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# **List of Acronyms**

AMW Auxiliary Midwife

BHS Basic Health Staff

CBO Community Based Organization

CF Community Facilitator

DoH Department of Health

FGD Focus Group Discussion

FO Field Office

FOC Field Office Coordinator

KII Key Informant Interview

MEN Men Engagement Network

MH Maternal Health

MMK Myanmar Kyats (Myanmar currency, 1 USD ~ 960 MMK)

MoH Ministry of Health

MS Muse Township

MSC Most Significant Change Stories

MSI Marie Stopes International

MTR Midterm Review

MW Midwife

NORAD Norwegian Agency for Development Cooperation

RHC Rural Health Centre

SRHR Sexual and Reproductive Health and Rights

SGBV Sexual Gender-Based Violence

SRH Sexual and Reproductive Health

STIs Sexually Transmitted Infections

VDC Village Development Committee

VSLA Village Saving and Loan Association

WAA Women Affair Association

WEP Women Empowerment Program

WIN Women Initiative Network

# **Executive Summary**

Gender inequality is deeply embedded in Myanmar. Whilst Myanmar is a signatory to the Convention on Elimination of all forms of Discrimination Against Women (CEDAW) and the constitution guarantees equality before the law, women face significant challenges in realizing equal participation in decision making positions at all levels and especially in local development structures. Women in Myanmar are actively involved in agriculture but they suffer from discriminatory practices affecting control and ownership over land. Only men can inherit land for example. Traditional gender roles and responsibilities in both marriage and community affairs severely constrain their economic security and rights. In the programme areas of Muse district in northern Shan state, which has a border and official crossing into china, reproductive health, trafficking of women and girls, drug use (opium and heroin in particular), and the risk of HIV AIDS, are negatively affecting the lives of women and girls.[[1]](#footnote-1)

CARE Myanmar has worked in Muse district in northern Shan State since 1998. The original expected outcomes or objectives of the CARE Myanmar Women´s Empowerment Programme (WEP) were:

* To increase economic security for Women’s Support Group members
* To reduce the impact of drug use in target communities
* To address barriers to women’s social development and participation
* To ensure that men engage in positive ways to promote women’s empowerment
* To promote the effective and efficient internal and external program learning

Based on the above objectives and outcomes, a mid-term review was conducted by CARE Myanmar in April 2012. As one of the main components of WEP is learning and expanding its initiatives, CARE Myanmar has been reflecting and assessing its program design throughout in order to address the community’s needs and scale up the projects’ results more effectively. One of the major learning points was the need to shift the programme’s primary focus on harm reduction to a focus on sexual and reproductive health rights (SRHR). For the endline evaluation, the logical framework was revised as follows:

Overall Program Goal: To increase voice, decision-making and social well-being of women in Northern Shan State, Myanmar.

* Objective 1: To reduce barriers in accessing quality SRH care and information
* Objective 2: To increase men’s positive engagement to promote women’s empowerment
* Objective 3: To increase effective and efficient internal and external program learning

The primary target group is women living in Muse and Namkhan townships in the Muse District who are experiencing vulnerabilities related to economic insecurity, water access and reproductive health issues, particularly those resulting from the presence of drug issues in their household. The indirect beneficiaries include men and children living in the participating villages.

|  |  |  |
| --- | --- | --- |
| **Outcome indicators** | **Baseline 2009** | **Endline 2014** |
| **2) Women's attitude towards the empowerment of women** | | |
| - The protection of women's economic security (property rights, inheritance, etc.) | - | 3.77 |
| - Women’s participation in the public sphere, decision making at community level | -[[2]](#footnote-2) | 3.59 |
| - Social inclusion | 3.84[[3]](#footnote-3) | 3.72 |
| - Protecting the rights of SRH and maternal health | -[[4]](#footnote-4) | 3.95 |
| - Attitudes of women regarding GBV (domestic violence, harassment harmful traditional practices such as FGM, early marriage, etc.) | 2.95 | 2.24 |
| 2) **Measurement of attitude of men concerning women's empowerment** | | |
| - The protection of women's economic security (property rights, inheritance, etc.) | 3.13 | 3.59 |
| - Attitudes of men regarding GBV (domestic violence, harassment harmful traditional practices such as FGM, early marriage, etc.) | 3.00 | 2.14 |
| **Indicators** | | |
| % Women who control over assets in the household | 96.3% | 58.1% |
| % Women with the capacity to cope with economic shocks | 25.1% | - [[5]](#footnote-5) |
| % of women reporting meaningful participation in decision - making bodies | - [[6]](#footnote-6) | 27.4% |
| % of women reporting being satisfied with the availability and quality of sexual and reproductive health services | - | 98.6% |
| % Women making decisions / making informed choices about their sexual and reproductive health. | - | 100% |

**Sexual and reproductive health and rights**

In relation to Objective 1, as Table 1 shows, CARE Myanmar has been successful in contributing to positive changes in the lives of program participants sexual and reproductive health rights (SRHR). The percentage of women reporting utilization of SRHR related services at endline has increased compared to the baseline. VSLA members are more likely to report satisfaction with combined oral contraceptive pill (OC pills). In terms of the percentage of women making informed choices/decisions with regard to SRHR, the percentage of women using contraceptives based on valid information and self/ joint decision has also increased since the baseline stage.

The support of CARE staff members, government, and Auxiliary Midwives (AMW) provided frequent trainings, education, awareness and discussions on SRH, family planning and birth spacing at VSLA meetings. There have been discussions among women at VSLA meetings on birth spacing, malaria eradication, and SRH. The provision of medicines by CARE and the continuous support from the AMW have helped women improved their SRH.

Both men and women evidence more positive attitudes in support of women´s SRHR compared to attitudes and views recorded at the start of the programme. The quantitative data shows that women’s attitudes towards gender equitable norms related to the protection of women’s SRHR and mental health are positive. At endline, in response to a set of questions relating to attitudes towards protection of their SRHR and maternal health, the average score for all women was 3.95 (on a scale from 1-5 where 5 is the most positive). Men also evidence greater support for women accessing SRH care and information and their decision-making about their own sexual and reproductive health. Both men and women surveyed evidence greater knowledge about HIV AIDS and STIs, than those who were surveyed at baseline stage.

The study shows that women and men have gained better knowledge about SRH and birth spacing. Many women stated that they transferred their SHR and birth spacing knowledge to their husbands and also freely and openly discussed SHR and birth spacing together with them. They had never done this before. In addition, many husbands accompanied the women to the clinics and hospital for medical check-ups and treatment and were also doing house chores such as cooking and cleaning during the women’s pregnancy.

Women’s knowledge and understanding of HIV issues have increased since baseline- a higher proportion of women respondents have heard of HIV-AIDS and STIs through sources such as health workers or through health education sessions conducted by NGOs. Similarly a higher proportion of women evidenced awareness of the place of treatment of STIs, and where to go for HIV counselling and testing compared to baseline stage.

**Men’s positive engagement to promote women’s empowerment**

Following the Mid Term Review in April 2012, men´s engagement in WEP was a new reflection point for CARE Myanmar and the staff had digested the concepts, improved awareness as a clear cross cutting strategy while doing WEP so that it will prevent men from exclusion and lead to gender equality. The project team with the support of Gender Advisor and Health Advisor then developed the Men engage (ME) strategy for WEP to contribute to the gender transformative program in the remaining projects period. The MTR sets out that More awareness raising activities will be carried out in Year 3 through activities such as men forum, women forum, special events and capacity building.

The programme has been successful at contributing to improved attitudes of men towards women’s empowerment in Muse, Namp Kham as Table 2 shows. Men (and women) are more likely to evidence more supportive views for prevention of Gender Based violence than at baseline. This is illustrated by response to the statement about beating of wives if food is burnt; this was supported by over 60% as acceptable at baseline; but by less than 3% at endline stage.

The WIN and MEN programme have been successful in shifting views and attitudes toward women’s economic security. Men and women were both more supportive that women should inherit property, work outside the home and that their roles extended beyond just taking care of the house.

**Women´s meaningful participation in decision-making activities**

VDCs were formed with the objective of creating a space for women being recognized and participating meaningfully at the community level. The endline results show that behavior in relation to women´s meaningful participation has shifted. Men interviewed for the qualitative research explained that women are free to participate in every development group in the village as members as well as leading the group. Many men also think that there is a need to cooperate and to exchange ideas with women, as there are many things that men alone are unable to handle. In some villages, women took the initiative to clean the villages and also lead anti narcotic drug groups, and became involved in church and monastery activities; and as a result they have gained in agency - health knowledge, financial management and business and even gained much more confident to speak in the meeting freely. The collected data also show that women’s participation in decision making for instance, public and community level increased.

The endline results also show that in some villages, the development activities of the village now become more vibrant and the members of VSLA are more proactive. Many of the women who were staying and working at home now come out and work together with other members for the villages; the villagers are now more united and have good social relationship. In some villages, women now can take the role of chairman, secretary, accountant, and audit positions. In addition, the men are also listening to women with respect in the meetings, and now more women participated in the meeting than men in terms of number.

Regarding the participation of women in decision making at the household level, the findings show that after CARE Myanmar development intervention, women have more chances to participate in other families’ incomes activities, share more responsibilities with their husband, and also in a position to make decision on some issues on their own and also have discussion with their husband and families for decision making. At household level work, according to the women respondents, men’s thinking, views and attitude toward women have significantly changed to some extent after CARE provided training and discussion frequently taken place with Care staff support. Many men in the villages now are seen to take or share responsibilities with women such as fetching water, cooking and even washing clothing. Some men stated that they keep the money with the women, discussed issues with them before making decision and they make decision together.

**Women´s economic security**

The endline highlights changes in people’s mindset regarding access and control over the household assets. At endline point women´s control of household assets is reported to be 58.1% from 96.3% at baseline stage this is linked to the pervasive, traditional inheritance transfers. However many of the participants in the qualitative research expressed that they are happy to share their property both to their sons and daughter. In some cases, some family members also inherited land and other property to their daughters and if the father inherited the land to the daughter, the land entitlement is with her name and the name cannot be changed.

Men’s attitudes towards women’s economic security and perception have also changed compared to baseline. According to the men surveyed, over 70% agreed that a married woman should be allowed to work outside the home; also nearly 99 % agreed that women should be able to own and control the same assets and more than 85% stated that women should be able to inherit and keep property or assets as well. Most importantly, over 66% correspondents disagreed that only men should make the major decisions.

Members from the community benefited from VSLA activities to solve their needs and also increase their incomes, and also use it for other emergency case such as health problems. Women were encouraged to save money for the saving day, especially for the next saving cycle at VSLA. Some families’ member have been able to invest in agriculture IGAs for example, with the money they borrow from VSLA.

**Attitudes to Gender Based Violence**

Women´s average attitude scores at endline indicate more positive views regarding gender-based violence compared to baseline stage (2.24 compared to 2.95)[[7]](#footnote-7). However men´s average attitude scores were less positive (with scores of 3.59 at endline compared to 3.13 at baseline). In a statement related to gender base violence, more than 70% of female correspondents disagreed to that a wife should tolerate being beaten by the husband or partner. More than 90 % of both men and women correspondents disagreed to that when a wife burns the food it is only proper that her husband/partner discipline her by hitting or beating her.

The qualitative research also indicates that domestic violence has reduced, especially after CARE arrived in these communities, as they provided training and awareness on domestic violence and counseling. In addition, the study also shows that in terms of domestic violence, the women from VSLA groups are active provided counseling, negotiation between husbands and wives, and helping couples to understand and solve their issues.

