# Community-Based Avian Influenza Risk Reduction Program for the Mekong Region Phase 2

# Mid-Term Review Report

22 October 2008

# TABLE OF CONTENTS

# ACRONYMS

| | |
|---|---|
| ADB | Asian Development Bank |
| AERAP | Australian Epidemiological Regional Assistance Program |
| AHI | Avian and Human Influenza |
| AHW | Animal Health Worker |
| AI | Avian Influenza |
| APSED | Asia Pacific Strategy for Emerging Diseases |
| AusAID | Australian Agency for International Development |
| BCC | Behaviour Change and Communication |
| CBAIRRP | Community-based Avian Influenza Risk Reduction Program |
| CDC | Centre for Disease Control |
| DAHP | Department of Animal Health Programs |
| EID | Emerging Infectious Disease |
| FAO | Food and Agricultural Organisation |
| FMD | Foot and Mouth Disease |
| IEC | Information, Education and Communication |
| IHR | International Health Regulations |
| INGO | International Non-Government Organisation |
| KAP | Knowledge, Attitudes, Practices |
| LEW | Livestock Extension Worker |
| LBVD | Myanmar Livestock Breeding and Veterinary Department |
| M&E | Monitoring and Evaluation |
| MOU | Memorandum of Understanding |
| MTR | Mid-Term Review |
| NAHICO | Laos National Avian and Human Influenza Coordinating Office |
| NGO | Non-Government Organisation |
| PAHI | Vietnam Partnership for Avian and Human Influenza |
| PDD | Program Design Document |
| PRA | Participatory Rural Appraisal |
| SEAFMD | South East Asia Foot and Mouth Disease |
| TOT | Training of Trainors |
| UN | United Nations |
| UNICEF | United Nations Children's Fund |
| USAID | United States Agency for International Development |
| VST | Village Surveillance Team |
| WHO | World Health Organisation |

# EXECUTIVE SUMMARY

### *Achievements at the Whole-of-Program Level*

The primary intention of the Program was to model different approaches to community-based responses to AI so that effective approaches could be adapted or adopted by stakeholders and successful models expanded. These stakeholders could be at the national or local government levels or key technical agencies operating in the country. The Program was not intended to be an implementation program where the target beneficiaries would only be in CARE Program locations.

Overall, the Program has contributed effectively to the reach of national AI control programs. Mostly, this has been achieved by facilitating the connection between the local level government and the communities they serve. The Program has brought about community adoption of preventative behaviours, as well as revitalizing volunteer networks to deliver preventative messages (to a range of target groups) and to report on community-level health events. Most of the benefits realised so far were limited to the Program locations in which CARE operates rather than making substantive progress toward adoption of successful approaches more broadly.

In Laos and Myanmar, CARE has achieved a high degree of ownership at the national level and has contributed to the development of national strategic thinking about suitable approaches to the delivery of national AI programs at the community level. In Vietnam, the AI Regional Program Manager contributed significantly to the National Communication Framework on AI with PAHI.

From a regional perspective, the Program has achieved only limited outcomes. CARE is a contributor to the ADB-funded Regional AI Practitioners workshop and tool kit; and CARE has presented at the Regional AHI interagency meeting in Bangkok (this is a monthly meeting, however CARE's attendance is *ad hoc*). The program is better characterised as a group of country level Programs that are integrated into and managed through an AusAID regional program strategy.

### *Key Achievements at the Country Level*

*Vietnam*

Vietnam activities have resulted in the adoption of preventative behaviours at the community level, within the Program locations that CARE is working. AI Committees at the local government level have increased capacity for planning, facilitation, financial management, and new approaches to communicating messages. The Program has contributed to an increase in the collaboration of animal and health sectors at the provincial level. There has been a high degree of ownership by local level government in the Program. CARE has worked closely with the PAHI, the national coordinating body for AI control, to prioritise AI messages for dissemination nationally.

*Laos*

The MTR team considered that Laos had the strongest of the four country programs. CARE has been a very active contributor to NAHICO and has positioned itself well to influence national planning on community-level engagement on AI control. CARE has achieved a high degree of involvement with other participating agencies such as CDC, WHO and FAO.

CARE has also assisted in facilitating enhanced coordination between WHO and FAO. CARE has contributed significantly to the development of national level IEC materials. Stakeholders perceived CARE as assisting with connecting the national strategy with the community. District level ownership of the activities is also well demonstrated. At the district level, stakeholders have developed new skills in planning and new approaches to training. There is now an active network of volunteers in Program locations working on community education and behaviour change, and surveillance of health events.

*Cambodia*

CARE has focused on achieving behaviour change at the community level, in its Program sites. There have been successes with behaviour change both at the community household level as well as in the activities of Volunteer Surveillance Teams. CARE has also facilitated the establishment of model farms where farmers demonstrate biosecurity practices. CARE has allowed FAO to extend the coverage of training from provincial to community-level animal health workers. The approach to village-based emergency preparedness training has the interest of WHO to integrate into its programs.

*Myanmar*

CARE has achieved a high degree of ownership at the national level by the Ministry of Livestock and Fisheries, LBVD. Although this Program has mostly focused on supporting the national delivery of AI control training to the provincial, township and community levels, there have been two pilots developed to address biosecurity at the village and market levels. Given the context in which CARE is working, they have developed a high degree of trust and engagement of national government partners, and have managed to secure permission to work in two cities to work on markets. Overall, they have enabled the national AI control strategy to reach the community level, stimulate village level volunteers to deliver AI control messages, and enhance their capacity through the introduction of new approaches to behaviour change - a good achievement in the short timeframe. CARE has also contributed to enhanced intersectoral collaboration between animal and human health sectors at the township level and improved relationships between LBVD and the community.

### *Key Issues*

The MTR has identified the following issues affecting the Program:

- Limited strategic oversight and governance systems in place with significant responsibilities passed on to staff not necessarily well equipped to handle those responsibilities without additional support (in Vietnam and Cambodia, but most notably in Myanmar).
- A strong focus on implementation rather than experimentation (most notably in Vietnam and Myanmar).
- Lack of clarity of intended, end-of-Program outcomes (in documentation and staff strategic planning) in all countries.
- Insufficient quality of monitoring, evaluation and progress reporting for a specialised pilot/experimental program with an investment of A$5.1 million (most notably in Vietnam and Myanmar).
- Lack of clarity over reporting requirements.
- Lack of strategies in place for replication or adoption of pilots/models in all countries.

- Limited focus on national level ownership or engagement resulting in limited progress toward adoption or replication of approaches (in Vietnam and Cambodia).
- Significant challenges to sustainability in all countries.
- Limited use of technical advice available through Program resources, most notably in Vietnam and Myanmar (although in Myanmar accessing international advice is difficult).
- Limited effort to address gender equality in all countries.
- Program significantly underspent to-date with limited capacity to meet expectations for full expenditure in the remaining period (currently projected to be about 15% underspent or A$800,000 by the scheduled competition of the Program in September 2009).

***Underlying Causes***

Several of the findings identified in this Review require further consideration to try and identify some of the underlying causes. They also bring up a range of questions beyond the scope of this particular Program that would be valuable for AusAID and CARE to consider.

Broadly, the causes have been categorised into two key areas: causes relating to the design processes; and causes relating to CARE's capacity to implement an experimental or pilot program of this nature. The issues summarised below are discussed in more detail in Section 3.

*Design Issues for AusAID Consideration*

- *There was insufficient design expertise*. As the Program was contracted as a single design/implement (rather than contracting out the design to experienced designers separately), CARE appointed its own designer. This individual was not supported by a consultant with suitable expertise in design and monitoring and evaluation which had a significant impact on the quality of some aspects of the design.
- As a result of the design peer review process, *AusAID required CARE to make a significant change to the design*. It was to move from a more typical NGO-style implementation program, to an experimental program testing models of community-based interventions that would be replicated by local or national government or other relevant stakeholders. The rationale for this change was the concern that the 30-month timeframe for the program was insufficient to achieve sustainable outcomes and that an experimental approach would be more appropriate. A full analysis of the impact of this decision identified several important areas which have led to some of the issues identified above. These are discussed in the main report.
- Governance and oversight were not addressed in the design.
- A lack of clarity on what AusAID expected as regional outcomes of the Program.
- There was a lack of clarity on the comparative advantage of the delivery mechanism (INGO) and how this could best be utilised.

*CARE Capacity Considerations*

- There was limited analysis of CARE's capacity to deliver through a program approach during the design phase resulting in insufficient risk management strategies being put in place. Discussions on governance during the design phase would have been beneficial.
- Delegation of strategic roles to staff with limited capacity (including time) to perform these roles.
- CARE's management structure resulted in CARE's AI Regional Program Manager having to rely more than should be necessary on goodwill and relationships to enable the delivery of the program rather than line-management authority.
- There were limited corporate-level support systems *observed* to enable country level staff to deliver some aspects of the program well. These include aspects such as monitoring and evaluation; mainstreaming gender equality into the work program; analysing; and developing strategies to enhance sustainability. Although many of these systems and resources do exist at the corporate and regional level, in the case of this Program, they have not been translated into implementation *practice*, nor are staff aware of the existence of many of these resources.
- Not all of CARE's country programs made use of the technical resources made available through the Program budget.

**Recommendations**

*Recommendation 1:*

CARE Australia to put in place a supervisory arrangement, consistent with the organisation's management structure, to ensure whole-of-program governance. A suggested mechanism is a Program Steering Group comprising of the Regional Program Manager, Senior Staff from CARE Australia, Country Directors or Assistant Country Directors, and AI Program Managers to meet on a regular basis (via teleconference) for the remainder of the Program. This could be supported by the development of revised TORs and a Program organigram that clearly sets out roles, responsibilities, and management lines for program personnel including the Regional Program Manager, CARE Australia based staff, and country office project staff.

*Recommendation 2:*

CARE Country Directors (Vietnam, Cambodia and Myanmar) to develop a *strategy to respond to the risks posed by the current arrangements for governance and strategic oversight* of the Program. Requirements of this strategy are outlined in Section 4.

*Recommendation 3:*

CARE's AI Program Managers, in consultation with the CARE AI Regional Program Manager, *access appropriate technical support* for staff to support enhanced M&E and sustainability of activities. The TOR for this M&E Specialist is in Annex 3 while the outputs of this support are outlined in Section 4.

*Recommendation 4:*

AusAID Bangkok could consider conducting a *review of progress on the response to the MTR findings* in March 2009. This could be carried out as a short input by the AusAID Activity Manager who would work only with country teams. Two days with each team would be sufficient and no field trips would be required.

*Recommendation 5:*

AusAID Bangkok could consider extending the current Program to allow full disbursement of funds, and to achieve the potential outcomes of the Program. It is not recommended to extend all country program activities, rather, identify and support only those pilot activities that are of sufficient quality and relevance to justify extension. This assessment should be undertaken by the contracted M&E specialist during the review of the pilot designs and M&E systems.

Pilots that may meet requirements for extension have been preliminarily identified based on outcomes to-date. These are the Community-based Surveillance Pilots in Vietnam and Laos; and the Biosecurity Model in Myanmar. However, these remain indicative with the final assessment for all countries to be made by the M&E Specialist once all pilots have been reviewed.

**Future Directions**

The MTR team considers that there is a sufficiently robust foundation in place to gain benefits from implementing a follow-on Program ***if this is consistent with AusAID's new regional strategy***. This is largely in response to the high degree of participation and ownership achieved at the national and local level in some countries. However, several issues will require clarification before further elaboration is possible:

- Identification of feasible approaches to enhancing the regional outcomes of the Program. Although there are no suitable regional fora that CARE could reasonably expect to fully engage with, there may be options to bring national partners together more systematically for discussions on effective and affordable approaches to community-based interventions. This could include linkages to other AusAID-funded regional AI activities.
- Clarification of whether an implementation program or an experimental pilot Program will add the most value at a regional and country level.
- The available budget - the MTR team considers an investment of A$5.1M over four countries over five years would be required to achieve an adequate level of sustainable outcome, including policy response, if an experimental approach is considered suitable.
- Clarification of the number of countries participating in any future activity.
- Clarification of the expected comparative advantage of working with NGOs, and definition of the expectations of capacity to deliver an experimental/pilot Program. Identify appropriate implementation mechanisms (e.g., partnering with a research institute) to ensure that the strengths/comparative advantage of an NGO are drawn on while ensuring requirements around technical rigour are fully met.
- Clarification of the conditions that the implementing NGO would need to meet in order to develop confidence that the quality of the Program could be maintained.
- Clarification as to whether a follow-on program would be subject to a competitive tendering process, and if so, determine if there is sufficient interest in the Australian INGO community to tender for this type of activity.

If a follow-on Program is considered appropriate, it is recommended that:

- The design process begin as soon as is practicable so as to maintain momentum and allow consolidation of newly developed relationships at the national level.
- Contract an independent design team with suitable expertise to carry out the design.
- Develop a design framework that is suitable, conceptually, for implementation by an NGO.

# 1. INTRODUCTION

## 1.1 Overview of the CBAIRRP

The Community-based Avian Influenza Risk Reduction Program (CBAIRRP) for the Mekong Region - Phase 2[1], is a A$5.1 million 30-month Program aiming to improve recognition, control and prevention of emerging infectious diseases in the Mekong region.

The Program goal is "*to contribute to improved recognition, control and prevention of emerging infectious diseases (EIDs) in the Mekong region.*"

The Program's purpose is to document lessons and successes from these pilot activities and to disseminate findings to inform wider AI programming in each country.

The component objectives of the Program are:

Component One: To identify operational models for strengthening community and local level capacity to prevent AI.

Component Two: To identify operational models for strengthening community participation in AI detection, reporting and response.

Component Three: To ensure efficient and effective implementation and evaluation of the regional program.

CARE Australia is managing the Program through the CARE country offices located in Cambodia, Laos, Myanmar, and Vietnam. While the generic approach is common to each individual country Program, the implementation strategy, entry point for activities and the focus for these activities vary according to the implementation context and identified needs in each country. Each CARE country office is implementing country-specific activities in close collaboration with partner government and relevant community organisations.

Phase 2 of the Program commenced in March 2007 and will end in September 2009.

## 1.2 Objective of the MTR

The primary objective of the Mid-Term Review (MTR) is to contribute to Program improvements through independently assessing the progress and quality of implementation and achievements of the Program to-date.

The specific objectives of the Review as described in the Terms of Reference (Annex 1) are to identify achievements and make recommendations for Program improvements in the following areas:

1. *Key Results* of the program to-date, which covers direct, indirect, intended, and unintended outcomes.

[1] Phase 2 drew heavily on lessons from the evaluation of the AusAID-funded CARE Australia Avian Influenza Local Risk Reduction Mekong Regional Program Phase 1 (June 2006 - February 2007).

2. *Implementation Progress* towards achieving outputs and outcomes under Year 1 implementation and against each of the program's three component areas outlined in the Program Design Document (PDD). This should include identifying issues that adversely affect activity outcomes and, working with CARE country teams, recommend strategies for addressing these issues.
3. *Relevance* of program objectives and activity approaches to current AusAID priorities and regional strategies.
4. *Effectiveness* of the program to-date in achieving its stated objectives. This includes an assessment on whether program activities will attain its objectives within stated timeframes and until the program's end in September 2009.
5. *Efficiency* of CARE Australia's program management arrangements at the regional and country-levels.
6. *Monitoring and Evaluation (M&E)* at the country-level and the extent to which outputs, outcomes, and achievement of objectives are captured by the current country M&E frameworks. This should include recommendations to improve country-level M&E frameworks and performance indicators. Related to this, the MTR team should also briefly assess the quality and adequacy of the 2007-2008 Annual Report and the 2008-2009 Annual Plan based on AusAID quality reporting standards.
7. *Sustainability* mechanisms and an assessment of the likely sustainability of program activities after September 2009 (i.e. if program partners from the government or NGO sectors have taken more responsibility and initiative in program components). This includes recommendations on a possible transition phase beyond the current Phase 2.
8. *Cross Cutting Issues* including the extent issues such as gender are mainstreamed in program activities.
9. *Partnerships* including program linkages with key stakeholders (e.g. local governments, national government, local community, non-government organisations, donor agencies, and international technical organisations such as WHO and FAO).
10. *Risk Management* mechanisms at the country-levels including a re-evaluation of Program risks.

## 1.3 Methodology

This MTR adopted a utilisation-focused approach where the primary intention is to ensure that all recommendations: meet the management decision needs of stakeholders; are feasible; and accepted by AusAID and CARE implementation teams before final production of the report. AusAID and CARE teams all participated in the development of the final agreed methodology and development of recommendations. All recommendations (except Recommendation 1) were tested with each country program, as well as with the CARE's AI Regional Program Manager and CARE Australia, Canberra.

Where time permitted, short, focused capacity building sessions were carried out in-country with implementation teams to allow them to progress the recommendations of the Review. Summaries of the sessions on Sustainability and Reporting can be found in Annexes 4 and 5. Additional sessions on M&E were conducted in Vietnam and Laos. These were designed to meet the country-specific needs.

The methodology and full list of Review questions, the methods employed, types of respondents interviewed, list of persons met, and documents reviewed are provided in Annex 1. This also includes the Terms of Reference for the assignment.

Given that the Program is delivered in four countries and each country delivers multiple activities or pilots, the Review took a case study approach. A pilot activity was selected in each country to explore the operations of the Program for a specific example. This, of course, is not expected to allow full generalisation across the Program pilots. The findings must be considered as reflecting the findings in the case studies only. However, it does allow insight into the way the Program operates on the ground.

Findings are not intended to suggest that other CARE programs are experiencing the same issues. All findings and discussions are confined to this Program only.

The time available to the Review Team in Cambodia was less than that for other country offices, limiting the Team's opportunity to investigate the implementation context in the same detail as the other countries.

Unfortunately, after the end of the first country visit (Vietnam), the Animal Health Specialist, one of the two consultants for the assignment had to return urgently to Australia. In order to manage the remainder of the mission, some small adjustments were made to the methodology. The review of the relevance of the Program was taken on by the AusAID Activity Manager, while quality of the financial systems and considerations of value for money were removed from the Review questions after Vietnam. Findings on the technical quality of the animal health work were only addressed at the broadest level.

Another critical limitation of the mission was the overall quality of translation provided. In Vietnam, the quality was particularly high, and in Laos, it was adequate. However, in Cambodia and especially Myanmar, the quality was low. For Cambodia, this meant that translation during field trips was significantly affected, but in Myanmar, it was challenging for the MTR team to conduct useful meetings with both the national partners and the CARE implementation teams themselves. This significantly affected the quality and depth of the findings. In Myanmar, it also affected the capacity of the MTR team to provide useful inputs and support to the CARE team.

# 2. FINDINGS

## 2.1 Summary of Achievements at the Whole of Program Level

The primary intention of the Program was to model different approaches to community-based responses to AI so that effective approaches could be adapted or adopted by stakeholders with expansion of successful models. These stakeholders could be at the national or local government levels or be key technical agencies operating in the country. The Program was not intended to be an implementation program where the target beneficiaries would only be in CARE Program locations.

Although the stated purpose in the design document was to *disseminate* information on the models or experiments, AusAID's underlying expectation was that some sort of policy response to information would be generated by these experiments – either the adoption or adaptation of successful approaches, or rejection of approaches shown to be ineffective by stakeholders in each country. Apparently, discussions during the peer review process resulted in a view that within the timeframe it was not possible to achieve a policy response, and that a realistic end-point would be the dissemination of lessons. Although this argument can be made, at a minimum, *interventions* would need to be established that promoted a policy response to the findings of experiments. With the wording "*to document and disseminate approaches and lessons…*" there were very limited strategies aside from writing down and "*sharing*" information which is unlikely to result in a substantive outcome for a A$5.1M investment. Across the four country programs, the intention to realise a response to the pilot findings, was not clearly recognised.

Overall, the Program has contributed effectively to the reach of national AI programs. In the most part, this has been through facilitating the connection between the local level government and the communities they serve. The Program has brought about community adoption of preventative behaviours, as well as revitalizing volunteer networks to deliver preventative messages (to a range of target groups) and report on community-level health events. Most of the benefits realised were limited to the Program locations in which CARE operates rather than progressing toward adoption of successful approaches in other locations, where this is feasible. Even if we cannot expect full adoption in the life of the Program, there could be strategies in place to move in that direction, and well beyond dissemination of information to a poorly defined target audience.

In Laos and Myanmar, CARE has achieved a high degree of ownership at the national level and has contributed to the development of national strategic thinking about suitable approaches to the delivery of national AI programs at the community level.

From a regional perspective, the Program has achieved only limited outcomes. CARE is a contributor to the ADB-funded Regional AI Practitioners workshop and tool kit; and CARE has presented at the Regional AHI interagency meeting in Bangkok (this is a monthly meeting, however, CARE's attendance is *ad hoc*). The Program could be characterised as a group of country level programs integrated into, and managed through an AusAID regional program strategy. Having said that, AusAID's expectations of regional outcomes have not been well communicated to the CARE AI Regional Program Manager.

Outcomes achieved at the country level are summarised in Section 2.3 below.

The detailed findings for each of the Review questions for each country can be found in Annex 2.

## 2.2 Continuing Relevance of the Program

***Relevance at the National Level***

The Program continues to address priority needs of partner countries particularly helping to address disease outbreaks at the village level where prevention and response capacity is weak. Activities and pilots are consistent with National AI Control Plans. CARE Vietnam (through the CARE AI Regional Program Manager) provided major inputs to Vietnam's National Avian and Human Influenza Communications Strategy, and has participated on the IEC and Biosecurity working groups. CARE Laos is the only international NGO (INGO) coordinating with the Laos National Avian and Human Influenza Coordinating Office (NAHICO). The Program participates in the annual implementation reviews of the National AI Control and Pandemic Preparedness Plan. CARE Laos is also an active member of six working groups – IEC, Surveillance, Wet Markets, Research, Outbreak, and Pandemics. Officials at the national level interviewed by the MTR team perceived the valuable role of the Program in implementing AI control activities at the community level, an identified gap as majority of external AI control assistance are national level initiatives not reaching the community level. In Myanmar, CARE is addressing a priority need of supporting the Livestock Breeding and Veterinary Department (LBVD) to deliver a national training program in AI control.

Across the four countries, CARE is considered as an important NGO working at the community level on AI control. There are very few NGOs working on AI control across the Mekong countries. While there are various INGOs working on AI control in Vietnam, the major ones are funded by USAID and AusAID. USAID and the US-Centre for Disease Control (CDC) are funding community-based AI control programs through CARE in Cambodia, Laos, and Vietnam. The Program has effectively partnered with UN agencies (e.g. FAO, WHO, UNICEF) on the technical aspects of activities including evaluation of pilots, coordinating, testing and standardizing community-level Information, Education and Communication (IEC) materials. The Program covers districts and villages that UN agencies, USAID or other NGOs are unable to cover.

CARE's comparative advantage as an NGO has been acknowledged by FAO, WHO and CDC in the areas of closer relationships with communities, raising community awareness on AI control, strengthening district and village surveillance and reporting systems, and capacity building for training and planning for community officials and volunteers.

***Focus and Approach***

The Program is essentially operating as four distinct country programs. Thus, unlike a typical regional program wherein benefits are often long-term, dispersed and intangible, the Program aims to provide direct benefits in each country specifically at the community levels (e.g. provincial, district, village). In each of the four partner countries, the community level is most vulnerable to disease outbreaks and has direct impacts on disease burden, livelihoods and poverty alleviation. Poultry in the Mekong region are largely owned by subsistence farmers.

