CARNEGIE CONSULT
Investment Advisory Services

Thematic Synthesis Study

for Transition in the East Alliance countries

Georgia, Lao PDR, Sri Lanka, Tajikistan, Vietnam

"The Challenge of Inclusive Development"

Commissioned by:

MCNV
SINCE 1968

Contents

Executive Summary, Conclusions and Recommendations 3
1. Context and methodology 10
2. Synthesis according to the OECD/DAC criteria 18
2.1. Relevance and consistency 18
2.1.1. Overall findings 18
2.1.2. Country findings relevance and consistency 19
2.2. Outcome and impact 22
2.2.1. Overall findings 23
2.2.2. Country findings outcome and impact 23
2.3. Efficiency 27
2.3.1. Overall findings 27
2.3.2. Country findings efficiency 30
2.3.3. Efficiency among MFS-2 consortium partners in the Netherlands 34
2.4. Effectiveness 35
2.4.1. Overall findings 36
2.4.2. Country findings effectiveness 36
2.5. Sustainability 39
2.5.1. Overall findings 39
2.5.2. Country findings sustainability 40
3. Lessons learned and recommendations 43
Recommendations on organisational development/ result area 1 43
Recommendations on livelihood development and inclusive finance/ result area 2 43
Recommendations on access to health services / result area 3 44
Recommendations on future fundraising activities 44
Appendices 46
Appendix 1: Summary of country evaluation reports for Result Areas 1,2,3 46
Appendix 2: List of persons interviewed 72
Appendix 3: Conference report TEA conference Colombo 2015 73
Appendix 4: Terms of Reference of the assignment .... external document
Appendix 5: Overview of evaluation process (drafted by MCNV) .... external document

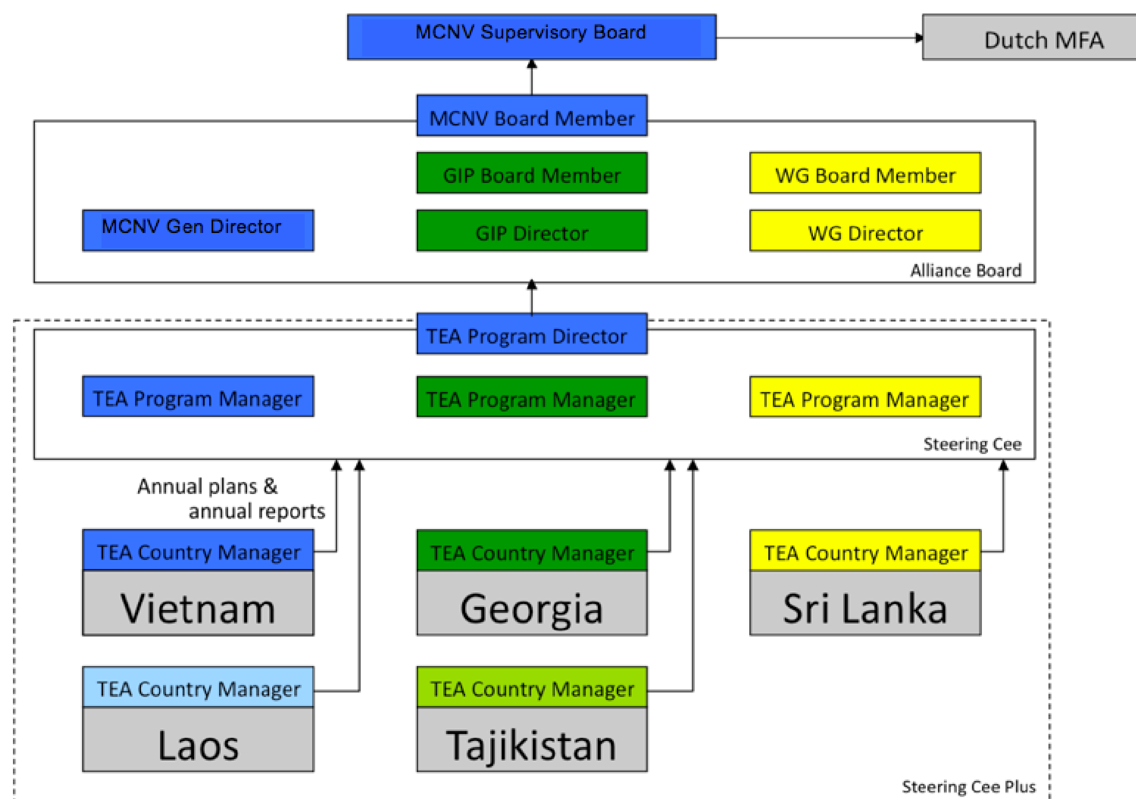
Executive Summary, Conclusions and Recommendations

The Transition in the East Alliance (TEA) programme aims to improve the position of different groups of marginalised persons in Georgia, Lao PDR, Sri Lanka, Tajikistan and Vietnam. Between 2011 and 2015 (at the end of 2015 the programme is scheduled to complete its work) the interventions, tailored to local contexts, focused on marginalised communities, in particular people living with disabilities, recipients of mental health services, ethnic minorities, rural population, internally displaced persons and elderly people.

The TEA programme is built on the following approaches: First is the approach of inclusivity. TEA works on the principle that nobody should be left behind in the development of their country. Second principle is the comprehensiveness of the approach. Marginalised groups need different types of support to succeed. People may need health support for their mental or physical disability, but they also need a livelihood for economic independence and social inclusion. Third is the principle of learning. TEA helps people and organisations to influence the social reality around them and speak up for themselves to secure better services and living conditions. The common mission for all the TEA partners involved is the empowerment of people irrespective of age, gender, social economic status, mental or physical health, location or ethnicity.

The consortium consists of three Dutch based foundations: Medisch Comité Nederland Vietnam (MCNV), Global Initiative on Psychiatry (GIP) and World Granny. TEA receives multiyear financing from the Ministry of Foreign Affairs of the Netherlands in the framework of the "*Medefinancieringstelsel 2*" (MFS-2) subsidy mechanism for a total amount of EUR 8 million for five years (2011-2105). The different partners are listed below in the graph. Countries are coordinated by one Dutch partner each, WG coordinates Sri Lanka (yellow), GIP coordinates Georgia and Tajikistan (green) and MCNV Vietnam and Lao PDR (blue). In the case of Sri Lanka GIP has financed other local health organisations outside the scope of the Sri Lankan country manager.

Graph 1: Governance structure TEA programme



The TEA programme consists of three separate result areas that are often also interrelated in terms of bringing about changes in the lives of the marginalised people:

Result Area 1 aims to provide better and sustained organisational capacity of target groups organised in Community Based Organisations (CBOs) and Non-Governmental Organisations (NGOs) who represent their rights. Collectively these Civil Society Organisations (CSOs) contribute to an improved capacity to speak up for the rights of marginalised communities in a dialogue with government authorities.

Result Area 2 aims to improve access to credit, insurance, pensions and other innovative livelihood products for the target groups through the CBOs and NGOs strengthened and/or established and through improved service delivery by other relevant microfinance institutes.

Result Area 3 aims to improve access to improved health and social services for the target groups, including psychosocial care through NGOs and CBOs as well as through institutions, improved referral systems, improved policies and improved or new training manuals or curricula for relevant training institutes.

In addition a **Result Area 4** has been identified for the organization of cross country learning as well as expenditures for monitoring and evaluation. Although this is formulated as a separate result area, the impact of the work manifests itself in the primary three result areas,

and as such it is not mentioned in the terms of reference for this assignment specifically. This synthesis will include it in the analysis on the outcomes for synergy and learning among the partners. It will also be looked at in the appraisal of efficiency of operations as expenditures for this result area are significant.

The **theory of change** of TEA is based on a constructive approach for improved service delivery by CBOs and NGOs in close cooperation with government bodies which also serves as the basis for the lobbying and advocacy for better services as well as a greater voice for marginalised groups in the five countries. Concrete and often innovative training or technical assistance approaches for CBOs and NGOs lead to better and more services to the poor, marginalised or elderly population. The added value also consists of introducing international best practices contextualised to the local needs and circumstances. This in turn can lead to acceptance by the local authorities of the methods/interventions and to better chances for influencing policy changes as well as improved curricula for health workers or higher standards for microfinance delivery. The strengthened civil society groups will have resulted in improved capabilities to empower the different target groups. In other words marginalised persons will be able to speak up for themselves and for their communities as a whole. The interventions will also help to change the way marginalised groups are perceived by the authorities and by their fellow citizens. TEA finally aims to improve the willingness by the government to listen and to consult citizens involved in policies or served by institutions (health, social and microfinance).

On the one hand this evaluation is meant to provide a summary of the independent country evaluation reports completed in 2014 and 2015 (Sri Lanka). This summary is enclosed in Appendix 1. In addition it aims to provide a synthesis and early indications on outcomes and impact according to OECD/DAC criteria. Since this report is commissioned before the end of the activities of TEA programme, in line with the expectations and instructions of the funder, it does not aim to and cannot provide any definitive finding on either impact or sustainability of the activities. The steering committee has agreed that for this reason the evaluation exercise should also be focused on producing lessons learned and directions for future strategies beyond the TEA programme. A utilization focused evaluation is used in line with the terms of reference where the primary users, i.e. the Dutch consortium partners and the country coordinators have joined in the formulation of recommendations.

The main conclusions on the various OECD/DAC criteria are listed below. As stated before at this stage they are meant to be seen as indications of outcomes and impact:

- TEA programme consists of **relevant** interventions in all five countries. At the start of the programme attention paid to the target groups and services provided to them were unsatisfactory and TEA set out to address these challenges. The introduction of new or improved interventions was relevant in the wider context of closing the gap between marginalised groups and non-marginalised groups. With regard to the strengthening of civil society the methods used (CIVICUS and 5C) have initially not always been perceived as relevant by the users, extensive contextualization as well as the effort to work from abstract organizational theory to the realities of rural communities has been time consuming and sometimes cumbersome. The legal or experienced limitations to civil society development in each of the five countries have meant that coordinating partners had to be flexible in the design of their interventions. For these reasons the relevance of CIVICUS for TEA is considered low. The choice

of the CIVICUS method is less relevant for a model where closer cooperation with the government in order to improve service delivery is chosen

- The country evaluation reports overall conclude that the outcome targets for the result areas as defined in the monitoring protocol have been reached or are likely to be reached within the time span of the TEA programme, leading to conclude that a basis for **outcome and impact** has been laid. In some cases more beneficiaries than originally envisaged have been included in TEA programme. A wider scope of TEA activities may also result from the work with authorities on policies, health and social infrastructure or curriculum work. Both the dissemination of results and an increased policy dialogue in 2015 are meant to contribute to a wider group of beneficiaries. Numerous case studies in the country reports indicate that a lasting impact on improved lives of marginalised groups may be expected.
- The **effectiveness** of the interventions has been difficult to determine at this stage but early indications are in general positive. The self-reported improved capacity to deliver results by NGOs and CBOs points at an effective approach under result area 1. Organizational development has not been a priority before for most of the CSOs and has been introduced under TEA leading to a possible and likely attribution of improved organizational capacity. Under the livelihood and microfinance result area 2 the direct positive effects have been measured and seen in the country evaluation reports. The financial reporting however was not always up to standard, the credit schemes not being linked to a formal microfinance institution with a reporting system in place. The combination of grants or credits and technical assistance has in general led to successful implementation of the various micro projects or community credit schemes. For result area 3 the direct improvement in services in health and access to services can be attributed to the interventions organised by the TEA programme. Specifically where new services or the establishment of new health centres are in place thanks to TEA, it can be attributed to TEA. Similarly, the improved collaboration with government institutions has contributed to the effectiveness of the RA 3 related interventions.
- The **efficiency** of TEA should be seen first of all in the context of the design of the governance and implementation structure. Many countries, local NGOs and CBOs and different stakeholders have been included. Also the demands from the MFS-2 tender instructions implied that a multi country approach with several partners had to be chosen. Given this pre conditions, a reasonably efficient approach has been followed. The harmonious and hands on cooperation between all partners, in many cases with long country experience, contributed to on time delivery and many times also under budget. Underspending in the early years compared to budget occurred because of insufficient insight in the exact roll out of activities in 2011 when the budget was formally approved. The local coordinators have worked well overall and demonstrated high degrees of commitment to the cause and to the activities. The holistic approach of combining organizational strengthening with service delivery has probably added to the avoidance of major delays, technical failures or misunderstandings. Maybe the exception is the use of CIVICUS, which was not efficient at the outset. A tool better geared at the CSOs included in TEA would have probably been more efficient with less confusion and less time spent on translation and adaptation.

- The **sustainability** of TEA activities should first and foremost be seen in the degree of being embedded in government policies or service delivery practice, taking into account the strong presence of government in many areas of society. In some cases closer cooperation with microfinance institutions in the future might lead to more inclusive finance practices leading to better and more finance for marginalised groups. Advocacy and dissemination of results will receive more attention in the final year of TEA which can further help to sustain positive results. Successes are already accomplished in result area 3. For example in Georgia with adoption of mental health policy guidelines, in Sri Lanka with raising the age limit and inclination to lend to elderly people by microfinance institutions. In Lao PDR the concept of village development committees has been welcomed and will be copied in other villages according to the provincial governor involved. The self-empowered communities in many instances will also be able to continue to implement livelihood activities which were initiated by result area 2 interventions. The revolving nature of the credit schemes of the communities will depend on sustained attention for management, transparency and record keeping practices as well as continued outside monitoring with linkages to formal micro finance institutions. A government induced grant culture tolerating low repayment rates may affect the repayment TEA funds in some instances. Among the target CBOs and NGOs the efforts to self-evaluate and continuously improve their own management may continue but it is doubtful whether CIVICUS will be employed in the future. As said in all cases the sustainability of the interventions can only be measured after the TEA programme has ended, preferably one year or two years later in time.

Finally in terms of **recommendations** the primary users of the evaluation moderated by Carnegie Consult have come up with recommendations and lessons learned. A workshop was held 30 March 2015 to this end. The partners have come up with the following recommendations and specific lessons learned which can be used in the near future within the framework of TEA as well as beyond the TEA financing period.

Organisational development methods were applied within the TEA programme for CBOs under result area 1. Especially the capacity to commit and act were seen as important. The adaptation of 5C for CBOs and junior CSOs is seen as an important achievement of the TEA programme. The following lessons and recommendations can be drawn from the work accomplished so far in this area:

- The TEA organisational development **toolkit** based on the adaptation for CBOs and junior CSOs in general has value beyond the TEA practice. It is recommended to share this tool for wider usage and discussion with other organisations involved in capacity building for CSOs both in the Netherlands and in countries of operation.
- It is recommended to describe specific **case studies** on how the adaptation of 5C took place and how CBOs experienced the process and developed ownership for the exercise.
- Organisational development works best when it involves **twinning** of CSOs active in the same sector with likeminded experts. Organisational development should preferably not be implemented as a standalone activity. TEA consistently combined organisational development with either livelihood or heath related activities.

The TEA programme combined **livelihood development** with **the provision of credit** to marginalised communities under result area 2. The technical assistance improved the capacity to pay back the loans and also included advice on proper administration of the funds provided. The community based microfinance provision within TEA has been implemented by informal credit groups. Hands on technical assistance and tools have been provided in the context of INFI, the inclusive finance network created in the framework of the TEA programme. The following learnings were identified:

- Informal delivery of inclusive finance should be embedded in a larger structure, either as part of a microfinance association or a Women's union/ other credit union. This may provide a better basis for the continuity of the funds, proper governance and transparency in operations.
- Advocacy for more inclusive finance products for marginalised communities should be based on demonstrating best practices for each target group. Case studies and promotional videos as well as speaking points for advocacy to policy makers should be prepared as part of the last implementation year of TEA (2015).
- With regard to the INFI network the work done on social performance standards for CBOs could be used as a basis for future fundraising. INFI is not designed as a sustainable advisory service centre and dependent on donor funding. INFI may fill a niche when proving its value added as an advisor on inclusive finance and livelihood development for marginalised communities.

The TEA programme has improved **access to health services** for marginalised communities in various pilot projects and has advocated for better policies and services to the health authorities in the various countries under result area 3. The approach has been based on strengthening the primary health care provision as well as attention to access to and improve the quality of district level health care. In the design of the result area 3 interventions this combined approach has been integrated, taking into account budget limitations and the generally larger investments needed to improve district level services and infrastructure. The following insights and recommendations were listed:

- The TEA programme has shown that advocacy for better policies for marginalised people can work well when close cooperation between CSOs and authorities can be demonstrated. Authorities can coordinate a sustainable approach for improved health services on a district or national scale based on pilot projects implemented by CSOs.
- A proper and functioning referral system from village or community based health care is essential. Linkages with the district health care system are needed even when the primary focus is on improving community based health services.
- With regard to the assistance for elderly people livelihood development and social inclusion are as important as the provision of health care services. The proceeds of livelihood projects should flow to the most vulnerable community members to build cohesion and solidarity within a community of elderly people.
- The roll out of curricula for training of health care workers is an important method to scale up a programme. The limited number of beneficiaries within the various pilot projects within TEA is justified when these pilots are used to demonstrate the effectiveness of a new approach valid to all members of the chosen target group.

- A committed trainer is essential for an intervention focused on teacher training institutes to succeed. This trainer serves as the champion for the new approach and can build the basis for the roll out of the new curriculum.
- The inclusion of problem based learning and the capacity to make adequate decisions are just as important in a health care related curriculum as the attention to transfer of new knowledge and treatment methods.

Since the TEA programme is in the last year of implementation discussions were held **on future fundraising** to continue the work for marginalised communities. The following recommendations were made:

- The chances to attract funding with private philanthropies or other non-governmental donors can be improved when a calculation on the cost per beneficiary and the estimates for wider impact outside the pilot group are included. This is often just as important as describing the relevance and impact of the programme. TEA carries various elements for a scalable approach. At this moment data on costs and expected outreach are not yet available. They should be collected to determine the total potential scale for the immediate future (2015-2017).
- Case studies, promotional videos and toolkits should be prepared to serve as building blocks for fundraising proposals. In particular the data and other findings of the country evaluation reports may be used to demonstrate effective approaches to improve the position of different groups of marginalised people in various countries.

This synthesis report consists of the following **chapters**: chapter two provides the context and methodology used in the country evaluation reports, chapter three the findings per OECD/DAC criteria and chapter four the lessons learned and recommendations as defined with the primary users. In line with the terms of reference a summary is provided for the three result areas, which is included in appendix 1. It follows the outcome targets as listed in the monitoring protocol as agreed for the TEA programme. The summary and the synthesis are based on desk study of the evaluation reports, annual reports and other relevant documents such as mid-term reviews. Interviews with various stakeholders were held. Participation in the TEA conference held in Sri Lanka between 9-12 February 2015 contributed to insight in learnings stemming from the different country experiences, helped the mapping of remaining work for 2015 and beyond when TEA financing will have ended. The assignment was executed in February and March 2015 by Hans Slegtenhorst, Hidde van der Veer and Marie Heydenreich from Carnegie Consult and an independent health expert Dr. Jarl Chabot.