# **Introduction**

## **Brief description of the project**

CARE Myanmar has joined Care Norway’s Women Empowerment Programmes in its second phase (2009-2013). CARE Myanmar’s Women Initiative Network (WIN) project funded by NORAD and supported by Care Norway is designed to promote women participation in community level decision-making and empower women to be able to initiate and implement actions to address their economic and social issues, which affect their day-to-day lives. The Men Engagement Network (MEN) project is designed based on CN’s concept note on engaging men in gender equality and women’s empowerment programs issued on March 2009 to ensure that men engage in positive ways to promote women’s empowerment.

## **Theory of change and results framework**

One important element of the ILPI evaluation has been to reflect on the WEP theory of change and establish those elements of the assumptions, pathways, and relationships within the theory of change that were functioning more or less effectively and the extent to which this theory was adaptable to the changing needs and context. In a sense the strength of a good theory of change, is that it is able to be a flexible and evolving tool that can adjust over time. The original expected outcomes or objectives of the CARE Myanmar WEP are as followed:

1. To increase economic security for Women’s Support Group members
2. To reduce the impact of drug use in target communities (This outcome was excluded in the Year 2 work plan submitted on 1 June 2011)
3. To address barriers to women’s social development and participation
4. To ensure that men engage in positive ways to promote women’s empowerment
5. To promote the effective and efficient internal and external program learning

Based on the above objectives and outcomes, a mid-term review was conducted by CARE Myanmar in April 2012. As one of the main components of the Women Empowerment Program (WEP) is learning and expanding its initiatives, CARE Myanmar has been reflecting and assessing its program design throughout in order to address the community’s needs and scale up the projects’ results more effectively. One of the major learning point of WIN-MEN was that the programme has changed from its primary focus on harm reduction to sexual and reproductive health rights (SRHR) based on a number of specific learning points. Firstly CARE and its previous partner have expertise on service unit based harm reduction approach rather than community based participatory harm reduction, this move was also in response to the shift of CARE Myanmar to program approach. Secondly Sexual and Reproductive Health and Right (SRHR) needs were stated by the community as a priority. Finally learning from WEP on SRHR workshop in Tanzania during April 2011.

In order to contribute the expected goal, VSLAs are used as the entry point. Though VSLA approach is not new to CARE Myanmar, SRHR and WEP including ME via VSLA approach is quite new to CARE Myanmar as well as to the project area (Muse, Namp Kham), where CARE and other agencies were implementing service based harm reduction and basic health promotion. CARE Myanmar has also recently adopted the program approach, and is in the process of aligning WIN and MEN projects to the women’s empowerment framework. In this context, the focus on sexual and reproductive health will help the programme to achieve its intended results more effectively. Although the design has changed significantly, the activities done so far were still valid with the new focus because majority of the activities in Year 1 focused on community mobilization, gender research, baseline study and assessment for water system construction. After having a new focus, the project team has developed its vision, mission and outcome challenges. According to outcome mapping facilitated by CO M&E team and these tools were used for second-time sensitization meetings with the community and the formed CBOs and volunteers such as Village Development Committee (VDC), Village Saving and Loan Association VSLA and Auxiliary Midwifes (AMW).

Due to the context of Myanmar, advocating women leadership and empowerment to the governmental leaders is a sensitive issue, hence, the CARE Myanmar women empowerment programme was designed to mobilize the inclusion of local leaders in VDC formation to raise their gender awareness and gender sensitivity by projects’ capacity building initiatives and their regular contacts with the project team. At the country office level, CARE Myanmar is partnering with other agencies working for gender equality in order to increase the gender awareness of the government.

For endline evaluation, the logical framework was revised as follows:

**Overall Program Goal:** To increase voices, decision-making and social well being of women in Northern Shan State, Myanmar.

**Objective 1:** To reduce barriers in accessing quality SRH care and information

**Objective 2:** To increase men’s positive engagement to promote women’s empowerment

**Objective 3:** To increase effective and efficient internal and external program learning**.**

The endline evaluation was conducted in March 2014. Before data collection was carried out, capacity building workshop was held in Muse Township in Shan State. The training incorporated Care’s theory of change as well. The findings of the endline evaluation were based on the revised logical framework.

## **Objectives of the endline study**

The objectives of the endline study are to:

* Assess the changes the program has contributed for creating on the lives of the program participants using expected objectives/outcomes at country level as a starting point.
* To explore unintended positive and negative effects the programs have had on the program participants and impact group.
* To explore the causes/ explanations for the observed changes

### Limitations of the study

There are a number of limitations in the end-line study that posed several challenges in the evaluation process. The main challenge rests with the timing the evaluation was conducted. Since the evaluation was carried out after the Care staff in Muse had already left, the team members were not able to speak with relevant persons who understand the project in the area. In addition, most of the researchers have not done evaluation limiting their interview skills.

Another limitation lies with the need of translation from Shan to Burmese, which could lead to understanding of concepts such as gender equality. Some respondents were also reluctant to important questions, which they perceived as sensitive and cultural practices.

### Structure of the report

The report has four sections related to the objectives of the study and the logical framework of Care Myanmar programme:

* The methodology employed to conduct the qualitative endline study in terms of sampling and data collection. It explains the techniques of data collection and how respondents were selected.
* The study results are reviewed in relation to the key outcome indicator areas
* The key findings of endline evaluation through qualitative data available.
* A short conclusion and recommendations.

# 

# **Methodology**

## **Qualitative Approach**

### Sample size

Before the training started in early March 2014 in Muse, the evaluation tools were developed and agreed in Yangon. Apart from observation, the following tools were employed for qualitative evaluation;

* Focus Group Discussion,
* Key Informant Interview, and
* Most Significant Changes

Table 3 below provides an overview of the qualitative evaluation tools used at endline stage.

**Table 3: Overview of evaluation tools**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Evaluation tools** | **Muse Township** | | **Namp Kham Township** | | **Remark** |
| **# of session** | **Respondents** | **# of session** | **Respondents** |
| **FGD** | 9 | VSLA (M +F), VDC (F),VSLA (F),VSLA (M),VDC (M),VDC (M+F),VSLA+ VDC, VSLA + Non-VSLA, Other (Third party) | 9 | VDC +Non-VDC,VSLA(M),VDC(F),VSLA+ Non VSLA, VDC(M),VDC (M+F),  VSLA(F),VSLA(M+F),  VSLA+VDC | Total FGD =18 |
| **KII** | 9 | AMW,VSLA,MW (DoH),VL,RL,CL,NGO,MWAF, | 13 | AMW,LA,VSLA(leader),VDC(4), DoH, CL,RL,VL, MW,  Other | Total KII= 22 |
| **MSC** | 8 | VDC(2).VSLA(2),AMW (2), Ex-Care staff (2) | 7 | VDC (3),VSLA(2),AMW(1),  Ex-Care staff (1) | Total MSC = 15 |
| **Grand Total** | **26** |  | **29** |  | **55** |

It’s noted that 35% of the respondents are men and 65% women in both townships. In addition, 15% of respondents are counted as non-VSLA/VDC members. Interviews were carried out in 16 villages (8 villages each in Muse and Nam Kham Townships).

### How qualitative respondents were selected

Gender perspective was the guiding principle in the study. Therefore, the study team interviewed both men and women reflecting the perspectives of the community. The perspectives of female-headed households and village administrators were also taken into account in selecting the respondents. It’s also worth to note that all the researchers are women. The average age of respondents ranged between 30 and 40. The researchers were instructed about self-introduction, objective of the study, and voluntary participation in the interview. Researchers were also instructed not to coerce into participating against their will and told that respondents have the right to ignore questions they feel inappropriate and told that they could withdraw during the interview at any time.

The majority of respondents are Shan and Palaung ethnics. A few Kachin respondents from Nam Kham were also interviewed. FGDs are divided into three types; (1) Male group, (2) Female group, and (3) Mixed sex in which most respondents are members of VDC/VSLA with a few from non-VSLA/VDC members taking part as third party.

### Qualitative Data collection techniques

The CARE Myanmar team data collection approaches for qualitative research involved the followings:

* Direct interaction with individuals on a one to one basis (using the Key Informant Interview Approach)
* Direct interaction with individuals in a group setting (using the Focus Group Discussion Approach)
* Most Significant Changes
* Observations

### Difficulties during qualitative data collection

The CARE Myanmar team endline qualitative study used semi-structured interviews and probing questions are to be undertaken by the researchers. The evaluation team noted the following difficulties:

* Local authorities didn’t approve selected villages to be studied due to security situation. For example, only 4 villages were approved by the Nam Kham authorities out of 8 villages
* Targeted villagers such as VSLA members were not present as they were in the farm field or busy with wedding ceremony, which the team could not reach.
* The team could not meet with people who have good knowledge of CARE activities in some villages.
* The team members had difficulty understanding of some questions (long), which were provided at later stage causing time constraint.
* Due to conflict occurring in Nam Kham area, respondents had to come from village to the town for attending interviews.
* The local authorities (line departments) could not give time for interview.

### Ethical considerations

During the training of trainers’ workshop in March 2014 in Muse township of Northern Shan State, it was agreed that researchers respect the respondents, treat them with confidentiality and their rights to withdraw during the interview as well as asking questions if they have any to the researchers as well. The researchers interviewed both male and female.

## **Quantitative sampling**

In order to help quantitative sampling, a pilot test of the survey was first done in Muse to 5 male and 7 females. Based on the result from the pilot test, the questionnaires were further modified. When selecting non-VSLA respondents, respondents were selected who have heard about Care activities in the area so that perspectives from VSLA members and non-VSLA members are reflected. Villages were selected in cooperation with surveyors that considered security situation and road access.

When sampling, both the consultant, surveyors and Care staff (from Yangon) altogether made agreement for the selection. Thus, 258 HH for both townships (120 HH for Muse and 138 HH) were selected, CARE Myanmar made the decision not to use using random sampling due to unavailability of many households anticipated during the interview in addition to security issues. In the final sample 80% of the sampling covered the Care project areas. 70% of respondents were VSLA/VDC members and 25% covered non-VSLA/VDC members. In total 257 respondents from project areas in Muse were interviewed, 182 of whom were women and 91% of them are women and 83 % of them are men from VDC/VSLA members.

**Table 4 Quantitative sample sizes**

|  |  |  |  |
| --- | --- | --- | --- |
|  | **Women** | **Men** | **Both** |
| VDC/VSLA membership | 91.8% | 62.7% | 83.3% |
| n | 182 | 75 | 257 |
| Age (Mean) | 38.06 | 39.01 | 38.34 |

## **Family and Education**

The majority of men and women (VDC/VSLA) members are married and a small number of other members are single, widow and divorced families. Regarding their education level, between 28 % and 30 % of the members, which are majority have completed middle school, the second highest number, 22% of members finished their primary school, the third group does not have any formal education and a few of them are university graduates.

Responses to the survey show that literacy rates are relatively high, 73 % of both men and women members can write and read and the rest of the 17 % of the members are unable to write and read. Some of the correspondents do not provide any response.

## **Main source of Income**

As Table 5 shows, the main sources of income and livelihood for both men and women in Muse and Nam Kham Townships is farming. The remainder of the sample are engaged in trading, charcoal making, transport and 8% of men and women engaged in casual labour. This compares to 77% of men and women at baseline who were engaged in farming.