While community awareness and capacity are being strengthened as part of the process of model piloting, the Program has good potential to provide community-level research inputs to inform National AI Control Plans. The bottom-up, operations research approach is highly relevant in each country as models operate under the mandates of National Plans and are

implemented and tested based on local structures and context (although the sustainability of some of these models currently limits the potential contribution).

The Program, by building community-level capacities in detecting, reporting and implementing preliminary control measures, is contributing to each country's achievement of the International Health Regulations (IHR) requirements. Prevention, surveillance and reporting messages tend to cut across the various livestock diseases. Field visits by the MTR team indicate that community interest to Program messages are more sustained if they include other priority livestock diseases such as Newcastle disease (ND), classical swine fever (CSF) or foot and mouth disease (FMD).

In response, the Program has started expanding its scope beyond AI control. CARE Laos, for instance, included main livestock diseases in its Events-Based Surveillance model which focuses on local detection, reporting, and response (The establishment of community events-based surveillance is a target area under the Laos National Emerging Infectious Disease work plan. The latter represent the Lao Government's commitment to achieve the minimum IHR requirements by 2010.).

CARE Laos is also closely coordinating with a WHO Epidemiologist, funded through AusAID's Australian Epidemiology Regional Assistance Program (AERAP). The expansion of the model to cover other livestock diseases also complements AusAID's existing regional EID support such as the South East Asia Foot and Mouth Disease Program (SEAFMD).

The Program satisfies certain criteria for a regional approach as outlined by the 2007 World Bank Review. While the issue of economies of scale is not evident given the lack of a suitable regional institution in which an NGO can engage, the Program compensates by closely aligning its objectives with country priorities and by adhering to the principle of subsidiarity (i.e. programs operating at the lowest level appropriate). Strong country-level commitment to AI control is reflected in part by the existence of national plans and coordinating mechanisms for AI control.

***Relevance to Regional and Bilateral Strategies***

The Program is directly contributing to the achievement of Objectives 1 and 2 of the Asia Pacific Strategy for Emerging Disease (APSED). Objective 1 is to reduce the risk of emerging diseases. Under this objective, the two expected results of the program are reducing risk through strategic communication and community participation; and reducing risks of emerging disease acquired from animals. Objective 2 is to strengthen early detection of outbreaks of emerging diseases. The Program is addressing this through strengthening early warning systems, establishing coordinated surveillance systems, and strengthening local capacity for surveillance.

The Program's focus and objectives fill a gap in AusAID's bilateral program across the four Mekong countries. None of the bilateral programs has initiatives directly addressing AI awareness and prevention at the community level. It should be noted, at the same time, that the Laos AusAID Country Program does not have a health component although AI control addresses a broad range of development needs especially related to secure incomes for small-scale poultry raisers.

## 2.3 Achievement of Sustainable Outcomes at the Country Level

The detailed findings for each of the following Review questions for each country can be found in Section 2 of Annex 2. This section provides a brief summary.

***To what extent do stakeholders have a shared view of the intended end-of-program outcomes?***

Across the four country Program teams, AusAID, and national stakeholders, there was no shared view of what the Program was trying to achieve. Although AusAID expected the Program to influence national and local government responses to AI, the implementation teams in Vietnam and Myanmar (as well as their national partners) considered that the Program was primarily meeting a need in CARE communities only. That is, the program was an implementation program rather than an experimental design to generate knowledge and influence the evolving AI control strategies in each country. In Laos and Cambodia, there was some recognition of the need to influence national stakeholder policy, but neither group had developed a clear intervention strategy to achieve adoption or rejection of the models, nor had they clearly articulated at what level they were trying to achieve this adoption (by national or local level government, by key technical agencies, or by other NGOs).

Although one contributing factor was that this was not well articulated in the design document, high quality strategic oversight would have identified this issue relatively quickly. From a design perspective, although the attention on approaches to influencing policy or planning responses was not well articulated, it did clearly identify that these activities were intended to be pilots. The design did not infer that this was to be an implementation program, indeed, this shift late in the review process was directly addressing the notion of pilots rather than implementation. Therefore, although the MTR team recognise that there was limited direction in terms of suitable *strategies* for adoption of the findings of pilots, there was clarity that the Program was intended to be a series of pilots or demonstrations.

Another key finding was that for all four country programs there was very limited articulation of the specific end-of-program outcomes expected. This was not addressed at the level of the pilot (what outcomes are we trying to sustain at the community, volunteer or local government/partner level?) nor at the level of adoption or response to the pilot findings (can these models be replicated in the context?). However, there was best clarity at the level of adoption of community-level behaviours.

Gender outcomes were not identified in any of the four countries.

***To what extent does program documentation <u>report</u> achievement of outcomes?***

For all countries, the approach to reporting made it difficult for the reader to get a sense of the progress the Program is making toward achieving outcomes. Where outcomes are discussed, it appears that these outcomes have not been considered systematically against intended outcomes, rather, they have been reported in an *ad hoc* manner.

AusAID did not clearly articulate their reporting requirements (especially in terms of outcome reporting) at the start of the Program, and have changed reporting requirements over the life of the Program. More recent requirements to conform with Quality at Implementation (QAI) reporting has made this even more challenging.

***To what extent do stakeholders <u>perceive</u> that development outcomes were achieved?***

*Regional*

From a regional perspective, the Program has achieved limited outcomes, rather, it has been a group of country-level Programs that are integrated into, and managed through an AusAID regional program strategy. As discussed earlier, this may have been, in part, due to a lack of clarity in AusAID's articulation of its expected regional outcomes.

CARE does engage in two regional fora. CARE are contributors to the ADB-funded Regional AI Practitioners workshop and tool kit; and CARE has presented at the Regional AHI interagency meeting in Bangkok (this is a monthly meeting however, CARE's attendance is *ad hoc*). Although this program fills an important gap with respect to generating lessons at the community or village level, regional fora such as the ASEAN EID would be unlikely to entertain special sessions facilitated by CARE. In addition, this program does not have the resources to develop a productive relationship with ASEAN or similar regional groups.

The Program has invested in bringing together CARE staff from across the four countries to discuss lessons; however, these meetings have been limited in analytical content, and have focused on discussing activities in each country. Next steps or action plans were not presented in documentation to AusAID, and individuals were left to determine their interest in other team's models. None of the national government partners have been brought together for any interaction in this Phase of the Program.

Publication in international refereed journals has not been planned (there is one exception in Myanmar on a Biosecurity pilot), nor would the M&E systems be likely to generate credible data for this type of publication.

*Vietnam*

Vietnam activities have resulted in the adoption of preventative behaviours at the community level, within the Program locations that CARE is working. AI Committees at the local government level have increased capacity for planning, facilitation, financial management, and new approaches to communicating messages. The Program has contributed to an increase in the collaboration of animal and health sectors at the provincial level. There has been a high degree of ownership by local level government in the Program. CARE has worked closely with the PAHI, the national coordinating body for AI control, to prioritise AI messages for dissemination nationally.

*Laos*

The MTR team considered that Laos had the strongest of the four country programs. CARE has been a very active contributor to NAHICO and has positioned itself well to influence national planning on community-level engagement on AI control. CARE has achieved a high degree of involvement with other participating agencies such as CDC, WHO and FAO. CARE has also assisted in facilitating enhanced coordination between WHO and FAO. CARE has contributed significantly to the development of national level IEC materials. Stakeholders perceived CARE as assisting with connecting the national strategy with the community. District level ownership of the activities is also well demonstrated. At the district level, stakeholders have developed new skills in planning and new approaches to training. There is now an active network of volunteers in Program locations working on community education and behaviour change, and surveillance of health events.

*Cambodia*

CARE has focused on achieving behaviour change at the community level, in its Program sites. There have been successes with behaviour change both at the community household level as well as in the activities of Volunteer Surveillance Teams. CARE has also facilitated the establishment of model farms where farmers demonstrate biosecurity practices. CARE has allowed FAO to extend the coverage of training from provincial to community-level animal health workers. The approach to village-based emergency preparedness training has the interest of WHO to integrate into its programs.

*Myanmar*

CARE has achieved a high degree of ownership at the national level by the Ministry of Livestock and Fisheries, LBVD. Although this Program has mostly focused on supporting the national delivery of AI control training to the Provincial, Township and Community levels, there have been two pilots developed to address biosecurity at the village and market levels. Given the context in which CARE is working, they have developed a high degree of trust and engagement of national government partners, and have managed to secure permission to work in two cities to work on markets. Overall, they have enabled the national AI control strategy to reach the community level, stimulate village level volunteers to deliver AI control messages and enhance their capacity through the introduction of new approaches to behaviour change - a good achievement in the short timeframe. CARE has also contributed to enhanced intersectoral collaboration between animal and human health sectors at the township level and improved relationships between LBVD and the community.

***To what extent are case study outcomes likely to be sustainable?***

Across the four country programs, sustainability of outcomes has not been well addressed. For many of the activities, partners reported that they would be heavily dependent on CARE to provide the momentum and financial resources to keep activities going. Several government partners considered that ongoing support provided by CARE would be necessary as there were limited resources to continue with the activities as they had been designed. In other cases (Myanmar), partners considered that they could continue with activities, but with less intensity.

There are a modest number of exceptions (most notably in Laos), but in the most part, considerations of sustainability had not been properly analysed. Implementation teams were not fully aware of issues of sustainability, nor had they had any guidance on how to analyse the factors that are likely to affect the sustainability of their work. Teams were, however, aware of the need to work through government systems and structures. Teams had not worked with their partners (target groups expected to adopt the models) to address the resource implications of their models or to discuss to what extent they could possibly replicate the models as delivered by CARE in the case studies under review. There were no formal interventions in place to enhance or achieve sustainability.

The design document did acknowledge that an important aspect of sustainability was the extent to which pilot activities could be adopted, but the direction provided in the design did not translate at the point of implementation.

Without specific attention to the issue of adoption of pilot activities that is supported or facilitated by senior staff, it will be unlikely that outcomes will be sustained beyond the life of the CARE Program in all of the case study activities examined by the Review.

***What factors account for the achievement (or not) of sustainable outcomes?***

Factors that have accounted for the achievement of sustainable outcomes have varied across the different country experiences. The following lists of factors were taken from all four participating country programs.

Key Enhancing factors have been:

- Where there is a strong national AI control coordinating body, the Program has been more able to contribute to the evolution of the implementation of the national AI control strategy;
- Where there are fewer players within the environment;
- Openness of national level to engage with NGOs;
- CARE's development of a reputation for credible work at the community level through consistent and regular participation by CARE in national fora;
- Suitable national institutions in place that allow CARE to integrate its activities, and CARE's choice to work through these;
- Willingness of CARE to work with both animal and human health;
- Integration of AI control messages into a broader range of animal and human health messages; and
- Allowing national and local level partners to be responsible for implementation of the activities (most notably in Laos and Myanmar).

Key Inhibiting factors have been:

- Lack of clarity around intended outcomes to be sustained;
- No clear strategies to enable the adoption or response to pilot findings;
- The Program timeframe was insufficient to develop strong relationships with partners in all countries, and to institutionalise new behaviours (the piloting approach does not mean that less time is required in these areas);
- Generally, pilots have not mimicked the resource environment in which they are being delivered – there can be significant subsidisation of costs, or intensive support provided with no exit strategy;
- Partners have not participated formally in discussions about their capacity to sustain particular outcomes;
- Limited involvement of local government (in Cambodia);
- Capacity to sustain new behaviours has been considered narrowly as the *skills* to adopt, rather than a more comprehensive interpretation of capacity to mean the motivation and the enabling environment in which to sustain the new behaviours. The design of implementation activities has reflected this interpretation;
- There are insufficient strategies in place to address the motivation and sustainability of village level volunteers;
- There is insufficient guidance available to implementation teams on effective Behaviour Change and Communication (BCC) models (although teams are doing well given the resources available); and

- Not giving seconded staff in Cambodia sufficient decision making power, or developing their capacity to influence their home institutions to adopt or respond to findings from the models.

## 2.4 The Quality of Program Implementation

The detailed findings for each of the following Review questions for each country can be found in Section 3 of Annex 2. This section provides a brief summary.

***What are the quality and effectiveness of program deliverables in the case studies?***

Overall, the quality of training materials was of a good standard. The only exception was in Cambodia where staff could not locate any training curricula to review (although most of the training was being delivered by a sub-contracted NGO for the biosecurity models; and FAO/DAHP for Province to Village Animal Health Worker training). Although generally, training design and content were appropriate, there was a focus on knowledge rather than other important aspects of capacity building such as motivation. An exception to this at the community level was, where the livelihood approach was used to provide an incentive for biosecurity practices.

In all countries, messages and technical content of the training and communication materials were appropriate and in line with current international good practice in AI control.

In all countries, CARE was able to demonstrate effective approaches to community mobilisation, although these were quite resource intensive for a piloting/modelling approach.

IEC materials were of an adequate standard across the four countries. However, international good practice on IEC materials development was not fully evident. For example, some posters were visually difficult to interpret for illiterate people. Several examples of IEC materials would have been too costly for national governments to replicate.

Gender has not been well addressed across the four country programs. Where gender considerations have been made, these have focused on the participation of women in training and educational activities, rather than addressing any gender inequalities relating to AI control. None of the four offices have conducted gender analyses.

***What are the Key Factors that account for the quality of program deliverables in the case study?***

Many of these deliverables were designed by staff that may not have adequate capacity or support to do this to a desirable standard. Some individuals that were tasked to design training materials for introducing BCC or develop IEC materials did not bring relevant experience or expertise from previous work placements. Instead, they relied on self-directed learning to do the best job they could, and in some cases had worked quite hard to achieve a reasonable standard. Staff interviewed were not aware of corporate materials to support them to design or develop good materials for BCC, M&E, or mainstream gender into their work.

The issue is not that CARE does not have corporate materials developed. For example, CARE has appointed a Regional Quality Advisor who provides training and regular visits to country programs to provide hands-on assistance across a range of topics; there are Program Quality Units established and supported in each country office with cross-cutting program responsibilities; CARE USA has developed a Program Design Handbook; CARE Australia has policies on gender and evaluation; there is a new International Operations Department within CARE Australia with specific focus on supporting country office operations; CARE

has also developed project manager training modules for country offices. The point is that for this Program, all these support mechanisms have not been translated into implementation *practice* to the expected standards.

For some of the technical training, country offices have effectively used experienced national staff (Vietnam), expatriate staff and national staff (Laos), partner agencies such as LBVD (Myanmar), DAHP (Cambodia) or sought input from UN technical agencies in the development of training curricula.

In Laos, CARE developed close working relationships with national fora to develop materials that were fully consistent with national direction, as well as accessing technical expertise that was available within the context.

***To what extent has the Program been delivered according to the schedule provided in annual plans?***

Significant delays have been experienced in Vietnam and Cambodia, while Laos and Myanmar have been delivered according to their annual plans. Causes of delays have included: delays in securing MOUs to operate in certain locations; delays in formative research to inform the on-going design of the pilot activities; delays in selecting pilot activities; distractions from other Programs; high staff turnover; and in the case of Myanmar, significant pressures managing the response to Cyclone Nargis.

Strategies to respond to these delays (and assess the implications in terms of impact on the capacity to achieve intended outcomes) have been limited. In the case of Vietnam and Cambodia, an impact is likely on the capacity of the implementation teams to bring about sustainable outcomes in the 12 months remaining on the Program.

***To what extent has Program expenditure been in accordance with the budget?***

By the scheduled end of the Program (September 2009), it will be approximately A$800,000 underspent. This amount is significant, representing 15% of the total budget. Causes for underspending may be related to: a large exchange rate gain; absorptive capacity of CARE to expend funds without dedicated staff in country programs with many Programs and activities underway (the program approach); limited strategic oversight and supervision by senior staff at the country level (see the following section on governance); costs were lower than originally budgeted for; and limited utilisation of funds for unallocated Technical Assistance.

## 2.5 Efficiency and Effectiveness of Program Management Systems

The detailed findings for each of the following Review questions for each country can be found in Section 4 of Annex 2. This section provides a brief summary.

***What is the quality of Program oversight and governance?***

Achieving effective oversight and governance have been a major challenge for the implementation of the Program. Overall, the MTR team did not develop sufficient confidence that this Program was receiving an adequate degree of supervision by senior staff for an A$5.1M investment. The team did note that the design document did not address governance of the Program. There was also no provision made for on-going independent technical supervision of the Program such as a technical advisory group (or individual), or some form of oversight committee.

The CARE AI Regional Program Manager's role is considered as advisory and facilitative and as such, does not have the authority to directly manage the Program. While country

program teams liaise with the CARE AI Regional Program Manager on program and financial matters, engage with him in review and planning exercises and provide him with reporting, he had to rely on goodwill and relationships more than should be necessary to implement the Program. This has been compounded by the fact that the Program has been fully integrated into a program approach in all four countries. The program approach in Cambodia and Myanmar was to integrate a range of programs in geographical areas. In Vietnam and Laos, the program approach was the integration across all donor funded AI control programs.

Although CARE's approach makes sense from its regular programming perspective, and is consistent with coordination and harmonisation approaches under the international aid effectiveness agenda pursued by donors and NGOs, it has had significant implications for both governance and the evaluation of pilots (see further discussion in the section dealing with M&E below).

In all four countries, there is no single senior officer (with the capacity to design and oversee the strategic direction of the Program) allocated full responsibility for the delivery of the Program. This means that strategic planning and oversight are shared across a range of positions, in some cases, part time positions are shared across a number of other programs.

- Vietnam: High Risk

The Country Program Manager works four days a week on four donor funded projects. She shares strategic oversight functions with two other people. With part-time responsibility, there can be overwhelming demands from other programs; with shared responsibility for this Program, there are challenges to decision-making and communication, blurring of focus, control and strategic thinking.

- Laos: Low Risk

Two senior staff allocate half of their time to the Program and oversee one other activity which is addressing the same issues, but in a rural location. Conceptually, this would be easier to manage than four or five projects addressing different development issues. There is a local Program Manager who allocates 70% of their time. Senior and middle level managers all demonstrate a good knowledge of the Program.

- Cambodia: Moderate Risk

A number of senior staff allocate varying amounts of time to this Program while addressing 10 other programs. This Program accounts for approximately 4% of total Rural Development Program budget and therefore would struggle to compete with other demands. Expatriate advisers on the Program have not enjoyed line-management authority to ensure the quality of the Program.

- Myanmar: High Risk

The Assistant Program Coordinator who is expected to lead the Program has seven programs in her area of responsibility. There is a National Program Adviser who capably supports the Program, but his role is unclear. The location of strategic direction, oversight and support is not clear for the AI Control Program and the implementation team does require significant support. Six months ago a restructure of the entire country program was put in place, which probably contributed to the lack of clarity of roles and responsibilities.

***What is the quality of strategic and annual planning?***

Overall, the attention to strategic planning has been quite limited. The meaning of strategic planning is not clear to some staff. Rather than reflect on the *broader directions and approaches* the Program is adopting, the focus has been on organising and planning the

*implementation* of specific activities. Although teams are well organised in terms of carrying out annual activity planning, and annual plans are of a good standard, there is limited capacity to reflect on the strategic direction of the Program. Indicative are the lack of clarity around the experimental purpose of the Program and the limited focus on sustainability and adoption of findings from the pilots or models. This situation is likely the result of the lack of focus on the Program at the senior level, and a strong reliance on middle level staff to design, deliver, and report on activities.

Annual plans have been overly ambitious in most country programs.

***To what extent has staffing been consistent?***

Consistency of staffing has varied across the different country programs. The most stable country has been Laos (which has been highly consistent). Laos has effectively analysed and responded to challenges in recruiting and maintaining staff in a highly competitive environment.

In Vietnam, high staff turnover has been experienced at the senior and implementation levels. Some staff left to persue international studies. Response to this has been mostly at the level of the local staff where a wage review was carried out. In Cambodia, since the inception phase, there have been three expatriate Program Managers for AI control (shared with the CDC Program). There has also been a transition of country office management (Assistant Country Director - Finance; and Assistant Country Director - Programs). CARE has responded by reducing the scope of the CDC Program, establishing management positions (using national staff) for the CDC Program, and clarifying overall line-management responsibilities and accountability.

In Myanmar, staff changes have been less of an issue, although a Program Manager was lost to the Program in June 2008 and an international BCC Advisor recruited under the Program left after three months. The latter position will not be replaced due to the timeframe required to gain approvals for international staff in Myanmar. There is a requirement for travel permits for international staff to visit the field (the processing of which takes at least 1 month) which limits his/her ability to provide effective technical support. As a result, technical support will be provided by three national staff - the AI National Consultant, AI Advisor and BCC Advisor.

Also in Myanmar, a major restructuring of the country program has been carried out over the past six months. The restructure announced 12 months ago, has been gradually implemented over this period. It is noted by the Myanmar office that the primary challenge of the restructure has been for programs that have national coverage (such as AI). For projects with a specific geographic focus, the restructure has resulted in strengthened program management. The risk for national programs has been identified and ongoing work is being done to monitor challenges and ensure appropriate support to these national programs. The country office lists a number of strategies including bringing a second APC (National Program) on board. This person has temporarily been supporting the Nargis response.

***What is the quality of M&E and reporting systems?***

The switch from implementation to pilot or experimental activities has meant that M&E systems need to be particularly strong. The M&E systems were not sufficiently well designed to meet this requirement, although in Laos and Cambodia there are some strengths in the most part related to knowledge, attitude and practice (KAP) survey design and conduct.

The most important challenge for M&E was the integration of this Program into CARE programs along with a number of other program activities. The Program is integrated into

CARE geographic locations in Cambodia. The issue in Vietnam, Cambodia and (to a lesser extent) Laos, was the decision to pilot a *package* of AI control interventions in one community. In many cases this has made it too complex to evaluate the extent to which new behaviours (or outcomes) have been adopted as a result of the pilot intervention compared to the other interventions being delivered in the same communities over the same time period, as well as to determine the extent to which these models might be adopted in non-CARE communities.

Other key issues identified were:

- There was insufficient clarity around the purpose of the Program – to bring about appropriate policy response at the national or local level to findings from the pilot evaluations;
- There was insufficient clarity of intended end-of-Program outcomes – although community-level behavioural outcomes were identified with respect to adoption of preventative behaviours and to some extent the volunteer's new behaviours, other beneficiary outcomes were not clearly identified nor included in the M&E system;
- The logical framework would have provided significant challenges to implementation teams trying to design M&E systems. It was structured according to processes rather than the pilots. The M&E systems could have been developed after the pilots had been designed;
- There were insufficient evaluation questions incorporated into the M&E system that would be of interest to a national partner who would be adopting the proposed models. The M&E systems addressed whether or not the model was effective at realising community-level behaviour change (does it work?), but did not address questions about feasibility of replication (can we adopt this?);
- Overall the quality of analysis and interpretation of data was inadequate. Simple frequency distributions were often listed with no further discussion on what the findings meant;
- There was insufficient expertise in naturalistic (qualitative) evaluation design, conduct and analysis. The majority of the evaluation work for this Program would be exploratory (qualitative), and should be of a reasonable standard if the findings are expected to influence national or local level AI control implementation strategies;
- There was insufficient high quality corporate guidance available to implementation teams to support the development of even simple M&E systems. The quality of M&E systems was dependent on the expertise of individuals;
- Monitoring and evaluation of gender equality outcomes were not included in the systems (beyond the proportion of participants in some activities that were women);
- Progress reporting was output and activity focused. Although there were attempts to discuss outcomes (titles of the report included outcomes), there were few outcomes actually reported on. Analyses of the implications of issues were not well developed, nor were clear response strategies to problems reported on. It would have been very difficult for an Activity Manager to track progress without conducting field visits to each office.

