Rakhine Rural Household Livelihood Security Project (RRHLSP) (2005-2011)

Final Evaluation Report

Prepared for CARE Myanmar by

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Abbreviations

ACD	Assistant Country Director
ACF	Action Contre La Faim
AEDP	Agro-Enterprise Development Process
AGM	Annual General Meeting
APC	Assistant Program Coordinator
CD	Country Director
CF	Community Forestry
CFI	Community Forestry Instructions
CFMC	Community Forestry Management Committee
CFUG	Community Forestry User Group
CHC	Community Health Committee
CHF	Community Health Fund
DHO	District Health Office
DMO	District Medical Officer
DoH	Department of Health
DPDC	District Peace and Development Committee
DRR	Disaster Risk Reduction
EART	Epidemic Assessment and Response Team
EOP	End of Project
FAO	Food and Agriculture Organisation
FD	Forestry Department
FFW	Food for Work
FFS	Farmer Field School
FGD	Focus Group Discussion
FM	Finance Manager
FOC	Field Office Coordinator
HE	Health Education
IGA	Income Generating Activities
INGO	International Non Government Organisation
KII	Key Informant Interview
LRD	Land Records Department
MAS	Myanmar Agriculture Service
MC	Management Committee
MFF	Myanmar Frontier Forces (Myanmar abbreviation: *NaSaKha*)
MFP	Minor Forest Product
MoAI	Ministry of Agriculture and Irrigation
MoF	Ministry of Forestry
MoH	Ministry of Health
MRCS	Myanmar Red Cross Society
MSN	Mangrove Service Network
MTR	Mid-Term Review
M&E	Monitoring & Evaluation
NRS	Northern Rakhine State
ORS	Oral Rehydration Solution
PC	Program Coordinator
PDD	Project Design Document
PDF	Production Development Fund
PE	Peer Educator
PM	Project Manager
PO	Program Officer
RHC	Rural Health Centre
RHLSP	Rakhine Household Livelihood Security Project
RHPC	Rural Health Promotion Centre
RRHLSP	Rakhine Rural Household Livelihood Security Project
RLC	Rural Livelihoods Coordinator
SC	(Rural Health) Sub-Centre
SMIG	Savings Mobilisation and Income Generation
SPDC	State Peace and Development Council
SPO	Senior Program Officer
TOR	Terms of Reference
TMO	Township Medical Officer

TPDC	Township Peace and Development Committee
UNDP	United Nations Development Programme
UNHCR	United Nations High Commissioner for Refugees
VDG	Village Development Grant
VPDC	Village Peace and Development Committee
VSLA	Village Savings and Loan Associations
VT	Village Tract
WASH	Water, Sanitation and Hygiene
WFP	World Food Programme

Executive Summary

Background

CARE has been engaged in Northern Rakhine State (NRS) since 1996, when it provided rehabilitative assistance to Rohingya refugees and host communities in the two townships of Maungdaw and Buthidaung. Since then, CARE's programming in NRS has continued a progressive transition from relief and rehabilitation to a longer-term development approach, as represented by the AusAID-funded Rakhine Household Livelihood Security Project (RHLSP; September 2001 – April 2004) and the Rakhine Rural Household Livelihood Security Project (RRHLSP; 2005-2011). RRHLSP is the subject of this evaluation.

An international consultant with prior experience of working in various parts of Myanmar (including NRS) was assigned overall responsibility for the conduct of the evaluation, which aimed to assess the performance of the project against the five standard OECD Development Assistance Committee (DAC) criteria for evaluating development assistance. The consultant had previously been hired by CARE Myanmar to conduct a detailed review of the project in January and February 2010, a task that involved him spending two weeks in NRS conducting a two-day review workshop with project staff, Key Informant Interviews (KIIs) with selected project staff as well as government and international agency representatives, and Focus Group Discussions (FGDs) with men and women in purposively sampled villages. Insights from this review were drawn upon to inform the Final Evaluation, in addition to the findings of a quantitative survey, KIIs and FGDs conducted in November 2011 by a national consultancy firm specifically for the Final Evaluation.

Major conclusions

RRHLSP succeeded in meeting its objectives under Component 1, which was the most successful component of the project. The community forestry activities are, without exaggeration, unique in the NRS context and ground-breaking in the context of Myanmar as a whole. 3,200 landless or land-poor largely Rohingya households were supported to establish and manage community forestry (CF) plots, and CARE facilitated the issuance of land-use certificates (valid for 30 years, and then potentially renewable) to plot holders. This is a major achievement, both in terms of the livelihood benefits and in terms of enabling Rohingya households to advance their claim to citizen's rights. Community stabilisation and protection benefits are therefore also likely to flow from this component.

The CF plots, despite still being fairly young, already constitute significant assets for households; 62% of households with plots of four years of age or older reported 'very substantial' or 'substantial' increases in their household's assets due to CF activities. A significant income stream is already flowing from these assets,[1] and this will grow considerably in future years. Environmental benefits such as increased stream flows during dry spells have also already been experienced. Benefits from this component will be sustainable; over 95% of the plots established remained in operation at the time of the Final Evaluation and plots were clearly highly valued by their holders. However, the quality of plot management was variable, with around 70% of the CF Management Committees (CFMCs) still lacking the capacity to manage their plots in full accordance with the Community Forestry Instructions (CFI).

The CF component is already having positive impacts in non-targeted communities and households in NRS that have established their own CF plots after seeing the success of project-supported plots. CARE's ongoing advocacy with the Ministry of Forestry (MoF) at national level holds the potential for broader institutional impact, resulting in

[1] The mean estimate of the value of the trees grown on CF plots of over four years of age was Kyat 923,343, and the mean household income from CF plots over the last 12 months was Kyat 84,706 (which equates to around 11% of the average annual household income of Kyat 782,705 reported in the Final Evaluation survey). 1 AUD equals approximately Kyat 825.

the replication of – or at least learning from – CARE's CF approach in other areas of the country. CARE itself is already applying lessons learned from NRS CF activities in other CARE projects around the country, with target locations including Southern Chin State, Kayah State and the Ayeyarwaddy Delta.

Hundreds of households benefited from crop and technology trials under the Production Development Funds (PDFs), but it is likely that these benefits were not sustained beyond the end of the project for a high proportion of households, as the requisite inputs supplied by CARE were too expensive to be purchased by households themselves. The consultant's opinion is that the PDF suffered from not having the status of a full Component Objective in the project, being represented merely in two outputs; consequently, it appears to have been somewhat under-funded. An estimated 20% - 30% of the participants in vocational training for income generation have experienced sustainable economic benefits, with other participants being unable to generate income consistently due to a lack of market opportunities.

The Savings Mobilisation and Income Generation (SMIG) groups provided access to financial services for over 6,700 women, 80% of whom were Rohingya and 90% of whom were landless or land-poor. However, the actual financial performance of the majority of the SMIG groups was poor, and the project therefore did not succeed in achieving its objectives under Component 2. Reasons for the poor functioning of the SMIG groups included: the fact that the financial model used was not suitable for most women in a context where income-generating opportunities remain very constrained and many households' main borrowing requirement is for consumption-smoothing purposes rather than microenterprise; a lack of income-generating opportunities, and a lack of specialist technical support. There is evidence to suggest that pressure to address the problem of under-spending that affected the project (particularly in the early stages) may have been the reason for the provision of CARE grants even to poorly performing groups, which undermined the intended incentive effect.

Although group financial performance was generally poor, it should be noted that in the minority of groups that functioned satisfactorily, the benefits for group members could be significant. The groups also brought significant and sustainable benefits by strengthening social cohesion as well as raising the status of women within their households and communities. Involvement in SMIG or other project groups has had an empowering effect on many women, who are now able to work outside their home, travel outside their community and/or deal with government officials and traders.

RRHLSP partially succeeded in achieving its objectives under Component 3. Quantitative targets regarding the establishment of Community Health Committees (CHCs) were met, but only 31% met basic performance criteria. The model employed to try to increase communities' access to health services proved to be unfeasible in the majority of targeted areas due to the failure of most Community Health Funds (CHFs) to generate sufficient income and the fact that government health staff had more lucrative income-generating options available to them. An underlying problem was that other INGOs began to provide free services in the same (or nearby) areas as CARE, and villagers understandably preferred to use these services, rather than pay for drugs at a CARE clinic. Based on the recommendations of the 2010 review, the CHCs and CHFs were closed down in May 2010.

Community health education, delivered by trained male and female Peer Educators (PEs), was much more successful. Health education, accompanied by complementary improvements in latrine ownership and drinking water sources, resulted in documented reductions in the incidence of serious diseases (e.g. a 28% reduction in the incidence of malaria and a 16% reduction in the incidence of diarrhoea). It can be argued that these improvements in public health represent sustainable benefits for the entire population of the 16 targeted village tracts (VTs) (11,779 persons). However, in nine of these VTs at least one other international organisation was working on similar health

issues, therefore it would be incorrect to attribute all the health improvements to CARE's activities alone.

The project partially succeeded in meeting its objectives under Component 4, which was added in Year 6. Disaster Risk Reduction (DRR) trainings were conducted at the village level for 76 trainees from 19 village tracts, and an advocacy workshop was conducted with local NGO Mangrove Service Network (MSN) for district level authorities, the Forestry Department (FD) and UN agencies. Other tangible benefits for communities were not realised as DRR activities did not progress beyond cross-visits and experience sharing.

In response to severe flooding in NRS in June 2010, Component Objective 5 was added to the project to assist 30,000 flood-affected persons. Budget approval for this emergency component reportedly took some time, such that the emergency phase had ended by the time the budget was approved. Activities therefore focused on rehabilitation and supporting affected households' transition back to their normal livelihood activities.

Recommendations

Community Forestry

- In any future phase, the project should continue to provide support to most of the existing CFMCs, as well as introduce CF operations in new areas.
- Priorities for CFMC capacity building should include: knowledge and understanding of the CFI; CF management techniques, including new techniques that will be required as plots mature (e.g. timber harvesting and marketing strategies to maximise profits); maintaining a CFMC fund.
- CARE should use the project's achievements to inform the activities of projects in other parts of the country, to magnify the overall impact. Project achievements should also support continued advocacy efforts with MoF and other stakeholders.
- An environmental education output should be added to the next phase.

PDFs

In any future phase, the project should consider the following:

- The production of off-season vegetables (such as rainy season tomatoes), as well as other high-value vegetables, should be piloted, using successful local farmers as trainers/advisors.
- New vocational training activities, including pump/motorbike maintenance, Professional Pest Applicator training, Minor Forest Product (MFP) processing and the production of fuel-efficient stoves (following a research and design process to identify designs that are locally appropriate).
- Continue with efforts with build up local stocks of good quality seed.
- Pilot the cultivation of betel leaf in ways that minimise the incidence of disease.
- Use an Agro-Enterprise Development Process (AEDP) (with which CARE already has experience) to investigate the market potential of possible products and devise ways to promote those that look promising.

SMIG

- Having closed the SMIG groups, an alternative model (e.g. an Accumulating Savings and Credit Association (ASCA) model, such as the Village Savings and Loan Associations (VSLA) being implemented in Southern Chin by CARE) should be considered, as there is still plenty of interest amongst women in a form of financial service that actually meets their needs. CARE's experience in Bangladesh should also be reviewed for relevant lessons. The number of new groups to be established needs to be selected carefully, so as to ensure that sufficient staff resources can be devoted to supporting the groups.

- In any future phase, program management should ensure that project staff receives adequate specialist technical support with regard to the microfinance component.

Health

- The emphasis in any future phase should be on community health education, delivered through community PEs as at present but with a greater emphasis on the promotion of health-seeking behaviour.
- Training and Information, Education and Communication (IEC) materials should be updated to cover in more depth issues of concern to the communities (including HIV/AIDS, H1N1 and H5N1), and efforts should be made to make training sessions more interesting and interactive. Audio-visual materials (e.g. DVDs) would increase effectiveness.
- PEs should be trained to more effectively facilitate the referral of patients to the most appropriate service provider, be it an INGO or a government facility.
- Nutrition training was seen as rather impractical by some participants, as it reportedly did not prioritise foods that are readily available locally. CARE should modify its approach to focus on how locally available products can be used to improve nutritional status, and link such efforts to agriculture and Natural Resource Management (NRM) activities. CARE is already collaborating in Laos with Welthungerhilfe (WHH, formerly GAA) in implementing a new approach to improving nutrition known as LANN (Linking Agriculture, Natural Resources and Nutrition), and WHH is due to start implementing LANN in Northern Shan State in Myanmar in 2012. CARE should consider collaborating on LANN with WHH in Myanmar also.

DRR

- To increase impact with regard to DRR, CARE needs to focus more on this component in any future phase, providing additional support and tangible DRR activities at community level that engage a significant proportion of the population. DRR activities should also be much more closely integrated with other relevant project components.

Project / program management

- Monitoring of activity implementation was unsatisfactory, which contributed to a lack of responsiveness and adaptability on the part of management with regard to a number of serious problems (including SMIG group and CHF failure). Monitoring systems need to be improved, and mechanisms for downward accountability (between project and target populations) need to be introduced.
- In any future phase, it is suggested that an adapted version of Outcome Mapping be piloted in order to capture outcomes in relation to one or two of the project's key partners.
- The absorption capacity of NRS with regard to project expenditure is limited, and putting pressure on a project to spend faster can have serious negative effects (as was the case with the aforementioned undermining of capital incentives for SMIG groups). This should be borne in mind when budgeting for future phases.

1. Background

1.1 Introduction

Situated on the western coast of Myanmar and bordering Bangladesh, Rakhine State is separated from the rest of the country by the Rakhine Yoma mountain range. This relative geographical isolation has contributed to the strong influence of Bengali culture and language on the population, particularly the Muslim Rohingya. The total population of Northern Rakhine State (NRS) was estimated in 2006 to be around 900,000,[2] of whom around 17% were Buddhist Rakhine.[3] 80% of the population were Sunni Muslims, including 234,000 persons who had taken refuge in Bangladesh in 1991-1992 in response to repression by the Myanmar authorities and then gradually returned to NRS. Many of the area's current problems can be put down to its geographical position, on the frontiers of modern India, Bangladesh and Myanmar. At the meeting point between Buddhist and Islamic civilisations, this tri-border region has always been ethnically mixed. Local religious and ethnic tensions, however, began to escalate in the 1920s when large numbers of migrants, especially Muslim Bengalis, crossed into Rakhine from colonial India and settled alongside Muslim communities that had existed in the area for many generations.[4]

CARE has been engaged in NRS since 1996, when it provided rehabilitative assistance to Rohingya refugees and host communities in the two townships of Maungdaw and Buthidaung[5] as an implementing partner of UNHCR. The rehabilitation program initiated community forestry and home garden development in 1997, and in 1999 income generation, water supply and women's health education components were added. Since then, CARE's programming in NRS has continued a progressive transition from relief and rehabilitation to a longer-term development approach, as represented by the AusAID-funded Rakhine Household Livelihood Security Project (RHLSP; September 2001 – April 2004) and the Rakhine Rural Household Livelihood Security Project (RRHLSP; 2005-2011) that is the subject of this evaluation.

1.2 Policy setting

Ever since the British started conducting ethnographically dubious censuses[6] in the early 20th Century, the Rohingya have been classified as itinerant residents of Bengali origin who are not indigenous to Myanmar. The 1982 Citizenship Law excludes them from citizenship, as it stipulates that only members of Myanmar's 135 'national races' or those who can prove residence prior to 1826 can be citizens. Historical evidence suggests that Muslims have been present in the northern Rakhine area since well before this date, but formally proving residence is virtually impossible. Since the 1970s, Myanmar governments have treated most of the Rohingya as illegal immigrants and have periodically engaged in crackdowns (most recently in 1991-1992) that have driven tens of thousands of them across the border into Bangladesh. Muslims in Rakhine experience 'the most comprehensive forms of government oppression short of

[2] Van de Velde, Patrick and Elisabeth Pirnay (2006) *Strategic Assessment and Evaluation of Assistance to Northern Rakhine State in Myanmar*, Brussels: EuropeAid. Rigorous up-to-date assessments of the size of the population in Myanmar are unavailable.

[3] There are also a number of much smaller ethnic groups in NRS, including Kamein, Kwe Myi, Dainet, Maramagyi, Mro and Thet.

[4] Smith, Martin (1994) *Ethnic Groups in Burma: Development, Democracy and Human Rights*, London: Anti-Slavery International.

[5] NRS is comprised of four Townships: Sittwe (the state capital), Maungdaw, Buthidaung and Rathedaung. Maungdaw and Buthidaung Townships together comprise Maungdaw District.

[6] Taylor, Robert (1987) *The State in Burma*, Hurst.

systematic physical violence'[7], encompassing the denial of civil, political, economic, social and cultural rights. Unsurprisingly, many Rohingya work overseas (often in Bangladesh or the Gulf) and despite tightened border controls, UNCHR estimates that illegal emigration from NRS is rising. Accurate statistics are unavailable, but UNHCR estimated in 2006 that some 10,000 Rohingya were working in Saudi Arabia alone. In recent years, desperation has driven some to flee by boat in an attempt to reach Thailand, Malaysia, Indonesia or India, frequently with tragic consequences.

The Myanmar Frontier Forces (MFF, often known by their Myanmar acronym *NaSaKha*) are the ultimate authority in NRS. Rohingya residents are subject to a variety of discriminatory practices, which vary from area to area and from time to time. These practices include the requirement that Rohingya must obtain (and invariably pay for) a permit before performing even very mundane actions, such as travelling outside of their village tract or getting married. Rohingya community land is frequently confiscated, often for the construction of military cantonments or 'new model villages' that house citizens from other parts of Myanmar who have been forcibly resettled because of illegal activities (a practice that contributes to social tensions in NRS). Conversely, Rohingya households often find it hard to get permission to construct even their own modest house. They may also be compelled to provide unpaid labour and to pay arbitrary taxes. The economy of the area is further distorted by the continuing presence of the 'agent system' that, although in theory dismantled (according to some informants), still persists. The system entails the granting to wealthy local individuals by the local commander the sole right to trade in certain commodities in defined areas, in return for which the commander and his subordinates receive covert payments. The ultimate impacts on farmers include higher prices for inputs and lower prices for products.

At the community level, leaders often hold their formal or informal positions as a result of religious status, lineage, wealth or a combination of these. Land ownership is often concentrated in the hands of such village elites, with landlessness being a major contributor to poverty. Gender relations amongst the Rohingya have traditionally been highly inequitable, with women being confined largely to reproductive roles in a context of severely constrained personal mobility and little decision-making power.

The radical reforms initiated in the past year by the new Myanmar government have included significant efforts on the part of President Thein Sein to work towards agreements with the wide range of ethnic minority groups with which the State has been in conflict for over 60 years.[8] It has also been reported that the Centre for Humanitarian Dialogue is involved in discussions with the governments of both Bangladesh and Myanmar concerning the Rohingya, with a view to improving the situation of the latter. In addition, despite the continued overbearing influence of the military in Myanmar, there are hopes that the new State / Division and Regional assemblies may make local decision-making more participatory and responsive to local needs, especially in the ethnic States such as Rakhine.[9] How these developments will play out in NRS are as yet unclear.

As regards changes in the operating environment for international organisations (IOs) in NRS since the new government took office in March 2011, IO representatives expressed mixed views in Key Informant Interviews (KIIs) undertaken during this evaluation. Some representatives felt that the environment had become easier, while others felt the opposite (see Section 3.3).

[7] Callahan, Mary P. (2007) *Political Authority in Burma's Ethnic Minority States: Devolution, Occupation and Coexistence*, Policy Studies 31 (Southeast Asia), Washington: East-West Centre.

[8] International Crisis Group (2011) *Myanmar: A New Peace Initiative*, Asia Report No. 214 (30 November).

[9] Pederson, Morten (2010) 'The Politics of Burma's "Democratic" Transition', *Critical Asian Studies*, 43 (1), 49-68.

1.3 Formulation and design

Project formulation and design processes were facilitated by an external consultant, who also led the document development process. The CARE RHLSP team then present in NRS played a key role, drawing on experience gained over the preceding seven years to identify successful interventions deemed worthy of scale-up. Consultations with all the main stakeholder groups were held, and a mapping exercise conducted in order to minimise overlap with other organisations' interventions. The RRHLSP project design document (PDD; p. 7) states that 'considerable emphasis was placed on the development of appropriate and practical indicators at component and output levels', but as discussed in Sections 3 and 4 below, a number of the indicators are problematic. The PDD (p. 8) also states that a 'detailed Community Forestry asset valuation exercise was undertaken with 100 current CFUG [Community Forest User Group] participants' in order to provide a baseline for future monitoring and evaluation; however, the evaluation consultant has not been able to locate this data.

Regarding the quality of the logframe, it should be noted that a number of indicators from Output level are repeated at Component Objective level (see Appendix 1), which suggests that the logical hierarchy is not as clearly defined as it might be. The risk analysis in the design was comprehensive, foreseeing a number of problems that did in fact materialise and are discussed in later sections of this report (including the halt in issuing CF certificates, the fact that the proposed 360° evaluations of management committees might be too time-consuming and the possibility that the Community Health Funds (CHFs) might not be viable due to limited investment opportunities).