**Table 5. Main sources of income**

|  |  |  |  |
| --- | --- | --- | --- |
| **Main source of Income** | **Women** | **Men** | **Both** |
| 1. Casual Labor | 8.80% | 6.70% | 8.20% |
| 2. Farmer | 58.80% | 62.70% | 59.90% |
| 3. Livestock Farmer | 1.10% |  | 0.80% |
| 4. Trader | 2.20% | 1.30% | 1.90% |
| 6. Government Employee | 2.20% | 4.00% | 2.70% |
| 7. Private Sector Employee |  | 1.30% | 0.40% |
| 10. Dependent | 1.10% | 1.30% | 1.20% |
| 11. Charcoal making | 2.70% | 5.30% | 3.50% |
| 13. Firewood cutting | 0.50% |  | 0.40% |
| 14. Transport business (own vehicle) | 0.50% | 1.30% | 0.80% |
| 99. Others | 22.00% | 16.00% | 20.20% |
|  |  |  |  |

# **Objective 1: Accessing quality SRH Care & information**

## **Key findings**

The focus of Objective 1 is to reduce barriers in accessing quality SRH care and information. According to the baseline study in August 2010, awareness on health services and SRH was high, however, the utilization was low.[[8]](#footnote-8) This was still a valid finding at mid term stage, as reported in the mid term report. According to the findings, the villagers have a better health condition regarding SRH. In relation to Objective 1, as Table 6 shows CARE Myanmar has been successful in contributing to positive changes in the lives of program participants sexual and reproductive health rights (SRHR). The % of women reporting utilization of SRHR related services at endline has increased compared to baseline stage and VDS, VSLA members are more likely to report satisfaction with OC Pills. In terms of the % of women making informed choices/decisions with regard to SRHR, the % of women using contraceptives based on valid information and self/ joint decision has also increased since baseline stage. Both men and women evidence more positive attitudes in support of women´s SRHR compared to attitudes and views recorded at the start of the programme. Men in particular evidence greater support for women accessing SRH care and information and their decision-making about their own sexual and reproductive health. Both men and women surveyed evidence greater knowledge about HIV AIDS and STIs, than those who were surveyed at baseline stage

**Table 6 SRHR: Baseline and Endline values of key verifiable log-frame indicators**

|  |  |  |
| --- | --- | --- |
| **Sexual and Reproductive Health Rights**  **\*Text in green indicates positive shift since baseline** | | |
| **% of women reporting satisfaction with the availability and quality of SRHR related services** | **% Women reporting utilization (satisfaction)**   * Condoms: 5% (100%) * OC Pills: 13% (82%) * Injectable contraceptives: 38% (85%) | VDS / VSLA members only  **% Women reporting utilization (satisfaction)**   * Condoms: 94.4% (91.7%) * OC Pills: (100%) 98.6 % * Injectable contraceptives: not asked. * Treatment for STIs: 46.6% (38.9%) |
| **% of women making informed choices/decisions with regard to SRHR** | **% Utilization based on valid information and self/ joint decision**   * Condoms: 3% * OC Pills: 6% * Injectable contraceptives: 23% * ANC: 46% * Institutional delivery: 12% * PNC: 38%   **% Supporting women’s SRHR**   * Couple should decide together how many children to have: 92% women and 84% men agree/strongly agree * Couple should decide on contraception: 88% women and 79% men agree/strongly agree * Women can independently seek healthcare: 70% women and 56% men agree/strongly agree | VDS / VSLA members only  **% Utilization based on valid information and self/ joint decision**   * Condoms: 94.4% * OC Pills: 100% * Treatment for STIs: 38.9%   **% Supporting women’s SRHR**   * Couple should decide together how many children to have: 96.2 % women and 97.3% men agree/strongly agree * Couple should decide on contraception: 97.8% women and 97.3% men agree/strongly agree * Women can independently seek healthcare: 69.2% women and 72% men agree/strongly agree |
| **HIV-AIDS and STI** | *Statements:  % Respondents Agree/Strongly agree*  **Knowledge on HIV-AIDS and STI**   * Heard about HIV-AIDS & STI: Women 73%, Men 67% * Knowledge of STI treatment place: Women 30%, Men 21% * Knowledge of HIV testing Centre: Women 26%, Men 21% | *Statements:  % Respondents Agree/Strongly agree*  **Knowledge on HIV-AIDS and STI**   * NA at endline * Knowledge of STI treatment place: 46.6% Women Men 57.3 % * Knowledge of HIV testing Centre: Women 63.6 % Men 47.9%, |
| **Attitude toward women’s decision making** | *Statements: % Respondents Agree/Strongly agree*   * Justified in asking for condom use: Women 80%, Men 67% * Equal opportunity for healthcare: Women 94%, Men 86% | *Statements: % Respondents Agree/Strongly agree*   * Justified in asking for condom use: Women 98.4%, Men 87.3% * Equal opportunity for healthcare: Women 98.4%, Men 98.7% |

We will explore the causes and explanations for the changes the program has contributed for creating on the lives of the program participants related to SRHR using expected objectives/outcomes at country level as a starting point in the following section.

### Health services related to pregnancy and birth care

The support of CARE staff members, government, and AMW provided frequent trainings, education, awareness and discussion about SRH, family planning and birth spacing at VSLA meetings. In addition, there have been discussions among women at VLSA meetings on birth spacing, malaria eradication, and SRH. In addition, with the medicine support and revolving fund provided by CARE and also the continuous support from AMW help the women improved their SRH issues.

Regarding women’s knowledge, use and satisfaction with health services related to pregnancy and birth care, there have been positive changes for both female members and non-members of VDC/VLSA. Especially for antenatal screening and care, (Table A18) nearly 100% of the women surveyed stated that they have heard about the services and information from reliable source, used it alone or with partner, and are completely satisfied with the services. This compares to less than 80% of women who had heard about antenatal services at baseline.

Additionally, 88 % of VDC / VSLA (compared to 82.9% of non members) have heard about hospitals, clinics or birth spacing centers where women can give birth assisted by skilled personnel, of those who heard about these services – 100% of non members and 91% of members reported they had used the services in the past 12 months. This compares to around 70% of women at baseline stage.

When it is related men’s knowledge, use and satisfaction with health services related to pregnancy and birth care, the responses percentage is slightly lower than women’s (Table A19). More than 90% of the male members and non members of VDC/VSLA responded that they heard about the services of antenatal screening and care (compared to less than 50% at baseline) but 85% of the correspondents stated that that they jointly or alone decided to use the service either on their own or together their partners within the past 12 months. Issue related to post natal care, 77% of male correspondents to information and use of the service.

In addition, women’s knowledge, use and satisfaction with all SRHR services have shifted positively since baseline for both members and non-members of the VDC/VLSA (Table A20). More than 96% percent of female VDC / VSLA members’ stated that they heard about the service and information from reliable source, used or made decision to use it alone or jointly with partner and are satisfied with the service. Similarly, the use and satisfaction applied to the same number of non-members except 73% percent of them heard about the service. Regarding male’s knowledge, use and satisfaction with all SRHR services, 96% of male members of the VDC/VLSA and 77% of non-members stated that they heard about the service.

Many men also stated that they reminded their wives of taking contraceptives bill. Some women also explained that VSLA funding which CARE support, as revolving funding is useful for them when they need money for delivering babies. Many of the women also stated that they have gained knowledge about birth spacing, AN care and vaccination and going to clinic or hospital for delivery from training, discussion and also from AMW. Moreover, VDC and VSLA also work closely together with AMW in order to help pregnant women, especially for emergency cases. AMW, VDC and VSLA organized and gather women for SRH and BS discussion and also informed all the women regarding SRH referral funding.  Moreover, many women and men decide together on BS and also said that they share SRH knowledge to other women and with their neighbors and friends.

In relation to general health facilities access and quality of services, female respondents stated that there used to be diarrhea in villages due to lack of health education and also being unable to access to water. For example Nan Aye Phaung, who is 23 years old from Mant Myaing Village, Nam Kham Township, reported major challenge to work in these two townships is not having enough equipment in the clinics of the AMWs. One of the AMW explained that children died of diarrhea because there were not sufficient medicines. However, medicines, napkins, clean delivery kits, and equipment’s were supported and now there have many changes in the village after CARE project came.

### Men and women´s attitudes towards protection of women´s SRHR and maternal health

The quantitative data shows that women’s attitudes towards gender equitable norms related to the protection of women’s SRHR and mental health are positive. At endline the average likert score for women in Myanmar in relation to the protection of their SRHR and maternal health was 3.95. According to women surveyed - 90% agreed/strongly agreed that they decide together with their husbands on how many children to have and using condoms, additionally stated that they make decision on their own to seek help of trained health personal and justified in asking to use a condom. Moreover, nearly 98% responded that women should have the same opportunities to receive health care as men do.

Similarly, regarding women’s health issues, over 95% of male correspondents (Table A5) agreed that they decide how many children to have, using condom and contraception, together with their wife, and also stated that women should have the same opportunities to receive health care as men. Regarding rural health care center, over 97% of both male and female correspondents know the existence of health care center in their village and recognized the usefulness of them.

Daw Lway A Sar is an Auxiliary Midwife from Saing KHaung Village, Muse Township.

She feels that the provision of health education at VLSA was effective. She often works together with VSLA members regarding dissemination of information about vaccination and encouraging the people to be vaccinated. Before the CARE project, there was no woman leader - but now there are women leaders youth group and VLSA.

“*With the support of Care, I attended the six month AMW course to be able to implement these health services. The staff from Care collaborated in the activities. I could practice what I was taught in the training so my skill improved. I was successful because I was interested. The villagers also trust and depend on me.”*

She was able to cooperate with the Department of Health and CARE staff to deliver many HE at monthly meetings and also at school. According to her, she could do all these successful work for villagers as CARE supported her and sent her to attend Auxiliary Midwife course for six months.

The study shows that women and men have gained better knowledge about SRH and birth spacing. Many women stated that they transferred their SHR and birth spacing knowledge to their husbands also freely and openly discussed about SHR and birth spacing together with their husbands, which they have never done it before. In addition, many husband accompanied the women to clinic and hospital for medical check-up and treatment and also taking care of house chores work such as cooking and cleaning during women’s pregnancy and even washing babies’ napkins. Due to all these educative talks, support and services, diarrhea problem, miscarriage cases, and usage of traditional medicine have been significantly reduced.

According to Daw Pa Pa Min, the MWAF staff member from Muse Township mentioned due to CARE development activities regarding health, there is a significant reduction in miscarriage as the women and families have gained knowledge from the training and meetings. Another midwife, Daw Aye Sein from Namp Ohn Sub-Health Center, mentioned that in the past men even beat their wives when they talked about birth spacing. However due to health education on reproductive health and birth spacing, men practice and even accompany their wives to clinic and hospital and now really supportive to women.

Women’s knowledge and understanding of HIV issues have increased according to the data (A16) since baseline- 73% of the women respondents have heard of HIV-AIDS and STIs through authentic sources such as health workers or through health education sessions conducted by NGOs. At Baseline Only 30 % of the respondents were aware of the place of treatment of STI, compared to 46% at endline. Similarly, only 26 percent knew about the place for HIV counselling and testing compared to 63% of women at endline.