***What is the quality of Risk Management Systems?***

There were few formal risk management systems in place. Most of the risk management was carried out intuitively. For Myanmar, risk management was the most sophisticated with annual reviews of the risk matrix and the team was able to identify three major risks. Laos does conduct simple reviews of the risk matrix. None of the teams were able to discuss risk mitigation strategies that had been systematically implemented. Vietnam and Cambodia did not conduct risk management activities. Risk monitoring was not addressed by the M&E systems.

# 2. ISSUES AND UNDERLYING CAUSES

## 3.1 Overview of the Key Issues

This section will review the key issues identified and explore the underlying causes. The discussion will lead into Section 4, which will list the recommendations for AusAID and CARE.

- Limited strategic oversight and governance systems in place with significant responsibilities passed on to mid-level or inexperienced staff (in Vietnam and Cambodia, but most notably in Myanmar);
- A strong focus on implementation rather than experimentation (most notably in Vietnam and Myanmar);
- Lack of clarity of intended, end-of-Program outcomes (in documentation and staff strategic planning) in all countries;
- Insufficient quality of Monitoring, Evaluation and Progress Reporting for a pilot/experimental program with an investment of A$5.1M (most notably in Vietnam and Myanmar);
- Lack of strategies in place for replication or adoption of pilots/models in all countries;
- Limited focus on national level ownership or engagement resulting in limited adoption or replication of approaches (in Vietnam and Cambodia);
- Significant challenges to sustainability in all countries;
- Limited utilisation of technical advise available through Program resources (most notably in Vietnam and Myanmar);
- Limited effort to address gender equality in all countries; and
- Program significantly underspent with limited capacity to meet expectations for expenditure (expected to be A$800,000 by September 2009).

## 3.2 Underlying Causes of Key Issues (Lessons Learned)

Several of the findings identified in this MTR require further consideration to try and identify some of the underlying causes. They also bring up a range of questions beyond the scope of this particular Program that may be valuable for AusAID and CARE to reflect on.

Broadly, the causes have been categorised into two key areas: causes that relate to the design processes, and causes that relate to CARE's capacity to implement an experimental or pilot program of this nature and magnitude.

***Design Issues for AusAID Consideration***

*Design Expertise*

The Program was contracted to CARE as a design-and-implement project. As such, a CARE employee, in consultation with a range of stakeholders, designed the Program, initially as an

implementation program and not as an experimental program. There was insufficient expertise available to reasonably expect the Program to be designed with sufficient rigour for a A$5.1M investment. There was also no M&E expertise dedicated to the design process resulting in an awkward logical framework. This made the Program conceptually very difficult for NGO staff to interpret and implement, especially the inadequately defined end-of-Program outcomes (although the MTR team recognise that the latter problem is widespread in the development sector).

*Implications of a Major Shift in the Design Were Not Analysed*

As a result of the peer review of the design, AusAID required CARE to make a significant change to the design. It was to be changed from a more traditional NGO-style implementation program, to an experimental program testing models of community-based interventions replicable by local or national government or other relevant stakeholders. The rationale for this change was concern that the 30-month timeframe for the Program was insufficient to achieve sustainable outcomes and that an experimental approach would be more appropriate.

This change has had a number of far-reaching impacts on the program. First of all, CARE is an agency with expertise in humanitarian assistance, community mobilisation and development. As noted above, CARE's comparative advantage as an NGO has been acknowledged by stakeholders in the areas of relationships with communities, raising community awareness, strengthening district/village surveillance and reporting systems, and capacity building for training and planning for community representatives. However, CARE does not necessarily possess the expertise to design and implement an M&E system that would generate sufficient credible evidence from pilot activities to bring about improvements to national AI strategy implementation. To proceed with this approach it would have been more suitable to partner with an academic institution that could support the evaluation of the pilots while CARE added value in terms of community-based approaches and providing access to known communities.

Second, NGOs often tend to design and implement approaches that are resource intensive. When this happens, such approaches would not be suitable for adoption by local or national government agencies in the kind of resource-constrained settings found in the Mekong Region. CARE staff would need clarification on the importance of mimicking the context in which the Program might operate sustainably in their absence. Senior managers in CARE did not appear to contribute to the institutionalisation of this different approach with their staff.

Third, there was insufficient time allocated to make this shift (the designer was required to make this change to the design within four weeks over the Christmas period) which would not have given sufficient time to consider the implications of this change, and consult with all the CARE teams as well as with CARE in Canberra. However, CARE could have benefited from highlighting the issue to AusAID, requesting more time to consider the implications of this major change, and importantly, its capacity to deliver in all aspects.

Fourth, the design did not address the importance of strategies to enable the *adoption* of successful models (or rejection of unsuccessful models). Rather, it focused in the *dissemination* of findings, which is not a compelling end-point for a A$5.1M Program.

Finally, the MTR team consider that the time required to manage an experimental design program is not less than that required to deliver a more typical implementation program. In fact, it would likely take longer. In the design peer review process the assumption was made that it would require less time. If the purpose of the program is to achieve a policy response at the national or local level, then CARE would need to: develop relationships where they have a high degree of credibility with partners; design a strategy to effect a national or local level

response; effectively review the information needs of partners; design robust experiments; implement those experiments, learn from them, and assess the likely sustainability; make necessary adjustments to the model and if necessary conduct another cycle of the adapted model; conduct, analyse and report on the findings with credible monitoring and evaluation; and enable partners to make the appropriate policy response. Thirty months were probably insufficient to meet these expectations, especially in an NGO with limited specialist experience in conducting and evaluating pilot experiments, with an active portfolio of other projects underway.

Additional confusion was experienced by CARE when recommendations from the peer review were not consolidated into a single AusAID position. Some findings of the reviewers were inconsistent, and in the time available, CARE struggled to respond appropriately.

*Governance was not Addressed in the Design*

Governance and strategic oversight were not addressed in the design. Personnel were described, but there were no clear descriptions of what line-management responsibilities were given to the CARE AI Regional Program Manager and those responsible for delivering the Program in each country. This resulted in having to rely more than should be required on relationships and goodwill, especially on the part of the CARE AI Regional Program Manager, to implement the Program.

There were no provisions made for any technical or programmatic oversight of the Program. AusAID was dependent on information from progress reports, which did not meet its needs well. It would have been very difficult for AusAID Activity Managers to assess the true performance of the Program without conducting visits to each country.

*Lack of Clarity in the Comparative Advantage of the Delivery Mechanism (INGO)*

The design did discuss CARE's access to national fora which would have placed them well to deliver a Program designed to influence national implementation of AI control strategies – although this situation was only fully realised in Laos and Myanmar. CARE also indicated that they had experience in delivering AI control programs in the region.

Although these are important points, the design did not provide a particularly strong basis for understanding why CARE was granted the contract to deliver this regional program. In the section addressing CARE's capacity to respond, institutional capacity was justified on the grounds that CARE had other AusAID Programs in the region and that CARE is AusAID-accredited - which results from a substantial review of CARE's documented systems. However, for this Program institutional capacity has been the most challenging aspect for CARE in its delivery of the Program, e.g., strategic oversight and planning, monitoring and evaluation, integration of gender equality strategies and designing effective approaches to sustainability and replication of models (see below).

A more effective analysis in the design of CARE's capacity to deliver the Program would have been helpful. This would articulate clearly where CARE's comparative advantage lies and is expected to add particular value, and to highlight areas where augmentation of that capacity may be required.

***CARE Capacity Considerations***

*Analyse Capacity to Deliver During Design Phase*

CARE would have benefited from a thorough analysis of its capacity to deliver the Program. This is not to suggest that it was not capable, rather, to systematically identify and manage the key risks. Some of the areas requiring more substantive consideration were:

- The implications of integrating the Program into a programmatic approach where the management structure has staff managing, in some cases, a large number of projects;
- The capacity of CARE to manage an experimental design within an implementation program focused on geographical locations;
- The capacity of CARE to conduct pilots with quality experimental M&E design;
- The capacity of CARE to deliver the Program within 30 months; and
- The capacity of CARE to expend funds within the timeframe.

*Delegation of Strategic Roles to Middle Level or Inexperienced Staff*

In some countries, the MTR found that CARE had delegated quite important strategic roles to staff that were unsuited to operate at this level. Although they would be considered suitable and competent for activity implementation, there was insufficient involvement of senior staff to support the conceptual development of the Program. This, in turn was exacerbated by the heavy work load of senior staff. In Myanmar, for example, senior Country Program management staff were allocated 1.5 days per month to work on this Program. This is unlikely to be enough to support the strategic direction of the Program, and provide oversight, supervision and support of staff, especially in a program such as this that poses many new challenges to NGO staff.

*CARE Management Structure*

Although it is not the intention of the MTR team to comment on the appropriateness of the management structure of CARE Australia, it is important to review how structural arrangements have impacted on this Program. The management structure of CARE requires that individuals responsible for implementing programs report to their Country Director. For regional programs such as this one, they liaise with the AI Regional Program Manager and CARE Australia staff on program activities and finances, they provide reports and engage with the AI Regional Program Manager in review and planning meetings, but they are not required to formally report to him in a supervisory sense. This has led to a number of issues in different countries relating to a reduction of strategic oversight, competition from other activities with dilution of effort, and significant delays in delivery of the Program. For regional activities to be well supported and successful, solutions need to be found to address this risk.

*Corporate Level Support Systems*

The MTR team is not familiar with the accreditation standards AusAID requires of NGOs, and therefore have not commented on the findings in that light (although this would be a very useful basis for future reviews of NGO programs). However, during the discussions with implementation teams it was apparent that there were only limited resources available to or accessed by staff to assist them to deliver their work according to a particular standard.

For example, the MTR team did not observe any guidelines in use for monitoring and evaluation generated from CARE Australia or CARE International (e.g. CARE USA program design manual). Country programs were looking to develop their own locally appropriate guidelines and standards. Given the expertise available at the country level, it would be unlikely that CARE country program staff would have the skills to develop guidelines that would enable staff to design and conduct simple evaluations. Training, hands-on support and other assistance has been provided across the four offices by CARE Australia's Regional Quality Advisor, and cross-cutting quality teams have been established in each Country Office, but the MTR team retains concerns over the capacity of AI teams in each location.

Given the increasing emphasis of donors on aid effectiveness, it would be beneficial to further develop corporate responses to these demands. The MTR team did note that there were resources available on the CARE intranet but these were not reviewed.

Other areas that would be very useful for implementation teams would include guidance on mainstreaming gender equality into their programs (including greater promotion of existing materials such as AusAID's gender toolkit); international practice for BCC; and development of approaches to analyse, enhance and monitor progress toward sustainability. These are all important skills for this Program, as well as for other community development programs being delivered by CARE. CARE Australia is working on relevant initiatives with the country offices concerned, through the existing Regional Quality Advisor as well as through the Quality Unit and International Operations Department in Canberra; however, it is important that such work be fully embedded and implemented in-country if improvements in project outcomes are to be secured.

*Limited Access of Resources Available*

Senior staff and implementation teams did not recognise (or respond) to the need for building staff capacity to deliver this Program. The budget allowed for access to significant resources to support implementation. These were, in the most part, not accessed (although Laos did contract an M&E specialist).

# 3. RECOMMENDATIONS

## 4.1 Introduction

As there is only 12 months remaining on this Program, the MTR team consider that adjustments to the Program should be as minimal as possible. They must be feasible within the timeframe, match the available resources, and add the most value in achieving the desired outcomes of the Program.

Potential future directions for community-based AI programming are also discussed.

The recommendations that follow have been discussed in detail with AusAID Bangkok, each of the Country Program teams, the CARE AI Regional Program Manager, and CARE's Manager of Program Cycle Management in Canberra. All stakeholders have indicated their capacity to implement these in a timely manner. Recommendation 1 has been discussed with AusAID Bangkok, the CARE AI Regional Program Manager, and CARE Australia.

## 4.2 To Complete the Current Program

*Recommendation 1:*

CARE Australia to put in place a supervisory arrangement, consistent with the organisation's management structure, to ensure whole of program governance. A suggested mechanism is a Program Steering Group comprising of the AI Regional Program Manager, senior staff from CARE Australia, Country Directors or Assistant Country Directors, and AI Program Managers to meet on a regular basis (via teleconference) for the remainder of the Program. This would be supported by the development of revised TORs and a Program organigram that clearly sets out roles, responsibilities, and management lines for Program personnel including the AI Regional Program Manager, CARE Australia-based staff, and country office project staff.

*Recommendation 2:*

CARE Country Directors (Vietnam, Cambodia and Myanmar) to develop a *strategy to respond to the risks posed by the current arrangements for governance and strategic oversight* of the Program. This strategy should clearly identify:

- An individual with suitable capacity to have final responsibility for the strategic direction and quality of the Program deliverables, and achievement of intended outcomes.
- An adequate commitment of time from the responsible individual.
- The extent to which they have line-management authority to ensure the quality of the Program deliverables and achievement of intended outcomes.
- The type of senior level/corporate support these individuals will receive to address the strategic issues identified by the MTR. It is not expected that this support will require additional allocation of days by senior management to this Program, rather that they use the allocated days more effectively to provide planned, meaningful support and strategic oversight and not limit their input to commenting on documents where this is the current practice.

It is not an expectation that CARE will carry out any restructuring of its Country Programs during the remaining 12 months of this Program. Rather, a simple but well-considered strategy is required to develop confidence that the remaining 12 months of the Program will be well resourced and supervised. This strategy should allow AusAID to develop confidence that targeted, but high quality support and oversight will be available to implementing teams.

*Recommendation 3:*

CARE AI Program Managers, in consultation with the CARE AI Regional Program Manager, *access appropriate technical support* for staff to enhance M&E and sustainability of activities. The TOR for this M&E Specialist is in Annex 3. The outputs of this support will be:

- Improved M&E systems for pilot activities.
- A strategy to support the utilisation of findings from the pilot studies which would identify the target audiences (at national, provincial, district or village level – whichever is considered most appropriate for each country program) for adoption or rejection of the models; and, identification of more comprehensive approaches to maximising the capacity of target audiences to respond.
- An analysis of the factors effecting sustainability of activities, and identification of key implementation strategies to enhance the likelihood of sustainable outcomes (see suggested approach in Annex 4).
- Enhancing Program reporting (see suggested approach in Annex 5).
- Ensuring the scope of the Program activities is feasible within the timeframe of the Program (for example, Myanmar should not pursue the development of the Surveillance model at this late stage in the Program).

Included under the current services order, the MTR team will be available to assist in the selection of a suitable candidate, by interviewing and assessing competency, and providing a comprehensive briefing to the successful applicant.

*Recommendation 4:*

AusAID Bangkok could consider conducting a *review of progress on the response to the MTR findings* in March 2009. The review could be carried out as a short input by the AusAID Activity Manager working with country teams. No field trips would be required and two days with each country team would be sufficient.

*Recommendation 5:*

AusAID Bangkok could consider extending the current Program to allow full disbursement of funds, and to achieve the potential outcomes of the Program. It is not recommended to extend all country program activities, rather, identify and support only those pilot activities that are of sufficient quality and relevance to justify extension. This assessment could be undertaken by the contracted M&E Specialist during the review of the pilot designs and M&E systems.

Pilots that may meet requirements for extension have been preliminarily identified based on outcomes to date. These are the Community-based Surveillance Pilots in Vietnam and Laos, and the Biosecurity Model in Myanmar. However, these remain indicative with the final assessment for all countries to be made by the M&E Specialist once all pilots have been reviewed.

## 4.3 Potential Future Engagement with Community-Based AI Programming

The MTR team considers that there is a sufficiently robust foundation in place to gain benefits from implementing a follow-on Program ***if this is consistent with the new AusAID regional strategy***. This is largely in response to the high degree of participation and ownership achieved at the national and local level in some countries. However, several issues will require clarification before further elaboration is possible:

- Identification of feasible approaches to enhancing the regional outcomes of the Program. Although there are no suitable regional fora that CARE could reasonably expect to engage with, there may be options to bring national partners together for discussions on effective and affordable approaches to community-based interventions.
- The available budget. The MTR team considers an investment of A$5.1M over four countries over five years would be required to achieve an adequate level of sustainable outcome.
- Clarification of the number of countries that would participate in any future activity.
- Clarification of whether an implementation program or an experimental pilot program will add the most value at a regional and country level.
- Clarification of the expected value-added of working with NGOs given their comparative advantage with local level engagement, and definition of the expectations of capacity to deliver an experimental/pilot program.
- Determine the conditions the implementing NGO would need to meet in order to develop confidence that the quality of the Program could be maintained.
- If the follow-on program was subject to a competitive tendering process, determine if there is sufficient interest in the Australian NGO community to tender for this type of activity.

If a follow-on program is considered appropriate, it is recommended that:

- The design process begin as soon as is practicable so as to maintain momentum and allow consolidation of newly developed relationships at the national level;
- Contract an independent design team with suitable expertise to carry out the design; and
- Develop a design framework that is suitable, conceptually, for implementation by an NGO.

# ANNEXES

# ANNEX 1: METHODOLOGY, TORs, AND PERSONS MET

Community-Based Avian Influenza Risk Reduction Program – Mekong Region Phase 2

September-October 2008

**Preliminary Methodology for Stakeholder Consultation – Version 1**

---

## 1. Overview of the CBAIRRP

The Community-based Avian Influenza Risk Reduction Program – Mekong Region Phase 2[1], is a A$5.1 million 30-month program aiming to improve recognition, control and prevention of emerging infectious diseases in the Mekong region.

The program goal is 'to contribute to improved recognition, control and prevention of emerging infectious diseases in the Mekong region.'

The program's purpose is to document lessons and successes from these pilot activities and to disseminate findings to inform wider AI control programming in each country.

The component objectives of the program are:

| | |
|---|---|
| Component One: | To identify operational models for strengthening community and local level capacity to prevent AI. |
| Component Two: | To identify operational models for strengthening community participation in AI detection, reporting and response. |
| Component Three: | To ensure efficient and effective implementation and evaluation of the regional program. |

CARE Australia is managing the program through the CARE country offices located in Cambodia, Laos, Myanmar, and Vietnam. While the generic approach is common to each individual country program, the implementation strategy, entry point for activities and the focus for these activities vary according to the implementation context and identified needs in each country. Each CARE country office is implementing country-specific activities in close collaboration with partner government and relevant community organisations.

Phase 2 of the program commenced in March 2007 and will end in September 2009.

## 2. Objectives of the MTR

The primary objective of the Review is to contribute to program improvements through independently assessing the progress and quality of implementation and achievements of the program to date.

[1] Phase 2 drew heavily on lessons from the evaluation of the AusAID-funded CARE Australia Avian Influenza Local Risk Reduction Mekong Regional Program Phase 1 (June 2006 - February 2007).

The specific objectives of the Review as described in the Terms of Reference (Attachment 1) are to identify achievements and make recommendations for program improvements in the following areas:

i. **Key Results** of the program to date which covers direct, indirect, intended, and unintended outcomes.

ii. **Implementation Progress** towards achieving outputs and outcomes under Year 1 implementation and against each of the program's three component areas outlined in the Program Design Document (PDD). This should include identifying issues that adversely affect activity outcomes and, working with CARE country teams, recommend strategies for addressing these issues.

iii. **Relevance** of program objectives and activity approaches to current AusAID priorities and regional strategies.

iv. **Effectiveness** of the program to date in achieving its stated objectives. This includes an assessment on whether program activities will attain its objectives within stated timeframes and until the program's end in September 2009.

v. **Efficiency** of CARE Australia's program management arrangements at the regional and country-levels.

vi. **Monitoring and Evaluation** at the country-level and the extent to which outputs, outcomes, and achievement of objectives are captured by the current country M&E frameworks. This should include recommendations to improve country-level M&E frameworks and performance indicators. Related to this, the MTR team should also briefly assess the quality and adequacy of the 2007-2008 Annual Report and the 2008-2009 Annual Plan based on AusAID quality reporting standards.

vii. **Sustainability** mechanisms and an assessment of the likely sustainability of program activities after September 2009 (i.e. if program partners from the government or NGO sectors have taken more responsibility and initiative in program components). This include recommendations on a possible transition phase beyond the current Phase 2.

viii. **Cross Cutting Issues** including the extent issues such as gender are mainstreamed in program activities.

ix. **Partnerships** including program linkages with key stakeholders (e.g. local governments, national government, local community, Non Government Organisations, donor agencies, and International technical organisations such as WHO and FAO).

x. **Risk Management** mechanisms at the country-levels including a re-evaluation of program risks.

### 3. Utilisation of Findings

Key management decisions that will be informed by the findings of the MTR are:

- concerned with enhancing the quality of on-going design of program approaches and interventions, This includes the identification and discussion of key issues with implementation teams to enhance their capacity to deliver a quality program that achieves sustainable development outcomes.
- to inform decisions about any no-cost extension of the Program to the end of 2009.

Approaches to enhance utilisation of findings that will be adopted for this MTR are:

1. Ensure that key stakeholders responsible for implementing the program have the opportunity to contribute to the design of the MTR information requirements and methodology;
2. Ensure that key stakeholders responsible for implementing the program have sufficient opportunity to discuss the findings and recommendations of the Review Team before the final report is submitted. This will include the cost implications and feasibility of recommendations.
3. Mechanisms to disseminate and follow-up on report recommendations will be developed by AusAID during the Review and will be described in the MTR report.

## 4. Information Requirements and Broad Approaches

### *4.1 Overview of Information Requirements*

This section describes the information required during this Review, and methods employed to collect that information. A more detailed list of information required or evaluation questions can be found in Attachment 2. Often TORs are written in a way that requires slight restructuring for the development of the methodology for the mission and to enhance clarity in allocating tasks to MTR team members according to their area of technical expertise. The following re-ordering of information requirements still includes all aspects of the original TORs.

The logic of the design is that the MTR focus on four main areas:

*1. Continuing Relevance of the Program*: this includes a review of the context in which the program is being delivered. Any significant changes in the environment will be identified including donor and national government responses to AI, and an assessment of whether or not the Program continues to fill gaps in national responses. The continuing relevance of the design will be assessed against a sample of relevant regional/national strategies. This area includes TOR requirements from the Scope of Work number 3.

*2. Achievements of the Program*: Firstly, this will include an assessment of the extent to which the program stakeholders have a shared view of the intended outcomes at the end of the program.

Secondly, it includes an assessment of the extent to which the program has either achieved ***sustainable development outcomes*** or has progressed toward intended (or unintended) outcomes. Development outcomes include technical outcomes relating to the prevention, surveillance and response to AI, as well as gender equality and partnership outcomes. The extent to which regional (versus national level) outcomes have been achieved will also be addressed. The likely sustainability of these outcomes will be an important focus. Factors that account for the achievement (or not) of sustainable development outcomes will also be identified. Some specific factors of interest will be explored. These include approaches to dissemination of information to achieve adoption and resourcing of successful pilot activities; the role of incentives for community behaviour change; dilution effects of working with other donors; and absorptive capacity of national partners.

*3. Quality of Implementation:* First, the ***quality of outputs*** will be assessed. This refers to the quality of program deliverables such as training and capacity building, pilot design, or other deliverables of the program. Factors accounting for the quality of outputs will be identified. Then, ***progress of implementation*** of activities will be assessed against the Annual Plan 07-08. This includes an analysis of the pace of program expenditure. Factors accounting for

delays will be identified, as well as a discussion of the implications of these delays (and any related under-spending) to ongoing approaches to achieving intended outcomes during the life of the program. This area includes TOR requirements from the Scope of Work number 1, 2, 4, 7, 8, and 9.