1.4 Objectives and scope at design

The scope of RRHLSP was broad at design and became even broader with the addition of two further Component Objectives in the latter stages of implementation. The Project Goal was: *Substantially enhance household livelihood security (assets, income & health) of poor, predominantly Rohingya households, in Northern Rakhine State* (see logframe in Appendix 1). There was no Purpose/Outcome, with the next level in the logical hierarchy consisting at design of three Component Objectives:

Component Objective 1 (*Facilitate 3,000 landless, predominantly Rohingya households to sustainably increase household assets and incomes through community forestry (CF)*) aimed to continue CARE's successful efforts in earlier phases to support households to register CF plots under the Community Forestry Instructions (CFI). In addition to building CF Management Committee (CFMC) capacity and strengthening relationships between CFMCs and the Forestry Department (FD), this component aimed to utilise the CFMCs to manage a wider range of development initiatives supported by a Production Development Fund (PDF). It was intended that the PDF would be used to fund trials – and, if successful, to encourage the dissemination – of new agricultural technologies, with priority being given to technologies suited to landless or land-poor households.[10] It was intended that some funds from the PDF would be disbursed on a grant basis, while for activities involving relatively high investment (and returns) per household, funds would be disbursed as loans that would be paid back into a fund managed by the CFMC.

Component Objective 2 (*Facilitate 6,000 predominantly Rohingya women to access high quality and sustainable financial services*) aimed to support women to establish and manage savings and loan groups (known as Savings Mobilisation and Income Generation or SMIG groups), and to build women's capacity (though appropriate training) to generate income through activities such as home gardening, snack-making

[10] Defined as possessing less than 2 kani (0.8 acres) of land.

and tailoring. The aforementioned PDF was also used to fund trials of innovative technologies related to income generation.

Component Objective 3 (*Targeted village tracts receive improved access to health services*) aimed to set up Community Health Funds (CHFs), which were to be managed by Community Health Committees (CHCs) and, through providing loans, generate a monthly income that would enable the community to pay an incentive to government health staff to visit the village regularly. Revolving drug funds were also established to sell basic medicines, the overall aim being to enable community members to access curative services in their communities. In addition, community health education was delivered by trained male and female community peer educators with the assistance of tailored IEC materials.

For Year 6 of the project, an additional Component Objective was added as part of a costed extension activity approved by AusAID on 10 June 2009. Component Objective 4 (*Build disaster risk reduction (DRR) capacity of 20 targeted villages*) was intended to achieve its aims through the provision of training on DRR to representatives of 20 villages as well as through the implementation of activities at the village level.

Finally, in response to severe flooding in NRS in June 2010, Component Objective 5 was added (*Address immediate and transition/rehabilitation needs of 30,000 flood-affected persons in 62 villages in Buthidaung Township, and 72 villages across 16 village tracts in Maungdaw township*). This Component involved WASH initiatives, the provision of emergency food and shelter, and the supply of inputs and tools to facilitate the resumption of household food production.

1.5 Implementation arrangements

Project implementation was overseen on a day-to-day basis by a project team composed of national staff based in Maungdaw and Buthidaung. Backstopping and additional technical support was provided by CARE's Rural Livelihoods Coordinator, Health Coordinator and other senior national and international staff based in Yangon, with CARE Australia staff making regular monitoring visits from Canberra. Occasional short-term national and international consultancy inputs were utilised to provide specialist advice and to conduct the Mid-Term Review (MTR; 2007), an additional review in 2010 and the Final Evaluation. The project was implemented under the auspices of CARE Myanmar's national Memorandum of Understanding (MoU) with the Ministry of Health (MoH), and collaborated with other relevant line agencies including the Ministry of Agriculture and Irrigation (MoAI) and the Ministry of Forestry (MoF). The project liaised as necessary with the relevant government agencies in NRS, including Township, District and Village Peace and Development Committees (dissolved upon the establishment of the new government) as well as the Myanmar Frontier Forces.

1.6 Evaluation methods

An international consultant with prior experience of working in various parts of Myanmar (including NRS) was assigned overall responsibility for the conduct of the evaluation (see Appendix 2 for the consultant's TOR), which aimed to assess the performance of the project against the five standard OECD Development Assistance Committee (DAC) criteria for evaluating development assistance: relevance, efficiency, effectiveness, impact and sustainability. The consultant had previously been hired by CARE Myanmar to conduct a detailed review of the project in January and February 2010, a task that involved him spending two weeks in NRS conducting a two-day review workshop with project staff, Key Informant Interviews (KIIs) with selected project staff as well as government and international agencies, and Focus Group Discussions (FGDs) with men and women in five villages (purposively sampled so as to reflect as far as possible the diversity of the target population). Insights from this review were drawn upon to inform the Final Evaluation, in addition to the findings of a quantitative

survey, KIIs and FGDs conducted in November 2011 by a national consultancy firm specifically for the Final Evaluation (see Appendix 5 for a list of key informants interviewed and Appendix 6 for a list of FGDs conducted).

The research tools for the Final Evaluation were designed by the consultant in collaboration with CARE staff. For the quantitative survey, a sampling frame consisting of 2,700 households with project CF plots of at least four years of age was used. A simple random sample of 418 households was selected for interview, resulting in a margin of error of under 5% and a 95% confidence interval (assuming a 50% response distribution). The quantitative survey was designed so as to repeat the Baseline Survey as far as possible, though the fact that there were significant weaknesses in the Baseline Survey (as discussed at relevant points in Sections 3, 4 and 5 below) meant that baseline data was not always available for comparison. In such cases, the guidelines for the KIIs and FGDs were drafted so as to try to fill the data gaps to the extent possible (see Appendices 3 and 4 for KII and FGD guidelines, respectively).

Twelve key informants were interviewed during the Final Evaluation, including project staff, village and district administrators, line agency staff at township level and staff from international agencies operating in NRS. Twenty FGDs were held in 12 villages selected so as to represent the diversity of the target population as far as possible. Eight FGDs involved women only, eight involved men only and four were mixed. Two of the FGDs (one mixed, the other men only) involved villagers who had not been involved in any project activity, to ensure that the views of non-participants were also captured. Eleven FGDs involved Rohingya only, four involved Rakhine only, three involved Dainet only, one involved both Rohingya and Rakhine, and one involved Dainet and Rohingya.

Preliminary results from the field research were discussed by the consultant with CARE Myanmar program staff in Yangon in December 2011 in order to clarify certain issues and provide program staff with an opportunity to contribute their views on the findings. A draft report was then prepared according to the format presented in AusAID's *AusGuideline 5.2: Undertaking activity evaluations*, and was submitted to CARE Myanmar and CARE Australia for comment prior to finalisation. The final version will be disseminated to AusAID, Government partners, other international organisations with a presence in NRS, project staff and local partner organisations. Feedback on the key findings will also be presented in an appropriate manner to project participants.

The fact that the consultant was unable to travel to NRS for the Final Evaluation field work due to the very lengthy period of time required to obtain the necessary permits was a constraint, as there is no substitute for personal presence in the field. However, the impacts of this were mitigated substantially by the exposure gained during the consultant's earlier review mission to NRS in 2010, as well as by careful design of the research tools. Other constraints included: some variation in the quality of the interviewers employed by the consultancy company; the fact that interviewers' limited familiarity with the project, as well as variable skill levels, meant that they generally did not ask follow-up questions during interviews; some variation in the quality of the translation of KII and FGD transcripts.

2. Relevance

2.1 Objectives

Component Objective 1 *Facilitate 3,000 landless, predominantly Rohingya households to sustainably increase household assets and incomes through community forestry (CF)*

This objective was clearly conceived and realistic, the project having achieved its target in terms of the number of households reached. However, the quantitative indicators selected to reflect household asset value and income would be challenging to measure in the best of circumstances, let alone in the economy of NRS which is highly distorted by government policies (see Section 4 for further discussion of problematic indicators). These challenges were exacerbated by weaknesses in the Baseline Survey (see Section 3 for further discussion).

Component Objective 2 *Facilitate 6,000 predominantly Rohingya women to access high quality and sustainable financial services*

This objective clearly identified women's need for financial services, but the model promoted was inappropriate and hence unrealistic, resulting in poor performance on the part of most of the SMIG groups. Poor monitoring and a lack of responsiveness meant that this problem remained unaddressed (see Section 3.4). Although the project met its target in terms of the number of women participating in SMIG groups, other targets were not met. In addition, some indicators were inappropriate or unmeasurable in the NRS context.

Component Objective 3 *Targeted village tracts receive improved access to health services*

This objective was clearly conceived and realistic, although changes in the operating environment over time meant that the project's Community Health Fund and clinic activities became less relevant over time (see Section 2.2); poor monitoring and a lack of responsiveness meant that the project did not adapt effectively to the changing context (see Section 3.4). Health education activities, however, remained highly relevant throughout the project. The related indicators were in general measurable.

Component Objective 4 *Build disaster risk reduction (DRR) capacity of 20 targeted villages*

This objective is clearly defined and highly relevant for the disaster-prone region of NRS, and progress towards it should be measurable. However, activities involved only a limited amount of training and awareness-raising over a relatively short period of time, and it is therefore unrealistic to expect that capacity levels will have been raised significantly.

Component Objective 5 *Address immediate and transition / rehabilitation needs of 30,000 flood-affected persons in 62 villages in Buthidaung Township, and 72 villages across 16 village tracts in Maungdaw township*

This objective was clearly defined and realistic, with measurable aims.

2.2 Project design

Regarding the adequacy of the project design to meet the above objectives and the related needs of the targeted populations, the Community Forestry (CF) component (Component Objective 1) clearly met its objective, addressing major needs regarding asset creation, income generation and legally recognised access to land. The Production Development Fund (PDF) and the technologies it supported were technically successful but often proved to be unsustainable, as participants could not

afford to purchase required inputs after CARE's support ceased. Similarly, participants trained in income-generating activities were generally unable to employ their skills profitably after training due to the lack of market opportunities. The design was therefore inadequate in these respects. Activities supported under the Village Development Grants (VDGs) were relevant to communities' needs concerning small infrastructure.

The design of the SMIG component (Component Objective 2) was clearly inadequate to meet its objectives, for a variety of reasons. Some of these are related to management and implementation while others are related to the model itself, which is not suitable for most women in a context where income-generating opportunities remain very constrained and many households' main borrowing requirement is for consumption-smoothing purposes (mainly food purchases[11]) rather than microenterprise. Although most of the SMIG groups were financially unsuccessful, there were significant social benefits from the groups for women (see Section 4.3).

The design of the health component (Component Objective 3) was adequate at the time of design but became less so as the project progressed, due to the inception of the operations of a number of specialist health INGOs that are providing health services for free. This undermined CARE's (ultimately more sustainable) model, which involved payment for health services and the operation of a Community Health Fund (CHF) to cover the costs of a nurse's regular community visits (see Section 4.1.3). However, the health education activities under this component remained highly relevant throughout the project.

The design of the DRR component (Component Objective 4) was adequate to meet its objectives, but the fact that the activities actually implemented under this component were relatively limited in extent means that this Component Objective has been only partially achieved. More attention was required by this component, as well as closer integration with other relevant project components (for example, small infrastructure activities supported by the VDFs and agricultural activities supported by the PDFs). The design of the emergency response component (Component Objective 5) enabled its objectives to be met.

Complementarity and coherence with other initiatives in NRS were generally satisfactory, as the project coordinated well with most other organisations and directly collaborated with some of these (e.g. WFP, FAO and the Myanmar Red Cross Society (MRCS)). There was some overlap with UNDP's microfinance activities, though this did not appear to cause widespread problems. More seriously (as noted above), a number of specialist health INGOs started offering free curative services in the same (or nearby) areas as CARE, thereby undermining the more sustainable health care model being promoted by CARE.

The project's targeting was accurate, with specified targets for the percentage of Rohingya participants being met. For any future phase, however, it is recommended that the target group be defined simply as 'vulnerable households', to be identified by a practical and reliable indicator: those households that are landless or land-poor.[12] Female-headed households that may possess land but lack the labour to work it should also be prioritised. Discussions during the 2010 review with the mixed Rohingya / Rakhine project team resulted in a strong consensus not to explicitly target Rohingya households, as the exclusive focus of many international organisations on such households while ignoring the needs of equally poor Rakhine households is felt to have exacerbated inter-community tensions that historically have often been high. This is not to deny that the Rohingya face particular challenges as a result of the discriminatory practices discussed in Section 1.2, and in fact the demographic composition of the area

[11] WFP (2009) *Food Security and Nutrition Assessment in Northern Rakhine State* (August-September).
[12] Defined as possessing less than 2 kani (0.8 acres) of land.

means that a large majority of project participants will continue to be Rohingya (94% of the population in Maungdaw is Rohingya, 84% in Buthidaung[13]).

A senior government official suggested during a KII that the smaller ethnic minority groups[14] in NRS should also be included in project activities. Although some members of these groups (e.g. Dainet) did participate in project activities, no research has been done with these groups to gain an understanding of the particular challenges they face. CARE should consider conducting such research, as a necessary prerequisite to deciding whether or not to engage with such groups on a larger scale during future projects.

In terms of geographical targeting, it is recommended that any future project focus most of its efforts within existing target village tracts, as the continuing level of need within these areas demands attention. In addition, certain components – including Community Forestry – require further support in order to maximise impact and augment sustainability.

[13] Van de Velde and Pirnay (2006), op cit.
[14] Including Kamein, Kwe Myi, Dainet, Maramagyi, Mro and Thet.

3. Efficiency

3.1 Timeliness and appropriateness

The formal inception date of the project was 15 December 2004, with an intended end date of 31 December 2009. After a number of no cost and costed extensions were granted by the donor, the official closure of the project occurred in November 2011. Project activities were fully funded by AusAID.

A number of events beyond the project's control had a significant impact on the timeliness of implementation. These included:

- Disruption to government administration and liaison services caused by the run-up to, and holding of, the constitutional referendum in May 2008 and the elections in November 2010.
- Cyclone Nargis in May 2008, which understandably diverted staff and also program management's attention away from NRS and towards the Ayeyarwaddy Delta. This may also have had an impact on the quality of implementation.
- Severe floods in NRS in June 2010 and Cyclone Giri in October 2010, both of which forced some project beneficiaries to direct all their efforts to meeting immediate needs (hence limiting their participation in project activities), caused direct damage to project initiatives and disrupted transport and communication links.

Under-spending was a problem in the early stages of project, partly due to cautious budgeting and partly to some financial management errors (e.g. in spreadsheet formulae). The limited financial absorption capacity of communities in NRS should also be highlighted here. As noted in Section 4.2.2, the SMIG consultant's report (2007) suggested that the pressure to spend in early years of the project caused SMIG groups that were underperforming to nevertheless be given additional funds, undermining the intended incentive structure.

The project's implementation approach was generally appropriate, with the major exception of the SMIG component that used a model inappropriate for the NRS context (see Section 4.1.2). In addition, changes in the operating environment reduced the appropriateness of the activities related to the Community Health Funds and clinics during the life of the project. Poor monitoring and/or a lack of responsiveness and adaptability meant that the project did not respond promptly and effectively to these issues concerning the SMIG groups and CHFs.

3.2 Contract and activity implementation

Regarding the standard of implementation, the CF activities were technically sound (Output and Outcome quality is discussed in more depth in Section 4). The new agricultural technologies trialled under the PDFs were technically successful but proved to be financially unsustainable in many cases due to the need for unaffordable inputs. Technical training of SMIG Management Committees (MCs) was of variable quality, partly due to variations in project staff performance and expertise, partly to project staff being spread too thinly. Specialist technical support for the SMIG component was inadequate. Training of women in income-generating activities was generally technically sound, but a lack of market opportunities severely constrained the impact of the training on households' livelihoods. Training of peer educators under the health component was technically sound, as was training under the DRR component. The emergency response to the June 2010 floods was competently implemented, with CARE drawing on the experience gained during the Cyclone Nargis response two years earlier.

Activities related to building the capacity of CF Management Committees (CFMCs) and User Groups (CFUGs), SMIG MCs and Groups, and Community Health Committees (CHCs) were of a lower standard than the majority of the technical activities mentioned above. The project was undoubtedly less competent with regard to organisational and institutional capacity development in comparison with technical training. Importantly, the inadequate monitoring of project activities contributed to a lower standard of implementation with regard to certain components (see Section 3.4).

Responsiveness and adaptability were on some occasions lacking significantly on the part of the project, for example with regard to the problems with the SMIG groups. As mentioned in Section 4.2.2, these problems were clearly identified in the 2007 SMIG consultant's report (as well as the 2007 MTR) and remedial actions proposed, yet only a limited amount of action was taken. In another example, the project took little or no action – other than stopping further expansion of the model – to address the inability of the CHFs to generate sufficient income. This was despite the fact that the project design document identified this as a risk that required monitoring and that the 2007 Health Component Review Report, as well as the MTR, noted that other international organisations were beginning to provide free health services in project target areas; the Health Component Review Report explicitly warned that this could undermine CARE's model. On the other hand, there have been instances when the project has been responsive to issues, as with the problem of traditional land owners resisting efforts to use their land for CF (for example, the CFMC FGD in Myin Hlut reported that the local landlords dug up CF plot seedlings until action was taken by CARE). The project developed an approach that involved negotiating with the landowners and offering them CF plots as well, calling in the township authorities when necessary. This tactic has proved to be successful.

Staff turnover was a problem, especially at Senior Project Officer (SPO) level (at the time of the 2010 review, the longest-serving SPO had been in place for around two years, compared to some of the Project Officers (POs) / Junior Project Officers (JPOs) who had been with CARE for 13 years). One conclusion to be drawn from this is that it is very worthwhile devoting resources to training up POs/JPOs, especially those from the local area; even if significant resources are required, this makes sense for a five-year project. Staff mobility was also constrained, in that CARE's Muslim staff needed to get travel permission prior to their movements within and beyond the project area. However, CARE successfully pushed the envelope on this, managing to get permission for such staff to travel to Yangon and other parts of the country (which had previously been impossible).

As a final – and very important – point with respect to the standard of implementation, it should be borne in mind that the ethnic and political context described in Sections 1.1 and 1.2 constitutes a challenging operating environment for any project.

3.3 Partner government support and project relations with other development organisations

The project generally managed relations with government stakeholders effectively, including relations with the Maungdaw District Peace and Development Council (DPDC) (dissolved since the new government took office in March 2011). Given the sensitive political context in NRS, the DPDC monitored INGO activities closely and was sometimes critical of them, for example in relation to perceived bias towards Rohingya communities. CARE's successful management of its relations with the DPDC should therefore be recognised as a key aspect of project implementation, as without DPDC approval, operations in NRS would be impossible. CARE's good relations with the DPDC were particularly important with regard to the issuance of CF certificates to Rohingya households (most of whom did not hold Myanmar citizenship) under Component Objective 1.

With regard to line agencies, the project had (and continues to enjoy) excellent relations with the Maungdaw District Forestry Department (FD), as well as with higher levels of the institution in Sittwe and Naypyidaw (these strong links are mainly due to personal contacts between CARE staff who were formerly FD members and senior individuals in the FD). The FD regularly attended project meetings and participated in planning and implementation. Two advocacy workshops with the FD were held during December 2010, attended by the FD's Assistant Director (AD) and CFMC members. The latter raised various issues, in response to which the AD provided advice and encouraged the CFMCs to apply for more CF plots on their own (assuring the CFMCs of FD support). These formal advocacy events complemented regular, less formal advocacy efforts on the part of project staff at field level (which were initiated partly in response to a recommendation in the MTR that further advocacy with the FD was required). The Director General, Ministry of Forestry, also visited some of the CF sites and expressed his satisfaction with the program's achievements. He assured the team and beneficiaries of continued support from the Forestry Department. In FGDs, villagers confirmed FD cooperation and involvement in implementation and, when necessary, enforcement: 'Some people who are not plantation committee members cut down trees from our plantation. The committee informs Forestry Department. Then, Forestry Department informs MFF. It then arrests those people and fines them.'[15]

Other government agencies, such as the Myanmar Agriculture Service (MAS), were involved for specific activities such as the provision of technical training. The project's relationship with the Health authorities appears to have been less close in recent years, although this relationship has tended to depend upon the personal stance of the Township Medical Officers (who are periodically rotated and replaced).

Regarding non-governmental and inter-governmental organisations, the project had good relations with MRCS, to which it sub-contracted some of the income-generating activity training. FAO has a number of experienced Myanmar agronomists, who were used by the project as resource persons. UNHCR has a long-standing protection and coordination role in NRS, with which the project cooperated. WFP was an important partner of the project and sees CARE's CF component as one of the best activities with which it has been involved.[16]

The project coordinated with a number of other organisations, including ACF (which implemented nutrition and feeding programs, as well as WATSAN and some income-generating activities) as well as Malteser and AZG (all provide free health services of various types). UNDP is implementing a range of livelihood activities under its Community Development for Remote Townships project.

As regards changes in the operating environment for international organisations (IOs) in NRS since the new government took office in March 2011, IO representatives expressed mixed views in KIIs. Some representatives felt that the environment had become easier, with coordination with the authorities becoming smoother; other informants felt that administrative procedures (e.g. for permission to access communities) had become more cumbersome. One informant commented: 'The obvious change after 2010 election is about changing the names. Before that, military government, now it becomes civil government. That is the only thing that is changing here.' Informants' views were no doubt coloured by the particular experiences of their organisation, but the operating environment in NRS needs to be monitored closely as further changes are probable, given the reformist trend in the country as a whole.