Men´s attitudes towards SRHR at endline are in the majority positive evidencing acceptable gender norms. At endline 75% of the males surveyed disagreed to statements such as contraceptives make ones give birth to babies with abnormalities and over 70% disagreed that there was nothing that women can do to prevent from HIV. Only 10% of men felt that women accepting to have sex with partners with HIV status, and virgin being unable to have HIV. Moreover, more than 90% disagreed that women should be blamed for spreading HIV and a person having HIV by looking at them. The baseline found that compared to the Shan and Paluang ethnicity villages, the other villages have relatively higher awareness regarding the reported methods of contraception as well as on other health services such as ANC, PNC and place of delivery where skilled birth attendants are present.

### Availability and quality of SRHS services

At endline the data shows positive improvement regarding satisfaction with availability and quality of SRHS related services, women’s informed decision-making with regard to SRHS, and Women’s knowledge, use and satisfaction with health services related to family for both VDC/VLSA and non-VDC/VLSA members. (Table A16). There are slight differences of responses from VCD/VLSA members compare to non-VDV/VLSA members regarding the above issues. More than 90% and above of both members and non-members stated that they used services alone or with husband, heard about the services, information, contraceptive pills and condom, and more than 98% of both members and non members are satisfied with the services. However, regarding treatment for STI and HIV testing and counseling, the result is relatively lower. Table A16. Less than 60% of member and non-members stated that they heard information and used the services of STI and HIV issues and only 60% of them both members and non-members are satisfied with the services.

According to male correspondents from both members and non-members of VDC/VLSA, men’s knowledge, use and satisfaction with health services related to family have also increased. (Table A17). The correspondents of members and non-members stated that they heard and used either alone or jointly, and he or his partner used during the past 12 months of contraceptive pills and condoms. Regarding STI treatment, HIV testing and counseling, less than 60% of both members and non-members stated that they heard about the information and services and used the services alone and with their partner. However, 100% of non-members stated that they decided to use the service of STI treatment.

# **Objective 2: Men positively promote women’s empowerment**

## **Key findings**

The focus of Objective 2 is to increase men’s positive engagement to promote women’s empowerment. The quantitative outcome level results indicate programme has been successful at contributing to improved attitudes of men towards women’s empowerment in Muse, Namp Kham as Table 7 shows. Men (and women) are more likely to evidence more supportive views for prevention of Gender Based violence than at baseline. This is illustrated by response to the statement about beating of wives if food is burnt; this was supported by over 60% as acceptable at baseline; but by less than 3% at endline stage. The WIN and MEN programme have been successful in shifting views and attitudes toward women’s economic security. Men and women were both more supportive that women should inherit property, work outside the home and that their roles extended beyond just taking care of the house.

Following the Mid Term Review in April 2012, men´s engagement in WEP was a new reflection point for CARE Myanmar and the staff had digested the concepts, improved awareness as a clear cross cutting strategy while doing WEP so that it will prevent men from exclusion and lead to gender equality. The project team with the support of Gender Advisor and Health Advisor then developed the Men engage (ME) strategy for WEP to contribute to the gender transformative program in the remaining projects period. The MTR sets out that more awareness raising activities were carried out in Year 3 through activities such as men forum, women forum, special events and capacity building on management and leadership skills for VDC and VSLA members.[[9]](#footnote-9)

**Table 7 Men´s engagement: Baseline and Endline values of key verifiable log-frame indicators**

|  |  |  |
| --- | --- | --- |
| **Attitudes toward Women Empowerment** | | |
|  | **Baseline Values** | **Endline Values** |
| **Attitudes regarding Gender Based Violence** | *Statements: % Respondents Agree/Strongly agree*   * Wife-beating to keep family together; Women 47%, Men 57% * Wife-beating if food is not proper: Women 62%, Men 67% * Women mostly provoke rape: Women 18%, Men 32% | *Statements: % Respondents Agree/Strongly agree*   * Wife-beating to keep family together; Women19.2 %, Men 13.3 % * Wife-beating if food is not proper: Women 2.7%, Men 2,7% * Women mostly provoke rape: Women 6.6%, Men 13.3 % |
| **Attitude toward women’s economic security** | *Statements: % Respondents Agree/Strongly agree*   * Women’s role is to take care of house: Women 64%, Men 65% * Women should inherit property: Women 81%, Men 61% * Women should work outside home: Women 61%, Men 36% | *Statements: % Respondents Agree/Strongly agree*   * Women’s role is to take care of house: Women 41.2% Men 38.7% * Women should inherit property: Women 84%, Men 85.3% * Women should work outside home: Women 80.8%, Men 72% |

## **Meaningful participation in decision-making**

The endline results show that behavior in relation to women´s meaningful participation has shifted. Men interviewed for the qualitative research explained that women are free to participate in every development group in the village as members as well as leading the group. In some villages, women took the initiative to clean the villages and also lead anti narcotic drug groups, and became involved in church and monastery activities; and as a result they have gained in agency - health knowledge, financial management and business and even gained much more confidence to speak in the meeting freely. They are now also participating not only at family affairs but also for villages’ and community affairs as chances were created by CARE and improved and empowered their capacity. Before the CARE project, respondents explained that women were more likely to exhibit shy, timid behavior resulting in them being inactive. However, since many women got more knowledge through trainings and meetings from CARE and village groups, they are now empowered and active. After CARE came many of the men and women’s perspective changes and women are participating in the meetings and in some cases their husbands take care of the children and do house chores work when the wives are attending the meetings.

VDCs were formed with the objective of creating a space for women being recognized and participating meaningfully at the community level. The CARE Myanmar Mid-Term report reflected that Men in VDCs became more aware of gender's rights and roles compared with other men in the community due to having regular contact with CARE staff and participating in trainings and men forum where gender roles and rights were explored and discussed.

The collected data also show that women’s participation in decision making for instance, public and community level increased. More than 93% of the men surveyed stated that women should be able to stand for election to all publicly elected bodies and also be the head of the state. (Table A9). Some 68% of the members provided that a woman can disagree with her husband’s political option and 60% of them somehow still stated that a married woman should obtain her husband’s permission in order to vote. This result may depend on the women and men’s level of understanding of the political situation and their individual rights. Only 51% of the correspondents disagreed that a woman should obtain the permission of her husband or the head of the household to go to most public places. This response may also depend on cultural and traditional practice that still hinders the free movement of women without permission, especially in public places.

Men are now supportive to women in terms of attending meetings. In some villages, for example when a mid wife visits the villages, women represent the village and meet MW. There are challenges for women to participate in some activities at village level as there is some language barrier but there is no discrimination against women especially after CARE came into these villages.  Overall, due to CARE support, the women now have easy access to water and they do not need to get early in the morning to fetch water, they now have fly proof latrine, also have shelter, and pregnant women can get AN care and many of the people gained knowledge on RH and other knowledge.

Challenges remain in realizing meaningful participation. According to U Zaw Wan from KII, Save The Children Save from Muse, the challenge for some women that they lose their opportunities because (1) they themselves lack self-confidence and think that the men are more superior to them, (2) because of the environment, if they are of the same caliber, people prefer men to lead, and (3) there are traditional, religious, and social restrictions.

According to U Uke Paung, the Chairman of Palaung Literature and Culture Association from Muse Township, although women are encouraged to participate in every group and activities, it is still a challenge for them to be part of church and pagoda related committee due to religious constraint. Another MW, Daw Aye Sein from Namp Ohn Sub-Health Center, mentioned that the attitude on women had improved now. Their participation in the anti-narcotic group for example is effective. They are united and their efforts are fruitful, and the administrator helps them by giving the necessary supports and issuing authorizing letters for them.

According to the findings, there are some challenges remain in the community for many women as they are unable to give their time as they have their family work, taking care of their children and cannot go out freely especially after marriage.

## **Women´s social inclusion**

**Table 8. Baseline and Endline values related to social inclusion in the community**

|  |  |  |
| --- | --- | --- |
| **Women’s perception of social inclusion in the community** | Statements: % Women Agree/Strongly agree   * Good social network: 94% * Feel lonely, isolated: 22% * Community leaders listen to me: 80% | **\* VDC / VSLA members**  Statements: % Women Agree/Strongly agree   * Good social network: 95.8% * Feel lonely, isolated: 12.6 % * Community leaders listen to me: 83.2 % |

As Table 8 above shows, women inclusion in the community, according to the responses from both women and men, has not changed significantly – given that the values of the indicators were high at baseline stage. At baseline and endline stage for example over 90% of women respondents from VDC/VSLA members agreed to that they have good social network in the community, get invitation to attend community events, community people are keen to support in case of shock and crisis; and approx. 80% felt that community leaders listen to them when talking about their opinions, and most importantly they feel being treated with respect and dignity when visiting health care, hospital and health facility.

Women from non-VDC/VLSA members’ perception on the inclusion of women in the community issues have improved slightly but according to the data, the responses percentage is slightly lower than women from VDC/VLSAs. 85% of the non VDC/VLSA members agreed to that they have good social network in the community, are happy with their involvement in funeral associations and other community support groups, and they also feel being treated with respect and dignity when visiting health care center, hospital and health facility, and also 80% of them stated that the community people are ready to help them in case of shock and crisis. However, less than 73% of them agreed that the community leaders listen to their voices when speaking out their opinions.

Many men also think that there is a need to cooperate and to exchange ideas with women as there are many things that men alone are unable to handle. In the village meeting, all the villagers got invited, however, the women did not speak much, only very few women speak and some of their good ideas were accepted. Now, the villages have more systematic and proper structured groups with the assistance from CARE. Many of the groups exist in the villages now have for instance, accountant, audit, treasurer, and key holder. Etc. However, some of the challenges are that women want to take management roles and responsibilities such as treasure, audit, and accountant, but the leadership roles are mainly in the hands of the men.

Some women also state that compared 5 years ago; the community is listening to their opinions now – which they attribute to their experiences with CARE. In addition, women were invited to attend meetings and to participate in other activities of these opportunities came since last 5 years because of the experiences the women got from CARE. There are other different groups in the village such as cultural group, youth, and school committee, and women are now part of the groups in roles such as treasurer in the youth group. Before the VDC groups were established, the women only got involved in Church related issues, but the women are now actively engaged in their village’s affairs.

There was no organization or group like CARE which provided awareness on women and men rights and how to speak and have group like VSLA/VDC to help each other in the community. Some men are now also supportive to their wives and take responsibility to take care of children while women are attending group meetings and activities. Now they have six groups and the group good rule and regulation. In addition, they also have annual finance clearance system and the accounts are cleared regularly and they get the profit. Many of them groups have learnt better financial accounting and work effectively for the groups as they gained more experiences. According to the two women participants Khun Haung Village, Muse Township mentioned that:

 “*When there is a group, you get united, there is work, we discuss and divide the work among ourselves it is convenient and beneficial for everyone. Initially we were not punctual. Now we understand about the holding of shares. Now we have more fellowship with each other. The other non members are becoming interested to join. In addition, now because of VSLA, we have money for school fees and to invest in the farm. The interest isn’t much. We dug a pool with the money we got from VSLA. Before we joined the group, we faced difficulties, now we are better off now. The VSLA is very successful, now almost everybody is a member.”*

Daw Kham Aye, who is 43 years old and the accountant at VDC from Hona village explained her experience that:

*“In the past five years, the men use to say that women were useful only for gossiping and nothing else. The administrator also did not support the women to come to the meetings. For instance, when there is voluntary work to be done in the village, women were always excluded from the list. However, after Care came and discussed about men and women affairs and the rights of men and women, things have now changed. Women are allowed to participate in the committees. Their works have been appreciated. They are going to build a new extension for the monastery, a committee was formed and 8 women were included in it. They are all from the VSLA group and there is one woman as secretary, one as treasurer, one as audit, one as accountant, two as money collectors, and two as members being appointed in the group*.”