1. Context and methodology

The Transition in the East Alliance

This synthesis study of the programme 'The Transition in the East Alliance' is conducted in line with the Terms of Reference (ToR) as enclosed in appendix 4. The TEA programme is funded by the Ministry of Foreign Affairs of the Netherlands in the framework of the MFS-2 tender for the support of civil society organisations in the Netherlands and developing countries. The programme period is for the years 2011-2015.

This synthesis study as well as the country evaluation studies were commissioned before all interventions are finalised, thus hampering the application of a proper methodological assessment framework. Moreover this synthesis is primarily based on five independent country evaluation reports which were all taking data into account up to the end of 2014. For this reason the ToR correctly refers to the aim of the synthesis being a utilization focused evaluation with lessons learned by the stakeholders which can still be used for the final phase of the programme. The country evaluation reports provide an adequate basis for that, the quality and the scope of the reporting was found generally to be of good quality.

In the utilization focused evaluations the primary users are defined as those implementing organisations in the five countries and the three Dutch organisations forming the MFS-2 alliance. These organisations are involved in the follow up. In the framework of this exercise an open and iterative process has been followed to formulate recommendations which are owned by the primary users and which thus have a high chance of being taken into consideration for future steps. The primary users are:

- MCNV- The Netherlands
- Global Initiative on Psychiatry- The Netherlands
- World Granny –The Netherlands
- Global Initiative on Psychiatry –Georgia
- MCNV Lao PDR
- Sarvodaya Sri Lanka
- Global Initiative on Psychiatry- Tajikistan
- MCNV Vietnam

Inclusive development

TEA covers three main result areas, organizational development (RA 1), income generation/ livelihood (RA 2) and health and social services (RA 3). The mission of TEA is the empowerment of people irrespective of age, social economic status, mental or physical health, location or ethnicity. TEA covers a wide range of activities in several countries, and approaches are necessarily tailored to local contexts with a common vision on the key approaches for inclusive development:

- First is the approach of inclusivity. TEA works on the principle – nobody should be left behind in the development of their country.

- Second is the comprehensiveness of the approach. The consortium partners understand that especially marginalised groups need different types of support to succeed. People may need health support for their mental or physical disability, but they also need a livelihood for economic independence and social inclusion. TEA mobilises different groups of partners to assist our target groups on many different levels.
- Third is the principle of learning. The consortium recognises that they are not doing mechanical work, but they are helping people and organisations to influence the social reality around them. To this end, they stimulate and employ an approach that makes sure it reflects and corrects the selected strategies, and include this approach as key component of the work.

The concept of inclusive development for TEA entails a multi stakeholder approach with community based organisations (CBOs) and non-governmental organisations (NGOs) providing better and more financial and social services to marginalised groups in close cooperation with the local and regional authorities and/or financial institutions. Improved service delivery in small scale projects can demonstrate the need to authorities to provide better care to previously underserved or neglected communities or marginalised groups.

Inclusive development benefits both the local communities and wider society. Inclusive development means facilitating higher productivity, sustainable earnings and greater empowerment for the poor. Inclusive development models depend on drivers for social change. They can include local 'champions' for development with CSOs, (health) institutes, community leaders, business leaders, financial institutions and government representatives. In addition inclusive development is a bottom up approach to sustainability whereby risk sharing and collective saving may lead to achievement of the project's mission and a model that is not dependent of outside funding.

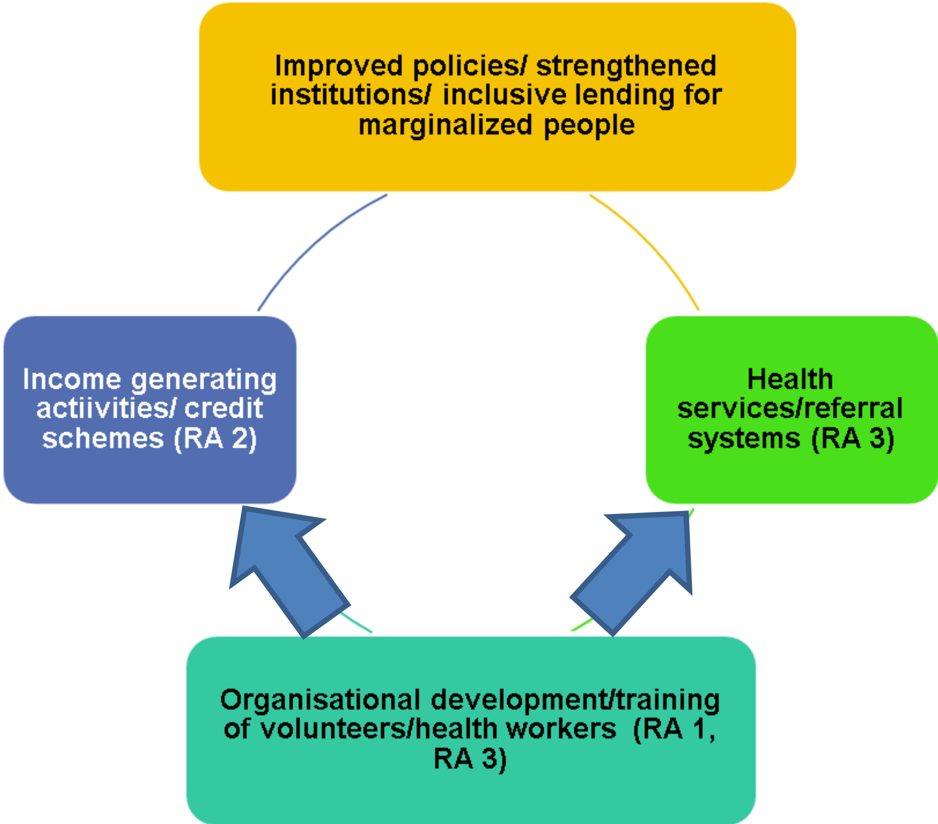
Theory of Change

The theory of change of TEA reconstructed as part of this synthesis evaluation is based on a constructive approach for improved service delivery by CBOs and NGOs in close cooperation with government bodies which also serves as the basis for the lobbying and advocacy for better services as well as a greater voice for marginalised groups in the five countries. Marginalised groups in TEA programme include disabled persons, recipients of mental health services, ethnic minorities, rural population, internally displaced persons and elderly people. Concrete and often innovative approaches lead to better and more services to the poor, marginalised or elderly population. The added value of bringing international best practices contextualised to the local needs and circumstances is another element of the theory of change of TEA which may lead to higher acceptance by the local authorities and better chances for influencing policy changes and producing improved curricula for health workers as well as higher standards for microfinance delivery. Technical assistance and vocational training has been provided to the groups and CBOs and NGOs forming a core element for the delivery of the three result areas of TEA.

The strengthened civil society groups will have resulted in improved capabilities to empower the different target groups. Marginalised persons will be able to speak up for themselves and

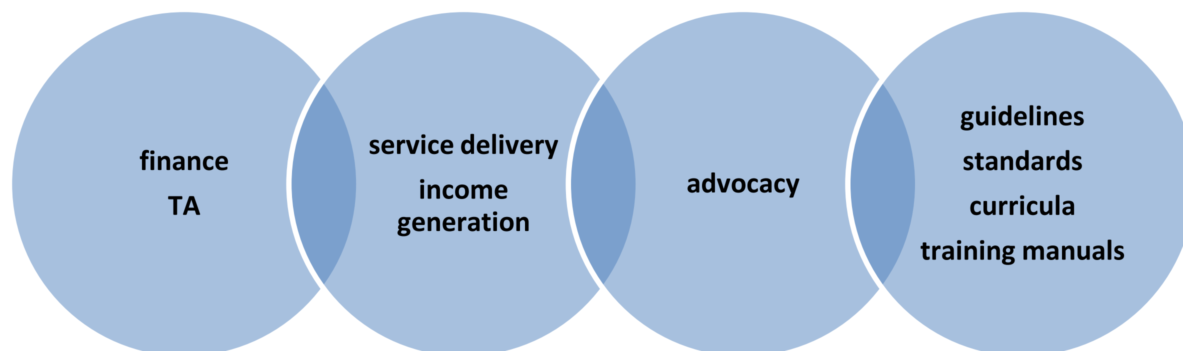
for their communities as a whole. The interventions will also help to change the way marginalised groups are perceived by the authorities and by their fellow citizens. TEA also aims to improve the willingness by the government to listen and to consult citizens involved in policies or served by institutions (health, social and microfinance).

Graph 2: Relations between the result areas and outcome area targets



Furthermore the theory presumes that the combined talents of each of the TEA groups involved, i.e. 'East East' twinning NGO partners, the CBOs, health workers, individual 'champions' and other key influential stakeholders in or outside the government will produce synergies which enable the delivery of improved services to poor, marginalised and elderly population. Finally, within this theory of change the idea is that international cooperation among five countries offers a joint path forward with state and non-state stakeholders which will also be able to ensure sustainability in the near or longer term.

Graph 3: Types of interventions of the TEA programme



Methodology

As mentioned the synthesis study is based on a summary of the five country evaluation reports stating the main findings for the results areas as agreed in the monitoring protocol with the Ministry of Foreign Affairs. In addition it is based on desk study and interviews conducted with stakeholders (list of people interviewed in appendix 2). The synthesis is made following OECD/DAC criteria for evaluations. No primary sources have been consulted in this synthesis assignment.

TEA interventions are still being conducted and any reasonable prediction of the sustainability and impact is premature. Another limitation is the establishment of the outcome targets in the monitoring protocol after the start of the interventions. Baseline studies among the target groups could therefore not have been established at the proper moment, in some instances up to one year later. In general the interactions with the Ministry of Foreign Affairs and the timing of the instructions on the type of methods to be used for measuring civil society strengthening (CIVICUS and 5C) have not been conducive to establishing a proper ownership by the implementing organisations in the five countries. According to the stakeholders interviewed they were instructed to use these methods and did their best to adapt it to the local circumstances.

Important distinction should be made between the different target groups. The definition of NGO in the country evaluation reports and in this report is a legally established organization with a governance structure in place (board, association of members or similar), a CBO, i.e. community based organization is an established cooperation framework between members of a community (typically a village or a group of peers, such as internally displaced persons, elderly people, disabled persons or persons receiving health care) with some governance in place but not necessarily registered formally. CBOs also can operate in a context where registration is an administrative or political obstacle. Civil society organisations (CSOs) includes NGOs and CBOs in the context of the TEA programme.

As regards the methodology used in the country evaluation reports control groups were used wherever feasible and available. The rigor of the methods applied by the local evaluators deserves praise given the time and means available for the studies. Wherever an assessment could not be made with the use of control groups, an analysis was made of the

changes before and after the interventions. Obviously attribution problems may occur and in any case the timing of the evaluations is an issue when interventions are still taking place.

The country evaluation reports were intensively scrutinised for consistency in the reporting of the results by the programme staff of MCNV, without of course interfering in the conclusions or recommendations. The monitoring capacity of MCNV in the Netherlands as the overall coordinator of TEA can be considered strong and this has helped all the partners to cope with the considerable M&E burden in the framework of the MFS-2 formal requirements. The description of the evaluation process as coordinated by MCNV is included in appendix 5 (drafted by MCNV).

According to the guidelines from the Ministry of Foreign Affairs the scope of the country evaluations could be limited to 50% of all interventions. This implies that a sample has been chosen.

Per country study a summary of the methods applied in the country evaluation study is provided here:

Methodology used in Georgia

In Georgia a baseline study on all three areas envisaged by the TEA programme was conducted.

In 2014 an outcome / impact evaluation took place with both a quantitative survey (questionnaire) and qualitative research, using focus group discussions and in-depth interviews.

As regards the quantitative part initially a control group of 200 non marginalised residents of Tbilisi was planned but at the inception phase it was decided with MCNV that a before/after survey of 130 randomly selected out of 380 clients of the family and child care centre was a better method to detect changes. For the Gori based internally displaced persons the baseline data were compared to findings from 50 randomly selected interviewed persons. This change in methodology was decided for ethical reasons. Denying interventions to vulnerable groups was deemed unethical so a control group was not selected. Other limitations of the 2014 study are mentioned. In particular the fact it is a review of an ongoing programme, as well as the possible interference of other programmes and events that took place during the implementation. To avoid possible sources of bias other programmes are mentioned explicitly.

Due to time and financial constraints, it was decided to select four projects for an in-depth qualitative case study that were representative for the way GIP in Georgia works. Evidence from other TEA managed interventions in the country was included, together with information from the baseline surveys, annual reports and from literature reviews. Quantitative methods were complemented with qualitative methods allowing for triangulation of the findings where feasible. Criteria for the selection of these four projects have been made explicit. They include two projects in Tbilisi on organizational development and health inclusion of recipients of mental health services and Prison Aid and Juvenile Prevention, one aiming at strengthening CSO (Trauma treatment) and IGA/Livelihood in Gori and three settlements of

internally displaced people. All interventions have inter-linkages between the three result areas.

In terms of CIVICUS baseline data were collected in 2012 and a second analysis in the framework of a workshop conducted in 2014 made it possible to compare progress in civil society development in CIVICUS terms. The availability of a CIVICUS report for Georgia also facilitated the ability to use this method. Learning trajectories for the application of the 5C method has helped the monitoring of the progress over time for each organization.

Methodology used in Lao PDR

The country evaluation was conducted for three years of implementation of the TEA programme in Lao PDR (2012-2014). The final evaluation has been done with an impressive rigor and consistency, comparing baseline (2011) with the findings of the final evaluation in July 2014 (both quantitative and qualitative studies with stakeholder perceptions) in the 14 villages of Nong district and in the capital Savannakhet (especially mental health unit and Health Science College).

For the quantitative part of the evaluation 4 out of 10 target villages were selected in Non district for participation in the household focus groups. Household interviews were also held in a control village in the same Nong district with non-marginalised households. The same villages were used in the baseline study in 2011, a total of 51 non marginalised household interviews were conducted and 65 marginalised households. The idea of control villages had to be dropped because of the activities of other donors in the same villages as the sample.

The evaluation provides an overview of the context in which the TEA programme was implemented, such as (i) poverty levels and socio-economic background, (ii) situation of ethnic minorities and (iii) health related indicators. The selection process to find the people conducting this thorough evaluation (sampling method) has been mentioned in detail for target and control (= non-marginalised) groups. Limitations of the evaluation were mentioned as problems with translation of the various languages, rainy season and some stakeholders not interviewed (absent).

The registration of CBOs and NGOs in Lao PDR is a time consuming and cumbersome process and organisations are also limited in their scope and type of activities, which led the TEA programme to shift its approach in 2013 to include government sanctioned village development committees. MCNV considered 5C complex and inappropriate to measure capabilities in villages in Lao PDR, therefore initially a SWOT analysis was undertaken, later followed by an adapted, lighter version of the 5C method.

Methodology used in Sri Lanka

Information on a baseline study is not provided in the country evaluation report. A mixed methodology was utilised in the Sri Lanka country evaluation using quantitative and qualitative methods. Information was gathered from 330 questionnaires sent out to CBO members and non member beneficiaries in communities where TEA interventions were extended. For the qualitative information desk study, focus group discussions and in depth interviews were used.

The questionnaires were sent out randomly to 11 CBOs (junior partners within TEA context) in the Northern, North Central and Southern Province and the size of the sample was based on the size of the membership of the CBO. When there was no adequate membership to conduct a sample, all the members of the CBO were chosen.

Limitations in the country evaluation study encountered were first of all the delay by discussions on inconsistencies in the inception report, secondly the occurrence of flooding as well as the political situation in the country (presidential elections). Also improper documentation, change of CBO staff, difficulties in encountering and locating staff members and other members of CBOs as well as poor participation of one CBO were among the other factors hampering the country study.

Methodology used in Tajikistan

In 2011 a baseline study was undertaken on all three areas envisaged by the TEA programme. Mid 2014 an outcome / impact evaluation with both a quantitative survey (questionnaire) and qualitative research, using focus group discussions and in-depth interviews was conducted. Three projects in health were selected for an in-depth study, representative for the way GIP works in Tajikistan. Information from other TEA managed interventions in the country was included, together with information from the baseline, annual reports and literature reviews. After an extensive sampling process, a total of 180 respondents were surveyed (face to face), out of which 100 non marginalised residents of Dushanbe, 27 in-depth interviews, 11 focus group discussions and 4 case studies were undertaken. Criteria for the selection of these projects have been made explicit. Several limitations of the 2014 study are mentioned: Intervention was still ongoing in mid 2014; the late start of interventions (2012/13); the challenges of attribution; comparison between baseline data and evaluation data. It was challenging to compare data received during the baseline study because at the baseline people were involved that were not necessarily direct beneficiaries of the TEA programme.

Organizational development training (training) activities were undertaken in 2013 and 2014 (under RA 1). The report mentions reflection workshops and the learning trajectories undertaken to prepare the CSOs with adequate organizational development. The 5C framework was used with positive appraisal by the participants. A CIVICUS analysis in CSOs was done in 2012 and 2013 thus enabling the evaluators to track progress at individual level. One organization MHAIDS was not assessed because of lack of cooperation with the evaluators. From the interview with the coordinator of TEA in Tajikistan it appeared that 5C was too abstract to understand by many CBOs. It was appreciated when it was explained in more simple terms.

Methodology used in Vietnam

The in-country final evaluation was conducted after four years (2011-2014) of implementation of the TEA programme in Vietnam. The final evaluation has been done with impressive rigor and consistency, comparing baseline (2011) with the findings of the final evaluation in 2014 (both quantitative and qualitative studies with stakeholder perceptions) in the three intervention provinces for each of the three RA.

The evaluation provides an overview of the context in which the TEA programme was implemented, such as (i) poverty levels, (ii) situation of ethnic minorities (53 minorities, constituting more than half of the population and 47% of total poor belonging to an ethnic minority) and (iii) relevant changes in the law for people with disabilities, the elderly and access to credit.

The study was conducted in three provinces, Quang Tri, Phu Yen and Khan Hoa. Random samples of 50 beneficiaries were taken in four districts of the three provinces. If sampling was not possible, purposive sampling was used.

For each RA, distinctions are made between marginalised (M) and non-marginalised (NM) populations. Sample size was 140 people in two provinces and 280 people in one province for M and 40 for NM. Limitations in finding control groups were first of all the support from different sources for the target groups (government as well as donors such as World Vision, Mines Advisory Group, Plan International and the Zhi Shan Foundation). Furthermore in some areas it was difficult to find a non-marginalised group and also because of the multi-generational tradition it was difficult to find a household without an elderly.

