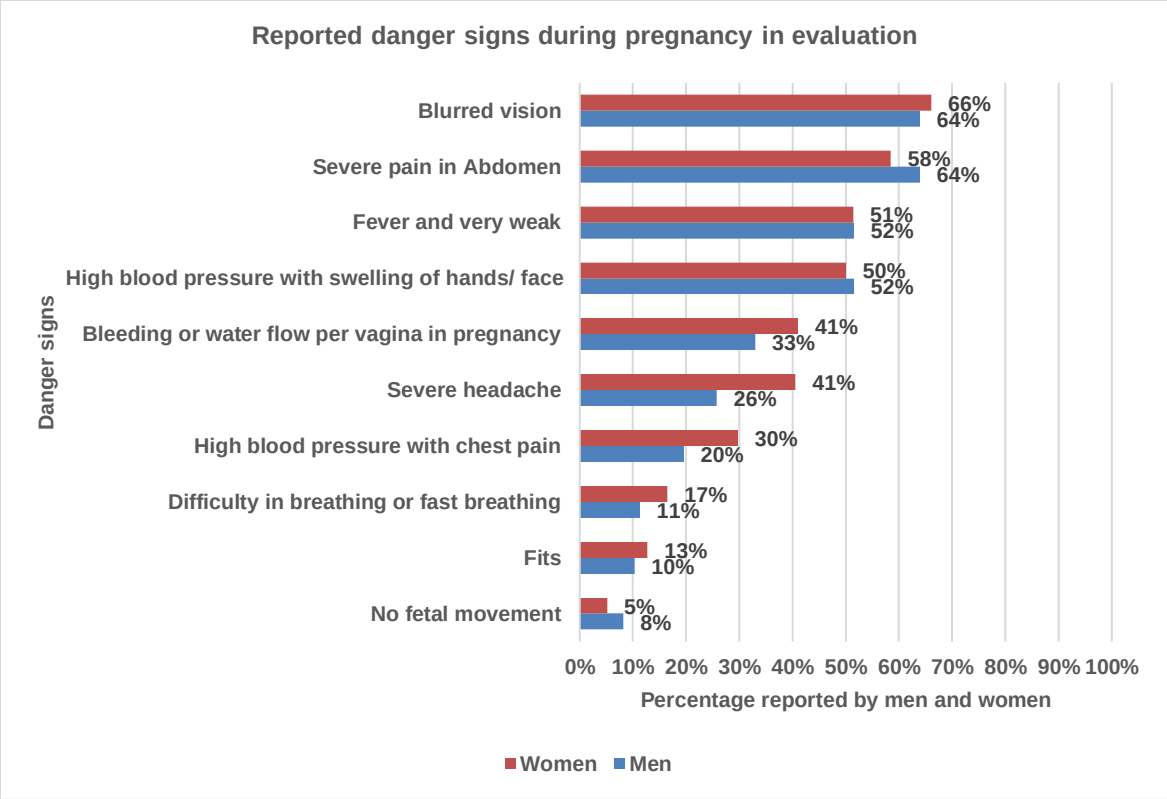

Figure 8: Reported danger signs during pregnancy in evaluation

Most of the respondents both male and female knew blurred vision, severe pain in abdomen, fever and very weak and high blood pressure with swelling of hand/ face as the danger signs during pregnancy as shown in Figure 8. Moreover, Figure 8 showed that 41% of the female respondents and 33% of the male respondents knew bleeding or water flow per vagina in pregnancy as danger signs.

% increase in the number of mothers and babies receiving least one PNC visit within 3 days of delivery - approximately 20%

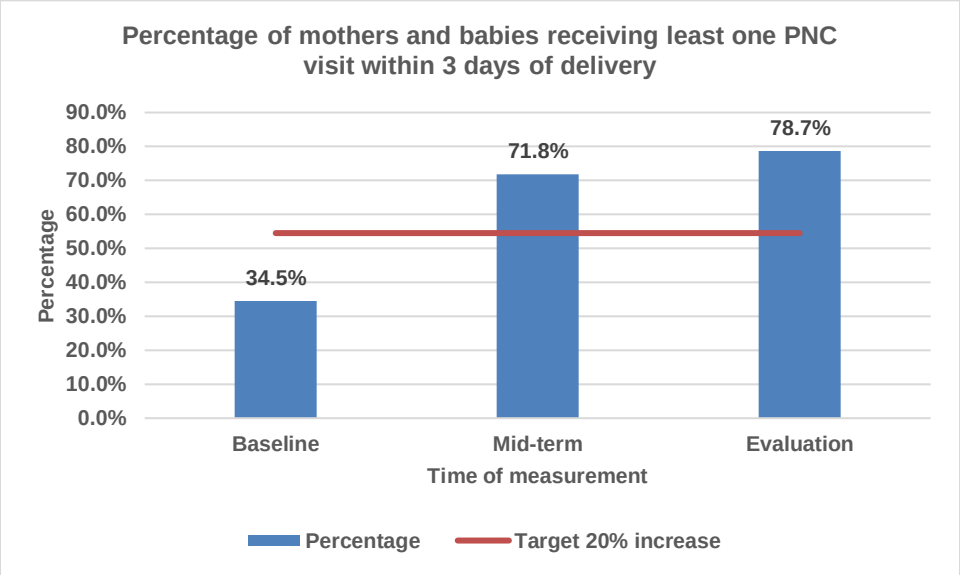

Figure 9: *Percentage of mothers and babies receiving least one PNC visit within 3 days of delivery*

Figure 9 indicated the comparison between baselines, mid-term and final evaluation on receiving least one PNC visit within 3 days of delivery by mothers and babies. The results showed that 78% of respondents from final evaluation received at least one PNC visit within 3 days of delivery which was over 40% higher than the program target comparing with the baseline evaluation results.

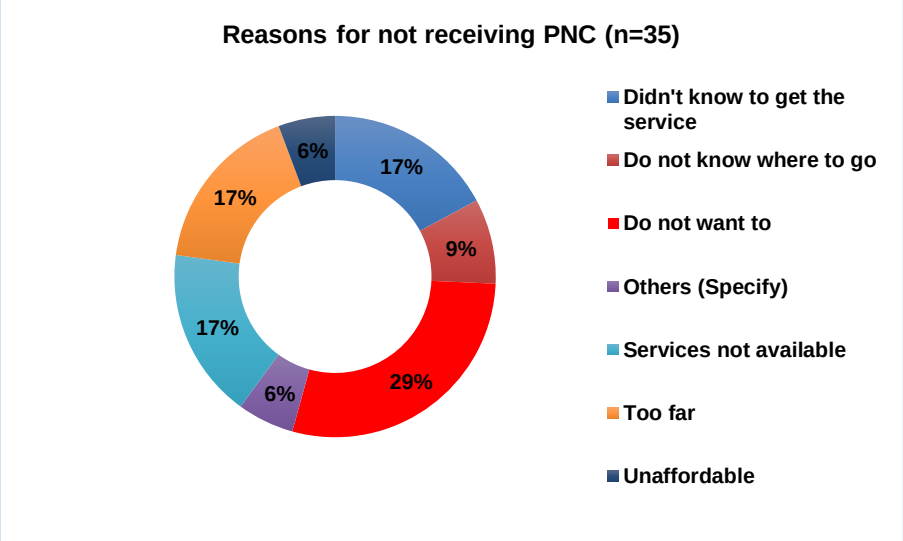

Figure 10: Reasons for not receiving PNC

There were 35 respondents (21% of the respondents) who did not receive at least one PNC visit within 3 days of delivery and the reasons they provided are shown in Figure 10. 29% of the respondents provided that they did not want to get the service and 17% of the respondents responded that they did not know how to get the service. 34% of the responses were the services not available and too far from their area.

Qualitative findings

Qualitative findings showed that AMW go to the home of delivered women and provide necessary health education message, measurement of blood pressure, care of wound and refer to clinics and hospitals if needed. Members of mother group also assisted in the PNC.

Knowledge about post-natal distress

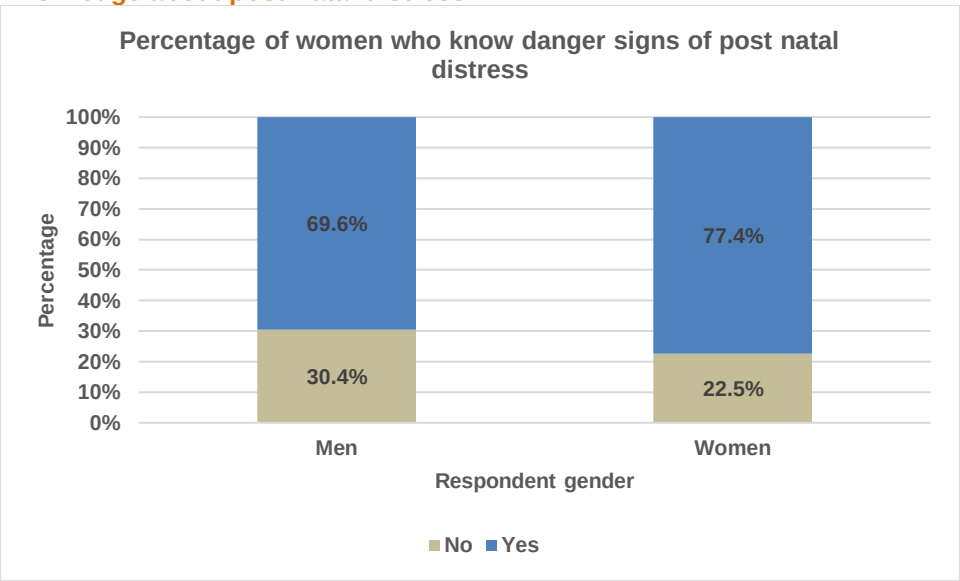

Figure 11: % of women who know danger signs of post-natal distress

Figure 11 showed the knowledge of danger signs of post-natal distress between male and female respondents. It is showed that 77% of female and 69% of male knew the danger signs of post-natal distress which means female had more knowledge than male.

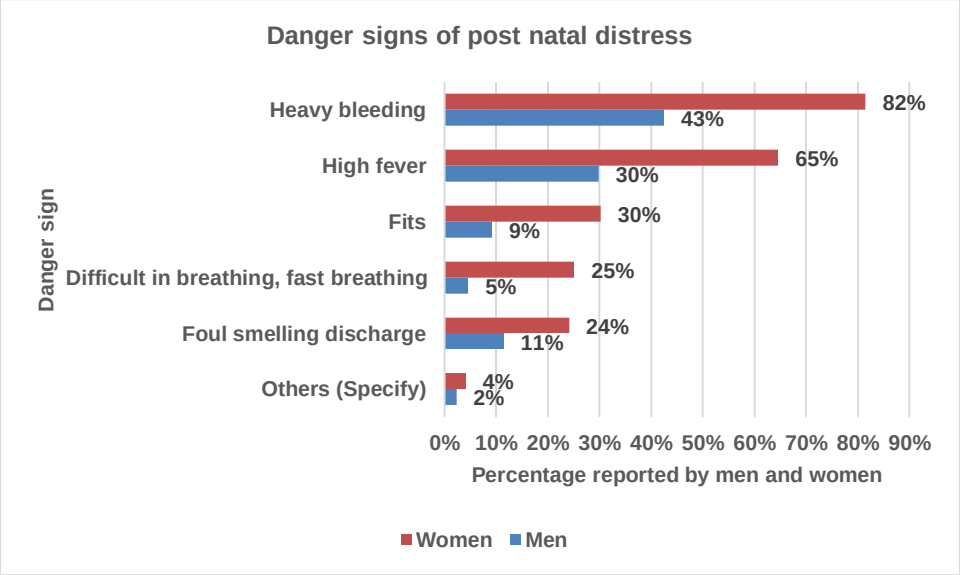

Figure 12: Danger signs of post-natal distress

Most female respondents (82%) and (65%) knew heavy bleeding and high fever as danger signs of post-natal distress. One fourth of the female respondent (30%, 25% and 24%) knew fits, difficulty in breathing, fast breathing and foul-smelling discharge as danger signs of post-natal distress. The results found that the

male respondents had limited knowledge on the danger signs of post-natal distress as under half of the respondents (43% and 30%) knew heavy bleeding and high fever and only a few respondents (9%, 5% and 11%) knew fits, difficulty in breathing, fast breathing and foul-smelling discharge.

% reduction in the number of abortions – 10% abortion rate reduce

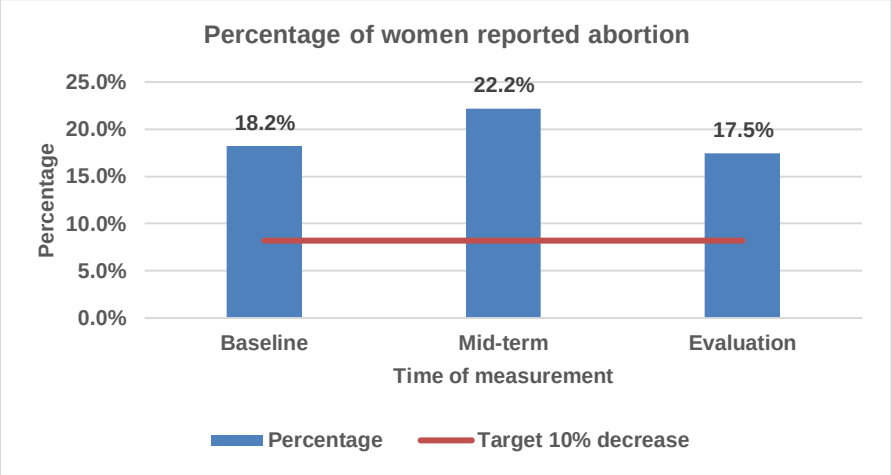

Figure 13: Reduction in the number of abortions

Figure 13 showed the comparison between baselines, mid-term and final evaluations on reduction in the number of abortions. It is shown that the abortion rates were not reduced according to the target as the initial baseline value was 18% and it would be very hard to reduce the target 10% reduction. However, nearly 1% of the abortion rate was reduced comparing between baseline and the final evaluations and it is almost 5% reduced in abortion rates comparing between mid-term and the final evaluations.