3.4 Activity monitoring

The project's M&E featured a number of weaknesses, including the following:

- Routine monitoring of SMIG group performance was weak, which meant that the broad extent of the problems with group functioning remained undetected for a

[15] FGD with Myin Hlut (Middle) CFMC.
[16] KII during the 2010 review.

number of years by CARE Myanmar management and during CARE Australia monitoring visits.

- Where problems with the SMIG groups were brought to the attention of management (as with the SMIG consultant's 2007 report and the MTR), effective action was not taken to address them.
- The PDD highlighted poor CHF performance as a risk that required monitoring. The inability of some of the CHFs to generate sufficient income was raised in both the 2007 Health Component Review Report and the 2007 MTR, although detailed data and analysis on the status of the CHFs was not presented. However, effective remedial action was again not taken by management, beyond deciding not to expand the number of CHFs further.
- The 2007 Health Component Review Report also noted that other international organisations were beginning to provide free health services in project target areas and warned that this could undermine CARE's model. However, CARE continued to try to implement this model under the existing CHCs / CHFs until the 2010 review recommended its closure, rather than taking decisive action to adapt the model.
- Some of the indicators for Component Objectives 1, 2 and 3 are inappropriate (see Section 4 for further discussion). This contributed to the problems with project monitoring.
- The monitoring of all types of Management Committee (MC) was poor. The 360° MC evaluations envisaged in the project design were not attempted by the project, as these were deemed too demanding of time and resources; this was probably a good decision. Instead, checklists were developed to monitor the performance of the CHCs and SMIG MCs (but not the CFMCs), but these needed to be improved so as to be able to capture gradual improvements in capacity related to relevant skills. Some indicators in the logframe attempted to capture percentage increases in MC capacity, but this was over-ambitious given the qualitative nature of many of the variables that needed to be assessed. The development of a "ladder" of criteria (similar to Progress Markers in the Outcome Mapping approach) would have been more appropriate.
- Precise data on the results of PDF trials (e.g. yield increases and/or income gained, as opposed to figures on the number of participants or area planted to a particular crop) are unavailable (or, if available, have not been analysed and presented in reports). This is an important gap, as it made it difficult for the project to rigorously determine which options were the most productive and/or economically rewarding for target communities. It also prevented the project from rigorously demonstrating its achievements in this regard. A better M&E system would have enabled a more thorough analysis of the variables influencing farmers' decision-making to be made, which would in turn have enabled project approaches to be adapted accordingly.
- SMIG members received training (under Output 2.4) in a variety of activities. However, there appears to be no data available that would permit a rigorous assessment of the profitability of such activities for those trained. Monitoring reports estimated that around 20-30% of participants had been unable to make a profit performing the activity in which they had been trained.
- Mechanisms for downward accountability (between project and target populations) need to be introduced. It is understood that the Country Office (CO) is currently working to address such issues across all projects.
- The Mid-Term Review (MTR) recommended building the capacity of project staff in monitoring (as well as planning and budgeting). Although some progress was made in this regard during the life of the project, further capacity-building was required.
- CARE's monitoring of changes in gender relations relied upon field staff taking a note of significant changes that they noticed. However, heavy workloads (as well as the fact that gender monitoring was sometimes pushed down the list of priorities) tended to cause monitoring to be patchy. CARE is already making efforts across all projects to strengthen its monitoring system with regard to gender relations and make it more systematic.

A Baseline Survey was conducted in October and November 2004 by a local consultancy company. The Executive Summary of the Baseline Survey report notes that the 'study was conducted under changing administrative structure, during which time rice and paddy prices were very unstable.' Comparisons of Baseline and Final Evaluation Survey financial and economic data should therefore be subject to a substantial caveat, given the particularly distorted nature of the NRS economy and the high inflation rates that were consistently reported in FGDs.[17] The Baseline Survey did not collect and/or report the data required by some key indicators, including two of the indicators for the Project Goal (concerning household asset values and household income). The raw data sets could not be located, meaning that they could not be reviewed to see if the required data was in fact available. The PDD envisaged a control group of households/communities that did not participate in the project being established, in order to facilitate the attribution of changes to various potential causes. However, a control group was not established.

As CARE was not satisfied with the performance of the company that performed the Baseline Survey, a different local company was selected to conduct the Final Evaluation Survey. The performance of the latter company was competent, although the fact that different companies conducted the two surveys meant that the approach taken was less consistent that would ideally be the case.

[17] As one man in a FGD in Phar Wat Chaung / Wut Pyin put it: 'Before this, if a person earned 500 Kyat for a day, that was enough for his family. But now, even if you got 3,000 Kyat for a day, that would not be enough for the family.' (NB Community locations are referred to using the format Village Tract / Village.)

4. Effectiveness

4.1 Achievement of objectives

4.1.1 Component Objective 1

The following table summarises project achievements with respect to the indicators for this objective:

Logframe descriptor	Indicators	Progress against indicators by End of Project (EOP)
Component Objective 1: Facilitate 3,000 landless, predominantly Rohingya households to sustainably increase household assets and incomes through community forestry.	At least 3,000 households possess one acre of CF land (with CF certificates) by EoP	3,180 acres of CF land have been established for 3,200 households (i.e. 0.99 acre/household, an insignificant undershoot), including 150 female-headed households. After a long delay (starting in 2005) in issuing certificates, the process restarted in 2009: 2,700 have been issued already; of the remaining 500, 400 should be issued by early 2012. Remaining 100 awaiting State level approval, which is now required due to changes in the administrative procedures.
	Average imputed asset value of household CF plots by age	In response to a final evaluation survey question asking households to estimate the value of the trees they have grown on their CF plot, the mean estimate was Kyat 923,343 (Kyat 940,736 for Maungdaw and Kyat 901,742 for Buthidaung). The maximum estimate recorded was Kyat 5,000,000, and the minimum Kyat 50,000. All households surveyed had plots of at least 4 years of age.
	At least 90% of established plots and CFMCs still in operation by EOP	Over 95% remain in operation (though the quality of operations is variable).
	% increase in annual household income (cash & in kind) from CF plots by plot age	Household income data disaggregated by plot age is not available. However, the final evaluation survey reported that the mean household income from CF plots (minimum 4 years of age) over the last 12 months was Kyat 84,706. This equates to around 11% of the average annual household income of Kyat 782,705 reported in the final evaluation survey. *[According to the final evaluation survey, mean household income averaged Kyat 782,705, compared to Kyat 483,696 four years ago. However, the precise methodology used to assess household income is unknown. In addition, the final evaluation survey's figure for mean annual household income four years ago (Kyat 483,696) is substantially higher than the baseline survey's figure (Kyat 60,000 – 120,000). This difference could be due to inaccuracies in the final evaluation survey or baseline, or to differences in the methodologies used.]*

RRHLSP succeeded in meeting its objectives under this component, which was the most successful component of the project. The community forestry activities are, without exaggeration, unique in the NRS context[18] and ground-breaking in the context of Myanmar as a whole. 3,200 landless or land-poor largely Rohingya households were supported to establish and manage CF plots, and CARE facilitated the issuance of land-use certificates (valid for 30 years, and then potentially renewable). This is a major achievement, both in terms of the livelihood benefits and in terms of enabling Rohingya households to claim their rights. Community stabilisation and protection benefits are therefore also likely to flow from this component.

[18] The activities were recognised as such by representatives of a number of other organisations working in NRS who were interviewed during KIIs.

Though two of the indicators were problematic (see above table), it is clear that significant assets have been created for households in the form of their CF plots and that a significant income stream is already flowing from these assets. As one FGD participant put it: 'Since the plantation has begun, people can invest more compared to the past, and for example, in the past if they can invest 5,000, now they can invest 10,000. Business becomes better.'[19] The mean estimate of the value of the trees grown on CF plots of over four years of age was Kyat 923,343, and the mean household income from CF plots over the last 12 months was Kyat 84,706 (which equates to around 11% of the average annual household income of Kyat 782,705 reported in the final evaluation survey). It should also be emphasised that CF plots are still relatively young; in future years, the harvesting of timber will begin and the income stream will grow significantly as a result. This is already being eagerly anticipated by CF plot holders, as one Dainet ethnic minority woman revealed: 'After [some] years later we can sell the wood. We will sell. It will be a huge benefit.'[20]

All the CFUGs met by the consultant during the 2010 review strongly requested additional CF establishment in their community, and the same request was made during several of the FGDs conducted during the Final Evaluation.[21] In addition, interviewees in villages visited during the 2010 review that had not been targeted by the project (e.g. Cah Lah Day Phatt and Thin Ga Net) had heard of CARE's CF activities and requested that these be implemented in their communities. Clearly, therefore, CF activities are viewed as strongly beneficial by community members. Some better-off villagers have begun to develop forest plots themselves, having seen the results achieved by CARE-supported CFUGs. This provides further confirmation of the utility of the plots.

4.1.2 Component Objective 2

The following table summarises project achievements with respect to the indicators for this objective:

Logframe descriptor	Indicators	Progress against indicators by EOP
Component Objective 2: Facilitate 6,000 predominantly Rohingya women to access high quality and sustainable financial services.	A minimum of 6,000 women are members of village SMIG groups by EoP	A total of 6,717 women formed 242 groups. However, most groups functioned poorly (see main text).
	70% of members are from landless / land-short households (up to 2 kani[22]) and 80% are Rohingya	Over 90% were from landless/land-short households and 85% were Rohingya
	% increase in household borrowing requirements met by SMIG	The information required by this indicator would be very challenging to obtain under the best circumstances, and in the context of NRS it is too complex. Project reports state that '98 % hh borrowing requirements met by SMIG'. This, however, does not relate to the indicator but is a result of the Customer Satisfaction Survey that was run annually on a sample of 200 group members. However, the sampling methodology meant that poorly performing groups were under-represented in the sample, meaning that the level of satisfaction indicated by the survey was significantly inflated.
	# of SMIG MCs independently managing group operations (and providing (quality) sustainable financial services)	2009 project data states that 130 SMIG MCs were independently managing group operations and sustainably providing financial services, but given the poor performance data on the groups (see main text) it appears unlikely that this

[19] FGD with Inn Chaung / Ywar Gyi CFUG.
[20] FGD with Inn Chaung / Inn Chaung CFUG.
[21] In Mee Kyaung Gaung Swe / Mg Hla Ma, for example.
[22] 2.5 Kani = 1 Acre

		many groups were providing sustainable financial services. 41% (i.e. the groups in savings rate categories A, B and C), or 90 groups, would seem a more realistic (but probably still over-generous) estimate.

Through the establishment of 210 new SMIG groups (to add to the 32 already established in the previous phase), the SMIG component provided access to financial services for over 6,700 women, 80% of whom were Rohingya and 90% of whom were landless or land-poor. It therefore met or exceeded its quantitative targets in these respects. However, the actual financial performance of the majority of the SMIG groups was poor, as is clearly shown by Table 1 below (from the 2010 review), in which groups are ranked from Category A (best) to Category F (worst) according to performance criteria defined by the project (Table 2). The project therefore did not succeed in achieving its objective under this component.

Table 1: Group performance rankings (January 2009 and January 2010)

Repayment Rates					
	Jan 2009			**Jan 2010**	
	Number	Frequency		Number	Frequency
A	32	15%	A	31	14%
B	7	3%	B	3	1%
C	8	4%	C	4	2%
D	0	0%	D	0	0%
E	0	0%	E	0	0%
F	173	79%	F	182	83%
	220	100%		220	100%

Saving Rates					
	Jan 2009			**Jan 2010**	
	Number	Frequency		Number	Frequency
A	49	22%	A	40	18%
B	33	15%	B	26	12%
C	28	13%	C	24	11%
D	0	0%	D	0	0%
E	0	0%	E	0	0%
F	110	50%	F	130	59%
	220	100%		220	100%

Table 2: Group performance criteria

Category	Savings rate	Repayment rate
A	x > 95%	x > 95%
B	80 < x < 95%	80 < x < 95%
C	70 < x < 80%	70 < x < 80%
D	60 < x < 70%	60 < x < 70%
E	50 < x < 60%	50 < x < 60%
F	X < 50%	X < 50%

It should be noted that Table 1 includes only 220 groups, excluding 22 groups that had already stopped functioning by the time of the 2010 review. Had all 242 SMIG groups been included, the overall averages would be worse.

Table 1 indicates that in January 2010, regarding repayment rates, 14% of groups were in Category A (> 95% repayment rate) and 83% in Category F (i.e. < 50%). Regarding savings rates, 18% of groups were ranked A and 59% F. These results indicate that

most groups were functioning poorly.[23] It can also be observed from Table 1 that the situation deteriorated further between January 2009 and January 2010, part of the reason for which may well be that group members were aware that the end of the project was approaching (this was given as one reason for the very high level of loan delinquency – virtually 100% – by group members in Mee Chaung Gaung Swee village tract during the 2010 review). The reasons for the generally poor performance of the SMIG groups are discussed in Section 4.2.2 in relation to the standard of Outputs under this component.

According to an internal audit conducted as a follow-up to the 2010 review, around six of the 242 groups had ceased to function entirely because members of the Management Committee (MC) had stolen the group's capital, amounting to a total of AUD $650. A further 56 groups (some 'old' groups established during the previous phase, some 'new' groups from the current phase) were found to be non-functioning for other reasons. In one of the villages in which the MC stole the group's capital, one member asked CARE to help them sue the MC. CARE replied that this was not a role they could play, but advised the individual to approach the village authorities for assistance. Reportedly, when so approached the authorities demanded a bribe in order for action to be taken, so the matter rested unresolved. In addition, the fact that groups were not legally registered entities means that the chances of successful legal action are reduced.

Following the 2010 review and the follow-up audit, CARE decided to phase out the SMIG groups. On the basis of the audit results, and in consultation with group members, group savings were distributed to members in December 2010 and January 2011. The sum received by each member was calculated according to the following formula: Amount Received = Savings + Profits Gained[24] - Outstanding Loans. The mean amount received by group members was Kyat 26,580 (around AUD 32, assuming an exchange rate of Kyat 800/USD); if CARE capital injections had been discounted, this would have been reduced to Kyat 13,051 (around AUD 16).

Regarding the closedown process, some FGDs revealed confusion amongst SMIG group members as to the reason for closedown: some members thought that the reason was simply the project ending, others that the groups were closed because of the 2010 floods or financial irregularities.[25] A number of focus groups expressed regret at the closing of the funds, particularly because this removed a source of emergency loans[26] (further supporting the argument proposed in Section 4.2.2 that a fund model suitable for consumption-smoothing and emergencies rather than micro-enterprise would be more appropriate).

One SMIG group (Maung Hna Ma / Aung Mingalar) out of the five involved in FGDs reported significant financial irregularities after the 2010 audit but before group closedown. The group's savings box went missing from the home of the treasurer, and male villagers suspected that the treasurer and the key-holder were involved; around AUD 1,200 was reported missing.[27] SMIG group members confirmed the story and expressed their opinion that CARE had had a responsibility to help solve the problem before the fund was closed, as members had been worried that if the fund were to be closed before a solution was found, the people responsible for the loss would never be held responsible.[28] As one member said: 'There are some members who haven't got all their saving money because some borrowers hadn't given the money back when the

[23] The SMIG consultant's 2007 review report notes that, based on global experience, repayment rates of 90-95% would be viewed as typical of well-functioning groups.
[24] Comprised of interest + CARE's capital injection to the group.
[25] For example, the FGDs with the Mee Kyaung Gaung Sw / Kone Tan and Maung Hna Ma / Aung Mingalar SMIG groups.
[26] As with the Myin Hlut / Myin Hlut (East) SMIG MC FGD, for example.
[27] FGD with Maung Hna Ma / Aung Mingalar CFUG.
[28] FGD with Maung Hna Ma / Aung Mingalar SMIG members.

money box was lost. [...] We think it is unfair. Because we didn't get any profit, even our saving money.' This issue has had negative effects on some members' livelihoods and on gender relations within their households: 'We had financial problem in doing business because we haven't got our saving money for investment. I had problems with my husband.' The extent to which such problems occurred across other SMIG groups could not be assessed.

Although group financial performance was generally poor, it should be noted that in the minority of groups that functioned satisfactorily, the benefits for group members could be significant. As one previously landless woman recounted, 'I work as a labourer. After getting a loan, I did gardening and kept on working as a labourer and raising pigs. Now, I can buy one acre of farm land.'[29]

Earlier reports on RRHLSP and RHLSP emphasise the positive social impacts of the SMIG groups, particularly as regards gender relations. The consultant would agree that women's involvement in the SMIG groups (as well as in agricultural and vocational training activities and as health educators under other project components) resulted in positive social impacts in terms of strengthening social cohesion as well as raising the status of women within their households and communities. Through discussions with SMIG group members (during both the 2010 review and the Final Evaluation FGDs), it became clear that many women who previously scarcely left their household compounds now attend meetings in their village or further afield, make a significant cash contribution to the household economy and practice active mutual support and information-sharing with their community peers. One woman noted: '[a]lthough we are living in the same village, we did not know each other. But when we did this, we became closer and we discussed about everything.'[30]

Involvement in the project has had an empowering effect on many women, who now 'have more courage in communicating with other people' as one woman put it.[31] Another woman put it thus:

> '[m]ost of the projects were led by men but this was by women. [...] Women can come to know how to manage micro credit society. That is development.'[32]

However, in both Rakhine and, particularly, Rohingya communities, it is generally the husband who decides what a loan shall be used for, though in some households the spouses do discuss the issue together. The degree to which the SMIG groups have increased women's decision-making power should not be exaggerated; as one group member put it during the 2010 review, 'If our husbands didn't agree, we wouldn't be in the group [in the first place]'.

4.1.3 Component Objective 3

The following table summarises project achievements with respect to the indicators for this objective:

Logframe descriptor	Indicators	Progress against indicators by EOP
Component Objective 3: Targeted village tracts receive improved access to health services.	16 CHCs established	16 CHCs were established by Year 3.
	At least 50% CHCs meeting performance management criteria after 2 years of establishment	The December 2009 Interim Report to AusAID states that around 5 groups (31%) met basic performance criteria.
	60% of targeted VTs receive at least 1 visit per week from	According to the 2010 review report, 31% (i.e. 5 VT) were receiving visits from RHC / SC staff, though this may well have

[29] FGD with Mee Kyaung Gaung Swe / Kone Tan SMIG MC.
[30] FGD with Mee Kyaung Gaung Swe / Kone Tan SMIG group.
[31] FGD with Inn Chaung / Inn Chaung CFUG.
[32] FGD with Mee Kyaung Gaung Swe / Kone Tan SMIG MC.

	RHC/SC staff within 6 months of est. until EoP	been less frequently than once per week.
	Health education materials developed and distributed in 16 VTs	Materials on 8 health topics were developed & distributed. Topics included TB, malaria, diarrhoea, sanitation & personal hygiene, nutrition, birth spacing, safe motherhood and immunization.
	CHCs distribute preventative health supplies to most vulnerable (20%) of households	Mosquito nets have been distributed to 100% of the most vulnerable households; latrine pipes and pans have been distributed to 18.4% of the vulnerable households. Female sanitary kits (provided by UNHCR) were distributed to 6.25% of the total female population.

RRHLSP partially succeeded in achieving its objective under this component. Quantitative targets regarding the establishment of Community Health Committees (CHCs) were met, but only 31% of CHCs met basic performance criteria. Efforts were made to set up Community Health Funds (CHFs), the intention being that these would be managed by a committee and, through providing loans, generate a monthly income that would enable the community to pay an incentive to government health staff to visit the village regularly. Revolving drug funds were also established to sell basic medicines, the overall aim being to enable community members to access curative services in their communities.

Unfortunately, this model – designed with sustainability very much in mind – generally did not function effectively, for a variety of reasons. These include the failure of most CHFs to generate sufficient income, the fact that government health staff have more lucrative income-generating options available to them and the low capacity of most CHCs. An underlying problem is that numerous other INGOs are operating in the same (or nearby) areas as CARE and many of these provide free curative services. Villagers understandably prefer to use these free services, rather than pay for drugs when they go to a CARE clinic. Community health education, delivered by trained male and female Peer Educators (PEs) with the assistance of tailored IEC materials, has been more successful. As a result, levels of knowledge have been raised and there is firm evidence of behaviour change, resulting for example in the reduced incidence of diarrhoea (see Section 4.2.3).

4.1.4 Component Objective 4

The following table summarises project achievements with respect to the indicators for this objective:

Logframe descriptor	Indicators	Progress against indicators by EOP
Component Objective 4: Build disaster risk reduction capacity of 20 targeted villages.	Capacity building training in 20 targeted villages	A total of 76 participants from 19 VTs received training on DRR from the local NGO Mangrove Service Network (MSN) to build their knowledge and skills.
	Cross visit to observe DRR activities in Delta Region	7 staff visited the Delta region to observe DRR activities in October 2009.
	Plantation of 12,000 Nipa Palms to provide a wind break	From the total of 3,180 acres of community forestry plots established under RRHLSP, 100 acres are mangrove where Nipa Palms have been planted.

The project partially succeeded in meeting its objectives under this component, which was added to the design in Year 6. Having started slowly (partly due to delays in identifying a suitable resource person / organisation to conduct the training), DRR training was eventually delivered in selected communities. However, other activities for DRR were limited to cross-visits and experience sharing. The planned Nipa palm plantation activity did not take place. The indicators for this Component Objective are not well designed, being more appropriate for Output level (or in some cases being more akin to Activities).

