SHAE THOT | ရှေ့သို့

TNS

Midterm Program Evaluation of Shae Thot "The Way Forward"

May 29, 2015

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TNS

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Executive Summary

Shae Thot is a five-year, USAID-funded project whose goal is to reduce suffering and death among the people of Central Burma through the use of an integrated, multi-sectoral approach that addresses the root causes. The project's objectives are to:

A. Decrease maternal, new-born and child mortality.
B. Improve household food security.
C. Increase access to sufficient quantities of safe water, potable water, and improved hygiene.
D. Strengthen social and community institutions for development.

This report presents the midterm evaluation (MTE) of the Shae Thot program, conducted by TNS. The midterm evaluation had five objectives:

1. Analyze key project outcomes compared to baseline and comparison group measurements in order to assess progress towards the project objectives.
2. Assess the integrated approach of Shae Thot and interactive effects of overlapping program interventions.
3. Collect and analyze qualitative data to assess changes in communities over time and response to evolving program context.
4. Collect baseline data for key outcomes in new project areas (where activities began in 2014).
5. Give recommendations and lessons learned for the final years of implementation.

The midterm evaluation employed mixed methods to meet these objectives. A quantitative household survey based on the baseline questionnaire was conducted with a representative sample of 4,680 households, 3,640 in Shae Thot areas and 1,040 in comparison areas. The baseline survey had sampled 4,400 households. The midterm evaluation was conducted in the same villages as the baseline study, with the addition of villages in townships where program implementation had just begun in order to meet evaluation objective four. Ten focus group discussions (FGDs) and 57 in-depth interviews (IDIs) were conducted to provide qualitative data on program outcomes and integration.

The MTE found strong evidence of participation in community governance groups. Communities especially value that Village Development Committees (VDCs) bring people in the community together, and that they fill gaps in services and development. Village Development Funds (VDFs) are supporting this through individual and community grants, providing resources needed for local development projects and a health and social safety net. These structures are still nascent and current practices of accountability and democracy require further solidification.

Shae Thot villages showed strong improvements in many indicators for maternal and child health, WASH and livelihoods, and the qualitative data supported these findings. Knowledge of danger signs during four key MCH periods rose by an average of 16 percentage points, an improvement of 244% over baseline. Use of clean delivery kits grew by 59%, increasing from 52% at baseline to 82% at midterm. Attendance at four ANC visits, two tetanus toxoid injections, and skilled delivery, neonatal and postnatal care all showed similar increases. Diet diversity increased by an average of 1.2 food groups, and treatment of diarrhea with ORS and zinc rose from 2% to 11% of cases. These improvements are reinforced through access to safe drinking water, which has grown 37% (rising from 65% to 89% of the

population), and improved latrines, which grew 14% (from 63% to 72%). Notably, open defecation in target communities decreased by 27% (from 14% to 11% of households). Together, these improvements in access to MCH services and WASH, as well as improved health and hygiene behaviors, form a foundation for healthier communities.

Food security has improved, both in respondents' perceptions and in key indicators. Reported income rose 20% from baseline, from MMK 85,500 to 101,375. Crop yield in target crops rose by an average of 26%, which should both decrease food scarcity and improve income from agriculture. There was a marked decrease in reliance on money lenders for loans, which fell by 520%. Large numbers of households are still taking out loans in order to smooth consumption, particularly to provide food for households, but Shae Thot's access to credit programs are clearly playing a role to provide these loans at low interest rates.

While there are few data on the efficacy of Shae Thot's integrated approach, the qualitative information gathered during the evaluation showed positive signs. Partners are coordinating well, and in several villages the MTE found that villages were implementing the different aspects of the project in a collaborative, additive way that found synergies in the different roles and skills community members had taken on and gained. FGD findings indicate that the program is having strong impacts on community empowerment, and that Shae Thot is helping create the conditions for community sustainability.

The growth that the quantitative indicators show is impressive, but it should be noted that the comparison group showed many improvements as well, possibly due to Burma's growing economy and reforms currently being implemented. The qualitative information gathered shows that community members link many of the improvements they find in health, water and livelihoods directly to Shae Thot. Selecting true comparison villages presents difficulties within any social research study as there is a wide array of factors to consider which might impact a village's pace of development. The comparison villages selected for this study were chosen on the basis of their proximity to the intervention villages without a thorough qualitative or quantitative analytical comparison to understand differences or similarities among villages. Comparison villages tended to be located in more central locations in relation to the main towns, with greater access to markets as well as presence of additional non-governmental and governmental actors during the same time period. For this reason, it may be misleading to consider comparison villages as truly comparable to intervention villages.

Key recommendations for the final years of project implementation include:

- Continue training for VDC members on active management skills and leadership
- Train VDCs on community needs assessments methods
- Deepen local leadership by mentoring potential leaders, with a focus on women and youth
- Scale up the VDC pilot and apply lessons learned to other VDCs
- Mentor communities and VDCs in advocacy, feedback and active participation
- Continue to promote increased access to credit
- Seek out opportunities for increased community engagement with local government officials
- Encourage Mothers' Group members to more actively serve as "health ambassadors"
- Consider expanding the current mobile health service approach beyond MCH
- Explore options to support health system strengthening

- Incorporate maintenance and sustainability plans more strongly into WASH activities
- Look at the gap between knowledge and practice related to hygiene
- Continue to support the positive uptake of the program's livelihoods activities through scaling up agriculture and access to credit interventions
- Pilot linking a sub-sample of villages to micro-insurance to mitigate against environmental shocks
- Expand the livestock and poultry banks and explore the possibility of diversifying further through adding other types of animals to the revolving banks
- Support key farmers further through either increasing the number of key farmers or mentoring them to widen their outreach, so that the skills they gain spill over into communities
- Strengthen training related to the mixed use of fertilizers (organic, chemical, and natural) where appropriate in order to improve uptake
- Develop risk reduction activities to augment communities' ability to respond to food scarcity during lean months related to environmental changes
- Conduct a study on the effectiveness of the integrated approach
- Conduct a sustainability study of VDCs, VDFs, savings groups and community volunteers in project areas that have phased out, using the lessons learned to strengthen ongoing activities
- Promote the participation of more women in water, agriculture and livestock activities

The complete recommendations can be found on page 32, and also include recommendations for conducting the final program evaluation.

List of Acronyms

AMW	Auxiliary Midwife
AN	Antenatal
ANC	Antenatal Care
ARI	Acute Respiratory Infection
CAP	Community Action Planning
CBO	Community-based Organization
CESVI	Cooperazione e Sviluppo
COPI	Community Performance Index
DP	Data Processing
FGD	Focus Group Discussion
GoB	Government of Burma
HHS	Household Hunger Scale
IDI	In Depth Interview
KII	Key Informant Interview
LPI	Local Partnership Initiative
MCH	Maternal Child Health
MIMU	Myanmar Information Management Unit
MMK	Myanmar Kyat
MOU	Memorandum of Understanding
MSI	Marie Stopes International
MTE	Mid-term Evaluation
NGO	Non-governmental Organization
ORS	Oral Rehydration Solution
PGMF	Pact Global Microfinance Fund
PNC	Post-natal Care
PPS	Probability Proportionate to Size
TT	Tetanus Toxoid
USAID	United States Agency for International Development
VDC	Village Development Committee
VDF	Village Development Fund
VIGO	Village Income Generation Organization
WASH	Water Sanitation and Hygiene

Shae Thot Mid-Term Evaluation Report

Introduction

Acknowledgements

The Shae Thot program is funded by the United States Agency for International Development (USAID) as part of its commitment to improving the lives of the people of Burma. Pact is the lead organization for Shae Thot ('the way forward' in Burmese) and implements the program with consortium partners Cooperazione e Sviluppo (CESVI), Marie Stopes International (MSI), Pact Global Microfinance Fund (PGMF), and UN-Habitat, as well as with seven local partners. The mid-term evaluation (MTE) of Shae Thot was advertised through a public tender and awarded to TNS in May 2014. TNS would like to acknowledge the efforts of those who contributed to the research process, including the consortium staff in Rangoon, the Shae Thot project staff in the field as well as the government officials, beneficiaries and community members.

Project Overview

The Shae Thot program began in September 2011 with an award from USAID of $55 million over five years to offer humanitarian assistance in rural communities within the central Dry Zone of Burma, which covers much of the regions of Magway, Mandalay, and southern Sagaing. Shae Thot uses an integrated development model to achieve the program's goal and four objectives:

> Goal: to reduce suffering and death among the people of Central Burma through the use of an integrated, multi-sectoral approach that addresses the root causes.
>
> Objectives:
>
> A. Decrease maternal, newborn and child mortality.
> B. Improve household food security.
> C. Increase access to sufficient quantities of safe water, potable water, and improved hygiene.
> D. Strengthen social and community institutions for development.

Approach and Sectors

Shae Thot has adapted to the changing context of Burma with guidance from USAID, and expanded programmatically as well as geographically. In response to increased opportunities to work in areas of community governance and village capacity development, the consortium has intentionally broadened Objective D as the core of the program. Shae Thot works though community groups with elected and networked villagers, who are owners and managers of their development activities, and community funds in order to implement activities in MCH, livelihoods and WASH. Implementation of different activities overlaps as necessary in response to local need. The full list of townships involved in the Shae Thot project and the interventions they are receiving or have received is found in Annex 1.

Key Actors

Pact is the manager and prime implementing partner for Shae Thot, a consortium of five international partners and seven local partners. The MCH component is implemented by Pact through community volunteers and education, and MSI through mobile clinics. The livelihoods objective is met through

CESVI's work in agriculture outreach, the PGMF microfinance provision, and Pact's women's empowerment savings groups. WASH work is conducted through UN-Habitat's water and sanitation infrastructure activities and Pact's sanitation and hygiene community awareness activities. The community governance objective is met primarily through Village Development Committees (VDCs) implemented by Pact and Cesvi, along with Water Committees implemented by UN-Habitat. See Annex 2 for a graphic representation of the consortium partners' division of responsibilities in Shae Thot and how their activities are implemented through village level committees and groups.

The project also benefits from good working relationships with its government counterparts, principally the Ministry of Social Welfare, Relief and Resettlement and Ministry of Health at the national level, and with district and village tract officials and village administrators at the community level.

Program Evolution

The project has evolved since its inception and expanded into two additional geographic areas following consultations with USAID. In 2012, the project began work in the township of Shwepyithar, a peri-urban area in Rangoon region. Two more peri-urban townships in Rangoon, Kyauktan and Thanlyin, were subsequently added. Following a series of assessments in 2012 and 2013, Shae Thot began activities in the three southern townships of Kayah State to provide much-needed services in long isolated areas. In response to the opportunities presented by Burma's dynamic transition towards a more robust civil society, Pact launched the Local Partner Initiative (LPI) in mid-2013. The LPI was designed to build the capacity building of local organizations, both to implement their activities more effectively and to strengthen their organizational capacities generally.

Baseline

The baseline study for Shae Thot was conducted in June and July of 2012 by Myanmar Survey Research in the original nine townships participating in the project (see Annex 1). The firm conducted a survey in 4,400 households, of which 3,080 were scheduled to receive programming and 1,320 selected as a comparison group. Probability Proportionate to Size (PPS) was used to select the intervention villages surveyed, stratified by township. Non-treatment villages were selected from the Myanmar Information Management Unit (MIMU) village list, but since this list did not include population estimates, it was not possible to use PPS; random selection was used instead. Three townships did not have a non-treatment group in the baseline survey because similar development activities implemented by other NGOs were being implemented in those areas, so any comparison group would have been contaminated. Within the selected villages, households were selected using a sampling interval based on village size. The household head or household head's spouse was interviewed or, when not available, the de facto household head was asked to respond to the questionnaire. The baseline survey was supplemented with 220 Key Informant Interviews (KIIs) of community volunteers, leaders, and local authorities.[1]

The context of development in Burma

The timeline for Shae Thot to date coincides with enormous and rapid political, economic and social transformations in Burma. These transformations are contributing to a decline in mortality and fertility rates (see Annex 9 for data table), while income, increased access to communications technology and

[1] Shae Thot Baseline Report. Myanmar Survey Research. April 2, 2013.

financial services, and public expenditure on social programs are all growing rapidly (Annex 9).[2] These dramatic changes are affecting the lives of Burmese people in rural and urban areas alike in myriad ways, including their health, incomes, livelihoods, and the role of community institutions.

These changes have affected both the sites where Shae Thot is working and those selected at baseline for comparison. Comparison groups are generally closer to urban areas, have good water sources and other infrastructure (see map in Annex 4). Thus, the comparison areas may also have had even more access to services and infrastructure expansion than treatment areas. Some also received development assistance from other NGOs or the Government of Burma (GoB) during this period. Because of this, comparison villages from baseline have also seen many improvements in health, livelihoods and WASH. This report focused primarily on quantitative outcomes within Shae Thot project areas, using the qualitative data to explore the contribution of Shae Thot to the observed changes, but also presents data from the comparison group so as to highlight that not all change can be attributed to Shae Thot.

Mid-term evaluation

Evaluation objectives

The Shae Thot mid-term evaluation (MTE) had five objectives:

1) Analyze key project outcomes compared to baseline and control group measurements in order to assess progress towards the project objectives.
2) Assess the integrated approach of Shae Thot and interactive effects of overlapping program interventions.
3) Collect and analyze qualitative data to assess changes in communities over time and response to evolving program context.
4) Collect baseline data for key outcomes in new project areas (where activities began in 2014).
5) Give recommendations and lessons learned for the final years of implementation.

This report will present the findings from quantitative and qualitative data together, grouped by Shae Thot's four objectives, and then separately consider the integrated approach. Finally, this report will present recommendations based on the evaluation's findings. Evaluation objective 4, the baseline data for new areas, has been collected but will not be presented in this report.

Mid-term evaluation design

The MTE began with a review of relevant project documents in May 2014. The desk review focused on the program description, progress reports, and baseline study, with particular attention to the Shae Thot logical framework to understand the project's structure. Three TNS staff conducted key informant interviews (KIIs) with representatives of the Shae Thot consortium partners (n=10). During field data collection, TNS interviewed field-based project teams, local partners, and local government officials as additional key informants (n=14). Following the desk review and KIIs, TNS prepared an inception report in July 2014.

[2] World Development Indicators, The World Bank. Retrieved May 14, 2015.

Field data collection

Primary data collection was done in July and August 2014. The TNS team visited the selected townships and gathered the qualitative data in July, and the quantitative household survey was conducted in late July and early August. TNS conducted ten Focus Group Discussions (FGDs) with project beneficiaries in intervention villages, using the FGD guide provided in Annex 4. The purpose of the FGDs was to: 1) gauge local knowledge of Shae Thot, 2) put the program in context of development within the village and the role of Shae Thot's activities within this context, and 3) solicit input for the project from its beneficiaries. Respondents were chosen to represent participants in different project activities.

TNS held in-depth interviews (IDI) with key informants (n=57) including Mothers' Group members, midwives, local officials, community volunteers, and Village Development Committee (VDC) members. The purpose of the IDIs was to gauge key informant understanding of the project and their levels of participation. IDI participants were selected to be those in the community with the most extensive knowledge of and experience with Shae Thot.

The FGDs and IDIs were only conducted in Shae Thot villages (not comparison sites) to provide insights into the survey data results and contextual information for the evaluation.

Survey sampling

The household survey was implemented in the same intervention and comparison villages as at baseline, with an additional sample in Yenangyaung and Sinbaungwe townships, where project activities had recently started up (these data are not included in the report but are intended to provide a baseline for Shae Thot's final evaluation). The target respondents were split between the head of household (or de facto head of household) and the head of household's spouse. If there was a child under five years old in the household, the mother/caregiver of that child answered questions in the MCH section of the questionnaire even if the main household interviewee was the male head of household. These inclusion criteria and sampling methods were consistent with the baseline methodology, and the questionnaire was adapted from the baseline tool. The total sample size was 4,680 households, of which 3,640 were in treatment areas and 1,040 in comparison areas.

Data cleaning and analysis

The completed questionnaires were reviewed by the field team, who performed random checks on a subset. After the questionnaires were edited and checked for quality, they were given to the Data Processing (DP) department. The DP team coded the open-ended questions with eight coders and used ten data entry assistants for quantitative data entry. Thirty percent of the questionnaires were randomly selected and entered for a second time to counter-check for data entry quality. Data entry was done using NIPO Nfield, which controls for logic and reduces possible errors.

After data entry was complete, the data processing analyst and manager cleaned the dataset by labeling and recoding, and then imported and structured it into IBM SPSS Statistics Version 19. Using frequency tables, the research and DP teams cleaned the data. The research team recoded and filtered the data after sharing the preliminary findings with Shae Thot in December 2014, and performed further cross-tabulation analysis and significance testing to combine the MTE data with the baseline dataset. The data were also re-analyzed using township weights to compensate for a possible location bias. However, results were not dramatically different from the unweighted analysis and the weighting required dropping townships without comparison groups, so the unweighted data are reported in this evaluation.

The filtering and re-analysis done to the baseline and midterm datasets delayed the production of the final results. The research team coordinated with Pact for clarification and standardization of indicators in both baseline and midterm datasets.

The qualitative team made audio recordings of all FGDs and in-depth interviews, and translated the FGDs into English transcripts. Notes from the IDIs were manually captured in a thematic analysis matrix and summary village reports.

Validation workshop

The preliminary results of the survey data and recommendations were shared and discussed at a validation workshop in Rangoon in December 2014 attended by all of the consortium partners. Following the baseline procedure, analysis was conducted for each sector using the entire sample surveyed. During the workshop, the consortium discussed the fact that this approach did not take into consideration that Shae Thot programming is not applied uniformly across all villages (i.e. villages could receive a single, or a combination of multiple, interventions in WASH, Livelihoods and MCH). The MTE design used the same sampling frame for all villages, so when analyzed together, the data reported for a given indicator included areas that did not have the relevant intervention, diluting the effect of the intervention on the results. In order to address this, TNS re-ran the analysis, filtering the data so that indicators for each component were analyzed using only data from households with the relevant intervention.

Limitations

The MTE was modeled on the baseline study as much as possible. However, the later articulation of the integrated approach and community governance as key elements of Shae Thot meant that there were no baseline measurements related to these objectives.

Activities in Kayah and Rangoon also had no baseline measurement, which, combined with the heightened sensitivities and language barriers in Kayah, led to a decision not to conduct the household survey in either region. Instead, five focus group discussions were held in Rangoon and Kayah to discuss what is working, what are the challenges on the ground, and to solicit program recommendations.

Because of the data filtering required, described in detail in the analysis section above, the sample size and statistical power of the results were reduced.

As discussed in the context section (p. 2), project villages were deliberately chosen to be those most in-need. Comparison villages are also often closer to urban areas (Annex 4), meaning they likely also benefited more from increasing investments in infrastructure and services currently happening in Burma (Annex 9). This limited the value of the comparison group as a counterfactual.

Findings

Project Awareness

In villages where Shae Thot is working, the project has made a strong impression on community members. The survey randomly selected households in implementation villages, so not all respondents have participated in all project activities. Still, 78 percent of those living in treatment villages say they are aware of Shae Thot, and 65 percent are aware of a particular activity in their community.

Figure 1: Awareness of the Shae Thot program and its activities

Participants in focus group discussions and in-depth interviews were able to cite USAID and "the American government" as the funding source for Shae Thot. Participants also primarily identified program activities as part of Shae Thot rather than attributing them to implementing partners, demonstrating that they perceive the Shae Thot program elements as operating as one.

Community strengthening

The primary building block for sustainable program outcomes is strong communities that make development decisions for themselves. While a fundamental program objective from the start, Burma's transition has enabled Shae Thot to position and promote community strengthening and self-governance as the cornerstone of the program. Most significant are the intensified efforts to strengthen the capacity of VDCs. A related community strengthening program component that has evolved through the course of implementation is the Village Health and Development Funds, which have transitioned to Village Development Funds (VDFs). The qualitative data, explored below, show that community solidarity is increasing in Shae Thot villages as members work together toward common goals and build on success. However, metrics on community strengthening were not measured at baseline, so there are limited quantitative data available to assess change over time (see recommendations).

Village Development Committees and subgroups

Central to the Shae Thot community strengthening process is partnering with communities to establish or revitalize existing VDCs to ensure that they employ inclusive, participatory decision-making and transparent, accountable community planning, implementation, and monitoring. Depending on the specific activities in each community, Shae Thot establishes sub-groups such as Mothers' Groups, WASH committees, Agriculture Committees, and VDFs, which implement sector-specific activities. The VDC coordinates these sub-groups and serves as the community's primary focal point for civil society. Shae Thot has jointly formed or revived VDCs through democratic elections in 1,130 villages to date.

Twenty-nine percent of households surveyed report serving on a sub-group, with 5% saying they serve on the VDC. Shae Thot areas have much more active group participation than comparison areas (Table 1). The program does not expect that all community members directly serve in these groups, but rather that participants in the groups act as agents for change within communities.

Table 1: Survey respondent participation in VDCs and sub-groups

	Treatment	Comparison	Difference
Women's savings group	11.7%	5.0%	6.7%**
Village Health and Development Fund	4.7%	1.3%	3.4%**
Village Development Committee	4.7%	2.3%	2.4%**
Income generation group	4.5%	1.8%	2.7%**
Agricultural extension network	1.9%	0.7%	1.2%**
Mother's learning group	1.0%	0.0%	1.0%**
Livestock extension network	0.9%	0.1%	0.8%**
Farmer's group	0.6%	0.0%	0.6%**

** Significant at the p=.05 level

While members of the VDC and subgroups are democratically elected or selected via a rural appraisal exercise and Shae Thot guidelines recommend that village leaders not serve as VDC chairs, but rather as non-voting "patrons" of the committee, focus group participants often mentioned that the VDC leaders and the village leaders tended to be one and the same and that they saw no real need for regular democratic transition of group leaders.

> *"Yes, the village head became the leader in this organization… he has been the leader of this group for a long time."* -Ywet Ma Sut Village, Yenangyaung

> *"The Village Head was elected by villagers' vote and he is responsible for two villages."* -Ban Si Village, Monywa

> *"Pact said that the leaders can be changed after six months but the members don't want to make any change; the members want us to keep on acting in the leadership role. We said that we would teach others how to do financial management but they don't want to. They just want to be followers in the group and so we have remained as leaders for a long time."* -Ywar Thar Yar Village, Myingyan

Nonetheless, these community governance groups have motivated community members and brought about increased confidence and ownership of community issues.

> "*Previously, we were very shy. We did not like to sit close to outsiders [project staff], but now we have changed. We have built our knowledge, and we sit at the front. We feel confident to try to answer questions now, even if we might be wrong.*" -Ywar Thar Yar Village, Myingyan

> "*They trained us to not just complain; but to be constructive. Our group wants to help to meet health needs in the village. But we don't have enough money yet.*" –Wet Ma Sut Village, Yenangyaung

Efficacy of Community Groups

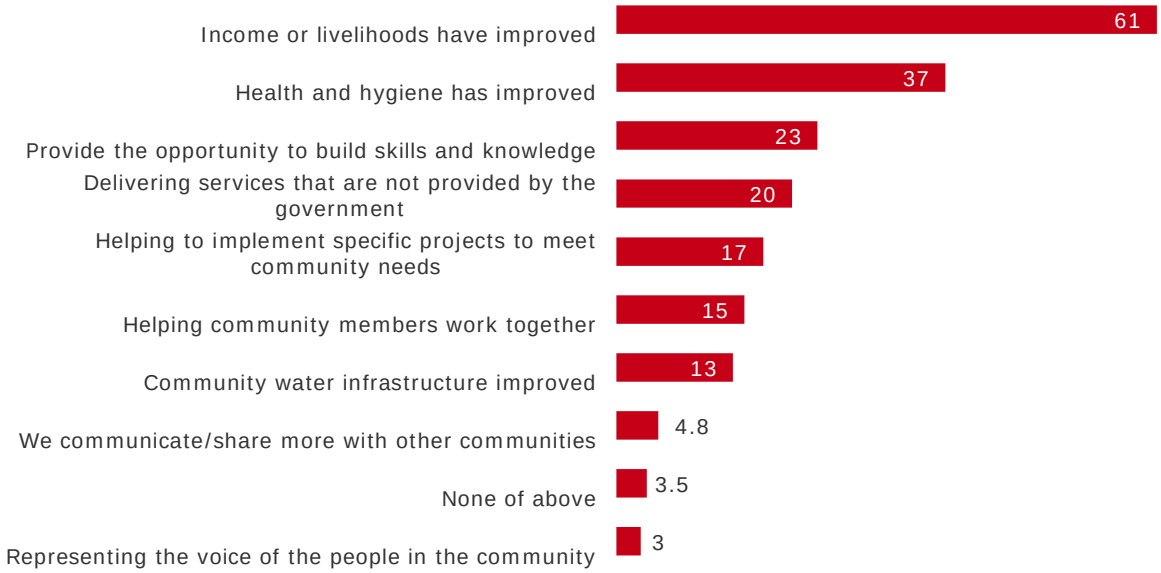
Ninety percent of respondents reported that community groups deliver a valuable service. Figure 2 shows the responses given when people were asked what contribution VDCs and sub-groups made to their community. People identified tangible outcomes related to income, health, agriculture, and WASH, but also recognized the VDCs' other contributions. For example, 23% cited 'building the skills and knowledge of community members' as a contribution of the VDCs, and 15% said community groups 'help people to work together.' The focus groups uphold the data, saying that communities are more unified and better able to work together:

> *"In the past, it was difficult … to gather people. Now, it is easy to gather people…they easily come if they are called."*
>
> -Mee Pauk Village, Myingyan

"Before this organization come to the village, it was difficult for us to gather people, but now villagers come because they are interested in gaining more health knowledge."