Qualitative findings

Most of the respondents from qualitative interviews said the abortion cases were lower. The cases of abortions were consulted with AMW and referred to the midwife if needed.

% of women undergoing abortion receive post-abortion care and counselling – 50% of abortion cases

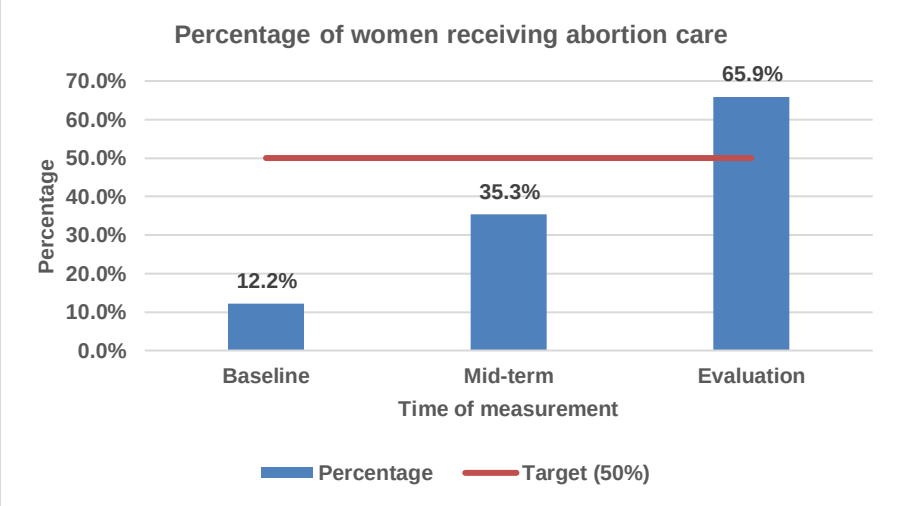

Figure 14: % of women undergoing abortion receive post-abortion care and counselling

66% of the respondents from final evaluations received post-abortion care and counselling as shown in Figure 14 which was 16% higher than the program target and 54% higher than the baseline evaluations results. Even though it does not meet the program target in mid-term evaluation results, it is now higher than the expected outcomes in the final evaluation results which showed the progress of the program.

Knowledge about danger signs of abortion

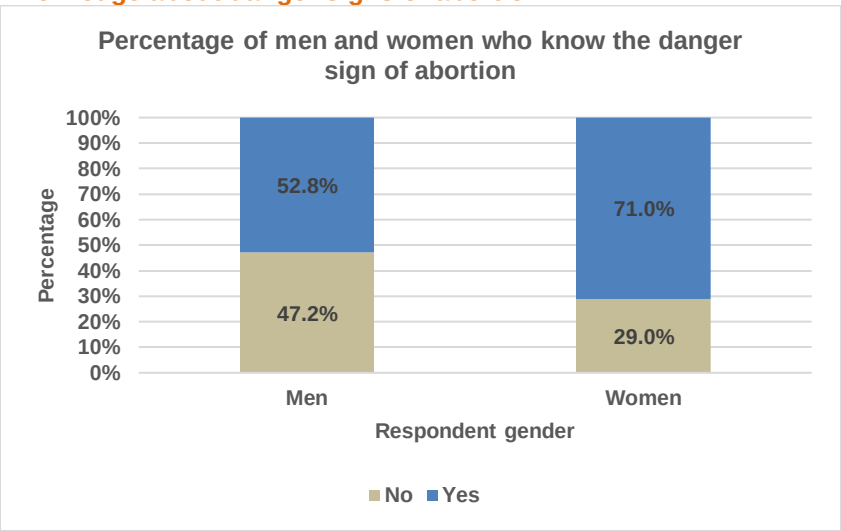

Figure 15: % of men and women who know the danger signs of abortion

Figure 15 showed the knowledge on the danger signs of abortion between male and female respondents. Just over half of the male respondents (53%) and nearly three fourth of the female respondents (71%) knew the danger signs of abortion.

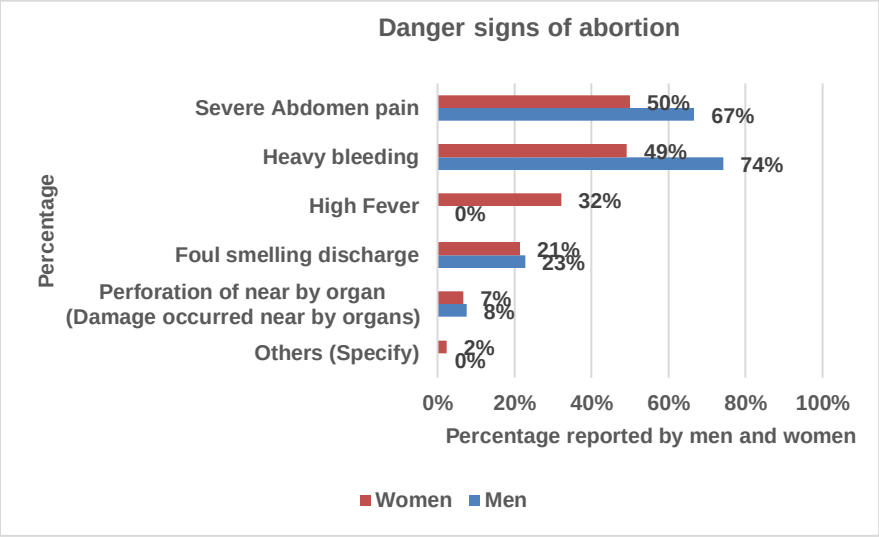

Figure 16: Danger signs of abortion

In Figure 16, most female and male respondents responded that they knew severe abdomen pain (50% of female and 67% of male) and heavy bleeding (49% of female and 74% of male). There were limited knowledge on other danger signs of abortion such as high fever (32% of female and 0% of male), foul smelling discharge (21% of female and 23% of male) and perforation of nearby organ (7% of female and 8% of male).

% increase in the number of couples report using modern contraceptive method - approximately 20%

% of men reported using modern contraceptive methods

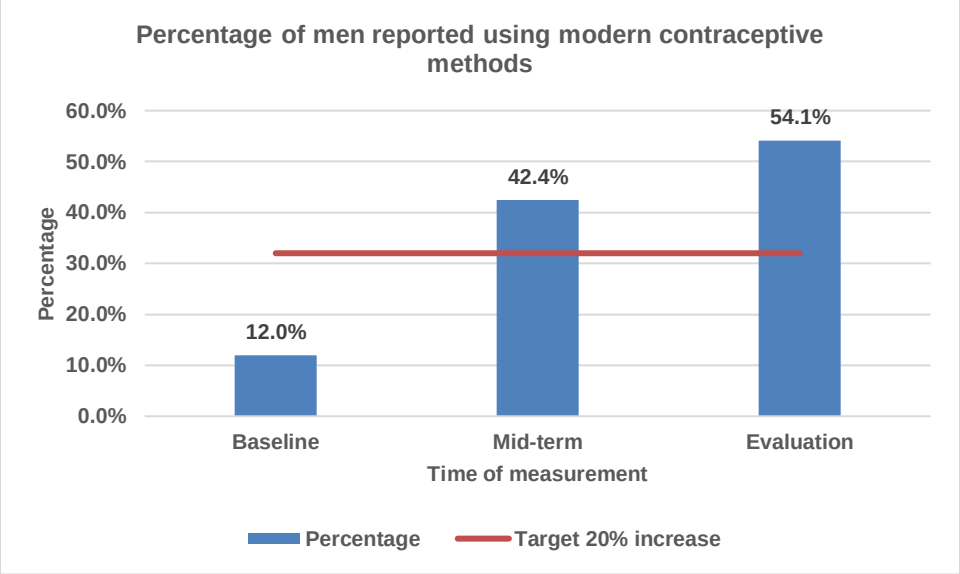

Figure 17: % of men reported using modern contraceptive methods

54% of male respondents from final evaluation reported using modern contraceptive methods in Figure 17 which indicated that over 20% higher than the program target and over 40% higher than the baseline evaluation. It is showed that more of the male respondents from final evaluation are using modern contraceptive methods than baseline evaluation.

Type of contraceptive used (Men)

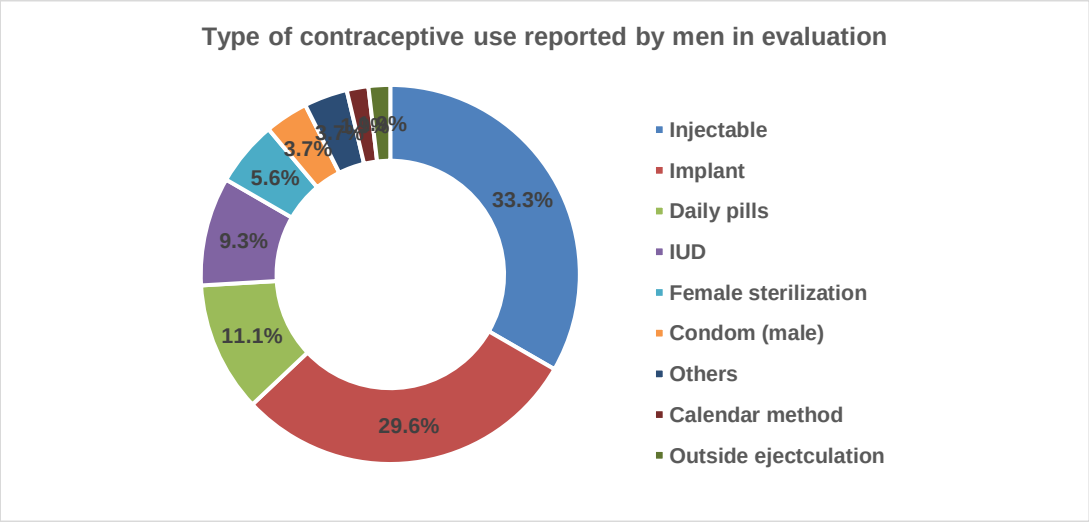

Figure 18: Type of contraceptive use reported by men in evaluation

As shown in Figure 18, 33% of male respondents reported that they are using injectable and 30% of the male respondents using implant as contraceptive methods. Very few 14% of the male respondents reported

they are using female sterilization (6%), male condom (4%), calendar method (2%) and outside ejaculation (2%) as contraceptive methods.

% of women reported using modern contraceptive methods

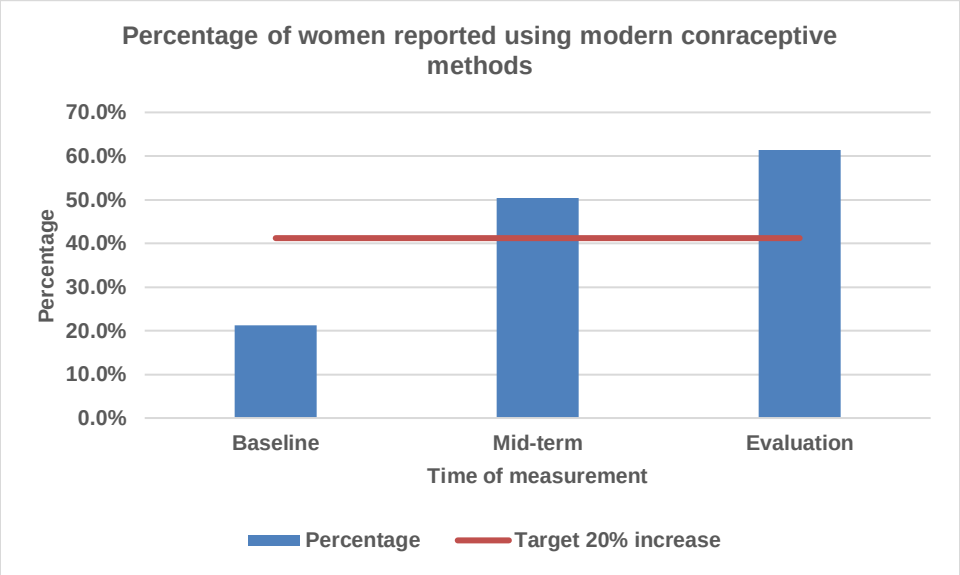

Figure 19: % of women reported using modern contraceptive methods

Figure 19 showed that 61% of female respondents from final evaluation reported using modern contraceptive methods which indicated over 20% higher than the program target and over 40% higher than the baseline evaluation. It is showed that more of the female respondents from final evaluation are using modern contraceptive methods than baseline evaluation.

Type of contraceptive used (women)

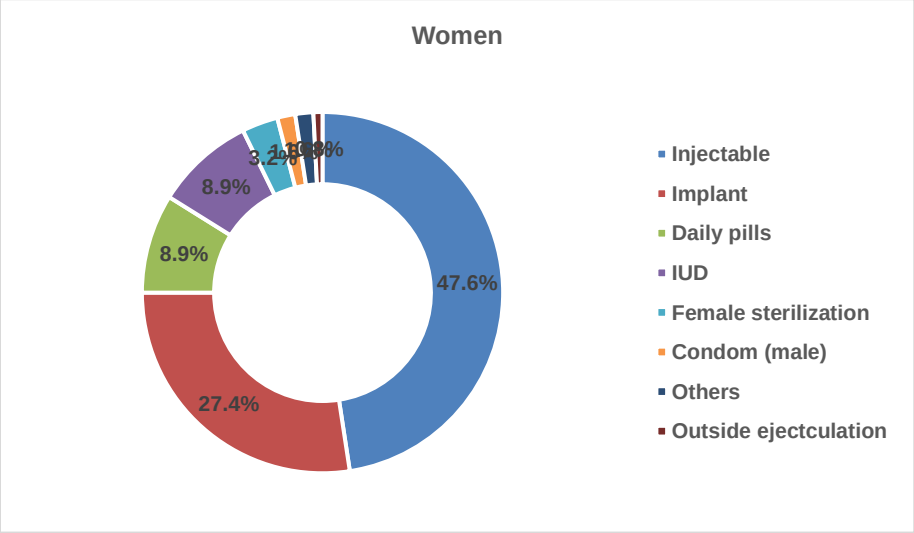

Figure 20: Type of contraceptive used (Women)

As shown in Figure 20, nearly half of the female respondents (48%) reported that they are using injectable and 27% of the female respondents using implant as contraceptive methods. Very few 6% of the female respondents reported they are using female sterilization (3%), male condom (2%) and outside ejaculation (1%) as contraceptive methods.