4.1.5 Component Objective 5

The following table summarises project achievements with respect to the indicators for this objective:

Logframe descriptor	Indicators	Progress against indicators by EOP
Component Objective 5: Address immediate and transition / rehabilitation needs of 30,000 flood-affected persons in 62 villages in Buthidaung Township, and 72 villages across 16 village tracts in Maungdaw Township.	None provided	N/A

In response to severe flooding in NRS in June 2010, Component Objective 5 was added to the project. The impact of the floods on some of the participants in other project components was severe. One SMIG group member described her experience thus: 'Economy here becomes better since we borrowed money and started businesses five years ago. But when flood happened, all things were blown away again.'[33] No Outcome indicators were provided, but the project appears to have met most of its aims with regard to the intended Outputs (see Section 4.2.5).

4.2 Standard of Outputs

4.2.1 Outputs under Component Objective 1

The following table summarises project achievements against relevant Output indicators:

Logframe descriptor	Indicators	Progress against indicators by EOP
Output 1.1: Households (mostly landless Rohingya) establish viable, CF plots registered under the Community Forestry instruction (CFI).	At least 3,000 households possess CF land (with CF certificates) of model size of at least 1 acre by EoP Landless households comprise at least 60% of CF User Group members Saplings planted in establishment year show survival rate of at least 70% across all CF plots per year	3,180 acres of CF land have been established for 3,200 households (i.e. 0.99 acre/household, an insignificant undershoot), including 150 female-headed households. 80% of CF user group members are landless, reflecting accurate targeting by the project. Sapling survival rate reported as over 70%. FGDs confirmed that villagers were generally happy with the quality of planting material supplied.[34]
Output 1.2: Community Forestry Management Committees have adequate capacity to manage CF operations and minimize risks	% growth in capacity of CFMCs as assessed through annual "360 degrees" assessment against CFMC duty statements At least 90% of established plots and CFMCs still in operation by EoP	The idea of a 360° assessment procedure is attractive but proved too time-demanding to implement. No performance checklist for the CFMC was developed, hence this indicator could not be assessed. Over 95% remain in operation (though the quality of operations is variable).
Output 1.3: Effective	# of CFMC initiated	Around 65 requests were made for assistance in various

[33] Mee Kyaung Gaung Swe / Kone Tan SMIG FGD.

[34] For example, FGDs in Inn Chaung / Ywar Gyi, Maung Hna Ma / Aung Min Ga Lar and Myin Hlut (Middle).

relationships continue to be built between Forestry Department and CFMCs	assistance requests to FD and FD response rates to such requests	areas, e.g. decentralised nursery management, thinning and pruning. The FD reportedly responded to the majority of requests.
Output 1.4: Simple, robust agricultural production technologies are trialled and scaled up	Production Development Funds support at least four technologically appropriate trials through at least 30 CFMCs Appropriate technologies are scaled-up through the provision of tied grants/loans in at least 30 CF villages (hamlets)	In Year 3, PDFs supported four technology trials (through 21 CFMCs and 37 SMIG MCs), with the introduction of treadle pumps, tomato cultivation, ground nut cultivation and poultry farming. Four technology trials were supported in Year 4 (through 32 CFMCs and 60 SMIG MCs): treadle pump installation, onion cultivation, cow pea cultivation and bio-fertilizer trials. Paddy cultivation in summer and the wet season (with quality seed production techniques) was added to the list of technologies in Year 5, through 52 CFMCs, 12 CHCs and 60 SMIG MCs. In Year 6, home gardening, cow pea cultivation, summer paddy cultivation and Farmer Field School (FFS) training were added through 34 CFMCs. In Year 6, there was a four-fold increase in the area under cow pea cultivation as a result of positive yields from previous years. Summer paddy cultivation increased from 40 participants (Y5) to 200 participants (Y6), and from 16 acres to 200 acres.

Although the project met most of its quantitative Output targets under this component, the standard of implementation could have been better in certain respects. Areas of weakness with regard to the CF Outputs included the following:

- The planting technique used by CFUG members was sometimes incorrect, e.g. planting hardwood and softwood species in mixed stands.
- Around 70% of the CFMCs still lacked the capacity to fully manage their plots in accordance with the CFI. For example, during the 2010 review it was reported to the consultant that around 70% of CFMCs still had no annual management plan, which is mandatory under the CFI and without which, therefore, a CFMC theoretically risks losing its certification. Key areas in which CFMCs require further capacity-building include: knowledge of the CFI;[35] understanding of CF management techniques, including future timber-harvesting.
- CFMC members received two courses of literacy and numeracy training aiming to raise them to a level whereby they could conduct simple record-keeping tasks. However, the literacy training results were not satisfactory, according to discussions with the project team during the 2010 review, for at least two reasons: firstly, the two courses were conducted with a gap of many months in-between, causing learners to lose momentum; secondly, it was difficult for learners to devote time to studying.

The PDF features under both Output 1.4 and Output 2.4; both outputs will be discussed here. It was intended that some funds from the PDF would be disbursed on a grant basis, while for activities involving relatively high investment (and returns) per household, funds would be disbursed as loans that would be paid back into a fund managed by the CFMC (if implemented under Output 1.4) or the SMIG fund (if implemented under Output 2.4). It is not clear what proportion of funds was actually disbursed as loans (though it appears that the majority was disbursed as grants), and to what extent such loans were paid back. Some communities did try to use their PDF for repayable loans, but loans were often not repaid and the process was not very transparent.[36]

The Project has met its targets for the number of technology trials supported (under both Output 1.4 and Output 2.4), and there is no doubt that many of these have been successful. However, precise data on the results (e.g. yield increases and/or income

[35] Confirmed in KII with Mee Kyaung Gaung Swe / Kone Tan administrator.
[36] FGD with Maung Hna Ma / Aung Min Ga Lar CFUG.

gained, as opposed to figures on the number of participants or area planted to a particular crop) are unavailable. This is an important gap, as it makes it difficult for the project to rigorously determine which options are the most productive and/or economically rewarding for target communities. Although the crop trials were generally successful in a technical sense, the extent to which new technologies are likely to be applied after the end of the project will be very variable; farmers' willingness to accept risk and the cost of inputs are key issues. Many participants interviewed during the 2010 review as well as some FGD participants[37] indicated that they will not be able to sustain the area cultivated during the trials because they cannot afford to buy the same level of inputs that CARE supplies.

SMIG members received vocational training (under Output 2.4) in a variety of activities including snack-making, needlework and sewing machine operation. Monitoring reports estimated that only around 20-30% of trainees actually made a profit from the activity in which they had been trained. Limited market opportunities is the main reason for this; staff and some participants also recommended increasing the length of some courses in order to provide participants with an adequate level of skill. The 2007 Mid-Term Review (MTR) recommended an expansion of PDF activities focused on non-agricultural activities, including vocational training and micro-business development. It appears that this expansion did not take place, although given the challenging environment for small businesses, it was probably better for the PDFs to focus more on agricultural activities. The MTR also recommended the recruitment of an additional Senior Project Officer (SPO) to oversee PDF activities, although this was not done. Having an SPO specifically to oversee the PDFs would have been useful, as it would have lessened the workload of the SPO Agriculture in particular.

The consultant's opinion is that the PDF suffered from not having the status of a full Component Objective in the project, being represented merely in two outputs (1.4 and 2.4). Although PDF activities were very important – particularly with regard to helping SMIG members engage in activities that provided good returns on SMIG loans – they appear to have been somewhat under-funded. For example, the Farmer Field School (FFS) approach introduced in Year 6 was successful, but this was despite the fact that significantly fewer than the recommended number of farmer trainings and meetings were held due to budget constraints.

Village Development Grants (VDGs) do not feature in the project logframe itself (though they are explained in the PDD narrative) but constitute a distinct feature of the project. The narrative states that the purpose of VDGs is to fund village development projects that will improve health and household livelihood security for all households in the village, thereby strengthening social cohesion. The VDGs were also envisaged as a means to build the capacity and local level legitimacy of the CFMCs and SMIG MCs that were envisaged as the managing agents for the VDGs. In the early years of the project, it was envisaged that VDG resources would be applied in particular to projects that would improve environmental health (such as wells). The most common uses of VDG funds in later years were in fact for school construction or improvement and bridge construction. In total, 59 VDG schemes were completed.

The original intention was for villagers to manage the procurement of construction materials, but problems with corruption meant that project staff had to play a larger role. Villagers interviewed during FGDs consistently expressed satisfaction with the schemes completed, and the schemes viewed by the consultant during the 2010 review were of good quality and had clearly contributed to improving villagers' livelihoods. The extent to which they have improved social cohesion is uncertain, though schemes to improve village schools may have had some impact in this respect.

4.2.2 Outputs under Component Objective 2

[37] For example: Inn Chaung / Inn Chaung CFUG FGD.

The following table summarises project achievements against relevant Output indicators:

Logframe descriptor	Indicators	Progress against indicators by EOP
Output 2.1: New SMIG groups established and existing groups expand membership	Min. 207 new management committees established by EoP	210 new management committees were established (adding to the 32 established in the previous phase), exceeding the quantitative target. The original target was to establish at least 36 much larger groups, with 100-200 members each. Difficulties with such large groups led the project to reduce group size to 20-40 members and increase the number of groups to be formed.
	% average natural growth rate in membership of MCs over two years of age by EoP	This indicator is in itself problematic, as MC membership should not grow, being set at five persons per MC. The indicator may well intend to refer to SMIG group membership instead.
Output 2.2: SMIG groups provide sufficient, quality financial services to their membership	At least 80% of established SMIG groups still in operation by EoP	74% (179/242) of established SMIG groups were still in operation as of January 2010. However, the quality of the operations of the majority of groups was highly questionable.
	% increase of household financial service needs met through group membership by age of SMIG group	Could not be evaluated due to lack of data. Indicator is too complex for the context.
	80% of members of 'graduated' groups are 70% "satisfied" with Loan and Savings product terms and conditions	A Client Satisfaction Survey was conducted in 2009 and indicated that 98% of group members expressed satisfaction with the program, while 86% were satisfied with the loan and savings status of their group. However, as noted in Section 4.1.2, the sampling methodology means that poorly performing groups are under-represented in the sample, meaning that the level of satisfaction indicated by the survey is significantly inflated.
Output 2.3: SMIG Management Committees are able to adequately manage internal operations and minimise risks	At least 80% of SMIG groups over 12 months of age consistently meet 'primary' (grant assessment) financial and management performance criteria	100% of SMIG groups formed in Year 1, 2, 3 and 4 met the primary financial and management performance criteria.
	At least 80% of SMIG groups over 24 months of age consistently meet 'graduation' (loan assessment) financial and management performance criteria	50% of SMIG groups established for 24 months or more consistently meet 'graduation' financial and management performance criteria. The significantly lower % of groups meeting these criteria (as opposed to the Year 1 criteria) suggests that group performance is often not sustained.
	% growth in capacity of all SMIG MCs as assessed through annual "360 Degrees" assessment against SMIG MC TORs	As was also the case for the CFMCs (see Output 1.2), the 360° process proved too time-demanding to implement.
Output 2.4: Simple, robust production technologies are trialled and scaled up	PDF support at least four technology trials through at least 30 SMIG MCs	As noted under Output 1.4, a wide range of trials have been supported via PDFs, many of which have included SMIG members as participants.
	PDF vocational technology training sessions provided to at least 5% SMIG members	SMIG members were trained in a variety of activities. However, it is unclear whether the target of 5% of SMIG members was met. However, monitoring reports estimated that only around 20-30% of trainees actually made a profit from the activity in which they had been trained (see Section 4.2.1).
	Appropriate technologies are	The degree to which technologies are applied increases when

	scaled up through the provision of tied grants/loans in at least eight villages (hamlets)	CARE provides inputs but then often returns to its previous level – or a little higher – when CARE support ceases. The cost of inputs, farmers' willingness to borrow to meet these, the availability of loans and their perception of the risk involved are all factors. In some cases, SMIG loans have helped farmers with this issue.

Reasons for the poor functioning of the SMIG groups (see Section 4.1.2) include the following:

- The financial model used was not suitable for most women in a context where income-generating opportunities remain very constrained and many households' main borrowing requirement is for consumption-smoothing purposes rather than microenterprise. This is borne out by the fact that monitoring by the project team revealed that nearly 90% of loans had actually been utilised for consumption purposes rather than productive investment (Final RRHLSP Y6 Semi-annual report July-Dec 2010, p. 7).
- A lack of income-generating opportunities, partly linked to the fact that the PDF was not sufficiently successful in facilitating women's involvement in profitable activities (as discussed in Section 4.2.1).
- Transportation problems (notably the fact that fees often had to be paid at checkpoints).
- Variable capacity amongst project staff, as well as the limited time staff had available to devote to each group. A rough voting exercise with all staff during the 2010 review revealed that the SMIG groups were taking up around three times as much staff time as any other project component.
- A lack of specialist technical support for the SMIG component.

Many of the above issues were foreseen as early as 2003 in the RHLSP Final Evaluation. In addition, a specialist SMIG review consultancy in November 2007 highlighted the poor performance of the groups and made a range of very detailed recommendations as to how the problems could be addressed. However, the recommendations were not effectively implemented.

100% of SMIG groups formed in Year 1, 2, 3 and 4 met the primary financial and management performance criteria (Output 2.3). The data showing poor group performance tends to confirm the conclusion contained in the SMIG consultant's 2007 report that the criteria being applied were too lax, enabling poorly performing groups to qualify for grants from CARE. This meant that the intended incentive effect of such grants was diluted, if not lost altogether. The SMIG consultant suggested that the provision of grants even to poorly performing groups was to some extent driven by the need to address the problem of underspending that was affecting the project at that time.

4.2.3 Outputs under Component Objective 3

The following table summarises project achievements against relevant Output indicators:

Logframe descriptor	Indicators	Progress against indicators by EOP
Output 3.1: CHCs established and generating required levels of income for remunerated outreach visits by RHC staff	16 CHCs established	16 CHCs were established by Year 3.
	At least 50% of CHCs meeting performance criteria after two years of establishment	The December 2009 Interim Report to AusAID states that around five groups (31%) met basic performance criteria.
	50-60% of CHCs established generate minimum monthly income of 25,000 kyats in 'profit' within six months of establishment until EoP	As of April 2010, 37.5% of CHCs (six CHCs) were running some form of income generating activities. However, it is doubtful that all six CHCs were generating 25,000 Kyat/month profit.

	% change in # of patients receiving treatments from RHC service providers (i.e. above Community Health Worker (CHW) level)	The June 2010 Interim Report states that 262 villagers from five targeted villages received curative services from midwives in the period July 2009 to April 2010, but no data is provided in terms of what this represents as a % change over baseline.
Output 3.2: Peer Educators providing quality health education on specified topics in target VTs	Development and distribution of appropriate IEC materials in 16 VTs 200 PE trained Regular health education sessions conducted in target VTs until EoP Increased knowledge/ awareness of specified health topics amongst target group at EoP	Flip charts containing information related to eight health topics were developed in Year 4 and were distributed to PEs from 16 village tracts to be used in HE sessions. A total of 199 PEs (105 female, 94 male) were trained in 2006 through a five-day training program. This was subsequently followed up with annual refresher trainings. 190 trained peer educators were active at the time of the 2010 review. From Aug-Dec 2010, a total of 778 HE sessions were delivered; 1,130 HE sessions were delivered in Y6 (July 09 to Dec 09), 1,768 HE sessions in Y5 (July 08 to June 09) and 1,992 HE sessions in Y4 (July 07 to June 08). In the baseline survey, 77.6% of respondents knew that malaria can result from a mosquito bite, compared with 98.8% in the final evaluation survey. This equates to a 27% increase in the correct response rate. In the baseline survey, 66.7% of respondents were aware that using a mosquito net is an effective means of preventing malaria, compared with 99.5% in the final evaluation survey. This equates to a 49% increase in the correct response rate. In the baseline survey, 38.0% of respondents were aware that TB can be cured, compared with 77.8% in the final evaluation survey. This equates to a 105% increase in the correct response rate. In the baseline survey, 48.8% of respondents were aware that drinking unclean water can cause diarrhoea, compared with 81.8% in the final evaluation survey. This equates to a 68% increase in the correct response rate. In the baseline survey, 40.1% of respondents fully understood how to prepare ORS from home ingredients, compared with 28.9% in the final evaluation survey. The reason for the drop in the level of understanding is unclear but may well relate to differences in the way the question was asked in the two surveys.
Output 3.3: Stand-by services and contingency stocks of preventative health supplies for major disease epidemics available within CHCs for distribution to vulnerable households in target village tracts in times of need	Provision of preventative health supplies for major disease epidemics to each CHC in year 1 of the project % of supplies distributed to and effectively utilised by vulnerable households Technical training and support to each CHC in health epidemic response related topics in years 2-5 % change in key health behaviours (mosquito net usage rates, latrine use, ORS usage etc)	Total # of items distributed throughout project: 22,334 mosquito nets; 3,615 latrine pipes and pans; 5,000 female sanitary kits. 100% of vulnerable households received mosquito nets, while 18.4% received latrine pipes and pans. 100% of the latrine pipes and pans have been utilised; see below for mosquito nets. An Emergency Assessment and Response Team (EART) team was formed in 16 targeted CHCs. In the final evaluation survey, 62.9% of households reported that all members use bednets. A comparison with the baseline is not possible, as it is not clear exactly what question the Baseline Survey asked in this regard.

		In the baseline survey, 91.2% of households reported that their members washed their hands before eating, compared with 93.1% in the final evaluation survey. In the baseline survey, 72.5% of households reported that all members wash their hands after using the latrine, compared to 83% in the final evaluation survey. This equates to a 14.5% increase. In the baseline survey, 80.2% of households reported that all members use the latrine, compared to 24.9% in the final evaluation survey (75.1% reported that some household members use the latrine). The reasons for this apparent 69% drop are unclear, though the way in which the question was phrased in the baseline survey may be the explanation. In the baseline survey, 39.6% of households reported obtaining water from a public tube well, 4.4% from a private tubewell, 1.0% from an unimproved well and 37.3% from a pond. In the final evaluation survey, the equivalent figures were 50.5%, 20.6%, 10% and 9.1%. These figures represent a significant shift away from pond water towards safer sources, notably tubewells. The shift was probably driven by a combination of health education activities and tubewell construction (the latter supported by both CARE and ACF).
	50-60% CHCs maintain contingency stocks for major disease epidemics until EoP	By the time CHCs were closed down, contingency stocks had already been exhausted due to the CHCs' inability to replenish them.

Given the limited success of the CHCs and CHFs (see Section 4.1.3), and based on the recommendations of the rapid review in February 2010, the CHCs and CHFs were closed down in May 2010. The majority of outstanding loans were reportedly recovered and the entire amount used to procure and distribute the additional mosquito nets under Output 3.3.

The standard of the health education delivered by the project was generally satisfactory, as evidenced by clear increases in the level of knowledge on the part of community members. For example, there was a 27% increase over baseline in the correct response rate to a question concerning the cause of malaria, a 49% increase in the proportion of respondents who were aware that using a mosquito net is an effective means of preventing malaria, and a 68% increase in the proportion of respondents who knew that drinking unclean water can cause diarrhoea. Increased knowledge resulted in behaviour change: for example, a 15% increase in the proportion of household members who wash their hands after using the latrine and an increase of 59% in the proportion of respondents who reported boiling drinking water. There has also been a significant shift away from pond water towards safer sources of drinking water, notably tubewells (the shift was probably driven by a combination of health education activities and tubewell construction, the latter supported by both CARE and ACF). Changes in behaviour resulted in a significant reduction in the incidence of diarrhoea and malaria (see Section 5).

Nutrition training, however, was seen as rather impractical by some participants, as it reportedly did not prioritise foods that are readily available locally. One participant observed: '[w]e cannot afford to eat as in the [nutrition training] instructions because of the scarcity of meat and fishes. [...] We can only have vegetables during the cold season. We came to know how to eat appropriately but we cannot afford to eat [like this] in reality.'[38]

[38] Mee Kyaung Gaung Swe / Mee Swe SMIG FGD.

4.2.4 Outputs under Component Objective 4

The following table summarises project achievements against relevant Output indicators:

Logframe descriptor	Indicators	Progress against indicators by EOP
Output 4.1: Capacity building improvement of 210 community members from 20 villages on disaster risk reduction.	Selection of 20 targeted villages at risk Technical training to the community in disaster risk reduction topics DRR activities in the targeted villages	The VTs selected all met the criterion that they must be located in 'geographically disaster-prone' areas of high vulnerability. Delivered. Prior to the training, a CBDRR township level advocacy workshop was conducted by CARE and MSN, attended by district level authorities, FD and UN agencies. Activities were limited to awareness training and experience sharing

The standard of outputs is difficult to assess, as no training evaluation reports are available. According to project reports, three CBDRR trainings were conducted at the village level for 76 trainees from 19 village tracts. Feedback reported from the participants showed that they found the trainings to be useful and relevant. However, DRR activities did not progress beyond awareness training and experience-sharing.