Also at the time of the baseline study a full picture of the list of indicators was not possible as decisions on the specific interventions were still to be made , therefore the most important indicators for the interventions at the end of the country evaluation did not match the baseline data.

In terms of organizational development a baseline in 2011 and a second analysis in 2014 enabled the evaluators to track the progress that disabled people's organization and older people's associations achieved in the five dimensions. All organizational development efforts were closely linked to the various projects, thus enhancing its effectiveness. CSOs have acquired skills and experience to improve access for marginalised people. For the 5C method the country evaluation tracked the progress reports of TEA for Vietnam. In total 28 senior CBOs were tracked and 8 junior CBOs were tracked. The 5C method was adapted in a way that CBOs were able to monitor their own performance.

2. Synthesis according to the OECD/DAC criteria

The findings are structured according to the OECD/DAC criteria for evaluations: (1) relevance and consistency, (2) impact and outcome, (3) efficiency, (4) effectiveness and (5) sustainability. As mentioned before given the fact that many of the interventions have not been completed and TEA programme as defined will terminate by the end of 2015 the synthesis can only define some preliminary trends. To map the outcome we should compare the baseline data with end line data preferably one or two years after the completion of the programme and not as in this case still during the implementation period. The country study evaluators have also mentioned this repeatedly. In this chapter the findings will point at likely outcomes and impact. In some cases success and fail factors are listed based on the current implementation experience and the influence of external factors, in particular the policy environment for promoting the position of marginalised people in the five TEA countries.

The report will also list findings on the cooperation between the Dutch consortium partners and the coordinators in the 5 countries; this will in particular be relevant for the OECD/DAC criteria efficiency. The working of the TEA steering committee and the overall coordinating role of MCNV in Amsterdam is reflected in terms of decisions on allocations of budgets, decision making on methods and the organization of cross programme events. In particular the question whether the set up was deemed to be transparent or more bureaucratic is important to determine the overall efficiency of TEA.

2.1. Relevance and consistency

Relevance refers to extent to which projects will potentially contribute structurally to an approach that is more responsive to the needs of the marginalised groups in the TEA countries. The questions in the terms of reference are threefold:

- Are the intended outcomes and impact relevant in light of the aim of structurally contributing to a comprehensive approach that is more responsive to the needs of the disadvantaged groups in the five countries?
- Are the activities and outputs of the programme consistent with the intended impacts and effects?
- Are there aspects of relevance in the programme in terms of changes in inclusiveness that were not intended/foreseen in project planning?

2.1.1. Overall findings

- The combination of livelihood support with income generation activities and support for the health sector has been relevant in all five countries. The combined approach of direct assistance to marginalised groups and improved service delivery in health services has matched the demand of the target groups involved and led in general to positive responses from district, regional and/or national authorities.
- Organizational development is consistent with the intended impact of better attention and service delivery to marginalised groups but it did not necessarily in all cases

contribute to a strengthened civil society. The capacity of marginalised persons to speak up for themselves and the willingness to listen by the authorities has improved. An overall consistent advocacy approach has not been identified or indeed has not been seen as a stated goal for the interventions. The choice of the CIVICUS method is less relevant for a model where closer cooperation with the government in order to improve service delivery is chosen.

- The result area 2 livelihood activities combined with credit may be also relevant for the wider debate on the impact of microfinance and lead to more inclusive microfinance by established financial institutions, depending on the activities in the final year of the TEA programme.
- The INFI organization was originally designed as a knowledge centre, harvesting lessons learned and ideas from the field. Part of this centre was meant to benefit from the experience from the micro pensions network as spearheaded by WG. After a mission to Vietnam it was concluded that both a micro pensions set up and an INFI centre was too innovative at the time and not relevant. After consultations with the Ministry of Foreign Affairs the INFI outcome was changed and INFI transformed to be a network with knowledge, trainings and tools on inclusive livelihood and microfinance for the TEA partners and microfinance partners.
- The attention to the health and social services for physically or mentally disabled people as well as elderly is found to be relevant. Most of the times the innovativeness of the approaches has been an eye opener for the authorities and the education institutes involved.

2.1.2. Country findings relevance and consistency

In **Georgia** mental health for internally displaced persons is relevant in the current context with recent hostilities with neighbouring country Russia. Also the post-Soviet heritage resulted in social and economic problems which affected marginalised groups as well as the general population intensively. TEA is relevant as regards the attention to mental health patients, juvenile delinquents and internally displaced persons. These targets groups did not receive special attention in Georgia either by authorities or NGOs. The programme is relevant as mental health in 2010 was still very much dominated by state and institutionalised services, providing very little patient-centred care and support. The TEA programme has been instrumental to bring new and innovative ideas into the mental health arena, in such a way that various ministries became interested and changed their approach because of the good and convincing results GIP was able to show through the TEA programme.

The combination of organizational development with targeted income generation activities is also found to be relevant. The strengthening of 13 civil society organisations, including professional associations through interventions in result area 1 combined with practical activities of result areas 2 and 3 means that the capability to deliver to marginalised groups has improved. In turn this has led to attracting the attention of the authorities meaning that the holistic approach of TEA can be deemed relevant for a wider impact than the direct beneficiaries of the project only. The experience and professional approach of GIP and Elkana has helped to identify relevant areas of operation.

Georgian civil society is very fragmented and in general an absence of a common agenda hinders the contribution of individual organisations to the sector as a whole. These conditions affect the relevance of some of the interventions under RA 1 according to the country evaluation report. They would have chosen the inclusion of more CSOs in order to be relevant to the strengthening of civil society as a whole.

Lao PDR is a country in economic transition with uneven benefits for the population. 75% of the population lives in the countryside, of which 30% are poor. Many marginalised minority groups live in remote areas where social and health services are scarce. Only 8% of the villages have access to a health centre. The attention for 14 ethnic communities in rural areas is therefore relevant and can lead to influencing a more inclusive comprehensive approach by the district and national authorities.

The relevance of organizational development in result area 1 has been hampered by the choice of methods (CIVICUS and 5C) which were too abstract for the target groups. Efforts were made to contextualise them for village development communities. The civil society is still weak in a transition country with a very dominant position of state structures within communities. The creation of village development committees to overcome the absence of CSOs has been relevant in this context.

Result area 2 interventions with concrete income generation activities and a revolving fund (e.g. rice banks) are relevant for the marginalised groups. Surveys have shown that they are popular and especially demand for the rice banks has been high. The country evaluation deemed the small scale livelihood support in agriculture consistent with the intended impacts of the programme.

The practical difficulties such as level of access to internet, language capability for health staff in Lao PDR means access to health policy related information is limited. This makes the TEA interventions in result area 3 relevant. Peripheral remote health facilities are very scarce (8% coverage) and primary mental health care needs are largely unaddressed even in the cities. Nong district is among the most remote and poorest. The support provided by TEA therefore sets an important example for the provincial and national health policy makers by showing good results from the simple but essential interventions with the use of village health volunteers and traditional birth attendants, good relations of the village health centre with district authorities and attention for mental health care. Staff of health facilities and teachers in one medical school have been capacitated with knowledge, skills and a more user-responsive attitude, showing good results, thus being a very effective and relevant intervention in Lao PDR.

In terms of synergies between the result areas the creation of grass roots communities and the practical cooperation with the authorities has led to positive feedback from all sides. The capacity to speak up for themselves, to organise themselves in groups is appreciated and the authorities consider the groups as spokespersons positive for a constructive dialogue. A concerted effort by MCNV to showcase aggregate results in 2015 may help wider impact for result area 2 and 3 in light of the high relevance of the interventions.

In **Sri Lanka** the context for TEA programme is defined by the rapid economic development of the country and the violence related to the conflict in the North and the military campaigns in the recent past. The rising living standards have increased the life expectations leading to a growing proportion of retired persons. The pacification of the country after the military

operations in the north of the country ended, has led to the possibility to reach out to marginalised groups there again.

The restrictive climate for civil society development in terms of freedom of expression and room for dissenting voices is expected to improve. The development of CBOs should be seen as development of civil society in a harmonious relationship with district authorities to improve services as well as improved wellbeing and self-esteem. Several of the older people organisations are managed by retired civil servants. The relevance for TEA to build an independent civil society is expected to be quite limited. NGOs and CBOs involved in mental health care who are managed by GIP fall outside the scope and relevance for civil society building is not discussed in this report

The organization of elderly in CBOs is relevant. The improved self-image by being engaged again is relevant where elders lose their status as head of the family. The relative high level of education means there is management capacity available to lead the groups. These characteristics make the TEA approach relevant to address the needs of marginalised groups.

The availability of microfinance for elderly is limited and limited opportunities for income generation (pension benefits decrease with acquired additional income). The creation of income generation activities as a group establishing a de facto social enterprise with proceeds serving those disabled or sick elderly unable to participate is an intervention consistent and relevant in the local context.

In **Tajikistan** the relevance for TEA programme is clear. The voices of marginalised groups are not heard and the efforts to include the elderly and disabled in government policies are relevant and needed in a country with major social and economic problems. Tajikistan is highly dependent on the income of remittances by foreign workers. The economic problems in Russia directly affect the level of income of many families in Tajikistan. The unstable region affects the social situation with high occurrence of drug abuse and crime. Corruption in Tajikistan is systemic and affects all areas of the public service.

Given the hard conditions for civil society groups in Tajikistan the capacity to deliver results for the target groups is relevant and result area 1 activities for strengthening civil society as such are among the most challenging. A wider impact of influence of civil society can be expected mainly through result area 3 where the cooperation with the authorities is most promising, albeit still in a nascent stage.

The relevance of creating income generating activities for disabled and elderly is demonstrated. The promotion of more inclusiveness by realizing concrete pilots can be instrumental in generating more attention to the overall situation of these marginalised groups. The country evaluators note the absence of awareness raising or communication strategy which can increase the relevance for the target groups as a whole. For the direct beneficiaries the activities were consistent and relevant. The positive impact ending isolation and helping the peers to communicate for the participants in the income generating activities is relevant and can serve as an example for other marginalised groups.

The interventions of result area 3 are relevant as attention for vulnerable groups, such as the elderly and mental health patients in 2014 is still dominated by the government and its institutionalised (rigid, old-fashioned) services, providing very little new and patient centered

care and support. The TEA programme has been instrumental to bring new and innovative ideas into the support for the elderly and recipients of mental health services, in such a way that the Ministry of Health and Social Protection for the first time established a forum for collaboration on these topics with civil society, sealed in a formal MoU with GIP on care for recipients of mental health services and the elderly. Over time this could become a focus for change and reforms, if managed with care. Unfortunately, the TEA programme has not given enough attention to the need for awareness raising or communication for policy makers as yet, health care providers and others involved in supporting those still have no voice in the country. The late start of the activities at the end of 2012 meant that relatively more had to be done in a very short time compared to other TEA countries.

In **Vietnam** the relevance of TEA programme has been demonstrated for all result areas.

Even though Vietnam is showing significant progress in attaining the Millennium Development Goals, in terms of the progress in the Human Development Index the progress has been much more modest. UNDP attributes this also to the growing disparities within society, where TEA programme aims to address the uneven progress in the living conditions of marginalised ethnic groups in rural areas.

For result area 1 the civil society organisations have been able to strengthen their internal management leading to being better able to deliver results. This in turn has been beneficial for bringing results for result area 2 and 3, making the combined approach of TEA relevant for the Vietnamese context. For result area 2 the relevance of introducing social performance standards for community based microfinance is high as credit can be better understood and accepted when part of a wider approach beyond finance.

Ethnic minorities are confronted with multiple disadvantages in Vietnam, which is one of the reasons for slowing down of government development efforts (growing disparities) and a continuation of inequality compared to the majority ethnic group. As the word 'minority groups' has different meanings in different locations, the TEA intervention focused its support on the elderly, the handicapped and the mentally challenged. The MCNV has rightly used a comprehensive health care approach, engaging CBOs and NGOs as well as working with commune health centres and district hospitals to address the needs of these minority groups. Staff of health facilities and teachers in one medical school have been capacitated with knowledge, skills and a more user-responsive attitude.

2.2. Outcome and impact

Outcomes within the framework of this study are defined as those results which show changes in the behaviour, characteristics and performance of state and non-state actors involved in the programme in the mid-term, i.e. two to four years. Impact is defined as results demonstrating changes in the lives of the beneficiaries. As mentioned in chapter 2 the information gathered in the baseline is not always complete or reflecting the indicators in the monitoring protocol which was agreed upon after the baselines had been established. The country evaluation reports in some instances were unable to select a control group for ethical reasons or contamination due to exposure to other donor initiatives. A before/ after analysis has been made in case a control group selection did not take place. Quantitative methods

were combined with qualitative methods to allow for triangulation of findings where feasible. The mid-term outcome and impact at this point in time however can only be an estimation and point at possibilities and likelihoods. Appendix 1 which sums up the progress for the different outcome targets under result areas 1,2,3 provides an indication for the potential of TEA to produce outcome and impact for marginalised groups. The overview per country here should be read in conjunction with this appendix 1.

In the monitoring protocol the impact is defined as:

- Interventions in the result areas 1,2 and 3 impact the lives of marginalised people in terms of better living conditions and access to better quality services.
- The attribution of the interventions to the improved situation for the marginalised groups.
- Change in behaviour of the state and non-state actors involved, inter alia health authorities, micro finance institutions, district level administrators leading to the formulation of better policies or the adaptation of policies for the benefit of marginalised people.
- Unforeseen impact derived from the interventions.

2.2.1. Overall findings

- On the basis of the methodology used, the comparison with incomplete baseline data and the timing of the evaluations it is quite hard to provide reliable conclusions about outcomes and impact.
- The organizational development of CSOs involved in TEA may impact the lives of the target groups positively as the delivery capacity has improved for almost all CSOs trained.
- With the inputs and/or when the credit as part of result area 2 interventions, the NGOs and CBOs are likely to be able to produce outcomes which can improve the lives of the beneficiaries. Attention to sustainability of the interventions is needed to secure impact over time (see para 2.5.1).
- The positive changes in the behaviour of state actors in the five countries in the areas of mental health and social services is in many instances likely to produce improved policies with the potential to impact on the lives of marginalised people positively.

2.2.2. Country findings outcome and impact

For **Georgia** outcome and impact in result areas 1, 2 and 3 are difficult to determine at this stage of the programme as the programme is currently still being implemented. As can be seen in appendix 1, outcomes in the three result areas have been achieved up till now according to plan.

The recent country evaluation report (December 2014) shows positive results (both in terms of outcome and impact) in the area of organisational development. The various junior and senior NGOs improved their internal organisation. These changes have contributed and even were essential for the technical and content related achievements of the various NGOs

involved. The country evaluation report describes that the three result areas taken together have the potential to converge to create impact for marginalised people in Georgia. According to the country evaluation there is a need to create awareness about the comprehensive approach and form more integrated partnerships. The advocacy capacity of civil society has improved and evidence of solid impact on the national policy level was found in the areas of mental health, internally displaced people and prison psycho rehabilitation services. The TEA programme has made an impact in the dimensions of trauma effect reduction and improvement of access to mental health and social services. The elaboration of the Mental Health Action Plan and the leading role of GIP means that potentially the outcomes of TEA programme may be sustained and lead to further impact for marginalised people in Georgia in the future beyond the relative small group of current TEA beneficiaries.

For **Lao PDR** outcome and impact in result areas 1, 2 and 3 are difficult to determine at this stage of the programme. This synthesis report is premature, as the programme started only in 2012 and there was still one year to go when the country evaluation was conducted in July 2014. Perhaps the most important outcome of the TEA intervention is the introduction of village development committees in the 14 villages that proved effective to introduce new development and health related interventions through the four sub-groups and the health related steering committee. All partners increased in competency over these three years and as a consequence quality of (health) services improved. However, it is too early to measure impact. Other outcomes in result area 3 are the opening of the first mental health unit outside the capital and the development of a new mental health curriculum for nurses by Savannakhet Health Science College that has been approved by to the Ministry of Health. As a result, marginalised and mentally ill people have better access to services and easier referrals to higher level of care.

On the outcome level of result area 1 the creation of village development committees laid a strong foundation to implement livelihood projects. The demand for microcredit under result area 2 has increased but is still low. It raises the question whether credit is the right product in these circumstances. The evaluation study states the impact may be limited because of the insufficient confidence to pay back the loans, with the exception of rice banks where responses were more positive. Rice banks provide rice during shortages, which means persons do not have to leave their village to search for employment. This is a direct and important improvement. Local services under result area 2 for agriculture and animal care mean better chances for higher food security for marginalised people. Unintended impact was created in terms of the provision of clean water supply. The need was identified and in the framework of the TEA programme it was decided to respond to it with boreholes and pipelines.

As cross cutting outcome is the increased cooperation with district authorities. In the country evaluation the authorities were happy with the creation of the village development committees, having a counterpart and an ally to improve services in rural areas for marginalised people. This may potentially lead to better impact on the lives of marginalised people through better service provision by the government structures.

For **Sri Lanka** the most likely impact to be expected is the improvement in the income generation capacity of elderly people, as positive results so far reported in the country evaluation report are encouraging. After the TEA programme will have finished the revolving funds could continue with sufficiently strong management of the funds in place. A federation

of the community based elderly groups could potentially take over technical assistance and administrative guidance to sustain the income and credit facilities in the villages. Obviously this remains to be seen and the most direct outcome is an improvement in the incomes and the well-being of the direct beneficiaries as noted in appendix 1.

The strengthening of management capacity at CBOs involved and the creation of deputy leaders also laid down in new constitutions may lead to lasting impact for effective income generation among the communities involved. Positive returns combined with sound management provides a solid basis for many CBOs to sustain positive impact on the lives of their members.

Remarkable achievements have been made in result area 3: the training programmes have improved knowledge and skills of health care volunteers, CBO members and families to provide better services to older people, people with special needs and recipients of mental health services. At least 68 people with special needs have been identified in the communities and some 450 people with special needs received treatment. The training of health staff has improved the quality of treatment of these three groups in the hospitals where TEA has been active. Relations between the communities, the health care volunteers and the health and local government institutes have improved positively. Overall the likely outcomes and potential impact for result area 3 is probably going to be positive.

For **Tajikistan** outcome and impact in result areas 1, 2 and 3 are difficult to determine at this stage of the programme, particularly because one year was lost due to internal human resources problems at GIP in Tajikistan. Most interventions started at least one year later and were already externally evaluated in the second and third quarter of 2014. Hence the actual duration of the various interventions was in effect only some 2.5 years at the time of the country evaluation. Assessing impact and outcome over such a relative short period therefore becomes rather premature.