*4. Effectiveness and Efficiency of Program Management Systems*: this includes reviews of the appropriateness of the program strategic oversight (governance); quality of strategic and annual planning; consistency of staffing; the quality of M&E and risk management systems; adequacy of financial reporting; and general considerations of value for money of the approaches adopted. This includes TOR requirements from the Scope of Work number 5, 6, 10.

### *4.2 Broad Approach*

The MTR will assess the program at the regional, country and pilot activity levels.

The Review will involve a combination of systematic reviews of documentation, and in-depth interviews with a range of key stakeholders. The time and resources available do not allow a review of all the activities being conducted across the four participating countries. Therefore, a sample of pilot activities will be selected and reviewed in more detail.

## 5. Scope, Phasing and Sampling

### *5.1 Scope and Flexibility of MTR Design*

The scope of the Review presented here is very broad, with limited time available for interviews in Bangkok (two visits), Hanoi, Vientiane, Phnom Penh, and Yangon. There is significant information required from interview respondents. It is not always possible to enable respondents to answer the broad range of questions within the time allocated for the interview (usually one hour). At times, the reviewers will need to make decisions to sacrifice some information to pursue important emerging information that was not anticipated during the design. At times the reviewers may need to conduct interviews separately.

### *5.2 Phasing of MTR*

Information collection will be conducted in two phases. The first phase is a preliminary documentation review followed a series of telephone interviews in Australia with the Post, CARE AI Regional Program Manager, and key AusAID stakeholders on gender, monitoring and evaluation, and from the Trans Boundary and Mekong Sections. These discussions are designed to allow a broad consultation process for the design of the methodology and identification of key issues. AusAID Whole-of-Government partners (DAFF and DOHA) were consulted during the development of the methodology to identify important contextual factors to consider.

More detailed document reviews will be conducted in Bangkok before the in-country visits begin.

Phase two will involve the in-country mission to the four program countries listed above.

There will be five groups of respondents for this part of the review:

1. AusAID Posted Officers in Bangkok

2. CARE Regional and Country Implementation Teams

3. A sample of representatives of relevant donors at the regional and national levels. Relevance is determined by their capacity to comment on contextual changes in AI

prevention, surveillance and response, as well as their own direct participation in AI programs especially those related to CARE activities.

4. A sample of Program Working Teams (PWTs) in each country or other relevant implementation partners. Relevance is determined by their participation in the oversight of the country level program, or their participation in the sampled piloted activities (see sampling below).

5. A sample of Community Program Implementers (CPIs) responsible for the implementation of each selected pilot activity.

6. A sample of beneficiaries (as a group interview) from each selected pilot activity.

### *5.3 Sampling*

Purposive sampling was applied to select the four pilot activities (one from each country) for closer review. The criteria for selection of these activities are: a) both completed and in-progress pilots; b) a range of program components and outputs; c) both successful and less successful pilots; and d) a range of implementation partners (local government, local NGOs, communities). The pilot activities selected are:

| Title of Activity |
|---|
| Vietnam: The 5-Step Model: Strengthening Training Outreach and Prevention of AI |
| Laos: Events-Based Community Surveillance |
| Cambodia: Biosecurity Demonstration Farms |
| Myanmar: National AI Training with Livestock Breeding and Veterinary Department |

## 6. Methods

Due to the limited time available in each country, the Review is not intended to provide *proof* of achievement of stated outcomes of the program. No primary data will be collected for any of the four countries beyond stakeholder perceptions. However, any evidence-based output and outcome data reported in any M&E reports or Program Progress Reports will be reviewed and incorporated into the findings.

The Review is a desk review of documentation, supplemented by in-depth interviews using qualitative questioning techniques seeking the perceptions of relevant stakeholders described in the five respondent groups above. Multiple perspectives strengthen confidence in the findings where primary data is not available. Although reliability and validity of findings will be weaker than if a formal outcome evaluation with the collection of primary data was carried out, this is well beyond the resources available to AusAID for this MTR. Many of the findings will be based on a combination of stakeholder perceptions and the professional judgment of the MTR team.

Attachment 2 shows, in detail, the Review questions that will be addressed, and shows the methods for each topic area. Tools include document checklists for document reviews, and interview guides for the in-depth interviews. These tools will be finalised by the team at the time of the in-country visit and will evolve somewhat during the review period. Questions presented in Annex 2 will be structured during interviews to ensure there is logical flow of discussion rather than going through a list of questions mechanically. This list is used by the

reviewers to guide topics of discussion during the interview, and to make certain that the information requirements of the Review's TORs are met.

Attachment 2 also shows the team responsibilities for information collection and report writing to allow team members to focus their reading during the document reviews, and questions during interviews.

## Attachment 1: Draft Terms of Reference for the CBAIRRP MTR

**8 September to 9 October 2008**

### I. Background

The Community-based Avian Influenza Risk Reduction Program – Mekong Region Phase 2[1], is a A$5.1 million 30-month program aiming to improve recognition, control and prevention of emerging infectious diseases in the Mekong region.

The objectives of the program[2] are:

1. To identify operational models for strengthening community and local level capacity to prevent Highly Pathogenic Avian Influenza (HPAI);
2. To identify operational models for strengthening community participation in HPAI detection, reporting and response; and
3. To ensure efficient and effective implementation and evaluation of the regional program.

The program's purpose is to document approaches and lessons from these pilot activities and to disseminate findings to inform wider HPAI programming in each country.

CARE Australia is managing the program through the CARE country offices located in Cambodia, Laos, Myanmar, and Vietnam. While the generic approach is common to each individual country Program, the implementation strategy, entry point for activities and the focus for these activities vary according to the implementation context and identified needs in each country. Each CARE country office is implementing country-specific activities in close collaboration with partner government and relevant community organisations.

Phase 2 of the program commenced in March 2007 and will end in September 2009.

### II. Role and Purpose of the Mid-Term Review (MTR)

As part of the program's monitoring and evaluation, the Program Design Document provided for a Mid-Term Review (MTR), to be organised by AusAID and conducted approximately 15 months after the Program has commenced.

The mid-term review will focus on assessing the achievements of the Program to date and to provide recommendations for improving Program implementation. CARE Australia will assist AusAID to make appropriate documents available and arrange relevant meetings and visits for the mid-term review team.

[1] Phase 2 drew heavily on lessons from the evaluation of the AusAID-funded CARE Australia Avian Influenza Local Risk Reduction Mekong Regional Program Phase 1 (June 2006 - February 2007).
[2] The program objectives are implemented under three component areas: 1) Community-based prevention; 2) Community-based surveillance and response preparedness; and 3) Program management.

## III. Scope of Work

An independent MTR team will be contracted by AusAID through the Asia-Pacific Emerging Infectious Diseases Facility (AusReady). Meetings with multi-country stakeholders will be as agreed to by AusAID in close consultation with CARE Australia's Regional and Country Offices.

The main objective of the MTR is:

- To contribute to program improvements through independently assessing the progress and quality of implementation and achievements of the program to date.

The Review should include assessments, recommendations, and, where appropriate, document lessons learned on:

i. **Key Results** of the program to date which covers direct, indirect, intended, and unintended outcomes.
ii. **Implementation Progress** towards achieving outputs and outcomes under Year 1 implementation and against each of the program's three component areas outlined in the Program Design Document (PDD). This should include identifying issues that adversely affect activity outcomes and, working with CARE country teams, recommend strategies for addressing these issues.
iii. **Relevance** of program objectives and activity approaches to current AusAID priorities and regional strategies.
iv. **Effectiveness** of the program to date in achieving its stated objectives. This includes an assessment on whether program activities will attain its objectives within stated timeframes and until the program's end in September 2009.
v. **Efficiency** of CARE Australia's program management arrangements at the regional and country-levels.
vi. **Monitoring and Evaluation** at the country-level and the extent to which outputs, outcomes, and achievement of objectives are captured by the current country M&E frameworks. This should include recommendations to improve country-level M&E frameworks and performance indicators. Related to this, the MTR team should also briefly assess the quality and adequacy of the 2007-2008 Annual Report and the 2008-2009 Annual Plan based on AusAID quality reporting standards.
vii. **Sustainability** mechanisms and an assessment of the likely sustainability of program activities after September 2009 (i.e. if program partners from the government or NGO sectors have taken more responsibility and initiative in program components). This includes recommendations on a possible transition phase beyond the current Phase 2.
viii. **Cross Cutting Issues** including the extent issues such as gender are mainstreamed in program activities.
ix. **Partnerships** including program linkages with key stakeholders (e.g. local governments, national government, local community, Non Government Organisations, donor agencies, and International technical organisations such as WHO and FAO).
x. **Risk Management** mechanisms at the country-levels including a re-evaluation of program risks.

## IV. Reporting Outputs

1. The Contractor will prepare, draft and present an Aide Memoire and a final MTR report in accordance with the Interim Guidelines for preparing AusAID reports. Suggested major headings of the Aide Memoire and the MTR report are as follows:

    - Executive Summary
    - Introduction
    - Key Results (i.e. major achievements – outcomes and key outputs)
    - Implementation Progress
        - Year 1: Implementation and Outputs
        - Management Arrangements
        - Financial Arrangements
    - Achievement of Objectives
        - Program Objectives
        - Three Component Areas
    - Monitoring and Evaluation
    - Sustainability
    - Cross-cutting Issues
    - Current Issues and Risk Management
    - Conclusions / Recommendations & Lessons Learned

2. There should be a strong focus on higher order issues in the Conclusions, Recommendations and Lessons Learned section of the report.

3. The MTR Report will be presented generally in the form specified in the Interim Guidelines (using MS Word and Excel) and forwarded to AusAID Bangkok. The report should have a 25-page limit inclusive of the Executive Summary but exclusive of Annexes.

4. Reports will be prepared and submitted to AusAID Bangkok as follows:

    a) Electronic and hard copies of the Aide Memoire to be submitted during the Aide Memoire presentation on 24 September 2008[3];
    b) An initial electronic draft of the MTR Report for review and feedback submitted by COB 30 September 2008;
    c) A final draft of the MTR Report incorporating AusAID's feedback, when appropriate;
    d) Four (4) hard copies of the final MTR Report and an electronic copy to be submitted by COB 9 October 2008.

5. The Contractor must provide the Services to a standard which would be expected of a competent, experienced and professional contractor and in accordance with applicable Australian Laws and in accordance also with all applicable industry or professional standards or requirements.

[3] The Aide Memoire should be a succinct document outlining the review team's major findings and recommendations.

## V. Mid-Term Review (MTR) Team: Composition and Responsibilities

The independent MTR team for the Community-based Avian Influenza Risk Reduction Program – Mekong Region Phase 2 MTR will consist of two members - a Team Leader (Dr.Susan Dawson) and an Animal Health Expert (Dr Tristan Jubb) from the Mekong or the ASEAN region.

1. The Team Leader (M&E Specialist) will have primary responsibility for:

    a) Leading the team and taking overall responsibility for the MTR and the drafting of MTR reporting outputs (e.g. aide memoire, draft and final MTR report);
    b) Ensuring the full participation and effective communication among nominated team members in the Review;
    c) Providing assessments and recommendations of the country-level M&E Frameworks including its ability to obtain Program-level outputs and report on broader outcomes;
    d) Assessing the effectiveness and providing recommendations on Program-level performance information and how this feeds into the programme-wide reporting of outcomes;
    e) Assessing the relevance and providing recommendations on programme indicators and baseline data;
    f) Preparing and drafting of an Aide Memoire in consultation with other members of the MTR team; joint presentation of the Aide Memoire to AusAID prior to the end of the in-country mission;
    g) Providing a draft MTR report to AusAID for comments;
    h) Ensuring review outputs are of high quality, incorporating comments from AusAID when appropriate and submitted to AusAID within the required timeframe.

2. The Animal Health Expert from the Mekong or the ASEAN region will have responsibility for:

    a) Assisting the Team Leader to assess information relevant to the Review's scope of work;
    b) Ensure that Review assessments and recommendations are provided within an Asian / Mekong region context;
    c) Joint attendance at key meetings scheduled for the Review process;
    d) Assist in the preparation and drafting of an Aide Memoire including participation in the joint presentation of the Aide Memoire to AusAID;
    e) Writing relevant sections of the MTR Report (to be decided in consultation with the Team Leader).

3. The AusAID Regional Program Manager based in Bangkok will accompany and participate in the MTR in-country consultations.

Skills of the MTR team members should include:

a) Experience and demonstrated capacity in M&E and Program implementation reviews particularly on Animal or Human Health Programs in the region;
b) Experience in conducting reviews in a multi-cultural setting in Asia preferably in the Mekong region;
c) Experience in assessing institutional capacity in a developing country context;

d) Knowledge of community-based interventions and the governance structure of international NGOs;
e) Writing skills of a high standard;
f) Good understanding of AusAID systems and processes.

## VI. Indicative Dates and Duration

The timeframe for the MTR is as follows:

| **Key Steps** | **Timing** |
|---|---|
| Pre-mission preparation (e.g. desk review, meeting with AusAID Canberra and Australian whole-of-government agencies, teleconference or videoconference with AusAID Bangkok) | 3 days maximum during the period 8-10 September 2008 |
| In country mission (consultations and drafting) – including travel | 13 days from 11 – 23 September 2008 |
| Aide Memoire submission and presentation (AusAID Bangkok) | 24 September 2008 |
| Draft MTR report | A maximum of 5 input days for the Team Leader and a maximum of 4 input days for the Regional Expert during the period 25-29 September 2008 |
| Submission of Draft MTR report to AusAID | By COB 30 September 2008 |
| Submission of AusAID comments to MTR team | By COB 6 October 2008 |
| Incorporation of revisions | A maximum of 2 days during the period 7-8 October 2008 for the Team Leader |
| Final MTR report and recommendations submitted to AusAID | By COB 9 October 2008 |

## Attachment 2: Review Questions, Methods and MTR Team Responsibilities

1. Continuing Relevance of the Program

| Method Section | Review Question | Method | Documents Reviewed/ Respondent | Team Member Responsible for Information Collection and Section in Report |
|---|---|---|---|---|
| 1.1 | Has the context for AI prevention, surveillance and response changed in significant ways since the original design of the program? | In-depth Interviews | Relevant Regional Donors, Bangkok<br>UNICEF Community IEC work<br>Relevant Country Donor Reps<br>Sample of PWTs reps<br>Other Relevant Country Level Government Representatives (national/local) | Tristan Jubb |
| 1.2 | Does the Program continue to meet gaps in AI prevention, surveillance and response, or have other stakeholders addressed these since mobilisation of the program? | In-depth Interviews | Relevant Regional Donors, Bangkok<br>Relevant Country Donor Reps<br>Sample of PWT reps<br>Other Relevant Country Level Government Representatives (national/local) | Tristan Jubb |
| 1.3 | Are the current annual plans still consistent with a sample of regional and national country AI response plans? | Document Review | Sample of one regional strategy<br>Sample of two national country strategies | Tristan Jubb |

2. Achievement of Sustainable Outcomes

| Method Section | Review Question | Method | Documents Reviewed/ Respondent | Team Member Responsible for Information Collection and Section in Report |
|---|---|---|---|---|
| 2.1 | To what extent do stakeholders have a shared view of the intended end-of-program outcomes?<br>*- technical outcomes relating to prevention, surveillance and response*<br>*- gender equality outcomes*<br>*- partnership outcomes*<br>*- to what extent are these consistent with program documentation?*<br>- whole of program regional level<br>- country level<br>- sampled pilots | Document Review<br><br>In-depth interviews | *PDD<br>*Annual Plans<br>*M&E Framework<br>* AusAID Bangkok Posted Officers<br>* CARE Regional Manager<br>* CARE Country Teams<br>* Relevant Implementation Partners at Country Level (PWTs)<br>* Sampled pilot implementation partners (CPIs)<br>* Sampled pilot beneficiaries | Susan Dawson<br>(Tristan Jubb to focus on technical outcomes relating to animal health) |
| 2.2 | To what extent did program documentation report achievement of outcomes?<br>*- was this evidence-based or" professional-judgement" reporting?*<br>- regional level<br>- country level<br>- sampled pilots | Document Review | * Six monthly reports<br>* Annual reports<br>* Products of M&E system (e.g. KAP studies) | Susan Dawson<br>(Tristan Jubb to focus on technical outcomes relating to animal health) |
| 2.3 | To what extent did stakeholders perceive that development outcomes were achieved? (A series of qualitative questions are required to assist the respondents to articulate outcomes achieved at the time of the MTR)<br>*- achievement of development outcomes relating to prevention, surveillance and response articulated in the design and annual plans*<br>*- achievement of unintended outcomes* | In-depth Interviews | * AusAID Bangkok Posted Officers<br>* CARE Regional Manager<br>* CARE Country Teams<br>* Relevant Implementation Partners at Country Level (PWTs)<br>* Sampled pilot implementation partners (CPIs)<br>* Sampled pilot beneficiaries | Susan Dawson<br>(Tristan Jubb to focus on technical outcomes relating to animal health) |
| 2.4 | To what extent are outcomes likely to be sustainable?<br>*- technical outcomes relating to prevention, surveillance and response*<br>*- gender equality outcomes*<br>*- partnership outcomes* | Document Review<br><br>In-depth Interviews | * Program Design Document<br>* Annual Plans<br>* AusAID Bangkok Posted Officers<br>* CARE Regional Manager<br>* CARE Country Teams Relevant Implementation Partners at | Susan Dawson<br>(Tristan Jubb to focus on technical outcomes relating to animal health) |

| Method Section | Review Question | Method | Documents Reviewed/ Respondent | Team Member Responsible for Information Collection and Section in Report |
|---|---|---|---|---|
| | | | Country Level (PWTs)<br>* Sampled pilot implementation partners (CPIs)<br>* Sampled pilot beneficiaries | |
| 2.5 | What factors have accounted for the achievement (or not) of development outcomes?<br>*- contextual factors*<br>*- partner institutional factors*<br>*- design factors*<br>*- implementation approach factors (inclu-ding incentives for adoption of new behaviours)*<br>*- program management factors*<br>*- what processes are in place to integrate (analyse and respond to) issues of gender equality?* | Document Review<br><br>In-depth interviews | * Progress and annual reports<br>* Products of M&E system<br>* AusAID Bangkok Posted Officers<br>* CARE Regional Manager<br>* CARE Country Teams<br>* Relevant Implementation Partners at Country Level (PWTs)<br>* Sampled pilot implementation partners (CPIs)<br>* Sampled pilot beneficiaries | Susan Dawson<br>(Tristan Jubb to focus on technical outcomes relating to animal health) |

3. Quality of Implementation

| Method Section | Review Question | Method | Documents Reviewed/ Respondent | Team Member Responsible for Information Collection and Section in Report |
|---|---|---|---|---|
| 3.1 | What are the quality and effectiveness of program deliverables?<br>*- training sessions delivered and extent of follow-up for roll-out*<br>*- technical content in terms of human and animal health*<br>*- design and conduct of pilot activities*<br>*- dissemination of information to achieve desired behaviour changes* | Document Review<br><br>In-depth interviews | * Program Design Document<br>* Progress and annual reports<br>* Relevant Implementation Partners at Country Level<br>* Sampled pilot implementation partners (PWTs)<br>* Sampled pilot beneficiaries | Susan Dawson<br>(Tristan Jubb to focus on technical quality with respect to animal health) |
| 3.2 | What are the key factors that account for the quality of program deliverables? | In-depth Interviews | * CARE Regional Manager<br>* CARE Country Teams<br>* Relevant Implementation Partners at Country Level (PWTs) | Susan Dawson<br>(Tristan Jubb to focus on technical quality with respect to animal health) |

| | | | | |
|---|---|---|---|---|
| | | | * Sampled pilot implementation partners (CPIs)<br>* Sampled pilot beneficiaries | |
| 3.3 | To what extent has the program been delivered according to the schedule provided in the annual plans?<br>*- what are the implications of any delays, especially in terms of achieving the desired objectives of the program?* | Document Review<br>In-Depth Interview | * Annual Plan<br>* Progress and Annual Reports<br>* AusAID Bangkok Posted Officers<br>* CARE Regional Manager | Susan Dawson |
| 3.4 | What factors have accounted for any delays?<br>*- contextual factors*<br>*- partner factors*<br>*- CARE program management factors* | Document Review<br>In-Depth Interview | * Progress and Annual Reports<br>* AusAID Bangkok Posted Officers<br>* CARE Regional Manager<br>* CARE Country Teams | Susan Dawson |
| 3.5 | To what extent has the program expended allocated budget?<br>*- are the expectations for expenditure for this year and next year realistic?* | Document Review<br>In-Depth Interview | * Annual Plan 08-09<br>* CARE Regional Manager<br>* CARE Country Teams | Tristan Jubb |

4. Effectiveness and Efficiency of Program Management Systems

| Method Section | Review Question | Method | Documents Reviewed/ Respondent | Team Member Responsible for Information Collection and Section in Report |
|---|---|---|---|---|
| 4.1 | What is the quality of Program oversight and governance?<br>*- adequacy of roles and functions for each stakeholder with an oversight function*<br>*- adequacy of performance of roles and functions*<br>*- outcomes of oversight functions* | Document Review<br>In-depth Interview | * Program Design Document<br>* AusAID Bangkok Posted Officers<br>* CARE Regional Manager<br>* Sample of relevant PWTs in each country | Tristan Jubb |
| 4.2 | What is the quality of strategic planning?<br>*- are current plans consistent with the original design document (to what extent has there been any design drift?)*<br>*- what are the factors accounting for the quality of strategic planning?* | Document Review<br><br>In-Depth Interviews | * PDD<br>* Annual Plans<br>* AusAID Bangkok Posted Officers<br>* CARE Regional Manager<br>* CARE Country Teams | Susan Dawson |
| 4.3 | What is the quality of annual planning?<br>*- are plans realistic?* | Document Review | * Annual Plans | Susan Dawson |
| 4.4 | To what extent has staffing been consistent?<br>*- what are the factors accounting for any undue staff turnover* | In-Depth Interview | * CARE Regional Manager<br>* CARE Country Teams | Susan Dawson |

| Method Section | Review Question | Method | Documents Reviewed/ Respondent | Team Member Responsible for Information Collection and Section in Report |
|---|---|---|---|---|
| 4.5 | What is the quality of M&E systems?<br>*- design and methods (especially of pilots)*<br>*- outputs (findings generated)*<br>*- response to findings*<br>*- dissemination (see also 3.1 above)*<br>*- is data sex disaggregated, and how is that data used?* | Document Review<br><br><br>In-Depth Interview | * Regional M&E Framework<br>* Country M&E frameworks<br>* Progress and Annual Reports<br>* M&E reports (including KAPs)<br>* CARE Regional Manager<br>* CARE Country Managers<br>* Relevant Partners who are expected to change behaviours in response to pilots | Susan Dawson |
| 4.6 | What factors account for the quality of M&E systems?<br>*- resources and expertise available*<br>*- contextual factors*<br>*- program management factors* | In-Depth Interview | * CARE Regional Manager<br>* CARE Country Teams | Susan Dawson |
| 4.7 | What is the quality of the risk management system?<br>*- documented system*<br>*- stakeholder analysis of risk*<br>*- feasibility and effectiveness of planned mitigations responses*<br>*- monitoring of risk* | Document Review<br><br>In-Depth Interview | * PDD<br>* Annual Plan<br>* Progress and Annual Reports<br>* AusAID Bangkok Posted Officers<br>* CARE Regional Manager<br>* CARE Country Managers<br>* Sample of PWT reps | Susan Dawson |
| 4.8 | How adequate is program financial reporting?<br>*For the program as a whole and for each of the 4 pilot activities (if possible):*<br>*-To what extent were there variations in acquittals?*<br>*-Did line items appear fair and reasonable?*<br>*-What was the reason for significant budget variations?* | Document Review | * Financial Reports | Tristan Jubb |
| 4.9 | To what extent are the program approaches considered to be good value-for-money? | Document Review<br><br>In-Depth Interview | * Annual Plans<br>* Progress and Annual Reports<br>* CARE Regional Manager<br>* CARE Country Teams | Tristan Jubb |