U Laung Saing, who is village Tract Administrator from Mant Khone Lone Muse Township, states that the women should also be given the leading role in the village group. A few respondents also mentioned that it is a challenge for them as the immigration departmental authorities look down on them as if villagers are not fit to associate with them. If we don’t give as much as they ask, they don’t give us the NRC card.

One of the village tract administrator mentioned that CARE helped his community to build the shelter, improve the water supply, provided the materials to build the latrines. The women became significantly united after the Care project. It was convenient to use water any time and it was beneficial for the youth because there is the shelter.

### Women´s meaningful participation

After CARE initiated WEP project, the villages have more VSLA and VDC groups that provide opportunities and chances for women´s empowerment and participation in the community which benefit the whole community such as water committee, and shelter committee etc. The majority of the men are included in the members of water committee and VDC but women are also included in the members. In interviews examples were given that men had got involved in initiatives to target narcotics use but often women took the leading role in some villages.

The finding also shows that in some villages, the development activities of the village now become more vibrant and the members of VSLA are more proactive. Many of the women who were staying and working at home now come out and work together with other members for the villages; the villagers are now more united and have good social relationship. In some villages, women now can take the role of chairman, secretary, accountant, and audit positions. In addition, the men are also listening to women with respect in the meetings, and now more women participated in the meeting than men in terms of number. Daw Khan Yin, a member of VSLA from Mant Han, Muse Township mentioned that

*“The women can give their opinion in the meetings about the community. There is no discrimination any more, both women and men participate in the discussions. If it concerns the whole village, the village head decides. The women decide if it is on women* affairs. *Now we are knowledgeable because of the frequent meetings. Women are invited to meetings and have taken the leading roles.”*

VSLA/VDC is one of the major activities that the women think it successful and beneficial for women, their families, and for their community. The main reasons why women wanted to became a member of VSLA/VDC are because they want their community to be developed. On the other hand, many of the members explained that they were being invited and persuaded by women who are already members and some became members based on their own decision hoping to get something knowledge and benefit out of VSLA/VDC. There used to be only two groups in the beginning and the members were not strong and active when it was started. Some people became interested in the groups and be members of the groups by looking at the existing groups members’ activities and benefits from the group.

More women know about the benefits of being a member of the group not only for individuals but also for their family. In addition, more women want to become member as they know that they can borrow money from the group and run their business and get benefits, some also said that they get valuable lessons and experiences from group meeting and activities. Some women also mentioned that since they have fellowship and meetings they got to know each member better, got stronger and dare to speak in front of others. For the group, members set up the rules and were clearly prescribed; people became punctual, more collaboration among the villagers, have more health knowledge, and now the members feel secure as they have savings. There is more unity in the group and it is easier for the leaders to organize the group meetings and the participation of the members is stronger.  It is also critical to have good heart, strong commitment, hard-working, and able to get trust from the members.

As part of the group, each individual explained the benefit and advantages of being a member and part of the group are as follows; the members get to know each other, share their knowledge, borrow money and can invest in their farm and support their family living expenses. The findings show that Community Learning Centre’s that CARE established for them is very helpful for conducting meetings, getting information, reading books, playing for children, running development activities, provision of vitamin for pregnant women, and gaining knowledge.

U Maung Hein who is 53 years old, a religious leader from Man Set Village, Nam Khan Township motioned that there are a lot of changes now compare to the past due to CARE program. For instance, the local authority had to ask people to repair and renovate road, however, people do not need to be told what to do as they have family spirit and repair road on their own will for the benefit of the villages, and the similar case happen to attend meetings in the villages.

## **Participation of women in decision making at the HH level**

Regarding the participation of women in decision making at the household level, the findings show that after CARE Myanmar development intervention, women have more chances to participate in other families’ incomes activities, share more responsibilities with their husband, and also in a position to make decision on some issues on their own and also have discussion with their husband and families for decision making.

Women are mainly responsible for unproductive work in general such as cooking, cleaning, washing, fetching water and taking care of their children. In addition, they also work as casual laborers for additional income for their family and work on other agriculture and farming activities for their livelihood to support their families. The main sources of income for most of the women in the targeted villages are from sugar cane and corn plantation, selling vegetable, charcoal making, and plucking flowers etc. The main income labors in this area are agriculture, trading, and carrying loads. In fact, most of the work - especially carrying loads pays a higher wages than other work as it requires a lot of energy and only men can do that.

At endline it is mostly women in the households that keep the families’ income and saving both received by women and men. Women are said to have better financial skills and management for the family and also make decision on their income expenditure such as on health, education, and purchasing house and kitchen utilities. In some cases, both men and women now discuss first before making big expenditures on important item such as machine etc., on the other hand, some men in the households still make decision on big expenditure for investment as they are perceived to know better management.

At household level work, according to the women respondents, men’s thinking, views and attitude toward women have significantly changed to some extent after CARE provided training and discussion frequently taken place with Care staff support. Many men in the villages now are seen to take or share responsibilities with women such as fetching water, cooking and even washing clothing. Some men stated that they keep the money with the women, discussed issues with them before making decision and they make decision together. Traditionally, men are only entitled to have household assets such as cow, land, and even names. However, this practice according to the male participants will change, in this time as they think that women also have the same and equal opportunities and should not differentiate gender. Therefore, either land or cow or other family assets will be equally shared and inherited to both son and daughter in the family according to majority respondents.

Another example is that when the family wants to buy or sell their land they both discussed first and make decision together. In addition, based on the money borrowed from CARE program with a lower interest, women can run more activities and get more money. This also upgrade their decision making power with men as they have more income.  This change in attitudes toward women not only change happened at household level but also at the community level. One Village Development Committee member from Khun Haung Village, Muse Township said that:

*“Before CARE program, people used to say that women are useless. Now women are actively participating, people are saying that the women had improved. Before CARE program, we were not included in the discussions. If women attended the meeting they just listened and left, they were not allowed to speak. Now in all meetings they are actively participating. Now the men themselves are saying that women should participate in the development work. Only when Care came women are attending meetings and speaking up. They are being invited to meetings, it has changed.”*

One of the VSLA woman members from Hpar Hptate Village, Muse township, in the interview also expressed her experiences that,

*Before CARE training and also VSLA support, my health was poor and didn’t have money.  I do not know what is where in Muse.  If something happens, I do not know where to go for medication.  Now, I can borrow money from VSLA.  Before that woman just provided suggestions and the men made the decisions at household. Now that have changed a lot and both women and men discussed first and decide before doing anything.*

## **Access and control of HH assets and community**

At endline point women´s control of household assets is reported to be 58.1% from 96.3% at baseline stage. Regarding access and control of household assets in community, the people living in this township have their own traditional inheritance transfer and ownership to their children and this is the basic principle or way of property ownership. In general, the father inherits his property such as land and other valuable of house, mainly to their sons and the daughters normally get jewelry, gold, silver and cow etc. In addition, household properties are also given to family members who took care of their parents and landownership is mainly connected with the head of the household who are mainly men.

However, after CARE came into these areas, there are changes in people mindset that interview participants mentioned regarding access and control over the household assets. Although the traditional practice of ownership of properly especially land is normally given to son in the family, the community people in general have less gender distinction over their sons and daughters. Many of the participants expressed that they are happy to share their property both to their sons and daughter. In some cases, some family members also inherited land and other property to their daughters and if the father inherited the land to the daughter, the land entitlement is with her name and the name cannot be changed. Moreover, nowadays the women get ownership on the HH assets for instance, TV, Antenna Dish, Cupboards etc: If they separate the women are given priority to take any HH assets.

U Ike Paung, the community leader from Muse township, mentioned that men are given land to the sons, however, people are educated these days and many parents share their inheritance to both sons and daughters. Another problem that they still have in the village is that many of the women are exploited by giving good jobs with high payment and later they are being sold, the cultural groups, CARE and with DOH, they provided educative talk to people living in rural areas as they are illiterate and still vulnerable for trafficking. In addition, although there is no gender discrimination, some of the family households’ property is kept in the names of someone who can speak Burmese so that they can deal with related government department.

At endline most men and women surveyed agreed /strongly agreed that Women should be able to own and control the same assets, and that Women should be able to inherit and keep property or assets. (Table A2, A3). The levels of men and women in agreement with positive statements about women´s economic security at endline were slightly higher than at baseline stage.

### Men and women´s attitudes towards women´s economic security

As Table A2 shows, men’s attitudes towards women’s economic security and perception have also changed compared to baseline. According to the male correspondents, nearly 60% of them disagreed that woman role is to take care of unproductive work. In addition, over 70% agreed that a married woman should be allowed to work outside the home; also nearly 99 % agreed that women should be able to own and control the same assets and more than 85% stated that women should be able to inherit and keep property or assets as well. Most importantly, over 66% correspondents disagreed that only men should make the major decisions.

Women’s understanding on their roles in family has also been increased As Table A3 shows. Of the women surveyed, 57% disagreed that women role is to take unproductive work at home and 91% responded that women also have the same rights as men. In addition, over 80% of the women reported that women should be allowed to work outside of home, own cash saving and make decision, also inherit and keep property and assets. Most interestingly, more than 96% agreed that women should be able to own and control the same assets and nearly 85% disagreed to that only men should make major decisions.

In relation to women’s ownership and control over assets, As Table 9 below shows in the household nearly 77% percent of women who owns the assets alone or jointly include land, house. Other assets such as livestock and tools are assets that less than 47% could own alone or jointly. However, most of the women still need permission to sell majority of the assets mentioned when only 40% of women stated that they do not need permission to use remittance and savings. Thus, the use of remittance and savings, including selling crops and land, according to the data, are assets that women can also take decision on their own.

**Table 9 Baseline and endline values Economic Security**

|  |  |  |
| --- | --- | --- |
|  | **Baseline Values** | **Endline Values** |
| **Economic Security** | | |
| **% of women with control over assets in household** | **Asset (% Ownership)**   * Land: Self-ownership 8%; Joint 59% * House: Self-ownership 10%; Joint73% * Cash/Savings: Self ownership 19%; Joint 27% | **Asset (% Ownership)**   * Land: Alone or jointly 76.9% * House: Alone or jointly 78.5% * Cash/Savings: Alone or jointly 86.8 % |

Issues related to children, family affairs and expenditure, women mainly made decisions together with their husbands or partners. According to the data, 40% of the women took decision children’s health and what to spend the money on. The rest of the issues such as children’s schooling, issues happen in the community, and issues occurring at work or at home, are decisions that both women and their husband jointly made together.

The study (Table A11) also shows that women can freely go to places for family needs and health related issues. More than 95% women stated that they go alone to places such as; religious centers, friends’ house or neighborhood, and community centers or meeting places. However, 33% correspondents provided that they got accompanied when they go to local health center or doctor. In addition, apart from VSLA group, 80% of the correspondents stated that they participated in the CBO committees.

## **Gender Based Violence**

According to the findings domestic violence cases were committed by men in the households and men who committed domestic violence are in general those who smoke opium and drink alcohol. In some cases, forced or arranged marriage, and gambling is also another problem that also cause domestic violence as their marriages were not built on love and do not last long. Women are being beaten or run away from the house as the husband asked money usually for smoking opium and drinking alcohol, selling household utilities, or damaging household assets. Stakeholder also report that domestic violence happened mainly because of drug and alcohol and there are several cases reported to MWAF however, the villagers normally resolve problems on their own.