4.2.5 Outputs under Component Objective 5

The following table summarises project achievements against relevant Output indicators:

Logframe descriptor	Indicators	Progress against indicators by EOP
Output 5.1: Water supply and sanitation improved in the flood affected villages	Restoration of water supply systems (immediate repair, fuel, pond cleaning, etc.) Distribution of water purification supplies Restoration of sanitation facilities (cleaning of latrines, etc.) and hygiene promotion	Pond cleaning activities were completed for 76 ponds in 22 village tracts in both Maungdaw and Buthidaung. These supplies were not distributed, as by the time the budget had been approved, the emergency phase had passed and the focus had shifted to other WASH activities. 1,000 hygiene kits were distributed to 1,000 households.
Output 5.2: Households in the flood affected villages provided with improved emergency family shelter and household recovery	Distribution of temporary shelter materials (incl. plastic sheeting) Distribution of shelter tools kits Support for mobilisation of community organisation committees in displaced persons centres to organise and improve shelter conditions.	NFI distribution was completed in both townships in July 2010 for 4,483 households. After assessment of damaged latrines and shelters, substitution of 679 shelters and 1,100 latrines was completed. No committees were mobilised for shelter activities. Instead, the focus was on supporting Village Development Committees to implement WASH activities, including the reconstruction of Fly Proof Latrines in each household.
Output 5.3: Vulnerable HHs in the flood affected villages have provided with food in the emergency for food security	Distribution of food in collaboration with WFP (emergency distribution & Food For Work for land repair) Support for recovery of food production (seeds, tools, fertilizer, cleaning of land, etc., for rice cultivation and home gardening)	For emergency response, 268.95 MT of food were distributed in partnership with WFP in all project villages to a total of 4,397 households in Buthidaung and 86 households in Maungdaw. As part of the recovery program, summer paddy seed, Urea and fertilizer was distributed to 1,200 beneficiaries in the two townships.

Budget approval for this emergency component reportedly took some time, such that the emergency phase had ended by the time the budget was approved. Activities therefore focused on rehabilitation (particularly with regard to water sources and fly-proof latrines) and supporting affected households' transition back to their normal livelihood activities. The standard of outputs was satisfactory, with CARE drawing on its recent experience with Cyclone Nargis.

4.3 Benefits to the target population

Component Objective 1

CF initiatives have resulted in very significant benefits for the target population. 3,200 landless or land-poor largely Rohingya households were able to establish, and are continuing to manage, household CF plots; all but 100 of these households[39] have received land-use certificates, valid for 30 years and then potentially renewable. The receipt of these certificates by Rohingya households, the majority of whom are not recognised as Myanmar citizens, marks a significant step forward for households along the path to regularising their citizenship status. Community stabilisation and protection benefits are therefore also likely to flow from this component. The CF plots, despite still being fairly young, already constitute significant assets for households, and a significant income stream is already flowing from these assets.[40] This income stream will grow considerably in future years, particularly once plots are mature enough for timber harvesting to start.

Other benefits from CF typically mentioned by participants included: construction materials and firewood; a reduced need to work as casual labour; the ability to afford one's own home and send one's children to school; the production of vegetables through inter-cropping during the first two years of CF establishment. Some CFUG members mentioned an increased sense of group solidarity as a benefit, such as the man who told the consultant during the 2010 review that 'before CARE, we had no habit of cooperating together like this'.[41] Ownership of plots has also had an empowering effect for some, such as the Dainet ethnic minority woman who stated: 'They [i.e. other community members] do not look down on us as we own the plantation. They wanted to look down on us as we did not own anything before.'[42] Environmental benefits such as increased stream flows during dry spells and shelter from strong winds were also mentioned by some groups.[43] CFMCs and CFUGs have learned plot management techniques, though further capacity building is required. As noted in Section 4.1.1, many targeted communities (as well as some not targeted by the project) have been requesting that additional CF plots be established, indicating that the plots are viewed as strongly beneficial (and hence desirable) by community members.

Hundreds of households benefited from PDF activities, but the precise extent of the benefits cannot be estimated with any rigour due to a lack of relevant data (e.g. on increases in yield or household income) as a result of poor monitoring. In addition, it is unlikely that these benefits were sustained beyond the end of the project for a high

[39] A change in administrative procedures means that a new and more time-consuming process has to be followed for the remaining 100 households. However, CARE is confident that certificates will eventually be issued.

[40] The mean estimate of the value of the trees grown on CF plots of over four years of age was Kyat 923,343, and the mean household income from CF plots over the last 12 months was Kyat 84,706 (which equates to around 11% of the average annual household income of Kyat 782,705 reported in the final evaluation survey).

[41] Interview in Letwaedat Pyin Shay / Thapyae Thaung during 2010 review.

[42] Inn Chaung / Inn Chaung CFUG (female) FGD.

[43] Including Mee Chaung Gaung Swe (2010 review interview) and the following FGDs: Inn Chaung / Inn Chaung CFUG, Inn Chaung / Ywar Gyi CFUG, Maung Hna Ma / Aung Min Ga Lar CFUG (Male).

proportion of households, as the requisite inputs supplied by CARE were too expensive to be purchased by households themselves.[44]

SMIG members received vocational training in a variety of activities, but monitoring reports indicate that the benefits to households' livelihoods were quite limited, in that only around 20-30% of trainees actually made a profit from the activity in which they had been trained.

59 VDG schemes supported the construction of wells, schools and bridges in target communities. The infrastructure built was of good quality and clearly contributed to improving villagers' livelihoods by bringing benefits such as better access to markets and services, a better learning environment for school children and better access to safe drinking water.

Component Objective 2

The SMIG groups provided access to financial services for over 6,700 women, 80% of whom were Rohingya and 90% of whom were landless or land-poor. However, the financial performance of the majority of the SMIG groups was poor, meaning that financial benefits for most SMIG members were limited or non-existent, and that some members actually lost their savings. However, in the minority of groups that functioned satisfactorily, the benefits for group members could be significant in the form of consumption-smoothing loans or capital to invest in income-generating activities. The groups also brought significant benefits by strengthening social cohesion as well as raising the status of women within their households and communities. Involvement in SMIG or other project groups has had an empowering effect on many women, who are now able to work outside their home, travel outside their community and/or deal with government officials and traders.[45]

Component Objective 3

Under the CHC/CHF model implemented by CARE, 31% of targeted village tracts (i.e. five out of 16) were receiving visits (at varying intervals) from Rural Health Centre (RHC) or Sub-centre staff at the time of the 2010 review. These village tracts therefore experienced improved access to health care; for example, 262 villagers from five targeted villages received curative services from midwives in the period July 2009 to April 2010.[46] In the other 69% of targeted village tracts, however, the model proved to be unfeasible (see Section 4.1.3). The benefits from community health education activities were highly significant, resulting in documented reductions in the incidence of serious diseases (e.g. a 28% reduction in the incidence of malaria and a 16% reduction in the incidence of diarrhoea; see Section 5). Distributions of latrine pipes and pans (to 18.4% of vulnerable households) and mosquito nets (to 100% of vulnerable households) contributed to the realisation of these benefits. It can be argued that these improvements in public health represent sustainable benefits for the entire population of the 16 targeted village tracts (VTs) (around 11,800 persons). However, in nine of these VTs at least one other international organisation was working on similar health issues, therefore it would be incorrect to attribute all the health improvements to CARE's activities. Peer Educators (PEs) benefited individually from their training on relevant topics and represent a valuable resource for their communities.

Component Objective 4

76 participants from 19 village tracts benefited from training on DRR and represent a valuable resource for their communities. However, other tangible benefits for communities were not realised as DRR activities did not progress beyond cross-visits and experience sharing.

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[44] Interviews during 2010 review; Inn Chaung / Inn Chaung CFUG FGD.

[45] FGDs with Mee Kyaung Gaung Swe / Kone Tan SMIG group, Inn Chaung / Inn Chaung CFUG and Mee Kyaung Gaung Swe / Kone Tan SMIG MC.

[46] June 2010 Interim Report.

Component Objective 5

30,000 flood-affected persons benefited from rehabilitation activities (particularly with regard to water sources and fly-proof latrines) and from the provision of tools and inputs to facilitate their transition back to normal livelihood activities.

5. Impact

5.1 Summary of impacts

The table below summarises progress towards the project's Impact indicators.

<table>
<tr><th>Logframe descriptor</th><th>Indicators</th><th>Progress against indicators by EOP</th></tr>
<tr><td>Substantially enhance household livelihood security (assets, income & health) of poor, predominantly Rohingya, households in Northern Rakhine State.</td><td>Average total asset values doubled for CF households with plots of four yrs age or older</td><td>No baseline data available. Final evaluation therefore attempted a qualitative assessment of change by asking households with plots of four years of age or older: 'How much have your household assets increased due to CF activities? Very substantially; Substantially; A little; No change; Don't know'.

Responses:
<table>
<tr><th></th><th colspan="2">Total</th></tr>
<tr><th></th><th>Count</th><th>Percent</th></tr>
<tr><td>Very substantially</td><td>48</td><td>11.5%</td></tr>
<tr><td>Somewhat substantially</td><td>211</td><td>50.5%</td></tr>
<tr><td>A little</td><td>115</td><td>27.5%</td></tr>
<tr><td>No changes</td><td>43</td><td>10.3%</td></tr>
<tr><td>No idea</td><td>1</td><td>0.2%</td></tr>
<tr><td>Total</td><td>418</td><td>100.0%</td></tr>
</table>

62% of households with plots of four years of age or older reported very substantial or substantial increases in their household's assets due to CF activities. 10.3% of households reported no change.</td></tr>
<tr><td></td><td>Increased proportion of household income available for improved livelihood investment and consumption (proportion of household income devoted to meeting rice needs measured against baseline & compared to 'control group' households).</td><td>No control group was established (an overambitious idea given the context).

Another problem made it impossible to assess progress against this indicator. The baseline report records the % of households that reported monthly income levels in each of seven bands. However, the actual (mean) household income level was not stated. The raw baseline data (from which mean income level could be calculated) could not be located, hence the necessary information to assess the indicator is unavailable.</td></tr>
<tr><td></td><td>Reduction in vulnerability to malaria, TB and diarrhoea in project area over baseline.</td><td>In the baseline survey, 76.6% of households reported having had a case of malaria in the past 12 months, compared with only 55.0% in the final evaluation survey. This equates to a 28% reduction in incidence.

In the baseline survey, 16.5% of households reported having had a case of TB in the past 12 months, compared with only 7.7% in the final evaluation survey. This equates to a 53% reduction in incidence.

In the baseline survey, 65.6% of households reported having had a case of diarrhoea in the <u>past month</u>, compared with 27.5% of households in the final evaluation survey that reported having had a case of diarrhoea within the <u>past two weeks</u>. If the final evaluation figure is doubled so as to be equivalent to the baseline figure, the revised figure of 55.0% represents a 16% reduction in incidence.</td></tr>
</table>

Project strengthens the enabling environment for group formation, greater self-reliance, social justice and economic opportunity	See main text below.

In terms of progress towards the project's Goal and related indicators, 62% of households with plots of four years of age or older reported 'very substantial' or 'substantial' increases in their household's assets due to CF activities. Although the indicator aiming to measure the 'increased proportion of household income available for improved livelihood investment and consumption' could not be assessed due to a lack of baseline data, a significant income stream (equivalent to around 11% of mean annual household income) is already flowing from CF plot assets. This income stream will increase substantially as plots mature. CF plots have thus had a substantial economic impact.

With regard to broader impacts, the receipt of land-use certificates by Rohingya households (the majority of whom are not recognised as Myanmar citizens) can be argued to have the potential to have a positive impact on the political and security context in NRS. CARE's inclusion of Rakhine communities in CF (and other) activities is likely to have had a positive socio-cultural impact on inter-ethnic relations. Positive environmental impacts have been reported by communities, and these are likely to grow with time as plots mature. The CF component is already having positive impacts in non-targeted communities in NRS that have established their own CF plots after seeing the success of project-supported plots.

CARE's advocacy with the Ministry of Forestry (MoF) at national level holds the potential for institutional impact, resulting in the replication of – or at least learning from – CARE's CF approach in other areas of the country (CARE is currently negotiating with the MoF under the new government for a national level Memorandum of Understanding (MoU) that should facilitate this replication process). CARE itself is already applying lessons learned from NRS CF activities in other CARE projects around the country, with target locations including Southern Chin State, Kayah State and the Ayeyarwaddy Delta.

Impacts from PDF activities were limited, as many households were unable to afford the required inputs once project support ceased. Vocational training activities also had limited impact due to a lack of viable marketing opportunities. VDG schemes to build wells, schools and bridges have had broader economic and socio-cultural impacts in terms of facilitating access to markets and services, contributing to a better learning environment for school children and improving public health.

The positive impacts of CARE's model for improving community access to health services were limited to the 31% of communities in which the model functioned (at least partially). Broader impacts were prevented by the model proving to be unfeasible in other areas due the presence of other organisations offering free services and the availability of more lucrative income-generating opportunities for government health staff. However, health education activities – in tandem with the distribution of preventative health supplies, such as mosquito nets – had a significant impact, resulting in documented reductions in the incidence of serious diseases (e.g. a 28% reduction in the incidence of malaria and a 16% reduction in the incidence of diarrhoea). These changes are likely to have had a broader impact in terms of improved public health for the entire population of the targeted village tracts (VTs) (around 11,800 persons).[47]

[47] However, in nine of the 16 targeted VTs at least one other international organisation was working on similar health issues, therefore it would be incorrect to attribute all the health improvements to CARE's activities.

The project has had significant impacts in relation to strengthening ‘the enabling environment for group formation, greater self-reliance, social justice and economic opportunity.’ Some CFUG members mentioned an increased sense of group solidarity and of feeling empowered in relation to other community members as a benefit of being involved in CF initiatives. Although the majority of SMIG groups failed to provide sustainable, high-quality financial services to the 6,700 mainly Rohingya and landless/land-poor women involved, they did have a significant socio-cultural and gender-related impact by strengthening social cohesion as well as raising the status of women within their households and communities. Involvement in SMIG or other project groups has also had an empowering effect on many women, who are now able to work and travel outside their home and/or deal effectively with government officials and traders. Economic impacts (in terms of benefits to the household economy) are likely to flow from these empowering effects. Successful participation in project activities by both men and women has instilled an increased sense of self-confidence and self-reliance in participants.

The DRR component had a limited impact, given that the scope and duration of activities were limited. The emergency response and rehabilitation component necessarily focused on short-term needs, though it did have a longer-term economic impact by enabling affected households to recover more quickly.

5.2 Advancing AusAID’s policies

CARE’s activities in NRS were in close alignment with the Australian government's longstanding practice of providing humanitarian assistance to the most vulnerable populations in Myanmar, with a particular concern for the Rohingya. The project’s long-term aims were also in-line with the Australian government’s intention of 'addressing the long-term challenges facing the Burmese people', as expressed by then-Minister for Foreign Affairs Stephen Smith, MP in a Ministerial Statement in February 2010. The project’s components included a number of those identified in the then-Minister’s statement as particular priorities for the Australian government, including agriculture (described as an 'area of great need') and WASH. The project has therefore made a significant contribution to advancing AusAID’s policies on the ground in NRS.

6. Sustainability

6.1 Sustainability of benefits to target population

Component Objective 1

The assets established in the form of CF plots will be economically sustainable, with the existing revenue stream flowing from these assets increasing in coming years. The issuance of 30-year land-use certificates (potentially renewable) to CF plot holders is an important guarantor of sustainability; as one male CFMC member put it, '[e]ven if the project is dissolved, there will be a benefit for the next thirty years. We got thirty year government land-grants.'[48] The plots are themselves environmentally sustainable, and because they have broader environmental benefits (such as improving dry season water resource availability in some areas) they will also contribute to the sustainability of other project components (including crop production and water source improvement).

Over 95% of the 3,200 CF plots established remained in operation at the time of the Final Evaluation, though the quality of operations was variable. The large number of requests for additional CF plots from communities that participated in the project as well as some that did not, as well as the fact that some better-off villagers have begun to develop plots themselves, clearly demonstrate that CF plots are highly valued by communities. This further supports the argument for plots' sustainability.

Although technologically sustainable, the new crops and varieties introduced under the PDF will not be economically sustainable for a high proportion of households, as the requisite inputs supplied by CARE were too expensive to be purchased by households themselves. An estimated 20% - 30% of the participants in vocational training for income generation have experienced sustainable economic benefits, with other participants being unable to generate income sustainably due to a lack of market opportunities (as well as variations in individual skill level and motivation).

Most VDG schemes are technologically and/or structurally sustainable (having been constructed soundly) and the economic and social benefits that they bring will be sustainable provided that the infrastructure is maintained. Maintenance standards appeared to be satisfactory during the 2010 review, as the costs for maintaining VDG infrastructure (as well as other community-level project infrastructure such as latrines and wells) are minimal and can be met by the communities themselves. An exception to this state of affairs was the damage to infrastructure (including bridges) caused by the severe floods of June 2010, in which case outside assistance was needed for rehabilitation.

Component Objective 2

A large majority of SMIG groups were not financially sustainable, for reasons discussed in Sections 4.1.2 and 4.2.2 (notably the fact that a financial model ill-suited to the NRS context was used). However, the significant benefits resulting from the groups in terms of strengthened social cohesion are likely to be socially sustainable, as will be the case with CFUGs. Similarly, social and gender-related benefits from the SMIG groups in terms of women's empowerment and mobility are also likely to be sustainable.

Component Objective 3

The model implemented by CARE with the aim of improving communities' access to health services was not sustainable in the majority of target communities, primarily for economic reasons as other organisations were providing free services, whereas the model used by CARE required payment. The highly significant benefits from health

[48] Inn Chaung / Ywa Gyi CFMC FGD (male).

education and related improvements in latrine ownership and drinking water sources will be sustainable, as communities have experienced for themselves the benefits that result from relevant behaviour change.

Component Objective 4
The sustainability of the capacity building activities in DRR is doubtful unless some tangible DRR activities are implemented at community level.

Component Objective 5
Understandably, sustainability was not the highest priority of the emergency response component. However, the rehabilitation of latrines and water sources is likely to be structurally sustainable.

6.2 Institutional capacity

The SMIG groups and the CHCs were disbanded by the project due to the poor results achieved with respect to the relevant Component Objectives; these community institutions were clearly unsustainable, requiring (especially in the case of the SMIG groups) very high levels of support from project staff. The CFMCs and CFUGs continue to operate, although the capacity of these groups is variable. For example, around 70% of CFMCs lack the capacity to manage their plots in full accordance with the Community Forestry Instructions (CFI).[49] To augment the sustainability of these groups, therefore, further capacity development is recommended.

Opportunities for building institutional capacity within government were limited because of the nature of the government (particularly the former regime), notably the suspicion amongst some senior officials of international organisations (especially in the sensitive context of NRS). However, the engagement of FD officials in project planning, monitoring and implementation, as well the involvement of local authorities in DRR awareness-raising, will have had a limited impact in terms of developing institutional capacity.

6.3 Recurrent costs

As noted above, the costs for maintaining VDG infrastructure (as well as other community-level project infrastructure such as latrines and wells) are minimal and can be met by the communities themselves, thus ensuring financial sustainability.

[49] Estimate from project staff during the 2010 review.

7. Cross-cutting themes

7.1 Gender

Involvement in SMIG groups (and, to a lesser extent, other groups such as CFUGs) and acting as Peer Educators helped women raise their status within their households and communities. Many women who previously scarcely left their household compounds now attend meetings in their village or further afield, make a significant cash contribution to the household economy and practice active mutual support and information-sharing with their community peers. Participating in SMIG groups had an empowering effect on many women, who now feel more confident in negotiating with outsiders such as government officials and traders.[50] That said, and although there is considerable variation from household to household, in most households the husband still plays the major role in decision-making. In some cases, the failure of SMIG groups (either because they were financially unviable or because of malfeasance) had negative effects on some members' livelihoods and on gender relations within their households.[51] However, the overall extent of such problems across the SMIG groups could not be assessed.

Interviews during the 2010 review indicated that some men have become more involved in reproductive activities. For example, men had become willing to look after their children while their wife attended a CARE training. However, further research is required into whether women's increased involvement in productive activities, combined with a virtually unchanged level of reproductive activities, contributed to an overall increase in their workloads.

Although CARE's activities contributed to positive changes in gender relations in target villages, other factors were also significant. These include exposure to media (particularly satellite TV, according to reports from project staff) and the realisation amongst many households that it is not possible for the household to have a decent livelihood if women's participation in productive activities remains very constrained. Further research into drivers of change in gender relations is required, and it is understood that some of the target communities in NRS are already engaged in a research study into barriers to, and opportunities for, women's participation in which CARE is one of the organisations involved (the others being Oxfam and ActionAid).

7.2 Environment

Environmental benefits from CF activities have already been reported by some communities,[52] such as increased stream flows during dry spells and shelter from strong winds. These benefits are likely to become even more significant as CF plots mature (though rigorous data on such benefits is difficult to capture). The CF component will also help address other problems related to environmental degradation that people face, including rapidly declining stocks of firewood and thatching material.