## Attachment 3: Persons Met

Alistair Briscombe – CARE AI Regional Program Manager
Andrew Rowell – CARE Program Cycle Management Unit, Canberra
Julia Landford - First Secretary, Regional Emerging Infectious Diseases Program, AusAID Bangkok

**Vietnam**

| Agency/Location | Name and Title |
|---|---|
| FAO Avian Influenza Programme | Mr Andrew Bisson - Technical Adviser |
| Partnership on Avian and Human Influenza | Mr David Payne - Donor Coordination Specialist |
| Ministry of Agriculture and Rural Development | Dr Hoang Van Nam - Vice Director, Department of Animal Health<br>Dr Do Huu Dung – Epidemiologist, Department of Animal Health |
| **Bac Ninh Province** | Mr Vu Thai Ninh - Provincial Department of Agriculture and Rural Development<br>Mr Nguyen Manh Dinh – Vice Director, Provincial Animal Health Sub-Department<br>Ms Nguyen Thi Hien – Provincial Women's Union<br>Mr Nguyen Van Hanh - Director of Provincial Preventive Medicine Centre |
| **Que Vo District** | Mr Nguyen Thanh Binh - District Department of Agriculture and Rural Development<br>Mr Duong Cong Hoat - Vice Chairman of Animal Health Division<br>Mr Nguyen Quang Tuan - District Preventive Medicine Center<br>Ms Le Thi Phuong - District Women's Union |
| **Mo Dao Commune Staff** | Mr Nguyen Cong Kien - Vice Chairman of People Committee<br>Mr Nguyen Trong Do - Head of Animal Health Station<br>Mr Nguyen The Dung - Head of Human Health Station<br>Ms Nguyen Thi My - Head of Commune Women Union |
| **CARE Team** | All staff involved with delivery of the AI Program<br>No senior executive available at the Country Program level. A senior manager from HCM made herself available for a phone discussion. |

**Laos**

| | |
|---|---|
| FAO Avian Influenza Programme | Mr Ricarda Mondry - Chief Technical Adviser<br>Ms Vicky Houssiere - Communications Officer |
| National Animal and Human Influenza Coordinating Office | Dr Bounlay Phommasack - Director<br>Dr Sompanh Chanphengxay - Deputy Director |
| WHO | Dr Justin Denny – Epidemiologist |

| | |
|---|---|
| US-CDC | Dr Andrew Corwin – In-Country Coordinator, Avian Influenza Program |
| Vientiane Province | Mr Saythong Phimboa – Deputy Director, Livestock Section, Provincial Agriculture and Forestry Office<br>Mrs Manysong Vilayhon - District Health Department, Tulakhom District<br>Mr Saman Inthavong - District Health, Hatsayfong District<br>Mr Vixien Yoisaykham - District Health, Xaythany District |
| Village Volunteers Nongphong Tai Village | Mrs Khamphan - Village Health Volunteer<br>Mr Kaysone - Village Veterinarian<br>Mr Bounthong - Village Veterinarian<br>Mr Khamsone - Village Chief |
| CARE Staff and Executive | |

**Cambodia**

| | |
|---|---|
| FAO Avian Influenza Programme | Dr Teresa Cereno -Technical Adviser<br>Etienne Careme - Operations Coordinator<br>Ms Maria Cecilia Dy - Information and Communication Officer |
| Ministry of Agriculture, Forestry and Fisheries | Dr. Sorn San – Director, National Veterinary Research Institute, Department of Animal Health and Production |
| Svay Rieng Province | Mr Vorn Vinara - Vice Chief, Provincial Health Department<br>Mr Sok Sotheavuth - Chief, Provincial Animal Health and Production Office<br>Mr Pen Tha - Member, Provincial Committee for Disaster Management<br>Mr Mey Yoeun - Vice Chief of Provincial Agriculture Department |
| **Seconded Staff** | Dok Savorn<br>Prek Sarun<br>On Samon |
| VST members at Trapaing Thlork Cheurng village | Mr Chum Lay - Village Chief<br>Mr In Sem - Vice Village Chief<br>Ms Nhim Loeun - Village Animal Health Worker<br>Ms Tes Hen - Village Health Support Group |
| CARE Staff | Mr Ian Clarke - Assistant Director, Programs<br>Mr Joseph Kodamanchaly - Rural Development Program Coordinator<br>Ms Jacquelyn Pinat - Avian Influenza Program Coordinator<br>Mr Sok Seyha - Senior Program Officer, Avian Influenza Program<br>Mr. Yi Pak - Community Development Officer, AI Program<br>Mr. Chun Sokhom - Community Development Officer, AI Program |
| CARE Programme Cycle Management Support | Ms Sharon Alder – Adviser<br>Mr Priyajit Samaiyar - Research Analyst<br>Mr. Mom Vortana - Database Manager<br>Mr. Seth Sopheap - Research Associate |

**Myanmar**

| | |
|---|---|
| Ministry of Livestock and Fisheries | U Maung Maung Nyunt - Director General, Livestock Breeding and Veterinary Department (LBVD)<br>Dr Aung Gyi - Deputy Director General, LBVD<br>Dr Ohn Kyaw – Director, LBVD<br>Dr Khin Mg Win - Deputy-Director (Coordinator for Collaboration on CARE Program), LBVD |
| FAO | Dr Than Htun - Program Coordinator, FAO/LBVD Collaboration Program |
| Township Level LBVD Staff | Dr Htay Myint - District Veterinary Officer, Yangon South District<br>Dr Htun Hla Sein - Township Veterinary Officer, Thanatpin Township<br>U Khin Maung - Township Veterinary Officer, Shwedaung Township<br>U Aye Kyu - Township Veterinary Officer, Yedashe Township |
| Extension Workers | Daw Myint Myint Yi - Kyauktan Township<br>Daw Nu Nu Swe - Kyauktan Township<br>U Thoung Htay Aung - Shwedaung Township<br>U Than Oo - Shwedaung Township |
| CARE Staff and Assistant Country Director - Programs | |

## ANNEX 2: FINDINGS BY COUNTRY PROGRAM

### 1. Continuing Relevance of the Program

**Vietnam**

**1.1 Has the context for AI prevention, surveillance and response changed in significant ways since the original design of the program?**

Yes, the context for AI prevention, surveillance and response is ever-changing in SE Asia and the CLVM countries. Many issues have emerged that have changed the context for the control of HPAI including:

- HPAI has proven unstoppable – it is now endemic with eradication unfeasible, at least in the short to medium term, particularly in scavenging poultry populations where bio-containment and biosecurity are difficult to achieve.
- Migratory birds play much less of a role in spread of HPAI in the region than originally thought, rather, the spread of disease can be explained by trading of infected poultry, including illegally across borders.
- The commercial poultry industry is suspected of contributing more to spread of disease than initially thought – generally, biosecurity is inadequate in commercial enterprises particularly in sector 3 which leads to flocks becoming infected and owners cutting their losses by dumping sick and dead birds, sometimes entire flocks, into markets.
- Vaccination is unsustainable.
- Surveillance programs relying on owner notification of poultry morbidity and mortality events are unsustainable - there are no incentives to report and no disincentives not to report (for example many countries have no veterinary laws which threaten penalties for non notification, and other countries with veterinary laws, do not enforce them; and when poultry are culled by animal health authorities, there is usually no compensation, and if there is, it is inadequate, delayed, or both).
- Effective, sustainable biosecurity systems for free ranging scavenging poultry, namely sector 4, remain undeveloped.

However, the Program activities remain highly relevant because the above list of changes is based more on anecdotal reports and observations than objective data. The pilot activities, if conducted, monitored and evaluated properly, will provide important information upon which decisions on policy changes, can be based.

**1.2 Does the Program continue to meet gaps in AI prevention, surveillance and response, or have other stakeholders addressed these since mobilization of the Program?**

Although other donors and NGOs are active in community-based prevention, surveillance and response, the program continues to meet gaps. In all countries, there are other donors and NGOs implementing community-based avian influenza risk reduction programs as well as other programs unrelated to avian influenza. WB, ADB and USAID have large and numerous avian influenza programs. There is a risk that duplication will occur and that multiple donor activities in a community will exceed the absorptive capacity of communities and associated local government partners. The reality is, however, that there is an enormous amount of work to be done to achieve behavioural change across each of these countries and that there are large geographical areas in each country still untouched by donor and NGO activities. Most

donors and NGOs participate in national level meetings and are engaged through formal agreements with the relevant country government ministry to ensure some level of coordination of activities and alignment with national strategies. CARE is aware of the risks and actively seeks information on the activities of others at the national level and in the districts in which they intend to operate.

**1.3 Are the current annual plans still consistent with a sample of regional and national country AI response plans?**

The Program is aligned with national programs and strategic frameworks and CARE should be congratulated on their efforts to ensure this. The national programs and strategic frameworks are quite broad; community-based activities for prevention, surveillance and response in the animal and human sectors, do however, receive specific emphasis.

In Vietnam, for example, there is the Government of Vietnam's *Integrated National Operational Program for Avian and Human Influenza (2006-2010)*, May 2006. This document is the Government of Vietnam's operational plan outlining key areas for action for HPAI prevention and control from central to local level. CARE's program directly supports the following three components: Component II.6: Public awareness and behaviour change (Agriculture sector); Component III.5: Public awareness and behaviour change (Human health sector), and Component III.1: Strengthening surveillance and response. In Vietnam, there is also the National Strategic Framework for Avian and Human Influenza Communications 2008-2010, a document that sets out the priority behavioural outcomes for AI communications activities in Vietnam. In association with the Partnership for Animal and Human Influenza, CARE played a lead role in the facilitation of the strategic planning process and the preparation of this document. Priorities were decided based on technical importance and practical feasibility. The priorities are used by CARE as basis for its programming.

**Summary Discussion on Continuing Relevance**

*Note: Due to the departure of the second consultant after the Vietnam part of the mission, the AusAID Activity Manager prepared this overview of the continuing relevance of the Program.*

**National Level**

The Program is implemented across four countries in the Mekong region considered to be the least developed in Southeast Asia. The current human, technical, and health system capacities of these countries to address disease outbreaks, particularly at the village level, are weak. In addition, the shared porous borders across these countries encourage unmonitored movement of people and animals which increases the risk of an AI pandemic.

The Program is addressing a priority need of partner countries. Activities and pilots are consistent with National AI Control Plans. Where an AI national coordinating mechanism exists in a country, CARE is seen by stakeholders as an active member that can influence national approaches while closely coordinating its activities with technical agencies. The intensity of this engagement does vary across countries (see more detailed findings below). CARE Vietnam provided major inputs to Vietnam's National Avian and Human Influenza Communications Strategy. CARE Laos is the only international NGO coordinating with the Laos National Avian and Human Influenza Coordinating Office (NAHICO). The Program participates in the annual implementation reviews of the National AI Control and Pandemic Preparedness Plan. CARE Laos is also an active member of six working groups – IEC, Surveillance, Wet Markets, Research, Outbreak, and Pandemics. Officials at the national level interviewed by the MTR team perceived the valuable role of the Program in implementing AI control activities at the community level, an identified gap as majority of external AI

assistance are national level initiatives.

Across the four countries, CARE is a major INGO working at the community level on AI control. There are very few INGOs working on AI across the Mekong countries. While there are various INGOs working on AI control in Vietnam, the major ones are funded by USAID and AusAID. USAID and US-Center for Disease Control (CDC) are funding community-based AI control programs through CARE in Cambodia, Laos, and Vietnam. The Program has effectively partnered with UN agencies (e.g. FAO, WHO, UNICEF) on the technical aspects of activities including evaluation of pilots, coordinating, testing and standardizing community-level Information, Education and Communication (IEC) materials. The Program covers districts and villages that UN agencies, USAID, or other NGOs are unable to cover.

CARE's comparative advantage as an NGO has been acknowledged by FAO, WHO, and US-Center for Disease Control (CDC) in the areas of closer relationships with communities, raising community awareness on AI control, strengthening district and village surveillance and reporting systems, and capacity building for training and planning for community officials and volunteers.

**Focus and Approach**

The Program is essentially operating as four distinct country programs. Thus, unlike a typical regional program wherein benefits are often long-term, dispersed and intangible, the Program is aimed to provide direct benefits in each country specifically at the community levels (e.g. provincial, district, village). In each of the four partner countries, the community level is most vulnerable to disease outbreaks and has direct impacts on disease burden, livelihoods and poverty alleviation. Poultry in the Mekong region are largely owned by subsistence farmers.

While community awareness and capacity are being strengthened as part of the process of model piloting, the Program is essentially providing community-level research inputs to inform National AI Control Plans. Compared to a purely academic research, this bottom-up approach is highly relevant in each country as models operate under the mandates of National Plans and are implemented and tested based on local structures and context.

The Program, by building community-level capacities in detecting, reporting and implementing preliminary control measures, is contributing to each country's achievement of the International Health Regulations (IHR) requirements. Prevention, surveillance and reporting messages tend to cut across the various livestock diseases. Field visits by the MTR team indicated that community interest to program messages are more sustained if they include other priority livestock diseases such as Newcastle disease, classical swine fever or foot and mouth disease (FMD).

In response, the Program has started expanding its scope beyond AI control. CARE Laos, for instance, included main livestock diseases in its Events-Based Surveillance model which focuses on local detection, reporting, and response (The establishment of community events-based surveillance is a target area under the Laos National Emerging Infectious Disease work plan. The latter represent the Laos Government's commitment to achieve the minimum IHR requirements by 2010).

CARE Laos is also closely coordinating with a WHO Epidemiologist, funded through AusAID's Australian Epidemiology Regional Assistance Program (AERAP). The expansion of the model to cover other livestock diseases also complements AusAID's existing regional EID support such as the SEAFMD.

The Program satisfies certain criteria for a regional approach as outlined by the 2007 World Bank Review. While the issue of economies of scale is not evident given the lack of a regional institution, the Program compensates by closely aligning its objectives with country priorities

and by adhering to the principle of subsidiarity (i.e. programs operating at the lowest level appropriate). Strong country-level commitment to AI control is reflected in part to the existence of national plans and coordinating mechanisms for AI response.

**Strategies: Regional and Bilateral**

The Program is directly contributing to the achievement of Objectives 1 and 2 of the Asia Pacific Strategy for Emerging Disease (APSED). APSED's Objective 1 is to reduce the risk of emerging diseases. Under this objective, Program activities contribute to Expected Results 1 and 2, which are: a) reducing risk through strategic communication and community participation, and b) reducing risks of emerging disease acquired from animals. APSED Objective 2 is to strengthen early detection of outbreaks of emerging diseases. The Program is addressing this through strengthening early warning systems, establishing coordinated surveillance systems, and strengthening local capacity for surveillance.

The Program's focus and objectives fill an important gap in AusAID's bilateral program across the four Mekong countries. None of the bilateral programs has initiatives directly addressing AI awareness and prevention at the community level.

## 2. Achievement of Sustainable Outcomes

**Vietnam**

### 2.1 To what extent do stakeholders have a shared view of the intended end-of-program outcomes?

Program staff and management considered that the key intended outcome of the Program was the achievement of improvements in community risk behaviours in relation to AI, in addition to increased capacity of partners to implement Program activities. The notion of the pilot or experiment as the primary purpose was not well institutionalized. Attention has been focused on what can usefully be adopted rather than the adoption process itself. This has resulted in the CARE Program teams taking on an implementation approach (with benefits accruing to Program communes only) rather than focusing on the development of a quality experiment that generates convincing evidence that can be used to facilitate a policy response – either adoption or replication of the pilot, or recognition that the proposed approach in the pilot is not effective. In the case study of the 5-Step Model, partners also held this view. This is not fully the case with all models, but it was the dominant view. At provincial, district and commune levels for the case study, there was limited development of ideas about replication and a focus on community-level behaviour change. Gender equality outcomes have not been defined.

### 2.2 To what extent does program documentation report achievement of outcomes?

The progress reports do attempt to report on outcomes, but on closer inspection the actual focus is on activities implemented. Outcomes reported were: the 5-Step Model was replicated in seven non-Program communes and adopted for use in a commune road safety campaign; that CARE has contributed to the development of a National AHI Communications strategy based on its community experiences; and that relevant risk behaviours and key messages have been identified for AI control. It is difficult to assess in Program documentation (by Annual Report, May 2008) what the specific outcomes of the implementation of the 5-Step Model have been – at the level of community behaviour change and partner capacity. Although KAP is referred to, it is not clear from the documentation whether follow-up studies have been conducted to measure outcomes. The result is that stakeholders would find it difficult to assess

the progress of the Program toward achieving outcomes in terms of: community behaviour change; partner capacity development; and adoption or replication of models. Although it is recognised that full implementation has only recently begun, commentary on progress toward these outcomes would be helpful.

**2.3 To what extent do stakeholders perceive that development outcomes were achieved?**

PAHI considers that CARE has played a key role in contributing to the National AI Communication Strategy. Contributions were to bring together community development expertise with technical knowledge to identify priority messages. PAHI would like to learn more about the feasibility of these messages at community level. The major input was from the AI Regional Program Manager. PAHI also considered that CARE had established good relationships with the Provincial levels, and had succeeded in bringing animal and human health sectors together.

The FAO representative had limited exposure to the Program, but did express an intense interest in findings from community-based work. This reflects the fact that the respondent was sitting in on behalf of the the relevant FAO representative who was unavailable. CARE has worked on a joint evaluation with FAO on the community-based surveillance.

Case Study Outcomes: The CARE team expected outcomes from the 5-Step model were that communities had adopted new behaviours in response to effective communication campaigns, and that the AI committees had developed specific skills in planning, facilitation and communication, financial management and monitoring – although they were unclear how these skills would be applied beyond the Program pilot. There was a lack of clarity about the extent to which they were expected to adopt or replicate the model. The teams expected that Provincial trainers would be able to replicate the training in other non-Program communes. Although CARE has worked in many districts previously on the 5-Step Model, they have not had the opportunity to return to assess sustained outcomes in those areas.

Partners expressed a high degree of satisfaction in the pilot model, but the MTR team were not able to determine with a sufficient degree of confidence the *actual* community behaviour responses to all key messages.

The provincial representatives demonstrated a high degree of ownership of the work. They considered that the important outcomes were that local government capacity had been raised (especially organisational skills, and approaching problems logically) and they had received equipment for their offices and BCC materials to use at community level. These skills could and would be applied to other aspects of their work. They considered the training provided to 125 district and commune officials as useful. They described the reach of community campaigns as high, and the new approaches to communication more effective than previous approaches which were administrative command. They also considered they had achieved better coordination with other sectors and organisations which had allowed them to achieve better targeting of risk groups. They considered that expansion from Sector 4 to 3 was useful, and although they had not conducted surveys thought that there had been behaviour change at the community level. Poultry vaccinations were now 97%. There has been strong executive support for the work. Plans for replication of models were poorly developed. For the Women's Union, outcomes were related to significant developments in skills to organise and conduct effective communication campaigns. They got particular benefit from skills in advocacy, lobbying and communications. They were able to deepen their knowledge of community KAP by participating in the KAP study.

The District AI Committee demonstrated a good knowledge of the model CARE is employing. They considered that the reach and effectiveness of communications to communities had been

good. They believed the new approaches had been far more effective than in the past where they just listened to information, now communities were able to actively participate in learning. They considered the 5-Step Model to be a more scientific approach than previous approaches to raising community knowledge and improving practices. They reported that communities are now reporting dead poultry, and are now disposing of dead poultry more appropriately. There is less free roaming of birds (this didn't seem like it was supported by actual evidence). Although they would like to scale up to other communes, there would be financial (not human) resource challenges in doing so (see Sustainability below).

Commune AI Committee members demonstrated a lesser understanding of the 5-Step model, but a high degree of knowledge of the communication campaigns. Considered major outcomes were the high level of community engagement in communication campaigns and they were especially positive about the approach allowing people to speak for themselves. Although they did not consider they had evidence of change, they were confident that change would result. They considered that replication was an issue for the Province although they do discuss the CARE activities with neighbouring communes. They valued the technical advice and gala nights the most, as community members got a lot out of it.

Beneficiary meetings were not conducive to extracting useful information, although they were able to identify key messages delivered by the Program.

### 2.4 To what extent are case study outcomes likely to be sustainable?

There are three levels of intended sustainability of outcomes. Sustained community behaviours, sustained behaviours of implementation partners, and likely replication of the model to other locations. Overall sustainability is not strong. The pilot appears to be heavily dependent on CARE to provide the momentum and financial resources to keep the cycle of community campaigns going. There has been limited analysis by CARE of the factors that influence sustainability of activities and outcomes at these three levels. As a result, there have been limited interventions integrated into the pilot to enhance this aspect. A major factor is the recurrent budget implications of the community campaigns. Partners and community-level representatives report that communes would have difficulty in finding the $500-$1000 required to conduct the campaigns. Another major factor is the perception that the risk of AI will continue without CARE - in a situation where there are no human deaths from AI. Partners at all levels identified the need for CARE to continue to provide support. Although partners stated that they were willing to continue activities, closer questioning revealed that there would be limited resources to do so. This is likely to have a major effect on the likelihood of continuation in pilot communes, let alone replication to new ones. Of note is the perception that the methods applied in the pilot are highly valued but this work focuses only on AI control messages rather than broader issues around animal or human health.

### 2.5 What factors account for the achievement (or not) of sustainable outcomes?

A key factor has been the lack of clarity around the intended outcomes of the Program. There has been a stronger focus on implementation rather than adoption and replication of models. There are no clear strategies to facilitate replication after the pilot has been completed (where there is demonstration of effectiveness).

At the level of commune, district, provincial and national partner capacity, desired outcomes were not clearly articulated. This would have had a major effect on the ability of the Program to design suitable interventions to institutionalize (fully integrate and become routine activities, and sustain them over time) these new capacities. This also applies to the outcomes relating to adoption or replication of the models to new locations. The case study pilot has not been designed to mimic the resource environment in which it is expected to be replicated.

At the community level, on sustained adoption of desired behaviours in the Program communes, there has been only limited thinking given to the factors that are likely to impact on community capacity to adopt new behaviours. For example, the incentives to report bird deaths are not in place. In the case study, there have been no further reports of dead birds (a key desired behaviour of the pilot) after a culling response to the last report three years ago. Communities and teams have formally interpreted this as a successful Program as no dead birds have been reported. The obvious issues here are not, presently, being overtly analysed or addressed by CARE or community members. However, barriers to reporting have been included in the recent evaluation of existing community-based surveillance models.

**Laos**

**2.1 To what extent do stakeholders have a shared view of the intended end-of-program outcomes?**

The specific end-of-Program outcomes have not been clearly identified at the whole-of-Program or pilot case study level. Extensive discussions revealed that more work is required to identify end-of-Program outcomes for all stakeholders as well as identifying the appropriate level in the Program hierarchy. Gender equality outcomes have not been defined.