- Sar Taing Village, Myingyan

Figure 2: Responses to the question "What do you believe are the most valuable contributions that these groups make to the community?"

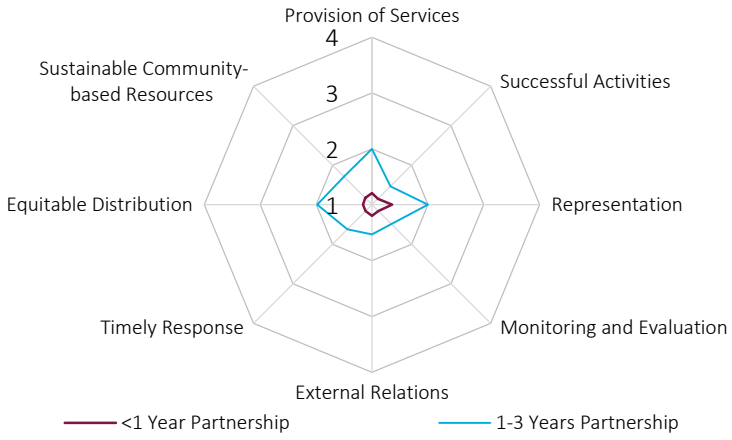


The qualitative research revealed that VDC and sub-group members are becoming more active leaders in their communities, but there are still gaps in capacity. The groups sometimes referred to themselves as "CESVI groups" or "Pact groups," and the language sometimes used demonstrates that they are still taking their direction from program staff rather than demonstrating full ownership of their development. When articulating the role of the group, the savings groups are able to do so very clearly and competently, while the other sub-groups are more hesitant and unsure, particularly the Farmers' Groups and the WASH Committees.

To identify and address capacity issues, Shae Thot conducted assessments of 135 VDCs across 12 townships that are part of a pilot for VDC strengthening. These VDCs were led through a participatory process to self-assess their performance on eight domains on the Community Organization Performance Index (COPI), which was adapted from Pact's validated Organization Performance Index tool.[3]

The COPI baseline found that VDCs that had been working with Shae Thot for more than one year scored higher on the COPI than those that were new to the project (Figure 3), demonstrating that the work Shae Thot had been doing with VDCs was improving their capacity to manage community development. The data also indicated that VDCs still overall have very low capacity and many areas for growth. In particular, the VDCs' advocacy and networking (External Relations), activity implementation (Successful Activities), and record keeping (Monitoring and Evaluation) skills had grown more slowly than other domains. These areas should receive special attention in Shae Thot's VDC pilot program.

Figure 3: COPI scores in pilot villages, disaggregated by length of partnership



An important part of community democracy is accountability—whether people give feedback on community activities and how that feedback is addressed. At the time of the midterm evaluation data collection, Shae Thot was developing a beneficiary accountability mechanism designed to provide a feedback loop for concerns about the project and be a model of responsive management.[4] The MTE survey found that, as a baseline before this mechanism began implementation, only 9% of respondents in intervention villages reported having ever registered a formal complaint or made an inquiry about public services, Shae Thot project activities, infrastructure, or another issue in their village. The majority of complaints – in both comparison and Shae Thot villages - were not resolved satisfactorily according to respondents. The low baseline rate of responsiveness suggests that giving feedback may not be a normal practice and that continuous encouragement in and mentoring around feedback and advocacy may be a necessary part of the mechanism as it rolls out (see recommendations).

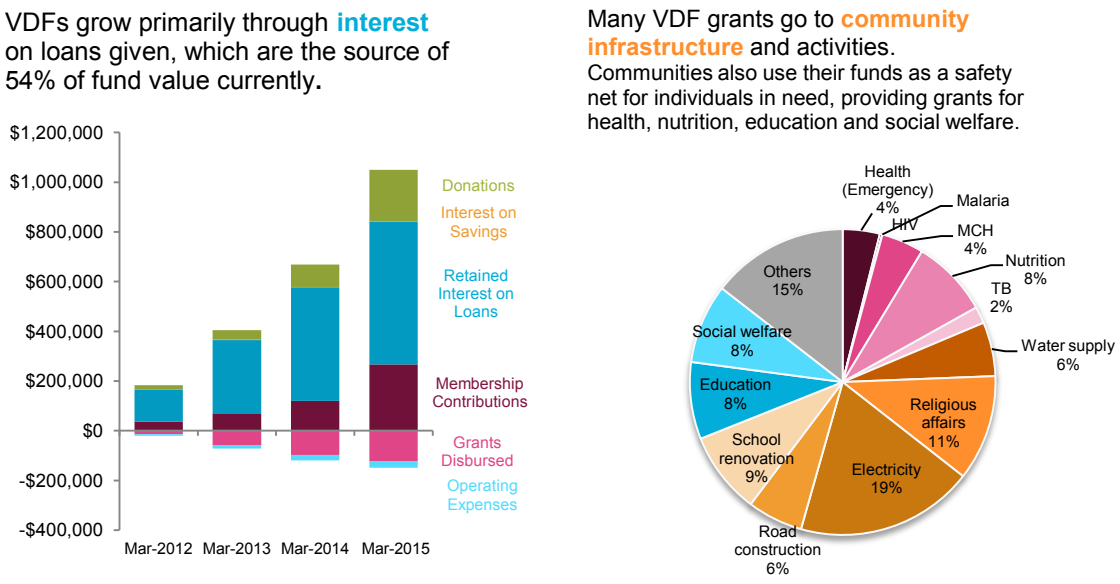
[3] Pact COPI Baseline Report, April 3 2014
[4] Shae Thot Semi-annual project progress report to USAID on 30 April 2015.

Village Development Funds

Shae Thot has facilitated the establishment of community-owned and managed VDFs in 970 communities across eight townships, which serve to provide financial resources for the VDCs. These community-owned funds were originally conceptualized to provide financial support for health needs and called Village Health and Development Funds. Over time, the funds in Shae Thot villages have transformed organically into funds with a broader development focus, as those who were administering them saw the potential for shared funds to improve the lives of the villagers in myriad ways; thus, the funds are now called Village Development Funds (VDFs). In addition to supporting community health needs, the VDF monies are now also being used for electrification, building/renovating schools, digging wells, and social welfare grants to elderly and marginalized families, as well as for health issues (Figure 3). The transformation of VHDFs into VDFs is an example of communities being empowered to make decisions for themselves, manage their own funds, and help communities to sustainably meet their development needs.[5]

Since March 2012, the initial capital of VDFs has grown 530%, from $207,836 raised through community contributions and matching Shae Thot grants of up to $200 per fund, to more than $1.1 million in total fund value as of March 2015.[6] This growth is due to continued community contributions to the fund and to the interest community members pay on loans they take from the VDF (see Figure 3). The MTE survey found that 2.6% of respondents in Shae Thot villages had taken a loan from the VDF in the past year. This low percentage is likely due to the relatively small size of the VDFs when they start, meaning that they do not have enough capital to give a large number of loans until they are more mature.

Figure 3: Growth of VDFs since project inception and use of VDF grants[7]



[5] Shae Thot Semi-annual project progress report to USAID on 30 April 2015.
[6] Shae Thot Semi-annual project progress report to USAID on 30 April 2015.
[7] Shae Thot Semi-annual project progress report to USAID on 30 April 2015.

The qualitative research found that VDF management committees are well-trained in the process of collecting and managing the funds, and demonstrate good accountability. Respondents spoke appreciatively of the VDFs, whose loans are valued when they or their family members are ill or have other urgent needs.

> *"If we are unwell, we can borrow money from [the VDF]."* -Mee Pauk Village, Myingyan

> *"We need to have cash. Now, we can use money from [the VDF]. If we have money, we don't need to be worried about the health and the education. If we have money, we can build a school. If I have capital for investment, I can do anything."* -Nan Kit Village, Hpasawng

In the final quarter of 2014, Pact's subsidiary Institute supported a study of prior VHDFs/VDFs Pact had established, and found that 68% of them continued operating and successfully growing resources five to eight years after program support had ended.[8] The emphasis on local ownership and community-led activities and financial resources introduced in this section is the foundation for the activities in MCH, WASH, and livelihoods that will be explored in the following three sections.

Community-managed Maternal and Child Health

Shae Thot works to improve maternal and child health (MCH) through building a community-managed safety net for women and children. While this safety net is being built, Shae Thot bridges the gap between health needs and the available health services through MSI's mobile clinics.

Key actors advocating for improved MCH are community volunteers, who serve on a VDC health sub-committee and often overlap with the villages' Auxiliary Midwives, and Mothers' Groups. Shae Thot's approach to health education and community outreach puts self-learning and community-led advocacy at the center, which empowers mothers and other caregivers to be active participants in safeguarding their health and that of their children.

Key findings related to MCH include increases in:

- Knowledge, e.g. on three or more pregnancy danger signs from 7.5% to 26.5%
- Four ANC visits from 21.1% to 35.2%
- Use of clean delivery kits from 51.7% to 82.2%

Maternal Health

A child's health starts with a healthy pregnancy. Women need knowledge to stay healthy and must receive appropriate care during pregnancy to ensure the health of the mother and child. Table 2 shows that women's knowledge of warning signs during pregnancy, delivery, the postnatal period, and the neonatal period has increased substantially in Shae Thot villages. Of particular note, knowledge of at least three pregnancy danger signs rose from 2.6% at baseline to 19.3% at midterm, which should help women identify problems in their pregnancies and increase their likelihood of seeking care. As noted in an interview:

[8] Virtas, Katrina. "An evaluation of Pact Myanmar's community-owned and managed health and development fund model." December 2014.

"We had limited health knowledge before, but this has increased a lot. Since this organization came to the village to build health knowledge, the villagers have gained a long-term perspective about health." -Sar Taing Village, Yenangyaung

While women in the general Shae Thot population showed strong gains in knowledge, program data on knowledge gains among Mothers' Group members, women who elect to participate in weekly reading groups to learn more about MCH, are much higher. These data are presented in Table 2 below. For example, while knowledge of postnatal danger signs in the general population rose from 2.6% to 15.1%, in Mothers' Group members this knowledge rose from 1.3% to 70.3%. This highly informed cadre of women in the Shae Thot villages is a resource that can play a vital role in spreading these messages more widely to their peers (see recommendations).

Table 2: Women's knowledge of MCH danger signs in Shae Thot villages

	Treatment (MTE data)			Mother's Group Members (Project Data)		
	Baseline	Midterm	Growth	Baseline	Midterm	Difference
% of women able to name 3 pregnancy danger signs	7.5%	26.5%	253.3%**	10.0%	78.3%	681.1%**
% of women able to name 3 delivery danger signs	2.6%	19.3%	642.3%**	2.2%	64.9%	2,864.7%**
% of women able to name 3 postnatal danger signs	2.6%	15.1%	480.8%**	1.3%	70.3%	5,449.1%**
% of women able to name 3 neonatal danger signs	13.7%	29.9%	118.2%**	5.9%	78.6%	1,238.4%**
N	1865	2200		868	866	

** Significant at the p=.05 level

A minimum of four antenatal care (ANC) visits are recommended for pregnant women to ensure that they receive a minimum of services and are screened for high-risk deliveries. Shae Thot community volunteers track pregnant women to encourage them to access recommended care, contributing to an increase in women reporting having four ANC visits during their last pregnancy from 21.2% at baseline to 35.2% at midterm, and a similar rise in women receiving two tetanus toxoid injections (Table 3). While there have been marked improvements in access to care in Shae Thot areas, a continuing shortage of midwives and other health care providers inhibits the access of all women to best practice antenatal care.

Table 3: Access to antenatal care in Shae Thot villages

	Baseline	n	Midterm	n	Growth
% of pregnancies with 4 ANC visits	21.2%	264	35.2%	213	66.0%**
% of pregnancies with 2 Tetanus Toxoid Injections	56.8%	310	67.3%	251	18.5%**

** Significant at the p=.05 level

Childbirth and post-natal care

Childbirth with a skilled birth attendant greatly increases the chance that a mother and her baby will survive labor and delivery, as does the use of a clean delivery kit. As Table 4 below shows, both of these behaviors have increased significantly from baseline. Women delivering with skilled birth attendants rose from 42.3% to 75.5%. Clean delivery kits are distributed and their use advocated by Shae Thot

community volunteers, leading to an increase from 51.7% of women using them at baseline to 82.2% at midterm. Access to neonatal care also improved. Overall, more women and children are receiving appropriate care during pregnancy, delivery, and the postnatal period.

Table 4: Key delivery and postnatal care indicators in Shae Thot villages

	Baseline	n	Midterm	n	Growth
% of deliveries with skilled birth attendants	42.3%	291	75.5%	298	78.5%**
% of deliveries using clean delivery kits	51.7%	230	82.2%	169	59.0%**
% of newborns receiving neonatal checks from skilled health provider within 2 days	64.3%	263	76.2%	298	18.5%**

The cost of facility delivery continues to be a deterrent for poor women in rural areas. Qualitative data illustrate the continued need for the VDFs described above to provide financial support for access to healthcare.

> *"Some women still have to give birth with the traditional birth attendant because of their financial situation."* -Sar Taing Village, Myingyan

> *"For 100 pregnant women, about 50 women give birth with a traditional birth attendant because of the money."* -Sar Taing Village, Myingyan

> "If there is enough money in the VDF, we will use it when the pregnant women are giving birth to their child in a clinic." -Mee Pauk Village, Myingyan

Child Nutrition

Malnutrition in the Dry Zone affects 28.2% of children, and lack of the micronutrients associated with poor diet diversity is one key contributor.[9] Respondents were asked about the food given to their youngest child (under age five) in the previous 24 hours. Their dietary diversity score was calculated by transforming the type of food into seven food groups, with the minimum acceptable nutritional score being four food groups. At baseline, children were consuming 4.7 food groups on average, which increased significantly to 5.9 food groups at midterm.

Table 5: Child nutrition in Shae Thot villages

	Baseline	n	Midterm	n	Growth
Average number of food groups consumed by children under 5	4.73	564	5.93	621	25.4%**
% of children under six months exclusively breastfed	70.5%	285	66.7%	78	-5.4%
% of children under five with diarrhea in the last two weeks	7.5%	415	9.0%	553	20%
% of children with diarrhea treated with ORS and Zinc	2.4%	41	11.8%	51	391.7%*

** Significant at the p=.05 level *Significant at the p=.10 level

[9] Myanmar Multiple Indicator Cluster Survey, 2009-2010.

Exclusive breastfeeding (no food or liquids other than breast milk) for the first six months of life provides maternal antibodies and well-balanced nutrients for newborns. The overall baseline value in the Shae Thot villages was 70.5 % for exclusive breastfeeding, which was already higher than the national average. This did not change significantly at midterm.

The qualitative data illustrate changes in knowledge and behavior about child nutrition.

> *"Because we never weighed children before, we were not aware whether our children needed nutrients or not. Now, we can feed them essential nutrients if they are underweight."*
> -Mee Pauk Village, Myingyan

> *"When Shae Thot first came to the village, they distributed the materials needed when giving birth and books about caring for newborns. When I had my first child, I didn't have any idea what we should feed him. When I had my second child, I knew that I needed to provide only breast milk for about six months, so because of the knowledge I had gained by reading the books, I didn't give my child any water, just breast milk."* -Sar Taing Village, Yenangyaung

Diarrhea contributes to poor nutrition and is especially risky for young children who can become easily dehydrated and fail to absorb nutrients during diarrhea episodes. At baseline, 7.5% of households reported having a child under age five who had diarrhea in the preceding two weeks; diarrhea incidence was 9% at midterm, not a statistically significant change (p=.191). Given that a large part of Shae Thot's diarrhea intervention focuses on case tracking and treatment, an increase in awareness and reporting of diarrhea cases is expected, but high diarrhea incidence clearly remains a problem in program villages.

Treatment of diarrhea has improved since baseline. The proportion of children who had diarrhea in the previous two weeks and were treated with both oral rehydration solution and zinc (best practice) rose from 2.4% at baseline to 11.8% at midterm, though this was marginally significant, likely due in part to a small sample size.

Mobile Clinics

More than 73,000 people have been served by Shae Thot's mobile clinics to date. Beneficiaries see mobile clinics as promoting both health and financial wellbeing. Focus groups revealed that many villagers were accessing MCH services before the program, but that the arrival of the mobile clinics made access to care much easier, saving time and financial resources.

> *"We are happy and comfortable because the mobile clinics are here now. Before they started coming to us, we had to go to a clinic."* -Ban Si Village, Monywa

> "*It saves money for us because we don't need to go to clinics in other villages.*"
> -Kyun Ywar Thit Village, Monywa

> *"It also interrupts our work if we have to go to clinics in other villages*."
> -Kyun Ywar Thit Village, Monywa

Respondents indicated that they would like to have the mobile clinics come to their villages more frequently.

Comparison to Non-Treatment Areas

Overall, access to healthcare in Burma is gradually improving due to changes in infrastructure and service availability, which has inevitably helped influence improvements in comparison areas (see Annex 9). For example, mobile phone penetration in Burma has increased from 10% in 2011 to 25% in 2014.[10] Improved mobile phone infrastructure is helping improve access to care through improving coordination with midwives in both treatment and comparison areas.

> *"Today, it is better because the communication is all right. We can find out whether [the midwife] is in the village or not just by phoning. Before, we had to go and bring her to the patient."* -Sar Taing Village, Myingyan

Many comparison villages are closer to urban areas and had better access to facilities (Annex 4). Possibly as a consequence, these areas tended to have higher growth in facility-related indicators like pregnancies with four ANC visits and delivery with skilled birth attendants, while Shae Thot areas tended to have faster growth in indicators like deliveries using clean delivery kits and knowledge-related indicators (Table 6). The latter have less to do with infrastructure access and are more directly impacted by project activities. Differences in nutrition indicators (exclusive breastfeeding and dietary diversity) changed at comparable rates. Because treatment areas were deliberately selected for their low access to services, it is possible that these indicators would have fallen behind in treatment areas without the program interventions.

Table 6: Comparison of Treatment and Comparison groups for MCH indicators

Indicator	Treatment		Comparison		Difference in Difference
	Baseline	Midterm	Baseline	Midterm	
% of pregnancies with 4 ANC visits	21.2%	35.2%	24.1%	51.9%	-13.8%
% of deliveries with skilled birth attendants	42.3%	75.5%	29.8%	73.3%	-10.3%
% of deliveries using clean delivery kits	51.7%	82.2%	53.8%	67.8%	16.5%
% of newborns receiving neonatal checks from skilled health provider within 2 days	64.3%	76.2%	76.0%	78.1%	9.8%
Average number of food groups consumed	4.73	5.93	4.8	6.15	-0.15
% of children under six months exclusively breastfed	70.5%	66.7%	73.5%	71.9%	-2.2%
% of children with diarrhea treated with ORS and Zinc	2.4%	11.8%	0.0%	0.0%	9.4%
% of ARI cases that received care from a skilled health provider	70.8%	72.3%	100.0%	90.9%	10.6%
% of women able to name 3 methods of modern contraception	28.5%	41.1%	19.8%	34.6%	-2.2%
% of women able to name 3 pregnancy danger signs	7.5%	26.5%	4.1%	18.5%	4.9%
% of women able to name 3 delivery danger signs	2.6%	19.3%	1.4%	13.4%	4.7%
% of women able to name 3 postnatal danger signs	2.6%	15.1%	1.4%	8.4%	5.5%
% of women able to name 3 neonatal danger signs	13.7%	29.9%	7.6%	22.0%	1.8%

[10] Zin Thu Tun. "Mobile Phone Users Up Tenfold Since 2010." Myanmar Business Today. December 14, 2014. http://www.mmbiztoday.com/articles/mobile-phone-users-tenfold-2010

The table in Annex 8 presents the full data on changes in Shae Thot areas against the change in comparison areas.

WASH

Personal water, sanitation, and hygiene (WASH) practices are a fundamental contributor to health. Shae Thot improves access to clean water and latrines and promotes community-led hygiene through UN-Habitat's "people's process" and Pact's WASH Promoters. All UN-Habitat WASH activities originate from a Community Action Planning (CAP) process and then are implemented through Water Committees. Pact's WASH promoters focus on hygiene education and latrine construction. The program has reached 478,970 people through clean water interventions and 180,259 through latrine construction as of March 2015.[11]

The selection of villages for Shae Thot WASH interventions was based on community-assessed need. One interviewee explained, "An assessment was done in villages beforehand to make sure a village really needs UN-Habitat's help, as well as which households should be the priority. They asked villagers to identify the poorest people in their village and make them the first priority."

Key WASH outcomes include:

- Households with access to safe drinking water sources rose from 65% to 89%
- Households with improved latrines rose from 63% to 72%
- Open defecation decreased from 14% to 11%

Access to Water

Access to clean water for drinking and domestic uses has increased dramatically in the Shae Thot villages selected for WASH activities (Table 7).

Table 7: Change in access to household water in Shae Thot villages

	Baseline	Midterm	Growth
% of households with access to safe water sources (drinking water)	65.0%	89.3%	37.4%**
% of households with access to safe water sources (domestic water)	56.4%	76.4%	35.5%**
n	440	440	

** Significant at the p=.05 level

Access to water not only has health benefits, but can also contribute towards improved livelihoods through a reduction in time spent collecting water (see Table 8 below). At baseline, households spent a daily average of 58 minutes collecting water in the rainy season, and 71 minutes in the dry season. This dropped to 27 and 28 minutes respectively at midterm as a result of increased access to water sources in the village.

[11] Shae Thot Semi-annual project progress report to USAID on 30 April 2015.

Table 8: Minutes per day to collect water

	Baseline	Midterm	Growth
Rainy season (minutes)	58.1	26.8	-40.0%**
Dry season (minutes)	71.0	28.4	-49.4%**
n	1166	520	

** Significant at the p=.05 level

Respondents noted the relative ease of getting water as a key benefit of improved water infrastructure.

Women and children typically collect household water, so the benefit of saved time accrues primarily to them. FGDs found that improved access to water also resulted in improved access to education:

> *"Our children used to have to draw water in the morning before going to school, but now they don't need to do this anymore."* -Ban Si Village, Monywa

While the value beneficiaries placed on program water activities is clear, some also raised concerns about their ability to maintain the infrastructure.

> *"We need to remove the sediment [in the well]. The well is going to be dead… We dig it again every year whenever the water is low but we still cannot find the solution for the sediment issue."* -Ban Si Village, Monywa

> *"The rain water gutter of the storage tank has been destroyed, so when it is raining rain water cannot flow to the tank. It should be repaired but we don't have enough money."* -Mee Pauk Village, Myingyan

Sanitation and Hygiene

Proper disposal of human waste is critical to disease prevention. Sanitation activities have heavily focused on the construction of fly-proof latrines, with communities showing high levels of interest and community participation. In the UN-Habitat model, trained carpenters initially construct the superstructures and then the remainder is completed at the household level. In the Pact model, latrine construction is taken on entirely by community members supported by community volunteers, often with financial support from the VDF or another program credit source. A FGD participant confirmed that Shae Thot supports people to build latrines, but that the project "just gives the necessary things to build it and then we have to build it ourselves." The labor contribution raised by the respondent is an intentional part of the project design, as requiring community members to participate in construction improves the likelihood of using and maintaining the latrines in the long-term.

According to the MTE survey, 71.6% of households have access to an improved latrine in Shae Thot WASH villages. This is a significant increase from the 62.9% who had improved latrines at baseline (Table 9). However, at both baseline and midterm similar proportions were using shared latrines—18.9% and 19.8% respectively. The increase in latrine availability appears to contribute to a decrease in open defecation, which dropped from 13.7% to 10.6% of households.

Table 9: Sanitary latrine access and handwashing practices in Shae Thot villages

	Baseline	n	Midterm	n	Growth
% of households with sanitary latrines	62.9%	1580	71.5%	1580	13.7%**
% of households with handwashing stations with soap	75.2%	1244	92.6%	1276	23.1%**

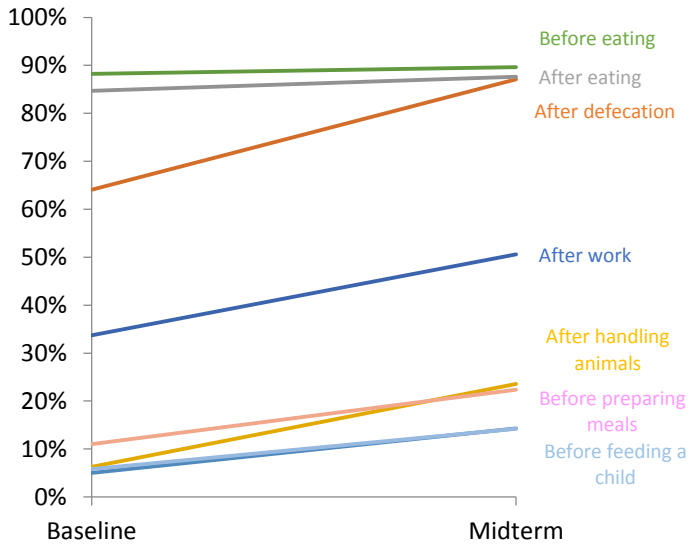
** Significant at the p=.05 level

FGD participants estimated that outdoor defecation had decreased by as much as 25% in their village, and diarrhea among children decreased as a result. "Yes, its rate is decreasing. Fewer children are suffering from diarrhea," said one respondent in Myingyan.