As regards the outcomes in result area 1 management capacity of CSOs has improved substantially over the past two years and this has led to better service delivery to marginalised groups. The strong advocacy demonstrated towards the Ministry of Health and Social Protection has resulted in better access to health for elderly.

As can be seen in the appendix 1, result area 2 contributed to direct impact of the lives of the beneficiaries. The wider impact of positive examples of disabled people being (self) employed can be further improved with more dissemination of the results and a communication strategy coordinated by GIP.

For result area 3 a limited number of good results have been documented for the elderly at the Central Asia Gerontology Centre, for persons with mental health problems (Centre for Social Support Mental Health & Centre for Mental Health and AIDS) and structurally through the MoU with the Ministry of Health and Social Protection. The platform for CSOs will help the monitoring of 32 gerontology rooms. Gerontology rooms in all health centres across the country will be established. Obviously the success of these rooms in terms of actual demand and availability of a doctor is subject to sustained efforts from civil society and the authorities over the next years.

Unintended impact was noted that deaf girls improved their communication skills, widened their circle of friends and gained respect in their families which will lead to a considerable improvement in their living conditions and social acceptance.

For **Vietnam** the final outcome and impact in result areas 1, 2 and 3 is difficult to determine at this stage of the programme with a lot of activities still taking place in the last year of implementation.

The impact of result area 1 interventions can impact the lives of the target groups indirectly because the civil society groups are better able to reach the groups and deliver the services needed. In Vietnam an elaborate and comprehensive approach was followed also based on the professional and long experience of MCNV in Vietnam. CBOs and NGOs involved developed networks with existing health centres as well as the capacity to advocate on behalf of marginalised groups to the authorities. The mapping of progress in 5C terms over three years and the monitoring by MCNV provide indications that organizational development thanks to TEA has improved significantly leading to better chances for reaching marginalised groups with better services or assistance.

With regard to result area 2 the provision of microfinance to 1513 more people and technical assistance for livelihood activities are likely to impact the lives of the target group positively. Besides TEA interventions, the parallel provision of microfinance by the Vietnam Bank for Social Policies has improved access to microfinance over the period 2011-2014 by 120% in terms of number of loans provided. The fact that parallel sources were available made it hard to conclude from the surveys what impact can be attributed to the TEA intervention. The majority of the respondent indicated the loans were for agricultural investments or other small businesses. A large proportion of respondents deemed the loans very useful (48% marginalised, 56% non-marginalised) in the intervention area. In the control group these percentages were much lower, 33% and 40% for marginalised and non-marginalised respectively. This could also indicate a positive impact of technical assistance combined with the micro lending. The research cannot establish attribution since different sources of credit were available in the intervention area.

For result area 3 it is unclear whether a difference in health status between Marginalised (M) and Non Marginalised (NM) villages can be found between 2011 and 2014. While it seems from the table below that the health status has worsened between M and NM, other factors, like higher age groups interplay, making a final judgment impossible. Similarly, differences between 2011 and 2014 for hygiene (diarrhoea), Malaria, the number of people with disability and immunised children or children with malnutrition do not provide clear answers to improvements in impact as regards health status over these three years. Attribution to the TEA programme is not possible.

While improvements in health status between 2011 and 2014 are difficult to 'prove', utilization of the various available services has increased substantially, thus providing information, treatment and care opportunities for the various disadvantaged populations (PWD, PMHP and elderly). The training and involvement of the village health workers associations, their relations with the health facilities (CHC, district hospitals) and the support by the CBOs and NGO's together have allowed the TEA programme to provide an effective (and comprehensive) intervention that is likely to impact the ethnic minorities in these three provinces (in utilization) positively, even if health status improvements cannot be verified.

2.3. Efficiency

Efficiency assesses how economically the resources (inputs) were used, and how they were applied and converted to direct results. Efficiency describes the relationship between input and output in financial terms. The questions in the terms of reference are the following:

- Have appropriate inputs been deployed at the lowest possible costs?
- What is the relative expenditure for activities in the Netherlands and in the target countries?
- Have activities been implemented in the most suitably uncomplicated manner, securing professional standards?
- Have decisions been made at the right level?
- Has bureaucracy been avoided as much as possible?
- Have overhead costs been kept to a minimum?
- Has duplication been avoided?
- Have conflicts during implementation been prevented or solved?
- Have outputs been achieved within planned periods and budgets?

The findings in this paragraph are based on the country evaluation reports, the interviews and the annual (financial) reports. An overview of costs per result area per country over the years of TEA implementation so far has been provided with overhead costs as well. As this assignment does not allow for a benchmark study nor for a sample study of detailed files or expenditures of individual organisations, the questions on efficiency cannot be fully addressed. The findings are of an illustrative nature mainly.

In the annual and financial reporting the result area 4 is mentioned, which described the cross country learning events which took place in the form of conferences. The learnings among the consortium partners are documented in conference reporting and the positive results are supposed to be reflected in the performance against all OECD/DAC criteria. In the conclusions and recommendations phase some findings as regards the result area 4 financed conferences will be presented. As an illustration the conference summary of the 2015 conference in Colombo is attached in appendix 3.

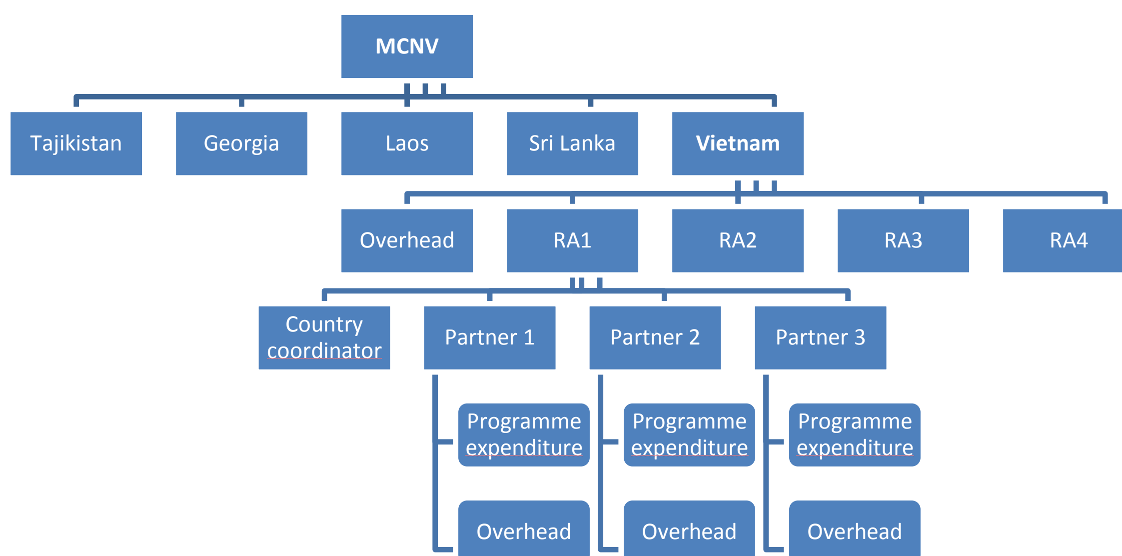
2.3.1. Overall findings

- Between 2011 and 2013, the total expenditure of the TEA programme amounted to EUR 4.3 million out of the total financial envelop of EUR 8 million. At the time of reporting figures for 2014 were not yet available.
- The TEA programme constitutes of three Dutch consortium partners, five country coordinators, various subcontracting civil society organisations and three substantive result areas and one additional result area with various distinct activities. This set up in itself is not conducive to an efficient implementation. Nonetheless given this elaborate and detailed set up in line with the subsidy guidelines of the Ministry of Foreign Affairs for MFS-2, the TEA programme can be described as reasonably

efficient up till now. It is noted that in many cases overheads and organizational costs have been kept to a minimum.

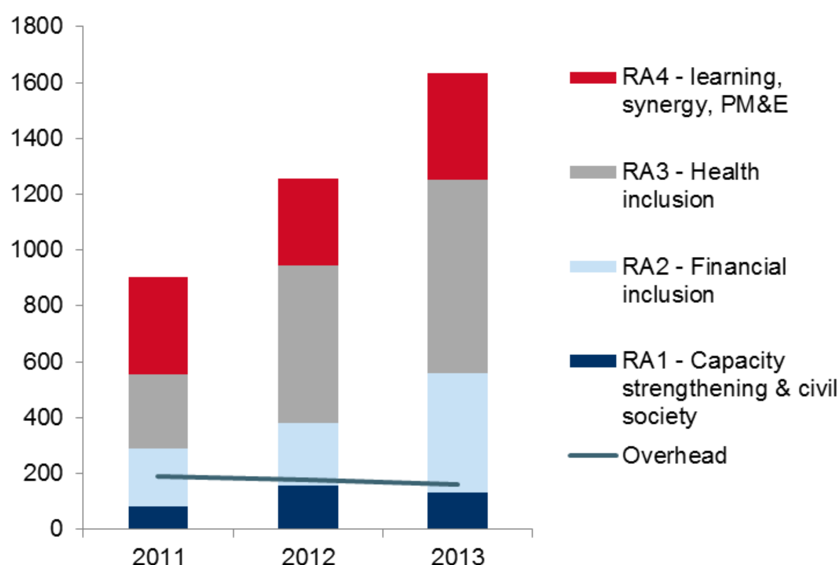
- Expenditures for learning and communication have been relatively high, in part a consequence of a five country approach with three Dutch main partners. The efficiency of international conferences is generally hard to measure even with proper reporting and follow up exercises. The 2015 conference in Sri Lanka , attended by Carnegie Consult, followed best practices in learning, active participation and reporting.

Graph 4: Organisation and expenditure flows TEA programme (Example MCNV in Vietnam)



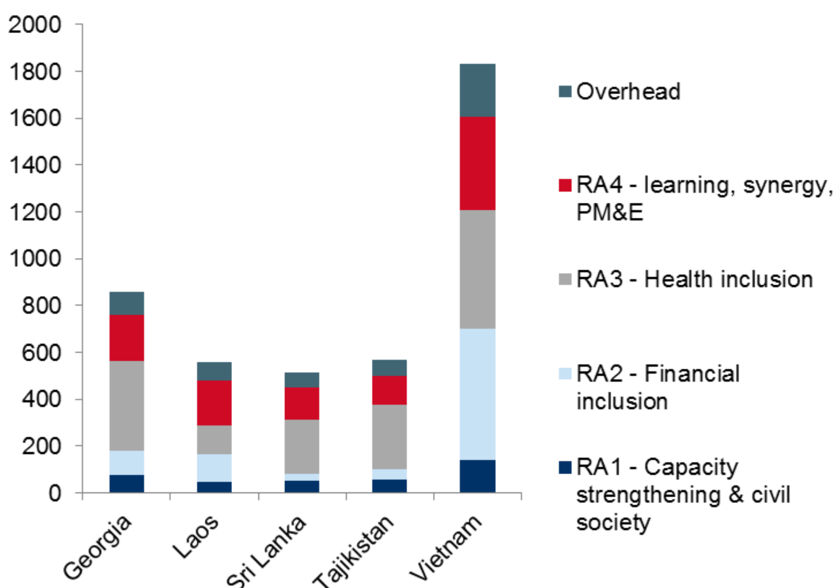
- During 2011-2013, 88% of total expenditure was spent on programme related activities and 12% on overhead of the three consortium partners (in the Netherlands). The overhead costs as defined by the consortium fall within the limits of 20%, indeed in the later years it is close to 10%. This does not include overhead costs of implementing partners as the organizational strengthening of the local parts can be seen as part of the outcomes for TEA.
- Programme expenditure was highest in result area 3 (EUR 1.5 million), followed by result area 4 (EUR 1 million) and 2 (EUR 0.9 million). Result area 1 was lowest with EUR 0.4 million).

Graph 5: Expenditure per year and result area (x1000)



- The largest country in terms of expenditure is Vietnam. Expenditure amounted to EUR 1.8 million across all result areas (including overhead). With EUR 0.9 million, Georgia is the second largest beneficiary country, while Lao PDR, Tajikistan and Sri Lanka all range around the same total expenditure of EUR 0.5-0.6 million.

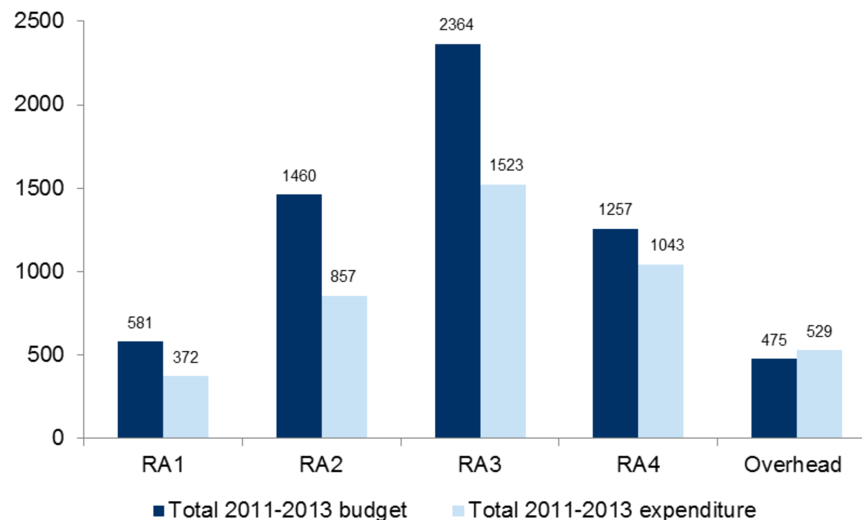
Graph 6: 2011-2013 expenditure per country (x1000)



- Expenditure across all countries, partners and result areas was at 77% of budgeted expenditure between 2011 and 2013. The main cause for the underspending was the incomplete picture at the time of submission of the budget of the planning of the TEA programme over the years. The revised planning was discussed with and approved by the Ministry of Foreign Affairs.

- Underspending occurred especially in the beginning of the programme, in 2011 (72%) and 2012 (68%). In 2013, expenditure increased to 90% of budgeted expenditure.
- Underspending was most visible in result area 1, 2 and 3. Expenditure on Synergy and Learning (result area 4) was closest to budgeted expenditure (83%). Result area 2 shows the lowest expenditure compared to the budget (59%).
- Expenditure on overhead costs was slightly higher than budgeted during the evaluation period (111%).

Graph 7: 2011 – 2013 budget vs expenditure (x1000)



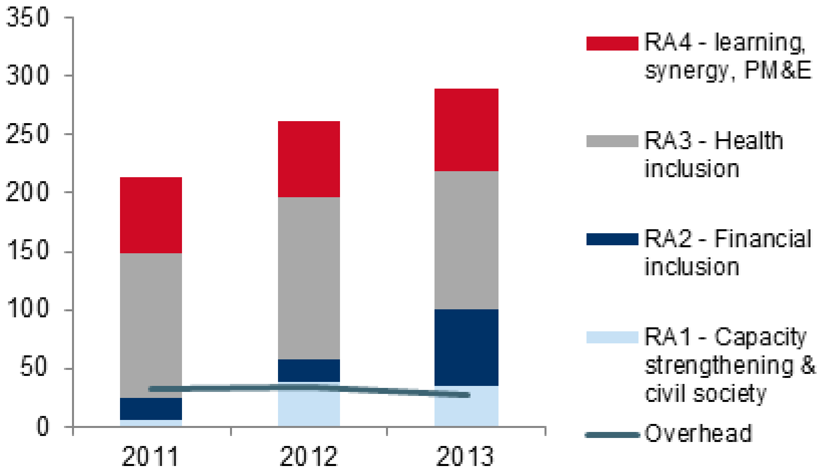
- 88% of *programme* expenditure was made in beneficiary countries. This is more than the 80% objective agreed with the Ministry. These 88% also include expenditure of the country offices/ coordinators. By result area, expenditure in beneficiary countries was highest in result area 1 (85%) and result area 2 (83%), whereas relatively more expenditures for result area 3 and result area 4 were made in the Netherlands with 33% and 45% respectively.
- No party in the Netherlands or in one of the five countries has complained about unnecessary procedures or bureaucracy. The steering committee, the coordinating role of MCNV and the country coordinators all decided on their level what they had to do. No competition or unclear responsibilities were noted in the country evaluations or the interviews. In light of the complex set up this is noteworthy and testimony to the harmonious nature of the cooperation and the professionalism of the organisations involved.

2.3.2. Country findings efficiency

Georgia is the second largest country in terms of expenditure within the TEA programme. Between 2011 and 2013, EUR 0.85 million were spent on this country, which is only 55% of budgeted expenditure however. Most expenditure was made in result area 3, with followed by result area 4 and result area 2. Overhead costs were with 11% the lowest (relatively) across all countries. This is still 114% of the budgeted amount however.

In general, the efficiency was rated positively by the country evaluation report. The programme activities were delivered well within budget and an impressive number of beneficiaries were reached according to the country evaluation report. The approach with a reach on both micro, meso and macro levels was also considered efficient in the health interventions of result area 3. In result area 2 the decision to engage Elkana is judged to be contributing to an efficient implementation in particular, in practice delegating almost all the work.

Graph 8: Expenditure Georgia 2011-2013 (x1000)

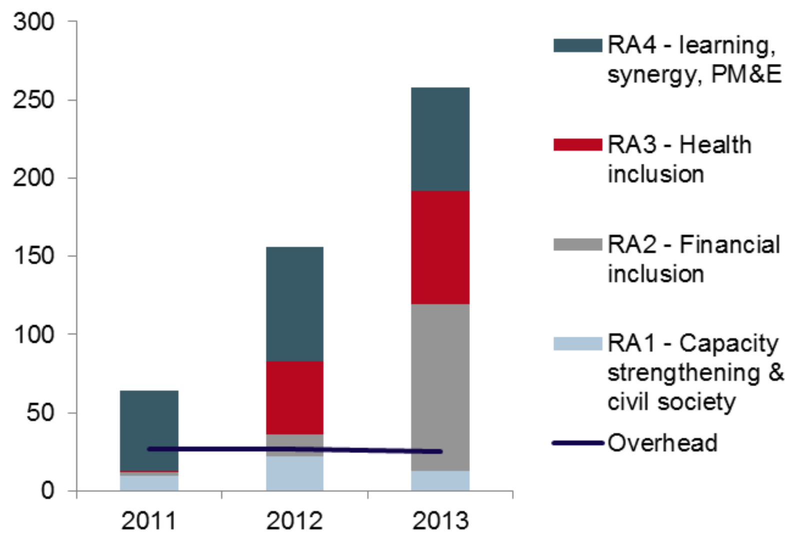


Lao PDR is the second smallest country in the TEA programme and the least efficient in terms of expenditures vs planned budget. Total expenditure between 2011 and 2013 amounted to EUR 0.56 million, which is 52% of the foreseen budget for this country. Spending has been highest in result area 4 (synergy and learning) followed by result area 3. Given the small total expenditure, overhead costs were relatively high at 14% with 102% expenditures compared to budget.