Percentage of women who have knowledge about modern contraceptive

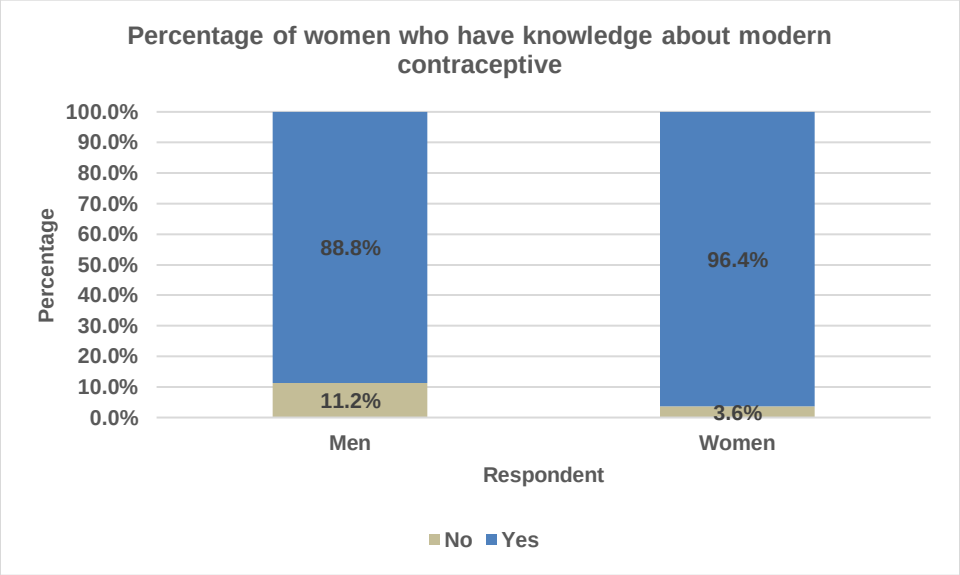

Figure 21: % of men and women who have knowledge about modern contraceptive

Almost all female respondents (96%) and 89% of male respondents had the knowledge about modern contraceptive as shown in Figure 21 which supported to figure 17 and 19 and this result showed the achievement of the program implementation.

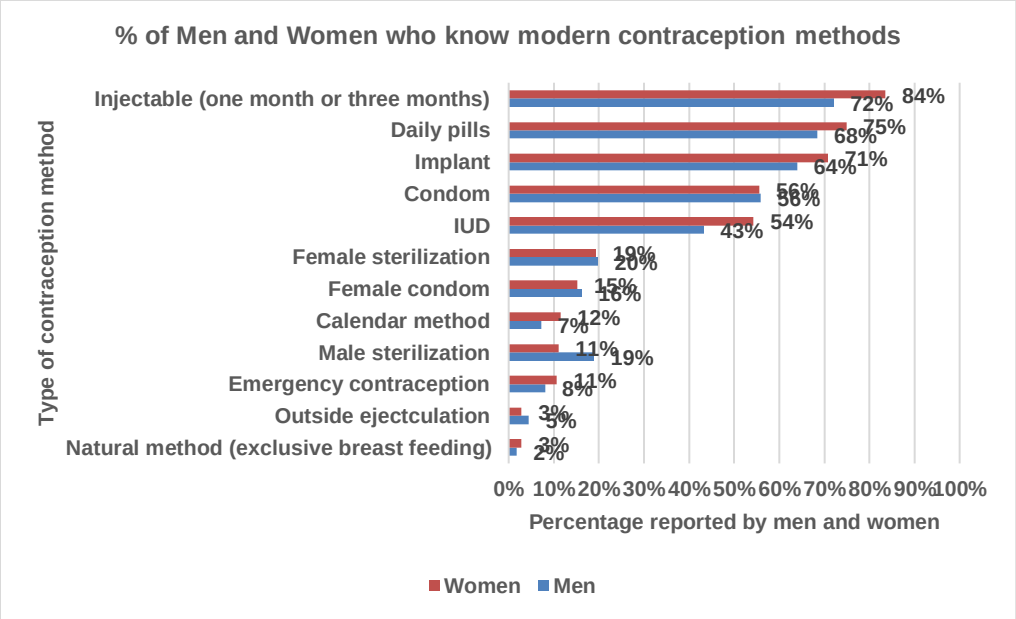

Figure 22: % of men and women who know modern contraception methods

Figure 22 showed what kind of modern contraception methods that the respondents both male and female had knowledge. In Figure 22, most female and male respondents answered injectable (84% of female and 72% of male), daily pills (75% of female and 68% of male), implant (71% of female and 64% of male), condom (56% of female and male) and IUD (54% of female and 43% of male) as modern contraception methods.

Qualitative findings

Regarding family planning, most of the respondents said the couples in their villages used the contraception methods. Only a few reported do not use of contraception methods. In most cases, the use of contraception were known and supported by the husbands. Is a few cases, the husbands did not interest or not agreed, the women manage herself to get contraception. Women get injection contraception from the AMW and some buy the oral contraceptive pills by themselves.

Respondents said people in there are did not know about family planning and the behavior of using contraception among women in the villages was not common before Care Myanmar project. Most of the respondents mentioned that the changes in using contraceptives was due to the health education messages provided Care Myanmar staffs and volunteers.

The reproductive health knowledge and contraception methods were also discussed among young people. Members of youth group reported that they received health education message about reproductive health and family planning methods from Care Myanmar.

% reduction in diseases prevalence among children in the under five age category approximately 20%

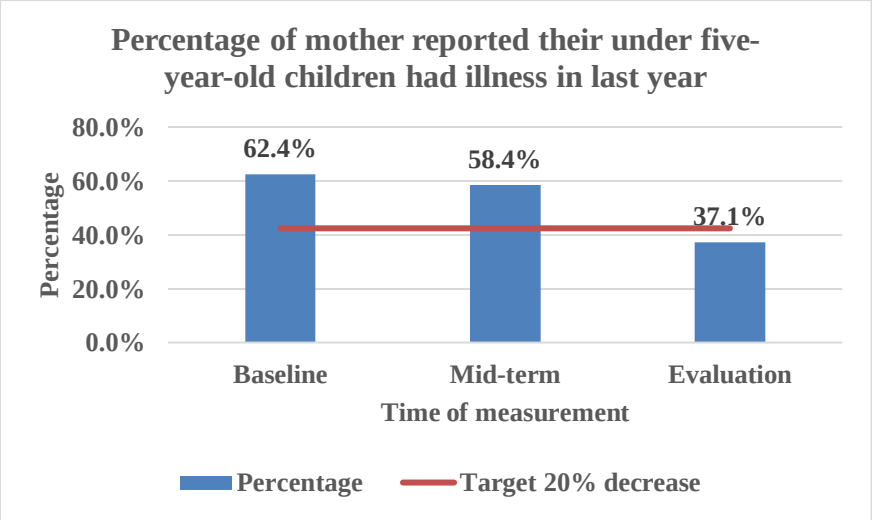

Figure 23: % reduction in diseases prevalence among children in the under-five age category

In Figure 23, the disease reported were common cold, diarrhea, malaria, dengue hemorrhagic fever. Figure 23 showed that 5% of the final evaluation result reduced than the program target and comparing with the baseline evaluation, the final evaluation result reduced 25% which showed the progress of the program.

% reduction in diseases prevalence among children in the under one age category -approximately 20%

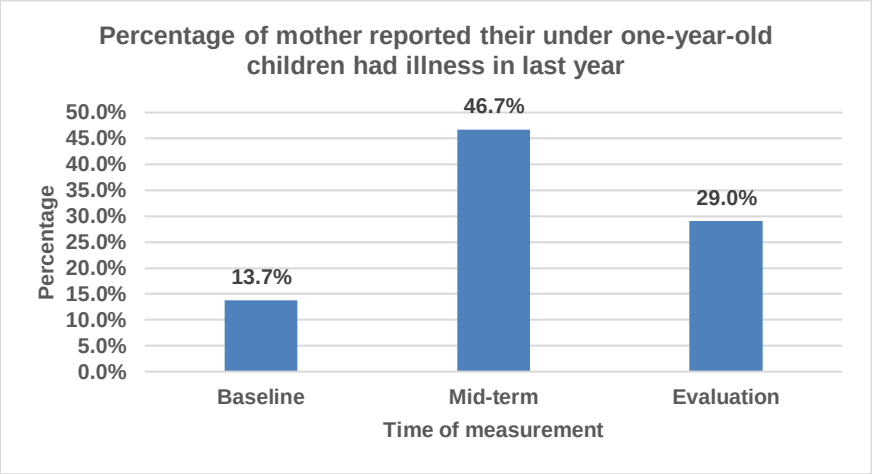

Figure 24: % reduction in diseases prevalence among children in the under-one age category

In Figure 24, the diseases reported in evaluation were malaria, pneumonia and common cold. The initial baseline value was 14% and it would be very hard to reduce the target 20% reduction. However, the study showed the progress between mid-term and final evaluations because there were 18% of reduction in diseases prevalence among children in the under-one age category comparing between mid-term and final evaluations.

Qualitative findings

When the child is ill, AMW check the child and provided the drugs such as paracetamol and amoxicillin. If the child is too ill, AMW refer the child to the nearest health center or hospital. Presence of emergency referral fund also support the referral of ill child to the clinics and hospitals.

Village health committee appreciate the presence of AMW and Care Myanmar support as there was no service available for the ill children in the village before GSK project. Whenever the child is ill, parents inform to AMW and they refer if needed. Referral was also supported by the village volunteer groups such as mother groups, village health volunteer, and members of village health committee.

Objective 2 To enhance the effectiveness of the health system

% increase in immunization coverage which were implemented by MOHS with supported by CARE and Stakeholder

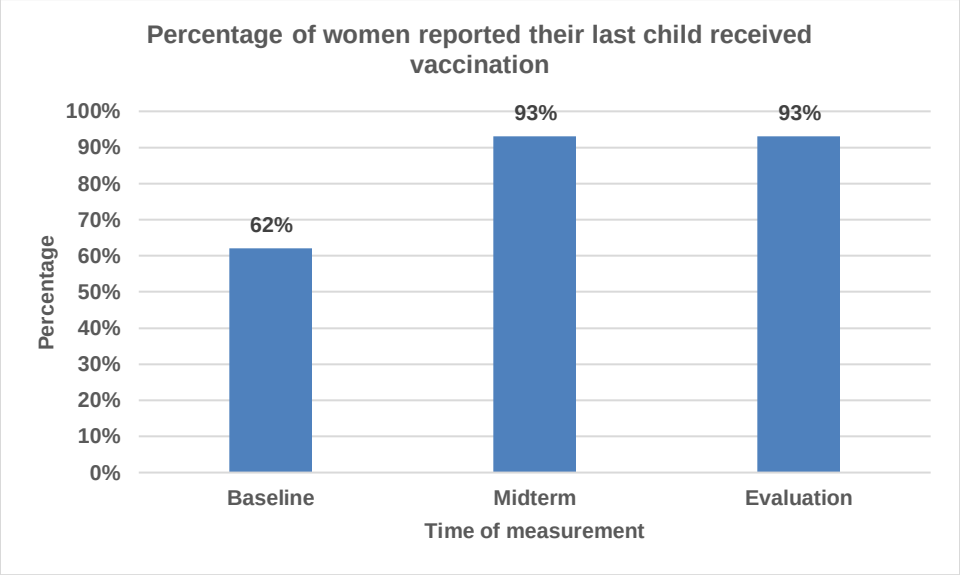

Figure 25 Percentage of women reported their last child received vaccination

Figure 25 showed the comparison between baselines, mid-term and final evaluations on receiving immunization by the respondents' last child. The results showed that there are no differences between mid-term and final evaluations as 93% is the results in both mid-term and final evaluations. However, the final evaluation result is 31% higher than the baseline evaluation which showed the progress of the program.

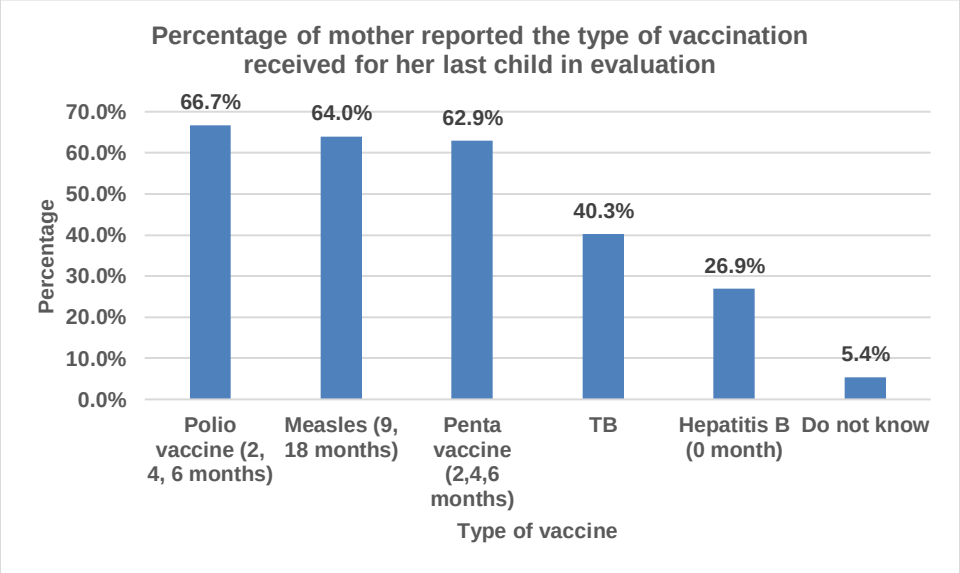

Figure 26: Percentage of mother reported the type of vaccination received for her last child in evaluation

Figure 26 demonstrates the percentage of types of vaccines reported in final evaluation. More than 60% of the women reported that their children received polio vaccine, measles vaccine and Penta vaccine.