The VDCs play a crucial role in keeping the villages clean. One example is a village which held three communal cleaning sessions. This was an activity that the village and VDC had decided to perform on its own initiative, without guidance from the program, showing that a combination of creating village leadership and promoting good WASH practices can lead to community initiative to improve sanitation.

Hygiene education is the final WASH component of the project. Households with a handwashing station have increased significantly since baseline, and people appear to be using them; as Figure 4 below shows, nearly all handwashing behaviors improved substantially between baseline and midterm. The exceptions were washing hands before and after eating, which improved by only 1% and 3% respectively, but also began with high baselines. Of particular note, people washing their hands after defecation increased from 64% to 87%. Handwashing after work and after handling animals both rose 17 percentage points. All of these are key behaviors for preventing water-borne and fecal-oral transmitted diseases.

Figure 4: Reported routine handwashing practices in Shae Thot villages



Comparison to Non-Treatment Areas

As with the Shae Thot areas, access to safe water also improved in comparison areas, sometimes much faster than in treatment villages (

Table 10). Hygiene-related indicators, namely improved latrine ownership and having a handwashing station, improved at more comparable rates to the treatment areas (

Table 10). The increased government expenditure on public services (see Annex 3) may be contributing to the rapid growth of water infrastructure in comparison areas. Latrines and hygiene promotion are less of a focus for government investment, explaining the relatively slower growth in comparison villages for these indicators.

Table 10: WASH indicators for treatment and comparison groups

	Treatment		Comparison		Difference in Difference
	Baseline	Midterm	Baseline	Midterm	
% of households with sanitary latrines	62.9%	71.6%	63.7%	75.1%	-2.7%
% of households with access to safe water sources (drinking water)	65.0%	89.3%	56.9%	93.9%	-12.7%
% of households with access to safe water sources (domestic water)	56.4%	76.4%	58.6%	92.5%	-13.9%
% of households with handwashing stations with soap	75.2%	92.6%	75.5%	94.3%	-1.4%

See Annex 8 for the full tables comparing treatment and comparison groups.

Livelihoods and Food Security

Agriculture is central to economic activity in Shae Thot villages, with 53% of households saying that they earn income through growing crops; the second- and third-most common income streams were casual labor, which includes farm labor, and livestock. Consequently, Shae Thot addresses livelihoods and food security in two ways. One is through agricultural outreach, increasing crop yield for farmers through sustainable and locally appropriate improved inputs, as well as through home gardening and livestock programs for landless households. The other is through improving access to credit through either WORTH savings groups or PGMF's microfinance service. Access to credit can help households improve their access to agricultural inputs and labor and also allow households to begin or expand businesses to generate additional income sources. Together, improved agricultural practices and access to credit can help households to improve income and productivity, becoming more resilient.

Key outcomes for livelihoods include:

- Increase in income from an average of MMK 85,500 per month to MMK 101,375, a 20% growth
- Average increase in crop yield of 26.3%
- Decreased reliance on commercial money lenders from 31% to 5%

Agriculture

Under the Shae Thot consortium, CEVSI is leading agricultural and animal husbandry activities in six townships. As with the health and WASH models, the agriculture intervention in Shae Thot identifies

community volunteers—key farmers and livestock extension workers—to receive in-depth technical training and mentoring. These community volunteers then become advocates in their communities to cascade training and encourage use of locally appropriate, sustainable agriculture practices, including use of fertilizers and organic pesticides. They make decisions about the most appropriate types of inputs based on demonstration plots, in which farmers directly compare the cost and crop yields of different methods. Shae Thot had trained 32,150 farmers as of March 2015.[12]

The use of pesticides and fertilizers, both organic and chemical, has risen since baseline (Table 11). More than 70 percent of farmers now use organic and natural fertilizers, a practice that can improve long-term agricultural and environmental sustainability. Though use of both chemical and organic fertilizers has risen, the practice of mixing the two has dropped, despite being encouraged as a best practice by the project.

Table 11: Use of pesticides and fertilizers in Shae Thot villages

Indicator	Baseline	Midterm	Growth
% of farmers using pesticides	67.5%	87.4%	129.5%**
% of farmers using organic and natural fertilizer	30.0%	70.9%	236.3%**
% of farmers using chemical fertilizer	21.1%	67.8%	321.3%**
% of farmers using mixed organic and chemical fertilizers	62.9%	34.7%	-55.2%**
n	237	199	

** Significant at the p=.05 level

These improved inputs have contributed towards increased crop yields. Table 12 reports yields for the commonly grown crops that Shae Thot's agriculture interventions target, most of which have increased in yield since baseline. In particular, green gram and chickpea yields have increased by 56.4% and 53.9% respectively, while rice paddy, the major staple, has increased yield by 16.1%. Groundnut and sesame have not changed their yield significantly. On average, the yield of key crops has increased 26.3% since baseline.

Table 12: Crop yields in Shae Thot program areas

Yield per acre	Baseline	Midterm	Growth
Rice paddy (baskets)	44.8	52.0	16.1%
Green gram (baskets)	5.5	8.6	56.4%
Chickpeas (baskets)	7.6	11.7	53.9%
Groundnut (baskets)	29.4	27.3	-7.1%

[12] Shae Thot Semi-annual project progress report to USAID on 30 April 2015.

Sesame (baskets)	6.5	7.3	12.3%

In focus group discussions, participants in farmer field schools said that this improvement in agriculture has helped improve their livelihoods.

> *"Before CESVI came to the village, I had to borrow money from others. For the parents who have children, many didn't send their children to school but had them work in the field. Now, we can grow more food … because CESVI supports us now. We have many advantages."*
>
> -Wet Ma Sut Village, Yenangyaung

> *"Our economic difficulties have decreased. Once, we had to borrow money from others, but now we can support ourselves with agricultural work."* -Wet Ma Sut Village, Yenangyaung

Food Security

The increasing yields appear to be reducing food scarcity, which was significantly lower in most months compared to baseline (

Table 13). The most extreme months of food scarcity also shifted, from March-June at baseline to July-August at midterm. This may be due to a short-term weather variation, or to changing environmental conditions affecting local agriculture. In these months, the rate of food scarcity was much higher than at baseline, implying that project interventions were insufficient to compensate for food shortages due to extreme environmental conditions.

Table 13: Food scarcity by month in Shae Thot villages

% respondents saying food was scarce in each month	Baseline	Midterm	Growth
January	9.3%	1.0%	-89.2%**
February	11.2%	1.7%	-84.8%**
March	25.5%	11.4%	-55.3%**
April	30.5%	11.2%	-63.3%**
May	28.8%	4.5%	-84.4%**
June	28.6%	3.3%	-88.5%**
July	14.0%	33.1%	136.4%**
August	18.6%	31.0%	66.7%**
September	4.5%	3.8%	-15.6%
October	11.2%	4.0%	-64.3%**
November	8.8%	4.5%	-48.9%**
December	6.7%	1.7%	-74.6%**

n	420	420	

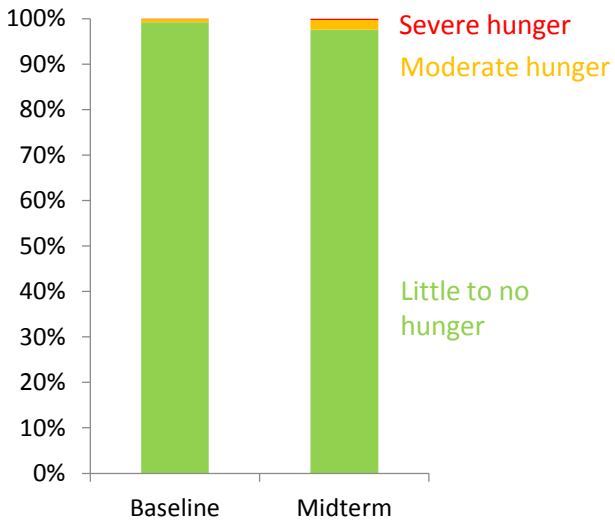
** Significant at the p=.05 level

Additionally, the midterm evaluation looked at food security using the Household Hunger Scale (HHS), which has been developed and tested by USAID for use across different cultures. It classifies households into three categories:

1. little to no hunger,
2. moderate hunger, and
3. severe hunger.

The figure below shows the results of the HHS at baseline and midterm (Figure 5). The survey showed very little change, with 97.6% of midterm respondents claiming little to no hunger, a slight decrease from baseline. These rates are lower than those from other external, nationwide data sources, and it is possible that a social desirability bias deterred respondents from saying that their household suffered from hunger both at baseline and midterm. However, while few households claimed to suffer from hunger, many were using loans as a coping mechanism to buy food. The role of Shae Thot's access to credit interventions is discussed below.

Figure 5: Household hunger status in Shae Thot villages as classified by the Household Hunger Scale



Access to credit

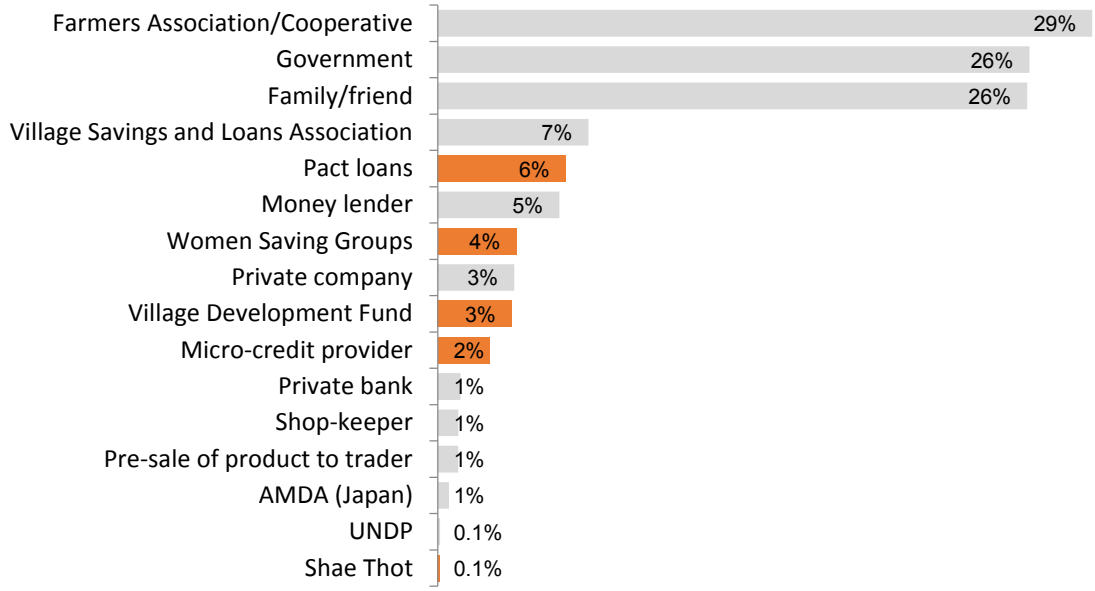
Many beneficiaries attributed improved financial wellbeing and livelihoods to better access to credit provided through Shae Thot. Shae Thot provides access to sustainable financial services through three means: institutional microfinance (PGMF), women's savings groups (WORTH), and the VDF (discussed in the community strengthening section above). This section will focus on the joint impacts of PGMF and WORTH, which together cover the majority of project areas.

As of the end of 2014, 19,713 women had participated in the WORTH savings group program through 764 savings groups. They have established funds totaling $540,882, which equates to personal savings of about one month's income for each woman.[13] In the midterm survey, 17% of community members said they were aware of the WORTH program and 12% said they were members of a women's savings group, showing that the program has had a strong influence on the villages where it is active. PGMF microfinance clients had grown to almost 45,000 across eight townships at the end of 2014. The large majority (94%) of microfinance beneficiaries are women, often borrowing for the first time.[14]

At midterm, people in Shae Thot areas were using credit streams more frequently than in comparison areas; 63% of respondents in Shae Thot areas had taken a loan in the last 12 months, while 55% of comparison group respondents had done so. Approximately 15% of loans taken in Shae Thot villages are through one of the Shae Thot interventions (

Figure 6).

Figure 6: Sources of loans in Shae Thot villages



[13] Shae Thot Semi-annual project progress report to USAID on 30 April 2015.
[14] Shae Thot Semi-annual project progress report to USAID on 30 April 2015.

In focus groups, loan beneficiaries appreciated the fact that they could borrow money at a much lower interest rate than what is usually charged by money lenders (10%-30% per month), compared to the PGMF rate of 2.5% and the average WORTH rate of 3%.

> *"The interest rates are also better for us. We used to have to pay 10% in interest, but now we only pay 3% in interest and so it is better for us."* -Ywar Thar Yar Village, Myingyan

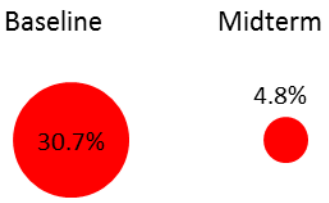
> *"I can buy rice in cash. I used to have to buy it on credit, so I had to pay much more for my rice. Now, rice costs me less because I can buy in cash."* -Ywar Thar Yar Village, Myingyan

Similarly, women spoke of how program activities changed their savings habits, another important aspect of household financial resilience:

> "*If we weren't required to put savings in the group, we would never be able to save at all.*" -Wet Ma Sut Village, Yenangyaung

This increased availability of low-interest alternatives is a contributing factor to the dramatic decline in the percent of loans taken from money lenders, which fell from 31% at baseline to 5% at midterm (Figure 7).

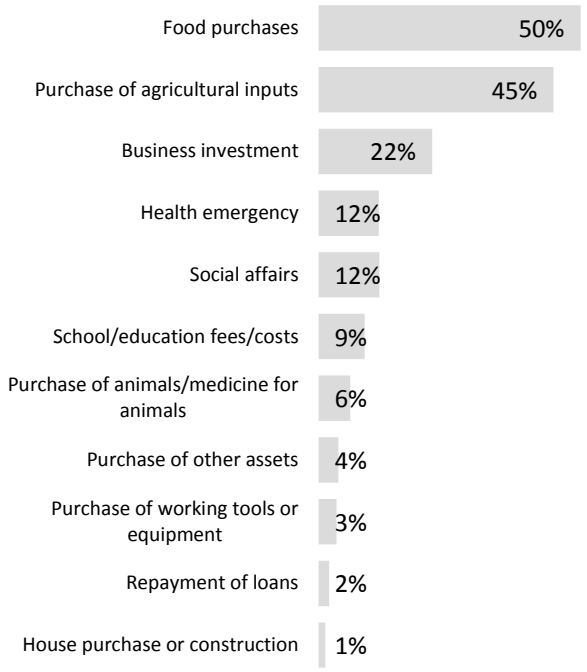
Figure 7: Percent of loans taken from money lenders

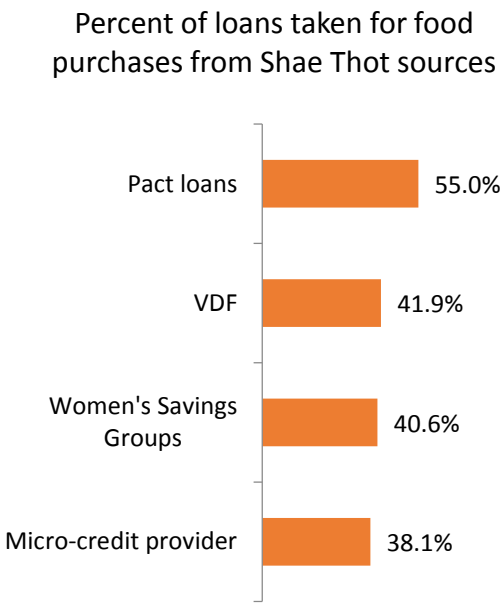


Despite Shae Thot's focus on loans for business investment and health emergencies, the largest demand for loans was for food purchases; 50% of respondents who had taken a loan had done so for this purpose (Figure 8). From Shae Thot loan sources, loans for food purchases ranged from 38.1% to 55.0% of loans.[15] While the MTE survey found few reports of severe or moderate hunger, these data demonstrate that households are resorting to loans to improve food security. Agriculture (45%), business investment (22%), and health emergencies (12%) were other major motivations for taking loans, but there clearly remains a strong need for income-smoothing loans for food security.

[15] "Pact loans" was not a pre-coded response, but was a frequently given answer. It is not clear which Pact loans refer to PGMF, which to WORTH, and which to the VDF.

Figure 8: Percent of respondents taking loans for different purposes





Women's Empowerment

The WORTH and PGMF models are not only focused on savings and loans, but also on empowering women through creating a cohesive support system. WORTH members are taught to balance these objectives, exploring the reasons why a member might be unable to save or repay loans, rather than cut someone struggling off from the support network:

> *"When lending money, sometimes, individuals cannot give back within the agreed time. If that happens, we have to go to their house to ask for money. We try to be understanding about their personal issues. The program told us to charge a fee to such people but we don't because we are worried that the groups will be disrupted if members are removed. We try to be patient."*
>
> - Ywar Tar Yar Village, Myingyan

Participants in both WORTH and PGMF felt that participation in the groups was empowering, giving them more confidence and more influence within their households.

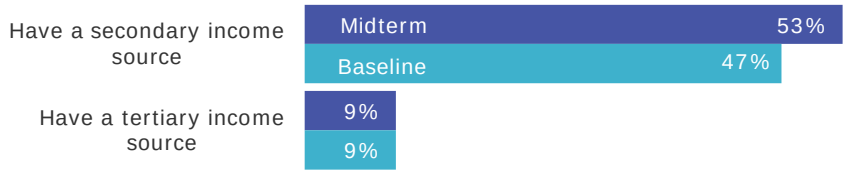
> *"Yes, we have [different relationships with our husbands]. Once, I didn't have any work of my own and so I don't dare tell correct my husband when he did something wrong."*
>
> -Shwepyithar, Peri-urban Rangoon

> "*Previously I only used the money which [my husband] gave me for the house and I had to be very careful with my expenditures. Now, I can also use my own earnings, so don't have to be so conservative with money*."
>
> -Shwepyithar, Peri-urban Rangoon

Secondary Income Sources

People living in areas where the program is conducting livelihoods programming are more likely to have secondary income sources compared to baseline (Figure 9), improving income diversity and therefore household resilience to shocks. Chicken and livestock breeding is the most common secondary source of income in Shae Thot villages. The survey found that livestock and poultry breeding increased substantially in Shae Thot villages with livelihoods interventions, from 7% at baseline to 21% at midterm, likely due in part to the small livestock management initiatives introduced by the project.

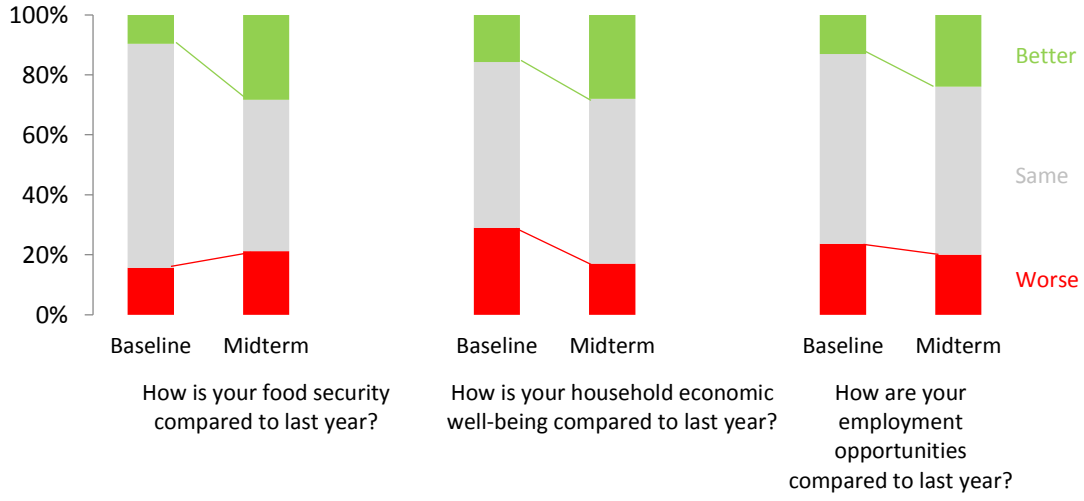
Figure 9: Households reporting two or more sources of income in Shae Thot areas



Improved Economic Opportunities and Outcomes

Together, Shae Thot's agriculture and access to credit components appear to be improving people's economic security. As the figure below illustrates, at midterm more people are saying that their food security, household economic well-being, and employment opportunities are improved compared to the previous year (Figure 10). Upholding this perception, household income rose dramatically in the Shae Thot villages between baseline and midterm, from 85,500 MMK per month to 101,375 (approximately $85.50 and $101.38 USD)—a growth of nearly 20%.

Figure 10: Perceptions of household livelihoods compared to last year



This easing of financial burden is resulting in improvements to access to education and healthcare:

> *"I was unable to send them [my children] to school because I couldn't afford the school fees. When I could not pay the fees, they were very sorry and didn't want to go to school because they were afraid of being scolded by the teachers. At home, sometimes I scolded them because we couldn't pay money for school. So they didn't want to go to school. But now we can afford to pay the fees."*
>
> -Shwepyithar, Peri-urban Rangoon

> *"In the past, we had difficulty paying for our children to go to school but now, it is better because we can borrow 30,000ks or 50,000ks for our children's education. This year, we can borrow 50,000ks or 100,000ks for education."* -Kyauktan, Peri-urban Rangoon

> *"We had difficulty with transportation before because we don't have trishaws and motor bikes. Now, it is all right. We can reach the hospital quickly. We don't need to be worried about health because we can borrow money any time."* -Kyauktan, Peri-urban Rangoon

Comparison to Non-Treatment Areas

While this economic growth is impressive and community members directly attribute changes to Shae Thot, comparison areas also grew during the period between baseline and midterm. Income grew faster in Shae Thot areas, and food scarcity each month decreased more overall in Shae Thot areas. However, people's perception of food security, economic wellbeing, and employment opportunities compared to the previous year improved at similar rates in treatment and comparison areas. Uptake of fertilizer inputs grew faster in comparison areas, possibly as a result of more fertilizer options being available to households closer to towns.

Table 14: Livelihoods indicators for treatment and comparison groups

Indicator	Treatment		Comparison		Difference in Difference
	Baseline	Midterm	Baseline	Midterm	
Average monthly household income (MMK)	85,487	101,374	89,732	102,669	2,949
% people who think their financial situation is good or somewhat good compared to the previous year	15.40%	27.70%	15%	29.40%	-2.1%
% people who think their employment opportunities are good or somewhat good compared to the previous year	14.20%	25.20%	11%	27.80%	-5.8%
% of farmers using organic and natural fertilizer	30.00%	70.90%	27%	78.40%	-10.5%
% of farmers using chemical fertilizer	21.10%	67.80%	16%	71.90%	-9.2%
% of farmers using mixed organic and chemical fertilizers	62.90%	34.70%	67%	24.60%	-14.2%
% of respondents saying their household food security was good or somewhat good compared to the previous year	9.30%	22.70%	8.70%	25.50%	-3.4%

The full data tables are in Annex 8.

Cross-cutting Issues

Integrated approach

Shae Thot's integrated model recognizes that health, livelihoods, food security, clean water, and improved sanitation are inextricably linked. The working hypothesis is that key outcomes, including cross-cutting outcomes related to empowerment, ownership, and sustainability, should improve more in areas where the program is working in multiple sectors compared to areas where a single component has been implemented. However, the baseline instrument was not originally designed to test this hypothesis, and the efforts to examine this aspect of the program were inconclusive. The program still needs to fully articulate its theory of change related to integration in order to develop clear quantitative metrics (see recommendations).

Intra-program cooperation/integration

Review of program documents and interviews with program staff clearly demonstrate that Shae Thot was designed as, and is being successfully implemented, as a unified program; Shae Thot employs a 'one-team approach' that was mutually affirmed by the partners. While some opinions varied, consortium partner management generally cited good relations between consortium partners. Program managers and technical advisors for the various components and representing all partners meet quarterly to align activities and discuss best practices, action research, learning, and other program implementation matters. The regular consortium-wide interaction has been critical to reducing inefficiency and duplication among the partners.

The Shae Thot partners hold a diverse set of Memoranda of Understanding (MOU) with six Burmese ministries that maximize their shared ability to deliver services quickly with minimum delays across all 24 program townships. In addition to line ministry relationships, the program has working relationships with key governmental units and divisions that have oversight of targeted interventions, and for approval for travel or operating in new areas. These relationships have allowed for quick maneuvering and facilitated adaptation.