The efficiency of TEA programme is rated positively by the country evaluation report. The support of the government which was leveraged has resulted in an efficient operation. The simple techniques minimised the risk for efficiency losses, although the low literacy has hampered smooth implementation of operations, according to the evaluation report. The country evaluation deems it a good approach to combine a top down and bottom up approach. Sufficient support for local partners to speak up and implement projects themselves was provided while at the same time cooperation took place with the government to improve the health infrastructure. This leads to a wider impact for more people than envisaged (5000 villagers only), making TEA a more efficient approach with lower cost per beneficiary. The contribution from the villagers and local counterparts, often on a voluntary basis has reduced costs and improved efficiency.

The abstract methods in organizational development are however less efficient. The methods had to be adapted radically to be able to be understood in the Lao PDR rural context. The added difficulty of a language barrier has also hampered a smooth approach in organizational development.

Graph 9: Expenditure Lao PDR 2011-2013 (x1000)

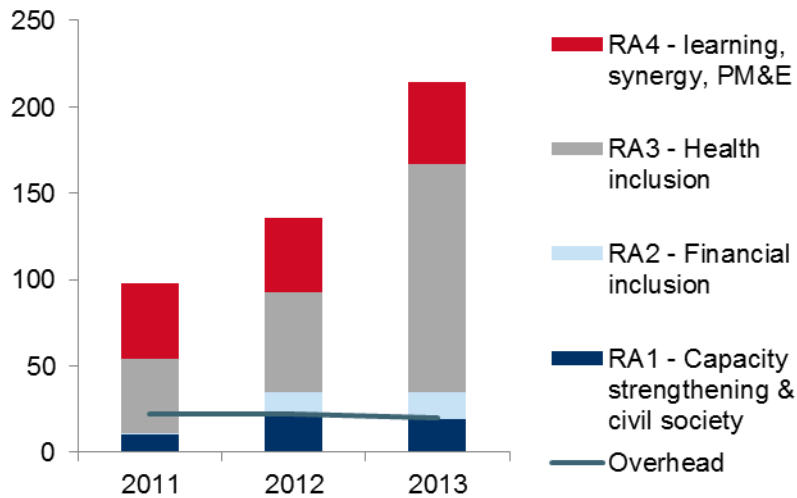


In Sri Lanka the country evaluation report did not include an analysis on the efficiency of TEA operations.

Sri Lanka is the smallest of the five TEA countries in budgetary terms. With EUR 0.5 million over 2011-2013, it reached 71% of budget expenditure. Health is the most important result area in Sri Lanka, followed by synergy and learning and capacity strengthening & civil society. Overhead costs stood at 12.5%, which is 106% of the budgeted amount.

With EUR 0.5 million spread across three years and a large number of activities, it can be questioned whether efficiency of implementation is high in Sri Lanka. Also the choice has been made to provide direct assistance by GIP to some CSOs outside the coordination of the country coordinator Sarvodaya which also may affect the overall efficiency of operations. The experienced coordinator Sarvodaya however can help on the other hand to secure smooth implementation. From interviews it became clear that a critical assessment of CBOs took place and when needed TEA interventions ended in a community/ at the CBO. In interviews the relations between WG and Sarvodaya were reported as good although recently the capacity of WG has diminished with the departure of the dedicated TEA programme coordinator. However, as said the scope of this evaluation is too limited to allow for reliable judgments of this kind based on triangulation of the initial findings.

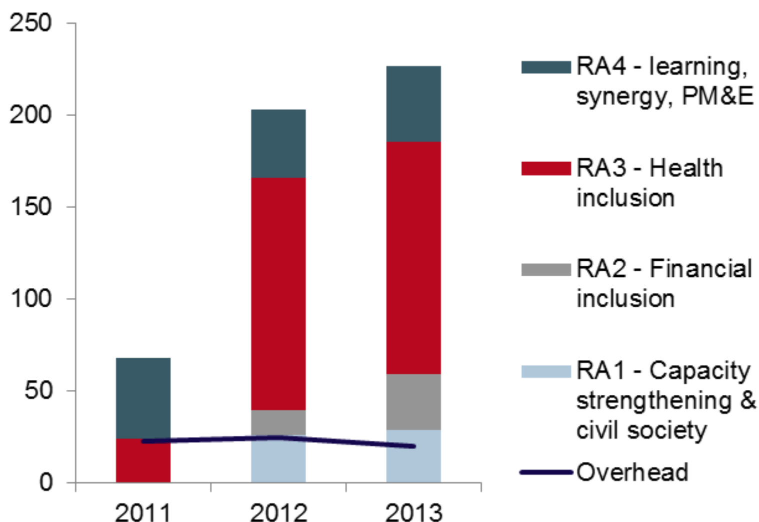
Graph10: Expenditure Sri Lanka 2011-2013 (x1000)



Tajikistan is the third smallest/biggest countries of the TEA programme in terms of expenditures. Total expenditure amounted to EUR 0.57 million over 2011-2013, which is 81% of the planned budget for this period.

As per result area, result area 3 accounts by far for the highest spending, followed by result area 4, result area 1 and result area 2. Overhead costs were 12% of total expenditure up till now, slightly more than budgeted.

Graph 11: Expenditure Tajikistan 2011-2013 (x1000)



In Tajikistan the country evaluation report considers TEA programme to be efficient in its implementation. It commends the modest office of GIP and limited staffing (three persons) and especially the low cost of two livelihood projects (EUR 2500) where one of them also leveraged additional financing from IFC.

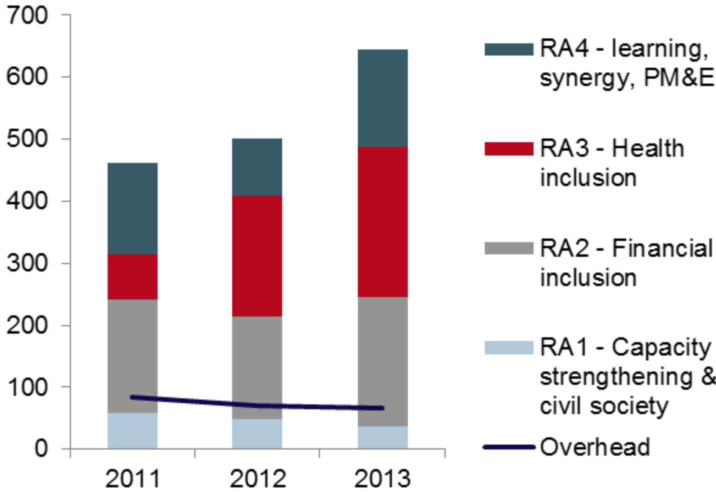
The hard work which was accomplished in a more limited time is impressive, making up in part for the inefficiency in the first year and half of operations.

Vietnam is by far the largest of the five TEA countries, and at the same time the only country with close to budget spending. Total expenditure between 2011 and 2013 amounted to EUR 1.8 million, which is 87% of the budgeted amount.

In Vietnam, spending has been highest across all result areas. Result area 2 and result area 3 account for the largest expenditure, followed by synergy and learning and capacity strengthening.

Overhead costs are obviously highest for Vietnam in absolute terms, but still in the range of 12% of total expenditure.

Graph 12: Expenditure Vietnam 2011-2013 (x1000)



The country evaluation report indicated that because of the strong and longstanding position of MCNV in Vietnam it was able to establish connections with authorities in many parts of the country easily and use the resources such as meeting rooms or health facilities. The organizational capacity of MCNV meant that efficiency gains could be achieved making use of existing budget, expertise as well as infrastructure which amounts to a de facto co-financing from other MCNV income to the TEA programme.

Also the hiring of local consultants helped to keep the costs for implementation low. The report also mentions the synergies created by the cooperation between MCNV, GIP and World Granny but this could be questioned as all these parties are financed from the TEA budget and include their respective overhead costs.

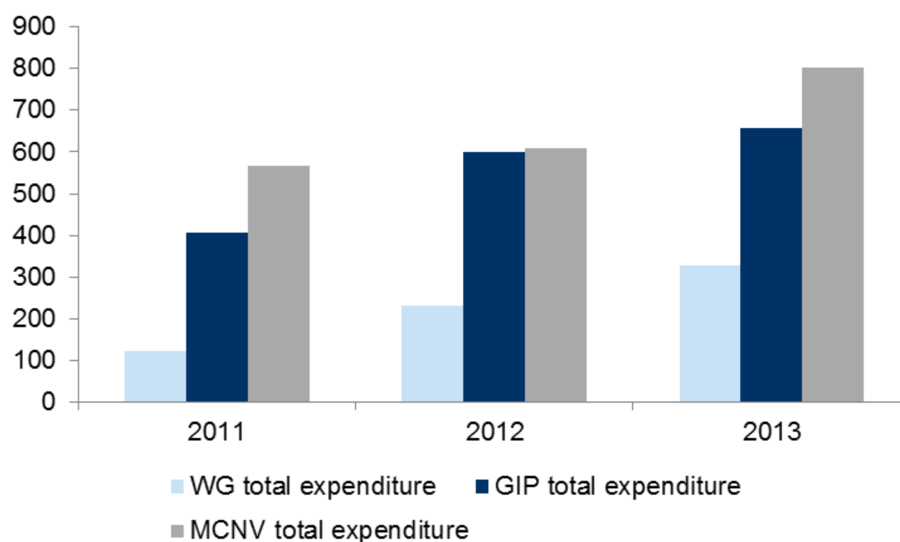
2.3.3. Efficiency among MFS-2 consortium partners in the Netherlands

Specific questions in the terms of reference were asked for the overall ratio between expenditures in the Netherlands and expenditures in the field. A separate question is on the overhead of the different organisations and whether unnecessary burden of bureaucracy was created by the consortium of three Dutch partners and five countries of operation.

Below we present the main findings based on an analysis of the (financial) reports of 2011-2013:

- 88% of programme expenditure was made in beneficiary countries. This is more than the 80% objective agreed with the Ministry. It should be noted that these 88% include expenditures of the country offices/ coordinators. By result area, expenditure in beneficiary countries was highest in RA1 (85%) and RA2 (83%), whereas RA3 and RA4 was more evenly distributed between the beneficiary countries and the Netherlands with 67% and 55% spend in beneficiary countries respectively.
- Highest expenditure over 2011-2013 is reported by MCNV with almost EUR 2 million, followed by GIP with EUR 1.7 million and WG with EUR 0.7 million.
- GIP's total spending is closest to budget with 90%, MCNV reports 77% and WG 56% of budgeted expenditure.
- As regards performance of spending close to budget, GIP scores best with 87% of budget spent, MCNV follows with 75% and WG stands at 51%.
- Overhead in relation to total expenditure is highest for WG (15%), followed by GIP with 12% and MCNV with 11%. GIP has substantially higher overhead expenditure than foreseen, with 22% more costs than the initial amount budgeted.

Graph 13: Expenditure per consortium partner 2011-2013 (x1000)



2.4. Effectiveness

Effectiveness describes the extent to which the results of the interventions (the outputs) contribute to sustainable achievements (the outcomes). For this synthesis we have mainly asked the question to what level the outcomes can be attributed to the TEA programme interventions. The counterfactual, what would have happened if the intervention had not taken place, can be reconstructed to a limited extent. As reported in chapter 1 in some country evaluation reports control groups were selected, but most often this did not happen because of similar donor interventions affecting the control group or for ethical reasons. A before/after analysis has been made in those cases and the country evaluation reports

attempted to describe the progress achieved over time. Quantitative methods were combined with qualitative methods to allow for triangulation of findings where feasible.

The questions in the terms of reference are the following:

- Can changes be measured in the outcome variables in comparison with the starting levels of those variables?
- How do stakeholders perceive the contribution of the TEA programme to the changes measured? Do they see other factors that can have led to the changes?

2.4.1. Overall findings

- For the result area 1 in most cases positive changes could be measured in organizational development compared to the starting level. Given the progress in organizational development for most CBOs and CSOs measured in the TEA programme up till now the result area 1 interventions can be seen as effective. This is especially the case for junior organisations who are not exposed to other interventions than TEA and the attribution to TEA is more straightforward than for senior organisations who are also learning from their work with other funders or with the government.
- For result area 2 the livelihood and microfinance activities are generally effective. The small scale, the grass roots character of the projects show results and progress over time. The revolving character of the funds is included in the design, country evaluations do pose questions on sustainability and the need for continued guidance in organizational management and keeping the administrative records.
- The activities in the framework of the INFI network have resulted in learnings across countries and have led to improved or better choices for income generating activities.
- For result area 3 the direct improvement in services in health and access to services can be attributed in most instances to the interventions organised by the TEA programme. Specifically where new services or the establishment of new health centres is in place, it can be attributed to TEA. In general result area 3 effective interventions were chosen to address the needs of marginalised persons in the five countries. This applies specifically where interventions focused specifically on the support for marginalised people by the formal (government) provided services, thus ensuring effectiveness and sustainability.

2.4.2. Country findings effectiveness

In **Georgia** an effective approach has been chosen in the TEA programme. From the amount of available information (baseline 2011/12, annual progress reports and annual plans, background documents and the country evaluation), GIP has clearly demonstrated its effectiveness in managing a substantial number of national NGO's, providing direction, updated / innovative information, training and regular support when needed and establishing excellent relations with government and religious authorities.

The changes in the lives can reasonably be attributed to the interventions of the TEA programme, without TEA the lack of livelihood and lack of health services would have implied

a sustained lower level of wellbeing among the marginalised groups. The TEA programme has introduced new activities and services previously unavailable. No other interventions took place for these specific groups of beneficiaries, for example children at risk related to juvenile delinquency prevention or internally displaced persons.

The country evaluation report states that the projects are effectively spread among the various target groups based on the needs of each group. Also the challenging external environment, the short duration of TEA and the frequent staff changes did influence operations under the TEA programme.

In **Lao PDR** the country evaluation states that there is some evidence that changes have been made in the lives of the beneficiaries in Nong since TEA programme started in 2012. Involvement in decision making and access to health services has improved. The rice banks in particular have shown positive effects for the villagers involved. It should at the same time be stated that the improvements are also due to the positive contributions of the authorities, which can be argued to be spearheaded by the TEA programme.

While improvements in health status between 2011 and 2014 are impossible to 'prove', utilization of the various available services has increased substantially, thus providing information, treatment and care opportunities for the various disadvantaged populations (people with disabilities, people with mental health problems and elderly). The training and involvement of the village health workers association, their relations with the health facilities (community health centre, district hospitals) and the support by the CBOs and NGO's together have allowed the TEA programme to provide an effective (and comprehensive) intervention that has supported utilisation of these disadvantaged groups in these three provinces. However, health status improvements cannot be verified and sustainability is not likely to be expected.

In **Sri Lanka** the effectiveness is rated as positive, which can be derived from the overall findings for the Result Areas in the country evaluation report. The report did not find interventions who were not deemed effective. The report finds that well qualified and experience personnel have been employed in the training programmes and the NGOs involved played a key role in effective delivery.

The livelihood and microcredits delivery was implemented with in general a positive response and encouraging demand. Derived from this it may be concluded from the report that an effective approach has been chosen. The lobby activities in the microfinance sector have not been included in the country evaluation report. From interviews with Sarvodaya , WG and the INFI coordinator at MCNV it appeared that a dialogue has been established with microfinance institutions and the two lobby events held may prove to lead to sustainable outcomes in the sense that older people up to 70 years are now also eligible for credits.

In **Tajikistan** the effectiveness has been affected by the 'troubled start' of the TEA programme, being the weak capacity of the management team in 2011. After the change in leadership activities started at the end of 2012 or beginning 2013 only. Furthermore a weak baseline study did not provide suggestions on how the TEA programme for each of the result areas could be better designed and implemented.

Other delays affecting effectiveness was with Central Asia Gerontology Centre that had to wait eight months for permission by Ministry of Health and Social Protection to start the

gerontology rooms. It was thanks to GIP that this issue was solved and the MoU was signed. The NGO MHAIDS (home care) had to wait many months for the psycho-neurological department to cooperate and provide care for people with mental health problems.

The combined interventions for organizational development for the CSOs involved in TEA with practical livelihood activities or health related interventions has been seen as effective by all stakeholders involved. Yet when there is very little or no previous knowledge about the sector, organizational development in itself may not suffice. The NGO MHAIDS lacked knowledge and experience and the effectiveness was hampered. The refusal of MHAIDS to cooperate in the country evaluation does not allow to take a view on their performance.

The overall public relations and awareness raising for the TEA programme has not been very effective or focused up till now.

In **Vietnam** the country evaluation report deems the improvements in organizational development to be related to the TEA interventions. The improved capacity of CBOs and NGOs to network and to advocate for marginalised groups can be attributed to the trainings provided with the TEA programme. The frequent monitoring of the progress by the groups involved has provided a more systematic approach to organizational development previously unavailable in the Vietnamese context.

Within result area 2 the effectiveness is much harder to determine. The parallel provision of microcredits through state sponsored schemes makes it difficult to distinguish the effects as perceived by the beneficiaries. The selection of control groups in the country evaluation leads to conclusion that there is to a small extent some improvement in the livelihoods thanks to the provision of micro credit. The income generation activities are seen to be effective in design: the ownership of the communities for the management is critical for the results. Also the support in agricultural production and vocational training in general is seen as critical for an effective delivery of livelihood projects.

With regard to the network activities of INFI for inclusive finance and livelihood activities Vietnam has shown most of the effects. The Vietnam experience has been used to demonstrate best practices to other TEA partners and practitioners. The appointment of a dedicated INFI officer within the MCNV office in Vietnam has helped to improve learning across countries for result area 2 activities. The workshops and the field visit were instrumental to map lessons learned provide insights in what works and what does not, hence contributing to selecting future activities that have a higher chance of being effective.

While improvements in health status between 2011 and 2014 are difficult to 'prove', utilization of the various available services has increased substantially, thus providing information, treatment and care opportunities for the various disadvantaged populations (people with disabilities, people with mental health problems and elderly). The training and involvement of the village health workers association, their relations with the health facilities (community health centre, district hospitals) and the support by the CBOs and NGOs together have allowed the TEA programme to provide an effective (and comprehensive) intervention that has supported the ethnic minorities and marginalised groups in these three provinces (in utilization), even if health status improvements cannot be verified.