The CARE Team perceive that the key outcomes overall have been primarily related to demonstrating new approaches that may be suitable for a wider national adoption. They did not perceive that adoption was targeted at the Provincial level (roll out to other districts). It is important to note that this would need to be mandated by the Laos government and most likely an MOU updated to reflect this. There was also a recognition that the activities carried out in the Program locations were also expected to be sustained after the Program is completed. The CARE team also noted that it has been quite difficult to enable government partners to understand and embrace the pilot/experimental approach as their focus is strongly on getting assistance to implement activities. This has required specific attention.

CDC and WHO representatives considered the intension of the work as trialling the effectiveness of interventions that would be suitable for on-going support and funding by donors. They thought CARE was experimenting on approaches that the government would then seek additional funding through other donors or NGOs. This was considered to be the case as Laos government would not be in a position for the immediate future to adopt any of the approaches on trial due to significant resource and capacity constraints. These two approaches have quite different implications for pilot design and evaluation, and are not yet fully clarified. FAO representatives considered the Program as both a pilot and an implementation program. They would like specific information to support their work on legislation.

For the CARE team, in terms of the case study on surveillance, the expected outcomes were at several levels. Communities were expected to actively report cases of symptoms relating to a range of human and animal diseases. Community volunteers were expected to: work together, visit about 10 households to inform the community about important symptoms and behaviour change messages, collect information from households about these systems, and report their findings monthly to the district. At the district level, new capacities in planning, training and monitoring would be applied in terms of animal and health surveillance at the community level. The long-term intension was to reduce the number of outbreaks of AI.

**2.2 To what extent does program documentation report achievement of outcomes?**

The 2008 Annual Report reported that CARE had contributed to the national preparedness plan; that the KAP (jointly developed with AED) had been used for national progress

reporting and is now a standardised national tool (this was not implemented nationally as a tool, rather was available for other donors to adopt as the GoL does not have the resources to do this) developing and contributing to national IEC materials development with other donors; adoption of community awareness pilot by national and international agencies; two unsuccessful pilots have realised as appropriate national response; formative research informed the development of a national surveillance pilot model. Outcomes were not presented in a systematic way against intended outcomes, nor *progress* toward other outcomes discussed. Other activities were mentioned, but no other actual outcomes were reported.

**2.3 To what extent do stakeholders perceive that development outcomes were achieved?**

NAHICO representatives considered that the Program had made significant contributions to helping the national government translate parts of its national plan at the community level. They clearly articulated the constraints they face at the level between the district and the community. They considered that CARE had been able to assist in identifying suitable approaches that work in the community. Although they certainly discussed the benefits in terms of national learning, there appeared to be an equally strong emphasis on needing CARE to support implementation at the local level.

Representatives from CDC and WHO both considered that CARE had made a significant and useful contribution to national planning for AI preparedness planning. They reported that CARE is considered to have a high degree of knowledge of the situation at the local level, and have brought its knowledge of what does and does not work to the national/donor table. They were considered to be effective advocates for people at that level that would not normally have had a voice at the planning table. CARE's main contribution is considered to have been the ability to short-cut national plans through the government systems to reach the community level quickly. CARE contributes the speed of translation of national policy. CDC/WHO considered that CARE had achieved a high degree of knowledge of, and participation by, the district level. CARE had also contributed to the development of national IEC materials by addressing the needs of less literate and ethnic populations who don't commonly speak in Lao. This is especially important during emergency outbreaks. CARE has participated actively in the annual WB sponsored review of progress against the national strategy.

FAO representatives considered that CARE simulation exercises had been very valuable. They also consider CARE's major contribution had been bringing its knowledge of communities to the national planning arena. They are considered to be a highly active member of the National Strategy Task Force.

CARE staff consider that they have been successful in feeding lessons into the national system. They have been able to influence how WHO and FAO work together when previously coordination was weak.

District ownership is considered to be high *[this is confirmed by the MTR team]*. CARE has contributed to a change of thinking from government considering they must demonstrate success to understanding that a poor outcome of a pilot is a useful outcome if it results in the rejection of the pilot approach in national planning.

An unintended outcome has been the contribution to creating a dependence of the national government on CARE (and others) funding activities such as festivals. There has been a hard balance to find between getting engagement and raising expectations on what outsiders are funding.

Case Study Outcomes: Community-Based Surveillance. The district level respondents were highly engaged and knowledgeable of the pilot intervention. They were cognizant of the need

for an approach that enabled sustainability of the activities. They considered that the district teams themselves had gained a deeper knowledge of AI, planning skills and new approaches to training. They especially benefited from systematic approaches to planning and new training methods and saw these as valuable new skills that could be applied in other ways *[although how to approach this had not been considered]*. Special benefits had been gained from the new notion of setting objectives. At the village level, the district representatives reported that the network of village volunteers has been established to respond quickly to reports from community members, and that they were actively giving out messages to community members on preventative behaviours for AI and other diseases. They consider the advantage of having this team is there is always someone available to do the surveillance work. The districts consider the reporting system is already working well and they feel confident that they can identify the key issues quickly during an outbreak *[respondents found it difficult to articulate exactly what outcomes they were aware of now and tended to speak in terms of what they expected]*.

The district team considered that the Program has enabled them to reach beyond the district to the community level effectively. Previously, community members did not know who to report events to.

District teams on the surveillance pilot considered the CARE approach was effective. What was especially important was the non-formal approach that stimulated good discussions and openness. They have found that the old approach of being "official" and giving instructions to communities was less effective. The previous approach did not allow communities to contribute to new ideas. The new approach involves "romancing" the community.

District teams consider other benefits to be that some of their non-Program villages have been requesting IEC materials. It is hard for villages to get materials from the national level (they are available) because of delivery costs. "*It's challenging when you don't have connections at the national level*". There have been no discussions held with other Provinces on the work to date. They would like to discuss with other provinces, but are not sure on how to approach this. They would like to compare their performance with outbreaks with other non-Program locations.

The last outbreak in a Program district was in 2007, *before the Program started*, and the community volunteers described an appropriate response at district and community level. However, the volunteers consider that since the CARE Program, there is a more "*lively atmosphere about AI control and people are more confident*". The big change has been that the community now sees that the volunteers and district are there to help them, not make problems for them. The content of the information has been of interest to the community, the T-Shirts have created interest, many community members see the job of the Volunteer Teams as desirable, and that the volunteers have Party Membership, which comes with a high status.

Community behaviours have been reported to have changed, the most important areas has been how chickens are housed, and the cessation of villagers eating duck blood. This is considered to be almost community-wide.

### 2.4 To what extent are case study outcomes likely to be sustainable?

Sustainability is a key requirement of the national government (NAHICO). At all levels of the Program, partners expressed the need for CARE work to be sustained after the completion of the Program. However, partners had not systematically worked through factors that may influence the extent to which activities will be sustained at the local level. Of special note was that the preliminary research on previous community-based surveillance systems had found them to have been periodic, based on outside funding availability and required a high degree of organisational involvement for implementation and monitoring of the system. This

important finding was not fully embraced in the on-going design of the community events-based surveillance system.

The District team considered there were several risks to sustainability around on-going provision of equipment and materials. They considered that village veterinarians would require additional assistance from the provincial level to make things go smoothly in the future. They considered that if they could not sustain their village monitoring visits then the veterinarians would "relapse into their old behaviours". They reported that village teams were selected from existing community volunteer groups. District representatives considered key factors in maintaining the village health workers motivated was because they had received an official appointment, that they were issued identification cards, they were given cheaper medical rates. They did identify that motivation varied across locations and that some were far less active.

The District team considers that it will be critical to keep the surveillance system operating after the Program. CARE provides the district with per diems, petrol and pre-paid phone cards. The district team considers they can continue with the activities, but not at the same level of intensity. They consider the funding at the moment to create the energy, but they will be able to continue on, just to a lesser degree. They thought they would have to reduce the monitoring visits from monthly to about three times a year. They consider roll out to other villages that are not in the Program locations appropriate, but had not considered their approach to this.

It was difficult to determine with a sufficient degree of confidence the true viability of the Village Volunteer Teams. Although they were knowledgeable of the Program and clearly highly involved, it was difficult to determine if this group could be sustained after the Program. They did appear to have meetings as a group that were not facilitated by the district. There is a high degree of community interest in AI issues (demand for their services) due to the economic implications of AI control. Volunteers considered that community members were still highly engaged despite the fact that there has not been a report or outbreak since 2007. The Community Health Worker was a TBA and would have been receiving income from this work. She described visits from the district health team about four times a year to do immunization *[demonstrating district capacity to motivate]*. She was motivated by being able to serve her community, demonstrate special skills like giving injections, having special equipment to work with. The Veterinarian was motivated by being able to demonstrate special skills to community members such as provide vaccines. He considered being able to give vaccines raised his status in the community. He also felt that community members were very happy when after an event, he could explain what happened. The group felt that the district involvement was very important in keeping them active, that the village authorities were also pushing them hard to be active. Party membership was considered essential for success.

Community volunteers report resource challenges around their capacity to buy the forms for reporting, but they are confident that the district will be active enough to keep pushing for surveillance activities. Other budgetary issues are to be addressed but they have not yet discussed these with the district.

In Laos, after a cull, owners of poultry are compensated at 60% of market value. There appears to be a strong community sense of responsibility to report.

### 2.5 What factors account for the achievement (or not) of sustainable outcomes?

Systematic analysis of factors contributing to sustainability has not been carried out. However, the team has intuitively made some progress and has incorporated several interventions to address this. This is still insufficient to develop a high degree of confidence in the

sustainability of the work at the community and district levels.

In Laos, there is a small community of government and donor representatives that are highly engaged in addressing AI issues. The government has an effective coordination mechanism in NAHICO that actively meets monthly and actively encourages line agencies to push through with implementation of the national plan. The national governments is also very open to engaging with international and local NGOs and have allowed close involvement of NGOs in the evolving area. In addition, in this small community of stakeholders, there has been a strong sense of team work, sharing and learning as different organisations have grappled with how to approach AI in this setting. Donors, NGOs and Governments have relatively open and regular communication. This context would be more conducive to the CARE success than other Program countries.

There was a national strategy in place to provide the structure, and the institutions in place to integrate the work.

CARE has also put in significant effort to find themselves a credible voice at the national level. They have worked hard to coordinate with and interact with all stakeholders in Laos. Technical agencies such as FAO have commented on CARE's reputation for listening to and adopting technical advice more than other organisations have done, and their willingness to meet and address urgent issues promptly.

CARE has also invested significantly in relationship building at many levels and across a broad range of stakeholders. This was estimated to take about nine months of Program time (which puts enormous pressure on achieving outcomes in a 30-month initiative).

FAO considers that CARE's success has been in part due to its willingness to work in both animal and human health areas to bring about sectoral collaboration at the community, district and provincial level. They also noted its high degree of national level coordination, the uncomplicated and open nature of the relationship with CARE, and its willingness to take new things on board.

Successful approaches to developing ownership were noted in the case study district. Good feedback to district teams was provided through systematic monitoring of their TORs. Importantly, CARE has taken a good step back and allowed the district to become fully responsible for implementation. In addition, the District team interviewed had a high degree of capacity.

The viability of the Village Volunteer Network is a risk point for the surveillance model. The strategy to maintain it and motivation after the Program is not sufficiently developed at this stage, nor sufficiently tied to the M&E system. Having said that, there are a number of good factors in place that could be built on.

District teams consider the Program has been too short to institutionalize the changes. They consider it should be aligned with the cycle of the National Strategic Plan.

There was insufficient focus on behaviour change models. For the surveillance pilot, CARE did conduct research into other experiences (international) on community-based surveillance which informed its design. But for the BCC aspects, the CARE team considered they needed more input on effective BCC models.

A lack of an adoption strategy for findings from pilots has limited, to some extent, the capacity to reach a policy response outcome. Even where the outcome is not reached during the life of the Program, it would still be useful to have strategies in work toward this.

There may have been insufficient reflection and analysis on pilot progress during team

monthly meetings with more focus on activity planning.

Integrating AI control into other human and animal health issues has been a successful approach.

**Cambodia**

**2.1 To what extent do stakeholders have a shared view of the intended end-of-program outcomes?**

The CARE team considered the primary intention of the pilots was to identify important lessons for use by the national government partners and FAO. They explain that they are trying to both demonstrate effectiveness of its models, as well as bring about institutional integration of activities beyond the life of the Program. There is no clear strategy on how findings from models will feed into national implementation of the AI control strategy.

The CARE team sees the key desired behaviours to be: a) adoption of preventative animal and human health practices at the community level; b) institutionalize a high level of cross sectoral collaboration through the Village Surveillance Team; and c) integrate AI control into Provincial and District level development planning.

FAO considered that CARE was contributing to the delivery of the national AI control strategy by assisting FAO to reach districts that they have not yet been able to reach. Although animal and human health departments work together at the national level, CARE is assisting in the connection of animal and human health workers at the community level. As this requires more time and resources than FAO has to facilitate community-level meetings, CARE is bridging this gap in the communities in which they are working. FAO considers the value of having animal and human health workers addressing AI control together is that if one is not available to conduct surveillance the other one may be. FAO considers that CARE's contribution is working at community level where they have a far more intimate relationship than FAO. There are no other NGOs working with FAO at the community level. FAO also considered that CARE was creating motivation for biosecurity practices using the livelihoods approach which FAO could not do themselves. In this discussion, FAO interpreted the Program as one of expanding coverage of community awareness raising and reporting rather than as a demonstration pilot to study important questions for national implementation of the AI control strategy. On further questioning, they did articulate that its interests were in low cost models that can meet sustainability requirements.

FAO and DAHP had not heard of the VST surveillance work that CARE was doing.

Intended outcomes of the Biosecurity Model were reported by CelAgrid to be focused on both enhancing AI preventative practices and demonstrating enhanced production. There was no concept of modeling for adoption or expansion beyond the specific villages in which CARE was working.

The Provincial government partners had very limited knowledge of the objectives of the Program.

Gender outcomes have not been identified for this Program.

**2.2 To what extent does program documentation <u>report</u> achievement of outcomes?**

The second year annual performance report stated that the following *outcomes* had been achieved: the CARE KAP study was to be used by OIM to inform one of its cross border Programs in AI control; for the Biosecurity model, neighbouring farmers have expressed interest; and there are 59 operational VST groups operating (although this was reported more in terms of them being established rather than providing evidence of functionality). The

remainder of the reporting on achievements was focused at the output/activity level.

**2.3 To what extent do stakeholders perceive that development outcomes were achieved?**

CARE staff considered that they had achieved behaviour changes at the community level, especially with respect to improved biosecurity; preventative health behaviours; enhanced livelihoods; and more active reporting of suspected cases. At the VST level, they considered that there had been demonstrated cross-sectoral collaboration between animal and human health; enhanced reporting of health events; modelling of good practices through the model farms; and a more active and systematic approach to community awareness raising (BCC).

FAO considered the major achievements to date are the delivery of training to the Provincial and District level as well as to village level animal health workers.

The provincial government partners reported that the key achievements to date were: CARE has provided PPE equipment and had gathered some animal raising information (related to production rather than AI control). When asked what they had experienced of the Program, they referred the MTR team to the Provincial Veterinarian. He was familiar with the training provided by CARE, but was unable to identify the names of all of his staff that had attended. He was unfamiliar with the content of the TOT training, but was aware that there had been training at the village level focusing on biosecurity. He was unaware of any demonstration farms. They reported that they did not meet with CARE, but perhaps the TOT trainers did. CARE reports that they have explained the Program to the Provincial level on several occasions. However, this approach has not resulted in ownership of the work.

The Government's Secondees consider as major achievements the good adoption of the desired behaviours at the community level and the current regular reporting of dead chickens. For example, about 60% of people have stopped eating dead chickens despite the perception of wastage. They consider that for communities to continue to keep chickens in a pen, CARE will have to provide the budget. Farmers discussing with farmers from other villages has also been new and valuable, and they have been to another CARE province to discuss the work. They consider that they have learned important new skills relating to chicken raising and conducting needs assessments. They consider that they can integrate needs analyses into other agricultural work. The community consultation is a new and now valued approach to planning as well as skills in training others, especially using the new materials and methods. This group had limited notions of sustainability or roll-out to other areas.

The farmers responsible for the biosecurity model considered that the major outcomes had been that CARE had provided the resources for them to build the pens and demonstrate good biosecurity practices to their neighbours. The considered that they had succeeded in generating interest in the model farms from their neighbours, but that no one had yet adopted the practices.

**2.4 To what extent are case study outcomes likely to be sustainable?**

The CARE team has not considered systematically the factors that are likely to enhance or limit sustainability. There are several factors that will likely limit the sustainability or capacity for adoption by other stakeholders of the model (see below).

FAO articulated concerns about the sustainability of the biosecurity model and the capacity of the national level to adopt the models. There was very limited attention to strategies for replication of the biosecurity model.

FAO was unaware that CARE was conducting as many models as they were. They would like to see more of the outputs of the M&E on these models. They would also like to participate in

the design of evaluation questions for these models so they can respond to national information needs more fully.

In terms of the Biosecurity Model, CelAgrid reports that it will be difficult to sustain, largely due to the requirement for start up funds to provide the incentive to get a new farmer involved. CARE has designed a mechanism whereby farmers are expected to pass on the benefits to a new farmer by providing chickens as an incentive, but CARE was responsible for managing this mechanism and it has not yet been passed on to the Head of the village. If it is considered to be too high risk for the Head to manage this aspect of the incentives, then it is not clear how the model can be rolled out after CARE funding stops.

The government's Secondees consider that what will be sustainable is that the village animal and human health workers will continue to meet and that they will continue to be supervised by the Health Centre and the District Veterinarian. They consider the key challenge will be with respect to the sustained behaviour change of the community. Its approach to sustain the volunteers after the Program will be to visit the volunteers and give them information. They consider that there will be sufficient budget to allow them to continue working at the village level after the Program, but did not seem to be aware that the Provincial staff were not familiar with what they were doing. They report that the Provincial staff have not visited its Program work.

### 2.5 What factors account for the achievement (or not) of sustainable outcomes?

A key factor has been the lack of clarity around the intended outcomes of the Program. There has been a stronger focus on implementation rather than adoption and replication of models. There are no clear strategies to facilitate replication after the pilot has been completed (where there is demonstration of effectiveness).

AI control messages are integrated with other priority animal health diseases which will enhance the sustainability by allowing volunteers to meet a wider range of priority issues at the community level.

The Village Surveillance team – as a group - is a creation of the Program; however the members are part of a national cadre of volunteers working in animal and human health. It will be important to address the viability of the VST as a particular group. CARE is the only group nationally that is addressing Community-Based Surveillance.

The training and support (the latter jointly with CARE) for the biosecurity model is sub-contracted to a national NGO which did not demonstrate during interview a high level of focus on sustainable outcomes. This group has very low capacity in M&E and therefore would not be able to contribute significantly to the identification and generation of important lessons in anything more than an *ad hoc* fashion, and if well supported by CARE.

Seconded staff have been brought in from the district level to work on the Program for about three days per week. Although this is a very effective approach to encourage adoption of the model, CARE has allocated them a role with limited decision-making power, and limited involvement in the identification and analysis of lessons learned. These secondees report that they have no strategy for integrating the Program's work into government systems after the Program. CARE officers consider that they are taking lessons from the Programs to their supervisors, but the extent to which this is happening *appears* to be limited. CARE field officers report that they conduct fortnightly meetings with secondee supervisors to discuss the Program (note that the MTR team did not meet with district level staff to assess their involvement).

CARE fully subsidizes the cost of provincial and district level training. They cover costs for accommodation, per diems and transport of participants. The capacity of the local government

partners to conduct refresher training, or update these new skills after the Program has not yet been discussed. There is no strategy yet to move toward provincial ownership.

The cost of the model farms is A$45. Although this is significantly lower than the previous estimates of the national government of A$200 (this does demonstrate a useful outcome for the national level), clarity on the extent to which local farmers will be willing and able to cover these costs requires analysis. FAO also discussed its concerns to the extent that the national level will be able to replicate the model if it is dependent on the provision of start up costs. They had more general concerns about the sustainability of CARE models.

CARE with CelAgrid do monthly visits to demonstration farms. CARE field officers do not have well developed approaches to sustainability (e.g. when the M&E system identified that volunteers were not meeting regularly because they have other responsibilities and priorities, their solution was to tell them again how important it was).

The viability of the volunteers from the Village Surveillance Team is not yet clear. Although Community health workers appear to be a more active group, the animal health workers nationwide may be less active and therefore, issues of sustaining their motivation will need addressing. FAO considered that incentives for volunteers were not well addressed nationally.

The provincial government partners report that the district veterinarians who support the volunteers have to pay for their transport to provincial meetings using their own money. They are not aware of any training that is delivered to the province from the national level on AI control. FAO came until early 2008, but this has stopped now. The Chief of Animal Health and Production was unaware of the key messages that were being passed on in terms of AI control, but was aware that village volunteers got leaflets. The Head of the Health Department was able to discuss the key human health messages.

DAHP considers that the volunteer network (14,000 nationally) is strong enough to integrate these new work requirements. They consider that about 60% of its volunteers are active and are met monthly by the District Veterinarian.

Interviews with the Biosecurity model farmers showed that although there had been interest from neighbouring farmers on their model farm, they were not aware of any neighbouring farmers who had adopted the model in any form (five months into the demonstration – note that it takes six months to demonstrate enhanced productivity). They did not consider that they had a role to play in bringing about new model farms, rather, they were waiting for CARE to come and provide the funding for interested farmers to take up the new practices.

CARE considers that the timeframe of the Program did not allow sufficient time to develop new relationships with FAO and DAHP – to be invited to participate in national level discussions and to discuss key evaluation questions.

Integration of this Program into the Rural Development work has resulted in significant challenges to designing and conducting experiments. There is significant blurring between what the different aspects of the CARE Programs are trying to achieve and poses a big challenge with M&E.

**Myanmar**

**2.1 To what extent do stakeholders have a shared view of the intended end-of-program outcomes?**

CARE teams had not fully explored the intended outcomes of the Program. Although the majority of the work is not intended to be experimental pilots, there are two pilots underway, one which does not fully reflect an experimental design to address issues of feasibility for

replication (Markets Pilot). For the markets model, there is a strong emphasis on outcomes at the level of the community and market traders, without good clarity on what the intended behaviour changes were expected at the level of the market authorities. There was a strong emphasis on awareness-raising rather than behaviour change (resulting in an activity rather than outcome focus). There was limited clarity about who was expected to learn from the model, or adopt the model beyond the market authorities that were already participating in the Program.

During the design phase, CARE staff reported that strategies on how models would be adopted or rejected were not considered. They were focused on simply whether or not it would work.

From November 2008, the focus will be on fewer markets and piloting interventions designed to enhance biosecurity practices, installation of simple infrastructure, more regular visits, and the establishment of peer educators.

The LBVD training was considered by the CARE team as providing additional reach for LBVD in providing training to the community level. For the LBVD training there was limited consideration given to identifying what outcomes were expected to be maintained by the LBVD after the Program (see section below on sustainability).

LBVD representatives saw the primary objective of the CARE Program was to raise community awareness of AI control and preventative practices. It was unclear on the precise mechanism for applying the learnings from the CARE pilot models (such as markets and biosecurity). LBVD trainers considered that the role of CARE was to speed up its work and allow a wider impact.