Key informant interviewees explained how Shae Thot re-organized its management structure early in the program to emphasize collaboration within the consortium. The 'one team' structure means that, where possible, field partners share one township office when their programming overlaps geographically. The structure also gives shared technical oversight of Shae Thot's programs, enabling each program component to benefit from the models used and lessons learned by the others. In addition to coordination, shared office space makes efficient use of program funds.

Local integration

Beneficiaries of the Shae Thot program recognize the importance of an integrated program and gave many examples of the inter-relationship of their development needs. One FGD discussed cases in which loans have been used to finance emergency labor and delivery in hospitals, leading to safer deliveries and reducing risks to mothers and their babies. Similarly, people connected WASH activities with making livelihoods activities like home gardening easier.

Other examples of use of VDFs for multiple purposes and the livelihoods impacts of mobile clinics and WASH interventions can be found throughout the report (p. 10, 14, 17, 18). WORTH groups have an intentional integration with the VDF, contributing a certain amount of money after every six months:

"If we get 100,000ks when collecting money, 10,000ks is available to provide loans for health access…We do this for the charity of our village." -Ywar Thar Yar Village, Myingyan

Several villages are good models of integrated programming. One example is a village that has a VDC, VDF, MCH, livelihoods, and WASH sub-groups, and mobile clinics. The groups coordinate well, and the village head supports each committee's activities. Trained committee members support government initiatives such as the Township Veterinary Department and midwife's activities. Social welfare groups have contributed funds to the VDF. In 2013, the village head advocated for transportation needs of his village to local authorities, and the township Development Committee then built a road.

In another village, community groups worked together to hold a Nutrition Day and repair the main village road, in cooperation with the village head. The VDC and sub-group members were interested in the village's development and participated actively. Midwives from the village cooperated with the Mothers' Group by weighing their children and providing health education messages. The Mothers' Group in turn helped the midwives during immunization and encouraged pregnant women to seek pre-natal care.

These examples of integration at the village level provide a model and can be used by the project when considering metrics for measuring the success of integration (see recommendations).

Empowerment

Members of the community groups repeatedly told the evaluation team that they are gaining confidence through their roles participating in community groups. They are gaining a level of empowerment from their increased sense of ownership and perceived ability to impact their community's wellbeing. The mothers' groups were particularly enthusiastic, and appreciated the materials and the self-managed learning sessions.

In one FGD, women were discussing changes in their confidence and public speaking skills. They concluded that,

"Before the program, we did not dare to speak out in public. Due to Pact's training, we started public speaking and the more Shae Thot came to our village, the more we dared to speak out." -Ywar Thar Yar Village, Myingyan

"*At first, we were so afraid to attend trainings or discussions, but not any longer. I used to just sit in the back because I was afraid that they would ask me questions. Now, I answer what they ask. I have confidence when attending trainings*." -Ywar Thar Yar Village, Myingyan

Women's empowerment outcomes specific to increased economic power are discussed in the livelihoods section above (p. 22).

Sustainability and self-reliance

A key component of program sustainability will be community ownership of activities and, as a corollary, community members' confidence in conducting activities themselves. Initial feedback during FGDs demonstrated that community members feel like they are more capable of assuming program activities.

"Pact Myanmar initially treated our children with the micro-nutrients, but now we do it by ourselves." -Mee Pauk Village, Myingyan

"[The lesson] taught us that we had to collect money regularly. In it, the duck gives a good egg every day. But, the owner was so greedy that he killed the duck because he thought he would get many good eggs if it was killed. But, his idea is wrong. He cannot get any more eggs after the duck is dead. If we leave the group, it is like killing the duck."

-Ywar Thar Yar Village, Myingyan

Much of this ownership comes from community volunteers, so retention of community volunteers is an important part of program sustainability. In FGDs, volunteers showed dedication to their activities and plans for training replacements.

"Nevertheless, we four leaders have to be patient in the groups because we don't want the groups to be mismanaged." -Ywar Thar Yar Village, Myingyan

"When I had to hand over duties to a trusted group member, I had to teach them how to complete the tasks before I left. I had to help the new leader become an expert in accounting."

-Ywar Thar Yar Village, Myingyan

Together, the feedback from community members on empowerment and leadership suggests that Shae Thot has built a good foundation for sustainability of program activities. Returning to communities after program activities have phased out would allow more robust evaluation of sustainability (see recommendations).

Conclusions

Shae Thot's impact on local governance and ownership is increasing as Burma's transition to a more open and democratic society allows freer discussion of transparency and accountability in communities. This has allowed the program's fourth objective, strengthening community institutions for development, to become the core of the program. The VDCs and the VDFs they manage are central to this community strengthening focus, and are the organizing structure for the other components of Shae Thot.

The MTE found strong evidence of participation in VDCs and sub-groups. Communities especially value that VDCs bring people in the community together, and that they fill gaps in services and development. VDFs are supporting this through individual and community grants, providing resources needed for local development projects and for a health and social safety net. These structures, though, are nascent and current practices of accountability and democracy require further development.

Shae Thot villages showed statistically significant improvements in many indicators for maternal and child health, WASH, and livelihoods, and the qualitative data supported these findings. Knowledge of key danger signs during the four key MCH periods rose by an average of 16 percentage points, an improvement of 244% over baseline. Use of clean delivery kits grew by 59%, increasing from 52% at baseline to 82% at midterm. Access to four ANC visits, two tetanus toxoid injections, and skilled delivery, neonatal, and postnatal care all showed similar increases. Diet diversity increased by an average of 1.2 food groups, and treatment of diarrhea with ORS and zinc rose from 2% to 11% of cases. These improvements are reinforced through access to safe drinking water, which had grown 37% (rising from 65% to 89% of the population), and improved latrines, which grew 14% (from 63% to 72%). Notably, open defecation in target communities decreased by 27% (from 14% to 11% of households). Together, these improvements in access to MCH services and WASH, as well as improved health and hygiene behaviors, form a foundation for healthier communities.

Food security appears improved, both in respondents' perceptions and in key indicators. Reported income rose 20% from baseline, from MMK 85,500 to 101,375. Yield in target crops rose by an average of 26%, which should both decrease food scarcity and improve income from agriculture. There was a marked decrease in reliance on money lenders for loans, which fell by 520%. Large numbers of households are still taking out loans in order to smooth consumption, particularly to provide food for households, but Shae Thot's access to credit programs are playing a role to provide these loans at low interest rates.

While there is not much data on the efficacy of Shae Thot's integrated approach, the qualitative information gathered during the evaluation showed positive signs that the integrated approach is valued by villagers. Partners are coordinating well, and in several villages the MTE found that villages were implementing the different aspects of the project in a collaborative, additive way that found synergies in the different roles and skills community members had taken on and gained. Focus groups suggest that the program is having strong impacts on community empowerment, and that the potential for sustainability is strong.

The growth that the quantitative indicators show is impressive, but it should be noted that the comparison group showed many improvements as well. The qualitative information gathered shows that community members see many of the improvements they find in health, water and livelihoods to be directly linked to the program. However, the rapidly changing context of Burma is no doubt also contributing to these gains.

The following section offers recommendations for the project**.**

Recommendations

Community/governance strengthening:

Continue training for VDC members on active management skills and leadership, to foster ownership and sustainability.

Train VDCs on community needs assessment methods to ensure they can continue to identify and address current development challenges.

Deepen local leadership by mentoring potential leaders, with a focus on women and youth, to ensure that VDCs truly represent their communities, are more gender equitable, and have a pool of qualified leaders to draw on.

Scale up the VDC pilot and apply lessons learned from other VDCs to broaden the VDC strengthening activities already underway.

Mentor communities and VDCs in advocacy, feedback, and active participation to ensure that uptake of the beneficiary accountability mechanism is robust.

Continue to promote increased access to credit to respond to still-unmet demand for loans – consider linking WORTH borrowers to microfinance services, piloting a larger community match in the Dry Zone (as done in Kayah), and sharing successes from rapidly growing funds with other communities.

Seek out opportunities for increased community engagement with local government officials. Such engagement will also position VDC members more prominently as leaders of their communities, as well as build confidence in interacting with officials. Potential activities could include peer exchange visits among communities to identify common areas of interest, inviting Village Tract officials to observe community development activities, or highlighting examples of successful government-program engagement.

MCH:

Encourage Mothers' Group members to more actively serve as "health ambassadors" to ensure their new knowledge is passed to neighbors and family members.

Consider expanding the current mobile health service approach beyond MCH to maximize the investment in mobile clinics by reaching additional community members with unmet health needs, e.g., the elderly and disabled.

Explore options to support health system strengthening. A stronger formal health system is necessary for the country to meet the needs of most of its citizens and reach national health goals; activities such as Shae Thot's can only fill gaps in service provision. Working in health system strengthening can allow Shae Thot to leverage its knowledge of community health challenges and good relationships with government to move systemic change forward.

WASH:

Incorporate maintenance and sustainability plans more strongly into WASH activities, possibly through the use of WASH revolving funds or linking Water Committees more strongly to VDFs.

Look at the gap between knowledge and practice related to hygiene, especially around handwashing, to ensure that gains in infrastructure and knowledge also result in behaviors that reduce disease incidence. This might include ensuring that handwashing stations are built with and next to latrines.

Livelihoods/food security:

Continue to support the positive uptake of the program's livelihoods activities through scaling up agriculture and access to credit interventions.

Seek to link a sub-sample of villages to micro-insurance to mitigate against shocks, including seasonal shocks, scaling up if there is a demonstrated market.

Develop risk reduction activities to augment communities' ability to respond to food scarcity during lean months related to environmental changes.

Expand the livestock and poultry banks and explore the possibility of diversifying further by adding other types of animals to the revolving banks.

Support key farmers further through either increasing the number of key farmers or mentoring them to widen their outreach, so that the skills they gain spread through communities.

Strengthen training related to the mixed use of fertilizers (organic, chemical, and natural), where appropriate, in order to improve uptake.

Cross-cutting issues:

Conduct a study on the effectiveness of the integrated approach to assess whether the multi-sectoral approach is quantifiably improving outcomes for beneficiaries compared to a single-sector approach. Shae Thot could use its varying mixes of intervention overlap to form a natural comparison group.

Conduct a sustainability study of VDCs, VDFs, savings groups, and community volunteers in project areas that have phased out, using the lessons learned to strengthen ongoing activities.

Promote the participation of more women in water, agriculture, and livestock activities. This could be done through gender participation guidelines.

Final evaluation recommendations:

Optimize the evaluation study design by rebalancing the sample to include more intervention households, while maintaining a core set of villages from the baseline and midterm studies. This can be done by adding a booster sample of direct program beneficiaries to better measure its impact on them, enabling comparison between them and the general population in the Shae Thot villages. The comparison group established was of limited utility and could be dropped at endline.

Shorten and simplify the questionnaire, and/or ask only those parts of the questionnaire related to interventions available to the household being surveyed, to reduce the time burden on respondents.

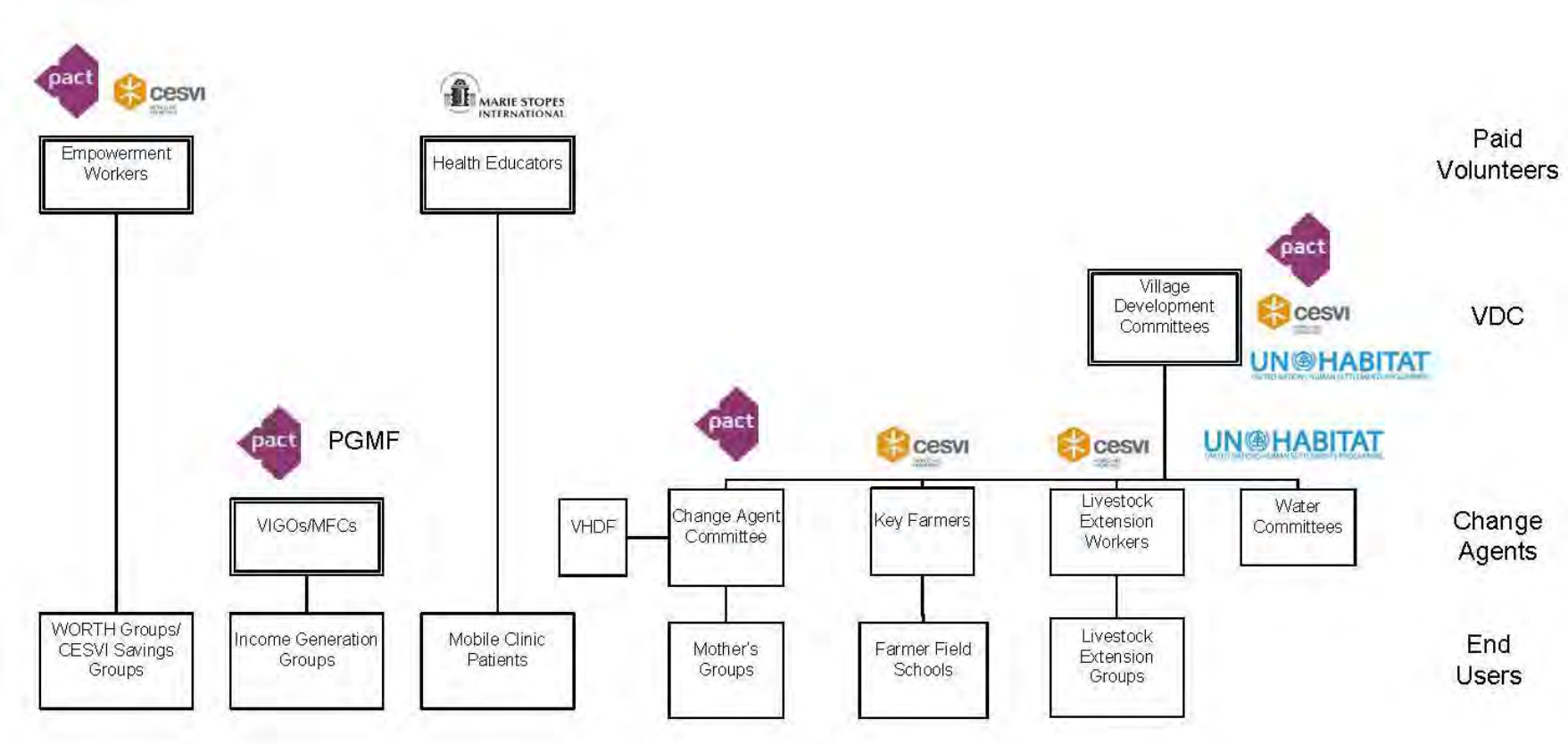
Include indicators on program integration to better capture the program's impact. Integration indicators should include quality of life measures, as well as rankings and identification of the strengths and weaknesses of integration.

Annex 1: Shae Thot townships and intervention tables

State/Region	Township	FY 1	FY2	FY3	FY4	FY5
Magway	Magway		Pact MCH	Pact MCH	Pact MCH	
		MSI	MSI	MSI	MSI	MSI
		CESVI	CESVI	CESVI		
	Yenangyaung			Pact MCH	Pact MCH	Pact MCH
			CESVI	CESVI	CESVI	CESVI
					UN-Habitat	
	Salin	Pact MCH	Pact MCH	Pact MCH		
			CESVI	CESVI	CESVI	CESVI
		PGMF	PGMF	PGMF	PGMF	PGMF
	Seikphyu	Pact MCH	Pact MCH	Pact MCH		
			CESVI	CESVI	CESVI	CESVI
		WORTH	WORTH	WORTH		
			UN-Habitat			
	Sinbaungwe		Pact MCH	Pact MCH	Pact MCH	
		PGMF	PGMF	PGMF	PGMF	PGMF
			UN-Habitat			
	Aunglan	Pact MCH	Pact MCH	Pact MCH		
			MSI	MSI	MSI	MSI
		PGMF	PGMF	PGMF	PGMF	PGMF
			UN-Habitat			
	Pakokku		UN-Habitat			
	Yesagyo			Pact MCH	Pact MCH	Pact MCH
			PGMF	PGMF	PGMF	PGMF
					UN-Habitat	
Mandalay	Myingyan	Pact MCH	Pact MCH	Pact MCH		
		MSI	MSI	MSI	MSI	MSI
		WORTH	WORTH	WORTH		
		UN-Habitat				
	Meiktila		CESVI	CESVI	CESVI	CESVI
		PGMF	PGMF	PGMF	PGMF	PGMF
		UN-Habitat				
				Pact MCH	Pact MCH	Pact MCH
	Nyaung Oo	UN-Habitat				

Sagaing	Monywa	MSI	MSI	MSI	MSI	MSI
				UN-Habitat		
	Pale		MSI	MSI	MSI	MSI
			CESVI	CESVI	CESVI	CESVI
				UN-Habitat		
	Yinmabin		Pact MCH	Pact MCH	Pact MCH	
			WORTH	WORTH	WORTH	WORTH
	Budalin			Pact MCH	Pact MCH	Pact MCH
				UN-Habitat	UN-Habitat	
				WORTH	WORTH	WORTH
Rangoon	Shwepyithar	Pact MCH	Pact MCH	Pact MCH		
			MSI	MSI	MSI	MSI
		PGMF	PGMF	PGMF	PGMF	PGMF
		UN-Habitat	UN-Habitat	UN-Habitat		
	Kyauktan		PGMF	PGMF	PGMF	PGMF
	Thanlyin		PGMF	PGMF	PGMF	PGMF
Kayah	Hpasawng		Pact MCH	Pact MCH	Pact MCH	Pact MCH
	Bawlakhe		Pact MCH	Pact MCH	Pact MCH	

Annex 2: Shae Thot organizational chart with partner responsibilities



Annex 3: List of villages sampled/people interviewed for the MTE

Sr #	State/Region	Selected Township	Selected Village Tract	Selected Villages	Treatment v comparison	Sample HH
1	Magway	Aung Lan	Dan Daunt	Dan Daunt	T	20
2	Magway	Aung Lan	Inn Kone	Gyaung	T	20
3	Magway	Aung Lan	Kwan Laung	Kwan Laung (Kone)	T	20
4	Magway	Aung Lan	Kyauk Pan Taung	Sa Khan Gyi	T	20
5	Magway	Aung Lan	Let Myaung	Let Myaung	T	20
6	Magway	Aung Lan	Maung Ma Hloke	Sin Kyan	T	20
7	Magway	Aung Lan	Myin Ka Paing	Myin Ka Paing	T	20
8	Magway	Aung Lan	Nga Pyin	Nga Pyin	T	20
9	Magway	Aung Lan	Nga Pyin Seik	Nga Pyin Seik	T	20
10	Magway	Aung Lan	Nyaung Pin Waing	Nyaung Pin Waing	T	20
11	Magway	Aung Lan	Pya Loet	Pya Loet	T	20
12	Magway	Aung Lan	Sa Mya	Shwe Thu Htay (S)	T	20
13	Magway	Aung Lan	Shwe Pan Taw Kyi	Shwe Pan Taw Kyi	C	20
14	Magway	Aung Lan	Te Pin	Yay Paw	T	20
15	Magway	Aung Lan	Thit Khaung Tee	Thit Khaung Tee	C	20
16	Magway	Magway	Alae Bo	Alae Bo	T	20
17	Magway	Magway	Hpoke Kone	Sie Pin Thar	T	20
18	Magway	Magway	Inn Taing Gyi	Inn Taing Gyi	T	20
19	Magway	Magway	Kayin (Kan Yin)	Kayin (Kan Yin)	T	20
20	Magway	Magway	Kyar Kan	Kyar Kan	T	20
21	Magway	Magway	Kyit Son Pway	Kyit Son Pway	T	20
22	Magway	Magway	Lat Pa Taw	Si Pin Thar (Hpoe Pauk Kan)	T	20
23	Magway	Magway	Ma Gyi Kan	Ma Gyi Kan	T	20
24	Magway	Magway	Mei Hla Taung	Chaung Hpyu	T	20
25	Magway	Magway	Min Ywar	Tha Put Kyaw	T	20
26	Magway	Magway	Myin Saing	Htan Pin San	T	20
27	Magway	Magway	Nan Kat Kyun	Tha Yet Pin Kwet	T	20
28	Magway	Magway	Nga Saung	Ngar Saung	T	20
29	Magway	Magway	Nyaung Kan	Nyaung Kan	T	20
30	Magway	Magway	Nyaung Pin Ywar	Nyaung Pin Ywar	T	20
31	Magway	Magway	Nyaung Pin Ywar	Kone Gyi	T	20
32	Magway	Magway	Pa Htana Go	Inn Oo	T	20
33	Magway	Magway	Pay Pin San	Pay Pin San	T	20
34	Magway	Magway	Phayar Kone	Phayar Kone	T	20
35	Magway	Magway	Phyar Pyo	Phyar Pyo (S)	T	20
36	Magway	Magway	Sar Taing Kan	San Kan	T	20
37	Magway	Magway	Shar Pin Hla	Shar Pin Hla	T	20
38	Magway	Magway	Su Kauk San	Su Kauk San	T	20
39	Magway	Magway	Tel Pin Kan Pauk	Tei Pin Kan Pauk	T	20
40	Magway	Magway	Tha Pyay San	Tha Pyay San (S)	T	20
41	Magway	Magway	Tha Yet Lay Pin	Tha Yet Lay Pin	T	20
42	Magway	Magway	Thit Yar Kauk	Yae Kyaw	T	20
43	Magway	Magway	Ywar Haung Kan	Ywar Haung Kan	T	20
44	Magway	Salin	Ah Nauk Kan Baung	Myaung Hla U	T	20
45	Magway	Salin	Chaung Hpyu (N)	Ah Muu	T	20
46	Magway	Salin	Kya Pin	Koke Ko Tan	C	20
47	Magway	Salin	Kyo Wun Gyi	Kyo Wun	T	20
48	Magway	Salin	Nyaung Inn	Chaung Kauk	T	20