2.5. Sustainability

As described in the ToR sustainability creates the social economic and other conditions in an intergenerational context. For this evaluation the following questions as stated in the terms of reference will be answered:

- Is there evidence to suggest that the activities or outcomes supported by TEA will continue to function beyond the TEA lifetime? Which factors and actors in the context promote and/or obstruct this sustainability?
- Is there any evidence to suggest that the activities and outcomes supported by TEA will expand beyond the existing TEA geographical areas? Which factors and actors in the context will promote and/or obstruct such replication?
- Have stakeholders of the project been open to learning about the new approaches that were introduced by the project? Which approaches do they perceive as new? What have been learning obstacles and what have been learning opportunities?
- What would stakeholders do differently if they could start afresh with this project to improve the chances for broadening and/or scaling up the project approach?

2.5.1. Overall findings

- As stated in the paragraph on outcome and impact it is too early to indicate whether the TEA programme can produce sustainable outcomes. Impact can often only be demonstrated over the longer term and the sustainability is of key importance to answer questions on the improvement of social and economic conditions for current beneficiaries as well as other potential beneficiaries.
- In TEA countries the cooperation with district, regional and/or national authorities has been close from the start. Involvement of government is a condition for a sustainable provision of services by CSOs or by health or social activities. The TEA programme does have a good strategy for sustainable improvement of services as regards result area 3. Improved policies and a better curriculum for health workers can lead to wider impact and a sustained improvement in a TEA country.
- The microfinance and livelihood interventions in result area 2 are more difficult to sustain without outside support. For the established microfinance institutions some indications were given for future more inclusive services in microfinance. The advocacy activities have led for example to raising the age limit for credit in Sri Lanka to 70 years. The institutional setting for microfinance institutions is often complex and the TEA programme is not always well placed to achieve more inclusive finance for a wider group. The livelihood activities show encouraging results which may result in continuation after the TEA programme. The country evaluations point at the need for continued attention to management of the funds and adequate record keeping.
- To sustain the INFI network of learning for inclusive finance new external fundraising is necessary as at this point income is 100% dependent on TEA means.

2.5.2. Country findings sustainability

In **Georgia**, for result area 2 and 3 sustainability is rated positively because of the close cooperation with the relevant authorities. The country evaluation states that numerous outcomes will likely be sustained after the TEA programme will have finished, mainly because of the cooperation with the authorities. With the apparent close collaboration between civil society and the public sector, impressive and sustainable results have been achieved in various Ministries, such as the Ministry of Health (master programme in mental health and the national mental health strategy), the Ministry of Education (juvenile delinquency programme by FCCC), the Ministry of Penitentiary (GCRT), the Ministry of Justice (FCCC), the Parliament of Georgia (CHC with Ndoba) and the Bishop of Gori, supporting IDP's in the development of Income Generating Activities.
For result area 1 it can be questioned whether CSOs will continue to monitor their own organizational development progress after the TEA programme has ended. It is to be expected that the capacity in organizational development and 5C, networking and technical information on mental health will not be lost after the withdrawal of the TEA programme.

In terms of the livelihood activities the country evaluation expects that some may not expand further beyond the current group of beneficiaries, but that others may grow into larger business enterprises that are able to be financially sustainable. The consistent attention to the capacity for planning and dealing with registration and tax issues by the implementing NGO Elkana has prepared the communities involved in the nine livelihood projects for continued and sustainable operations after the TEA programme. Also the social element where stronger members of the communities of internally displaced persons help the weaker could continue because of the establishment of a tradition/culture of solidarity according to the country evaluators. Obviously it is much too soon to conclude anything decisively about the sustainability: the projects have started in the autumn of 2013, TEA is still being implemented and 15 persons who run their own business since 2013 should be visited for example in 2016 to ascertain whether sustained operations were realised and how they may have expanded or not.

In **Lao PDR** for result area 1 the village development committees will likely continue after the TEA programme has ended as local support and participation is encouraging. The establishment of these grass roots community organisations has been welcomed by the local and district authorities as they see the benefit of the practical cooperation in livelihood and health activities. There are positive expectations for a wider impact and sustained improvement of services for rural marginalised communities. The close cooperation with the authorities in particular will be able to lead to sustainable outcomes and impact. The district governor of the Nong district for example has indicated that other villages will be encouraged to implement similar associations and livelihood projects as in the villages supported by the TEA programme in the context of a government sponsored aid programme.

Access and utilization of health care services has been improved and stakeholders have been involved and contributed to the implementation of the various interventions for the marginalised populations. Communication skills of village health workers have been strengthened and teachers have improved their training skills. The presence of village development committees, improved services in health centres and district health, training in mental health with a new curriculum, all suggest sustainability. However, without stronger

(financial) support by the Lao Provincial and District authorities, long-term sustainability is uncertain.

In **Sri Lanka,** the draft report presented to us does not cover sustainability in detail. With regard to result areas 2 and 3 interventions the report does indicate that because of the close linkages with government structures sustainable outcomes may be achieved. These close linkages at community level as well as with health institutes may lead to changes in national policies. It is indicated that an inclination now exists among the health authorities to integrate the bottom up approach of TEA in a public mental health policy. In the interview with Sarvodaya it became clear that the TEA advisory body in Sri Lanka can also be instrumental in the lobby for a change in national policies. The advisory body includes key players in the health sector in Sri Lanka.

The evaluation report concludes that the trainings have led to strengthening of management capacity at CBO level. From interviews with Sarvodaya it also appeared that sustainability has improved at CBO level because of the involvement of more people in the day to day management. The risk of dependency on a single person is thus avoided and transparency in financial operations may also be higher.

In **Tajikistan** for result area 1 several CSOs have been strengthened or established with good chances for continuation of their activities after TEA has ended. The country evaluation report provides a mixed picture as regards result area 2 in terms of sustainability. The sustainability of the organisation Imkoniyat is rated positively also thanks to the additional support of the International Finance Corporation. Also the project for sewing by disabled persons in Gafurov provided for at least 15 women with incomes and jobs that may continue after TEA programme will end. The continued high demand for the products and securing orders from the authorities by the chairperson of the Society of Disabled Persons is the basis for the success of this project.

To provide another example of the challenges, the nail art livelihood activities as implemented by Ishtirok may or may not continue. At the time of assessment, the country evaluators found that none of girls of the nail project was able to find a job, they used their skills either to train others or do nail art to their friends and relatives. The lack in skills in marketing or opening their business may prevent them from opening their own business or development of strategies to find employment and make this project sustainable. The country evaluators also are of the opinion that Ishtirok was mainly encouraged and motivated to connect girls with each other and empower them. From interviews however it appeared that many one person business ventures may result from this activity.

While there are examples that suggest sustainability, such as gerontology rooms authorised nationwide by MOHSP, gerontology course by Tajik Medical University and the Resource Centre for Imkoniyat, their viability remains to be seen. The MoU is for only two years, the quality of course is doubtful and no immediate resources are identified to continue funding at this stage. The country evaluators do think the establishment of gerontology centres is an important institutional change that was upheld also after the changes in the Ministry of Health, this is a reassuring sign for a possible continuation of the rooms also after the TEA programme will have ended after 2015. Of course the rooms are only useful when they are used and when a doctor will be present , something that cannot be guaranteed at the moment.

Overall the combined approach of organizational development with the practical interventions in result area 2 and the interventions for improved services under result area 3 puts a better foundation for sustainable results in the future. This applies in particular for the main coordinator GIP who may be able to attract new funding with the positive track record of the TEA programme as a whole. The connection with an international TEA network will also be instrumental in convincing international donors in being involved in a sustained effort to work for marginalised groups in Tajikistan.

In **Vietnam** for result area 1 many CBOs have been strengthened in their capacity to deliver results and for some organisations the monitoring of the organizational capacity will be repeated in the future according several TEA persons interviewed. The country evaluation report however doubts that without outside support it may not continue. The gains in capacity and empowerment have lead to a more positive assumption in the country evaluation report about the lasting effects of result area 1 interventions for the CBOs and NGOs to continue being able to better service delivery and in their advocacy capacity.

The sustainability of result area 2 interventions depends on the final remaining year of implementation of TEA programme and their attention for the capacity in management and in technical skills of the organisations managing the funds. Repayment of loans is an issue for CBOs when a culture of government grants leads to refusal of households to pay back the loans provided under the TEA programme. The combined approach of credit and technical assistance may be attractive enough to satisfy demand in the villages but it should be managed well in order to have a continued operation of the funds in the villages. The country evaluation report refers to the transparency and accountability of the funds to guarantee equal access and good social performance. From the customers point of view financial education is important to understand the terms and conditions. Otherwise some of the possibilities are likely to be underused given uncertainty about the capacity to pay back. This education is envisaged for 2015 with TEA for Vietnam.

Access to and utilization of health care services has been improved and stakeholders have been involved and contributed to the implementation of the various interventions for the marginalised populations. Staff capacity and communication skills of village health workers have been strengthened and teachers have improved their training skills. The provincial health department has allocated budgets to all districts in support of marginalised groups. Finally, relations and collaboration among disabled people organisations, older people associations, village health workers associations and community health centres have also improved. CBOs and NGOs have been instrumental to lobby for technical and political support from higher levels. These developments indicate good chances for continuation of the attention for ethnic minorities and marginalised groups, even if the financial support by the TEA programme will be reduced or phased out.

3. Lessons learned and recommendations

A list of recommendations is developed with the primary users of the evaluation and has been moderated by Carnegie Consult in a workshop held 30 March 2015. The partners have come up with the following recommendations and specific lessons learned which can be used in the near future within the framework of TEA as well as beyond the TEA financing period.

Recommendations on organisational development/ result area 1

Organisational development methods were applied within the TEA programme for CBOs under result area 1. Especially the capacity to commit and act were seen as important. The adaptation of 5C for CBOs and junior CSOs is seen as an important achievement of the TEA programme. The following lessons and recommendations can be drawn from the work accomplished so far in this area:

- The TEA organisational development toolkit based on the adaptation for CBOs and junior CSOs in general has value beyond the TEA practice. It is recommended to share this tool for wider usage and discussion with other organisations involved in capacity building for CSOs both in the Netherlands and in countries of operation.
- It is recommended to describe specific case studies on how the adaptation of 5C took place and how CBOs experienced the process and developed ownership for the exercise.
- Organisational development works best when it involves twinning of CSOs active in the same sector with likeminded experts. Organisational development should preferably not be implemented as a standalone activity. TEA consistently combined organisational development with either livelihood or heath related activities

Recommendations on livelihood development and inclusive finance/ result area 2

The TEA programme combined livelihood development with the provision of credit to marginalised communities under result area 2. The technical assistance improved the capacity to pay back the loans and also included advice on proper administration of funds provided. The community based microfinance provision within TEA has been implemented by informal credit groups. Hands on technical assistance and tools have been provided in the context of INFI, the inclusive finance network created in the framework of the TEA programme. The following learnings were identified:

- Informal delivery of inclusive finance should be embedded in a larger structure, either as part of a microfinance association or a Women's union/ other credit union. This may provide a better basis for the continuity of the funds, proper governance and transparency in operations.
- Advocacy for more inclusive finance products for marginalised communities should be based on demonstrating best practices for each target group. Case studies and promotional videos as well as speaking points for advocacy to policy makers should be prepared as part of the last implementation year of TEA (2015).
- With regard to the INFI network the work done on social performance standards for CBOs could be used as a basis for future fundraising. INFI is not designed as a

sustainable advisory service centre and dependent on donor funding. INFI may fill a niche when proving its value added as an advisor on inclusive finance and livelihood development for marginalised communities.

Recommendations on access to health services / result area 3

The TEA programme has improved access to health services for marginalised communities in various pilot projects and has advocated for better policies and services to the health authorities in the various countries under result area 3. The approach has been based on strengthening the primary health care provision as well as attention to access to and improve the quality of the district level health care. In the design of the result area 3 interventions this combined approach has been integrated, taking into account budget limitations and the generally larger investments needed to improve district level services and infrastructure. The following insights and recommendations were listed:

- The TEA programme has shown that advocacy for better policies for marginalised people can work well when close cooperation between CSOs and authorities can be demonstrated. Authorities can coordinate a sustainable approach for improved health services on a district or national scale based on pilot projects implemented by CSOs.
- A proper and functioning referral system from village or community based health care is essential. Linkages with the district health care system are needed even when the primary focus is on improving community based health services.
- With regard to the assistance for elderly people livelihood development and social inclusion are as important as the provision of health care services. The proceeds of livelihood projects should flow to the most vulnerable community members to build cohesion and solidarity within a community of elderly people.
- The roll out of curricula for training of health care workers is an important method to scale up a programme. The limited number of beneficiaries within the various pilot projects within TEA is justified when these pilots are used to demonstrate the effectiveness of a new approach valid to all members of the chosen target group.
- A committed trainer is essential for an intervention focused on teacher training institutes to succeed. This trainer serves as the champion for the new approach and can build the basis for the roll out of the new curriculum.
- The inclusion of problem based learning and the capacity to make adequate decisions are just as important in a health care related curriculum as the attention to transfer of new knowledge and treatment methods.

Recommendations on future fundraising activities

Since the TEA programme is in the last year of implementation discussions were held on future fundraising to continue the work for marginalised communities. The following recommendations were made:

- The chances to attract funding with private philanthropies or other non-governmental donors can be improved when a calculation on the cost per beneficiary and the estimates for wider impact outside the pilot group are included. This is often just as important as describing the relevance and impact of the programme. TEA carries various elements for a scalable approach. At this moment data on costs and

expected outreach are not yet available. They should be collected to determine the total potential scale for the immediate future (2015-2017).

- Case studies, promotional videos and toolkits should be prepared to serve as building blocks for fundraising proposals. In particular the data and other findings of the country evaluation reports may be used to demonstrate effective approaches to improve the position of different groups of marginalised people in various countries.

Appendices

1. Summary of achievements under result areas 1, 2 and 3
2. List of persons interviewed
3. Conference report TEA conference Colombo 2015
4. Terms of Reference of the assignment
5. Overview of evaluation process (drafted by MCNV)

Appendix 1: Summary of country evaluation reports for Result Areas 1,2,3

This appendix provides summaries of achievements so far within TEA for the three result areas per country. The main findings of the country evaluation reports are presented here as well as updates provided by the country coordinators in interviews and in writing. TEA will complete its activities at the end of 2015 so no comprehensive overview could be provided at this stage. The findings in the country evaluation reports were gathered up till mid/ end 2014. In the case of Sri Lanka the findings date back to February 2015).

Result area 1: Organizational Development of Civil Society

Description of the Result Area 1 interventions

In terms of organizational development TEA aims to improve the organizational capacities of participating civil society groups in the five countries. The methods chosen for this result area are CIVICUS and the 5C method.

The CIVICUS Civil Society Index (CSI) is a participatory needs assessment and action planning tool for civil society around the world, with the aim of creating a knowledge base and momentum for civil society strengthening initiatives. The state of civil society in their national context is assessed along four basic dimensions using a structured methodology:

- The structure of civil society.
- The external environment in which civil society exists and functions.
- The values practiced and promoted in the civil society arena.
- The impact of activities pursued by civil society actors.

These four dimensions can be represented graphically as the civil society diamond which are also graphically provided in some of the country evaluation reports.

The goal of the 5C method is to assess in a participative way the capabilities of an organization and to assist in evaluating the changes over time. Capacity development takes place at three levels, individual, organizational and institutional. Five core capabilities are distinguished:

- The capability to act and commit.
- The capability to deliver on development objectives.
- The capability to adapt and to self-renew.

- The capability to relate to external stakeholders.
- The capability to achieve coherence.

These capabilities are separate but interdependent. Within the five capabilities several pointers have been identified to describe the current status of the organization and the relative progress.

Within the five country evaluations the progress has been described in CIVICUS terms as well as progress of junior CSOs and senior CSOs in the 5C approach. The CSOs participated in the reflections on how TEA programme and their organisations have contributed to civil society along the lines of the various CIVICUS dimensions. It has been a complex exercise since the basis of many of the principles are or were not enshrined in charters or in the culture of civil society or communities in the five TEA countries. Since CIVICUS was not deemed relevant by the stakeholders involved this method was overall not successfully applied after some initial exercises with this method.

For all the five countries 5C had to be contextualised as well as specified in order to be understandable by the local users. The 5C model was a new model for all participants in the process. The strategy was to use 5C as an integral part of awareness raising and organizational development and to focus on existing strengths to build on per organization.

The country evaluation reports provide detailed overviews of the progress achieved since 2011 until mid or end 2014. Below the main findings are summarised per country and per outcome area.

Georgia

RA 1.1: Contribution to improvement of civil society enabling environment in CIVICUS terms

In terms of CIVICUS measurement a two day workshop was organised in 2013 to compare progress against the baseline in 2012. In general Georgian civil society organisations are quite well developed, but their quality and capacity to act differs significantly. For the TEA partners who participated in the workshop progress was seen as modest. The challenge of decreased funding was mentioned as a limiting factor. On dimension 1, civic engagement the situation was likely to be the same as before. On dimension 2, level of organisation also the situation was comparable to the year before, even though their internal management procedures had improved. As regards the dimension 3, the practice of values the situation is similar and the need to do more on transparency and a code of conduct was recognised. On the perception of impact in dimension 4, organisations recognised the impact of their own work but for sustainable results political will for funding from the health budget and capacity building in the sector was needed. On the fifth dimension the environment had not changed dramatically, more work could be done as regards public relations strategies and finding a niche for each organisation within the civil society.

Significant progress for the dimensions was not expected by the CSOs and compared to the baseline measurement on most indicators the situation is the same. CSOs mention the

limitations of civil society fragmentation in Georgia as well as competition for limited resources among civil society organisations.

RA 1.2.: In terms of the 5C method tracking progress in at least two pointers of at least two capabilities for senior CBOs and in at least four pointers for at least three capabilities for junior CBOs.

TEA efforts contributed to improvements in the 5cs of all the 13 CSO organisations involved under result area 1. The results showed that improvements in five capabilities have been achieved in at least two pointers. All organisations wanted to improve the capability to deliver and to commit at the time of planning.

Whereas they are more confident in lobbying more needs to be done. Cooperation between governmental bodies and CSOs had increased resulting in developing a national health action plan. Contextualization of 5C method is seen as important. The alliance of civil society has cooperated to work on the improvement of the civil society environment. The climate is seen as quite favorable: open attitude of government to outside and especially foreign influences.

Among the junior groups one (FCCC) already achieved the target of making progress in three capabilities. Another two made progress in two capabilities according to the country evaluation study.

The country evaluation report concludes that result area one is well on track to be achieved. Almost all 13 CSOs targeted by result area 1 have achieved progress in at least two capabilities. One junior CSO has already achieved progress on three capabilities. The progress in CIVICUS terms is noted, although overall more structural challenges for civil society in the country remain. Especially a fragmented civil society competing for limited resources is mentioned as a structural problem.