FAO reported that CARE was not an implementation partner and was not fully familiar with the work. They were aware that CARE focuses on community awareness-raising which they considered essential.

Gender equality outcomes have not been defined.

**2.2 To what extent does program documentation report achievement of outcomes?**

LBVD Training: to date, 30% of extension workers (expected to train 100 households through 10 training sessions) have conducted community training as expected. Biosecurity model: a single approach has been recommended (report submitted) to Ministry of Livestock and Fisheries as a feasible approach. Six households replicated the model without support from CARE. Market model: A water access system has been established by one market authority and traders have adopted intended hygiene practices. The remaining achievements were reported in terms of outputs and activities.

**2.3 To what extent do stakeholders perceive that development outcomes were achieved?**

The MTR observed a high degree of ownership by the LBVD on the training and support of LEWs. In addition, CARE has reported a high degree of participation of City Market Authorities and have allowed them access to work in city markets in Yangon and Mandalay. These are significant achievements in this country context.

The Director General of LBVD considered that CARE had contributed strongly to the village level, a level that they have difficulty in reaching. He also considered that the Biosecurity models would play an important role in strengthening community practices as Myanmar cannot change the practices of raising native chickens.

The LBVD operational staff consider that the CARE approach (training and support of the

LEWs) has been far more effective than that of UNICEF. They consider that the benefit of the CARE approach is that they work through government systems and staff, whereas, UNICEF works directly, delivering training to the township level (UNICEF focus on human health aspects, CARE on animal health). LBVD reports that the extension workers don't get much support, but CARE has worked specifically on enhancing their performance. LBVD considers that while other programs focus on radio and TV messages, CARE is specialising in the person-to-person communication which is more effective and can reach communities that cannot be reached by radio or TV. CARE also contributed to the production of some IEC materials for LBVD.

The CARE team focused their perceptions of achievements at the level of community behaviour change. There was not a clear idea of outcomes achieved in addition to this.

LBVD district and township trainers considered the major outcome of the Program to be that people are now burying dead chickens systematically, and that communities are now reporting dead chickens and outbreaks. They also consider that CARE has given them not only technical knowledge, but skills in communication which are much more effective. They also have valued the enhanced skills in training. They also valued the opportunity to discuss their experiences with staff from other townships. They consider that the intersectoral collaboration that has been stimulated by CARE has had an important impact on getting more interest and momentum on AI control. They also consider that after the Program the relationship between the LBVD and the community will be significantly enhanced. Previously they thought LBVD was only interested in cattle, but now they understand that it also includes chickens. The IEC materials that CARE has distributed have made it easier to generate interest.

The extension workers interviewed reported that they are currently doing approximately one to two trainings per month across all their communities, and they accompany LBVD when they visit poultry farms. They are each responsible for between 900 and 1,300 households. They report a variety of suitable approaches to training, although one group reported that they had to use their own funds if they conducted AI community meetings. Funds were required for travel and photos to report on the event. Some respondents were integrating AI control into their usual community activities at no cost. Extension workers reported that they have benefited from CARE by having access to IEC materials which makes it easier for them to stimulate interest in the community. They also enjoy having special knowledge to share with their communities and enjoy watching communities learn. They consider their jobs as popular and others would be interested to do the work. They report that having an educational role brings status. They demonstrated good knowledge of their communities and the challenges they faced with behaviour change. They have seen positive changes to date, especially breeding animals separately, traders no longer tying chickens by their feet, washing kitchen utensils, fully cooking eggs, and separating sick animals. Reporting dead chickens has also started (there were many reports of dead chickens in the summer). They stated that if they cannot report dead chickens to the township level (if there are no symptoms of AI), they will use gloves to bury them. They distinguished CARE training from other training in that they didn't have to pay to attend, and the methods were more interesting. LBVD, MOH and CARE all participated in their training. They report weekly visits from LBVD to their area (35 miles from township).

### 2.4 To what extent are case study outcomes likely to be sustainable?

CARE staff report that they are not sure about what the plans are for further training and continuing to work on the LEWs by LBVD. When asked if the community extension workers will be expected to continue to work after the Program, team members stated that they were not sure if they would be able to sustain the work or not.

For the market model, CARE has employed full time community facilitators. This will not be within the resource capability of the LBVD. They play a strong role in communicating (raising awareness) with market stall traders (30 minutes per month for each market – 10 to 30 traders), and liaise with City Development Councils.

LBVD considered that they could support in the future LEWs, and it would be within its capacity to conduct refresher training twice yearly. All that would be required is to instruct the township level. However, there had been no training of animal health workers for five years before the Program – it was stopped as there were insufficient resources. LBVD had concerns about the incentives they needed to provide to LEWs, but did not have the capacity to pay allowances.

LBVD township trainers were not sure to what extent they could continue the work after the CARE Program. They considered that it will be difficult to sustain the LEW reporting as they cannot pay incentives, and would not be able to continue the LEW training without travel allowances. They believe that LEWs will have more success if they give their community training with the township trainers (but they did not address the resource implications of this). They do believe that using the Animal Health Workers (AHW) may be more sustainable as they are already active (however, this varied from area to area for the trainers). In one location, there had been no AHW training since 1988. They also considered that CARE needed to visit the LEWs more often so that they could be more effectively motivated.

### 2.5 What factors account for the achievement (or not) of sustainable outcomes?

CARE relationship with LBVD is highly productive. There is a high degree of ownership by the LBVD in its work. This will have a strong influence on the sustainability of the work. The approaches adopted to gain this ownership have been well designed. The approach was to focus strongly on meeting LBVD needs rather than pushing a particular agenda. The relationship has a high degree of trust, which CARE gained by being fully transparent and open. The CARE staff member involved in the establishment of this relationship had been a government worker for many years and understood the sensitivities well. Another contributing factor is the appointment of the National Program Adviser, a retired and well-respected Deputy Director General of the LBVD. This would have resulted in getting much more effective engagement at the township level.

All training materials for the LBVD trainer were developed by LBVD with CARE support. UNICEF is responsible for the design, technical quality and production of almost all AI-related IEC materials in Myanmar. All agencies involved in AI programming use these materials in the implementation of their projects. As a result, project-produced IEC materials were based on these existing UNICEF AI resources.

Unfortunately, FAO was not involved and hence did not provide technical input. FAO began engagement in Myanmar in AI control in 2007.

CARE has no formal discussions with LBVD about what aspects they intend to support into the future. M&E findings had shown that extension worker use their own personal money to support their work. CARE team reported that the extension workers are only working on AI and that it would be better if it were integrated into the AHWs (although these are not necessarily active in all areas). The CARE team considers there are challenges with the capacity of the Township Veterinarian to continue to support extension workers as the veterinarians only have a limited budget for transport – although LBVD at the national level reported that they provided motorbikes and fuel, but no per diems.

FAO does invite CARE to national level donor meetings, but its role has not been strong in terms of responding to national information needs and feeding back quality data on its pilots.

FAO appears to have more emphasis on their technical role rather than a strategic role in the implementation of the national AI control strategy, or key facilitator in national coordination.

The Coordinator of the joint FAO-LBVD AI control program considered that Myanmar will always need assistance to implement activities, especially assistance from NGOs to deliver anything at the community level.

A session was held with LBVD to demonstrate how to assess some aspects of sustainability. The findings of this discussion were that there may be some aspects that will support sustainability: the high degree of national ownership; the fact that LBVD has been doing all the training to date; the potential viability of the LEWs (although this has not been verified); and the low cost health education options employed. Factors that may inhibit sustainability were: the high cost of reproducing the IEC materials; the handing over of BCC skills to LBVD technical trainers; and monitoring of activities.

## 3. Quality of Implementation

**Vietnam**

**3.1 What are the quality and effectiveness of program deliverables in the case study?**

Training methods have been participatory and highly valued by participants in case study interviews. Technical content has been of a high standard and consistent with current international good practice.

Communication campaigns have been reasonably well designed, adopting good practice approaches to community mobilisation and communication, however internationally accepted models of behaviour change may not have been fully applied systematically - rather staff have had to base much of the design of models on their own individual experience rather than on organisation-wide guided approach based on accepted theories of behaviour change.

Design of the experimental component of the work is inadequate (see section below in M&E).

Systematic dissemination of findings of pilots has not yet occurred.

Gender is not being formally addressed.

**3.2 What are the key factors that account for the quality of program deliverables in the case study?**

CARE has expertise and competence in the delivery of training and community mobilisation activities.

CARE does not necessarily have the expertise to design, conduct, analyse, or report on high quality evaluations required for conducting experiments that demonstrate with credible evidence the effectiveness of its approaches.

**3.3 To what extent has the program been delivered according to the schedule provided in annual plans?**

There have been significant delays in the delivery of the Program. This began with delays in signing the MOU to work in the proposed locations – it is unclear to what extent senior management gave this sufficient attention to move forward. This situation was exacerbated by delays with participatory rural appraisal (PRA) which was to be applied in the identification of topics and priority messages for the pilots that would follow. The Biosecurity pilot has not yet started with 12 months remaining on the Program. This was caused by insufficient

consideration given to the TORs for the task, and limited capacity or perspective required to develop a TOR for research; and the limited availability of a good pool of consultants. This was exacerbated by a substantial amount of staff turnover at both senior and operational levels with limited active response planning by senior management.

Implications to achieving outcomes within the timeframe are significant. For successful replication of a pilot there needs to be careful design of the intervention, several cycles of the intervention implemented, a high quality M&E system in place (and generating credible findings), and an intensive strategy to achieve ownership and response by target partners. To begin with, the design did not provide sufficient guidance for the true requirements of a pilot activity, and the expectations were already highly ambitious for a 30-month program. In addition, NGOs are not usually well equipped to design and implement experimental work that is expected to have an outcome of government policy response or replication. With the additional delays, there is a high degree of risk that the Program will not achieve its intended outcomes by September 2009.

**Laos**

**3.1 What are the quality and effectiveness of program deliverables in the case study?**

CARE materials and messages are consistent with international good practice and the Laos National Plan.

District and community volunteers all benefited from CARE's approach to training and community engagement, especially the approach of having open and participatory activities. This was considered a far more effective approach than previously applied approaches that were command driven.

Training materials were reviewed and considered to be of a good standard. There was, however, a focus on knowledge and skills and not enough overt consideration given to the motivation of participants to adopt new behaviours.

Gender is being addressed to some extent. CARE is an active member of the Laos Gender Development Group and the Program Manager has participated in a gender training delivered by a Lao Gender Specialist. There is a plan that AusAID will provide some additional support in gender mainstreaming. To date, there have been limited attempts to analyse the special gender outcomes in relation to AI control in Laos, or work out how to integrate gender equality considerations into training materials and key messages delivered at the community level. There have been some intuitive responses to gender issues by attempting to address the needs of women at the community level, but there has been no systematic approach adopted to analysis and response planning. With the time remaining on this Program and the capacity of the team, it is not expected that major achievements will be made against these outcomes.

**3.2 What are the Key Factors that account for the quality of program deliverables in the case study?**

CARE has put in a lot of effort working meaningfully with technical agencies in Laos to ensure that its IEC materials are consistent with international thinking as well as national priorities. Other positive factors were: that preliminary research was conducted to inform the design; good collaboration with technical agencies in the design of the model; training was designed with appropriate technical input; and a good standard of monitoring forms.

**3.3 To what extent has the program been delivered according to the schedule provided in annual plans?**

The Program has been largely on track. There were some minor delays with the signing of

MOU, but activities were able to continue through this period. There are some further delays predicted with the flooding in the Mekong districts. It is too early to assess the likely implications to the Program, but there is some risk that these districts may not complete expected activities by the end of the Program.

**3.4 To what extent has the Program expended allocated budget?**

There was a 20% underspending on the indicative budget. This was more due to an overestimation of the budgetary requirements as activities costed less than anticipated.

**Cambodia**

**3.1 What are the quality and effectiveness of program deliverables in the case study?**

There have been no formal gender analyses. Recently the team have identified some important questions relating to the effect of the savings made by women who experience enhanced production. Also reasons why female and males volunteers and the different burdens this places on their roles.

It was not possible to review the curricula employed for CARE training. The most recent training had been delivered in May 2008, but staff were unable to locate a curricula or lesson plan. The only material available was the Veterinary Manual that the veterinarians use in their work. CARE staff considered their role in training was to organise sessions - invite participants, arrange food and meeting place, and observe the training.

The pilots were not well-designed as experiments, rather as implementation programs. There was no well-defined strategy to bring about adoption or replication on the pilots at the community, district, provincial or national levels (DAHP and FAO).

**3.2 What are the Key Factors that account for the quality of program deliverables in the case study?**

CARE Cambodia has limited expertise in gender and there is currently no one in the office (of about 350 staff) nor at the corporate level identified as having gender expertise. The pilot design had not considered gender, and the baseline research work did not include gender issues.

CARE staff considered their role in training was to organize sessions - invite participants, arrange food and meeting place, and observe the training. They had not considered a role in contributing or ensuring the quality of the curricula employed by CelAgrid.

A lack of strategic oversight may have contributed to the lack of strategies to meet the needs of a pilot as experiment, as well as approaches to get models adopted (or rejected) if this is more appropriate.

**3.3 To what extent has the program been delivered according to the schedule provided in annual plans?**

There were some delays in getting a clear concept for the pilots. After the three-month design phase, there was another three-month bridging phase. It took five months from Program commencement to get final identification of pilots on VSTs and Biosecurity. There were three changes to the AI Program Manager. The first left after phase one, the second left three months into Phase 2 and the third left 11 months into Phase 2. The delays in Program development may have been exacerbated by limited strategic oversight.

**Myanmar**

**3.1 What are the quality and effectiveness of program deliverables in the case study?**

Overall, training materials were satisfactory. However, market authority training materials focused on raising community awareness rather than on the full range of capacities defined – such as BCC skills. Staff involved in the early stages of the Program reported that there was no technical expertise used for training materials.

IEC materials developed in coordination with LBVD were adequate, but the CARE officer in charge of IEC does not have any formal training and is self-taught. CARE International has not provided guidance or technical support with respect to IEC development which is an expected value-added of working with NGOs. The human health messages were appropriately identified in collaboration with UNICEF, MOH, and WHO.

Approaches to gender equality have been to focus on recruiting females as CARE staff. They also encourage women to participate in CARE's health education sessions at the community level. The team stated that women were more at risk of AI, but continued to focus their work on men and women equally. There are no other systematic approaches to gender. CARE staff had a two-day training in September 2007 where gender analysis was taught, however this has not been applied to the Program. CARE staff report that they do not have the confidence to do gender analysis and need further support. The team is unaware of any gender analyses conducted relating to AI in Myanmar. A Burmese Gender Advisor joined in September 2008, and CARE is expecting a Quality Adviser (whose role includes overseeing gender) to join the country program in January 2009. The Gender Advisor is expected to design and support delivery of the technical aspects of the work on gender.

The quality of the M&E/reporting on the Biosecurity model was of a suitable standard, designed and reported on by the National Program Adviser.

**3.2 What are the Key Factors that account for the quality of program deliverables in the case study?**

Overall, there is insufficient capacity within the country program to address some aspects of programming. This relates mainly to the design of pilots, gender, and the development of training materials that meet the full range of expected capacities. There appears to be limited support provided to staff to meet these needs effectively.

**3.3 To what extent has the program been delivered according to the schedule provided in annual plans?**

The Program has not experienced any significant delays.

**3.4 To what extent has the Program expended allocated budget?**

The Program is underspent by 13%.

4. **Effectiveness and Efficiency of Program Management Systems**

**Vietnam**

**4.1 What is the quality of program oversight and governance?**

In Vietnam, there are risks posed to Program delivery as there is no one person with full-time oversight of the Program. The Program is managed by two or three people, all of whom work

part-time. The senior position is the Health Program Coordinator, who has 25% of his position allocated to the Program; the next is the Country Program Manager who works 4 days per week and manages three other USAID and US-CDC funded programs. A technical consultant (whose contract has now expired) also provided some oversight and contributed three days per week to the Program. It is unclear if this arrangement contributed to the delays in Program roll-out in the first 12 months. The MTR team believe a Program of this size (A$1.1M) deserves the full-time attention of a full-time country manager, particularly now that the Program is behind schedule. With part-time responsibility, there are demands from other Programs; with shared responsibility, there are challenges to decision-making and communication; and blurring of focus, control and strategic thinking. The arrangement will threaten roll-out over the remainder of the Program, a period of probably 12 months, when inputs are likely to increase if the Program is to be delivered on time, within budget, and with meaningful results.

**4.2 What is the quality of strategic and annual planning?**

As a result of the governance and oversight issues above, there has been a reduction in the quality of strategic planning at the country level. Strategic oversight rests with two part-time positions with a lack of clarity as to who is ultimately responsible for facilitating the team to think through the Program at a whole-of-Program level. There has been limited strategic direction provided by CARE Canberra. Although there has been a visit from Canberra to assist in annual planning, the strategic aspect was not well addressed.

Selection of topics for pilots (or experimentation) was to be based on a preliminary PRA. Although this approach is considered appropriate, the final quality of this work was not of a sufficient standard to provide the justification on which to base the future pilot designs. As a result, activities were selected based on historical factors (where CARE had previous experience) and appropriateness in terms of the national strategy. There was not a systematic approach to identifying the key questions needing to be answered by national level stakeholders.

Annual planning processes have not succeeded in involving partners in a meaningful way, i.e., that leads to a substantive contribution. Importantly, there was limited focus on sustainability issues from partners.

**4.3 To what extent has staffing been consistent?**

There has been significant turnover of staff at the implementation and supervisory level. At the implementation level, one staff member left to study overseas, while another left to take on a better position with another organisation. It has been difficult for CARE to meet wage requirements in a context where inflation is running at about 25%. CARE has attempted to address staff turnover by conducting a staff survey, which resulted in recommendations to increase salary and enhance professional development opportunities. Action plans have not yet been fully implemented or yet been successful. Another factor has been the four-weeks notice requirement on resignations, which is limited by staff taking owed leave on departure.

**4.4 What are the quality of M&E systems?**

M&E systems are weak, however, the MTR team is unaware of current standards of practice required of AusAID-accredited NGOs. CARE does not appear to have the in-house expertise to do this type of work, and not to a standard that would be required for a pilot program. This is especially important where the intention is that the findings of pilots are to feed into a District/Provincial/National response of adoption or replication or rejection of a proposed approach.

Another challenge has been to design M&E systems based on the logframe. Working with the

team it would appear that designing M&E systems around the primary purpose (adoption, replication or rejection of a model) would be a suitable starting place. The rest of the M&E systems would be better designed around each of the pilot activities.

Currently the focus of M&E is on long-term outcomes at the level of community behaviour change. Desired behaviour changes of other beneficiaries such as community implementers and district or provincial officials have not been clearly articulated and therefore not included systematically in the M&E system.

The approach has been to design a KAP survey which is carried out in communes where CARE has a range of models (pilots) on trial. Currently it is impossible to determine which of the pilot interventions is responsible for behaviour change detected. This has significant implications on the ability to provide credible evidence of the effectiveness of each of the pilot interventions.

The quality of the KAP sampling strategy and questionnaire is considered of a suitable standard. The analysis of the implications of the KAP findings is not well developed. The KAP alone does not allow an exploration of the factors that account for the adoption (or not) of desired behaviours. This would be a critical component of the M&E system for a pilot or trial intervention.

Packaging of lessons learned is insufficiently rigorous for pilot/experimental work of this nature.

**4.5 What is the quality of Risk Management systems?**

Currently, there is no systematic approach to risk management. There is a risk matrix in the design document, but it is not reviewed systematically with each annual reporting cycle. There is probably limited capacity in the team to address these types of analyses without specialist support.

**4.6 How adequate is program financial reporting?**

Good. The financial management system used by CARE appears sound, allowing adequate tracking of expenditure. At the country level, line items reflect the operational requirements, variance on expenditure is reported, and spending limits are appropriately applied to positions of different levels of responsibility. Importantly, under- and over-expenditure is readily detected and traced. Given the considerable scaling-up of activities anticipated for the remainder of the Program and the associated increased intensity of spending, close monitoring of the budget will be required to meet budgetary targets. Current budget variations (mainly underspending) reflect the delays in starting activities.

**4.7 To what extent are the program approaches considered to be good value for money?**

Value for money is difficult to determine at this stage of the Program. The Program is behind schedule and the desired outcomes are only now becoming clear to country teams. NGOs, including CARE, are traditionally good value for money for implementation programs, which is what they ordinarily do. They tend to be thrifty in expenditure and low in overheads, using in-country labour and foreign volunteers to deliver programs sparsely funded by hard won public donations. The demands of implementation programs are very different than experimental programs and this Program is in fact a series of social experiments. At this stage, there is a real risk that a value-for-money outcome will not be realised.

**Laos**

**4.1 What is the quality of program oversight and governance?**

There are two Programs being managed by the Laos CARE Office. The AusAID Program and the CDC Program, both addressing similar issues. AusAID focuses on urban and peri-urban areas, while the CDC Program focuses on rural/remote areas. At the strategic level, the Health Coordinator allocates 50% of her time to the AusAID Program; and at the AI program management level, 50% of her time is allocated to the AusAID Program. There is an additional local Assistant Program Manager who currently allocates about 70% of her time to the AusAID Program. CARE is currently focusing on building the capacity of the Assistant Program Manager to take over the full role of the AI Program Manager. This poses some risks where delineation of roles and functions and carriage of full responsibility for providing oversight is unclear. However, it was clear to the MTR team that senior managers were closely in touch with the AusAID Program and were able to demonstrate a high degree of involvement, oversight and direction.

At the program/technical level as well as the administrative level, staff are in dedicated positions and allocate 100% of their time to the AusAID Program.

**4.2 What is the quality of strategic and annual planning?**

The CARE team does not make a clear distinction between strategic planning and annual planning. There is a tendency to focus immediately on the annual plan without reflecting on the broader strategic direction of the Program. However, there has been ample consideration given to how the Program fits in with the Laos Government's National Strategy. This may have resulted in several of the findings of the MTR relating to the strategic direction of the Program.

There have been attempts to involve Laos partners in the planning process, although there has been limited capacity to allow a fuller type of engagement. CARE has involved partners to ensure that CARE activities were in line with local priorities, to enhance understanding and ownership, to increase CARE knowledge of partner geographical areas of responsibility, and to reduce overlap.

Overall, the Program in Laos is highly ambitious. There are issues of scope whereby the Program may be trying to implement a wide range of pilots in a short time frame. Consideration has not been given to focusing work on developing a smaller number of high quality pilots with high quality M&E systems and strong adoption strategies, while continuing with implementation of a small number of activities where there are provincial level expectations of implementation of AI control activities.

Selection of pilot Program topics was based on the broad national plan, and trying to piggy-back pilots onto existing systems and activities. The selection of the broader topics was not based on a systematic review of key questions needing answers at the national level (in terms of translating the national plan at the community level). Although CDC/WHO considers the government may be unable to articulate these types of questions easily. The technical focus of the UN agencies has also inhibited this approach. The surveillance model was designed in response to a specific research activity which is good practice.

In defense of this approach, it should be noted that as the original design of the Program was not a pilot/experimental approach. The original intention was to expand engagement in provinces that CARE was already working in. The late change to the pilot approach would have made a national approach to selecting pilots very difficult.