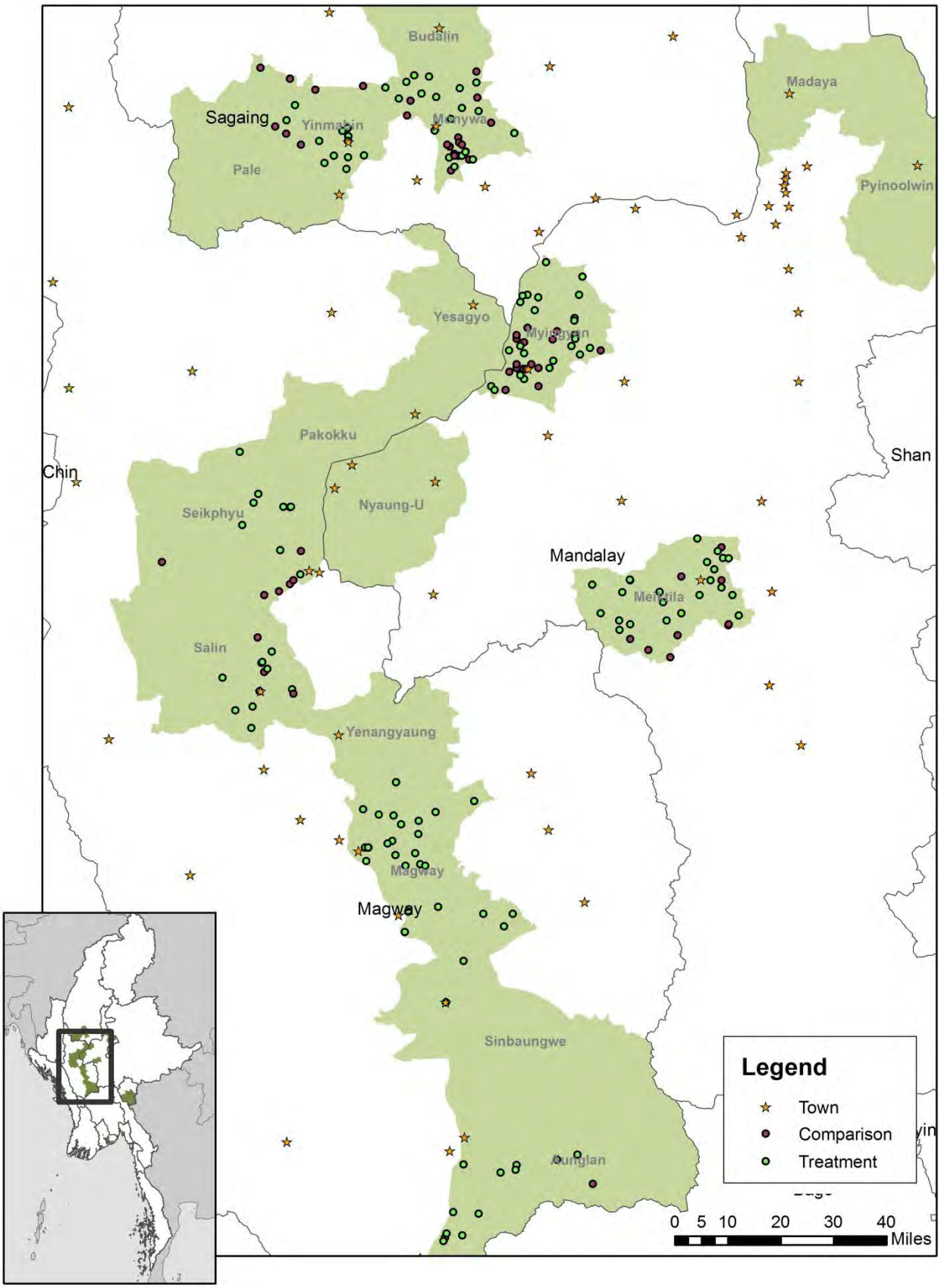
49	Magway	Salin	Pyoe Khin Kone	Kone Tei	T	20
50	Magway	Salin	Shan Su	Wet Thaik	T	20
51	Magway	Salin	Sin Phyu Kyune 1	Thone Pin Taung	C	20
52	Magway	Salin	Ta Nyaung	Ta Nyaung	C	20
53	Magway	Salin	Taw Gyi	Na Zin Yine Kone	C	20
54	Magway	Salin	Tha Mann Kyin	Tha Man Kyin	C	20
55	Magway	Salin	Tha Yet Chin	Tha Yet Chin	T	20
56	Magway	Salin	Yone Pin Kan	Maw Nga Kawt Kan	T	20
57	Magway	Seik Phyu	Ah Shey Kan Twin	Ka Paing (E)	T	20
58	Magway	Seik Phyu	Ah Shey Kan Twin	Sin Lan Chaung	T	20
59	Magway	Seik Phyu	Chaung Ma Gyi	Chaung Ma Gyi (East)	C	20
60	Magway	Seik Phyu	Chin Taung	Yae Lel Thaung	C	20
61	Magway	Seik Phyu	Chin Taung	Zee Kat	C	20
62	Magway	Seik Phyu	Hnet Pyar Gyi	Hnet Pyar Gyi	C	20
63	Magway	Seik Phyu	Htan Ma Kauk	Htan Ma Kauk	T	20
64	Magway	Seik Phyu	Ka Shey	Ku Shey Ywar Ma	T	20
65	Magway	Seik Phyu	Koe Taunt	Koe Taunt	T	20
66	Magway	Seik Phyu	Kyauk Gyi	Yae Htwet	T	20
67	Magway	Seik Phyu	Myay Kyan Taw	Gyoke Chaung Gyi	T	20
68	Magway	Seik Phyu	Myin Ka Pa	Su Lay Kone	C	20
69	Magway	Seik Phyu	Taung Ywar Ma	Taung Ywar Ma	T	20
70	Magway	Seik Phyu	Ywar Thar Aye	Leik Chan	T	20
71	Magwe	Yaynangyaung	Tone Se Chauk	Kyee Myint	T	20
72	Magwe	Yaynangyaung	Tone Se Chaul	U Yin Su	T	20
73	Magwe	Yaynangyaung	Hpaung Ka Taw	Ku Lar Kone	T	20
74	Magwe	Yaynangyaung	Bu Kyun	Bu Kyun (East)	T	20
75	Magwe	Yaynangyaung	Ah Shey Kone	Si Pin Tat Poe	T	20
76	Magwe	Yaynangyaung	Sein Pan Pin	Wet Gaung	T	20
77	Magwe	Yaynangyaung	Thone Se Chauk	Nyaung Zauk Chaung	T	20
78	Magwe	Yaynangyaung	Wet Lut	Thu Htay Kone	T	20
79	Magwe	Yaynangyaung	Kan Gyi	Hpan Khar San	T	20
80	Magwe	Yaynangyaung	Wet Ma Sut	Pay Taw	T	20
81	Magwe	Yaynangyaung	In Taw	Zee Cho Pin	T	20
82	Magwe	Yaynangyaung	TBC in field	TBC in field	C	20
83	Magwe	Yaynangyaung	TBC in field	TBC in field	C	20
84	Magwe	Yaynangyaung	TBC in field	TBC in field	C	20
85	Magwe	Yaynangyaung	TBC in field	TBC in field	C	20
86	Magwe	Sinbaungwe	Kyar Inn	Kyar Inn	T	20
87	Magwe	Sinbaungwe	Ngan Pyar	Ngan Pyar	T	20
88	Magwe	Sinbaungwe	Let Pan	Ma Gyi Yin	T	20
89	Magwe	Sinbaungwe	Sit Say Chaung	Thar Poe	T	20
90	Magwe	Sinbaungwe	Kyaung Kone	Kyaung Kone	T	20
91	Magwe	Sinbaungwe	Zaung Chan Taung	Swei Kyoe	T	20
92	Magwe	Sinbaungwe	Lel Kyoe	Ma Gyi San	T	20
93	Magwe	Sinbaungwe	Htein Inn	Htein Inn	T	20
94	Magwe	Sinbaungwe	Ma Gyi Kan	Ah Lel Kan	T	20
95	Magwe	Sinbaungwe	Chaung Kauk	Chaung Kauk	T	20
96	Magwe	Sinbaungwe	Le Zin	Kyaw Thar	T	20
97	Magwe	Sinbaungwe	Shwe Pan Taw	Sa Par Yin Htwin	T	20
98	Magwe	Sinbaungwe	TBC in field	TBC in field	C	20

99	Magwe	Sinbaungwe	TBC in field	TBC in field	C	20
100	Magwe	Sinbaungwe	TBC in field	TBC in field	C	20
101	Magwe	Sinbaungwe	TBC in field	TBC in field	C	20
102	Mandalay	Meikhtila	Ah Lel	Ah Lel	T	20
103	Mandalay	Meikhtila	Ga Lon Kone	Oke Myay Kan	C	20
104	Mandalay	Meikhtila	Gway Aing	Gway Aing	T	20
105	Mandalay	Meikhtila	Hta Mon Kan	Set Pin Taung	T	20
106	Mandalay	Meikhtila	Hta Mon Kan	Oke Kyin	T	20
107	Mandalay	Meikhtila	Ka Hpyu	Min Te Kone	C	20
108	Mandalay	Meikhtila	Kan Ni	Nyaung Kone (East)	T	20
109	Mandalay	Meikhtila	Kan Thar	Sat Khin Pauk	T	20
110	Mandalay	Meikhtila	Koke Ko Kone	Koke Ko Kone	C	20
111	Mandalay	Meikhtila	Koke Ko Kone	Tha Pyay Pin	C	20
112	Mandalay	Meikhtila	Kwet Nge	Pan Thwin	T	20
113	Mandalay	Meikhtila	Kyauk Hpu	Da Hat Tan	C	20
114	Mandalay	Meikhtila	Kyauk Hpu	Kan Kyar (South)	C	20
115	Mandalay	Meikhtila	Kyaung	Kyaung	C	20
116	Mandalay	Meikhtila	Kywe Kan	Nyang Pin That (South)	C	20
117	Mandalay	Meikhtila	Kywe Ta Lin	Lu Khin Gyi	T	20
118	Mandalay	Meikhtila	Ma Gyi Su	Nyaung Kone	T	20
119	Mandalay	Meikhtila	Me Za Li Kone	Tet Po	C	20
120	Mandalay	Meikhtila	Me Za Li Kone	Tet Poe	C	20
121	Mandalay	Meikhtila	Mway	Oh Ma Twayt	T	20
122	Mandalay	Meikhtila	Myauk Lel	Myauk Lel	T	20
123	Mandalay	Meikhtila	Nyaung Kan	Nyaung Kan	T	20
124	Mandalay	Meikhtila	Nyaung Zauk	Nyaung Zauk	T	20
125	Mandalay	Meikhtila	Sat Pyar Kyin	Tha Phan Khar Kone	C	20
126	Mandalay	Meikhtila	Se Kone	Sin Myee	C	20
127	Mandalay	Meikhtila	Shan Ma Nge	Chaung Gwa	T	20
128	Mandalay	Meikhtila	Shaw Hpyu Kan	Hlyaw Hpyu Kan	T	20
129	Mandalay	Meikhtila	Taw Ma	Chauk Pin	T	20
130	Mandalay	Meikhtila	Tha Yet Pin	Kyee Thar Aint	T	20
131	Mandalay	Meikhtila	Than Bo	Than Bo	T	20
132	Mandalay	Meikhtila	Thee Kone	Thee Kone	T	20
133	Mandalay	Meikhtila	Thee Pin Kone	Thee Pin Kone	T	20
134	Mandalay	Meikhtila	Yae Wai	Inn Pin Wa	T	20
135	Mandalay	Meikhtila	Yone Taw Gyi	Yone Taw Gyi	T	20
136	Mandalay	Meikhtila	Zaung Chan Kone	Gway Tauk Kone	T	20
137	Mandalay	Myingyan	Aye	Aye	T	20
138	Mandalay	Myingyan	Ba Lon	Ywar Thar	T	20
139	Mandalay	Myingyan	Chaung Dan	Chaung Dan (south)	C	20
140	Mandalay	Myingyan	Chaung Dam	Kyauk Yan	C	20
141	Mandalay	Myingyan	Gaung Kwe	Gaung Kwe	T	20
142	Mandalay	Myingyan	Gint Ge	Gint Gei	T	20
143	Mandalay	Myingyan	Hta Naung Kone	Taung Poet	C	20
144	Mandalay	Myingyan	Htein Pan	Htain Pan	T	20
145	Mandalay	Myingyan	Kaing	Kaing	T	20
146	Mandalay	Myingyan	Kan Swei	Kan Swei	T	20
147	Mandalay	Myingyan	Kan Taw	Thein Taing	T	20
148	Mandalay	Myingyan	Koke Ke	Koke Ke	T	20
149	Mandalay	Myingyan	Kun Saik	Kun Saik	C	20

150	Mandalay	Myingyan	Kun Thee Pin (Lay Ein Tan)	Aung Pyay Soe	C	20
151	Mandalay	Myingyan	Kun Thee Pin (Lay Ein Tan)	Bawt Lone	C	20
152	Mandalay	Myingyan	Kun Thee Pin (Lay Ein Tan)	In Gyin Pin	C	20
153	Mandalay	Myingyan	Kun Thee Pin (Lay Ein Tan)	Kun Thee Pin (Lay Ein Tan)	C	20
154	Mandalay	Myingyan	Kun Thee Pin (Lay Ein Tan)	Kyet Shar	C	20
155	Mandalay	Myingyan	Kun Thee Pin (Lay Ein Tan)	Let Pan Pin	C	20
156	Mandalay	Myingyan	Kyar Taing	Kyar Taing	T	20
157	Mandalay	Myingyan	Kyee Pin Kan	Saik Kone	T	20
158	Mandalay	Myingyan	Lint Gyi	Lint Gyi (S)	T	20
159	Mandalay	Myingyan	Mee Pauk	Mee Pauk	T	20
160	Mandalay	Myingyan	Ngar Nan	Ngar Nan (S)	T	20
161	Mandalay	Myingyan	Pin Lel	Ywar Thar Aye	T	20
162	Mandalay	Myingyan	Pyar	Pyar	C	20
163	Mandalay	Myingyan	Pyawt (Shwe Bon Thar)	Shwe Bon Thar	T	20
164	Mandalay	Myingyan	Shar Taw	Shar Taw	T	20
165	Mandalay	Myingyan	Ta Loke Myo	Myo Gyi Kone	T	20
166	Mandalay	Myingyan	Taw Pu	Taw Pu	T	20
167	Mandalay	Myingyan	Thar Paung	Ah Neint	C	20
168	Mandalay	Myingyan	Thar Paung	Myauk Kyun	C	20
169	Mandalay	Myingyan	Thar Paung	Pat Tar	T	20
170	Mandalay	Myingyan	Thar Paung	Taung Kyun	T	20
171	Mandalay	Myingyan	Thar Paung	Te Kone	C	20
172	Mandalay	Myingyan	Thin Pyun	Khin Ma Kan	P	20
173	Mandalay	Myingyan	Thit Yon	Thit Yon	C	20
174	Mandalay	Myingyan	Tu Ywin Bo	Tu Ywin Bo	C	20
175	Mandalay	Myingyan	Ye Taing	Ye Taing	C	20
176	Mandalay	Myingyan	Yon Htoe	Ywar Thit (S) Kyi	T	20
177	Mandalay	Myingyan	Ywar Si	Ywar Si (S)	T	20
178	Mandalay	Myingyan	Ywar Thar Yar	Ywar Thar Yar	T	20
179	Mandalay	Myingyan	Zee Taw	Hta Naung Pin Su (S)	T	20
180	Sagaing	Monywa	Aung Thar	Aung Thar	C	20
181	Sagaing	Monywa	Bu Ba	Bu Ba	T	20
182	Sagaing	Monywa	Bu Taung Kan	Bu Taung Kan	T	20
183	Sagaing	Monywa	Hpan Khar Kyin	Hpan Khar Kyin	T	20
184	Sagaing	Monywa	Hta Naung Taw	Hta Naung Taw (South)	T	20
185	Sagaing	Monywa	Kaw La Pya	Kyi Kone	T	20
186	Sagaing	Monywa	Kha Tet Kan (North)	Kyauk Kwe	T	20
187	Sagaing	Monywa	Kha Wea Kyin	U Thar Pon Kaing (East)	T	20
188	Sagaing	Monywa	Kya Paing	Kya Paing	C	20
189	Sagaing	Monywa	Kyauk Kar (South)	Kyauk Kar (South)	T	20
190	Sagaing	Monywa	Kyaung Kone	Kyaung Kone	C	20
191	Sagaing	Monywa	Kyaung Kone	Thar Ya Su	T	20
192	Sagaing	Monywa	Kyun Gyi	Kyun Gyi (South)	T	20
193	Sagaing	Monywa	Kyun Ywar Thit	Kyun Ywar Thit	T	20
194	Sagaing	Monywa	Kywe Ye	Tha Man Tar	T	20
195	Sagaing	Monywa	Ma Au	Lin Pin	C	20

196	Sagaing	Monywa	Ma Au	Swe Son	C	20
197	Sagaing	Monywa	Ma Yoe Taw	Ma Yoe Taw (North)	T	20
198	Sagaing	Monywa	Min	Ku Taw Pa Lin (Pu Taw Pa Lin)	T	20
199	Sagaing	Monywa	Min	Min	T	20
200	Sagaing	Monywa	Mon Yway	Mon Yway	C	20
201	Sagaing	Monywa	Mon Yway	Shit Se	T	20
202	Sagaing	Monywa	Myay Ne	Moe Hnyn Than Boke Day	C	20
203	Sagaing	Monywa	Nyaung Hpyu Pin	Nyaung Hpyu Pin	C	20
204	Sagaing	Monywa	Pauk Pin	Pauk Pin	C	20
205	Sagaing	Monywa	Pu Yit Kone	Taung Pon	T	20
206	Sagaing	Monywa	Taung Kyar	Kyauik Khwet	C	20
207	Sagaing	Monywa	Te Gyi Kone	Te Gyi Kone (East)	T	20
208	Sagaing	Monywa	Thet Kei Kyin	Thet Kei Kyin	C	20
209	Sagaing	Monywa	Yaung Taw Tone	Yaung Taw Tone	C	20
210	Sagaing	Monywa	Za Loke	Za Loke (West)	T	20
211	Sagaing	Yinmarbin	Bant Bway	Bant Bway (North)	T	20
212	Sagaing	Yinmarbin	Bant Bway	Shwe Su	T	20
213	Sagaing	Yinmarbin	Byama Dat	Tha Yet Kan	T	20
214	Sagaing	Yinmarbin	Kan Chaung (Aung Moe)	Let Khoke Pin	C	20
215	Sagaing	Yinmarbin	Kyat	Kyat	C	20
216	Sagaing	Yinmarbin	Lel Ngauk	Lel Ngauk	T	20
217	Sagaing	Yinmarbin	Let Ka Byar	In Taw	T	20
218	Sagaing	Yinmarbin	Mauk Loke	Mauk Loke	C	20
219	Sagaing	Yinmarbin	Min Kan Gyi	Min Kan Gyi	T	20
220	Sagaing	Yinmarbin	Min Zu	Min Zu	T	20
221	Sagaing	Yinmarbin	Myo Gyi	Myo Gyi	T	20
222	Sagaing	Yinmarbin	Myo Gyi	None Gyi	T	20
223	Sagaing	Yinmarbin	Nyaung Kaing	Kwin Sat	C	20
224	Sagaing	Yinmarbin	Nyaung Pin Gyi Su	Nyaung Pin Gyi Su (West)	T	20
225	Sagaing	Yinmarbin	Se Gyi (Htan Taw Gyi)	Kyai Sar Kya	T	20
226	Sagaing	Yinmarbin	Sin Te	Min Ma Kone	C	20
227	Sagaing	Yinmarbin	Sone Chaung	Gway Chaung	T	20
228	Sagaing	Yinmarbin	Sone Kyin	Bein Nwe Chaung	C	20
229	Sagaing	Yinmarbin	Tar Wa	Chaung Kauk (Ywa Thit)	T	20
230	Sagaing	Yinmarbin	Taung Pu (Kyauk Pyoke)	Hta Yaw Kyin	C	20
231	Sagaing	Yinmarbin	Tha Min That	Tha Min That	C	20
232	Sagaing	Yinmarbin	Yin Paung Taing	Pyar Oh (Pya Oh)	C	20
233	Sagaing	Yinmarbin	Ywar Htaung	Ywar Htaung	T	20
234	Sagaing	Yinmarbin	Zee Taw	Zee Taw (South)	T	20

Annex 4: Map of intervention and comparison villages surveyed by the MTE



Annex 5: FGD guides

PROJECT "Evaluate" 2014-076 DISCUSSION GUIDE – IDI Mothers Group

Research Objectives:

- To understand the project design, implementing activities and outputs of the selected village
- To deeply understand the capacity and functions of Mothers Groups
- To understand the effectiveness and efficiency of integrated approach
- To explore the sustainability plan and existing capacity of mothers groups and community

Flow of discussion:

- Section 1: INTRODUCTION/ WARM UP (10 mins)
- Section 2: History of Shae Thot (5 mins)
- Section 3: Getting to know MOTHERS GROUPS (20 mins)
- Section 4: Capacity and Functions of MOTHERS GROUPS (20 mins)
- Section 5: Integrated Approach (20 mins)
- Section 6: Most significant change (10 mins)
- WRAP UP/ CLOSE

Section 1: INTRODUCTION/ WARM-UP
→ *To make respondent feel comfortable before starting interview (10 mins)*
	▪ Moderator self-introduction
	  ○ Thank respondents for agreeing to take part in the research
	  ○ Inform audio recording
	  ○ Reassure confidentiality
	  ○ Inform for third party evaluation, anonymity and confidentiality
	  ○ No right or wrong answers.
	▪ Introduction for purpose of interview – to understand the outcomes, strengths and weakness of Shae Thot project to lead to better and more effective project implementation
	▪ In this interview, I am going to ask some questions about Mothers Groups and its functions
	▪ Get to know respondent's name, job, family etc.

Section 2: History of Shae Thot → *To understand the project design and activities (5 mins)*	▪ How do you learn about Shae Thot? Or Project Name? Or NGO name? ▪ Can you explain to me what the objective of the project is? ▪ When did Shae Thot project start to implement in the village? ▪ Why was (Village's Name) selected for this aid support? ▪ What were the existing problems/needs at that time? ▪ What activities has the project implemented until now? Why? ○ **Probe** – direct services, capacity buildings, different component areas (WASH, MCH, Livlihoods as relevant to the particular village) ▪ Has the current approach of Shae Thot been relevant to the needs of your community? For mothers and children in particular? Why do you say so?

Section 3: Getting to know MOTHERS GROUPS
→ *To understand briefly about the MOTHERS GROUPS formation*
(20 mins)
	▪ ***Let me ask about Mothers Groups now.***
	  ○ *How do you refer to the Mothers Groups locally? Why do refer to it in this way?*
	  ○ *When was the committee formed?*
	  ○ *What are the reasons/objectives for forming this group?*
	  ○ *Do you have any mission/vision statements? If so, what are they?*
	  ○ *Who is the leader of the group?*
	  ○ *How many and what type of members are there in the group?*
	  ○ *How did you select the leader and team members?*
	  ○ *What are their roles and responsibilities?*
	  ○ *What does the organization structure look like?*
	  ○ *What are the main functions of this group?*
	  ○ *What are the ground rules of this group?*
	  ○ *How does the group link with other committees?*

Section 4: Capacity and Function of MOTHERS GROUPS *→ To access the capacity and performance of the MOTHERS GROUPS, services received by MOTHERS GROUPS* *(20 mins)*	▪ ***What type of trainings has the MOTHERS GROUP received?*** ○ *What are the trainings?* ○ *Who conducted them? Where? How long for each training? Who attended?* ○ *Training methodology – how was the training conducted? Participatory? How? What were the group works?* ○ *Pre and Post assessment of the training?* ○ *What training materials did you receive?* ○ *Were the trainings useful?* ▪ *How did the training help you to carry out your MOTHERS GROUPS activities?* ▪ ***How do you record your activities?*** ○ *What is the system?* ○ *Who is responsible for this?* ○ *If available, please show us some records.* ▪ ***How do you access how well the MOTHERS GROUP is working?*** ○ *Where are you at now? Service Provision, Successful Activities, Representation, Equitable Distribution, Timely Responses, External Relations, Community Based Resources, M&E* ○ *Can you give me an example/success story of it?* ○ *How do you operate these?* ▪ ***What is your sustainability plan for this MOTHERS GROUPS?*** ○ *Funding – where does the funding come from? How is it circulated and sustained? Any system? Any capacity?* ○ *Do you believe that the mothers groups will continue if Shae Thot project is phased out?* ○ *Collaboration with local partners and government sectors – how do you cooperate/coordinate for the health care needs?*
Section 5: Integrated Approach *→ To understand the efficiency and effectiveness of the integrated approach (20 min)*	▪ ***We talked earlier about the activities which Shae Thot implements in your village,*** *How do these activities link with your committee's functions?* ○ ***Probe for how they work with MCH project functions and beyond to other component areas if relevant*** ▪ *How do you work together with Shae Thot project staff?* ○ *?* ○ *How do you plan for joint activities with Shae Thot? With Pact? With MSI? With UN-HABITAT?* ○ *What are the strengths of these integrated activities? Weakness?* ○
Section 7: Significant change and Gender	▪ ***What are the significant changes in the community? Can you share with me a story of change to highlight this? MCH*** ○ *Do you believe that communities have a greater understanding about MCH and the issues involved?* ○ *Do the volunteers and the committee have enhanced capacity to prioritise and solve problems around MCH issues?* ○ *Is there reduction in pregnancy related and neo-natal and under 5 morbidity and mortality? By how much? Do you have target? Why do you say so?* ○ *Have the health and development of children and mothers improved? Why?* ▪ *What are the good practices? Barriers and how did you overcome?* ▪ ***What is Mothers Group's role in VDC? Decision making for village development?*** ▪ *Which services did you receive from Shae Thot to become like this?* ▪ *What are the roles of women leaders in the community? How did it change over the year?* ▪ *What are you suggestions to help women involve in decision making process?*
WRAP UP/ CLOSE	▪ What are the overall strengths of Shae Thot project in the community? Weakness? ▪ What have been the main unforeseen challenges? What were the major factors influencing the (non-)achievement of the outcomes to date? ▪ **Can you give any suggestion or feedback for current Shae Thot project?** Why do you give such suggestion? ▪ Before we close, is there anything else that you want to ask or add? ▪ *Thank respondents*

Annex 6: Key informant interview guide

PROJECT "Evaluate" 2014-076

DISCUSSION GUIDE – IDI Midwife/Township Medical Officer

Research Objectives:

- To understand current public sector approaches and strategies toward MCH
- To understand the current MCH needs of the community
- To explore the challenges/constraints/barriers in public sectors
- To explore the integrated activities of public sector and Shae Thot
- To explore the opportunity for better collaboration with public sector

Flow of discussion:

- Section 1: INTRODUCTION/ WARM UP (10 mins)
- Section 2: Getting to know public sector services (20 mins)
- Section 3: Contact with Shae Thot (10 mins)
- Section 4: Contact with VDC and Mothers Groups (10 mins)
- Section 5: Significant Changes (10 mins)
- WRAP UP / CLOSE (10 mins)

Section 1: INTRODUCTION/ WARM-UP
→ *To make respondent feel comfortable before starting interview*
(10 mins)
	▪ Moderator self-introduction
	  ○ Thank respondents for agreeing to take part in the research
	  ○ Inform audio recording
	  ○ Reassure confidentiality
	  ○ Inform for third party evaluation, anonymity and confidentiality
	  ○ No right or wrong answers.
	▪ Introduction for purpose of interview – to understand the outcomes, strengths and weakness of Shae Thot project to lead to better and more effective project implementation
	▪ Get to know respondent's name, title and roles etc.