Lao PDR

RA 1.1: Contribution to improvement of civil society enabling environment in CIVICUS terms

It was decided that it was not quite suitable to use CIVICUS given the regulatory environment. A description of the TEA environment in CIVICUS terms was made in the 2013 review. CIVICUS method is not useful in the context of Lao PDR as domestic NGOs are not prevalent or encouraged. For that reason it was decided to work with communities and set up Village Development Committees. CIVICUS does not work well in terms of describing the role of community based groups.

RA 1.2. : In terms of the 5c method tracking progress in at least two pointers of at least two capabilities for senior CBOs and in at least four pointers for at least three capabilities for junior CBOs.

For the 14 participating CBOs (village development committees) it was challenging to use the 5C method. A SWOT analysis was used instead. Organizational development led to strengthening internal management and the capacity to act has been improved in terms of sourcing safer water supply as well as increased food security. So result area 1 is well on

track, progress in at least three capabilities is shown in the TEA annual report of 2013 and more success in outcome objectives is expected in 2015. The SWOT exercise in 2012 allowed the team members to engage better with government officials. As of 2013 5C had to be used again.

The country evaluation report concludes that result area 1 has been achieved. However close supervision and monitoring are still needed to strengthen the capacity of villagers and to maintain all activities and their capacity to organise themselves through CBOs. Most significant is that villagers are more open and committed to learning. For progress on the capabilities to adapt and achieve coherence 5C should be contextualised first. At this moment it is not understood and progress can not be measured.

Sri Lanka

RA 1.1: Contribution to improvement of civil society enabling environment in CIVICUS terms

The three senior CSOs involved in TEA were analyzed in terms of progress in CIVICUS terms. The three NGOS have increased their social initiatives, have organised a number of lobby events. They have improved management and governance thanks to TEA. The practice of values notably improved at the NGO Suwasetha. The trainings conducted sharpened the sensitivity to the needs of marginalised groups. The environment for social projects by NGOs is conducive according to the country evaluation report.

GIP commented that the climate for civil society development is restrictive. Most of the NGOs are government controlled and the room for manoeuvre in terms of being a countervailing power is limited. Until recently the authorities limited public activities of civil society and non-governmental organisations in Sri Lanka. After the new president took office January 2015 steps are taken to dismantle the restrictions imposed on civil society as reported in newspapers (e.g. Guardian 10-01-2015).

From the interviews we understand that CIVICUS was not successfully applied in Sri Lanka and 5C had to be adapted first in order to be able to apply it at community levels with junior organisations.

RA 1.2. : In terms of the 5c method tracking progress in at least two pointers of at least two capabilities for senior CBOs and in at least four pointers for at least three capabilities for junior CBOs.

5C was contextualised and at the end of 2014 it could be used more extensively among the CBOs.

The country evaluation report focused on how CBOs performed according to them and did not reveal information how CBOs practiced 5C themselves.

Whereas the country evaluation report mentions the senior organisations (NGOs) under CIVICUS, for the 5C method 11 junior organisations are included and judged upon in terms of progress achieved. The country evaluation report concluded that the target for noting progress in at least three capabilities was achieved. The capability to commit and act, to

deliver on development objectives and to relate were included in their survey. A 100% mark was given to the organisation who got the best qualitative judgment from the evaluators. The averages for the three capabilities ranged between 60% of the full score for the weakest and 96% of the full score for the best. In the questionnaires only 4 out of the 100 persons surveyed indicated unsatisfactory performance of the CBOs they worked with. Most of the persons interviewed answered that their perceptions have changed positively on how they can contribute to society in a more productive manner. Organisations have been strengthened in terms of management, governance, finance and the ability to relate and lobby to local and provincial authorities. The relations between CBOs and authorities are traditionally very close. The country evaluation report does not indicate whether CBOs have a more independent position towards the authorities and a better capacity to speak up for themselves and the marginalised communities in general.

Tajikistan

RA 1.1: Contribution to improvement of civil society enabling environment in CIVICUS terms

Compared to the other TEA countries the application of CIVICUS worked reasonably well in Tajik context. Questions were introduced and assessed. The country evaluator was able to assess the progress in CIVICUS terms. The CIVICUS scores for the three organisations are listed in the report. Where a decline in scores was noted, the Central Asia Gerontology Centre explained it in terms of challenges in securing their premises and the relations with the Ministry of Labour and Social Protection. The NGOs involved in TEA gained respect among civil society in Tajikistan because of their advocacy and lobby work with the government.

RA 1.2. : In terms of the 5c method tracking progress in at least two pointers of at least two capabilities for senior CBOs and in at least four pointers for at least three capabilities for junior CBOs.

The three senior organisations included in the survey showed progress in two areas, the capability to deliver results and the capacity to relate to external stakeholders. For all organisations they showed progress in two pointers for each capability. Two organisations showed additional progress in another two capabilities, i.e. the capability achieve coherence and the capability to act and commit.

In terms of challenges the internal organizational development the lack of delegation by NGO leaders was mentioned. Progress is shown in terms of appointing staff that can replace the directors and also improved capacities in terms of drafting proposals.

Overall for RA 1 the country evaluation concludes that the outcome objectives have been achieved.

Vietnam

RA 1.1: Contribution to improvement of civil society enabling environment in CIVICUS terms

TEA made a contribution to the improved environment for civil society. CSOs scored average in 2011 at baseline level according to the CIVICUS dimensions and in 2013 improvements have been revealed to various extents. Because of the principle of democratic centralism within the Vietnam political and administrative system, civic engagement had to be channeled via more informal networks, in TEA the community based organisations were the only civil society organisations involved.

CIVICUS was a tool that helped to document that civil society can speak up for their target group, i.e. ethnic minorities and marginalised groups in general. Even for senior CBOs the CIVICUS model was hard to comprehend. Nevertheless the country evaluation managed to compare the scores between the baseline in 2011 and the mid-term review in 2013. The TEA programme has made contribution to the improved environment for civil society. In CIVICUS terms, the evidence is demonstrated in the enhancement of scores for five CIVICUS dimensions according to the Civil Society Index (CSI). The scores improved modestly. Level of organization is hampered because of lack of finances. Practice of values scores improved modestly. The impact and external environment scores were generally stable. As regards the external environment score it was perceived that there is room for improvement for the relations between CSOs and government and party/state bodies. Frequent criticism is expressed on registration conditions of CSOs. In Quang Tri province more tolerance towards the treatment by government and party/state bodies was seen, emphasizing the values of trust and cooperation.

RA 1.2. In terms of the 5c method tracking progress is seen in at least two pointers of at least two capabilities for senior CBOs and seen in at least four pointers for at least three capabilities for junior CBOs.

Since 2012 most organisations have reported progress measured by their pointers in the five capabilities. In 2013, 28 senior organisations (out of 28) and 5 junior organisations (out of 8) achieved the criteria for organisational development. In 2014, 27 senior organisations (out of 28) and three junior organisations (out of eight) achieved the criteria. All four senior organisations and two junior organisations interviewed in the Vietnam country evaluation reported an improvement of staff capacity and the active engagement of members. Regarding the capacity to deliver results and to relate to networks the CBOs and NGOs have delivered activities for their members and developed networks of health centres, their staff and women's unions. Interviews with organisations showed little evidence of how to adapt, self-renew and stay focused to the changing environment.

After 5c was simplified and contextualised it was used well by Vietnamese CBOs. To a certain extent CIVICUS was also integrated into the 5c model.

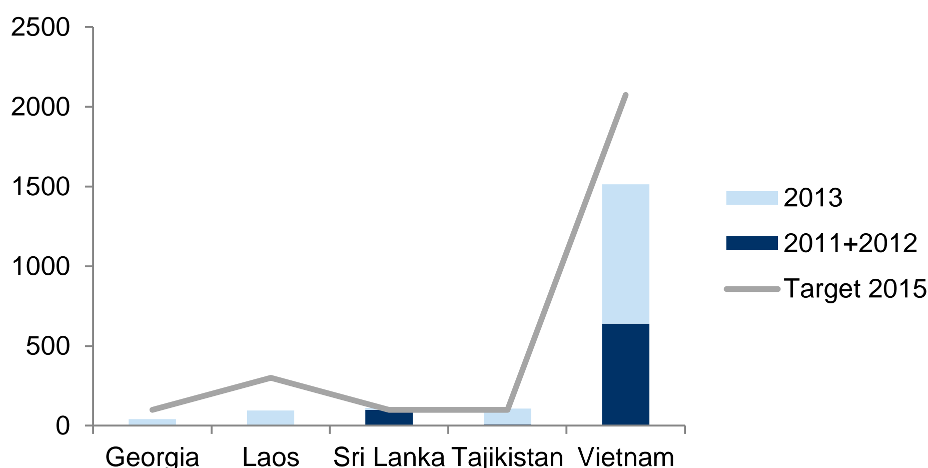
The outcome targets for result area one have been achieved. Improved environment for civil society has been achieved as well as progress in 5C terms is fully achieved according to the country evaluation study.

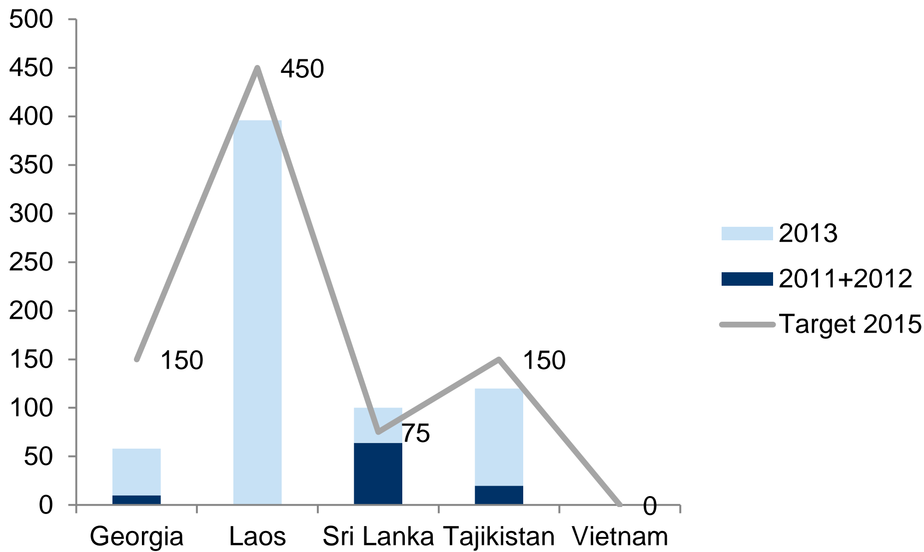
Result Area 2: Inclusive Livelihood Services and Microfinance

Result Area 2 aims to improve access to credit, insurance, pensions and other innovative livelihood products through CBOs and NGOs for marginalised groups, i.e. elderly, disabled, ethnic minorities or internally displaced persons (Georgia). The outcomes describe the improved service delivery by groups themselves, by financial institutions or better referral systems as well as the strategy pursued to improve financial inclusion with existing institutions where present as well as to improve standards for responsible microfinance.

The findings of the country evaluation reports show that because of training provided to several groups in income generation activities, either revolving funds could established or it has led to informal community groups which could be seen as social enterprises. Also the practical implementation of livelihood projects in rural areas (agriculture, livestock rearing) resulted in social outcomes in terms of individual empowerment and inclusiveness in society.

In terms of microfinance technical assistance and advocacy tools were provided as part of the INFI related interventions. After the decision to create a network, trainings and tools were developed for inclusive livelihood and microfinance for the TEA partners and microfinance partners. Outcome target 2.6 should be understood in terms of the network, not the institute as described in the monitoring protocol. The heading for 2.6 has been changed in this report accordingly to ensure consistency. The country evaluation reports provide limited information on the services provided by INFI. The information in this chapter for this part is derived from information provided by MCNV in documents such as the TEA annual plans and reports. MCNV coordinated the INFI interventions which encompass the financial inclusion strategy for the five countries. Since 2013 INFI employed a microfinance advisor in Vietnam responsible for support in result areas 2.3 and 2.5. By 2013 all countries except Georgia work to promote more inclusive financial services by existing microfinance institutions.





Georgia

In Georgia result area 2 concentrated on the provision of livelihood activities to internally displaced persons (IDPs). For the implementation of result area 2, the CSO Elkana was hired. The country evaluation study describes Elkana staff as professional and committed to the mission of improving the position of marginalised people.

RA 2.3: 80% of the targeted NGO/CBO reach marginalised people with increased or better variety of services.

In case of Georgia the services to IDPs have been provided by one CSO Elkana only. No data are available to measure whether 80% of targeted internally displaced persons have been reached. Elkana selected nine business projects for financing based on a marketing and value chain survey. Trainings were held with the selected beneficiaries. The country evaluation study describes that 120 persons have been reached by the TEA with new livelihood activities. 60 internally displaced persons learnt to write a business proposal. 15 internally displaced persons run their own business and 25 internally displaced persons are employed and it is feasible that they will improve their income by the end of the programme period (2015). All in all between 90-100 persons will benefit from income generating activities. Social benefits (discounted or free services) were provided to 150 persons.

In the year 2013, 48 internally displaced persons participated in the capacity building trainings. In 2013, 48 persons were reached with more inclusive microfinance services. The 2013 TEA annual report indicates that twice as many beneficiaries will be reached, which will allow the consortium partners to include double the number of 150 persons envisaged for the end of the project.

RA 2.4: List of indicators measuring success and progress of microfinance and they are used for monitoring

The country evaluation does not seem to measure whether indicators were decided upon and used.

RA 2.5: Institutes providing increased microfinance in terms of the offered amount and/or variety of inclusive services to reach 25% more marginalised people.

Since no microfinance institutes were involved in the TEA project this outcome target is not applicable.

RA 2.6: Partners benefit from the services of the INFI learning network.

A workshop was held in 2013 to decide on next steps for promoting livelihood activities in Georgia. Participation of Georgian expert in a mission to Vietnam in 2013 was realised and thus benefited from INFI organised tools and services.

Lao PDR

In 2012 the village development fund committees have been solidly established in the ten target villages. At least two persons per village are responsible for the management of the livelihood and credit facilities. The committees received training in fund management and book keeping.

As of September 2014 602 people have been registered with the funds, which is a little over 13% of the population in those villages.

RA 2.3: 80% of the targeted NGO/CBO reach marginalised people with increased or better variety of services.

100% of the targeted 14 village development committees have reached marginalised people with new services. 4478 (4528, updated 2015) people living in the target villages have been reached with new and better services. According to TEA annual reports 2886 of the poorest individuals were included.

Although sufficient funds are available villagers are still reluctant to borrow money because they are still afraid of not being able to pay back. The country evaluation team does not find this surprising as the microcredit is a new product for the target group.

Goats were delivered to 66 households, cows delivered to 74 household members in total. Rice banks were set up. The rice banks work well, with the income in rice harvest distributed to the needy and during periods of harvest shortfalls. Overall 480 households borrowed a total of 72 tons from the rice banks. There is still 14 tons of rice available for lending. Also fish was distributed to 34 families. Technical assistance is planned for pilots in mushroom plantations and home gardens.

Goats suffered from foot and mouth disease with 30% mortality as a result. Cows did better as very few cows died. Throughout 2014 there were no reports of animals dying. Communities are now better prepared for outbreaks of diseases with veterinary assistance provided by the authorities. Rice banks need continued outside support for management of the portfolios and collection of rice paid back. There are no reports of overdue payments however.

RA 2.4: List of indicators measuring success and progress of microfinance and they are used for monitoring

Due to language barriers and low literacy this outcome target was hard to accomplish. After consultation with TEA staff two indicators were agreed upon: at least one income generating activity is identified and one rice bank is established. Case studies were made to illustrate the success of micro finance support in the context of Village Development Funds and these are published in the 2013 TEA annual report for Lao PDR.

RA 2.5: Institutes providing increased microfinance in terms of the offered amount and/or variety of inclusive services to reach 25% more marginalised people.

In the inception phase of TEA it was decided that due to the lack of formal microfinance institutions and traditional banks access to microfinance through financial institutions was not feasible.

RA 2.6: Partners benefit from the services of the INFI learning network.

Capacity building was offered to the village development committees by programme staff through two trainings. Attendance to a conference on social performance management in Vietnam was sponsored for programme and government staff involved in microfinance. For 2015 tools and techniques will be adapted to monitor the success of village development funds, see the description for result 2.6 for Vietnam.

Sri Lanka

RA 2.3: 80% of the targeted NGO/CBO reach marginalised people with increased or better variety of services.

The target is reached for the CBOs involved in 90% of the cases according to the country evaluation report. From 22 older people interviewed 16 had an increased income. For the three recipients of mental health services all had an increased income. From the four people with special needs interviewed two had an increased income. The collective business activities such as the tea and cinnamon seedling nurseries are successful so far: short term employment is generated for 31 members and 26 non members.

Microcredits have been provided to 364 loans to elderly people in the North Central Province, in the Northern Province ten loans have been extended (as a supplement to credits from other donors, GIZ and UNDP) to persons receiving mental health care and in the Southern Province 16 individual loans have been provided to persons with special needs and elderly people. Three persons were not able to improve their income, the others improved their income with 67% (southern), 78% (Northern) and 146% (North Central).

In interviews it was also indicated that this outcome has been achieved successfully.

RA 2.4: List of indicators measuring success and progress of microfinance and they are used for monitoring

The three NGOs coordinating the delivery of RA 2 services have a list of seven indicators determining the use, reach to marginalised people, repayment, improvement of living conditions and proper use of systems and governance of CBOs involved in microfinance.

RA 2.5: Institutes providing increased microfinance in terms of the offered amount and/or variety of inclusive services to reach 25% more marginalised people.

The country evaluation report does not provide information on microfinance provided by formal institutions (outside the CBOs involved in TEA).

In the microfinance sector two lobbying events were organised, leading to the policy change among MFI's to raise the age limit for credit to 70. The Government now not only thinks of grant schemes in social policies but also considers credit schemes such as practiced in TEA context.

RA 2.6: Partners benefit from the services of the INFI learning network.

No information is provided on INFI In the country evaluation report. The participation of a Sri Lankan expert in a mission to Vietnam in 2013 was realised and thus benefited from INFI organised tools and services. A relative large amount of work was done in terms of advocacy on more inclusive microfinance for Sri Lanka within the TEA programme.

Tajikistan

For result area 2 income generating activities were delivered in Dushanbe, Gafurov and Tajikabad and reached disabled people (mainly women and girls) and elderly population. Projects were focused on sewing, nail art, knitting and potato cultivation. NGOs are not permitted to provide microfinance activities in Tajikistan so not all outcome objectives are relevant for this country.

RA 2.3: 80% of the targeted NGO/CBO reach marginalised people with increased or better variety of services.