Qualitative findings

AMW and VHV make a list of children in the village who need to be vaccinated and inform to MW every month. There is a regular communication between AMW and MW and the children from the villages were vaccinated either by MW coming to their village or going to the health center. In some cases, if the children did not come to the immunization place, the MW and AMW went to the child's home and provide vaccination. As Care Myanmar has provided the necessary health knowledge about immunization, the community perception was changed and almost all of the children in the villages were vaccinated nowadays.

"In the past, people in the village were afraid of getting vaccinated. Now they are afraid of not getting vaccinated" one of the AMW said.

However, there are a few cases where the family members of the children were in the farm land which is away from the village at the time of vaccination, the children are not get vaccinated. And one of the volunteer said, there is one mother in the village who refuse to vaccinate to her children as the child got high fever after the vaccination.

% increase in the number of pregnant women receiving Voluntary Confidential Counselling and Testing for HIV and STI - APPROXIMATELY INCREASED 20%

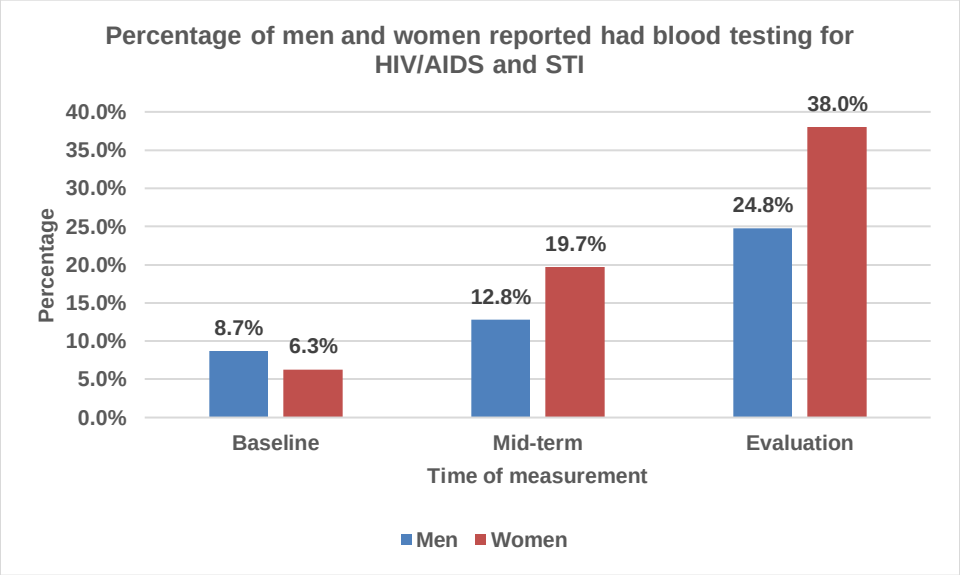

Figure 27: % of men and women reported had blood testing for HIV/AIDS and STI

Figure 27 showed the comparison between baselines, mid-term and final evaluations on men and women who had blood testing for HIV/AIDS and STI. The results showed that the final evaluation increased in percentages a lot comparing with baseline and mid-term. In final evaluation, 38% of female and 25% of male respondents reported that they had blood testing for HIV/AIDS and STI which was over 30% of female and 15% of male higher than the baseline evaluation.

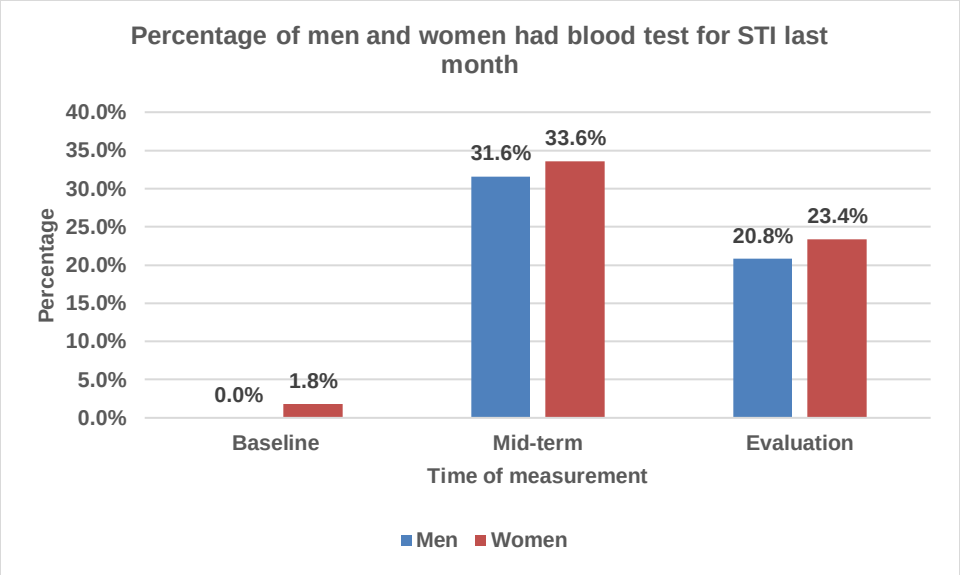

Figure 28: % of men and women had blood test for STI last month

23% of female and 21% of male respondents from final evaluation had blood test for STI last month as shown in Figure 27 which indicated that over 20% higher than the baseline evaluation even it is a bit lower than mid-term evaluation.

Objective 3. To mobilize communities to adopt health service-seeking and health-enabling behaviors

% of mothers report practicing early-initiated breast feeding - approximately 80%

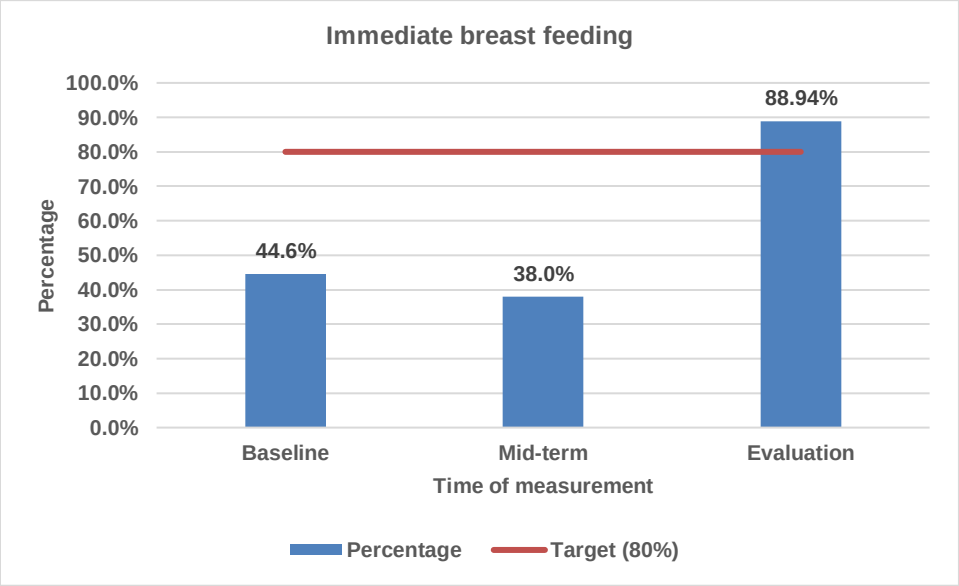

Figure 29: % of mothers reported practicing early-initiated breast feeding

As shown in Figure 29, 89% of the final evaluation result is over 45% higher than baseline evaluation and 51% higher than mid-term evaluation. The results proved that the immediate breast-feeding practice is increasing in Care Myanmar project areas as shown in Figure 29.

% of reproductive-age men and women have knowledge to recognize at least three indications of complications in pregnancy - approximately 80%
Percentage of men and women have knowledge to recognize at least three indications of complications in pregnancy

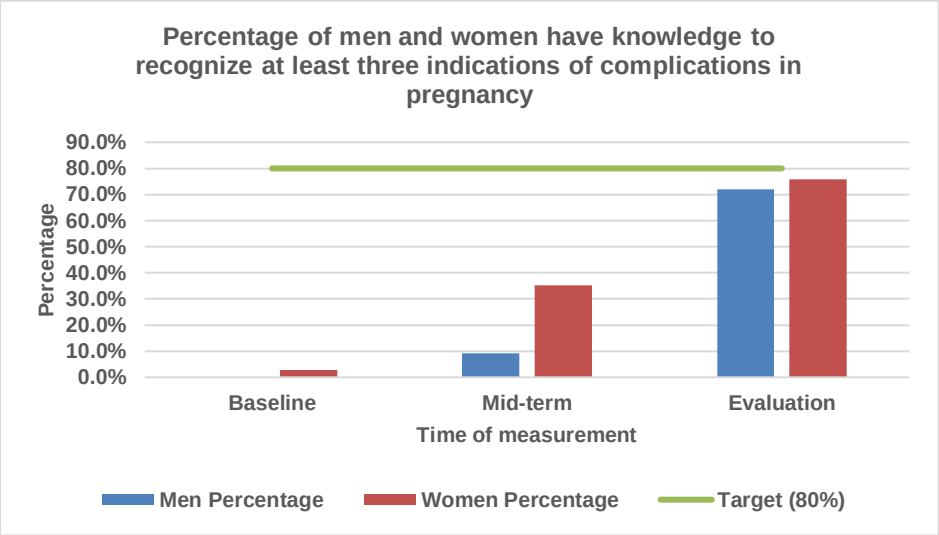

Figure 30: Percentage of men and women have knowledge to recognize at least three indications of complications in pregnancy

76% of reproductive-age female and 72% of reproductive-age male reported that they had knowledge to recognize at least three indications of complications in pregnancy according to Figure 30. This is also indicated that the final evaluation result was a lot higher than baseline and mid-term evaluation results even it did not reach to the program target (80%) as shown in Figure 30.

% of youth demonstrate increase awareness of correctly identify ways of preventing HIV - approximately 30%
Percentage of male and female youth demonstrate increase awareness of correctly identify ways of preventing HIV

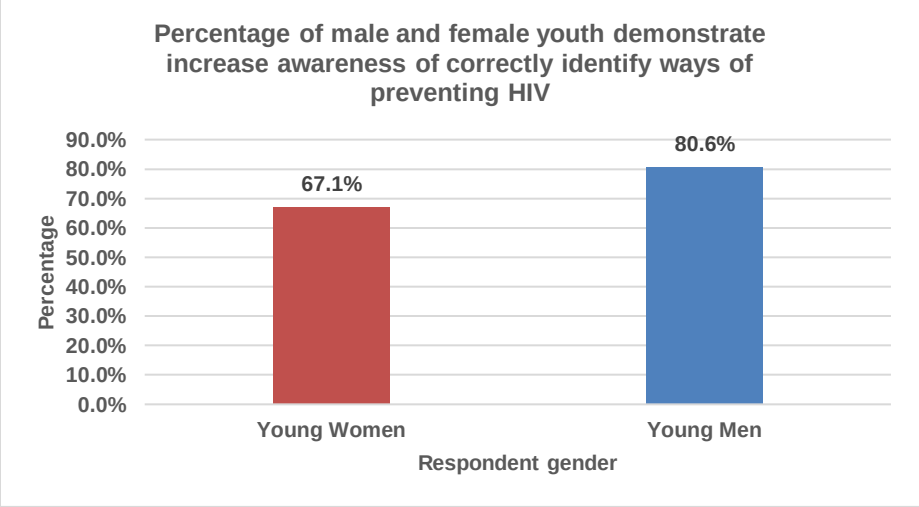

Figure 31: % of youth demonstrate increase awareness of correctly identify ways of preventing HIV

Figure 31 showed the percentage of 14 to 30-year-old age of men and women and there were no baseline and mid-term evaluation results to compare the increase awareness of correctly identify ways of preventing

HIV. However, Figure 31 indicated that 81% of young men and 67% of young women demonstrated the awareness of correctly identify ways of preventing HIV.

% of men and women demonstrate increase awareness of correctly identify ways of preventing HIV

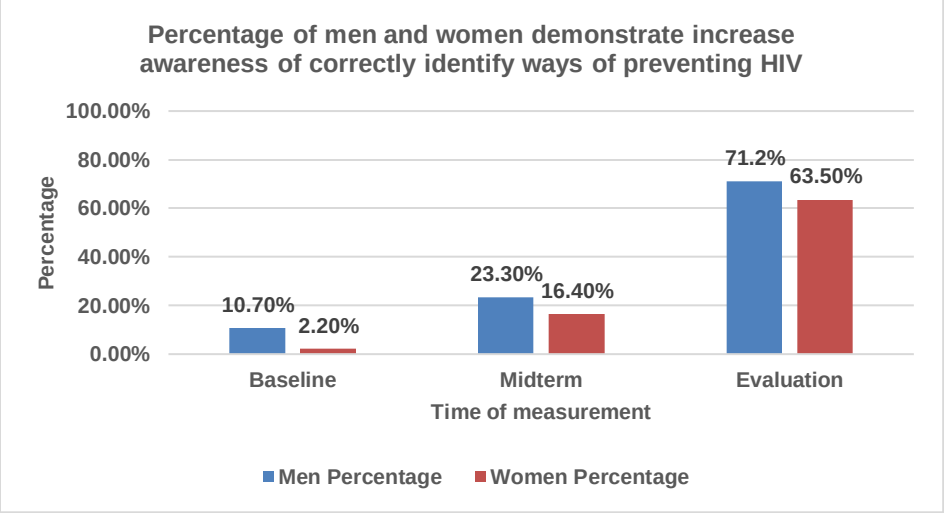

Figure 32: Percentage of men and women demonstrate increase awareness of correctly identify ways of preventing HIV

As shown in Figure 32, 71% of men and 63% of women demonstrated increase awareness of correctly identify ways of preventing HIV which indicated that both men and women had a lot awareness than baseline and mid-term evaluation results.