Section 2: Getting to know public sector services *(20 mins)*	▪ Can you tell me which area (township/village tract) that you are responsible for? ▪ What are your overall roles and responsibilities? For children? For mothers and pregnant mothers? ▪ What are the overall health needs of township/village? ▪ What are the health needs for under 5 children, pregnant mothers and infants in the township/village? ▪ What are the top morbidity and mortality cases in the township/village? ▪ What are you current strengths and weakness for MCH care services? ▪ What is your short term strategy and long term strategy to fulfil the MCH needs of your township (TMO only)? Why? If it is more than one, which one you prioritise most? ▪ What is your plan to provide MCH services in short term and long term for the needs of the village (Midwife only)? Why? If it is more than one, which one you prioritise most? ▪ How many partners/NGOs contributing for MCH needs of your township/village? What are their main activities? ▪ What are the shortfalls for your ongoing activities to meet the MCH impacts? ▪ What are your barriers/constraints/challenges?
Section 3: Contact with Shae Thot *(10 mins)*	▪ Have you ever heard of Shae Thot Project? What about Pact/MSI activities? ▪ When did Shae Thot project start to implement in the village? ▪ How did the project and township health department/rural health centre choose the right village for the project? When? Who involved? Why? ▪ What were the existing problems/needs at that time? ▪ What activities has the project implemented until now? Why? ○ **Probe** – direct services, capacity buildings, different component areas (WASH, MCH, Livlihoods as relevant to the particular village) ▪ Has the current approach of Shae Thot been relevant to the needs of your township/village? For mothers and children in particular? Why do you say so?
Section 4: Contact with VDC and mothers groups → *To understand about the MOTHERS GROUPS* *(10 mins)*	▪ Do you know VDC in your village? What do they do? ▪ What is your opinion on having VDC in your village? ▪ Do you know Mothers Groups in your village? What do they do? ▪ What is your opinion on having Mothers Groups in your village? ▪ What are the benefits of having mothers groups? ▪ How do Mothers Groups cooperate with your ongoing activities? Plan together? Assist your activities? How?

Section 5: Significant change
(10 mins)
	▪ ***What are the significant changes in the community within 2 years? Can you share with me a story of change to highlight this?***
	  MCH
	  ○ *Do you believe that communities have a greater understanding about MCH and the issues involved?*
	  ○ *Do the volunteers and the committee have enhanced capacity to prioritise and solve problems around MCH issues?*
	  ○ *Is there reduction in pregnancy related and neo-natal and under 5 morbidity and mortality? By how much? Do you have target? Why do you say so?*
	  ○ *Have the health and development of children and mothers improved? Why?*
	▪ *What are the good practices? Barriers and how did you overcome?*

WRAP UP/ CLOSE (10 mins)	▪ What are the overall strengths of Shae Thot project in the community? Weakness? ▪ What have been the main unforeseen challenges? What were the major factors influencing the (non-)achievement of the outcomes to date? ▪ What are the possible areas of cooperation with Shae Thot project with your current ongoing activities? ▪ **Can you give any suggestion or feedback for current Shae Thot project?** Why do you give such suggestion? ▪ Before we close, is there anything else that you want to ask or add? ▪ *Thank respondents*

Annex 7: Household questionnaire

TNS Precision growth	PROJECT NAME	JOB NO.	**QUESTIONNAIRE HOUSEHOLD SURVEY**	Q'NAIRE ID NO._____
	Evaluate	**2014-076**		DP ID NO._____

RESPONDENT'S NAME						
RESIDENTIAL ADDRESS						
TELEPHONE NUMBER	*Home* _____ *Work* _____ *Mobile* _____					
DATE OF INTERVIEW		*START TIME*		*Hours*	*END TIME*	*Hours*
INTERVIEWER NAME			INT. Code			
SUPERVISOR NAME			SUP Code			

INTERVIEW STATUS:	by	Yes	No	SIGNATURE	*DATE:*
ACCOMPANIED (FS)		1	2		
LOGIC-CHECKED (FS)		1	2		
TEL BACK-CHECKED (QC)		1	2		
F2F BACK-CHECKED (QC)		1	2		

SUCCESSFUL CONTACT RATE:
PLEASE WRITE DOWN THE FIRST CONTACT NUMBER IN THE FIRST ROW AND THE SUCCESSFUL COMPLETED INTERVIEW IN THE SECOND ROW (REFERRED TO CONTACT SHEET) IN THE ANSWER SHEET BELOW:

Starting contact number	**1**
Successful completed Interview number	

PROGRESS MONITOR / QUOTA CONTROL:

Location	**Age**	**HH income**	**Working Status**
Aung Lan 1			Working 1
Magway 2	18 – 25 1	0-80,000 1	Non-working 2
Salin 3	26 – 30 2	80,001 – 300,000 2	
Seik Phyu 4	31 – 35 3	300,001 – 800,000 3	**Gender**
Yaynangyaung 5	36 – 40 4	800,001 – 1,500,00 4	Male 1
Sinbaungwe 6	41 – 45 5	1,500,001 – 2,000,000 5	Female 2
Meikhtila 7	46 – 50 6	2,000,001 – 2,500,000 6	
Myingyan 8	51 – 55 7	>2,500,00 7	
Monywa 9			
Yinmarbin 10			

HOUSEHOLD QUESTIONNAIRE

VILLAGE PROFILE

VP1	Village name		
VP2	Village MIMU code		
VP3	Village tract name		
VP4	Township name		
VP5	State/Region		
VP6	Active consortium partners		VP7 Year of beginning activities for Shae Thot
	MSI	1	
	Pact	2	
	UN-Habitat	3	
	WORTH	4	
	CESVI	5	
VP6	Phased out consortium partners		VP7 Year of phasing out activities for Shae Thot
	UN-Habitat	3	
	WORTH	4	

Introduction

Hello, I am ……. [insert interviewer name], an interviewer of TNS, an independent market research company in Myanmar. We are carrying out a study to find out about health-related behaviors and the household situation of [name of township]. We are doing interviews to household heads and mothers of this village regarding their health care behaviors, livelihoods status, water, sanitation and hygiene habits and perception toward community development activities. Your household has been chosen through a randomization method and you are requested to participate because you are household head/spouse.

The consolidated findings will only be used for further community development programs for the community which will inform the respective development agencies. I ensure that this is a genuine piece of research and the information will be used for research purposes only. Only the research team will be able to access the information you will give and no other people will have access to it.

Your cooperation is voluntary and the objection to the interview will not affect the current services you are receiving like health care services provided by government and other agencies. I can guarantee that there will be no other harmful affect for you or your family. We would be grateful if you could spare about 1 hour and 20 minutes of your time to assist us in our research. You can also refuse to answer any questions which make you worried and can stop the interview at any time.

You may be re-contacted again from our independent quality control team in near future. It's not because of the breach in anonymity; it is only for the quality control procedure which is part of the research process.

Do you have any other clarifications needed? If you have any further queries you can also contact our Project Manager, Su Wai Tun, 01401560.

Yes	1	
No	2	**Close the Interview**

Note for Interviewer: Let the respondent sign for informed consent. Thanks for your kind cooperation in this research. Can you let us have your signature for your approval?

I understand the objectives of research, confidentiality and agree to be interviewed.

Name

_____

Date

_____

Section 1: Household / Respondent Information

1.2 Position in the Household

Head of Household	1
Spouse	2
De facto Head of Household	3

1.3 **Record the sex of respondent**

Male	1
Female	2

1.4 What your completed years of age? _____ Years

If specific age is unknown, round to nearest 5 years upward.

1.5 What is your ethnicity?

Chin	1
Kachin	2
Kayah	3
Karen	4
Mon	5
Rakhine	6
Burmese	7
Shan	8
Mix	9
Other (Specify)	99
Refuse to answer	98

1.6 How many household members in total in your household? | | |

	1.8	1.9	1.10	1.11	1.12	1.13	1.14	1.15
HH Id No	**Name**	**Relationship with the Head of Household (Oldest to youngest)** Head of HH.....1 Spouse…….2 Son, daughter, son/daughter-in-law…….. 3 Parent/parent-in-law……..…..4 Other relative…….5 Non-relative…..…..6	**Sex** Male.....1 Female...2	**Age** Specify age in years. If specific age not known, round to the nearest 5 years upwards.	Highest completed level of schooling for HH members of age 5 - 30 years old Grade 1 (Thu Nge Tan)……..1 Grade 2……2 Grade 3……..3 Grade 4…….....4 Grade 5……..…5 Grade 6……..…6 Grade 7……...……7 Grade 8……..……8 Grade 9……..……9 Grade 10……..10 Grade 11……..11 College/ University……12 Monastic education ……..13 Never been to school ……..……99	Are you still in school? (For HH members 5 - 30 years old) Still in school……..1 Drop out…… 2 Never attended school.....3	Birth registration (Children under 18 years old) Yes……..1 No…..…..0	Main Occupation of HH members over the age of 12 Agriculture (raise own crops) ……..…..1 Raising own livestock (poultry, pigs, cattle etc.)……..…..2 Fishing/shrimp farming……..……3 Agricultural wage labor……..……...4 Non-agri unskilled wage labor…..……..5 Salary (government, military, private.....6 Own account sales/service (incl. Street vendor or house front sales)……...7 Sales/service employee (daily wage)……8 Shop or business owner.....9 Unpaid family work.....10 Dependent.....11

									Student.....12 Retired/pensioner.....13 Other (specify____)..99
1	Head of the HH								
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									

MATERNAL AND CHILD HEALTH

If the selected respondent is male household head, ask this section to spouse or mother of children in the household.

Please list the youngest child under the age of five based on the table above. If not children under the age of 5, skip to next section (Malaria).

	Name	Born		Age		Male	Female
		Year	Month	Year	Month		
Youngest child under 5						1	2

Section 1 – Mother's Information

M1.1 Name of Mother.

M1.2 Completed years of age.

M1.3 Can you read?

Yes	1
No	2

M1.4 Can you write?

Male	1
Female	2

M1.5 What is the highest level of school you attended?

Preschool	1
Primary	5
Middle	9
High	11
University/College	12
Monastery/Nunnery	13
No Schooling	99

M1.6 What was your age at the time your marriage?

	Record in years of completed age

M1.7 How many pregnancies have you had?

Pregnancies including abortions.

M1.8 Number of sons or daughters to whom you have given birth who are now living?

M1.9 Number of children who died after birth.

M1.10 Number of miscarriage/abortions.

M1.11 Is (name) youngest child adopted?

Yes	1
No	2

Section 2 ANC visits, Delivery

Note for interviewers: This section is to ask for mothers with children under 2 years old children. If the household does not have children under 2 years (23 months) old, skip to Section 6. If they have no children under 5 years old, skip to Section 11.

M2.1 Did you see anyone for antenatal care during your last pregnancy? Any check-ups during pregnancy?

Yes	1	**Continue**
No	2	**Skip to M2.19**

M2.2 If YES, who did you see?

Doctor	1
Nurse	2
Health Assistant	3
Lady Health Visitor	4
Midwife	5
Auxiliary midwife	6
Traditional Birth Attendant	7
Other (Specify)	99

M2.3 Where did you see the antenatal care giver?

Government hospital	1
Private hospital	2
Private clinic	3
Rural health center	4
Sub rural health center	5
Mobile clinic/outreach	6
In the village	7
Other (Specify)	99

M2.4 Do you have a pregnancy card or MCH handbook?

Yes	1	**Continue**
No	0	**Skip to M2.7**

Code "1": only if the respondent can show the MCH handbook/pregnancy card.

M2.5 Interviewer: If code "1" at M2.4, record the followings from the handbook.

	Write down the numbers
Number of Abdominal examinations	
Number of tetanus toxoid injections	
Number of iron tablets	
Number of blood pressure checks	
Number of blood test	
Any urine test	
HIV/AIDS test	
Others (Specify)	
Don't have/Don't know	98

M2.6 Interviewer: Was the handbook legible (readable)?

Yes	1	**Skip to M2.19**
No	2	**Continue**

M2.7 Did you receive any abdominal examination? (for those who do not have a MCH handbook)

Yes	1	
No	2	**Skip to M2.10**

M2.8 How many times did you receive an abdominal examination?

	Record the number of times

M2.9 How many of these visits were with a doctor, or nurse, or midwife, or LHV?

	Record the number of times

M.2.10 Did you receive tetanus toxoid injections?

Yes	1	
No	2	**Skip to M2.12**
Don't know	98	

M2.11 How many times did you receive tetanus toxoid injection?

	Record the number of times

M2.12 Did you receive any iron tablets?

Yes	1
No	2
Don't know	98

M2.13 Did you receive a blood test?

Yes	1	
No	2	**Skip to M2.15**

Don't know	98	

M2.14 How many times did you receive blood test?

	Record the number of times

M2.15 Did you receive blood pressure checks?

Yes	1	
No	2	**Skip to M2.17**
Don't know	98	

M2.16 How many times did you receive blood pressure checks?

	Record the number of times

M2.17 Did you receive a urine test?

Yes	1
No	2
Don't know	98

M2.18 Did you receive an HIV/AIDS test?

Yes	1
No	2
Don't know	98

M2.19 Where did you give birth to your last child? **SA**

Government hospital	1	**Skip to M2.21**
Private hospital	2	
Private clinic	3	
Rural health center	4	
Sub rural health center	5	
At home	6	**Continue**
Others (specify)	99	**Skip to M2.21**

M2.20 If you delivered your last child at home, did you use a clean delivery kit?

Yes	1
No	2

M2.21 When you gave birth, who assisted you with the delivery? **SA**

NOTE: Highest rank person who assisted with the birth. i.e., if doctor and nurse were there, only code for doctor.

Doctor	1
Nurse	2
Health assistant	3
Lady Health Visitor	4
MW	5
AMW	6
TBA	7
Community Health Worker	8
Mother / relative	9
Self	10

Section 3: Post-Partum Care

Note: Ask only for mothers with children under 2/mothers whose youngest child is under 2 years old.

M3.1 After delivery, did you have a check-up? **SA**

Yes	1	
No	2	**Skip to Section 4**
Don't know/ Don't remember	98	

M3.2 How long after giving birth did you have your first check up? **SA**

	Record the number of days

M3.3 With whom did you have your first check up? **SA**

NOTE: Highest rank person who assisted with the birth. i.e., if doctor and nurse were there, only code for doctor.

Doctor	1
Nurse	2
Health Assistant	3
Lady Health Visitor	4
MW	5
AMW	6
Community Health Worker (Gov)	7
Health volunteer (INGOs/NGOs)	8
TBA	9
Doctors/nurses from mobile clinics	10
Others (Specify)	99

M3.4 How many checks-ups did you have within six weeks of delivery?

(Including going for check-ups by yourself and receiving check-ups from different organizations)

	Record the number of times

Section 4 – New Born Care

Note: Ask only for mothers with children under 2 years old.

M4.1 After the baby was delivered, what was applied to the cord? **SA**

Nothing	1
Antibiotics(powder/ointment)	2
Antiseptic	3
Saffron (herbs)	4
Don't know	98
Other (Specify)	99

M4.2 How soon after delivery was the child wrapped? **SA**

As soon as delivery	1
Within 30 minutes	2
After 30 minutes	3
Don't remember	98

M4.3 When was the child bathed after being delivered?

Immediately after delivery	1
After the chord dried and fallen off	2
Other (Specify)	3

M4.4 How many newborn visits did you receive/make in one month after birth of the baby?

	Record the number of times Code 98 for "Don't remember"

M4.5 When was the first visit made?

On the day of delivery	1	
Within 2 days after delivery	2	
Within 1 week after delivery	3	
Between 1 week and 1 month after delivery	4	
No visits made	5	**Skip to M5.1**
Don't remember	98	

M4.6 With whom did you have your first check-up?

NOTE: Highest ranking person who assisted with the birth. i.e., if doctor and nurse were there, only code for doctor.

Doctor	1
Nurse	2
Health Assistant	3
Lady Health Visitor	4
MW	5
AMW	6
Community Health Worker (Gov)	7
Health volunteer (INGOs/NGOs)	8
TBA	9
Doctors/nurses from mobile clinics	10
Others (Specify)	99

Section 5: Breast Feeding

Note: Ask only for mothers with children under 2 years.

M5.1 Are you presently breastfeeding your youngest child? (child under 2 years old)

Yes	1	**Skip to M5.2**
No	2	

M5.1.1 For how long did you breastfeed him/her? **SA**

0-1 month	1
2- 3 months	2
4 - to 6 months	3
7 - 12 months	4
13 months to 18 months	5
18 – 23 Months	6
I never breastfed	7

M5.2 How soon after birth, did you put your child to the breast? **SA**

Within 30 minutes	1
Within 1 hour	2
Within 24 hours	3
Within … days after birth (Specify days)	4
Did not put to breast	5
Do not remember	98

Skip to Section 6 if Code "5", otherwise, continue.

M5.3 Did you give (NAME) colostrums? (yellowish milk in the first three days after birth)

Yes	1
No	2
Don't know/ Don't remember	98

M5.4 During the first 3 days after delivery did you give anything to drink other than breast milk?

Yes	1
No	2
Don't know/ Don't remember	98

M5.5 Have you ever given your child any solid/mushy food and/or any liquid including water?

Yes	1	
No	2	**Skip to Section 6**

M5.6 How long after delivery was the child given any solid/mushy food?

	Record the number of months Code 98 for "Don't remember"

M5.7 How long after delivery was the child given any liquid?

	Record the number of days Code 98 for "Don't remember"

Section 6: Nutrition

Note: Ask only for mothers with children under 5 years old.

SHOWCARD

M6.1 Since this time yesterday has (Name) received the following food? **MA**

Any rice, rice noodle, sticky rice, corn, wheat flour?	1
Any locally available root or tuber; potato, arrowroot or taro?	2
Locally available pumpkin, carrots, golden sweet potato? (Other locally available vegetables with orange/red flesh)	3
Any foods made from beans, peas, lentils or nuts? Eg Peanut (ground nut), Lentil (dahl), chick peas or beans	4
Any dark green leafy vegetables? Eg watercress, gourd (pumpkin) leaves, green spinach, tamarind leaves.	5
Any locally available fruits with orange or red flesh? Eg papaya, ripe mango	6
Any other fruits or vegetables? E.g. Tomatoes, bananas, guava, eggplant, cucumber, onion, garlic	7
Liver, kidney, heart or other organ meats?	8
Any meat such as beef, lamb, goat, chicken, rat or frog?	9
Fresh or dried fish, shellfish, or seafood?(oysters, mussels, squid (not fish paste)	10
Eggs? (chicken, quail, duck)	11
Yoghurt / other milk products/ tinned/ powder/ fresh milk?	12
Any oil or fats or foods made with any of these? Eg Sesame, sunflower, ground nut, palm oil	13
Any sugary foods such as jaggery, chocolates, sweets, candies, pastries, cakes or biscuits?	14
Salt / savory snacks / fish paste	15
Commercially available baby food (Dumex ……..)	16
Tea/coffee	17
Plain water / sugar water / honey water	18
Juice / juice drink	19
Broth / soup	20

M6.2 How many meals did you feed (Name) from this time yesterday till now? (A meal consists of solid or mushy food)

	Record the number of times Code 99 for "Breast milk only"

M6.3 How many snacks did you feed (Name) from this time yesterday till now?

	Record the number of times Code 99 for "Breast milk only"

Section 7: Immunization

Note: Ask only for mothers with children under 5.

M7.1 Do you have an immunization card/Weight Chart Card for your child? If YES, May I see it please?

Has a card, seen	1		
Has a card, not seen	2	→	skip to 7.3
Does not have a card	3	→	skip to 7.3

Note for Interviewer: If seen, check the card for new version or old version. If it is old version, go to M7.2. If it is new version go to M7.2.1.

M7.2 Copy dates for old immunization card.

	Date of Immunization			No date, only mark	
				Yes	No
	Date	Month	Year		
1. BCG BCG				1	2
2. Polio 1 OPV-1				1	2
3. Polio2 OPV-2				1	2
4. Polio3 OPV-3				1	2
5. DPT1 DPT-1				1	2
6. DPT2 DPT-2				1	2
7. DPT3 DPT-3				1	2
8. Hepatitis-B at birth Hep-0				1	2
9. Hep-B2 Hep-1				1	2
10.Hep-B3 Hep-3				1	2
11.Measles MMR-1				1	2
12.Measles MMR-2				1	2

M7.2.1 Copy dates for new immunization card.

	Date of Immunization			No date, only mark	
				Yes	No
	Date	Month	Year		
1. BCG BCG				1	2
2. Polio 1 OPV-1				1	2
3. Polio2 OPV-2				1	2
4. Polio3 OPV-3				1	2
5. PENTA1 PENTA-1				1	2
6. PENTA2 PENTA-2				1	2
7. PENTA3 PENTA-3				1	2
8. Hepatitis-B at birth Hep-0				1	2
11.Measles MMR-1				1	2
12.Measles MMR-2				1	2

M7.3 Has (name) received any vaccination (BCG) against TB – which is an injection in the arm or shoulder that causes a scar?

Yes	1
No	2
Don't know	98

M7.3.1 When did the child receive BCG? **SA**

At the time of delivery	1
Within 1 month of delivery	2
Other (Specify)	99
Don't Remember	98

M7.4 Has (name) received any vaccination drops in the mouth to protect him / her from polio?

Yes	1	
No	2	**Skip to M7.6**
Don't know	96	

M7.5 How many times did your child receive the polio drops?

	Record the number of times Code 98 for "Don't remember"

M7.6 Has (name) ever received a DPT vaccine in the thigh or buttock – to prevent him/her from getting tetanus, whooping cough or diphtheria? (Probe: DPT is sometimes given along with polio)

Yes	1	
No	2	**Skip to M7.7**
Don't know	96	

M7.6.1 How many times did you receive DPT?

	Record the number of times Code 98 for "Don't remember"

Only ask M7.7 if the child's age is over 8 months.

M7.7 Has (name) ever received measles vaccine when the child was 9 months of age and 1.5 years of age in the upper arm?

Yes	1	
No	2	**Skip to M7.8**
Don't know	96	

M7.7.1 How many times did you receive measles?

	Record the number of times Code 98 for "Don't remember"

M7.8 Has (name) ever received a Hep-B vaccine in the thigh or buttock – to prevent him/her from getting Hepatitis B? (Probe: Hep B is sometimes given along with polio)

Yes	1	
No	2	**Skip to Section 8**
Don't know	96	

M7.9 How many times did your child receive the HepB vaccine and when was each time?

	Age in Months
First Time	

Second Time	
Third Time	
Fourth Time	
Don't remember	98

Note: If the child received first time at birth, code "0". Leave blank for not received. Code "98" for "don't know/don't remember".

Section 8: Childhood illness - Diarrhea

Note: Ask only for mothers with under 5 children.

M8.1 Have any children under-five in the family suffered from diarrhea in the past 2 weeks?

	Yes	No	If "Yes", record completed age in months	Selected
Youngest Child	1	2		1
Second Youngest Child	1	2		2
Third Youngest Child	1	2		3

Note: If none of the children suffered from diarrhea, go to Section 9.

If more than one child suffered from diarrhea, ask the mother who is more severe, select the code under "Selected" column and ask only about that child.

M8.2 Thinking about the most recent occurrence, did you seek treatment from any source?

Yes	1	
No	2	**Skip to M8.5**
Don't know	96	

M8.3 From whom did you seek treatment? **SA**

Doctor	1
Nurse	2
Health Assistant	3
Lady Health Visitor	4
MW	5
AMW	6
Community Health Worker (Gov)	7
Health volunteer (INGOs/NGOs)	8
Doctors/nurses from mobile clinics	10
Quack	11
Drug Store	12
Others (Specify)	99

M8.4 When did you take the child for treatment / after how many days since the diarrhea began? **SA**

Within 24 hours	1
Within 48 hours	2
After 2 days	3
After 3 days	4
Do not remember	98

M8.5 During the diarrhea period, how did you feed the child compared to usual days? **SA**

More than usual	1
Less than usual	2
Fed nothing	3
No change from usual	4
Don't remember	98

SHOWCARD

M8.6 During the incidence of diarrhea, did you give your child any of the following? **SA**

ORS from a packet, after mixing it with boiled and cooled water?	1
Other recommended home-made fluid?	2
None of the above	99

M8.7 Was there anything else given to the child to treat diarrhea?

Yes	1	
No	2	**Skip to Section 9**
Don't know	96	

M8.8 What else was given to treat the diarrhea? **MA**

Herbal medicine	1
Antibiotics	2
Syrup	3
Pill	4
Zinc	5
Injection	6
Others (specify)	99

Section 9: Childhood Illness – Acute Respiratory Infection

Note: Ask only for mothers with under 5 children.

M9.1 Have any children under five in the family suffered from cough in the past 2 weeks?

	Yes	No
Youngest Child	1	2
Second Youngest Child	1	2
Third Youngest Child	1	2

M9.2 Have any children under five in the family suffered from fast breathing in the past 2 weeks?

	Yes	No	Selected	If "Yes", record completed age in months
Youngest Child	1	2	1	
Second Youngest Child	1	2	2	
Third Youngest Child	1	2	3	

Note: If none of the children suffered from cough OR fast breathing, go to Section 10.

If more than one child suffered from cough OR fast breathing, choose the child who suffered both symptoms and code under "selected" column for that child and ask only about that child.

If more than one child suffered from cough AND fast breathing (or) cough OR fast breathing, ask the mother who suffer more severely and select code under "Selected" for that child and only ask about that child.

M9.7 Thinking about the most recent occurrence, was treatment given?