7.3 Participation of the poorest and most vulnerable groups, particularly women and ethnic minorities

Project targeting was generally satisfactory, with targets for the participation of women and ethnic minorities being met. For example, 80% of CFUG members were landless,

[50] FGDs with Mee Kyaung Gaung Swe / Kone Tan SMIG group, Inn Chaung / Inn Chaung CFUG and Mee Kyaung Gaung Swe / Kone Tan SMIG MC; KIIs.
[51] FGD with Maung Hna Ma / Aung Mingalar SMIG members.
[52] Including Mee Chaung Gaung Swe (2010 review interview) and the following FGDs: Inn Chaung / Inn Chaung CFUG, Inn Chaung / Ywar Gyi CFUG, Maung Hna Ma / Aung Min Ga Lar CFUG (Male).

while 150 of the 3,200 member households were female-headed (it should be noted in this regard that the project instituted a sensible policy of only accepting applications from female-headed households for CF plots if they had sufficient labour resources with which to work their plots). All 6,717 SMIG group members were women, over 90% of whom were from landless/land-short households and 85% of whom were Rohingya. A total of 199 PEs were trained under the health component, 105 of these being women.

Although some members of the smaller ethnic minority groups in NRS[53] did participate in project activities, no research has been done with these groups to gain an understanding of the particular challenges they face. CARE should consider conducting such research, as a necessary prerequisite to deciding whether or not to engage with such groups on a larger scale during future projects.

FGDs with villagers who did not participate in any project activities indicated that some villagers did not have an opportunity to participate in CFUGs because they were ill or away from the village when the relevant meetings were held. The fact that other villagers did not inform them suggests a certain degree of social exclusion. Other villagers were initially not interested in project activities because they were occupied with their own; they later developed an interest when the potential benefits became clear, but too late to participate. With regard to the CF component, many villagers initially feared that the plots would eventually be taken back by the government and hence did not wish to participate. In some households consisting of several families, only the name of the household head was listed for activities, meaning the various other family heads in the household were inadvertently excluded.[54] From villagers who did not participate in activities, the main expressions of interest if future opportunities for participation arise involved CF, small livestock and betel plantations. As one 53 year-old widow said, ‘I can do even without a man. I can raise goats. I can do the betel plantation.’[55]

[53] Including Kamein, Kwe Myi, Dainet, Maramagyi, Mro and Thet.
[54] Phar Wut Chaung / The Chuwng Not Involved FGD (Male).
[55] Inn Chaung / Inn Chaung Not Involved FGD (Male & Female).

8. Conclusions and lessons learned

8.1 Overall assessment

RRHLSP succeeded in meeting its objectives under Component 1, which was the most successful component of the project. The community forestry activities are, without exaggeration, unique in the NRS context and ground-breaking in the context of Myanmar as a whole. 3,200 landless or land-poor largely Rohingya households were supported to establish and manage CF plots, and CARE facilitated the issuance of land-use certificates (valid for 30 years, and then potentially renewable) to plot holders. This is a major achievement, both in terms of the livelihood benefits and in terms of enabling Rohingya households to advance their claim to citizen's rights. Community stabilisation and protection benefits are therefore also likely to flow from this component.

The CF plots, despite still being fairly young, already constitute significant assets for households; 62% of households with plots of four years of age or older reported 'very substantial' or 'substantial' increases in their household's assets due to CF activities. A significant income stream is already flowing from these assets,[56] and this will grow considerably in future years. Environmental benefits such as increased stream flows during dry spells and shelter from strong winds have also already been experienced.[57] Benefits from this component will be sustainable; over 95% of the 3,200 CF plots established remained in operation at the time of the Final Evaluation. However, the quality of plot management was variable, with around 70% of the CFMCs still lacking the capacity to manage their plots in full accordance with the Community Forest Instructions (CFI).

The CF component is already having positive impacts in non-targeted communities and households in NRS that have established their own CF plots after seeing the success of project-supported plots. CARE's advocacy with the Ministry of Forestry at national level holds the potential for broader institutional impact, resulting in the replication of – or at least learning from – CARE's CF approach in other areas of the country.

Hundreds of households benefited from new crop and variety trials under the PDFs, but it is likely that these benefits were not sustained beyond the end of the project for a high proportion of households, as the requisite inputs supplied by CARE were too expensive to be purchased by households themselves. The consultant's opinion is that the PDF suffered from not having the status of a full Component Objective in the project, being represented merely in two outputs; consequently, it appears to have been somewhat under-funded. An estimated 20% - 30% of the participants in vocational training for income generation have experienced sustainable economic benefits, with other participants being unable to generate income consistently due to a lack of market opportunities.

The SMIG groups provided access to financial services for over 6,700 women, 80% of whom were Rohingya and 90% of whom were landless or land-poor. However, the actual financial performance of the majority of the SMIG groups was poor, and the project therefore did not succeed in achieving its objectives under Component 2. Reasons for the poor functioning of the SMIG groups included: the fact that the financial model used was not suitable for most women in a context where income-

[56] The mean estimate of the value of the trees grown on CF plots of over four years of age was Kyat 923,343, and the mean household income from CF plots over the last 12 months was Kyat 84,706 (which equates to around 11% of the average annual household income of Kyat 782,705 reported in the final evaluation survey).

[57] Including Mee Chaung Gaung Swe (2010 review interview) and the following FGDs: Inn Chaung / Inn Chaung CFUG, Inn Chaung / Ywar Gyi CFUG, Maung Hna Ma / Aung Min Ga Lar CFUG (Male).

generating opportunities remain very constrained and many households' main borrowing requirement is for consumption-smoothing purposes rather than microenterprise; a lack of income-generating opportunities, and a lack of specialist technical support. There is evidence to suggest that pressure to address the problem of under-spending that affected the project (particularly in the early stages) may have been the reason for the provision of CARE grants even to poorly performing groups, which undermined the intended incentive effect.

According to an internal audit conducted as a follow-up to the 2010 review, around six of the 242 groups had ceased to function entirely because of theft by Management Committee (MC) members (amounting to a total of AUD $650). Following the audit but prior to group closedown in December 2010 / January 2011, one group[58] out of the five involved in Final Evaluation FGDs experienced the suspected theft of a significant amount of group funds (AUD 1,200) by MC members. How widespread such post-audit problems were could not be assessed.

Although group financial performance was generally poor, it should be noted that in the minority of groups that functioned satisfactorily, the benefits for group members could be significant. The groups also brought significant and sustainable benefits by strengthening social cohesion as well as raising the status of women within their households and communities. Involvement in SMIG or other project groups has had an empowering effect on many women, who are now able to work outside their home, travel outside their community and/or deal with government officials and traders.

RRHLSP partially succeeded in achieving its objectives under Component 3. Quantitative targets regarding the establishment of CHCs were met, but only 31% met basic performance criteria. The model employed to try to increase communities' access to health services proved to be unfeasible in the majority of targeted areas due to the failure of most CHFs to generate sufficient income and the fact that government health staff had more lucrative income-generating options available to them. An underlying problem was that other INGOs began to provide free services in the same (or nearby) areas as CARE, and villagers understandably preferred to use these services, rather than pay for drugs at a CARE clinic. Based on the recommendations of the 2010 review, the CHCs and CHFs were closed down in May 2010.

Community health education, delivered by trained male and female Peer Educators (PEs) with the assistance of tailored IEC materials, was much more successful. Health education, accompanied by complementary improvements in latrine ownership and drinking water sources, resulted in documented reductions in the incidence of serious diseases (e.g. a 28% reduction in the incidence of malaria and a 16% reduction in the incidence of diarrhoea). It can be argued that these improvements in public health represent sustainable benefits for the entire population of the targeted village tracts (around 11,800 persons).[59]

The project partially succeeded in meeting its objectives under Component 4, which was added in Year 6. DRR trainings were conducted at the village level for 76 trainees from 19 village tracts, and an advocacy workshop was conducted with local NGO MSN for district level authorities, the FD and UN agencies. Other tangible benefits for communities were not realised as DRR activities did not progress beyond cross-visits and experience sharing.

In response to severe flooding in NRS in June 2010, Component Objective 5 was added to the project to assist 30,000 flood-affected persons. Budget approval for this emergency component reportedly took some time, such that the emergency phase had

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[58] Maung Hna Ma / Aung Mingalar.

[59] However, in nine of the 16 targeted VTs at least one other international organisation was working on similar health issues, therefore it would be incorrect to attribute all the health improvements to CARE's activities.

ended by the time the budget was approved. Activities therefore focused on rehabilitation and supporting affected households' transition back to their normal livelihood activities.

8.2 Lessons learned

Project design and management

- Monitoring of activity implementation was unsatisfactory, which contributed to a lack of responsiveness and adaptability on the part of management with regard to a number of serious problems (including SMIG group and CHF failure, which was widespread yet was not addressed effectively). A lack of precise data on the results of PDF trials (e.g. yield increases and/or income gained) and vocational training meant a rigorous assessment of these activities to identify promising interventions was not possible. Improved monitoring is a critical area requiring improvement.
- The selection of a number of inappropriate indicators contributed to the monitoring problems. The need to ensure that indicators are measurable should always be borne in mind, particularly for an area such as NRS where economic distortions and a lack of reliable data are especially acute.
- A good quality baseline survey is another critical requirement for M&E. Baselines need to be carefully designed and should aim to capture only relevant data that is actually needed. If a baseline survey is outsourced, close monitoring of the contractor is required to ensure quality.
- Downward accountability (between project and target populations) was lacking and needs to be improved.
- The project was generally better at technical capacity development, as opposed to the development of the capacity of community institutions and organisations. Plans for staff capacity-building in future should bear this in mind.

SMIG

- Financial services for women should focus on the provision of small loans for consumption-smoothing or emergency purposes, not on lending for income-generating activities.
- The absorption capacity of NRS with regard to project expenditure is limited, and putting pressure on a project to spend faster can have serious negative effects (e.g. the provision of grants to SMIG groups that were not performing well undermined the intended incentive effect).

8.3 Recommendations

Community Forestry

- Overall, it is recommended that in a future phase the project continue to provide support to most of the existing CFMCs, as well as introduce CF operations in new areas (both within currently targeted village tracts that possess available land and within a limited number of village tracts that are not currently being targeted).
- Priorities for CFMC capacity building should include: knowledge and understanding of the CFI; CF management techniques, including new techniques that will be required as plots mature (e.g. timber harvesting and marketing strategies to maximise profits); approaches to dealing with the FD; maintaining a CFMC fund, as required by the CFI.
- Literacy training for CFMC members should be made more effective if possible, for example by providing one longer continuous course rather than two short ones.
- In a future phase, the project should use its achievements to inform the activities of projects in other parts of the country run both by CARE and by other

agencies, i.e. to magnify the potential impact. Project achievements should also support continued advocacy efforts.
- An environmental education output should be added to the next phase.

PDF

In any future phase, the project should consider the following:
- The production of off-season vegetables (such as rainy season tomatoes), as well as other high-value vegetables (such as a type of gourd from India that is in high demand), should be piloted, using successful local farmers as trainers/advisors.
- Goat breeding with appropriate breeds.
- New vocational training activities, including pump/motorbike maintenance, Professional Pest Applicator training, Minor Forest Product (MFP) processing and the production of fuel-efficient stoves (following a research and design process to identify designs that are locally appropriate).
- Continue with efforts with build up local stocks of good quality seed.
- Pilot integrated farming models (bringing together a pond, vegetable plots and fruit trees, plus poultry).
- Pilot the cultivation of betel leaf in ways that minimise the incidence of disease.
- Use an Agro-Enterprise Development Process (AEDP) (with which CARE already has experience) to investigate the market potential of possible products and devise ways to promote those that look promising.

SMIG
- Having closed the SMIG groups, an alternative model (e.g. an Accumulating Savings and Credit Association (ASCA) model, such as the Village Savings and Loan Associations (VSLA) being implemented in Southern Chin by CARE) should be considered, as there is still plenty of interest amongst women in a form of financial service that actually meets their needs. CARE's experience in Bangladesh should also be reviewed for relevant lessons. The number of new groups to be established needs to be selected carefully, so as to ensure that sufficient staff resources can be devoted to supporting the groups.
- In any future phase, program management should ensure that project staff receive adequate specialist technical support with regard to the microfinance component.

Health
- The emphasis in any future phase should be on community health education, delivered through community health educators as at present but with a greater emphasis on the promotion of health-seeking behaviour.
- Training and IEC materials should be updated to cover in more depth issues of concern to the communities (including HIV/AIDS, H1N1 and H5N1), and efforts should be made to make training sessions more interesting and interactive. Audio-visual materials (e.g. DVDs) would increase effectiveness.
- Health educators should be trained to more effectively facilitate the referral of patients to the most appropriate service provider, be it an INGO or a government facility.
- Nutrition training was seen as rather impractical by some participants, as it reportedly did not prioritise foods that are readily available locally. CARE should modify its approach to focus on how locally available products can be used to improve nutritional status, and link such efforts to agriculture and Natural Resource Management (NRM) activities. CARE is already collaborating in Laos with Welthungerhilfe (WHH, formerly GAA) in implementing a new approach to improving nutrition known as LANN (Linking Agriculture, Natural Resources and Nutrition), and WHH is due to start implementing LANN in Northern Shan State in Myanmar in 2012. CARE should consider collaborating on LANN with WHH in Myanmar also.

DRR

- To increase impact with regard to DRR, CARE needs to focus more on this element in any future phase, providing additional support and tangible DRR activities at community level that engage a significant proportion of the population. DRR activities should also be much more closely integrated with other relevant project components.

Project / program management

- Monitoring systems need to be improved, and mechanisms for downward accountability (between project and target populations) need to be introduced.
- In any future phase, it is suggested that an adapted version of Outcome Mapping be piloted in order to capture outcomes in relation to one or two of the project's key partners.

Appendices

Appendix 1: Original RRHLSP Logical Framework

(NB Component Objectives 4 and 5 are not mentioned, having been added in the latter stages of the project; see Section 1.4 for details.)

LOGFRAME DESCRIPTOR	INDICATORS	MEANS OF VERIFICATION	RISKS
PROJECT GOAL: Substantially enhance household livelihood security (assets, income & health) of poor, predominantly Rohingya households, in Northern Rakhine State.	• Average total asset values doubled for CF households with plots of 4yrs age or older. • Increased proportion of household income available for improved livelihood investment and consumoption (proportion of household income devoted to meeting rice needs measured against baseline & compared to 'control group' households). • Reduction in vulnerability to malaria, TB and diarrhoea in project area over baseline. • Project strengthens the enabling environment for group formation, greater self-reliance, social justice and economic opportunity	• Baseline and EoP evaluation sample stratified household survey. • Annual sample CF plot valuation and income estimation survey • Monitoring mission observations and reports • Comments and qualitative feedback from beneficiaries and stakeholders during annual participatory planning and review activities	• Local authority leadership significantly alter local policies and practices towards INGO's. • Ethnic unrest and conflict. • Large scale refugee movement back to Bangladesh. • Economic shock – such as hyper-inflation – significantly undermines asset values and income generation potential

COMPONENTS			
COMPONENT OBJECTIVE 1 Facilitate 3,000 landless, predominantly Rohingya households to sustainably increase household assets and incomes through community forestry.	• At least 3,000 households possess one acre of CF land (with CF certificates) by EoP • Average imputed asset value of household CF plots by age. • At least 90% of established plots and CFMC's still in operation by EoP. • % increase in annual household income (cash & in-kind) from CF plots by plot age.	• Annual sample CF plot valuation and income estimation survey (Oct/Nov). • CF Operation and Status Inventory (all plots est. since 1998) • EoP evaluation. • CF establishment records.	• CF land is confiscated by authorities for use by model villages or other purposes. • 'model village' or other households destroy/ encroach CF plots. • DPDC does not support change in land status from LRSD to FD. • Authorities cease to allow non-citizen Rohingya's to gain CF certificates. • Traditional land owners dispute CF ownership rights of CFUG members.
COMPONENT OBJECTIVE 2 Facilitate 6000, predominantly Rohingya women to access high quality and sustainable financial services.	• A minimum of 6,000 women are members of village SMIG groups by EoP. • 70% of members are from landless / land-short households (up to 2 Kani[1]) and 80% are Rohingya. • % increase in household borrowing requirements met by SMIG	• Annual sample client satisfaction and impact survey (subcontracted). • SMIG database (excel) and monthly consolidated reports.	• Government bans operation of savings and loan groups in NRS. • Religious/village leadership oppose formation of women's groups.
COMPONENT OBJECTIVE 3 Targeted village tracts receive improved access to health services	• 16 CHC's established. • At least 50% of CHC's meeting performance management criteria after 2 years of establishment. • 60% of targeted VT's receive at least 1 visit per week from RHC/SC staff within 6 months of est. until EoP • Health education materials developed and distributed in 16 VTs • CHC's distribute preventative health supplies to most vulnerable (20%) of households.	• CHC Financial and Service Database • Annual Capacity Assessment Surveys • RHC / SC attendance and treatment records • Distribution records	• DMO does not support project and opposes use of RHC staff in outreach activities.

Component Objective One: Facilitate 3,000 landless, predominantly Rohingya households to sustainably increase household assets and incomes through community forestry.			
OUTPUT 1.1 Households (mostly landless Rohingya) establish viable, CF plots registered under the Community Forestry Instruction (CFI).	• At least 3,000 households possess CF land (with CF certificates) of modal size of at least 1 acre by EoP. • Landless households comprise at least 60% of CF User Group members. • Saplings planted in establishment year show survival rate of at least 70% across all CF plots per year.	• Monthly project reports. • Project Community Forestry database and record system. • Project undertaken (10% area) survival rate assessments (Oct/Nov – planted in June/July)	• WFP unable to provide sufficient rice, in timely manner and in line with CF manual requirements. • CF plots damaged by livestock/wild animals.
OUTPUT 1.2 Community Forestry Management Committees have adequate capacity to manage CF operations **and** minimise risks.	• % growth in capacity of CFMC's as assessed through annual "360 degrees" assessment against CFMC duty statements. • At least 90% of established plots and CFMC's still in operation by EoP.	• Annual CFMC capacity assessments against CFMC duty statement by themselves, project staff, CFUG members and peer CFMC.	• CFI policy of ensuring 'tax free' status does not translate into practise.
OUTPUT 1.3 Effective relationships continue to be built between Forestry Department and CFMC's.	• # of CFMC initiated assistance requests to FD and FD responses rates to such requests.	• Six monthly progress review workshop documentation. • Final Evaluation.	• Breakdown in relations between FD and CARE staff. • CFMC's unwilling to provide reasonable 'per diems' to FD staff.
OUTPUT 1.4 Simple, robust agricultural production technologies are trialled and scaled up.	• Production Development Funds support at least 4 technology trials through at least 30 CFMC's • Appropriate technologies are scaled-up through the provision of tied grants / loans in at least 30 CF villages (hamlets) • *Additional specific indicators will be developed on an annual basis for each technology trial.(see Annual Plans)*	• CFMC grant / loan distribution records • Monthly project reports • Six monthly progress review workshop documentation.	• Sufficient robust technologies are unable to be identified.

Component Objective Two: Facilitate 6,000 predominantly Rohingya women's to access quality and sustainable financial services.			
OUTPUT 2.1 New SMIG groups established and existing groups expand membership.	• Min. of 36 new management committees established by EoP. • % average natural growth rate in membership of MC's over 2 years of age by EoP.	• SMIG monthly financial reports. • SMIG database and monthly consolidated reports.	• Religious/Village leadership oppose creation of women's groups. • Religious beliefs forbidding the charging of interest on loans threatens MC's.
OUTPUT 2.2 SMIG groups provide sufficient, quality financial services to their membership.	• At least 80% of established SMIG Groups still in operation by EoP • % increase of household's financial service needs met through group membership by age of SMIG Group. • 80% of members from 'graduated' groups are 70% "satisfied" with Loan and Savings product terms and conditions.	• Annual sample (10%) client satisfaction and impact survey.	• MC's have insufficient capital to be able to meet member needs. • MC's unwilling to lend to perceived "high-risk" members. • Extent of investment opportunities in target areas significantly declines.
OUTPUT 2.3 SMIG Management Committees are able to adequately manage internal operations and minimise risks.	• At least 80% of SMIG groups over 12 months of age consistently meet 'primary' financial and management performance criteria. • At least 80% of SMIG groups over 24 months of age consistently meet 'graduation' financial and management performance criteria. • % growth in capacity of all SMIG MC's as assessed through annual "360 degrees" assessment against SMIG MC TORS.	• SMIG monthly financial reports • Annual Capacity Assessment Surveys. • Primary and Graduation Criteria.	• MC capacity for record keeping and accounting is unable to be developed to sufficient levels in all sites. • MC '360' degree capacity assessment tools absorb excessive staff time threatening other outputs.
Output 2.4 Simple, robust production technologies are trialled and scaled up.	• Village Development Grants support at least 4 technology trials through at least 30 SMIG MC's • Appropriate technologies are scaled-up through the provision of tied grants / loans in at least 8 Villages (hamlets) • *Additional specific indicators will be developed on an annual basis for each technology trial.(see Annual Plans)*	• SMIG MC grant / loan distribution records • Monthly project reports • Six monthly progress review workshop documentation.	• Sufficient robust technologies are unable to be identified. • Implementation of technology pilots absorbs excessive staff time threatening achievement of other outputs.