% increase in positive behavior change among men regarding SMRH and GBV

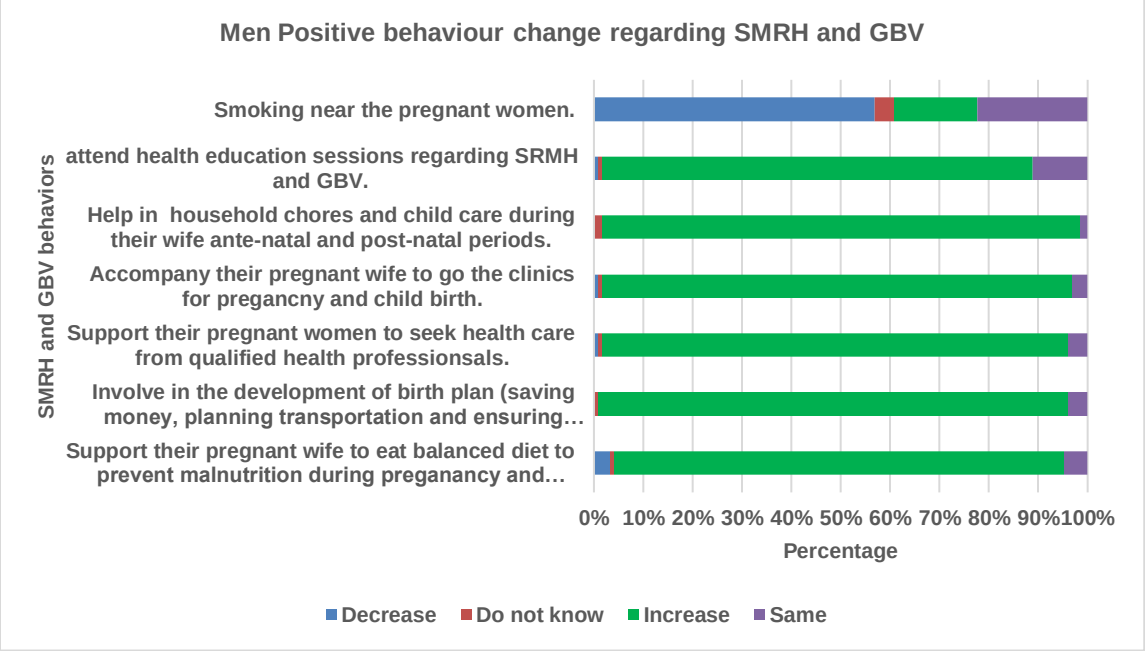

Figure 33: % increase in positive behavior change among men regarding SMRH and GBV

Men were asked whether the behaviors of SMRH and GBV has increase or decrease in their community. The following questions were asked.

- Support their pregnant wife to eat balanced diet to prevent malnutrition during pregnancy and post-natal period.
- Involve in the development of birth plan (saving money, planning transportation and ensuring skilled birth attendant) while his wife is pregnant.
- Support their pregnant women to seek health care from qualified health professionals.
- Accompany their pregnant wife to go the clinics for pregnancy and child birth.
- Help in household chores and child care during their wife ante-natal and post-natal periods.
- Attend health education sessions regarding SRMH and GBV.
- Smoking near the pregnant women.

There were no baseline or mid-term evaluation information to compare with the final evaluation results. However, the question was asked with four degree such as same, increase, do not know and decrease to understand the positive behavior change among men regarding SMRH and GBV. Most male respondents (over 90%) believed that they changed their behavior regarding SMRH and GBV but over half of the male respondents (61%) also responded that they did not know or change the behavior of smoking near the pregnant women as shown in Figure 33. The average percentage of increase in positive behaviors of men regarding SMRH and GBV was 88.1% which is used to report for the indicator value.

% increase in the number of women reporting improved decision-making regarding family planning - approximately 20%

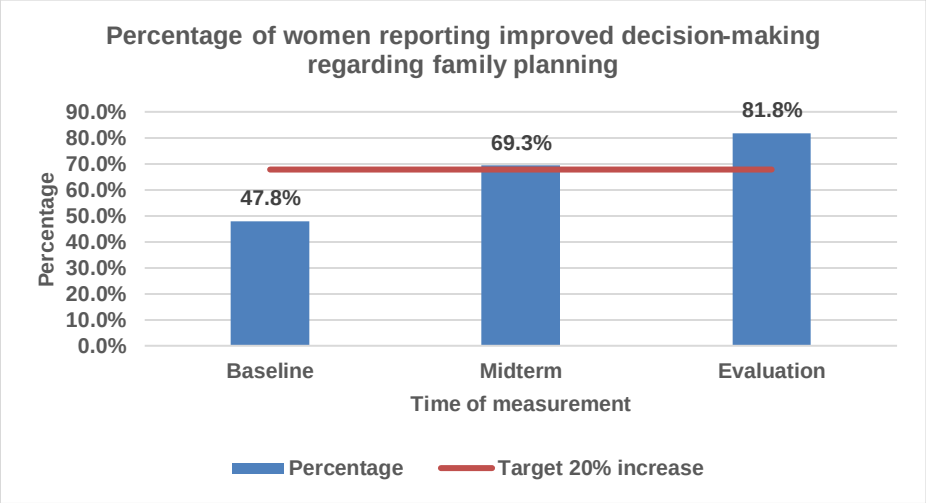

Figure 34: % increase in the number

The Figure 33 showed the comparison between baselines, mid-term and final evaluation of improved decision-making regarding family planning by women. The final evaluation results showed that 82% of the women respondents reported that they participated in the decision-making regarding family planning which indicated that over 10% higher than the program target and over 30% higher than the baseline evaluation according to Figure 34.

Qualitative findings

Most of the respondents from qualitative interview reported that women are aware of the family planning method. Men agree to use contraception methods in most of the cases as Care Myanmar provided health message to both men and women and both of them understand about family planning.

"If a women want to use a different method of contraception after childbirth, they consult about how to use a contraceptive method with AMW. The women tell their husbands and they decide which method to use. More people are using contraceptives than ever before" one of the member form village saving and loan association said.

"As Care Myanmar educated about family planning, both men and women want to use contraceptive methods" one of the member of mother group said.

However, there are a few cases where men do not interest or not agree to use contraception methods. A few respondents reported that men are not interested in the family planning methods and women have to manage themselves to get the contraception method with the help of AMW.

"Some men have knowledge and some do not have, especially who work at hill site farm do not have knowledge. Their wives contact with AMW and use by themselves" one of the member of village health committee said.

% of MEN improve understanding causes of harmful SMRH behaviors and key vulnerabilities
Percentage of men improve understanding causes of harmful SMRH behaviors and key vulnerabilities

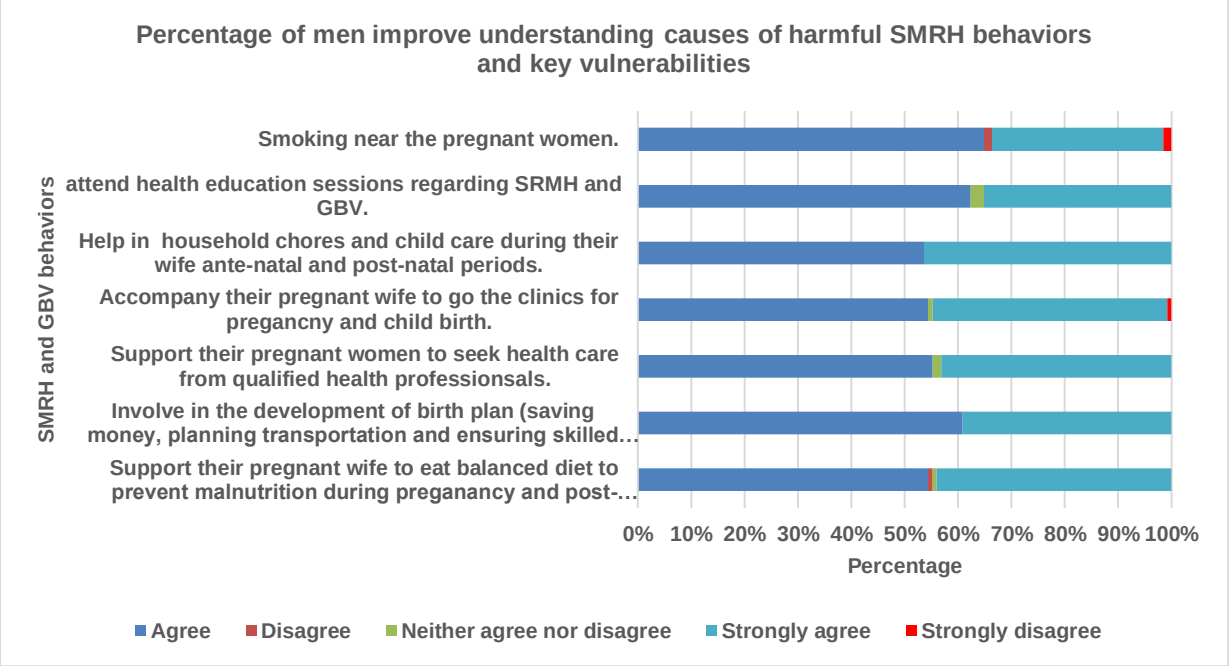

Figure 35: % of beneficiaries improve understanding causes of harmful SMRH behaviors and key vulnerabilities

Men were asked their level of agree or disagree of the SMRH and GBV behaviors. The following statements were read and their perceptions were asked.

- Support their pregnant wife to eat balanced diet to prevent malnutrition during pregnancy and post-natal period.
- Involve in the development of birth plan (saving money, planning transportation and ensuring skilled birth attendant) while his wife is pregnant.
- Support their pregnant women to seek health care from qualified health professionals.
- Accompany their pregnant wife to go the clinics for pregnancy and child birth.

- Help in household chores and child care during their wife ante-natal and post-natal periods.
- Attend health education sessions regarding SRMH and GBV.
- Smoking near the pregnant women should not done.

Figure 35 indicate responses of beneficiaries to check their confident on their understanding causes of harmful SMRH behaviors and key vulnerabilities. The respondents were asked to respond with 5 levels as strongly agreed, agreed, neither agreed nor disagreed, disagreed and strongly disagreed with the level of confidence to understand causes of harmful SMRH behaviors and key vulnerabilities. Figure 34 found that there are very few percentages of strongly disagree and disagree in some cases which means almost all of the beneficiaries believed they understood causes of harmful SMRH behaviors and key vulnerabilities. The average percentage of who answered agree or strongly agree to those statements were 98.5% which is used to report for the indicator value.

% of women reporting their husbands participating in SRMH activities

74.5% of women said their husband accompanied them during the ANC visit of current/last pregnancy.

Qualitative finding

Care Myanmar staffs and volunteers educate both men and women regarding the SMRH. Some of the respondents from the qualitative study also reported that men were also participated in the health education sessions. The couples also supported each other in getting service for ANC, delivery and PNC.

"In the past, there were no such referrals to hospitals. We also educate to men regarding maternal and reproductive health. The village elders also asked their wives to accompany them, and now the men accompany their pregnant wives to go to clinics and hospitals", one of the member of mother group said.

Only a few respondents said, some men are not accompanying their wives to get maternal health services and they focus only to earn money for the family.

% of women reporting men engaged on health-enabling masculinities

This indicator was measured by asking the following questions to women participants.

- Did your husband involved in the development of birth plan of your last pregnancy?
- Did your husband support you in seeking maternal care from qualified health professional?
- Did your husband involved in household chores and child caring during your last pregnancy and post natal period?
- Did your husband participated in health education (HE) sessions regarding SMRH?