Yes	1	
No	2	**Skip to Section 9.10**
Don't know	96	

M9.8 When did you take the child for treatment/ after how many days since cough and rapid breathing began? **SA**

Within 24 hours	1
Within 48 hours	2
After 2 days	3
After 3 days	4
Don't remember	98

M9.9 From whom did you seek treatment? **SA**

Doctor	1
Nurse	2
Health Assistant	3
Lady Health Visitor	4
MW	5
AMW	6
Community Health Worker (Gov)	7
Health volunteer (INGOs/NGOs)	8
Doctors/nurses from mobile clinics	10
Quack	11
Drug Store	12
Others (Specify)	99

M9.10 Was the child given any drug for treatment? **SA**

Yes	1	
No	2	**Skip to Section 10**
Don't know	96	

M9.11 What type of drug(s) was the child given for treatment? MA

Antibiotics	1
Paracetamol	2
Cough tablets/syrup	3
Vitamins/Tonic	4
Others (Specify)	99
Don't know	98

Section 10: Childhood Illness – Malaria

Note: Ask all households.

M10.1 Has any child in your household been ill with fever in the last two weeks?

	Yes	No
Youngest Child	1	2
Second Youngest Child	1	2
Third Youngest Child	1	2
Any other members (Specify)	1	2
Any other members (Specify)	1	2

M10.3 Did the child suffer any symptoms of fever with chills?

	Fever with chills	Fever without chills	Selected	If "Fever with chills", record completed age in months for children and years for adult
Youngest Child	1	2	1	
Second Youngest Child	1	2	2	
Third Youngest Child	1	2	3	
Any other members (Specify)	1	2	4	
Any other members (Specify)	1	2	5	

Note: If none of the household member suffered from fever with chills, go to Section 11.

If more than one household member suffered from fever with chills, ask the mother who suffered more severely and select code under "Selected" for that child and only ask about that child.

M10.4 Thinking about the last time your child/ one of your children experienced fever, did you seek advice or treatment from any source?

Yes	1	
No	2	**Skip to M10.7**
Don't remember	96	

M10.5 From whom did you seek treatment? **SA**

Doctor	1
Nurse	2
Health Assistant	3
Lady Health Visitor	4
MW	5
AMW	6
Community Health Worker (Gov)	7
Health volunteer (INGOs/NGOs)	8
Doctors/nurses from mobile clinics	10
Quack	11
Drug Store	12
Others (Specify)	99

M10.6 How long after you noticed <NAME's> fever did you seek treatment from that person or place?

Within 24 hours	1
Within 48 hours	2
After 2 days	3
After 3 days	4
After a week	5
Don't remember	98

M10.7 Was the child/adult tested by blood test through finger prick?

Yes	1
No	2
Don't remember	96

M10.8 Was (name) given any drugs?

Yes	1	
No	2	**Skip to M10.10**
Don't remember	96	

M10.9 What medicines were given to the child/adult? **MA**

Herbal medicine	1
Fever pill (specify name)	2
Fever syrup (specify name)	3
Antibiotics (specify name)	4
Chloroquine	5
Quinine	6
Injection	7
Other medicine (Specify)	99
ACT- combo drug	9
Don't know	98

M10.10 Do you have a mosquito net(s) which is still usable in your house?

Yes	1
No	2

M10.11 Are they long lasting insecticide net or regular nets (needs regular treating)? **MA**

Long Lasting Insecticide Net	1
Regular Net	2
Don't know	98

M10.13 Did you and your children sleep under the net last night?

Yes	1
No	2

Section 11: Contraception

Note: Ask only housewife.

M11.1 Are you pregnant now?

Yes	1
No	2
Not sure/ Don't know	98

M11.2 Are you or your partner currently using any methods to delay or avoid pregnancy?

Yes	1
No	2

M11.3 Can you please list methods of contraception that you are aware of? Any others? (Probe more)

MA, Do not prompt

Injection	1
Pill (Daily/Emergency)	2
IUD	3
Condom	4
Tubal ligation	5
Vasectomy	6
Lactational amenorrhea	7
Abstinence	8
Calendar method	9
Withdrawal	10
Implant	11
Others (Specify)	99

M11.4 Can you tell me which one of you described methods you are using as a major method including the major method used by spouse? **SA, Do not prompt Ask only those who answered Code 1 at M11.2**

Injection	1
Pill (Daily/Emergency)	2
IUD	3
Condom	4

Tubal ligation	5
Vasectomy	6
Lactational amenorrhea	7
Abstinence	8
Calendar method	9
Withdrawal	10
Implant	11
Others (Specify)	99

M11.5 To whom did you go for advice regarding contraception and birth spacing? **MA**

M11.6 From where did you receive services regarding contraception / services? **MA**

	M11.5	M11.6
Doctor	1	1
Nurse	2	2
Health Assistant	3	3
Lady Health Visitor	4	4
MW	5	5
AMW	6	6
Community Health Worker (Gov)	7	7
Health volunteer (INGOs/NGOs)	8	8
TBA	9	9
Doctors/nurses from mobile clinics	10	10
Quack	11	11
Drug Store/ Pharmacist	12	12
Friends/neighbours	13	
Spouse	14	
No one/ Don't receive services	98	98
Others (Specify)	99	99

M11.7 I would like to ask you some questions about the future: would you like to have another child, or, would you prefer not to have any more children?

Have another child	1
No more children/none	2
Undecided/ don't know	98

Section 12 – Knowledge

Ask all housewives

All questions in this section are unaided questions.

M12.1 What are the danger signs during **pregnancy** indicating the need to seek health care? Anything else? **MA**

Fever and too weak to leave the bed	1
Shortness of breath/Difficulty Breathing	2
Bleeding	3
Severe headache/dizziness	4
Loss of fetal movement	5
Fits	6
Severe abdominal pain	7
Swelling of face/hands/feet	8
Unconsciousness	9

Blurred vision	10
Significantly decreased urine	11
Don't know	98
Other (specify)	99

M12.2 What are the danger signs **during delivery** that indicates the need to seek emergency care outside home? Anything else? **MA**

Prolonged delivery of more than 12 hours	1
Bleeding	2
Retained placenta (over 1 hour)	3
Fits	4
Shortness of breath	5
No abdominal pain after 6 hours after membrane rupture	6
Don't know **(SA)**	98
Others (specify)	99

M12.3 What are the danger signs **after giving birth** that indicate the need to seek emergency care outside of the home? Anything else? **MA**

Excessive bleeding	1
Fever and too weak to get out of bed	2
Smelly vaginal discharge	3
Fits	4
Severe abdominal pain	5
Shortness of breath	6
Painful, red, or torn vagina	7
Painful, swollen nipples or breasts	8
Difficult to urinate	9
Incontinence or urine dribbling	10
Don't know **(SA)**	98
Others (specify)	99

M12.4 Can you mention any danger signs indicating that newborns may be sick and you need to seek health care? Anything else? **MA**

Very small child	1
Poor sucking	2
Fast noisy breathing, inward drawn chest	3
Very sleepy, fatigue, poor movement	4
Fever	5
Poor movement	6
Fit	7
Yellow discoloration, jaundice	8
Skin infection	9
Bleeding from cord or body	10
Unconscious	11
Grunting	12
Condition not improving	13
Swollen/redness discharge from eyes	14
Don't know **(SA)**	98
Other (specify)	99

M12.5 Do you know the danger signs of pneumonia? / Can you identify the danger signs of pneumonia? **MA**

Fits	1
Unable to drink or feed	2
Drowsiness	3
Unconscious	4
Continuous vomiting	5
Cyanosis in lips, nails and tongue	6
Coldness of extremities	7
Cough	8
Fast/rapid breathing	9
Sunken chest/indrawn chest	10
Wheezing	11
Don't know **(SA)**	98
Other (specify)	99

M12.6 Can you identify danger signs of diarrhea in children? **MA**

Sunken eyes	1
Restlessness	2
Drowsiness with fatigue	3
Intense thirst	4
Dry throat	5
Pinched skin gets back very slowly	6
Don't know **(SA)**	98
Other (specify)	99

M12.7 What are the causes of malaria? **MA**

Mosquito Bites	1
Witchcraft	2
Rainy season	3
Intravenous drug use	4
Blood infusions	5
Injections	6
Don't know **(SA)**	98
Other (specify)	99

Section 13: Health Contacts and Source of Information

ASK ALL.

SHOWCARD

M13.1 During the last month, how often have you come in contact with each of the following? **SA PER ROW**

	1-3 times	4 times and more	Never
Doctor (Government)	1	2	3
Doctor (Private)	1	2	3
Nurse (Government)	1	2	3
Nurse (Private clinic)	1	2	3
Midwife	1	2	3
Community health volunteer	1	2	3
Mobile clinic / outreach	1	2	3
Traditional Birth Attendant	1	2	3
Traditional Healer	1	2	3

M13.2 Who is your primary source for information or advice on health and nutrition? **MA**

Government doctor	2
Government nurse	3
Private doctor	4
Private nurse	5
Mobile clinic	6
Midwife	7
Community health worker	8
Trained volunteer	9
TBA	10
Husband	11
Mother/Mother in law	12
Friend/Neighbor	13
Traditional healer	14
Village elder	15
No one	98
Others (specify)	99

SHOWCARD

M13.3 In the past month, have you received any health messages from the following: **MA**

Doctor	1
Nurse	2
Health Assistant	3
Lady Health Visitor	4
MW	5
AMW	6
Community Health Worker (Gov)	7
Health volunteer (INGOs/NGOs)	8
TBA	9
Doctors/nurses from mobile clinics	10
Quack	11
Drug Store/ Pharmacist	12
Friends/neighbours	13
Spouse	14
Radio	15
Newspaper	16
TV	17
No one/Nowhere else **(SA)**	98
Others (Specify)	99

LIVELIHOODS

Section 1. Source of HH Income

L1.1 What were the sources of income for your household during the previous 12 months? **MA**

L1.2 List the **three** most important sources of income for your household during the last 12 months.
Note: From the selected income sources from L1.1, rank 1-3 at L1.2.

	L1.1	L1.2 Importance (1-3)
Grow Agricultural crops (all food and non-food cash crops)	1	
Livestock and poultry breeding	2	
Fish breeding/catching	3	
Small scale trading of agricultural products (all food and non-food cash crops)	4	
Small scale trading of livestock and fishery products	5	
Small scale trading of non-agricultural products (forest products and non-timber forest products)	6	
Small Shop/grocery store	7	
Hawker	8	
Large scale trader/dealer	9	
Casual labor- agriculture, fishery, forestry, other	10	

Government (pension)/NGO assistance (cash for work)	11	
Full time employment	12	
Service Provider	13	
Remittances/Gifts/Migrant labours	14	
No Income	98	
Other (Specify)_____	99	

SHOWCARD

L1.3 What is the average monthly total income for your household from all sources in a year? **SA**

Less than Ks 25,000	1
> Ks 25,001 – Ks 50,000	2
> Ks 50,001 – Ks 75,000	3
> Ks 75,001 – Ks 100,000	4
> Ks 100,001 – Ks 150,000	5
> Ks 150,001 – Ks 200,000	6
> Ks 200,001 – Ks 250,000	7
> Ks 250,001 – Ks 300,000	8
Over Ks 300,000	9
Don't know/no response	98

L1.4 How do you describe your household's financial well being over the past 12 months with the previous year?

Very good	1
Somewhat good	2
Neutral (the same as before)	3
Somewhat not good	4
Not good at all	5

Section 2: Casual Employment (not full-time)

L2.1 How do you describe the employment availability in the past 12 months in this area with the previous year?

Very good	1
Somewhat good	2
Neutral (the same as before)	3
Somewhat not good	4
Not good at all	5

Section 3: Household Diet Diversity Score

L3.1 Now I would like to ask you about the types of foods that you or anyone else in your household ate **yesterday** during the day and night. Did you or anyone else in your HH eat: Anymore? **MA, CAN PROBE**

Note: If they have unusual event yesterday, please ask a day before for usual meals.

Any rice, sticky rice, or any other food made from rice, sticky rice, maize, wheat, barley, oats, millet, sorghum?	1
Any noodles, bread, biscuits or any other foods made from of flour/sticky rice	2
Any potatoes, cassava, yams, taro, or any food made from roots or tubers?	3
Bamboo shoot, mushroom, etc.	4
Any vegetables?	5
Any fruits?	6
Any beef, pork, lamb, goat, rabbit, chicken, duck, other birds, other meats or organs such as liver, heart, kidney etc?	7
Any other meats from frogs, rats, snakes, dogs, cats etc?	8
Any eggs from chickens, quails, ducks or other birds?	9
Any fish, crabs, prawns, or shellfish, either fresh or dried?	10
Any food made from gram, peas, cowpeas, pigeon peas, lentils, beans, peanuts or other nuts?	11
Any milk, milk solids, yogurt, cheese, or other milk products?	12
Any food made with peanut oil, coconut oil, palm oil, sesame oil, sunflower oil or other oils, animal fat, butter or margarine?	13
Any sugar, jaggery, honey?	14
Coffee, tea, green tea, black tea, pickle tea	15

L3.2 How many meals did your household eat yesterday? **SA**

1 meal	1
2 meals	2
3 meals	3
More than 3 meals	4

L3.3 Over the past week, how many days did you household eat meat?

	Record the number of days

Section 4: Months of Adequate HH Food Provisioning

L4.1 I'll read out the months here. Which of these months did you have problems meeting food needs of your household? **MA**

June, Nayone	1
July, Waso	2
August, Wagaung	3
September, Tawthalin	4
October, Thadingyut	5
November, Tazaungmon	6
December, Nadaw	7
January, Pyatho	8
February, Tabodwe	9
March, Tabaung	10
April, Tagu	11
May, Kasone	12

Section 5: Coping Strategies and HH Hunger Scale

L5.1 In the past four weeks, how many days did your family reduce the size and/ or the number of meals eaten in a day because there was not enough food to eat?

Rarely or Sometimes (1-3 days)	1
Often (more than 3 days)	2
Never	0

L5.2 In the past four weeks, how many days did your family change the family diet to cheaper or less-preferred foods, in order to have enough food to eat?

Rarely or Sometimes (1-3 days)	1
Often (more than 3 days)	2
Never	0

L5.3 In the past four weeks, how many days did your family eat wild food (e.g. berries, fruits, roots, leaves, insects, small animals etc) more frequently than usual, in order to have enough food to eat?

Rarely or Sometimes (1-3 days)	1
Often (more than 3 days)	2
Never	0

Household Hunger Scale

L5.4 In the past four weeks, was there any time when there was no food to eat of any kind in your household?

Rarely or Sometimes (1-3 days)	1
Often (more than 3 days)	2
Never	0

L5.5 In the past four weeks, did you or any member of your household go to sleep at night hungry?

Rarely or Sometimes (1-3 days)	1
Often (more than 3 days)	2
Never	0

L5.6 In the past four weeks, did you or any member of your household go a whole day and night without eating?

Rarely or Sometimes (1-3 days)	1
Often (more than 3 days)	2
Never	0

L5.7 In the past 12 months, did your HH sell off (or consume) seeds meant for planting next season's crops in order to have enough food to eat?

Yes	1
No	2

L5.8 In the past 12 months, did your HH use savings in order to have enough food to eat?

Yes	1
No	2

L5.9 In the past 12 months, did one or more children from your HH discontinue school in order to save money or work to bring in additional income, so that your HH had enough food to eat?

Yes	1
No	2

L5.10 In the past 12 months, did you or any member of your HH decrease money spent on health or medicines, so that your HH had enough food to eat?

Yes	1
No	2

L5.11 In the past 12 months, did your HH borrow food or money for food from relatives, friends or neighbors, in order to have enough to eat?

Yes	1
No	2

L5.12 In the past 12 months, did your HH borrow money from money lenders, loans associations, banks, traders or shop keepers in order to buy enough food to eat?

Yes	1
No	2

L5.13 In the past 12 months, did your HH sell, pawn or exchange any of the household's assets, including tools, equipment or any other possessions, in order to buy enough food to eat?

Yes	1
No	2

L5.14 In the past 12 months, did your HH sell (or consume) more of your livestock than usual (e.g. cattle, goats, chicken, ducks, pigs, buffalo) in order to have enough food to eat?

Yes	1
No	2

L5.15 In the past 12 months, did your HH sell, mortgage or rent any of your land, in order to have enough food to eat?

Yes	1
No	2

L5.16 Overall, how would you describe your household general food security in the past 12 months with the previous year?

Very good	1
Somewhat good	2
Neutral (the same as before)	3
Somewhat not good	4
No good at all	5

Section 6: Access to land for agriculture (everyone)

ASK ALL.

L6.1 Does your household or any of its members own any agriculture land?

Yes	1	
No	2	**Skip to L6.3**
I don't work agriculture	3	**Skip to L12.1**

Note: Ownership should be considered very broadly to include cases where land is formally titled and registered in one or more household member's name; land that has been purchased, transferred or inherited but not formally titled (or if titled not registered in the household's name); land leased from government; and, land where the household believes it has an established right (formal or informal) to use the land, a right that is generally recognized by the community

L6.2 What is the total area of land that your household owns?

	Record the units of land in Acres

L6.3 What type is that agriculture land which is also your major land for agriculture?

Own Land	1
Rent land in cash or kind	2
Share crop	3

Note: Ask the following questions for the selected type of land only.

L6.4 In the past 12 months, largest area cultivated

	Record the units of land in Acres

L6.5 In past 12 months, did you irrigate on it?

Yes	1	
No	2	**Skip to Section 7**

L6.6 Largest area under irrigation

	Record the units of land in Acres

L6.7 What is the main source of irrigation during the dry and wet seasons? **SA PER COLUMN**

	Dry Season	Rainy Season
Rehabilitated canal	1	1
Lake, stream, river	2	2
Community ponds	3	3
Dam/reservoirs	4	4
Private pond	6	6
Community boreholes/wells	7	7
Private boreholes/wells	8	8
Not applicable	98	98
Others (specify)_____	99	99

Section 7: Agriculture Inputs (Fertilizer)

L7.1 Does the household apply pesticides on crops?

Yes	1
No	2

L7.2 Does the household apply on crops? (please specify all of them) MA

Compost or Farm Yard Manure	1
Chemical fertilizer	2
Mixed	3
None of above	99

SECTION 8: CROPPING PATTERNS in the last 12 months (PLEASE LOOK AT CROP CODES PROVIDED BELOW)

	L8.1	L8.2	L8.3	L8.4	L8.5	L8.6	L8.7	L8.8	L8.9	L8.10	L8.11	L8.12	L8.13	L8.14	L8.15	L8.16
	Crops Cultivated (Code)	Source of planting material (seed source) **% required** **Rate according to most popular source to least**	Acres planted **% required**	Total yield/acre (baskets / viss) **% required**	Quantity retained for HH consumption (baskets/viss) **% required and classify according to number of baskets/** **viss by creating ranges**	Quantity retained as seed for next cropping season **% required**	Quantity Sold (baskets/viss) **% required**	Quantity used to repay loans (basket / viss) **% required**	Quantity milled/ husked **%**	Quantity after milled/ Husked **%**	Do you store your farm products? **%**	Where do you store your farm products? **% for each option**	Did you have the problems in keeping/storing your products? **%**	If yes, what are these problems? *(multiple choices* **% for each option***)*	How much seed do you lose in total? **%**	Reasons for losses **% for each option**
	Code	Code									Yes .....1 No.....2 DK ....96 If Code 2 & 96, Skip to 8.15	Code	Yes ..... 1 No..... 2 DK ..... 96 If Code 2&96, skip to 8.15.	Code		Code
1																
2																
3																
	Dry season															
4																
5																
6																

L8.1 Crop codes and unit measures

Cereals
- Paddy - Basket..... 1
- Wheat - Basket 2
- Milet and Sorghum - Basket.. 3
- Maize - Kyat..... 4
- Other grains/ cereals - Basket5

Pulses and beans
- Black gram - Basket..... 6
- Green gram (Pedisein)-Basket7
- Chick pea - Basket..... 8
- Pigeon - Basket..... 9
- Duffin bean (Pephyukalay) - Basket..... 10
- Lablab bean (Pegyi) - Basket11
- Rice bean (Peyin) - Basket.. 12
- Mung bean (Penauk) - Basket13
- Other beans - Basket 14

Oil crop
- Groundnut with shell - Basket15
- Soybean (Peboke) - Basket 16
- Sunflower - Basket..... 17
- Mustard - Basket..... 18
- Sasame - Basket..... 19
- Oil palm - Bunch 20
- Other oilseed crops - Basket21

Root crop and tuber
- Potato - Viss 22
- Onion - Viss 23
- Garlic - Viss 24
- Sweet potatoes - Viss 25
- Taro - Viss 26
- Tumeric - Viss..... 27
- Ginger - Viss 28
- Others (yams, arrow root) - Kyat 29

Vegetables
- Cauliflower - Number 30
- Cabbage - Number..... 31
- Mustard - Kyat..... 32
- Other leafy or steam vegetables - Kyat 33
- Chillies (dry) - Viss 34
- Chayote - Viss 35
- Tomato - Viss..... 36
- Other fruit bearing vegetables - Kyat 37
- Raddish/carrot - Viss..... 38
- Other root, bulb and tuberous vegetables - Kyat 39

Citrus fruits
- Orange - Number..... 40
- Pomelo - Number..... 41
- Other citrus fruits - Kyat 42

Other fruits and nuts
- Apple - Number..... 43
- Pear - Number 44
- Plums - Viss..... 45
- Tamarind - Viss..... 46
- Banana - Kyat 47
- Custard apple - Number..... 48
- Guava - Kyat..... 49
- Mango - Number..... 50
- Papaya - Number..... 51
- Pineapple - Number 52
- Water melon - Number..... 53
- Cucumber - Number 54
- Durian - Number 55
- Rambutan - Viss 56
- Jack fruit - Number..... 57
- Da-nyin - Number..... 58
- Grapes - Viss..... 59
- Strawberry - Viss..... 60
- Other fruits - Kyat..... 61
- Cashew nut - Viss 62
- Other nuts - Kyat..... 63

Beverage crop
- Tea - Viss 64
- Coffee – Pound (lb)..... 65
- Other beverage crop – Kyat 66

Other industrial crops
- Tobacco - Viss 67
- Thanatphet - Viss..... 68
- Toddy palm –Jiggery viss.... 69
- Sugarcane - Ton 70
- Cotton - Viss 71
- Jute - Viss..... 72
- Coconut - Number..... 73
- Rubber - Viss 74

Other crops
- Flowers - Kyat 75
- Betel leave - Viss 76
- Betel nut - Viss..... 77
- Animal feed crop - Kyat..... 78
- Any other crop - Kyat 79

L8.2	L8.12	L8.14	L8.16
Seed from previous crop……..1	Keep it open.....1	Pest Damage.....1	Loss in harvesting time and in the field.....1
From market……..2	Keep it inside the house.....2	Rodent and other animal damage.....2	Loss while moving from the field to threshing floor 2
Myanmar Agri Service……..3	Keep it covered.....3	Fungus.....3	Loss in threshing time.....3
Local NGOs……..4	Keep it in a building/shed with air passing through 4	Dampness.....4	Loss in milling/cleaning/winnowing time.....4
INGOs……5	Others (specify).....99	Extremely hot.....5	Loss in storage time.....5
Other farmers……6		Low market potential.....6	
Community seed bank…….7		Scarce source of labor.....7	
Others (specify)……99		Other (specify) ……99	

L8.17 How do you rate the quality of the soil on your agricultural land? **SA**

Very fertile	1
Good	2

Average	3
Poor	4
Other (specify)	99

L8.18 What measures did you take to improve the fertility of your land? **MA**

Add compost	1
Add Green manure	2
Growing synergy crops with sequential pattern	3
Growing compatible crops	4
Mulching/growing cover crops	5
Contouring	6
Soil testing	7
Leave land fallow for a season	8
Add organic fertilizer	9
Add inorganic fertilizer	10
Did nothing **(SA)**	11
Don't know **(SA)**	98
Others (specify) _____	99

L8.19 Have you tested your soil in the last 12 months?

Yes	1	
No	2	**Go to Section 9**

L8.20 How have you tested your soil in the last 12 months?

By hand	1
By hand with equipment	2
By machines (Soil test kit)	3
Other (Specify)	99

Section 9: Post-Harvest Activities

L9.1 Did you thresh your crops during the last 12 months? **SA**

Yes	1	
No	2	**Go to L9.3**

L9.2 How did you thresh? **MA**

By hand	1
By hand with equipment	2
By animals	3
By machines	4
Others (Specify)	99

L9.3 Did you dry your crops after harvesting? **SA**

Yes	1	
No	2	**Go to Section 10**
Don't know	98	**Go to Section 10**

L9.4 Where do you dry your crops?

On farms	1
At home	2
On the street	3
Others (Specify)	99

L9.5 How do you dry your crops?