Component Objective Three: Targeted village tracts receive improved access to health services			
OUTPUT 3.1 CHC's established and generating required levels of income for remunerated outreach visits by RHC staff.	• 16 CHC's established. • At least 50% of CHC's meeting performance management criteria after 2 years of establishment. • 80% of CHC's established are generating a minimum of 25,000 kyats in 'profit' per month within six months of establishment. • % change in # of patients receiving treatment from RHC service providers (i.e. above CHW level)	• CHC's monthly financial and treatment/service records. • Project monthly reports • Six-Monthly Service quality assessment.	• Sufficient investment opportunities do not exist in targeted VT's to enable effective utilisation of CHC Capital Fund. • CHC management abuse their position and steal earnings and/or capital
OUTPUT 3.2 RHC staff providing quality health education services within targeted VTs.	• 60% of targeted VT's receive at least 1 health education / promotion visit per month from RHC/SC staff within 6 months of est. until EoP. • Development and distribution of appropriate health IEC materials in 16 VTs	• CHC's monthly financial and treatment/service records. • Project monthly reports • Six-Monthly Service quality assessment	• .CHCs fail to prioritise health education services
OUTPUT 3.3 Stand-bye services and contingency stocks of preventative health supplies for major disease epidemics available within CHCs for distribution to vulnerable households in target village tracts in times of need.	• Provision of preventative health supplies for major disease epidemics to each CHC in year 1 of the project • % of supplies distributed to and effectively utilised by vulnerable households • technical training and support to each CHC in health epidemic response related topics in years 2-4 • % change in key health behaviours (mosquito net usage rates, latrine use, ORS usage, etc)	• Procurement and distribution records • Baseline and repeat evaluation survey. • Six-Monthly Service quality assessment.	• Services and supplies fail to reach most vulnerable • Authorities fail to support health emergency response measures

Appendix 2: Evaluation consultant's TOR

CARE Myanmar

Terms of Reference: Final Evaluation Consultant

Rakhine Rural Household Livelihood Security Project, Maungdaw, Northern Rakhine State

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Location of assignment:	Yangon, Maungdaw, Buthidaung, Northern Rakhine State.
Duration of assignment:	Estimated 27 working days with one field visit (tentatively 14 days in Northern Rakhine State)
Responsible to: (ACDP)	Joseph Kodamanchaly, Assistant Country Director-Programs
Main counterparts:	U Nay Myo Zaw, Program Coordinator Dr. Mya Thet Su Maw, Assistant Program Coordinator Daw Nang Mya Theingi Soe, Field Office Coordinator U Shwe Thein, Program Quality Team Leader Dr. Sithu, M&E Advisor

1. Background

CARE has been engaged in NRS since 1996, when it provided rehabilitative assistance to Rohingya refugees and host communities in the two townships of Maungdaw and Buthidaung as an implementing partner of UNHCR. The rehabilitation programme initiated community forestry and home garden development in 1997, and in 1999 income generation, water supply and women's health education components were added. Since then, CARE's programming in NRS has continued a progressive transition from relief and rehabilitation to a longer-term development approach, as represented by the AusAID-funded Rakhine Household Livelihood Security Project (RHLSP; September 2001 – April 2004) and the ongoing Rakhine Rural Household Livelihood Security Project (RRHLSP; 2005-2010).

The Project Goal of RRHSLP is: *Substantially enhance household livelihood security (assets, income & health) of poor, predominantly Rohingya households, in Northern Rakhine State*. There is no Purpose/Outcome, with the next level in the logical hierarchy consisting of four Component Objectives.
Component Objective 1 (*Facilitate 3,000 landless, predominantly Rohingya households to sustainably increase household assets and incomes through community forestry (CF)*) aims to continue CARE's successful efforts in earlier phases to support households to register CF plots under the Community Forestry Instructions (CFI).
Component Objective 2 (*Facilitate 6,000 predominantly Rohingya women to access high quality and sustainable financial services*) aims to achieve its aims through supporting women to establish and manage savings and loan groups (known as Savings Mobilisation and Income Generation or SMIG groups), and to build women's capacity (though appropriate training) to generate income through activities such as home gardening, snack-making and tailoring.
Component Objective 3 (*Targeted village tracts receive improved access to health services*) aims to set up community health funds (CHFs), which should be managed by Community Health Committees (CHCs) and, through providing loans, generate a monthly income that will

enable the community to pay an incentive to government health staff to visit the village regularly.
For Year 6 of the project, an additional Component Objective was added. Component Objective 4 (*Build disaster risk reduction (DRR) capacity of 20 targeted villages*) aims to achieve its aims through the provision of training on DRR to representatives of 20 villages as well as through the implementation of activities at the village level.

Key strategies to achieve the specific objective are:
- Building stakeholder trust and village groups for sustainable project implementation
- Delivering technical improvements in three crucial livelihood sectors: assets, income and health
- Organising community based delivery of agriculture extension and health education
- Providing community planned, constructed and managed infrastructure
- Designing innovative interventions that are gender sensitive and draw on local culture

A baseline survey was conducted in October 2004, which focused on measuring quantitative indicators and qualitative indicators within the logical frame work.

The mid-term review was conducted in May 2007, which focused on the efficiency, effectiveness and impact of the project, as well as the sustainability of activities, with recommendations for the remaining phase of the project using qualitative and quantitative tools.

The final evaluation will focus on the efficiency, effectiveness and impact of the intervention as well as the sustainability of project activities following the end of the project in May 2011.

2. Objectives of the Final Evaluation

The overall objective of the final evaluation is to provide AusAID donor with sufficient information to make an informed judgment about the performance and overall impact of the project. In addition, this review will help to facilitate a process, which increases the capacity of key stakeholders to engage in all steps of a learning cycle; from observation (assessment of project progress) to reflection (generation of lessons learned) and planning (next steps following the end of project). Eventually the process should mobilise the various stakeholders to take action informed by this social learning process.

The specific objectives of the final evaluation are:
- To assess baseline versus end line survey data and information regarding impact, outcomes up to specific objective level;
- To assess overall objective (purpose), specific objectives and outcomes achieved as outlined in project documents and log-frames indicators.
- To assess project outcomes and results for different groups of people (by gender, ethnicity)
- To assess how and to what extent the project has effectively addressed the challenges faced by the target communities.
- To assess planned activities against the work plan, using strategies and approaches in the project design document.
- To assess the efficiency and effectiveness of the project in making timely progress towards achieving area of impact; realising the expected results and specific objectives (as specified in the logical framework) by project end;
- To evaluate the strengths and weaknesses of the program, and the appropriateness of project components and strategies, in relation to the overall goal of the project and assess the sustainability of these strategies
- To capture lessons learned and good practices from all aspects of the project and to assess the prospects for sustainability of benefits from project interventions;
- To provide practical recommendations for planning/adjustments or alternatives for the future program development.

3. Information to review during project final evaluation

The project final evaluation consultant will be expected to review the following information:

- All qualitative and quantitative data and information within log frame indicators to review status and impact of the project: level of achieving the Component objective against the indicators and comparison of progress made against revised project objectives and plan, and changes that have occurred in the community;
- Indicators of project goal, component objectives and outputs
- Lessons learned, good practices
- Information on cross cutting issue such as gender participation, environmental impact
- Additional and remaining needs for sustainability of project interventions based on the phased out workshop outputs
- Unexpected outcomes such as benefit, harm, social changes etc.

4. Issues to be studied during project final evaluation

The final evaluation consultant will be expected to deliver the following outputs:

- Status of the project: level of achieving the Expected Results against the indicators and Specific Objectives, comparison of progress made against revised project objectives and plan, and changes that have occurred in the community;
- Responses from key stakeholders regarding their participation in the management and implementation of the project and the level of local ownership including plans for taking the program forward;
- Responses from beneficiaries relating to project implementation strategies, outcomes and achievements;
- Participation levels of the poorest and most vulnerable groups, with a specific focus on women, minor ethnic groups, in established groups and project activities;
- Effectiveness of particular models or technical approaches (e.g. TOT approaches in Health Education);
- Extent to which an enabling environment for behaviour change has been achieved through the establishment of community technical groups in all targeted components (agricultural, health and water);
- Skill levels among trained groups, and effectiveness of knowledge and skill dissemination through PEs;
- Effectiveness and efficiency of the approach, strategies, management systems and coordination arrangements, and the extent to which timely and appropriate decisions were made to support effective implementation and problem solving;
- Key challenges and lessons learned to be documented; and
- Prospects for sustainability using current intervention strategies and established groups.

Wherever appropriate, the consultant will prepare session (question) guides for the issues around efficiency, effectiveness, impact and sustainability of the current approaches and strategies applied during the implementation, as well as the quality of the current outputs produced.

Based on these assessments, the consultant will be expected to provide:

- Thorough report detailing all findings and recommendations
- Thorough debriefing with project staff in the field and senior staff in Yangon
- Recommendations for future program development and implementation
- Final Evaluation Report which will be used as a reference for later program development activities.

5. Methodology

AusAID's Evaluation guidelines will be provided to the Consultant. Once these have been reviewed and stakeholders consulted, the consultant will be invited to propose various methodologies for conducting the study and data collection. It is envisaged that a participative approach to the evaluation will be employed to allow opportunities for social learning, capacity building and mobilisation of key stakeholders at various levels. This will help to improve the impact and sustainability of the project based on internal and external knowledge and experiences.

The following is indicative of qualitative and quantitative methods to be utilised during the Final Evaluation but not limited to:

Initial (13 Days)

- Desk review of documents such as project documents, narrative and financial periodical reports and other relevant project documents and descriptions.
- Orientation with key project and program staff
- Development of the draft methodology (including workplan) using participatory approaches, the logical framework indicators and cross cutting themes (e.g. gender, ethnicity) including calculation of sample size and methods to be utilised for data collection.
- Development of triangulation tools
- Development of guidelines for tools
- Development of the work plan
- Training of project staff (How to use the tool)

Field Visit (to be performed by local consultancy firm)

- Participatory facilitation of stakeholders through focus group discussions and other PRA exercises to evaluate ongoing activities out and new activities that may need to be introduced;
- In-depth interviews with key informants utilising review instruments such as open-ended and closed questionnaires for the collection of both qualitative and quantitative data;
- Participatory self review workshops conducted at both village and project level;
- Participatory facilitation of a lessons learned workshop with key project and program staff and further development of recommendations;
- Review activities conducted in the field, and initial analysis of findings and feedback to key project staff;
- Data analysis (using appropriate methods for data analysis), data cleaning, recording, feedback to key project and program staff

Reporting and workshop in Yangon (14 Days)

- Report drafting and finalisation in CARE Myanmar Office in Yangon
- Lessons learned workshop conducted with key project and program staff in Yangon

In general the consultant will facilitate, lead and guide the key stakeholders including target beneficiaries (CFMC, CFUG, SMIG and PEs), cooperating partners (WFP, FAO, etc), and respective line departments (e.g. FD, MAS, DOH, LSRD), local authorities, and project staff, etc. with a view to ensuring all key stakeholders sufficiently contribute to the final evaluation.

6. Expertise Required

The Consultant shall be selected based on the following criteria:

- Extensive facilitation skills and ability to use participatory tools for evaluation processes;
- At least four years of continuous professional experience in the monitoring and evaluation of integrated conservation and development projects;
- Excellent grasp of financial analysis, planning and management of development projects;
- Updated and proven knowledge of AusAID policies and procedures;
- Knowledge of gender mainstreaming;
- Willing to work with national professionals and project-level staff;
- Experience in organisational capacity improvement;
- Willing to travel and work in remote and challenging environment; and
- Familiarity with the Myanmar development context, particularly in Northern Rakhine State, would be useful.

The final evaluation consultant will have overall responsibility for ensuring all parts of the TOR are addressed satisfactorily in the review report. Upon completion of the draft report and the feedback from key program staff, the consultant will be responsible for incorporating the comments and suggestions into the final report.

CARE Myanmar will be responsible for supplying a local facilitator/consultancy firm and an interpreter for the facilitation of workshops, interviews and discussions with stakeholders, beneficiaries and groups in the field.

7. Reporting Requirements

The product of the review is an End of Project Evaluation Report. The report should be in English and font not smaller than 10pt Arial, with the following structure (as outlined in the AusAID Project Management Guidelines):

- Executive Summary
- Introduction and Project Background
- Methodology
- Key findings, Outcomes and Analysis - Progress towards indicators
- Unexpected outcomes (Positive and Negative)
- Lessons learned and good practices
- Analysis of relevant cross cutting themes (gender, ethnicity)
- Sustainability strategies
- Conclusions and Recommendations
- Annexes
    1. Tools (Guidelines for FGDs, IDIs)
    2. Reference
    3. Logical Framework
    4. Map of project area, if relevant
    5. Lists of persons/organisations consulted
    6. Other technical annexes where relevant (e.g. statistical analysis)

The Executive Summary should not be more than three (3) pages and the main text of the review report should not exceed 30 pages. Findings and recommendations must be fully cross-referenced. The report will be prepared using Microsoft Word Software and according to the above-listed donor format with descriptions in English. The report shall essentially follow the structure of the Terms of Reference and detailed materials shall be attached as appendix. It shall be clear and concise, limiting itself to essential points.

The consultant shall be responsible for providing a soft copy of the report. CARE Myanmar and/or CARE Australia will be responsible for printing hard copies for the AusAID and for distribution to other relevant partner organisations and agencies and stakeholder groups. CARE Myanmar will facilitate the translation of key portions of the review report to local languages, especially the findings, lessons learned, recommendations and the revised log frame if required, for non-English speaking stakeholders.

8. Work plan and timetable

The selected consultant was invited to propose their own work plan, based on the analysis of the issues studied, proposed methods and reporting requirements.

The work plan proposed by the consultant is as follows:

Date(s)	Action	Responsible
July	Desk review of documents & planning	Consultant
31 July	Finalisation of design, including questionnaires/guidelines	Consultant
1 – 15 August	Data collection	Local consultancy firm
16 – 31 August	Basic data analysis: • Raw quantitative data to be analysed by consultancy firm to the point where the firm can provide to the consultant the figures required to assess progress against indicators (e.g. '% of established plots and CFMC's still in operation'). • FGDs to be transcribed by the consultancy firm and preliminary analysis done by CARE's M&E Team; full	Local consultancy firm

	transcripts to be provided to the consultant also.	
10 Sept	Deadline for consultant to submit draft report to CARE	Consultant
10 Sept – 10 Oct	*Consultant not available*	
10 Oct	Deadline for CARE to send comments on draft report to consultant	CARE Myanmar
11 Oct – 19 Oct	Finalisation of report	Consultant
20 Oct	Deadline for consultant to submit final report to CARE	Consultant
31 Oct	Deadline for CARE to submit final completion report to Canberra	CARE Myanmar

Appendix 3: Key Informant Interview guidelines

Key informant interview guidelines

Local administration officials
(e.g. Forestry Department, Township Agriculture Service Offices, Township Medical Officers, DPDC, TPDC)

1. How would you describe the relationship between your department and the project?
2. Do you coordinate in terms of planning / implementation / monitoring in any way? If so, how?
3. Have you personally attended any coordination meetings? Were they useful? How could they be improved?
4. Is communication / coordination between the project and your department effective? If problems have arisen in the past, how have these been resolved?
5. What do you think about the project? Are the technical approaches used appropriate for the target population and areas? Does it 'fit' with what other organisations are doing?

   How successful has the project been in reaching women?

   What appear to be the main challenges / problems that have been encountered by the project? What improvements could be made to the project (if there is a new phase) to address these?

   When necessary, prompt the interviewee about the main activities of the relevant project component(s), e.g.:

Community Forestry:

- How effective are the CFMCs? How is their relationship with the FD?
- Do the CFMCs understand and follow the CFI?
- How could CFMC performance be improved?
- Do CFUGs manage their plots well? What could be improved in this regard?
- What have been the main positive (and negative) impacts of the CF activities?
- Are positive impacts likely to be sustainable?
- If there is a new phase, will the issuance of Land Use Certificates be easy or are there likely to be some challenges?
- What aspects of the CF component should be changed in the new phase to make it more effective?

SMIG:

- What do you think about the performance of the SMIG groups?
- Have any problems come to your attention? (e.g. religious objections to interest payments; members losing deposits)
- What have been the main positive (and negative) impacts of the SMIG groups?
- What do you think about the process used to close the SMIG groups? Was it regarded as being fair and effective?
- Do you think a new model (VSLA) should be used in the next phase?

PDF:

- Have any successful new agricultural or income generating technologies/activities been introduced through the project? [ask for details]
- How widely have these technologies / activities been adopted? Will households continue with these activities after the end of the project? If not, why not (for example, will households be able to afford the required inputs)?
- If some households have been more successful in implementing new activities than others, what has been the key to their success? Why are their results better?
- Have any recent changes in the local economy or government policies opened up new opportunities for agricultural production or income generating activities? If so, ask for details.

CHCs, CHFs and PEs

- What do you think about the performance of the CHCs and the CHFs?
- What do you think about the process used to close the CHFs? Was it regarded as being fair and effective?
- How effective have the PEs and other project health activities been in improving peoples' (a) knowledge and (b) behaviour with regard to key health promoting practices?
- How effective were IEC materials developed by the project?
- Do you think many PEs will continue with their activities after the end of the project?

6. What changes (positive & negative) do you feel the project has caused in participating villages? Are some / all of the positive changes likely to be sustainable? [ask for details / examples]
7. Has the project had any broader impacts (positive or negative) in the area? [ask for details / examples]
8. Have any technical models / approaches developed by the project been adopted by your department? Or vice versa?
9. If there is a new phase of the project, what changes should be made to CARE's approach (technical, managerial)?
10. Are there any other issues that you would like to discuss?

Other stakeholders
(e.g. UNHCR, WFP, ACF, FAO, AZG, UNDP, MRCS)

(Depending on their knowledge of CARE's work in NRS, interviewees may not necessarily be able to answer all of the following questions.)

1. How would you describe the relationship between your organisation and the project?
2. Do you coordinate in terms of planning / implementation / monitoring in any way? If so, how?
3. Have you personally attended any coordination meetings? Were they useful? How could they be improved?
4. Is communication / coordination between the project and your organisation effective? If problems have arisen in the past, how have these been resolved?
5. What do you think about the project? Are the technical approaches used appropriate for the target population and areas? Does it 'fit' with what other organisations are doing?
6. How successful has the project been in reaching women?
7. What changes (positive & negative) do you feel the project has caused in participating villages? Are positive changes likely to be sustainable?
8. Has the project had any broader impacts (positive or negative) in the area?
9. Have any technical models / approaches developed by the project been adopted by your organisation? Or vice versa?
10. What appear to be the main challenges / problems that have been encountered by the project? What improvements could be made to the project (if there is a new phase) to address these?
11. [Ask this question if possible] How has the policy / governance / operating context in NRS changed in the last 5 years or so? Have you noticed any significant changes as a result of the November 2010 elections?
12. Are there any other issues that you would like to discuss?

Project staff

(Again, these questions will need to be adapted slightly according to whom is being interviewed. ***Interviews should be conducted one-on-one and confidentially****.)*

Technical competence, including ability to effectively apply participatory methodologies

1. What is your professional background? When did you join the project?

2. What is your role? Has this changed over time? Do you feel adequately equipped (in terms of knowledge & skills) to perform this role? Possible areas of discussion could include:
    - planning
    - documenting progress
    - conducting PRA, M&E, training & extension work (including tailoring of health education materials to the local context...)
    - computer use
    - specific technical skills
    - cross-cutting themes, e.g. ethnicity, gender, environment
3. Do project staff have opportunities for further professional development / training?
4. Has a training needs assessment of project staff been carried out? By whom, when and how? Was it effective in identifying staff training needs/priorities?
5. What types of training have been provided to staff, and to which staff members? Who were the trainers?
6. Were staff satisfied with the trainings (in terms of content and delivery)? Were training materials adequate? How could trainings be improved?
7. Has the project team received 'regular backstopping support from a community development expert', as mentioned in the project proposal? If so, has this been effective?
8. Has the project team received support from the Livelihood and Health Advisors? If so, has this been effective?
9. How do the issues of gender and ethnicity influence the approach you take to your work with the project? Do you feel women are able to participate sufficiently? Are IDPs able to participate sufficiently?

<u>Management and administrative skills, including PCM and budget management (as relevant)</u>

1. How was the Project designed? Who participated? What are your views on the original design (Logical? Addressing real needs? Flexible?)
2. Do you feel the project is based on a clear strategy?
3. Do you feel clear and realistic targets and indicators have been identified? Does baseline data exist, against which progress can be tracked? (report available?)
4. Is an effective monitoring system in place? How does the monitoring system work?
5. Could you explain how the planning and financial management processes work (e.g. the annual planning process)?
6. What are your views on the quality of management:

    i. within the project?

    ii. in Yangon?

    iii. in Canberra?

    Possible issues to consider include:
    - organisational structure (e.g. area-based management vs component-based management)
    - personnel, information and budget management
    - coordination with stakeholders
    - responsiveness
    - activity planning
    - Is there a clear mutual understanding between Yangon and the project concerning strategies, plans, etc.? Is there a free two-way flow of ideas and information?
7. Has the project used consultancy inputs to support some activities? Were these inputs effective? If not, what were the problems and how could they be addressed in future?
8. How would you assess the project's relationships with key stakeholders (Depts of Health and Forestry, Land Records & Settlement Dept, other international organisations)? Have these relationships changed over time?

9. Is there evidence of CF groups forming spontaneously, i.e. without assistance from the project (perhaps drawing on the experiences of nearby groups already in existence)?
10. Have changes in the broader capacity of MCs been noticed (e.g. increased ability to negotiate with authorities, ability to create new links with other organisations/actors, etc.)? [ask for specific examples]
11. How effective do you feel the PDFs and VDGs have been?
12. Have any issues arisen with regard to ‘model villages’ (e.g. encroachment on CF land)? What has the project done in response?
13. What have been the most significant benefits that have resulted from the project’s work? How sustainable are these? What could be done to increase the probability of benefits being sustainable?
14. Have there been any unexpected negative impacts from the project’s work? When did the project become aware of these? Was anything done to mitigate these negative impacts?
15. Are there any other issues that you would like to discuss?