However domestic violence has reduced, especially after CARE arrived in these communities, they provided training and awareness on domestic violence and counseling. In addition, the study also shows that in terms of domestic violence, the church, assistant village administrators, and the women from VSLA group members provided counseling, negotiation between husbands and wives, and helping the couples understand and solve the problems. In addition, the people in the communities also have learnt not to cause domestic violence through CARE and UNICEF training on how to prevent domestic violent and how to care of children. Other factors that reduced or lessened domestic violent is also due to the fact that women have discussion at VLSA group meetings and have more knowledge and also because o opium eradication in the community in another factor.

According U Mar Gum, who is 50 years old and the local authority from Hpar Hpate Village, Muse Township said that there is no longer arranged marriage as the marriage did not last long in the past and regarding the transfer of the household property, only a few parents share their land and household assets equally to both men and women since there is still some Kachin traditional practice. Regarding domestic violence, narcotic abuses cause the problem and if it affected family problem or needs reconciliation, the cultural groups have since helped them for negotiation.

## **Attitudes of men and women regarding gender based violence**

Women´s average attitude scores at endline indicate more positive views regarding gender-based violence compared to baseline stage (2.24 compared to 2.95)[[10]](#footnote-10). However men´s average attitude scores were less positive (with scores of 3.59 at endline compared to 3.13 at baseline).

In a statement related to gender base violence, more than 70% of female correspondents disagreed to that a wife should tolerate being beaten by the husband or partner whereas 19% of the correspondents somehow agreed to the statement. In addition, more than 80 % of the correspondents disagreed on the following statements that important advantages for a circumcised girl, never too young to get married to a good husband, husband being justified in beating the wife without telling, a girl to get circumcised in order to preserve her virginity before marriage, better to send a son to school than daughter and women being raped for doing nothing to provoke it. Moreover, nearly 90% of the correspondents agreed to that women to refuse having sex when she is tired or not in the mood and women to choose whom they want to marry on their own.

Regarding attitudes of men on GBV, (A23) nearly 85 % of the correspondents disagreed on the following statements that important advantages for a circumcised girl, never too young to get married to a good husband, husband being justified in beating the wife without telling, a girl to get circumcised in order to preserve her virginity before marriage, better to send a son to school than daughter and women being raped for doing nothing to provoke it. Moreover, nearly 90% of the correspondents agreed that women to refuse having sex when she is tired or not in the mood and women to choose whom they want to marry on their own. More than 90 % of both men and women correspondents disagreed to that when a wife burns the food it is only proper that her husband/partner discipline her by hitting or beating her.

There are a lot of sex workers in this area according to a village elder in Muse; highlighting a need for awareness raising on unsafe sex practices and the right of the sex workers to refuse unsafe sex practices. To date, there is no organization that endeavors such activities in this area and there is a feeling in the community that there is an urgent need to start these activities.

## **VSLA´s as an entry point**

The research shows that members from the community benefited from VSLA activities to solve their needs and also increase their incomes, and also use it for other emergency case such as health problems. Some families’ member can invest in agriculture with the money they borrow from VSLA. The members of the group also utilize the money by collecting 200 Kyats for the funding and 3,000 to 5,000 Kyats for shares, most of them member put in 3,000 Kyats. From the funding they support for health, orphans, and education fees for the poor. The amount is decided after discussing with all members in the meeting. The remainder is used for donations. The members borrow from the group. The financial clearance is done annually. According to the local authority person, women often have a separate VSLA group from men.

In the past, many of the women did not practice saving money. However, due to VSLA activities, many women were encouraged to save money for the saving day, especially for the next saving cycle at VSLA. One of the challenges is that some non-members see problematic of being members of the VSLA as they only can think of money. However, these members got other beneficial such as knowledge, awareness, understanding each other, unity and having confident and being able to speak in front of others. Many of them also have increased their level of financial management skill and practices and are able to handle large sum of money. In some villages women became key holders and account in VSLAs. The endline study showed a better functioning of VSLA, strengthened their capacities on financial management which is an improvement compared to the midterm review. In addition, VSLAs are still functioning in many villages after Care project ended in December 2013.

## **Economic empowerment**

The study shows that both men and women from village groups collaborated in solving social economic problems for instance, many villagers from different villages worked together in building latrines and the shelters and water supply for their restive community. In addition, in the case of celebration such as traditional or religious festival, all the villagers cooperate and work together to do the celebration.

U Saing Lat who is 56 years old and a community leader from Khu Haung village from Muse township mentioned the usefulness of the VSLA that the AMW is a good example of how women are empowered by participating in development. By giving time and attending the trainings his daughter gained a lot of knowledge as well as the trust of the villagers. Some learned accounting by joining the VSLA. One of his daughters had just passed the second standard but now she can do the accounts well after joining the VSLA. At first she met a lot of challenges but with the help and encourage of CARE staff, eventually she succeeded.

Moreover, financial difficulty was always a problem for many of the women in the villages. Due to CARE program, women now have access to borrow money for investment with low interest and can support their family income and increase their own decision making power at household level, access to water for all the villagers and gained health education to improve villagers’ health situation. After having many different meetings conducted by CARE, groups in the villages, the villagers got to know each other better, more united and run meetings like family members.

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| **Annex 1. Quantitative results tables**  **Table A1 Background characteristics of Women and Men in Myanmar** | | | |
|  | **Women** | **Men** | **Both** |
| VDC/VSLA membership | 91.8% | 62.7% | 83.3% |
| n | 182 | 75 | 257 |
| Age (Mean) | 38.06 | 39.01 | 38.34 |
| **Marital status(%)** | **Women** | **Men** | **Both** |
| 1. Single | 2.7% | 5.3% | 3.5% |
| 2. Married | 86.8% | 93.3% | 88.7% |
| 3. Widowed | 9.3% | 1.3% | 7.0% |
| 4. Divorced/Separated | 1.1% |  | .8% |
| **Education (%)** | **Women** | **Men** | **Both** |
| 1. No Formal Education | 14.3% | 12.0% | 13.6% |
| 2. Primary School | 22.5% | 18.7% | 21.4% |
| 3. Finished Primary School | 18.7% | 20.0% | 19.1% |
| 4. Finished Middle School | 28.0% | 30.7% | 28.8% |
| 5. Finished High School | 14.3% | 10.7% | 13.2% |
| 6. University Graduate | 1.1% | 4.0% | 1.9% |
| 7. Have Post Graduate Degree | 1.1% | 4.0% | 1.9% |
| **Literacy(%)** | **Women** | **Men** | **Both** |
| No response(Read) | 7.7% | 16.0% | 10.1% |
| 1. Yes(Read) | 75.3% | 74.7% | 75.1% |
| 2. No(Read) | 17.0% | 9.3% | 14.8% |
| No response(Write) | 7.7% | 20.0% | 10.1% |
| 1. Yes(Write) | 75.3% | 73.3% | 75.1% |
| 2. No(Write) | 17.0% | 6.7% | 14.8% |
| **Main source of Income** | **Women** | **Men** | **Both** |
| 1. Casual Labor | 8.8% | 6.7% | 8.2% |
| 2. Farmer | 58.8% | 62.7% | 59.9% |
| 3. Livestock Farmer | 1.1% | 0 % | .8% |
| 4. Trader | 2.2% | 1.3% | 1.9% |
| 6. Government Employee | 2.2% | 4.0% | 2.7% |
| 7. Private Sector Employee |  | 1.3% | .4% |
| 10. Dependent | 1.1% | 1.3% | 1.2% |
| 11. Charcoal making | 2.7% | 5.3% | 3.5% |
| 13. Firewood cutting | .5% |  | .4% |
| 14. Transport business (own vehicle) | .5% | 1.3% | .8% |
| 99. Others | 22.0% | 16.0% | 20.2% |

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| **Annex 2. Attitudes regarding women’s empowerment** | | | | | | | |
| **Table A2 Attitudes towards women’s economic security. Myanmar, Men** | | | | | | | |
| **Statements(Men)** | **1. Strongly disagree** | **2.**  **Disagree** | **3. Neither agree or disagree** | **4.**  **Agree** | **5.**  **Strongly agree** | |
| 1. Woman role is to take care of the house and prepare meals | 10.7 | 48.0 | 2.7 | 36.0 | 2.7 | |
| 2. Women have the same rights as men | 0 | 2.7 | 2.7 | 82.7 | 12.0 | |
| 3. A married woman should be allowed to work outside the home | 0 | 13.3 | 14.7 | 69.3 | 2.7 | |
| 4. Women should be able to own and control the same assets | 0 | 0 | 2.7 | 88.0 | 9.3 | |
| 5. Women should be able to own cash savings and decide | 1.3 | 20.0 | 6.7 | 68.0 | 4.0 | |
| 6. Women should be able to inherit and keep property or assets | 1.3 | 6.7 | 6.7 | 80.0 | 5.3 | |
| 7. Only men should make the major decisions | 5.3 | 61.3 | 0 | 32.0 | 1.3 | |
|  |  |  |  |  | |  | |
| **Table A 3 Attitudes towards women’s economic security. Myanmar, Women** | | | | | | | |
| **Statements(Women)** | **1. Strongly disagree** | **2.**  **Disagree** | **3. Neither agree or disagree** | **4.**  **Agree** | | **5. Strongly agree** | |
| 1. Woman role is to take care of the house and prepare meals | 10.4 | 47.3 | 1.1 | 41.2 | | 0 | |
| 2. Women have the same rights as men | .5 | 1.6 | 1.1 | 90.1 | | 6.6 | |
| 3. A married woman should be allowed to work outside the home | 0 | 12.6 | 6.6 | 76.4 | | 4.4 | |
| 4. Women should be able to own and control the same assets | 0 | 1.6 | 1.1 | 93.4 | | 3.8 | |
| 5. Women should be able to own cash savings and decide | 0 | 8.8 | 7.1 | 78.0 | | 6.0 | |
| 6. Women should be able to inherit and keep property or assets | 1.1 | 6.0 | 8.8 | 81.3 | | 2.7 | |
| 7. Only men should make the major decisions | 9.9 | 74.2 | 1.6 | 14.3 | | 0 | |