Sunlight	1
Dry in shade	2

Under roof of home	3
Fan dry	4
With drying machine	5
Others (Specify)	99

Section 10: Constraints to Crop Production

L10.1 What are the major constraints or problems limiting your HH's crop production? Probe more (Why didn't your household produce more baskets of crop?) **Do not read out the answers**. **MA**

Lack of money to buy the necessary inputs (or lack of credit)	1
Lack of land	2
Lack of draught power/mechanical power (or too expensive)	3
Lack of other tools and equipment (or too expensive)	4
Lack of fertilizer (or too expensive)	5
Lack of seeds (or too expensive)	6
Lack of household labor	7
Lack of casual labor available locally (or too expensive)	8
Lack of pesticides / insecticides / fungicides (or too expensive)	9
Lack of knowledge, skills or experience	10
Not interested/grows enough/too risky to grow more	11
Low prices for the agricultural crops grown	12
Bad/unreliable weather (including too little or too much rain)	13
Lack of water resources or irrigation infrastructure	14
Crop pests and disease	15
Low soil fertility/poor soil structure etc	16
Salinity	17
Lack of market potential	18
Other (specify) _____	99

Section 11: Household Ownership and Access to Agricultural Equipment and Machinery

ASK ALL - SHOWCARD

L11.1 Does your household currently own any of the following agricultural equipment and machinery? **MA**

Note: The equipment must be functioning.

	Owned	Shared
Ploughs/tillage equipment for use with draught animals	1	1
Power tiller	2	2
Tractor	3	3
Power thresher	4	4
Backpack sprayer	5	5
Improved crop storage bin or silo	6	6
Tarpaulin or seed drying net	7	7
Irrigation pump	8	8
Animal drawn cart	9	9
Trailer (drawn by vehicle)	10	10
Seeder	11	11
Other 1 (specify)	12	12
Other 2 (specify)	13	13
Other 3 (specify)	14	14

Section 12: Household Livestock Ownership

ASK ALL.

L12.1 How many animals does your household currently own? Does your household share the ownership of any livestock with others? **MA**

	Owned/Shared	Owned Numbers	Shared Numbers
Cattle	1		
Horses	2		
Goats and/or sheep	3		
Buffalo	4		
Pigs	5		
Chickens	6		
Ducks	7		

Other 1 (specify)	8		
Other 2 (specify)	9		
Other 3 (specify)	10		

Section 13: Marketing

NOTE: If Code 1/2/3 is coded at QL1.1, ask this section. Otherwise, skip to L14.1.

L13.1 Did your household sell your main products alone or did you sell in a group? **SA**

Sold alone only	1
Sold in group only	2
Sold alone and in group	3

L13.2 Were you able to access information on prices for the main products before you sold it? **SA**

Mostly	1	
Sometimes	2	
Rarely	3	
Never	4	**Skip to L13.4**

L13.3 If you were able to access information on prices, where did you get this information from? Anything else?

MA, Do not prompt

TV/Radio	1
Newspaper/weekly journal	2
Friends/Family	3
Farmer association/cooperative	4
NGO/other organization	5
Dealer/broker	6
Other (Specify)	99

L13.4 Where did you sell your main crop? **MA**

Own village/at home	1
Other village	2
Market in the town	3
Dealer in the village	4
Dealer in township	5
Other (Specify)	99

L13.5 How did you transport your product to the market? MA

On foot	1
Bicycle	2
Push Cart	3
Animal Cart	4
Motorcycle	5
Hire/Owned vehicle	6
Boat	7
Other (Specify)	99

Section 14: Credit

ASK ALL

L14.1 Have you or any household member taken a loan in the **last 12 months**?

Yes	1	**Skip to L14.3a**
No	2	

L14.2 Do you have any outstanding loans?

Yes	1
No	2

NOTE: if code 2 has been coded in both L14.1 and L14.2, skip to L15.1.

Interviewer: Record all loans taken in the last 12 months and any outstanding loans.

	L14.3a	L14.3b		L14.3c	L14.3d	L14.3e
	Source of loan	**Loan taken in the month of:**		**Amount of loan**	**Interest on loan (Monthly)**	**Purpose of loan**
	Private bank……..1 Micro-credit provider……2 Village Savings and Loans Association……3 Family/friend……4 Money lender……5 Shop-keeper……6 Private company……....7 Farmers Association/Cooperative ……..8 Pre-sale of product to trader…..9 Government……10 Village Health and Development Fund……12 Women Saving Groups…….13 Others (specify)……..11	**%** Month	Year	Less than Ks 25,000 ..... 1 Ks 25,001 – 50,000 ..... 2 Ks 50,001 – 75,000 ..... 3 Ks 75,001 – 100,000 ..... 4 Ks 100,001 – 150,000 ..... 5 Ks 150,001 – 200,000 ..... 6 Ks 200,001 – 300,000 ..... 7 Ks 300,001 – 400,000 ..... 8 Ks 400,001 – 500,000 ..... 9 Over Ks 500,000 ..... 10 No debt 11	**Least interest %, highest interest %**	Home improvement including water supply……1 House purchase or construction……2 Construction other than house……..... 3 Land purchase/rent..... 4 Purchase of working tools or equipment ..... 5 Food purchases ..... 6 Purchase of agricultural inputs..... 7 Purchase of animals/medicine for animals ..... 8 Purchase of other assets ..... 9 Social affairs..... 10 Health emergency.....11 Business investment..... 12 Repayment of loans.....13 School/education fees/costs .....14 Other (specify) _____..... 99

Section 15: Other Household Assets

L15.1 What is the major source of **lighting** in your household? **SA**

Electricity from grid	1
Village generator	2
Own generator	3
Shared generator with households	4
Lamp (kerosene/oil)	5
Candle	6
Batter (rechargeable)	7
LED battery	8
Solar System	9
Other (Specify)	99

L15.2 What is the major source of **cooking fuel** in your household?

Electricity	1
Gas	2
Charcoal	3
Kerosene	4
Wood	5
Dung	6
Other (Specify)	99

SHOWCARD

L15.3 Does your household, including the head, spouse and all members, own any of the following items which are still functioning? **SA PER ROW**

	Owned	Shared
Bicycle	1	2
Motorcycle	1	2
Trishaw	1	2
Trawlarjeep	1	2
Car	1	2
Truck	1	2
Bed	1	2
Mattress	1	2
Stove (gas or electric)	1	2
Fuel efficient wood stove	1	2
Chairs	1	2
Table	1	2
Gold/ Jewelry	1	2
Radio/cassette	1	2
TV / satellite dish	1	2
DVD player	1	2
Sewing machine	1	2
Weaving loom	1	2
Wrist Watch	1	2
Solar panel	1	2
Boats without motor	1	2
Boats with motor	1	2
Fishing nets	1	2
Fish/aquaculture pond	1	2
Household savings	1	2
Other 1 (specify)	1	2
Other 2 (specify)	1	2

Note: If the respondent owns one item as personal and shared, please choose owned.

L15.4 Does your household own the house you are living in?

Yes	1
No	2

L15.5 What is the **main** material of the house roof, walls and floors? if more than one house record for the best house. **SA**

NOTE: If possible answer based on observation –

Zinc sheets or corrugated iron	1
Tarpaulin or plastic sheet	2
Palm frond or thatch	3
Brick	4
Earthen tiles	5
Timber	6
Other (Specify)	99

L15.6 Wall Material **OBSERVATION, SA**

Zinc sheets or corrugated iron	1
Tarpaulin or plastic sheet	2
Bamboo, Palm frond or thatch	3
Timber	4
Brick, cement, cement block, or cement and stone	5
Mud bricks/mud	6
Other (Specify)	99

L15.7 Floor Material **OBSERVATION, SA**

Timber	1
Bamboo	2
Earth	3
Cement	4
Other (Specify)	99

Section 16: Training

ASK ALL.

L16.1 Over the past 3 years, has any member of your household received any training in crop production?

Yes	1
No	2

L16.2 Over the past 3 years, has any member of your household received any training in livestock production?

Yes	1
No	2

L16.3 Over the past 3 years, has any member of your household received any training in fisheries (aquaculture)?

Yes	1
No	2

L16.4 Over the past 3 years, has any member of your household received any training in any other vocational skill?

Yes	1
No	2

L16.5 Over the past 3 years, has any member of your household received any training in financial literacy training?

Yes	1
No	2

WATER, SANITATION AND HYGIENE (WASH)

Section 1: Water Source & Utilization

ASK ALL

W1.1 What is your main source of drinking water in the dry and wet seasons? **SA, UNAIDED**

	Rainy Season	Dry Season
Piped water into house	1	1
Piped water into yard	2	2
Public water tap	3	3
Protected dug well	4	4
Unprotected dug well	5	5
Tube well with hand pump	6	6
Rain water	7	7
Surface water (pond, river, lake, etc.)	8	8
Protected Spring water	9	9
Unprotected spring water	10	10
Motor equipped tube well	11	11
Sand hole	12	12
Other (specify)	99	99

W1.2 What is your main source of water for washing and bathing water during the dry and wet seasons?

SA, UNAIDED

	Rainy Season	Dry Season
Piped water into house	1	1
Piped water into yard	2	2
Public water tap	3	3
Protected dug well	4	4
Unprotected dug well	5	5
Tube well with hand pump	6	6
Rain water	7	7
Surface water (pond, river, lake, etc.)	8	8
Protected Spring water	9	9
Unprotected spring water	10	10
Motor equipped tube well	11	11
Sand hole	12	12
Other (specify)	99	99

W1.3 Does your household have any rain water harvesting system?

Yes	1
No	2

W1.4 If you had water shortage for drinking and washing purposes, what months of the year did you face these difficulties? **MA**

	Drinking Water	Domestic Water
January, Pyatho	1	1
February, Tabodwe	2	2
March, Tabaung	3	3
April, Tagu	4	4
May, Kasone	5	5
June, Nayone	6	6
July, Waso	7	7
August, Wagaung	8	8
September, Tawthalin	9	9
October, Thadingyut	10	10
November, Tazaungmon	11	11
December, Nadaw	12	12
January, Pyatho	13	13
February, Tabodwe	14	14

W1.5 How far is the drinking water source from your house? (in feet) (SA)

In Dry Season		**Record in Feet** **Code "98" for unkown/not applicable**
In Rainy Season		**Record in Feet** **Code "98" for unkown/not applicable**

W1.6 How long does it take to go there, get water (including queuing), and come back (one trip)?

In Dry Season		**Record in minutes** **Code "98" for unkown/not applicable**
In Rainy Season		**Record in minutes** **Code "98" for unkown/not applicable**

W1.7 How does the person fetch water? **SA PER COLUMN**

	Rainy Season	Dry Season
By foot	1	1
Bicycle/trishaw	2	2
Water cart	3	3
Animal drawn cart	4	4
Motorcycle/other motorized vehicle	5	5
No need to fetch water	6	6
Other (specify)	99	99

Note: Skip to W1.9 for Code "6".

W1.8 How many trips does your household make in a week to fetch water?

In Dry Season		**Record in times** **Code "98" for unkown/not applicable**
In Rainy Season		**Record in times** **Code "98" for unkown/not applicable**

W1.9 Do you treat water to make it safe and prevent from diseases before drinking?

Yes	1	
No	2	**Skip to W1.11**

W1.10 How do you usually treat water to have safe drinking water? MA, UNAIDED

Let it stand and settle (sedimentation)	1
Cloth filtration	2
Filtration (ceramic, sand)	3
Eathern filtration pot	4
Boil	5
Solar disinfection	6
Use bleach	7
Don't know/None of above **(SA)**	98
Other (Specify)	99

W1.11 If the drinking water is NOT available throughout the year, what do you do when the drinking water source goes dry? **MA**

	W1.11
Buy drinking water	1
Fetch drinking water from an neighboring village	2
Fetch drinking water from another source	3
Available for the whole year (**SA**)	4
Other (Specify)	99

W1.12 If the water for domestic use is NOT available throughout the year, what do you do when the water source goes dry? **MA**

	W1.12
Buy drinking water	1
Fetch drinking water from an neighboring village	2
Fetch drinking water from another source	3
Available for the whole year (**SA**)	4
Other (Specify)	99

Section 2: Latrine and Hygiene

ASK ALL.

W2.1 What type of toilet facility does you or your family use?

Flush/pour flush to: Piped sewer system	1
Septic tank	2
Ventilated improved pit latrine (VIP)	3
Direct Pit latrine/Pit latrine without slab/open pit	4
Offset Pit latrine with slab	5
Composting toilet	6
Hanging toilet/latrine	7
Latrine without pit	8
No latrine/ open defecation/bush/field	9

Other (Specify)	99	

NOTE: Skip to W2.9 for code "9".

W2.2 Do you share the toilet with other Households?

Yes	1	
No	2	**Skip to W2.4**

W2.3 How many households use this toilet facility?

	Record in Persons

W2.4 How far is the latrine from the nearest water source?

	Record in Feet

W2.5 Do you own that toilet?

Yes	1	
No	2	**Skip to W2.9**

Ask only for codes 1/2/3/4/5/6 at W2.1

W2.6 What do you usually do when your septic tank/pit is full? **SA**

Seal off current pit and dig another pit	1
Order vehicle tanker and pump out the faeces	2
Let out the faeces during the flood so that septic tank never gets full	3
Run out of space so former pit has to be dug and used again	4
Put a lot of salt into the pit	5
Pour acid into the pit	6
Other (Specify)	99

W2.7 How often do you deal with the situation of your septic tank/pit getting full? **SA**

Regularly (whenever it is full)	1
Once a year	2
Once in every two years	3
Once in every three years	4
Once in every four – five years	5
Have dug a very deep hole. Do not need to empty it	6
Never	98

W2.8 What are the problems with your latrine? **MA**

Not enough water to wash	1
Had flies and mosquitoes	2
Bad smell	3
Flooding in the rainy season	4
Difficult for children to use	5
The toilet floor is not strong. It is dangerous	6
Difficult to use in the rainy season (no roof)	7
It can partly be seen from outside	8
Difficult to access the latrine during wet season	9
No problem **(SA)**	98
Other (Specify)	99

ASK ONLY CODE "2" AT W2.5.

W2.9 What is the main reason for not building and utilizing a latrine? **SA**

No space to build it	1
Can't dig the pit (swamp/daily tide)	2
Can't dig the pit (hardness of earth	3
Neighbours do not approve	4
Can't afford to build one	5
Not customary	6
No one urges me (Health/authority)	7
No one urges me (family/friends)	8
Do not know the consequences	98
Other (Specify)	99

ASK ONLY FOR THE HOUSEHOLD WITH CHILDREN UNDER 5.

W2.10 Now, I would like to ask you about disposal of feces of children under 5 years of age. Where are the feces disposed? **MA**

Into the surface latrine	1
Into the sewer system	2
In the pit latrine	3
In the compound	4
Bury	5
Into the river / stream	6
Outside the compound	7
Other (Specify)	99

ASK ALL

W2.11 When do you wash your hands? **MA**

After defecation	1
Before preparing meals	2
Before feeding a child	3
Before eating	4
After eating	5
After cleaning baby's bottom	6
After work	7
After handling animals	8
Other (Specify)	99

NOTE FOR INTERVIEWER: W2.12 to W2.14 are for your observation only. Please observe and note down the findings.

W2.12 Please show me where members of your household most often wash their hands.

Observed	1	
Not observed (not in dwelling/ yard/ plot)	2	**Skip to next section**
Refused permission to see	3	

W2.13 Check water availability.

Water available	1
Water not available	2

W2.14 Check availability of soap / detergent or other cleansing agent. **SA**

Soap present (bar/liquid/powder/paste)	1
Ash/mud/sand	2
None	99

STRENGTHENED SOCIAL AND COMMUNITY INSTITUTIONS FOR DEVELOPMENT

CI1 Are you aware of any of the following community-based groups operating in the village?

Village health development fund	1
Village development committee	2
Income generation groups	3
Women's savings groups	4
Mother's learning groups	5
Village farmers groups	6
Agricultural extension networks	7
Livestock extension networks	8
None of above	99

Note: Although the respondent does not aware of any groups, the following questions will be asked in his/her opinion.

CI2 Do you believe that such community-based groups deliver a valuable service in your community?

Yes	1
No	0
Don't know	98

CI3 What do you believe are the valuable contributions that such groups make to the community?

MA, UNAIDED

Delivering services that are not provided by the government	1
Helping to implement specific projects to meet the needs of the community	2
Representing the voice of the people in the community	3
Helping community members work together	4
Provide the opportunity to build skills and knowledge of community members	5
Health and hygiene has improved	6
Income or livelihoods have improved	7
Community water infrastructure improved	8
We communicate/share more with other communities	9
Other (Specify)	99

CI4 Do you personally take part in any of the following community-based groups?

Village health development fund	1
Village development committee	2
Income generation groups	3
Women's savings groups	4
Mother's learning groups	5
Village farmers groups	6
Agricultural extension networks	7
Livestock extension networks	8

None of above	99

CI5 Have you ever made an enquiry or raised a formal complaint about the public services, project activities, infrastructure or anything else in your village?

Yes	1	
No	0	**CLOSE INTERVIEW**

CI6 Who did you complain about the most recent issue to? **UNAIDED, MA**

Village head	1
Village elders	2
Other government officials (ie Midwives)	3
Village development committee	4
(List sub-committees/groups from C1)	5
Township authorities	6
Shae Thot staff	7
Within (mothers, savings, other group they belong to) group	8
To friends or family	9
Other (Specify)	99

SHOWCARD

CI7 How well do you feel that your complaint was dealt with?

My issue was fully and very satisfactorily dealt with									***There was no follow up or resolution on my issue***
1	2	3	4	5	6	7	8	9	10

SHAE THOT PROJECT AWARENESS AND SERVICES

S1. Have you heard of the Shae Thot Project?

Yes	1	
No	0	**CLOSE INTERVIEW**

S2 What activities are you aware of that have been implemented in your community?

Mobile clinics	1
Medical advice / support from volunteer health workers	2
Credit provision from the Village Health Development Fund Loans	3
Service / advice from mobile clinics	4
Credit provision through microfinance institute (WORTH)	5
Credit provision through savings group	6

Micro-enterprise training	7
Training on farming techniques	8
Training on irrigation	9
Training on livestock management	10
Training on sanitation and hygiene practices	11
Training on building water and sanitation solutions / infrastructure e.g. water filters, wells	12
Infrastructure grants for the community	13
Establishing of Village Development Committees	14
other (please specify)	99

THANK YOU AND CLOSE THE INTERVIEW

Annex 8: Supplementary data tables

	Treatment						Comparison						Difference in Difference
	Baseline	n	Midterm	n	Difference	p	Baseline	n	Midterm	n	Difference	p	
% of pregnancies with 4 ANC visits	21.2%	264	35.2%	213	14.0%	0	24.1%	79	51.9%	79	27.8%	0.000	-13.8%
% of deliveries with skilled birth attendants	42.3%	291	75.5%	298	33.2%	0	29.8%	84	73.3%	77	43.5%	0.000	-10.3%
% of deliveries using clean delivery kits	51.7%	230	82.2%	169	30.5%		53.8%	65	67.8%	59	14.0%	0.080	16.5%
% of newborns receiving neonatal checks from skilled health provider within 2 days	64.3%	263	76.2%	298	11.9%	0.001	76.0%	75	78.1%	105	2.1%	0.438	9.8%
Average number of food groups consumed	4.73	564	5.93	621	1.2	0	4.8	220	6.15	200	1.35	0.000	-0.15
% of children under six months exclusively breastfed	70.5%	285	66.7%	78	-3.8%	0.3	73.5%	83	71.9%	32	-1.6%	0.517	-2.2%
% of children with diarrhea treated with ORS and Zinc	2.4%	41	11.8%	51	9.4%	0.098	0.0%	16	0.0%	16	0.0%	*SS too small	9.4%
% of ARI cases that received care from a skilled health provider	70.8%	24	72.3%	65	1.5%	0.544	100.0%	5	90.9%	11	-9.1%	0.687	10.6%
% of women able to name 3 methods of modern contraception	28.5%	340	41.1%	1844	12.6%	0	19.8%	460	34.6%	708	14.8%	0.000	-2.2%
% of women able to name 3 pregnancy danger signs	7.5%	1865	26.5%	2200	19.0%	0	4.1%	735	72.5%	860	68.4%	0.000	-49.4%
% of women able to name 3 delivery danger signs	2.6%	1865	19.3%	2200	16.7%	0	1.4%	735	13.4%	860	12.0%	0.000	4.7%
% of women able to name 3 postnatal danger signs	2.6%	1865	15.1%	2200	12.5%	0	1.4%	7.35	8.4%	860	7.0%	0.000	5.5%
% of women able to name 3 neonatal danger signs	13.7%	1865	29.9%	2200	16.2%	0	7.6%	735	22.0%	860	14.4%	0.000	1.8%

	Treatment						Comparison						Difference in Difference
	Baseline	n	Midterm	n	Difference	p	Baseline	n	Midterm	n	Difference	p	
% of households with sanitary latrines	62.9%	1580	71.6%	1580	8.7%	0.000	63.7%	2020	75.1%	1020	11.4%	0.000	-2.7%
% of households with access to safe water sources (drinking water)	65.0%	440	89.3%	440	24.3%	0.000	56.9%	720	93.9%	720	37.0%	0.000	-12.7%
% of households with access to safe water sources (domestic water)	56.4%	440	76.4%	440	20.0%	0.000	58.6%	720	92.5%	720	33.9%	0.000	-13.9%

% of households with handwashing stations with soap	75.2%	1244	92.6%	1276	17.4%	0.000	75.5%	713	94.3%	717	18.8%	0.000	-1.4%

	Treatment						Comparison						Difference in Difference
	Baseline	n	Midterm	n	Difference	p	Baseline	n	Midterm	n	Difference	p	
Average monthly household income (MMK)	85,487	1025	101,374	937	15,886	0.000	89,732	795	102,669	754	12,936	0.000	2,949
% people who think their financial situation is good or somewhat good compared to the previous year	15.40%	1060	27.70%	1060	12.30%	0.000	15%	840	29.40%	840	14.40%	0.000	-2.1%
% people who think their employment opportunities are good or somewhat good compared to the previous year	14.20%	1060	25.20%	309	11.00%	0.000	11%	840	27.80%	230	16.80%	0.000	-5.8%
% of farmers using organic and natural fertilizer	30.00%		70.90%		40.90%	0.000	27%		78.40%		51.40%	0.000	-10.5%
% of farmers using chemical fertilizer	21.10%	237	67.80%	199	46.70%	0.000	16%	196	71.90%	167	55.90%	0.000	-9.2%
% of farmers using mixed organic and chemical fertilizers	62.90%		34.70%		-28.20%	0.000	67%		24.60%		-42.40%	0.000	-14.2%
% respondents saying food was scarce in each month													
January	9.30%		1.00%		-8.30%	0.000	3.10%		1.40%		-1.70%	0.102	-6.6%
February	11.20%		1.70%		-9.50%	0.000	5.30%		0.30%		-5.00%	0.000	-4.5%
March	25.50%		11.40%		-14.10%	0.000	14.20%		2.50%		-11.70%	0.000	-2.4%
April	30.50%		11.20%		-19.30%	0.000	18.10%		4.20%		-13.90%	0.000	-5.4%
May	28.80%	420	4.50%	420	-24.30%	0.000	18.30%	360	2.50%	360	-15.80%	0.000	-8.5%
June	28.60%		3.30%		-25.30%	0.000	16.90%		2.20%		-14.70%	0.000	-10.6%
July	14.00%		33.10%		19.10%	0.000	11.40%		24.20%		12.80%	0.000	6.3%
August	18.60%		31.00%		12.40%	0.000	12.80%		22.50%		9.70%	0.000	2.7%
September	4.50%		3.80%		-0.70%	0.365	3.60%		3.30%		-0.30%	0.500	-0.4%

October	11.20%		4.00%		-7.20%	0.000	5.00%		3.10%		-1.90%	0.128	-5.3%
November	8.80%		4.50%		-4.30%	0.009	2.80%		1.70%		-1.10%	0.225	-3.2%
December	6.70%		1.70%		-5.00%	0.000	1.90%		1.40%		-0.50%	0.386	-4.5%
% of respondents saying their household food security was good or somewhat good compared to the previous year	9.30%	1060	22.70%	1060	13.40%	0.000	8.70%	840	25.50%	840	16.80%	0.000	-3.4%

Annex 9: World Bank Development Indicators for Myanmar, 2011-2013

Series Name	2011 [YR2011]	2012 [YR2012]	2013 [YR2013]
Adolescent fertility rate (births per 1,000 women ages 15-19)	12.8906	12.058	11.3314
Antiretroviral therapy coverage (% of people living with HIV)	20	27	35
Borrowers from commercial banks (per 1,000 adults)	0.765215699	0.798102342	1.314894266
Export value index (2000 = 100)	570.189548	547.8999117	635.7357561
Goods exports (BoP, current US$)	$ 7,699,035,580.07	$ 8,220,307,242.73	$ 9,022,394,473.08
Goods imports (BoP, current US$)	$ 7,490,988,035.66	$ 7,628,622,808.38	$ 9,462,248,987.11
Health expenditure per capita, PPP (constant 2011 international $)	31.90092407	34.81409563	36.66269851
Health expenditure, public (% of GDP)	0.291504696	0.426863354	0.482092027
Health expenditure, public (% of total health expenditure)	15.92891195	23.90242302	27.2346972
Internet users (per 100 people)	0.98	1.0691	1.2
Mobile cellular subscriptions (per 100 people)	2.375550859	7.064027247	12.82858801
Mortality rate, adult, female (per 1,000 female adults)	184.559	182.576	180.7028
Mortality rate, infant (per 1,000 live births)	42.4	41	39.8
Mortality rate, under-5 (per 1,000 live births)	54.2	52.2	50.5