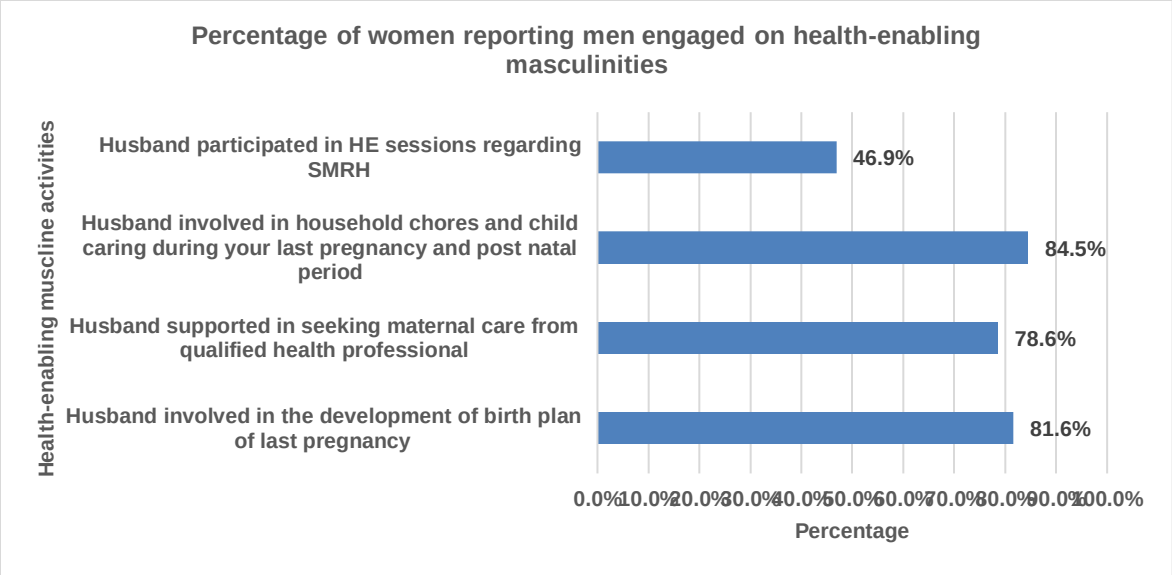

Figure 36 Percentage of women reporting men engaged on health-enabling masculinities

About 80% of women said their husband involved in development of birth plan in the last pregnancy and supported in seeking maternal care from qualified health professional. Men involvement in household chores to support their pregnant and post-natal wives was reported as 84.6%. Nearly half, 46.7% of women reported that their husband participated in HE sessions regarding SMRH as shown in figure 36. Average percentage of all response was 72.9% which was reported as indicator value.

Qualitative findings

Most of the respondents from qualitative findings said the men and women have more understanding about gender. Men also helped their wives while they are pregnant. The gender based violent activities were lower than before they received knowledge from Care Myanmar. Women were more aware about their rights and dare to talk with their husbands. Volunteer groups and village leaders also educate about gender and women can approach to them if there is any violence case happened in their household.

"Men and women understand their roles and responsibilities after Care Myanmar educate them, there are changes after that. Previously men shout or hit their wives, and nowadays, those are not happening," one of the AMW said.

Perception on SRHR

Women Perception of SRHR

Over 90% of the female respondents agreed that both husband and wife should together decide about the number of children to have and the contraceptive methods to use. 98% of the female respondents agreed that they should have the same opportunities as men as shown in Table 3 which means they clearly understood their rights to health services. Nearly three fourth of the female respondents agreed that women may decide on their own to seek the help of trained health personal when they have health problems or questions related to pregnancy, child birth or care. 77% of the female respondents agreed that only a woman should make the decision for breastfeeding according to Table 3.

Table 3 Women perception on SRHR

Please tell me the extent to which you agree or disagree with each statement.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
A couple should decide together how many children should have	35.7%	60.3%	0.8%	2.8%	0.4%
Only husband should decide how many children to have	0.0%	6.8%	4.0%	71.4%	17.9%
Only the wife should decide how many children to have.	1.2%	9.9%	5.6%	69.4%	13.9%
Only the husband should decide what kind of contraception to use.	0.8%	5.2%	5.2%	66.7%	22.2%
Only the wife should decide what kind of contraceptive to use.	4.0%	17.9%	9.5%	54.0%	14.7%
The husband and wife should decide what kind of contraception to use together.	29.0%	63.9%	3.2%	3.2%	0.8%
When a woman has a health problem or question related to pregnancy, she may decide on her own to seek the help of trained health personal.	16.7%	53.6%	4.4%	24.2%	1.2%
When a woman has a health problem or question related to child birth, she may decide on her own to seek the help of trained health personal.	17.1%	50.8%	6.4%	24.2%	1.6%
When a woman has a health problem or question related to care after she has given birth, she may decide on her own to seek the help of trained health personal.	16.3%	53.6%	4.8%	24.2%	1.2%
Women should have the same opportunities to receive health care as men.	23.4%	74.2%	0.8%	1.2%	0.4%
Women should not be put at risk by pregnancy and childbirth.	26.2%	63.5%	7.1%	2.8%	0.4%
Women should have the right to decide on their own at what age to marry.	8.7%	58.3%	6.0%	18.7%	8.3%
Women should have the right to be free from degrading treatment, including to be treated with respect and consideration when accessing sexual and reproductive health care services.	20.2%	75.0%	3.6%	0.4%	0.8%
Women should have the right to decide sexual and reproductive health issues (includes avoiding unwanted pregnancies, STIs, and sexual violence). Decisions must be respected.	20.2%	70.6%	5.2%	1.6%	2.4%
Only women should decide to breast feed.	17.9%	59.1%	7.9%	12.7%	2.4%

Men perception on SRHR

Table 4 indicated to understand the knowledge of men related with SRHR and maternal health. Almost all male respondents (99%) responded that women should have same opportunities to receive health care as men. Over 60% of male respondents agreed that when a woman has a health problem or questions related

to pregnancy, childbirth or care after she has given birth, she may decide on her own to seek the help of trained health personnel. Over 95% of the male respondents agreed and were positive about deciding together as a couple on the number of children to have and the use of contraceptive methods as shown in Table 4.

Table 4 Men perception on SRHR

Please tell me the extent to which you agree or disagree with each statement.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
A couple should decide together how many children should have	34.4%	64.0%	0.8%	0.8%	0.0%
Only husband should decide how many children to have	0.0%	12.0%	3.2%	73.6%	11.2%
Only the wife should decide how many children to have.	0.0%	4.8%	4.0%	78.4%	12.8%
Only the husband should decide what kind of contraception to use.	1.6%	3.2%	6.4%	74.4%	14.4%
Only the wife should decide what kind of contraceptive to use.	0.0%	17.6%	6.4%	63.2%	12.8%
The husband and wife should decide what kind of contraception to use together.	24.8%	71.2%	0.8%	3.2%	0.0%
When a woman has a health problem or question related to pregnancy, she may decide on her own to seek the help of trained health personal.	12.8%	52.0%	2.4%	31.2%	1.6%
When a woman has a health problem or question related to child birth, she may decide on her own to seek the help of trained health personal.	13.6%	50.4%	4.0%	31.2%	0.8%
When a woman has a health problem or question related to care after she has given birth, she may decide on her own to seek the help of trained health personal.	13.6%	52.8%	1.6%	30.4%	1.6%
Women should have the same opportunities to receive health care as men.	19.2%	80.0%	0.0%	0.8%	0.0%
Women should not be put at risk by pregnancy and childbirth.	20.0%	65.6%	9.6%	4.8%	0.0%
Women should have the right to decide on their own at what age to marry.	10.4%	57.6%	4.8%	22.4%	4.8%
Women should have the right to be free from degrading treatment, including to be treated with respect and consideration when accessing sexual and reproductive health care services.	17.6%	80.0%	1.6%	0.8%	0.0%
Women should have the right to decide sexual and reproductive health issues (includes avoiding unwanted pregnancies, STIs, and sexual violence). Decisions must be respected.	16.0%	79.2%	2.4%	2.4%	0.0%

Only women should decide to breast feed.	10.4%	58.4%	5.6%	25.6%	0.0%

Perception on GBV

Women's awareness and their attitudes on GBV

Table 5 showed the attitudes of women towards GBV and their role in decision making. The results indicated that more than 60% of female respondents did not accept violence in the home as common and it is also proved that between 60% - 80% of female respondents did not agree on physical abuses or punishments towards women. Only 41% of female respondents agreed that they could marry at any age if they found a good husband. However, 73% of female respondents agreed that women can choose whom they wanted to marry. In the case of earning household income, the results showed that it is responsible for both men and women because 56% of female respondents disagree that men were most responsible for income and also 78% of female respondents disagree that women were most responsible for income either. 80% of female respondents disagree that women should be blamed for rape. Table 5 also indicated that the decision making on family planning and household affairs should decide by both husband and wife because 60% of the female respondents did not agree that only men should decide on child and household affairs and over 70% of female respondents disagree that only women should decide on child and household affairs either.

Table 5 Women's awareness and their attitudes on GBV

Please tell me the extent to which you agree or disagree with each statement.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
A wife should tolerate being beaten by her husband /partner in order to keep the family together.	8.7%	6.8%	0.8%	51.2%	32.5%
Husbands can give punishment when their wife does not obey him	7.5%	24.2%	6.0%	46.0%	16.3%
Violence at home is a common thing.	3.6%	28.6%	5.2%	52.8%	9.9%
A girl is never too young to be married if a good husband is found.	2.8%	38.1%	6.0%	41.3%	11.9%
If a wife goes out without telling her husband, he is justified in hitting or beating her.	2.4%	19.1%	1.6%	50.0%	27.0%
Women should choose themselves whom they want to marry.	14.3%	68.7%	4.0%	7.5%	5.6%
It is better to send a son to school than it is to send a daughter	1.2%	3.6%	0.4%	51.2%	43.7%
Men are responsible for earning most of the household income	6.0%	29.8%	7.9%	46.8%	9.5%
Women are responsible for earning most of the household income	0.0%	9.1%	12.7%	61.5%	16.7%
Only men should decide on child-related and household affairs.	3.6%	21.4%	14.7%	48.4%	11.9%
Only women should decide on child-related and household affairs.	0.8%	7.9%	18.3%	58.7%	14.3%

Men should use hard words/rude words based on the behavior of women.	3.6%	22.2%	3.2%	53.2%	17.9%
Women should be locked at home as punishment.	1.2%	3.2%	2.8%	54.4%	38.5%
Women should have equal rights as men.	27.0%	69.4%	1.6%	1.2%	0.8%
Men can have sex with wife as he wishes.	1.6%	12.7%	5.2%	69.1%	11.5%
Women cannot refuse sex to their husband.	0.4%	31.0%	6.0%	46.4%	16.3%
Women should not go out alone at night.	10.7%	57.9%	7.1%	21.0%	3.2%
Women should blame themselves when they are raped.	2.8%	13.1%	3.6%	57.1%	23.4%
Women can be blamed for rape because of their behavior (out late at night, in a quiet place, dressed sexy)	4.0%	19.8%	8.7%	51.6%	15.9%
Violence occurs due to power imbalance.	7.1%	73.8%	7.1%	9.9%	2.0%
When women experience violence, they should not talk about it to other people because it can bring shame to the family	3.6%	21.8%	3.2%	44.4%	27.0%
Regardless of the same type of work, women should not be paid the same as men.	2.0%	18.7%	2.8%	49.6%	27.0%
Only women should keep and preserve traditions and customs.	2.0%	2.8%	3.2%	51.2%	40.9%
Women should inherit like men.	1.2%	3.2%	1.6%	59.9%	34.1%

Men's awareness and their attitudes on GBV

Table 6 showed the attitudes of men towards GBV and the role of women in decision making. 61% of male respondents did not accept that violence at home is common because around three fourth of male respondents did not agree on physical abuses or punishments towards women. 41% of male respondents agreed that a girl can marry at any age if they found a good husband as shown in Table 6. However, over three fourth of the male respondents (82%) agreed that women can choose who they want to marry. 75% of male respondents disagreed that women should blame themselves when they are raped because one third of the male respondents (35%) believed that being raped is not only related with women but also related to men. 55% of male respondents did not agreed that they were responsible to earn most of the household income nor 87% of the male respondents also did not agreed that women were responsible to earn most of the household income as shown in Table 6.

Table 6 Men's awareness and their attitude on GBV

Please tell me the extent to which you agree or disagree with each statement.	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree
A wife should tolerate being beaten by her husband /partner in order to keep the family together.	3.2%	9.6%	4.0%	58.4%	24.8%
Husbands can give punishment when their wife does not obey him	4.0%	21.6%	8.0%	55.2%	11.2%
Violence at home is a common thing.	1.6%	29.6%	8.0%	48.0%	12.8%

A girl is never too young to be married if a good husband is found.	3.2%	37.6%	4.0%	46.4%	8.8%
If a wife goes out without telling her husband, he is justified in hitting or beating her.	4.8%	20.0%	1.6%	56.0%	17.6%
Women should choose themselves whom they want to marry.	13.6%	68.0%	2.4%	13.6%	2.4%
It is better to send a son to school than it is to send a daughter	2.4%	1.6%	0.0%	58.4%	37.6%
Men are responsible for earning most of the household income	7.2%	31.2%	6.4%	44.0%	11.2%
Women are responsible for earning most of the household income	9.6%	3.2%	0.0%	72.0%	15.2%
Only men should decide on child-related and household affairs.	6.4%	35.2%	8.0%	40.0%	10.4%
Only women should decide on child-related and household affairs.	13.6%	5.6%	0.0%	66.4%	14.4%
Men should use hard words/rude words based on the behavior of women.	3.2%	32.0%	5.6%	47.2%	12.0%
Women should be locked at home as punishment.	0.8%	5.6%	0.0%	67.2%	26.4%
Women should have equal rights as men	22.4%	76.0%	0.0%	0.8%	0.8%
Men can have sex with wife as he wishes.	2.4%	18.4%	8.0%	61.6%	9.6%
Women cannot refuse sex to their husband.	1.6%	27.2%	12.8%	44.0%	14.4%
Women should not go out alone at night.	8.8%	55.2%	4.8%	26.4%	4.8%
Women should blame themselves when they are raped.	2.4%	17.6%	4.8%	63.2%	12.0%
Women can be blamed for rape because of their behavior (out late at night, in a quiet place, dressed sexy)	3.2%	32.0%	10.4%	44.8%	9.6%
Violence occurs due to power imbalance.	8.8%	76.8%	4.0%	8.0%	2.4%
When women experience violence, they should not talk about it to other people because it can bring shame to the family	2.4%	30.4%	1.6%	40.8%	24.8%
Regardless of the same type of work, women should not be paid the same as men.	3.2%	19.2%	3.2%	54.4%	20.0%
Only women should keep and preserve traditions and customs.	0.8%	4.8%	1.6%	60.8%	32.0%
Women should inherit like men.	0.0%	5.6%	2.4%	70.4%	21.6%

Objective 4: Adolescents have equal access to sexual and reproductive health information and services, including family planning.