Appendix 4: Focus Group Discussion guidelines

Community Forestry Management Committee (CFMC) / Community Forestry User Group (CFUG) members

1. Background and role of the CFMC

- When and how was the committee established (how were members selected?) and what are its roles?
- How does it relate to other village organisations (especially traditional/pre-existing organisations)?
- What is its make-up in terms of ethnicity?
- What % of members of the CFMC are from poorer households (including landless/land poor households, i.e. those with less than 2 Kani)[60]?
- Does it include any women? Does the CFUG include any women? If so, what %?
- Is there a 'duty statement'/list of performance criteria/TOR for the committee? Has performance been measured against the statement (e.g. via 360° evaluations)?
- Does the CFMC have an annual management plan, as required by the CFI?

2. CFMC training

- Have committee members received any training? If so, on what topics and from whom (e.g. Community Forestry Instructions, thinning or harvesting techniques, literacy)?
- How would members rate the training? How could it be improved?
- Did members learn anything from CFMC members from other VTs?
- How much do CFMC members know about the CFI? Can they explain some of the most important points?

3. CF plot establishment

- How many plots have been established and how many are still in operation?
- Were there any problems related to traditional owners of the land (if any)?
- How were plots allocated? What % of CFUG members were landless households?
- Was FFW used? Could the plots have been established without FFW?
- Were sufficient saplings available for planting? Was the quality of saplings satisfactory?
- Were saplings planted correctly? (e.g. hardwood and softwood species in separate stands?)

4. Benefits from CF

- What are the main benefits from CF activities? Which benefits will continue after the project finishes? (NB If not mentioned by participants, ask about environmental benefits: water sources in dry season, stream flow, etc.?)
- On the issue of Land Use Certificates: has every CFUG member received a LUC? If anyone has not yet received a LUC, how do they feel about this? Do they know the reason?
- Discuss income gained from the plots (of various ages) in various ways (e.g. from inter-cropping). Has the income been subject to taxes and/or agents' fees?
- Have any plots been harvested for timber yet? If so, were any issues encountered, e.g. regarding taxes?

5. Relations with the Forestry Department

- Has the CFMC ever asked for assistance from the Forestry Department? What happened?
- Does the CFMC pay any incentives to FD staff?
- Do CFMC/CFUG members feel that their capacity to deal with the FD and other local authorities has changed as a result of the project? If so, in what ways?

6. Problems and challenges

- Have CF activities had any negative impacts (e.g. on pasture land; in terms of increased labour demands on households; in terms of intra- or inter-community disputes)?
- What are the main challenges/problems encountered regarding the CF activities? What has been done to try to address these?

7. PDF activities

[60] 2.5 Kani = 1 acre

- Have any new technologies/activities been supported through PDFs? If so, how were these technologies selected? Who trialled them?
- What have been the results, e.g. successful / not successful and reasons why?
- If successful, how widely have they been adopted? Will households continue with these activities after the end of the project? If not, why not?
- If some households have been more successful in implementing new activities than others, what has been the key to their success? Why are their results better?

8. VDG activities

- Has any community activity been funded through a VDG? If so, what kind of activity?
- How was the activity chosen?
- What was CARE's contribution and what was the community's contribution?
- Who benefited from the activity?
- Were there any negative impacts?

9. General questions

- What do CFMC/UG members think of the SMIG group/MC (e.g. strengths/weaknesses)? And CHC? [It may be interesting to hear the CFMC/UG's views of the other project groups in the village, and vice versa]
- For very poor households in the village, if they need assistance (e.g. money, food), whom do they go to in the village? How are they helped? (For example, is there a tradition of borrowing money/receiving support from a landlord? If so, what are the terms of the arrangement? What are the impacts of these terms on the poor household?). Has the CARE project helped these very poor households in any way? If so, how?
- Are some important community problems/needs/opportunities not being addressed by the project? What could be done to address these?
- Do any other external organisations (including NGOs or UN or government agencies) work in the village?
- What major changes have occurred in the local economy and environment over the past 5 years or so? (e.g.: price changes for household goods, food or agricultural inputs? Increased demand from agents/traders for certain products?) How have community members responded?
- Are there any other issues that CFMC/UG members would like to discuss?

Savings Mobilisation and Income Generation Management Committee (SMIG MC) and group members

NB Questions are generally written in the present tense, even though it is understood that the SMIG groups have been disbanded. Questions relate to past SMIG group operations as well as current operations (if any).

1. Background and role of the SMIG MC

- When and how was the committee established (how were members selected?) and what are its roles?
- How does it relate to other village organisations (especially traditional/pre-existing organisations)?
- What is its make-up in terms of ethnicity?
- What % of members of the SMIG MC are from poorer households (including landless/land poor households, i.e. those with less than 2 Kani)[61]?
- Does it include any men? Does the SMIG group include any men?
- Is there a 'duty statement'/list of performance criteria/TOR for the committee? Has performance been measured against the statement (e.g. via 360° evaluations)?

2. SMIG MC training

- Have committee members received any training? If so, on what topics and from whom (book-keeping, literacy)?
- How would members rate the training? How could it be improved?
- Did members learn anything from SMIG MC members from other VTs?

[61] 2.5 Kani = 1 acre

- Can members explain the rules and regulations of the group (e.g. interest or 'donation' rates, contribution levels, policy regarding loan delinquency/default, etc.)? How were these developed? Are they satisfactory? If not, how could they be improved?

3. SMIG group operations

- Does the committee keep the SMIG group's accounts and records itself, or does it hire someone to do so? If so, whom and for what fee? Have any problems been experienced?
- Has the group received loans (or grants) from the CARE project? How much? What was the impact of the loans/grants?
- Have religious attitudes to interest caused problems?
- Do SMIG group members need to have a guarantor (e.g. a relative or wealthy villager) in order for them to be able to take out a loan? If so, explore how this system works and, in particular, what benefits (financial or otherwise) accrue to the guarantor.
- In general, are members satisfied or dissatisfied with the SMIG group operations? Explore the range of different opinions within the group and the reasons for these.
- What use is being made of the loans (try to assess the relative popularity of different uses, e.g. emergencies (e.g. serious illness), food purchases, consumption (e.g. weddings), income generation)?
- For loans used for income generation: are most loans used profitably or unprofitably? What constrains more productive use of loans (e.g. Limited opportunities for income generation? Lack of knowledge/skills?)
- Have all members of the group received a loan at some point? Do some members receive loans more often than others? Why?
- Did many people fail to pay back their loans on time? If so, what were the reasons for this?

4. SMIG group closure

- How do SMIG MC and UG members feel about the process used to close the SMIG group?
- How was the process decided upon? Were SMIG MC/UG members consulted in advance?
- Did most members agree with the closure process? If some members did not agree, why not? Did they share their concerns with CARE staff? How did CARE staff respond?
- Was the process clear and well-understood by all members? If not, what was not clear?
- Were all outstanding loans collected? If some were not collected, why not?
- Do group members feel that the amount of money they finally received was fair? If not, why not?
- Did some people, overall, lose money by being involved in the SMIG group? About what % of group members were affected in this way?
- If some people lost money overall, what were the consequences for them? (e.g. Were they unable to meet other financial needs? Was their husband angry, which led to problems in their household?)
- Explain to the group how the Village Savings and Loan Association (VSLA) model works. Would members be interested in participating in such an association if there was an opportunity in future? If not, why not?

5. Benefits from the SMIG group

- What were the main benefits from the SMIG group?
- Have any SMIG MC/UG members taken on roles within the VT administration?
- Have SMIG MC members/group members been approached by other groups/individuals in the village to help with problems/give advice?
- Are SMIG MC members tasked by the community with maintaining/managing some type of asset/infrastructure?
- Do SMIG MC members/group members feel they are better able to engage/negotiate with individuals/organisations as a result of their involvement in the group? For example, can they discuss matters with their husbands on a more equal basis? Are they able to deal better with government officials? [ask for examples]
- Do SMIG MC members/group members feel that they are able to participate more actively in community affairs as a result of their involvement in the group? [ask for examples]

6. Other problems and challenges

- Were there any other problems or challenges concerning the SMIG group that have not already been discussed? For example, did some members find that SMIG group activities took up too much of their time, or was this not a problem?

7. PDF activities

- Have any new technologies/activities been supported through PDFs? If so, how were these technologies selected? Who trialled them?
- What have been the results, e.g. successful / not successful and reasons why?
- If successful, how widely have they been adopted? Will households continue with these activities after the end of the project? If not, why not (for example, will households be able to afford the required inputs)?
- If some households have been more successful in implementing new activities than others, what has been the key to their success? Why are their results better?

8. VDG activities

- Has any community activity been funded through a VDG? If so, what kind of activity?
- How was the activity chosen?
- What was CARE's contribution and what was the community's contribution?
- Who benefited from the activity?
- Were there any negative impacts?

9. General questions

- What do SMIG MC/group members think of the CFMC/UG (e.g. strengths/weaknesses)? And CHC? [It may be interesting to hear the SMIG MC/group's views of the other project groups in the village, and vice versa]
- For very poor households in the village, if they need assistance (e.g. money, food), whom do they go to in the village? How are they helped? (For example, is there a tradition of borrowing money/receiving support from a landlord? If so, what are the terms of the arrangement? What are the impacts of these terms on the poor household?). Has the CARE project helped these very poor households in any way? If so, how?
- Are some important community problems/needs/opportunities not being addressed by the project? What could be done to address these?
- Do any other external organisations (including NGOs or UN or government agencies) work in the village?
- What major changes have occurred in the local economy and environment over the past 5 years or so? (e.g.: price changes for household goods, food or agricultural inputs? Increased demand from agents/traders for certain products?) How have community members responded?
- Are there any other issues that SMIG MC/group members would like to discuss?

Community Health Committees (CHCs)

NB Questions are generally written in the present tense, even though it is understood that the CHCs have been disbanded. Questions relate to past CHC (and CHF) operations as well as current operations (if any).

1. Background and role of the CHC

- When and how was the committee established (how were members selected?) and what are its roles?
- How does it relate to other village organisations (especially traditional/pre-existing organisations)?
- What is its make-up in terms of ethnicity?
- What % of members of the CHC are from poorer households (including landless/land poor households, i.e. those with less than 2 Kani)[62]?
- Does it include any women? If so, what % of the CHC members are women?
- Is there a 'duty statement'/list of performance criteria/TOR for the committee? Has performance been measured against the statement (e.g. via 360° evaluations)?

[62] 2.5 Kani = 1 acre

- Was an Emergency Assessment and Response Team (EART) team formed? If so, did it receive training? Can CHC members explain about the role of the EART? What has the EART done during emergencies that have occurred since it was formed, e.g. the floods in June 2010?

2. CHC training
- Have committee members received any training? If so, on what topics and from whom?
- How would members rate the training? How could it be improved?
- Did members learn anything from CHC members from other VTs?
- Can members explain the role of the CHC (e.g. CHF management)?

3. CHF operations
- Was a Community Health Fund established? If so, what were the sources of the funds?
- What was the status of the CHF at closure (e.g. incidence of outstanding loans)?
- How much 'profit' did the CHF generate per month on average (if any)?
- If the CHF generated some 'profit', how was this used to improve access to health services (e.g. CHW / RHC staff incentive payments; replenishment of stock of preventive health materials)? Was use of funds in this way effective (e.g. did RHC staff come to visit the VT more frequently than before)?
- If the CHF did not generate any 'profit', why not?

4. CHF closure
- How do CHC members [and other community members] feel about the process used to close the CHF?
- How was the process decided upon? Were CHC members / other community members consulted in advance?
- Did most members agree with the closure process? If some members did not agree, why not? Did they share their concerns with CARE staff? How did CARE staff respond?
- Was the process clear and well-understood by all members? If not, what was not clear?
- Were all outstanding loans collected? If some were not collected, why not?
- How was money from the CHF used after it was closed?
- Do group members feel that the way the CHF money was used was fair and useful? If not, why not?
- What was done with the clinic constructed by the project (if applicable)? What is it used for now? Was it sold?

5. RHC/SC staff
- How frequently do RHC/SC staff visit the village tract now? And how often did they visit before the project? So has the project made any difference to how often these staff visit the VT?

6. Health education
- Was the CHC involved in the development of IEC materials? In what way?
- What are committee members' views on the IEC materials (e.g. do they feel they are effective and easy to understand)? How could they be improved?

7. Preventive health materials
- Did the committee receive preventive health materials (e.g. mosquito nets)? What type of materials?
- How were these used (e.g. to which households have they been distributed)?
- Were they used effectively by recipients?

8. Behaviour change in the community
- Do committee members think that community members' behaviour as regards key health issues (e.g. mosquito net usage, latrine use, handwashing, ORS usage, boiling water) has changed? In what ways and how much? [ask for specific examples]
- Is any data available to back up members' opinions?
- If some households have changed their key health behaviours more than other households, what is the reason?

9. Benefits of the community health activities

- In the view of CHC members, what are the main benefits from CH activities? Which benefits will continue after the project finishes?
- Were there any non-health related benefits? For example, have CHC members developed their capacity to deal with the local authorities?

10. Problems and challenges

- What were the main challenges/problems encountered regarding the CH activities? What was done to try to address these?

11. General questions

- What do CHC members think of the SMIG MC / group (e.g. strengths/weaknesses)? And the CFMC/UG? [It may be interesting to hear the CHC's views of the other project groups in the village, and vice versa]
- For very poor households in the village, if they need assistance (e.g. money, food, medical treatment), whom do they go to in the village? How are they helped? (For example, is there a tradition of borrowing money/receiving support from a landlord? If so, what are the terms of the arrangement? What are the impacts of these terms on the poor household?). Has the CARE project helped these very poor households in any way? If so, how?
- Are some important community problems/needs/opportunities not being addressed by the project? What could be done to address these?
- Do any other external organisations (including NGOs or UN or government agencies) work in the village?
- What major changes have occurred in the local economy and environment over the past 5 years or so? (e.g.: price changes for household goods, food or agricultural inputs? Increased demand from agents/traders for certain products?) How have community members responded?
- Are there any other issues that CHC members would like to discuss?

Peer educators (PEs)

1. Selection

- How were people selected to be PEs?
- What % of PEs are women?
- Do PEs in this village include members of all ethnic groups present in the village? Do they include representatives from poorer households?
- Do some PEs train both male and female community members?

2. Training of PEs

- What training did PEs receive?
- What are their views on the training? Did it enable them to carry out their assigned roles?
- Were PEs asked by the trainer/project to give feedback on the training?
- How could the training be improved?
- Are there topics PEs feel they still need (further) training on? What topics?

3. Peer education activities

- Do PEs feel they have been able to provide health education effectively to their fellow community members?
- What changes do PEs feel their work has brought about in their community? What evidence is there to support their views?
- Did PEs encounter any problems? What kind of problems?
- Were PEs able to seek help (e.g. from project staff or the CHMC) to solve these problems?

4. End of RRHLSP activities & planned new phase

- Have PEs been able to continue their work as PEs since the end of project activities? If not, what are the reasons they have been unable to continue?
- Do PEs currently receive any support from other organisations, including government?
- Would PEs like to be involved if there is a new phase of the project?
- How could CARE improve its health education activities if there is a new phase? Are there things RRHLSP didn't do but the new phase should start doing? Are there activities the new phase should implement differently? Are there RRHSLP activities that should not be repeated or continued? [ask for specific examples]

- On what health topics (including reproductive health issues) do men and women (who are very likely to have different views) most want to improve their knowledge?
- Are there any other issues PEs would like to discuss?

Women-only group

1. Planning of activities

- When the project was deciding what activities to implement in the village, were any of the women consulted? If so, how?
- Is anyone a member of a project group (e.g. SMIG, CF, CHC)? How are decisions taken in the group? Are women members able to influence decisions?
- How are plans made for group activities? And how is implementation monitored? Are women members involved in planning and monitoring activities, and if so, how?

2. Participation in activity implementation

- What project activities have the women participated in? [Use the relevants list(s) above to ask questions about activities in which some women have participated].
- What have been the main changes (positive and negative) women have experienced as a result (including changes within their families and within their community)?
- Which activities have been the most useful for the women? Do women agree on the answers, or are there different views? If the latter, explore the reasons why. What could be improved with regard to the activities?
- Do women who participate in project activities include members of all ethnic groups present in the village? Do they include women from poorer households? Do they include members of IDP households?
- Are there obstacles that make it hard for women to participate in project activities? If so, what are they? Has the project tried to address these?
- Do the women think their households' diets have changed since the start of the project? If so, in what way and why? [has there been an increase in consumption of vegetables, pulses, legumes and/or oil?]
- If some households have been more successful in implementing project activities than others, what has been the key to their success? Why are their results better?
- If problems have been experienced with some activities, have the women been able to communicate these to the project? Has the project then taken action to address the problems?
- Have women received any training on health and nutrition from the project and / or PEs? If so, was the training useful? What did they learn? How could the training be improved?
- Have the women seen any of the information materials that the project has produced (e.g. on health)? What do they think about them? Are they clear? Did the women learn much from them?

3. Other benefits from participating in the project

- Do (some) women feel they are better able to engage/negotiate with individuals/organisations as a result of their involvement in the project? For example, can they discuss matters with their husbands on a more equal basis? Are they able to deal better with government officials? [ask for examples]
- Do (some) women feel that they are able to participate more actively in community affairs as a result of their involvement in the group? [ask for examples]
- Are there any other issues that the women would like to discuss?

Group of villagers who have not been involved in any project activities

- Has anyone had any contact with the project? If so, what kind of contact?
- Were you consulted when activity plans were being made?
- Were you given an opportunity to participate in one or more project activities? If not, why not?
- If you were given an opportunity to participate in an activity but chose not to participate, why was this? Could the project do something to remove constraints to your participation?
- Are there activities that you would be interested in but that the project did not implement? If so, what kind of activity?

- Have you seen any of the information materials that the project has produced (e.g. on health)? What do you think about them? Are they clear? Did you learn something from them?
- Have you had any contact with the PEs who are working with the project? If so, was your contact useful? What did you learn?
- Have you learned anything from other people who are involved in project activities, e.g. CFMC or UG members? If so, what did you learn? Was it useful? [seek specific examples]
- Do you have any suggestions as to how the project could help you more effectively, if there is another phase in the future?

Appendix 5: List of key informants interviewed

Key Informants (KI)	Buthidaung	Maungdaw	# of KI
Village Administrator	2		2
CARE Program Officer	1		1
District Administrator (Dept. of Agriculture)		1	1
District Administrator		1	1
Assistant Township Medical Officer		1	1
FAO-Field Assistant		1	1
CARE Field Office Coordinator		1	1
Assistant Director (Forestry)		1	1
WFP Program Assistant		1	1
UNDP-Program Officer		1	1
UNHCR-Senior Program Officer & Assistant Program Officer		1	1
TOTAL			12

Appendix 6: List of Focus Group Discussions conducted

Township	Village tract / village	Attributes of FGD participants		
		Role in project	Ethnicity	Gender
Buthidaung	Inn Chaung / Ywar Gyi	CFUG	Rohingya	Male
Buthidaung	Inn Chaung / Ywar Gyi	CFMC	Rohingya	Male
Buthidaung	Inn Chaung / Inn Chaung	CFUG	Dainet	Female
Buthidaung	Inn Chaung / Inn Chaung	CFUG	Dainet	Male
Buthidaung	Inn Chaung / Inn Chaung	Not involved	Dainet	Male & Female
Buthidaung	Mee Kyaung Gaung Swe / Kone Tan	SMIG member	Rakhine	Female
Buthidaung	Mee Kyaung Gaung Swe / Kone Tan	SMIG MC	Rakhine	Female
Buthidaung	Mee Kyaung Gaung Swe / Mee Swe	SMIG	Rohingya	Female
Buthidaung	Mee Kyaung Gaung Swe/ Mg Hla Ma	CHC	Dainet & Rohingya	Male
Buthidaung	Mee Kyaung Gaung Swe / Mg Hla Ma	PE	Rohingya	Male & Female
Maungdaw	Maung Hna Ma / Aung Min Ga Lar	CFUG	Rakhine	Male
Maungdaw	Maung Hna Ma / Aung Min Ga Lar	SMIG member	Rakhine	Female
Maungdaw	Mg Na Ma / Taung Ywar (Aung Minglar)	CFUG	Rohingya & Rakhine	Female
Maungdaw	Myin Hlut / Myin Hlut (Middle)	CFMC	Rohingya	Male
Maungdaw	Myin Hlut / Myin Hlut (East)	SMIG MC	Rohingya	Female
Maungdaw	Myin Hlut / Ywa Thit	SMIG member	Rohingya	Female
Maungdaw	Phar Wat Chaung / Wut Pyin	CFUG	Rohingya	Male
Maungdaw	Phar Wat Chaung / Wut Pyin	CHC	Rohingya	Male & Female
Maungdaw	Phar Wat Chaung / Wut Pyin	PE	Rohingya	Male & Female
Maungdaw	Phar Wut Chaung / The Chuwng	Not involved	Rohingya	Male