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| **Annex 3.**  **Table A 4 Attitudes towards the protection of women’s SRHR and maternal health.  Myanmar, Women (Women %)** | | | | | | | | |
|  |  | |  | |  | |  |  | |
| **Statements** | **1. Strongly disagree** | **2.**  **Disagree** | | **3.**  **Neither agree or disagree** | | **4.**  **Agree** | **5.**  **Strongly agree** |
|  | % | | | | | | |
| **8. Couple should decide together how many children to have** | 0 | 1.6 | | 2.2 | | 79.7 | 16.5 |
| **9. Couple should decide together to use contraception** | 0 | 1.6 | | .5 | | 84.6 | 13.2 |
| **10. Wife decide on her own to seek the help of trained health personnel** | 0 | 27.5 | | 3.3 | | 67.0 | 2.2 |
| **11. Wife justified in asking to use a condom** | .5 | 0 | | 1.1 | | 88.5 | 9.9 |
| **12. Women should have the same opportunities to receive  health care as men** | 0 | 1.1 | | .5 | | 91.8 | 6.6 |
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| **Table A5 Attitudes towards the protection of women’s SRHR and maternal health. Myanmar, Men** | | | | | |
| **Statements** | **1.**  **Strongly disagree** | **2. Disagree** | **3.**  **Neither agree or disagree** | **4.**  **Agree** | **5.**  **Strongly agree** |
| % | | | | | |
| **8. Decide together how many children to have** | 1.3 | 1.3 |  | 80.0 | 17.3 |
| **9. Decide together to use contraception** | 2.7 |  |  | 85.3 | 12.0 |
| **10. Wife decide on her own to seek the help of trained health personnel** |  | 24.0 | 4.0 | 68.0 | 4.0 |
| **11. Wife justified in asking to use a condom** | 1.3 |  | 1.3 | 80.0 | 17.3 |
| **12. Women should have the same  opportunities to receive health care as men** |  |  | 1.3 | 88.0 | 10.7 |
| **Table A6** |  |  |  |  |  |
| **Statement(Men %)** | **1. Yes** | **2. No** |  |  |  |
| **13. Is there health center in your village (If no, go to Q 15)** | 97.3 | 2.7 |  |  |  |
| **14. Is it useful for you** | 96.0 | 4.0 |  |  |  |
|  |  |  |  |  |  |
| **Table A7** |  |  |  |  |  |
| **Statement(Women%)** | **1. Yes** | **2. No** |  |  |  |
| **15. Is there any health center in your village** | 99.5 | .5 |  |  |  |
| **16. Is it useful for you** | 98.9 | .5 |  |  |  |

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# **Annex 4. Economic security of women**

**Table A 8 Women’s ownership and control over assets in the household. Myanmar**

|  |  |  |
| --- | --- | --- |
| **Asset/resource** | **Women who owns the asset alone or jointly** | **Women that do not need permission to sell the asset\*** |
| 125.1 Land | 76.92 | 20.88 |
| 125.2 The house/dwelling you live in | 78.57 | 19.78 |
| 125.3 Any other residence (house, apartment or dwelling) or business building | 47.80 | 13.74 |
| 125.4 Livestock such as [sheep, goats, cows, chickens] | 32.42 | 12.09 |
| 125.5 Tools | 51.65 | 11.54 |
| 125.6 Transport means such as [bicycle, car, wagon, cart, motorbike] | 69.78 | 15.38 |
| 125.7 Furnishings such as [bed, modern stove, generator, refrigerator, radio] | 59.89 | 7.14 |
| 125.8 Cash [savings, remittances] | 86.81 | 39.56 |
| 125.9 Crops harvested from the garden | 69.78 | 24.18 |
| 125.10 Other, please specify | 2.20 |  |

# **Annex 5. Meaningful participation in decision-making**

**Table A9 Women’s participation in the public sphere, decision making at community level, etc.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Statements** | **No response** | **1. Disagree** | **2. Neither agree or disagree** | **3. Agree** |
| 135. Women should be able to stand for election to all publicly elected bodies | 1.6 | 2.2 | 1.6 | 94.5 |
| 136. Women should be head of state | 1.6 | 2.7 | 2.2 | 93.4 |
| 137. Women should decide on their own whom to vote for in elections | 1.6 | 14.8 | .5 | 83.0 |
| 138. A woman can disagree with her husband’s political opinion | 2.7 | 19.2 | 9.9 | 68.1 |
| 139. Women should have a say in important decisions in the community | 3.3 | 2.2 | 3.3 | 91.2 |
| 140. A married woman should obtain her husband’s permission in order to vote | 1.6 | 59.9 | 6.6 | 31.9 |
| 141. A woman has no place in the decision making of the household | 1.1 | 77.5 | 1.6 | 19.8 |
| 142. Women should not be allowed to go to school | 1.1 | 97.3 | 1.6 | 100.0 |
| 143. Going to most public places, a woman should obtain the permission of her husband or the head of the household | 1.1 | 50.0 | 7.7 | 41.2 |
| **Table A 10 Women´s perspective on decision making** | | | | |
|  |
| **Statements** | **1 .**  **Respondent herself** | **2 . Husband / partner** | **3 .**  **Respondent and partner jointly** | **4 .**  **Someone else** |
| 146. Any decisions about children's schooling | 17.6 | 9.9 | 59.8 | .5 |
| 147. What to do if a child falls sick | 43.4 | 4.4 | 40.7 | 1.1 |
| 148. How children should be disciplined | 29.7 | 11.5 | 48.9 | 9.9 |
| 149. Things that happen at work | 18.1 | 17.0 | 57.1 | 6.0 |
| 150. Things that happen at home | 23.6 | 12.6 | 56.6 | 5.5 |
| 151. What to spend the money on | 39.6 | 10.4 | 45.1 | 3.8 |
| 152. Things that happen in the community | 12.1 | 20.9 | 37.4 | 19.8 |
| Table A11 **Women´s perspective on freedom within the community** | | | | |
|  | **%** | | | |
| **Statements** | **1 .**  **Yes alone** | **2 .**  **Yes if accompanied** | **3 .**  **Never** | **Total** |
| 153.1 To the local market to buy things | 88.5 | 11.5 |  | 100.0 |
| 153.2 To the local health centre or doctor | 66.5 | 33.0 | .5 | 100.0 |
| 153.3 To the community centre or other nearby meeting place) | 94.0 | 5.5 | .5 | 100.0 |
| 153.4 To homes of friends in the neighbourhood | 99.5 | .5 |  | 100.0 |
| 153.5 To nearby church/ mosque/ shrine / temple) | 96.7 | 3.3 |  | 100.0 |
|  |  |  |  |  |
| **Table A12 Apart from a VSLA group, respondent participates in the CBO committees?** | | | | |
| Yes participate | 80.7% |  |  |  |
| No do not participate | 19.3% |  |  |  |
|  |  |  |  |  |
| **Table A13 Men´s attitudes on SRHR** | | | | |
|  | **%** | | | |
| **Statements** | **1. Disagree** | **2. Neither agree or disagree** | **3. Agree** | **No response** |
| 162. Men who accompany women to the hospital for antenatal care are powerless | 57.1 |  | 42.9 |  |
| 163. Contraceptives makes ones give birth to babies with abnormalities | 75.8 | 6.6 | 17.6 |  |
| 164. A woman should accept to have sex with her spouse, regardless of his HIV status | 87.4 | 2.2 | 8.8 | 1.6 |
| 165. Women should be blamed for the spread of HIV in a home | 95.6 | 2.2 | 2.2 |  |
| 166. Women need permission from the spouse to start of ART (HIV prevention)? | 80.2 | 1.6 | 18.1 |  |
| 167.There is nothing I can do to prevent myself from acquiring HIV | 78.6 | 3.8 | 17.6 |  |
| 168. Virgins do not have HIV | 75.3 | 6.6 | 18.1 |  |
| 169. I can tell that a person has HIV just by looking at them | 92.3 | 1.6 | 6.0 |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Annex 6. Social inclusion in the community**  **Table A14 Women’s perception of social inclusion in the community., Women** | | | | | | | | | | | | | |
| **Statements VDC/VLSA members** | | **1. Strongly disagree** | | **2. Disagree** | | **3. Neither agree or disagree** | | **4. Agree** | | **5. Strongly agree** | | | |
| 17. I have a good social network in the community | | .6 | | 1.8 | | 1.8 | | 89.2 | | 6.6 | | | |
| 18. Happy with my involvement in funeral associations, informal women’s support groups, etc | |  | |  | | 2.4 | | 85.0 | | 12.6 | | | |
| 19. I am frequently invited to attend community events | |  | | 3.0 | | 2.4 | | 85.6 | | 9.0 | | | |
| 20. The community members are ready to support me in case of shock or crisis | |  | | 2.4 | | 4.2 | | 88.0 | | 5.4 | | | |
| 21. The community leaders listen to my voice when I speak out my opinion | |  | | 1.8 | | 15.0 | | 81.4 | | 1.8 | | | |
| 22.I feel lonely, isolated in this community. | | 16.8 | | 64.1 | | 6.6 | | 12.6 | |  | | | |
| 23. I feel that I have sufficient access to the market to buy and sell things (from garden, farming). | | 1.8 | | 7.2 | | 4.8 | | 79.0 | | 7.2 | | | |
| 24. I feel that I am treated with respect and dignity when I visit the health centre/ hospital/ other health facility | |  | | .6 | | 7.2 | | 86.2 | | 6.0 | | | |
|  | |  | |  | |  | |  | |  | | | |
| **Table A15 Women’s perception of social inclusion in the community. Myanmar, Women** | | | | | | | | | | | | |
| **Statements Non VDC/VLSA members** | | **1. Strongly disagree** | | **2. Disagree** | | **3. Neither agree or disagree** | | **4. Agree** | | **5. Strongly agree** | | | |
| 17. I have a good social network in the community | |  | |  | | 6.7 | | 80.0 | | 13.3 | | | |
| 18. happy with my involvement in funeral associations, informal women’s support groups, etc | |  | | 6.7 | | 6.7 | | 73.3 | | 13.3 | | | |
| 19. I am frequently invited to attend community events | |  | | 6.7 | | 6.7 | | 80.0 | | 6.7 | | | |
| 20. The community members are ready to support me in case of shock or crisis | |  | | 6.7 | | 13.3 | | 73.3 | | 6.7 | | | |
| 21. The community leaders listen to my voice when I speak out my opinion | |  | |  | | 26.7 | | 73.3 | |  | | | |
| 22.I feel lonely, isolated in this community. | | 6.7 | | 80.0 | |  | | 13.3 | |  | | | |
| 23. I feel that I have sufficient access to the market to buy and sell things (from garden, farming). | |  | | 20.0 | |  | | 73.3 | | 6.7 | | | |
| 24. I feel that I am treated with respect and dignity when I visit the health centre/ hospital/ other health facility | |  | |  | |  | | 80.0 | | 20.0 | | | |
|  | |  | |  | |  | |  | |  | | | |
| **Annex 7 and 8: SRH service use and informed decision making** Indicator 7. Satisfaction with availability and quality of SRHS related services  Indicator 8. Women’s informed decision making with regard to SRHS | | | | | | | | | | |
|  | | | | | | | | | | |
| **Table A16 Women’s knowledge, use and satisfaction with health services related to family planning and HIV/AIDS. Myanmar, Women** | | | | | | | | | | | |
| **Statements (Women)** | **Member of VDC/VLSA** | | **25.1 (1.Contraceptive – condoms)** | | **25.2 (2. Contraceptive – pills and others)** | | **25.3 (3. Treatment for STIs)** | | **25.4 (4. HIV/AIDS testing and counseling)** | | |
| Ever heard about the service | VDC/VLSA member | | 94.3% | | 99.1% | | 46.6% | | 63.6% | | |
| Non VDC/VLSA member | | 85.3% | | 97.1% | | 35.3% | | 58.8% | | |
| Information from a reliable source | VDC/VLSA member | | 88.7% | | 99.2% | | 36.3% | | 48.8% | | |
| Non VDC/VLSA member | | 92.3% | | 100.0% | | 23.1% | | 46.2% | | |
| She or her husband has used the service during the past 12 months | VDC/VLSA member | | 91.7% | | 98.8% | | 36.9% | | 50.0% | | |
| Non VDC/VLSA member | | 100.0% | | 100.0% | | 60.0% | | 60.0% | | |
| Decided herself to use service | VDC/VLSA member | | 94.4% | | 100.0% | | 38.9% | | 50.0% | | |
| Non VDC/VLSA member | | 100.0% | | 100.0% | | 100.0% | | 100.0% | | |
| Decided jointly with spouse to use services | VDC/VLSA member | | 91.0% | | 98.5% | | 37.3% | | 50.7% | | |
| Non VDC/VLSA member | | 100.0% | | 100.0% | |  | |  | | |
| Decided herself or jointly with spouse to use service, and the information came from a reliable source | VDC/VLSA member | | 92.6% | | 99.1% | | 41.7% | | 53.7% | | |
| Non VDC/VLSA member | | 100.0% | | 100.0% | |  | |  | | |
| Satisfied with the service | VDC/VLSA member | | 91.7% | | 98.6% | | 38.9% | | 48.6% | | |
| Non VDC/VLSA member | | 100.0% | | 100.0% | | 60.0% | | 60.0% | | |
|  |  | |  | |  | |  | |  | | |
| **Table A17 Men’s knowledge, use and satisfaction with health services related to family planning and HIV/AIDS. Myanmar, Men** | | | | | | | | |  | | |
| **Statements(Men)** | **Member of VDC/VDSA** | | **15.1 (1.Contraceptive – condoms)** | | **15.2 (2. Contraceptive – pills and others)** | | **15.3 (3. Treatment for STIs)** | | **15.4 (4. HIV/AIDS testing and counseling)** | | |
| Ever heard about the service | VDC/VLSA member | | 94.9% | | 94.9% | | 57.3% | | 47.9% | | |
| Non VDC/VLSA member | | 93.4% | | 92.1% | | 71.1% | | 69.7% | | |
| He or his spouse has used the service during the past 12 months | VDC/VLSA member | | 86.7% | | 93.3% | | 43.3% | | 43.3% | | |
| Non VDC/VLSA member | | 91.7% | | 91.7% | | 58.3% | | 50.0% | | |
| Decided himself to use service | VDC/VLSA member | | 100.0% | | 66.7% | |  | | 33.3% | | |
| Non VDC/VLSA member | | 100.0% | | 100.0% | | 100.0% | | 50.0% | | |
| Decided jointly with spouse to use services | VDC/VLSA member | | 86.2% | | 89.7% | | 44.8% | | 41.4% | | |
| Non VDC/VLSA member | | 83.3% | | 91.7% | | 41.7% | | 41.7% | | |