The indicator values for the objective 4 were obtained from the same dataset which was filtered for 14-24 year-old-age group.

% of adolescents reporting decision making regarding family planning

Percentage of adolescent reported they themselves or with their husband decide regarding the family planning was 42.4 % (n=33) in evaluation. There is no baseline or midterm data.

% reduction in ADOLESCENTS BIRTH rate

The fertility data is measured at township or state level by the government health system.

% adolescents' deliveries by skilled birth attendants (AMWs or MWs)

Only a few, 3 out of 33 respondents reported for this indicator. Among them 2 women reported that they delivered with traditional birth attendance and 1 woman reported delivered by midwife. There is no baseline or midterm data.

% reduction in early pregnancy

The adolescent fertility rate should be measured per 1,000 population and in Myanmar the fertility data is measured by the government. Nearly one third, 27.3% (n=33) of the 14 to 19-year-old women reported that they have ever been pregnant. This proxy percentage can be used as the indicator value for report. There is no baseline or midterm data.

Participated in project activities and benefits received
Place to Get treatment for illness

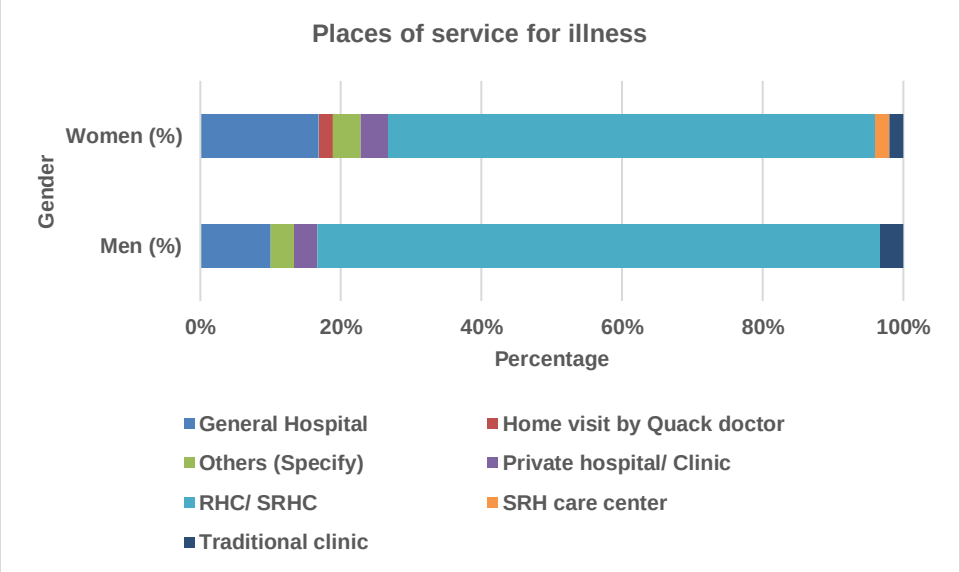

Figure 37: Places of service for illness

Men and women are asked whether they had illness and received treatment service in last year, and 81.1% and 92.7% of men and women who got illness had services. Among them, 80% of male respondents and 69% of female respondents responded that they got the services from RHC/ SRHC as shown in Figure 37. It was also found that there are only 2% of female respondents stated that they got the services from home visit by quack doctor and 3% of male respondents and 4% of female respondents responded that they got the services from others. It is showed that over 85% of male and female respondents got the services from General Hospital and RHC/ SRHC.

Service Provider for Illness

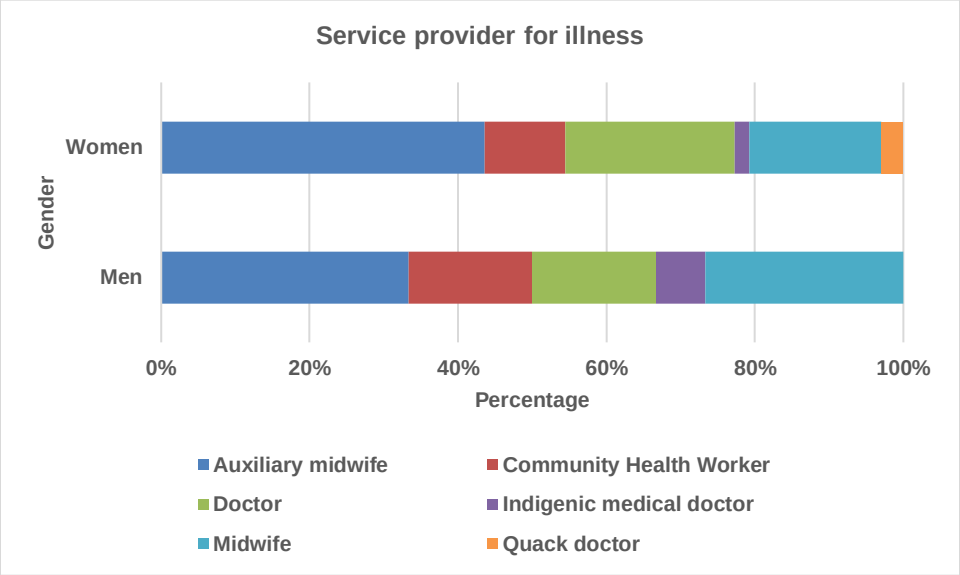

Figure 38: Service provider for illness

Figure 36 showed the services received by various health worker for the respondents. 44% of female and 33% of male respondents responded that they received the services from AMW and 18% of female and 27% of male respondents stated that they received the services from MW as shown in Figure 36. There are only 3% of female respondents mentioned that they received the services from Quack doctor and 2% of female and 7% of male respondents stated that they received the services from traditional medical doctor.

Referral for illness

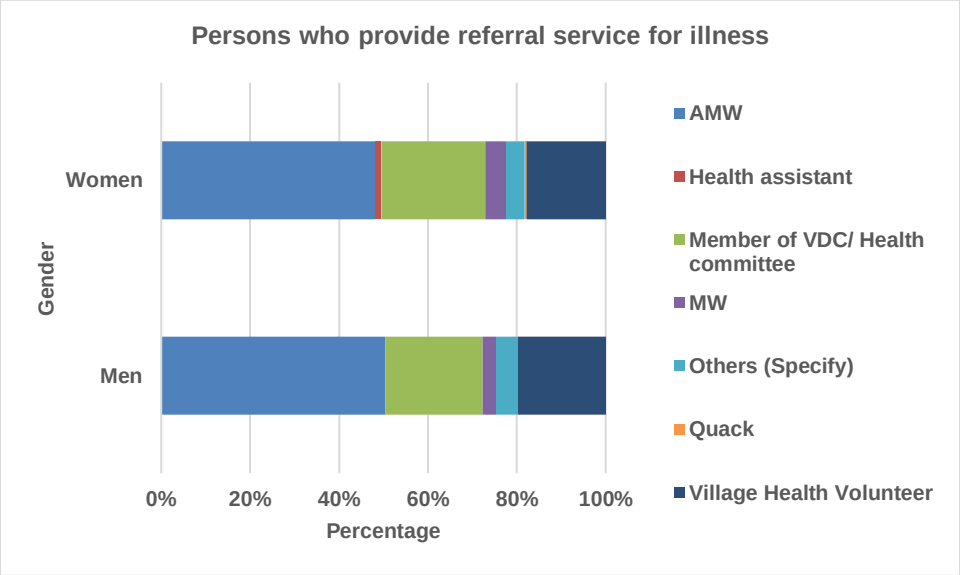

Figure 39: Persons who provide referral service for illness

About half, 48% of female and 51% of male respondents responded that they got the referral services from AMW and 23% of female and 22% of male respondents stated that they received the referral services from member of VDC/ Health committee as shown in Figure 39.

Received HE sessions regarding SMRH

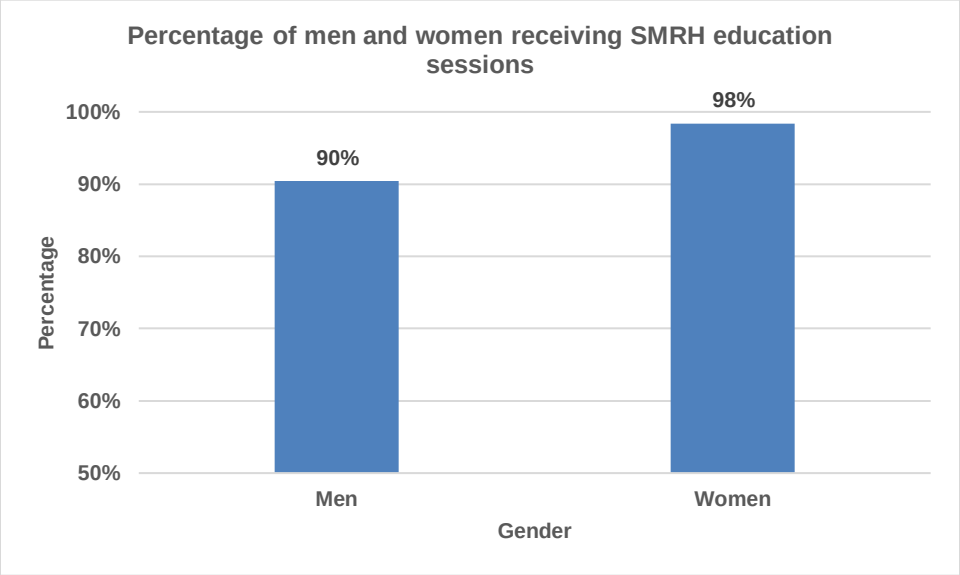

Figure 40: Percentage of men and women receiving SMRH education sessions

Figure 38 showed that almost every female respondent (98%) and 90% of male respondents received health education sessions regarding SMRH.

Person who provided HE session

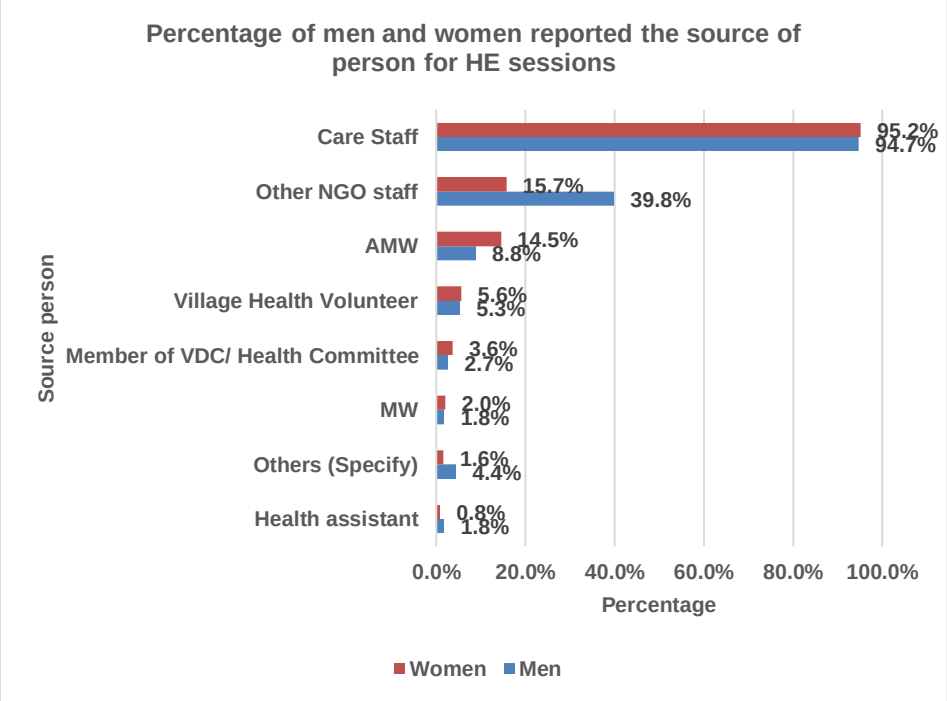

Figure 41: Percentage of men and women reported the source of person for HE sessions

Over 90% of the respondents both male and female received HE sessions from Care Myanmar staff and 16% of female and 40% of male respondents stated that they also received HE sessions from other NGO staff as shown in Figure 39. 15% of female and 9% of male respondents responded that they also received

HE sessions from AMW and there are very few respondents responded that they received HE sessions from other such as village health volunteer, member of VDC/ health committee, MW and health assistant as shown in Figure 41.

Relevance

The project's relevancy was measured against Care international program strategy, national plan, township situation, and community need.

The objective of the project is closely aligned with the 2020 Program Strategy of CARE International to help 100 million women and girls worldwide exercise their rights to sexual, reproductive and maternal health (SRMH). The partnership is strongly linked at the national level to the overall program strategy of CARE Myanmar, which focuses on women's empowerment in four priority areas: addressing gender-based violence (GBV); improving maternal and sexual reproductive health; social and political participation; and economic participation.

According to country's national strategic plan for maternal, newborn and child health development (2015-2018), community volunteers e.g., Community Health Workers (CHWs) and Auxiliary Midwives (AMWs) at village level are a critical link between the community and formal public health system.[1] Care Myanmar GSK project took the crucial role in linking community and formal public health system by providing supports for AMW and village level volunteer groups.

Care Myanmar can also contribute the need of the understaff issue of government health care system. The AMW from Care Myanmar can support the hard to reach areas and villages where the government health staffs cannot go. AMW assisted the midwives in maternal and child health care so that services provision could be expanded.

The literacy rate of those aged 15 and over in Lashio Township is 71.7 per cent. It is lower than the Union (89.5%). Of the rural population aged 25 and over, 55.9 per cent have never been to school. For women aged 15-49, the total fertility rate is 2.6 children per woman and is slightly higher than the total fertility rate of 2.5 at the National level. In Shan State, there are 278 women dying while during pregnancy/delivery or within 42 days of termination of pregnancy for every 100,000 live births.[2] Care Myanmar GSK project supported the community with health education messages in maternal and child health. Moreover, the project helped the couples in accessing the family planning methods. The project volunteer group members and money from village emergency fund and saving group helped the pregnant women to go to health centers and hospitals in case of emergency situations, which in turn contributed to reduce the maternal mortality of the township.