**4.3 To what extent has staffing been consistent?**

Staffing has been very consistent. There has been a low staff turnover. This has been challenging to achieve in a context where it is difficult to attract and maintain staff as there is a good deal of competition from the private sector and the UN where salaries are higher. CARE has developed a specific strategy to address this in Laos. They have a well-defined career path for staff. They have well-developed staff profiles and these are regularly reviewed with staff. CARE also provides targeted capacity building/professional development opportunities to its local team. CARE also tries to be flexible in meeting staff needs. CARE local staff reported to the MTR team that they felt a strong factor was the openness of CARE managers and their interest in allowing staff to express their ideas and influence the direction of the Program. These approaches have not been discussed with other CARE country teams. Expatriate supervisors have also been consistent within the Laos CARE office.

**4.4 What is the quality of M&E systems?**

Overall, the M&E system is of a reasonable standard where non-specialists have had to develop the system. CARE has accessed technical agencies to get assistance in developing some aspects of its M&E system. Other technical agencies expressed confidence in the quality of CARE's presentation of case study findings (although respondents were not themselves experienced in M&E). CARE has also provided a local M&E Specialist (to address both the AusAID and CDC Programs) who is supported by a part-time international consultant who has mid-level expertise.

The key issues with the M&E system are that the system is insufficiently robust for a pilot/experimental program. Because there has been poor articulation of intended end-of-Program outcomes (and which ones are to be sustained), the M&E system is not always addressing the right areas in which to collect data – directly related to the intervention.

In some cases, there are several pilots being implemented in a single location and a single KAP survey being applied (as in Vietnam). It is not possible to attribute the outcomes to a particular approach. The other issue is that the M&E system focuses quite strongly on the outcomes at the community level, and does not explore important issues of implementation such as quality of training, costs of implementation, or exploring other factors relating to sustainability.

The team has tried to use the logical framework as the basis for developing an M&E system. Conceptually this would have been very difficult. They are now moving toward a pilot-based approach, which is more suitable.

CDC/WHO also expressed challenges with respect to their M&E systems. In early October 2008, they have arranged for an epidemiologist to come and assess tools for data collection. However, they recognised that this may be insufficient to address M&E needs more broadly. They considered that they could also benefit from any additional expertise AusAID could provide in this area and would be keen to work with CARE on the development of national tools for performance management.

FAO considered that the quality of information disseminated from CARE case studies was important. FAO considers that the quality of information will determine whether or not the government would consider adopting or rejecting models tested by CARE. FAO considers that high quality data is required to support these decisions at the government and international community levels. FAO was happy with the narrative case study approach, but would prefer more rigorous data if this could be managed within the resource constraints.

Reporting has the same issues as identified for Vietnam: an insufficient focus on outcomes,

too much detail, and very difficult for AusAID to access specific management information.

**4.5 What is the quality of Risk Management systems?**

Risk management has been addressed in a rudimentary way – however quite well for what an NGO would be used to doing. They do review the risk matrix during annual planning. However, as with most Programs, the matrix is too detailed and distracts the reader from identifying those important risks that need analysing.

**Cambodia**

**4.1 What is the quality of program oversight and governance?**

CARE's Rural Development Program (where this Program is located) has 11 programs nationally with an annual budget of about A$5.5M. Of this, the AusAID AI component accounts for A$226,000. The management of the Rural Development program is fully integrated (program approach) which means that all oversight is managed by a range of senior staff who share their work among the 11 programs. For example, the Rural Development Coordinator reports that he allocated 15-20% of his time to this Program (although in terms of strategic planning and formal oversight this may be less); the AI Coordinator has allocated 75% and the Senior Program Officer has allocated 100% of their time to this Program. There are other support positions such as Program Management Advisers who allocated less than 10% of their time to supporting this Program.

The location of the strategic direction rests with the AI Coordinator. This position was filled in the past three months. The findings with respect to some strategic issues in the Program (relating to lack of strategy to achieve adoption of models, ownership at the provincial level, sustainability, and focus on implementation versus experimentation) suggest that there is not yet an adequate level of senior level oversight to ensure the intensions of the Program are preserved, especially in the context of an integration of the AI control activities into the Rural Development Program.

The previous expatriate AI adviser (working on this Program half time) did not have a line-management position and was only empowered to provide advise rather than make decisions on implementation issues for this Program. The ability of the AI Advisor to design pilots was limited by the strategy to implement Program activities within the Rural Development Program. In addition, the CARE country program is designed to be based on geographical locations which mean that a range of programs are being implemented in the same place (which will affect AusAID's ability to conduct useful experiments where many activities are going on in the same place).

**4.2 What is the quality of strategic and annual planning?**

Annual activity planning has been of a suitable standard.

There has been limited emphasis on strategic planning. This is due to the governance issues raised above, in addition to staff turnover, and the fact that the US-CDC Program was behind and pulled staff attention to deal with these issues (note that the CDC has been scaled back) CARE also reports that senior management didn't have a clear enough idea on the experimental focus.

The Program is being delivered where CARE plays the role of provider rather than facilitator.

The design for the Cambodia Program conducted in Phase 1 was contracted to an external consultant. It was appraised by CARE Australia as being of poor quality and required significant re-working prior to start-up.

**4.3 To what extent has staffing been consistent?**

From the Inception Phase there have been three expatriate Program Managers for AI (shared with CDC Program), and a transition of senior management (Assistant Country Director – Finance; and Assistant Country Director - Programs). CARE has responded to the risks posed, by reducing the scope of the CDC Program, putting in management positions (national staff) for the CDC Program, and clarifying overall line-management and accountability responsibilities. This has impacted on the Program as described in the section on governance (see above).

**4.4 What is the quality of M&E systems?**

Overall, the M&E system is reasonable for an NGO intervention program. The quantitative side of the work is particularly strong. However, for the purposes of this Program, there was too much emphasis on community level behavioural outcomes rather than a balanced focus on behaviour changes at the level of the implementation partners especially the VST, and the model farmers in the biosecurity model (see below). There were no evaluation questions incorporated that would be of particular use to national partners such as DAHP and FAO, or evaluation questions to explore in more detail (using naturalistic [qualitative] designs) factors that inhibit or work against adoption of desired behaviours; or resource implications of the models for parties expected to adopt or roll out these models.

Outcomes (desired behaviour changes) were not clearly identified across all Program partners including Community Households, Model Farmers, VSTs, Commune Administration, District, Province and National levels.

There is no data in the Biosecure Model at the moment that addressed the number of new households that have adopted the model in CARE villages. As this is a central question of the model, it would be expected that this type of information be included in the data collection monitoring forms filled in by CelAgrid. CelAgrid reports that its M&E is to meet CARE requirements as they don't normally do M&E. However, the primary data is still collected by CARE and seconded staff.

There is insufficient capacity in the M&E team to develop reasonable standards of qualitative methods for pilots, and there are no corporate systems to support this.

**4.5 What is the quality of Risk Management systems?**

The CARE team considered that risk management was the responsibility of the AI Regional Program Manager. They consider that the country teams do not have the skills for that, rather its *ad hoc* or intuitive. The team did not perceive any risks with integrated programming to the AI control program.

**Myanmar**

**4.1 What is the quality of program oversight and governance?**

This Program accounts for A$300,000 of the Country Program.

Current budgetary allowances for senior staff oversight are as follows: Country Director - 1.25 days per month; Assistant Country Director Programming - 1.25 days per month (A$10,667); Assistant Country Director Finance - 1.25 days per month (A$8,000); Assistant Program Coordinator - 2 days per month; and Technical AI Advisor (national) – full time.

The Assistant Program Coordinator, who is expected to lead the Program, has seven programs in her area of responsibility. There is a National Program Adviser who capably supports the

Program, but his role is unclear.

This is unlikely to provide the level of support required of the implementation team. The team does require sufficient strategic direction and some facilitation support to address key issues such as sustainability, adoption strategy planning, and broad design of M&E systems. Currently, senior management comment on draft documents and plans developed by junior staff, rather than providing the necessary support to facilitate that process. The number of days allocated to the Program by senior staff would prevent this being done effectively in any case. The Program is facing considerable risk in Myanmar. Junior field officers are currently expected to take on a major role in model design. This is unlikely to result in the quality of design required.

The team responsible for the implementation of the Program was unfamiliar with budget information of the Program and was unaware of the extent of underspending and how much expenditure was still required. Senior management reinforced their confidence in the Assistant Program Coordinator's understanding of the budget despite the impression gained during the MTR discussions.

**4.2 What is the quality of strategic and annual planning?**

Planning currently focuses on activity level planning for annual plans. There is currently limited reflection on the strategic direction of the Program. This is likely to be caused by the governance issues noted above. There is no involvement of national partners in planning processes. The CARE team did not identify any challenges to planning.

**4.3 To what extent has staffing been consistent?**

Staffing has been somewhat consistent, although a Program Manager was lost to the Program in June 2008. An international BC Advisor was also lost to the program after three months and was not replaced due to the time required to get a visa for another adviser. CARE senior staff report that a major restructuring of the country program has also been carried out over the past 12 months and this has had an effect on the capacity of the CARE to deliver its programs. In addition, the recent emergency from the cyclone has pulled a number of community facilitators into other areas of work.

**4.4 What is the quality of M&E systems?**

Overall, the M&E capacity at CARE Myanmar is weak. Current M&E systems could be considered acceptable for a local NGO with a focus on Program implementation, but not strong enough for an INGO, especially one working on pilots. M&E guidance that is provided to the teams consists of a two day training (once). M&E guidance reviewed in the Program Management Guidelines was not of a satisfactory standard. Teams were unable to recall more than the topic headings from M&E trainings. The standard is unlikely to meet AusAID requirements. Team members were expected to design, conduct and analyse qualitative data. It would be difficult for them to meet these demands given the degree of staff development that they have received. The Program does not currently access a local Social Scientist. The quality of the KAP (contracted out) is considered of an acceptable standard. The M&E systems for the pilot were recently developed by the Assistant Program Coordinator (in coordination with the team) and then integrated into the logframe format. The individual would not necessarily have the required skills to deal with this task confidently.

The quality of the M&E/reporting on the Biosecurity model was of a suitable standard, designed and reported on by the National Program Adviser.

**4.5 What is the quality of Risk Management systems?**

Risk management is addressed during annual planning. The risk matrix is actively reviewed. The team were able to identify three key risks (which were appropriate), but mitigation strategies were not well considered and there was no integration of risk monitoring into the M&E system.

## ANNEX 3: TERMS OF REFERENCE FOR M&E SPECIALIST

### 1. Qualifications

The consultant should hold a post-graduate degree that has included a research dissertation component. Alternatively, evidence of training in *advanced* research or evaluation design, conduct and management. Short professional development courses in M&E are not considered advanced training. Where a post-graduate degree in research or evaluation methods has not been completed, evidence of the quality of research or evaluation activities previously designed and conducted should be sought.

### 2. Experience

***Essential***

2.1 Experience developing M&E systems for programs in resource constrained settings. This is required to ensure that the proposed M&E systems are feasible in the context.

2.2 Demonstrated practical experience in research or evaluation design, conduct, and management. This experience should reflect expertise in developing a fully elaborated design of an M&E system which includes the design approach, articulation of M&E questions, development of sound methods and tools, conduct of data collection activities, analysis of data (or supervision of such), interpretation and dissemination of results and report preparation.

2.3 Demonstrated ability to breakdown and communicate complex concepts simply with a range of stakeholders in multi-cultural settings.

2.4 Demonstrated ability to develop and deliver M&E capacity building activities for implementation teams.

2.5 Ability to facilitate discussions about the intent of the Program and learning from M&E findings with all relevant stakeholders.

***Desirable***

2.6 Demonstrated experience in the delivery of development programs. This is required to ensure that the consultant is sensitive to the difficulties of implementing development Programs in complex settings, that the design of M&E activities are feasible and value for money, and that the M&E systems meet the needs of all relevant stakeholders.

2.7 Demonstrated on-going membership of a domestic or international evaluation society, or other demonstrated commitment to keeping up to date with the theoretical and practice developments in the field of evaluation.

### 3. Terms of Reference

For Vietnam, Laos, Cambodia and Myanmar country programs:

3.1 Facilitate the implementation teams to identify the full range of beneficiaries, and the expected behavioural outcomes at the end of the Program;

3.2 With 12 months remaining on the Program, identify only important outcomes and outputs for each pilot/experiment that will need monitoring and evaluating – this must be negotiated with AusAID before progressing to designing the monitoring and evaluation plan. Ensure that the scope remains feasible within the timeframe;

3.3 Facilitate implementation teams to: a) identify what outcomes are expected to be sustained; b) identify the key factors that will influence the sustainability of the Program; c) design suitable interventions to enhance sustainability based on the analysis of factors; d) integrate monitoring and evaluation of the quality and effectiveness of these into the monitoring and evaluation plan;

3.4 Using a participatory approach, design a modest but fully elaborated monitoring and evaluation plan that meets the expectation of AusAID and international standards of practice in M&E – it should also reflects the time and capacity constraints presented by the Program. AusAID standards are available from AusAID Activity Managers, while reasonable international standards are described in the DAC Evaluation Quality Standards, or the Joint Committee Standards (the latter addressing professional standards of evaluators);

3.5 Review the format of reporting to AusAID. Suggestions for this can be found in the MTR report. The M&E system should be able to deliver against those key questions;

3.6 Identify where the implementation team will require on-going M&E technical support, and where they will be expected to implement the M&E plan themselves;

3.7 Although there will not be time to conduct formal capacity building sessions, the specialist should take a capacity building approach using on-the-job training approaches to enhance potential learning – this should not, however, jeopardise the quality of the design, conduct and reporting of evaluation activities;

3.8 Provide interim support to the implementation of the M&E Plan. The focus should be on any on-going design of M&E activities; assuring the quality of the M&E system implementation; providing technical support for the analysis and interpretation of data; and over see the preparation of outcome-focused, evidence-based progress reports;

3.9 Supervise the final evaluation activities and oversee the compilation of outcome-focused, evidence-based Program Completion Report; and

3.10 Working as a facilitator, support the implementation team and other relevant stakeholders to interpret and respond to M&E findings for each pilot and to maximise the potential for a suitable policy response (adoption, replication, adaptation or rejection of the model on trial).

**4. Inputs**

*Note that travel time has not been included;* this is to be added once the travel itinerary is known.

| Assignment | Indicative Tasks | No. Days |
|---|---|---|
| 1 | Develop the M&E Plan (activities 3.1 to 3.5 above) | 20 |
| 2 | During implementation of the final 12 months of the Program, supervise the conduct of evaluation activities that are beyond the skill sets of the implementation (activities 3.6 and 3.7 above) | 20 |
| 3 | Supervise the final Program evaluation activities, and assist in the analysis, interpretation and reporting on findings in preparation for the Program Completion Report (activities 3.8 and 3.9 above) | 30 |

## ANNEX 4: GUIDANCE ON SUSTAINABILITY FACTOR ANALYSIS

This annex provides guidance on how to conduct a factor analysis and to integrate effective interventions to enhance the sustainability of the pilots in all countries, and the training in Myanmar delivered by LBVD. A number of common factors are listed below to allow teams to review each pilot against the factors that commonly affect sustainability. This should not be considered as a comprehensive list of sustainability factors, rather, a list of the factors most relevant to the Program pilots.

*Step 1: Identify the Key Management Questions Relating To Sustainability*

The following questions would need addressing when considering sustainability:

- What are the outcomes that are expected to be sustained?
- What are the factors that influence the outcomes we wish to sustain?
- What is the quality of our interventions on these factors?
- Are we moving toward or away from achieving sustainability?

*Step 2: Identify the key outcomes to be sustained*

Not all of the development outcomes in each pilot will be expected to be fully sustained. It is difficult to assess the conditions in the future, beneficiary behaviour is unpredictable, and the future context may be a moving feast. This step can be facilitated by the M&E Specialist, but teams would benefit from preliminary discussions to ensure the limited time with the M&E Specialist is put to best use.

*Step 3: Identify key factors that may influence the sustainability of outcomes*

Analysing the factors that influence the sustainability of the interventions should be done first by the CARE team, and then through a focused discussion with partners at national and local government levels, as well as at the village level, including with volunteers. A number of factors that could have a strong influence on sustainability of outcomes include (but are not limited to):

a) Differentiation between achieving **participation** (influencing design and implementation) and ***ownership*** (taking responsibility for implementation and outcomes). The four features of ownership that must be addressed are: *willingness* to take ownership (incentives and motivation); *accountability* (being answerable to another); the *capacity* to take responsibility; and the *opportunity* in terms of power relations between CARE and partners (who has control over the final decisions).

This is particularly important when reviewing the behavioural outcomes expected of implementation partners at the level of the volunteers (if implementing through them); village leadership; local government; provincial government; national government; and relevant donors in the context. Given the focus on replication and adoption in the Program, this analysis is of primary importance.

b) ***Institutional integration*** issues: staff incentives to adopt new behaviours; sustainability of staff salaries or per diems; allowances provided to do the new work; additional resources provided to do the new work; and the quality of the supervision system that will be essential to sustain (motivate) new staff behaviours. Structural issues such as integration of new work into existing units (such as ensuring volunteers are part of a *viable* network of government supported volunteers); and integration of new committees into existing institutional structures.

This will also be an important focus of the analysis. The models being demonstrated and tested (pilots) are all expected to be adopted in some fashion if they are deemed effective. For this reason, all pilot activities will need full integration into country institutional structures. If this is not the case, then consideration must be given to what *can* be integrated into existing structures and systems, and the ongoing design and implementation of the models must reflect this reality after Program support and funding has ceased. All models need to mimic the resource environment in which they are expected to operate. It is of limited value to demonstrate an effective model that requires intensive resources and support. However, there may be some pilots that are demonstrating modes that are intended to be taken up by other NGOs or donors with adequate resources. If this is the case, then it should be clear from the approach to replication that this is the intention.

c) ***Capacity Building issues:*** the extent to which training addresses the *motivation* to adopt new behaviours not just knowledge and skills; the appropriateness and range of training methods; and the enabling environment on return to the work setting which includes executive support, a demand for the new behaviours, equipment and other resources to do the work.

This is of particular importance when training village volunteers and local government workers. Often we focus on *training session* as the key intervention for capacity building and achieving sustained behaviour changes. Sustained outcomes from training can only be achieved if you consider the work environment in which people return to after the training. Your intervention needs to address motivation to adopt new skills and the enabling environment to do so. A commonly neglected aspect is creating a sustained demand for new practices. For example, if there is limited community demand for the services of a volunteer's new skills they will be unable to sustain interest in continuing. Equally, if a government secondee to a program (e.g. Cambodia) does not have any demand from their supervisor to practice the new skills, then they are unlikely to continue into the future.

d) ***Absorptive Capacity:*** the number of donors or NGOs working on AI with the same target beneficiaries; and the capacity to take on new work within the normal set of job responsibilities.

The latter point will be important in most of the pilots for all beneficiary groups, but especially important for those that deliver the models through volunteers. It is essential that you consider the competing work demands of all target groups (including government workers) and consider those in the context of no financial support or interest from CARE after the Program has completed.

e) ***Financial Capacity***: the extent of counterpart contribution and the recurrent budget implications of the new work.

For all development programs, awareness of the true recurrent budget implications of the program is essential. How much money, human and material resources will be required to continue the work into the future? Every aspect of your pilots needs costing this way. This needs comparison with the capacity of partners to continue to support the work at the same level of intensity. If this is impossible, then a discussion about what can reasonably be supported in the future is needed. When you are demonstrating new approaches to solve problems, it can be very useful to inject intensive resources to the point where you can achieve sufficient interest and momentum, but you will need a plan to hand over the costs to partners, so it will be necessary to discuss their capacity in this respect as soon as you can.

f) ***Time horizons:*** the scope of the interventions is realistic in terms of the time available to reach the intended outcomes.

The scope of your interventions must be consistent with the time you have to bring about the desired behaviour changes. For something to be sustained, you not only have to achieve the desired outcome in the timeframe for the program, but also early enough to consolidate interest and motivation by partners (and volunteers) to continue into the future, and with sufficient time to fully hand over responsibility for continuation of the work. This Program has been especially challenged by this limitation.

g) ***Appropriate technology:*** in terms of technical, financial, gender, social/cultural and maintenance aspects

Although unlikely to be a major risk to this Program, it still warrants consideration, especially with respect to gender and the maintenance of any PPE that has been distributed; or where IEC materials have been developed, will partners be able to continue to develop similar quality of materials, or will IEC materials stop being available once they deteriorate?

*Step 4: Identify Approaches to Address Important Factors*

Once the key outcomes have been analysed in terms of these and other factors considered to be influential, specific response strategies need to be developed.

*Step 5: Monitor the Quality and Effectiveness of Response Interventions*

The M&E system ought to track the quality and effectiveness of only the important interventions that were designed to enhance sustainability. Good professional judgement reporting in progress reports would be acceptable for other less critical factors, but the process of analysis of factors and discussions about suitable interventions and their success play an important role in improved program performance.

*Step 6: Report on Implementation of the Sustainability Strategies*

There should be a dedicated section in the progress report that addresses the five management questions listed above. There should be a mix of evidence generated from the M&E system, complemented by well-informed professional judgement to provide confidence that progress is being made.

# ANNEX 5: RECOMMENDED APPROACH TO REPORTING

This Annex provides some suggestions for approaching progress reporting. This would assist in terms of reducing the reporting burden on the program teams, as well as enhancing AusAID's capacity to monitor the progress of the program more effectively.

The format is based on a series of key management questions:

***1. What are the key end-of-Program outcomes?***

To assist AusAID to reflect on the progress of the program, it is useful to restate the intended outcomes that should be achieved by the end-of-program. Ideally, these outcomes would be found in the logical framework or program design, but as they are not fully described, the identification of these outcomes should be facilitated by the proposed M&E Specialist. There should be outcomes at the level of the adoption or replication of pilots, as well as for each of the pilot activities. This means that behavioural outcomes should be achieved at the provincial or national level where pilots are expected to be replicated, as well as at the community level and among volunteers.

***2. What outcomes have you achieved?***

This needs discussing both in terms of what has been achieved in this reporting cycle, as well as what has been achieved by the program to date. This allows more informed tracking of progress toward the objectives of the program.

This section must include achievements in terms of outcomes – new behaviours adopted by target beneficiaries at all levels (from community to national government). Where there is no formal evidence from the M&E system, good professional judgement should be used to assess progress towards these outcomes.

***3. What has been delivered?***

Only important outputs (deliverables or products of the program such as training, campaigns, IEC materials developed, or provision of equipment) should be reported. You can decide what is important by assessing the expenditure involved as well as the effort of the staff to deliver it. Do not report on all activities that have been conducted. For each of these important outputs it is necessary to report on their quality. For example, what was the quality of the training provided or the IEC materials developed?

***4. How is implementation progressing?***

Here you discuss the progress of the program in terms of whether or not it is on track according to the annual plan, in terms of both timeframe and expenditure. If there are any delays, you need to discuss the cause, implications to the successful completion of the program, and a response strategy. For expenditure, you need to report any variations to the original budget and identify the causes, implications to the successful completion of the program, and a response strategy, if appropriate.

***5. Are the Program approaches proving to be value for money?***

This section does not require any form of cost-benefit analysis. Rather, you can simply reflect on whether your approaches are at the lowest reasonable cost to achieve the same outcomes; or whether you could get better outcomes for the same expenditure. Your approaches to delivery of capacity building activities are always a good place to consider.

### *6. Additional Issues*

If there are any additional issues that should be reported then this can be done here. Keep this only to the most important issues that are likely to affect the successful implementation of the program. For any issues you identify, it is useful to consider the causes; implications to the program; and any response strategies that have been developed.