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| --- | --- | --- | --- | --- | --- |
| **Annex 8. Use of Pregnancy and Birth care services**  **Table A 18 Women’s knowledge, use and satisfaction with health services related to pregnancy and birth care. Women** | | | | | |
| **Statements**  **(Women)** | **Member of VDC/VDSA** | **32.1 (1. Antenatal screening and care)** | **32.2 (2. Hospitals, clinics or birthing centres where a woman can give birth assisted by skilled personnel)** | **32.3 (3. Postnatal care)** |
| Ever heard about the service | VDC/VLSA member | 99.5% | 88.7% | 77.6% |
| Non VDC/VLSA member | 100.0% | 82.9% | 60.0% |
| Information from a reliable source | VDC/VLSA member | 99.6% | 86.7% | 73.0% |
| Non VDC/VLSA member | 100.0% | 69.2% | 76.9% |
| She or her husband has used the service during the past 12 months | VDC/VLSA member | 100.0% | 91.7% | 72.2% |
| Non VDC/VLSA member | 100.0% | 100.0% |  |
| Decided herself to use service | VDC/VLSA member | 100.0% | 100.0% | 84.6% |
| Non VDC/VLSA member | 100.0% | 100.0% |  |
| Decided jointly with spouse to use service | VDC/VLSA member | 100.0% | 87.0% | 65.2% |
| Non VDC/VLSA member | 100.0% | 100.0% |  |
| Decided herself or jointly with spouse to use service, and the information came from a reliable source | VDC/VLSA member | 100.0% | 96.4% | 73.2% |
| Non VDC/VLSA member | 100.0% | 100.0% |  |
| Satisfied with the service | VDC/VLSA member | 100.0% | 91.4% | 74.3% |
| Non VDC/VLSA member | 100.0% | 100.0% |  |
|  |  |  |  |  |
| **Table A19 Men’s knowledge, use and satisfaction with health services related to pregnancy and birth care. Myanmar, Men** | | | | | |
| **Statements(Men)** | **Member of VDC/VDSA** | **21.1 (1. Antenatal screening and care)** | **21.2 (2. Hospitals, clinics or birthing centres where a woman can give birth assisted by skilled personnel)** | **21.3 (3. Postnatal care)** |
| Ever heard about the service | VDC/VLSA member | 94.9% | 95.7% | 77.8% |
| Non VDC/VLSA member | 91.8% | 98.6% | 75.3% |
| He or his spouse has used the service during the past 12 months | VDC/VLSA member | 86.4% | 100.0% | 59.1% |
| Non VDC/VLSA member | 66.7% | 100.0% | 66.7% |
| Decided herself to use service | VDC/VLSA member |  |  |  |
| Non VDC/VLSA member |  |  |  |
| Decided jointly with spouse to use service | VDC/VLSA member | 85.0% | 100.0% | 65.0% |
| Non VDC/VLSA member | 85.7% | 85.7% | 71.4% |

|  |  |  |
| --- | --- | --- |
| **Annex 9. SHR Services combined**  **Table A 20 Myanmar, Women’s knowledge, use and satisfaction with all SRHR services combined. Women** | |  |
| **Statements(Women)** | **Member of VDC/VDSA** | **%** |
| Ever heard about the service | VDC/VLSA member | 96.4 |
| Non VDC/VLSA member | 73.3 |
| Information from a reliable source | VDC/VLSA member | 97.2% |
| Non VDC/VLSA member |  |
| She or her spouse has used the service during the past 12 months | VDC/VLSA member | 100.0% |
| Non VDC/VLSA member | 100.0% |
| Decided herself or jointly with spouse to use service, and the information came from a reliable source | VDC/VLSA member | 96.1% |
| Non VDC/VLSA member | 100.0% |
| Satisfied with the service | VDC/VLSA member | 96.9% |
| Non VDC/VLSA member | 77.8% |
|  |  |  |
| **Table A 21 Men’s knowledge, use and satisfaction with all SRHR services combined. Myanmar, Men** | |  |
| **Statements(Men)** | **Member of VDC/VDSA** | **%** |
| Ever heard about the service | VDC/VLSA member | 96.9% |
| Non VDC/VLSA member | 77.8% |
| He or his spouse has used the service during the past 12 months | VDC/VLSA member |  |
| Non VDC/VLSA member |  |

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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Annex 10. Attitudes on GBV**  **Table A 22 Attitudes of women regarding GBV. Myanmar, Women** | | | |  | | |  |  | | |
|  | |  | | | |
|  | **%** | | | | | | | |
| **Statements (Women)** | **1. Strongly disagree** | **2. Disagree** | **3. Neither agree or disagree** | **4. Agree** | | | **5. Strongly agree** | **No Response** | | |
| 56. A wife should tolerate being beaten by her husband/partner | 18.7 | 55.5 | 6.6 | 19.2 | | |  |  | | |
| 57. Are important advantages for a circumcised girl | 26.4 | 58.8 | 5.5 | 3.3 | | |  | 6.0 | | |
| 58. A girl is never too young to be married if a good husband found | 15.9 | 73.6 | 1.1 | 9.3 | | |  |  | | |
| 59. Refusing to have sex she is tired or not in the mood | 1.6 | 8.8 | 1.6 | 82.4 | | | 4.4 | 1.1 | | |
| 60. Husband is justified in hitting or beating her wife goes out without telling | 13.7 | 73.6 | 2.2 | 10.4 | | |  |  | | |
| 61. A girl should be circumcised in order to preserve her virginity before marriage | 17.0 | 71.4 | 2.7 | 2.2 | | |  | 6.6 | | |
| 62. Women should choose themselves whom they want to marry | .5 | 7.7 | 1.1 | 85.2 | | | 5.5 |  | | |
| 63. It is better to send a son to school than daughter | 24.7 | 69.2 | .5 | 5.5 | | |  |  | | |
| 64.Wife burns the food it is only proper that her husband/partner discipline her by hitting or beating her. | 21.4 | 73.6 | 2.2 | 2.7 | | |  |  | | |
| 65. Woman was raped, that means she have done to provoke it | 10.4 | 76.4 | 5.5 | 6.6 | | |  | 1.1 | | |
|  |  |  |  |  | | |  |  | | |
| **Table A 23 Attitudes of men regarding GBV. Myanmar, Men** | | | | | | | | | | |
|  | **%** | | | | | | | |
| **Statements(Men)** | **1. Strongly disagree** | **2. Disagree** | **3. Neither agree or disagree** | **4. Agree** | | | **5. Strongly agree** | **No Response** | | |
| 45. A wife should tolerate being beaten by her husband/partner | 10.7 | 73.3 | 2.7 | 9.3 | | | 4.0 |  | | |
| 46. Are important advantages for a circumcised girl | 25.3 | 57.3 | 14.7 | 2.7 | | |  |  | | |
| 47. A girl is never too young to be married if a good husband found | 9.3 | 68.0 | 5.3 | 13.3 | | | 4.0 |  | | |
| 48. Refusing to have sex she is tired or not in the mood | 1.3 | 14.7 | 4.0 | 70.7 | | | 9.3 |  | | |
| 49. Husband is justified in hitting or beating her wife goes out without telling | 8.0 | 73.3 | 5.3 | 12.0 | | | 1.3 |  | | |
| 50. A girl should be circumcised in order to preserve her virginity before marriage | 13.3 | 72.0 | 4.0 | 5.3 | | |  | 5.3 | | |
| 51. Women should choose themselves whom they want to marry |  | 12.0 | 2.7 | 80.0 | | | 5.3 |  | | |
| 52. It is better to send a son to school than daughter | 8.0 | 82.7 | 2.7 | 5.3 | | | 1.3 |  | | |
| 53.Wife burns the food it is only proper that her husband/partner discipline her by hitting or beating her. | 18.7 | 78.7 |  | 2.7 | | |  |  | | |
| 54. Woman was raped, that means she have done to provoke it | 9.3 | 69.3 | 8.0 | 13.3 | | |  |  | | |
| \* = Includes women that can sell without telling anyone and those that need to inform the husband but do not need his permission | | | | |

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1. CARE Norad multi year plan 2009 – 2013 [↑](#footnote-ref-1)
2. Not collected at baseline stage [↑](#footnote-ref-2)
3. Female non members [↑](#footnote-ref-3)
4. Not collected at baseline stage [↑](#footnote-ref-4)
5. Not collected at endline [↑](#footnote-ref-5)
6. Not collected at baseline stage [↑](#footnote-ref-6)
7. Lower scores indicate rejection of GBV on a scale 1-5. The high score reflects favourable attitudes to violence, i.e. negative attitudes. [↑](#footnote-ref-7)
8. Over 70 percent of the married women in the reproductive age group (15 – 49 years) have heard of condoms but only five percent report use. Nearly 80 percent of the women who have given at least one birth are aware of institutional deliveries but only 20 percent have utilized the service. (Joe, August 2010) [↑](#footnote-ref-8)
9. Source: WIN (2012) CARE Myanmar Mid Term Review Report. Draft April 2012. [↑](#footnote-ref-9)
10. Lower scores indicate rejection of GBV on a scale 1-5. The high score reflects favourable attitudes to violence, i.e. negative attitudes. [↑](#footnote-ref-10)