Community members said Care Myanmar has introduced them with the health education system, working as a volunteer groups, and how to seek health care. Domestic violence training was also tailored to the needs of the community and underwent changes after joining Care Myanmar.

"People who have never seen medicine have never been injected. The health workers here can't explain because they speak different languages. The volunteer at Care Myanmar can explain because they speak the same language", one of the member from village saving and loan association said.

[1] National Strategic Plan for maternal, newborn and child health development, Ministry of Health and Support (2015-2018)
[2] Lashio Township Profile report, Ministry of Labor, Immigration and Population, 2017

Efficiency

The cost effectiveness of the intervention was not measured theoretically as recommend by the efficiency measurement as those measurement need the compares group. The similar interventions in the different areas was not available to analyses the cost benefit analysis such as incremental cost-effectiveness ratio and benefit-cost ratio.

The efficiency was measured from the implementation aspect as follows. The majority of the activities were conducted according to the budget plan. There was some variation in the category of expenses regarding AMW which was previously planned to provide refresher training but need to do full trainings as government health staffs requested. However, the overspending of this category is the efficient use of budget as most of the maternal and child health issues were managed by AMW at the village level. Some of the budget use can be efficiently reduced by travelling together for one or more activities especially in the remote areas.

Sustainability

The project sustainability was measured through the interviews with staffs and volunteers. The findings of qualitative data showed the following aspects of the projects can be sustainable in the community after the project.

AMW

AMW were played the crucial role in the project not only in linking government health staffs and community, also as the main frontline person to provide treatment and care of mothers and children. The project has worked with government health staffs in training of AMW and after the project end, AMW functions will continue to operate in the villages with the supervision and support from government health system.

"Even though we do not get paid, our village still has health problems and language barriers I do not go anywhere else, I think I will always work for the village if I can get some medicine even though I do not have a salary," one of the AMW from the village said.

Emergency referral fund

Emergency referral fund has contributed to the emergency health care need cases in the village level. Almost all of the villages with emergency referral fund has its system to keep the amount of money intact or increase.

"Now it is over 10 lakhs. Now we have a long-term plan of how can we continue to operate and to increase the amount of money," one of the AMW said.

As part of exit strategy of GSK project, Care Myanmar staffs has discussed with government health staffs to monitor the efficient use of emergency referral fund in the village level. The village health committee has agreed to provide regular report to health staffs.

"After the Care Myanmar project, the midwife is responsible for overseeing the emergency health fund on the village committee. Since the auxiliary midwives are on that village health committee, they have to send a report to the relevant midwife, how much is left, how much is owed, and they have to send a report to the RHC to make sure the money is not lost often," one of the government health staff from RHC said.

However, there were some villages, where the emergency referral fund was decrease in amount. Villages fleeing the war have run out of emergency health funds. Some villages have to be replenished.

Knowledge

The community members has reported to have knowledge regarding sexual, maternal and child health due to the health education sessions conducted by the Care Myanmar staffs and volunteers. Moreover the volunteer group members monitored the situation of mothers and children and assisted to seek health care whenever necessary, men and women in the community nowadays understand to seek health care from health staffs.

Coordination

AMW and village health committee members had the regular contact with government health staffs regarding maternal and child health. The habit of working together in the ANC, delivery, PNC, immunization and treatment of ill children has built the foundation for the villagers to communicate with government health staffs for the future. As part of exit strategy of GSK project, Care Myanmar has discussed with both government health staff and community groups.

Community groups

Care Myanmar has mobilized the community groups such as village health committee, village saving and loan association, mother groups, and youth groups. The practice in the community working as group in the development activities has become a foundation for the other development activities and other projects.

The villages cooperate with the different local and international local organization with the current volunteer groups and this is one of the sustainable growth of the community.

“We have met with all organizations and discussed. When they are gone, we will continue to operate as they always have. There is an AMW in the village, and she work with the village volunteers and liaises with the government health department,” one of the member of mother group said.

Best Practices

The following best practices of the project were identified according to the quantitative and qualitative findings.

AMW

Selecting and training of AMW is one of the good practice of the GSK project. It helps the health system to provide health care to the community level and hard to reach areas. AMW midwives took the role in frontline health care provider for the villagers especially mother and children. The capacity building support and logistic supply support such as basic drugs to the AMW has become investment for the health of the villages. Moreover, most of the AMW were from the same villages so not only more sustainable for the community also community members can explain their health problems in their own language.

"Before the Care Myanmar asked me to work as a midwife, the villagers did not seek antenatal care whey they are pregnant and they delivered with the traditional birth attendant. They did not accept the child vaccination because of fever. I do health education monthly. As soon as I found a pregnant woman, I made a list and report to health center. People now accept the vaccine and pregnant women seek antenatal care. They also came to understand and family planning methods," one of the AMW said.

Village Emergency Referral Fund

For the case of emergency delivery and under 5 year old child illness, the patient can have the support of money from the emergency referral fund. The amount of money paid is different from 10,000MMK to 50,000 MMK as per the situation and village. In some villages, the money have to be returned but a few cases did not returned money. In some villages, the money is lent with interest to the other villagers who are ill. The community appreciated about the emergency funding support and they reported the contribution of that money to the saving of lives of mother and children in the village.

"If there is an emergency, it is difficult to go to the hospital in an emergency situation. I have experienced a lot. It is difficult. For someone who is poor and in state of emergency health state, she can get the money support easily and quickly. We arrange car for the transport with that money and send her to the hospital," one of the AMW said.

Good coordination with government health system staffs

Care Myanmar staffs conducted regular coordination meeting with government health staffs. As a result the health staffs mobile clinic activities were increased in term of frequency and area. Care Myanmar also support the transportation and communication with local community to health staffs, health staffs can go hard to reach villages.

"Care Myanmar helped us in immunization or health education campaigns. AMW also participated in every activities we conduct," one of the health staffs said.

Participatory approach method for project activities

In GSK project, Care Myanmar staffs has informed the community in every step of the implementation before the implementation, during the implementation and at the end of the project. Community consultations were conducted for the activities and decisions were made by the community facilitated by the Care Myanmar staff.

"They came to talk about mother and child death rates and asked us to participate or not. After we have agreed, they choose an AMW and trained. …… Now they said the project has ended and told us to maintain the emergency referral fund and continue the activities. Without them, we would have planned to make it sustainable" one of the member of village health committee said.

Village Saving and Loan Association

Care Myanmar has trained about the basic accounting to village saving and loan group. The group members said they have learnt how to save money and also how to do account for money. They planned

to continue saving practice as it is the good practice for them to use money in the health, education and family livelihoods.

“I know how to save money. Previously, we spend money as we earn and there was no big amount of money in hand. Now after Care saving group has founded, I have such amount of 2.5 Lakhs – 3 Lakhs per year,” one of the mother group member said.

Lesson learnt

The project lesson learnt reported here were drawn from the review of progress report and interviews with project staffs. The project has the following lessons learnt during the implementation period.

Community members have not been able to memorize the messages sent by project staff and volunteers. Audio-visual techniques and devices such as the use of the projector and role-playing sessions for health education sessions were used to better understand and pay much more attention to project staff. Participants are more interested and it was noted as one of the effective method for conducting health education sessions.

In conducting training courses, high levels of illiteracy was a challenge. It was difficult to generate proper understanding during the limited training days due to the low literacy level of targeted communities. Care Myanmar staffs used tools such as flipcharts, local dialogue, posters and group discussion to generate a better understanding of the training sessions.

In a saving group, bookkeeping skill is an important skill. Regular bookkeeping monitoring enhances their skills and increases the confidence of VSLA members who are assigned to accounting management.

In the targeted villages, youth target groups were not available because most of them had migrated. In coordination with the school health program, the project has changed the strategy for reaching young people. As a result, young people have been able to receive sexual and reproductive health and health education messages.

Challenges

Challenges from beneficiaries

Some of the beneficiaries especially men could not able to participate in the HE sessions and the reasons were reported they are busy with earning jobs or not interested as they are on drugs. There are still traditional belief that are hard to change reported by the volunteers such as exclusive breast feeding practice.

Challenges of implementation

Staffs

Project staffs reported the capacity need to implement the project activities more effectively. The new staffs need proper technical trainings to provide health education session in the villages.

As there were only a few young people in the community, the project staffs could not reach young people to provide health education. Some of the activities for the young people were cancelled Youth groups are not strong and members of the youth groups said they only participated in education sessions and no other youth group activities were reported at the time of evaluation.

Volunteers

There are some village health volunteers who reported capacity need to perform their duties. AMW also reported need of refresher training to know more about maternal, child health and other current health issues in the local area. There were some times the volunteers coincide their own earning activities and project activities and could not be able to provide.

Challenges that are beyond project scope

Transportation

There are some villages where transportation is very difficult. Some villages are not accessible even with motorcycle and walking is the only way to reach that village. The pregnant women from those villages faced difficulties to travel at the time of term pregnancy and emergency cases.

Arm conflicts

There are arm conflict areas in the targeted implementing villages. Project staffs activities were sometimes delayed due to the conflicts. From the community site, some villages have moved from place to place to avoid the war, they could not have health care or support. The village emergency referral fund were used during their difficult times.

Illiteracy

Some of the villages could not have AMW as there were no literate person to train as AMW. AMW should be at least primary education level and some villages do not have people who is at primary education and understand Myanmar language. Illiteracy also contributed to difficulty in understanding of health messages.

Some of the village emergency referral fund were not used properly as there was no person to manage those fund and do bookkeeping of money.

Migration

According to the reports from project staffs, most of the young people in the area were migrated to the other countries mostly to China and Thailand. As a result, the participation of young people in the project activities was low.

Challenge due to current pandemic

Some of the project activities were not implemented as planned due to the restriction of current pandemic. The activities that need group of people were cancelled as the gathering of people was restricted. There were also travel restrictions and government health staffs could not perform the routine immunization sessions. As a result, immunization schedule was late in some of the villages.

Conclusion

Conclusion was drawn based on the following perceptive.

Effectiveness: The GSK project has reached most of the target of the objective of strengthen the quality and sustainability of frontline health services; enhance the effectiveness of the health system for maternal, new-born and child health; mobilize communities to adopt health services-seeking and health-enabling behavior by various strategies. There was increase in percentages of women who received ANC, delivery and PNC from the qualified health staffs and volunteers. The immunization rates were increased. Children disease prevalence were reduced, and reported immunization percentage were increased. There was also increased in percentage of men and women tested for HIV and STI. Men and women knowledge about complication of pregnancy increased. Knowledge about SMRH and gender based violence increased.

Impact: At this time, the community is aware about the important of seeking health care during pregnancy, delivery and post natal periods. Wrong perceptions about immunizations were reduced and people accept the immunization more. Gender based violence cases were reduced in the community and men participation in SMRH activities were improved. The community volunteer groups have formed and their institutional capacity was built to some extent.

Relevance: The GSK project has filled the staff need of the government health care system by training AMW and volunteers. It also contribute the national strategic plan of maternal and child health by linking government health staffs and community. The community members themselves expressed that the project has full filled their need regarding knowledge and support for sexual, maternal and reproductive health issues.

Efficiency: The use of project expenses are according to the project budget. There are some possible ways of using the budget to be more efficient to produce output such as combining travel costs.

Sustainability: The community members from the targeted villages received knowledge about maternal, child and reproductive health and health seeking behaviors for pregnancy and child care. There are volunteer groups from the community who will continue sharing knowledge to the mothers. AMW were recruited mostly from the same villages who will continue to work for the community after the GSK project. The village health committee has coordinated with government health staffs for the supervision support.

Recommendation

Given that the evaluation is the end of the evaluation of the project, the following recommendations intend to support the new projects to be implemented in other areas. Based on differences between other areas in the local context, additional considerations may be needed to apply those recommendations to other areas.

To apply the good practices in other implementation areas

The project has implemented many good practices such as working as complementary to government health system, informing community in project decisions, establishment of community volunteer groups, recruitment of AMW, and provided village emergency referral fund. Those good practices should be applied to other similar projects in the different area.

Management capacity building of volunteer groups

Although the GSK project has mobilized the volunteer groups at the community level, some of the volunteer groups need management capacity building of members such as financial management, planning, leadership, coordination and communication with different organizations. In the areas where there is more than one organization to support the village, the village level groups need to allocate resource efficiently and coordinate well with different stakeholders.

Refresher training to volunteers

One of the challenges reported by the AMW and village health volunteer is the need of training in some cases and refresher training for those who already had training. AMW should be provided regular refresher training and include the updated health issues in the local area.

Capacity Building Plan for the Project Staffs

There were drop-out of staffs during the project implementation period. The newly recruited should receive a package of trainings related to his/her responsibilities including both technical and management knowledge. The new staff training package should be developed with all of the training curricula related to technical issues of the project and should make a plan to provide to all new staffs.

Safe Migration Message to youth groups

The evaluation found out the migration issue of young people in the targeted area. The organization should consider the migrant issue which can be related to trafficking, HIV and STI. The safe migration training should be included in the trainings of youth groups.

Annexes

Annex A: Tabulation Reports (attached)

Annex B: Female Questionnaire (attached)

Annex C: Male Questionnaire (attached)

References Page

- Myanmar Demographic and Health Survey (2015-2016)
- Lashio Township Report, Department of Population, Ministry of Labor, Immigration and Population, October 2017
- Five-year Strategic Plan for Reproductive Health (2014-2018), Ministry of Health and Sport, Myanmar.
- National Strategic Plan for Newborn and Child health Development (2015-2018), Ministry of Health and Sport, Myanmar