Under result area 2 income generating activities were delivered by all three CSOs to disabled people leading to the introduction of new activities i.e. gardening, sewing, knitting, potato growing and manicure/pedicure. In total 70 women were trained, much more than the 30 targeted in the project plan.

Permanent jobs were created for at least 15 women through orders from public bodies for products such as bed linen and school uniforms. This was secured through strong cooperation with the authorities who placed purchase orders for uniforms and bed linen. 70% of the orders come from the authorities.

With regard to the nail art vocational training was offered to 15 women and girls with disabilities. Positive spin off witnessed was the peer support, especially for the deaf women who increased their self-esteem and ended their isolation. The project will facilitate the independent practice of nail art and has led to income generation capability previously unavailable.

Out of the 12 people trained two people with disabilities were employed to provide accounting services as part of the Resource Centre for Disabled Persons of the NGO Imkoniyat. Cooperation with International Finance Corporation in this project was instrumental.

Both the livelihood activities and the self-help groups in health have improved the range of services provided to marginalised groups.

RA 2.4: List of indicators measuring success and progress of microfinance and they are used for monitoring

No list of indicators to measure success and progress was made for result area 2.

RA 2.5: Institutes providing increased microfinance in terms of the offered amount and/or variety of inclusive services to reach 25% more marginalised people.

Provision of microfinance by CSOs is not allowed in Tajikistan. The TEA programme did not establish a strategy to reach micro finance organisations to include marginalised groups. Also at the baseline no measurement was conducted on the number of marginalised persons reached by micro finance organisations.

RA 2.6: Partners benefit from the services of the INFI learning network.

Participation of Tajik expert in a mission to Vietnam in 2013 was realised and thus benefited from INFI organised tools and services. The advocacy to existing microfinance institutions was started in 2013 with the involvement of four banks and thirteen microfinance institutions according to the overall 2013 TEA Annual Report.

Vietnam

Result area 2 of the TEA programme in Vietnam included three micro credit models: and supported twelve community development fund, twenty community based organisations development funds and six village managed micro credit funds. Thus in total 38 funds were supported. CSOs offered access to financial support for income generating activities and the funds delivered technical support to the members requesting loans.

RA 2.3: 80% of the targeted NGO/CBO reach marginalised people with increased or better variety of services.

The vast majority 30 out of 32 (94%) of the targeted CBOs in the intervention areas showed an increase in the offered amount in the microcredit services in the sense that they reached more people since 2011. During the process of the programme, there were 1513 more people who were provided with microfinance services. Out of a sample of 282 people interviewed 25.6 % obtained loans. Out of 35 people with disabilities 10 people reported to borrow. Out of 72 elderly people surveyed 8,3% have borrowed from the development fund. Use of microcredit has decreased among marginalised and non-marginalised groups whereas access to loans from bank has increased.

63% of the marginalised group received training. The TEA supported village shop is well appreciated. Majority claims their ability to pay back (60%). For some repayment is hampered by lack of understanding or lack of sanctions on overdue payments.

When combined with technical assistance microcredit can be an attractive package for marginalised communities compared to government sponsored subsidised loans. It also takes much more effort to get the subsidised loan. That explains the increased demand for the microcredit as provided within TEA framework. The variety of agricultural services expanded, as well as assistance with writing business plans. About 63% of the marginalised groups received training in agricultural production and about 10% received other training in various topics such as financial education or writing business plans. Some inadequacies in the content of trainings was reported in the interviews.

Apart from livelihood support and training 11 village shops were supported. The country evaluation shows that 47% of the people in the survey appreciated the shops for their location close to home (proximity) and their reasonable prices. The shops can also give credit to the customers for agricultural products. The location, small scale and low buying volume will hamper sustained impact on the local supply chain in agriculture according to the country evaluation report.

RA 2.4: List of indicators measuring success and progress of microfinance and they are used for monitoring

All NGO's /CBOs have indicators. This outcome has been partially achieved. Out of five indicators three are monitored by 97%, one by 78%. One indicator should have been monitored (% households out of poverty), but the country evaluators felt they could not monitor it reliably. 78% of CBOs keep good data on timely repayments. The country evaluation report mentions that from their own observation of the records many households had fallen behind in payments for several months. Many management boards commented that people have become used to grants from the government and refused to pay back loans provided in the framework of the TEA programme.

A separate study by a researcher Kristianne Kok in 2013 indicated that most of the management boards of the funds had effective systems in place. Despite insufficient records the fund committees agreed that realizing an improvement in living standards is the main criteria for success. The country evaluation study still considers more financial management capacity building necessary and this is expected to happen with a financial literacy programme starting in 2015.

RA 2.5: Institutes providing increased microfinance in terms of the offered amount and/or variety of inclusive services to reach 25% more marginalised people.

This target has been fully achieved. The Vietnam country evaluation indicated an increase in financial support as well as credit to both marginalised group and non marginalised groups: between 2011 and 2014, the number of marginalised people who got access to bank loans increased by 120%. However, access to other source of microfinance including credit fund and Women's Union tend to decrease through the years in both marginalised and non-marginalised group. The loans were reported to be used mostly for agricultural production or

small business, and except one region the majority of households (range 56-77%) reported that the loans were useful and people could repay the loans within the time without much difficulty. In two regions 9% of the clients were falling behind in payments.

As regards micro credit services, bank loans are the main source of financial support and these have reached more respondents since 2011. Most remarkable, 141 marginalised persons in the intervention area had access to loans from banks in 2014, an increase of 120% compared to 2011, which was significantly higher than the increase for the non-marginalised group. However, although the gap between the marginalised and non-marginalised within intervention group has reduced during the period, the marginalised in intervention area still had lower rate of access to loans compared to the control group. This could be inferred that the financial access from other sources to marginalised households, particularly in the intervention area, is still limited. On the one hand, this again emphasises the exigency of TEA programme in financial provision for the most vulnerable households, on the other hand however the country evaluation study suggests that the impact of TEA on more inclusive finance is not yet apparent.

RA 2.6: Partners benefit from the services of the INFI learning network.

Objective 6 was partly achieved. About 30 funds made changes as a result of a workshop. The country evaluation shows there is plenty room for INFI to improve learning and good practices. This could be subject to INFI's success in mobilizing external funding to sustain its activities.

Since 2013 INFI has organised three conferences on microfinance. From the evaluation country study it is not clear how CBOs have benefitted from the learnings in terms of practical advice. Advocacy for more inclusive microfinance for Vietnamese citizens as a whole is provided as well as information to the existing MFI's. INFI developed a detailed toolset to apply social performance standards at CBO level. These standards were designed originally for microfinance institutions.

MCNV, who coordinates the INFI interventions, argues that in spite of a great deal of international standards for microfinance, it has been a challenge to implement these on a very local grassroots level. INFI has organised an international mission in 2013, joining experts from six Eurasian countries, to develop a toolset that adapts international social performance standards developed for microfinance organisations to grassroots-level realities. Experts from non-profit microfinance organisations from Georgia, Lao PDR, the Netherlands, Sri Lanka and Vietnam joined on a mission to Quang Tri to test the usability of the new toolset in the field based on the Universal Standards for Social Performance Management.

Result Area 3: Health care and social service to Marginalised Groups

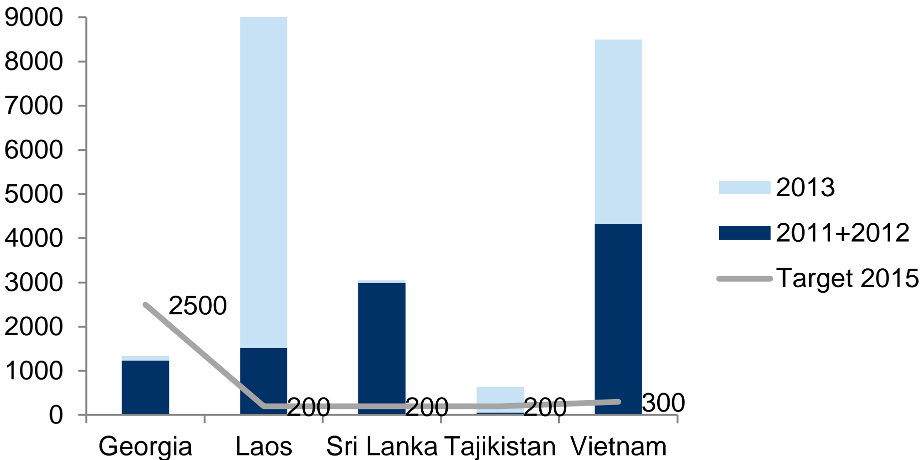
Result area 3 aims to improve access to health and social services for marginalised groups in the five TEA countries. Improved services include psychosocial care through the selected CBOs and NGOs and/or through health institutes or referral systems. Improved policies and curricula of knowledge and training institutes help to achieve sustainable outcomes for the wider target groups in the country, not just the beneficiaries involved in the TEA interventions of the CBOs and NGOs.

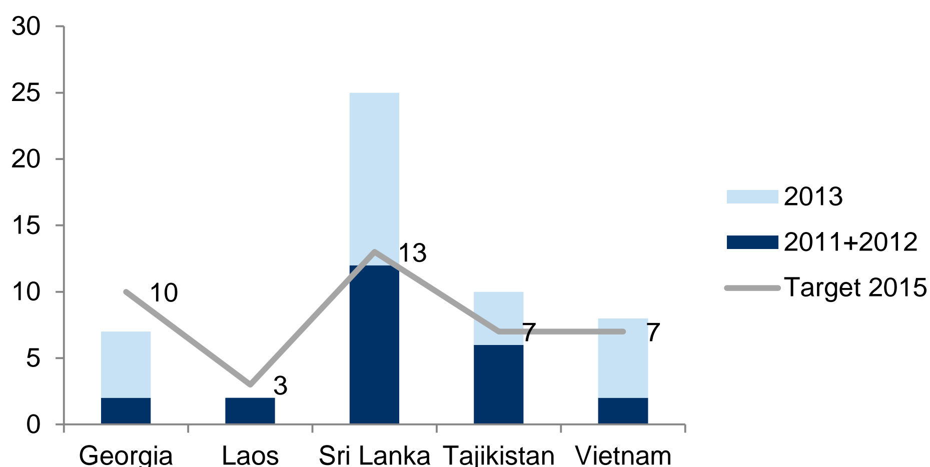
A combined approach of training health care professionals and volunteers is chosen, as well as targeting referral systems. Also lobbying was done to national policy makers to promote a more inclusive health system.

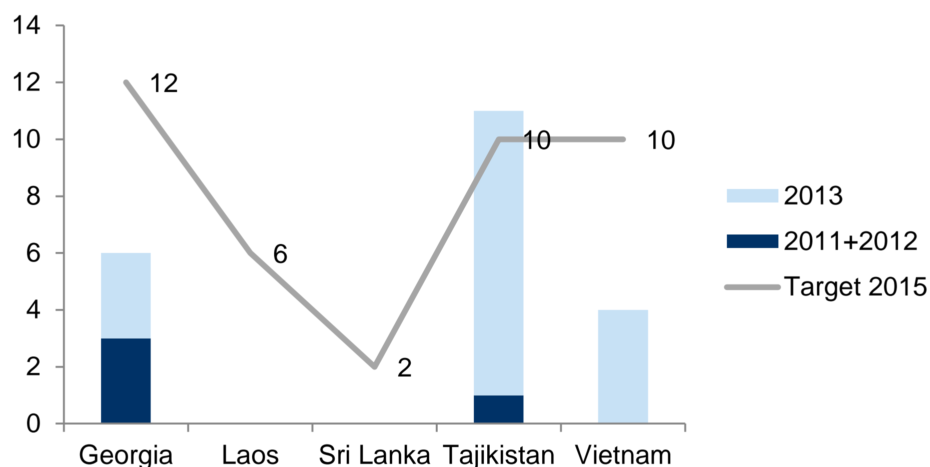
To get an idea about the scope of result area 3 activities the following data: According to the TEA 2013 annual report a total of 52 CSOs were trained to provide more or better health services between 2011-2013. A total of 25 CSOs or institutes provided comprehensive care projects and 51 workshops were held between 2011 and 2013. In the same period two conferences on inclusive comprehensive health were organised. In 2013 a total number of 10,490 marginalised persons were reached, out of which 7,313 in Vietnam and 2400 in Georgia.

In terms of influencing the policy agenda more is expected in the final stage of the TEA programme. As this summary is provided before TEA has finished it can unfortunately not provide a comprehensive overview of all achievements. Typical activities still to be expected is dissemination of results, more work on establishing guidelines and policy documents wherever possible in close cooperation with the relevant health authorities or institutes.

Graph: 16 People benefitting from more inclusive health services







Georgia

GIP coordinates the TEA programme in Georgia. It has implemented the programme over the 5 years (since 2011). A total of 13 CSOs were strengthened. There is a detailed description on the socio-economic context, including health and social welfare policies, internally displaced persons in South Ossetia, mental health, people with disabilities, prison mental health and juvenile delinquency. The socio-political background in Georgia changed dramatically in August 2008 (war with Russia) and October 2012 (presidential elections and a democratic transfer of power). In 2013 the Association Agreement with the EU was initiated and the former Prime Minister and the Minister of Prison Affairs were imprisoned for serious human rights violations. These changes had important implications for the policies being implemented by the TEA programme, especially in the areas of mental health, internally displaced persons and prison care.

RA 3.8: 80% of the targeted NGO/CBO reach marginalised people with increased or better variety of services.

RA 3.9: 75% of the health actors involved (NGOs, CBOs and institutes) in comprehensive care programmes perceive that relationships have intensified and are stronger.

These two targets cannot be fully verified as out of the participating CSOs/NGOs only four have been reviewed in detail. However, as these four CSOs are likely to give a representative picture of the remaining organisations, it is likely that targets have been met.

As examples of RA 3.8 and RA 3.9. the programme presented the following three cases:.

1. The Juvenile Prevention Project implemented by FCCC. This is a new intervention that did not exist before: 139 youth/children and 120 parents have been reached with support from a newly created Alliance with 25 members. Significant improvements have been documented before and after treatment in the reduction of aggressive behaviour, reduction of mental health problems and a positive assessment by children and parents. The intervention is considered not only successful and innovative, but also achieving sustainability, as it was incorporated in the psychological service of the Ministry of Education.

2. Similarly in Gori a new Trauma Treatment Centre was established, where 300 IDP families traumatised by the 2008 war with Russia were given concrete support that changed their hope and expectations for the future (based on 50 in-depth interviews). Internally displaced persons in Ossetia had been neglected for years. The establishment of the Gori Trauma Centre (GTC) with support from the TEA programme, reduced the risk of addictive behaviour (alcohol), reduced depressions among males / females and their feeling of helplessness and marginalization. The interventions have become sustainable with the incorporation of GTC in the Gori Patriarchy by the Gori Bishop.

3. A prison programme in support of women and youth did not exist in Georgia until in the context of TEA a prison aid NGO was established aiming to initiate human penal reforms. Through an innovative rehabilitation, re-socialization and re-integration programme the interventions by multi-disciplinary teams and frequent consultations showed results in terms of prevention of suicides, building capacity of key stakeholders (three training modules) and the protection of human rights of prisoners. Through the project, a psychiatrist was appointed by the medical department of the Ministry of Corrections.

RA 3.10: Participating health institutes have improved or developed curricula on inclusion that are being applied.

Through information sharing, lobbying and good public relations, the TEA programme initiated and contributed to:

- The establishment of a master programme on mental health at Ilia State University, being the first master programme in mental health in the country with specializations in social psychiatry and psycho-traumatology.
- The creation of a mental health resource centre at the same university, fully equipped with a proper library, being a resource for mental health professionals

- GIP is currently participating (leading) in the development of a new Mental Health Strategic Action Plan to be implemented nation-wide.
- Guidelines for Treatment of mental health problems of children have been developed and adopted by the Ministry of Health.
- A screening instrument to assess mental health needs and problems of inmates was adopted.
- The RRR programme has contributed to humane reforms of the penal system in Georgia.

RA 3.11: Targeted health centres reach 1200 more marginalised people.

The TEA programme helped to run four comprehensive health care projects, focusing on marginalised people with mental health problems (including prisoners, IDP, traumatised people, juvenile delinquency, women in prisons). Local guidelines were produced, referral pathways defined, quality assurance measures introduced and trainings given, aiming to assure sustainability. Whether the number of 1200 marginalised people has been met, has not been documented.

RA 3.12: Concrete steps taken and progress shown in making national and local health guidelines and/or policies more inclusive

Good relations with national stakeholders prepared for the elaboration of national guidelines. In more general terms, the TEA programme helped Georgia to stimulate and implement innovative developments in the field of mental health care with lasting and sustainable results.

Lao PDR

The office of MCNV in Vientiane implemented the TEA programme in Lao PDR in the following areas with the following activities:

• The capital of the province of Savannakhet: training in mental health of students at the Health Science College and establishment of a mental health unit at the Provincial Hospital.

• The district of Nong (in the same province): support marginalised people through village development committees (each with five members) in 14 villages with a total of 4,500 inhabitants. All three RA are being addressed by the TEA programme, being (i) development through 4 sub-committees under the village development committee, being the rice bank committee, village development fund committee, water user group and income generating activities; and being (ii) health through village health volunteers/ traditional birth attendants. The actual period of the TEA intervention studied has been around 3 years.

Lao PDR population is around 6,7 million. Savannakhet is the most populous province (825,000) with 15 districts (each with an average of around 55,000). There are 49 officially recognised ethnic groups, an unknown number of them is marginalised.

The Lao PDR MCNV office received content-related support from the MCNV office in Vietnam in introducing a community-managed health and livelihood development model and support for mental health interventions (curriculum development) for GIP.

Beneficiaries are marginalised people, being poor ethnic minorities and people with mental health problems, through village development committees. Supervision is undertaken by the Lao Women's Union, district and provincial departments of health and agriculture and the Health Science College.

RA 3.8: 80% of the targeted NGO/CBO reach marginalised people with increased or better variety of services.

After (re-)training of village health volunteers and traditional birth attendants and provision of drugs and birthing kits, there is substantial increase in attendance (doubled) between 2011 and 2014 by the people in these 14 villages. At health centre level staff has been trained in day to day management and record keeping and at district level laboratory staff was trained in lab and ultra-sound practices, while basic medical supplies were also provided. Mobile outreach with visits to all villages was organised on a quarterly basis. It is doubtful or at least uncertain if this has improved health care.

RA 3.9: 75% of the health actors involved (NGOs, CBOs and institutes) in comprehensive care programmes perceive that relationships have intensified and are stronger.

Thanks to this broad support by the TEA programme of both village (village health volunteers, traditional birth attendants) and service levels (health centre and district hospital), relations between the two has been strengthened, trust has been built, resulting in a strong collaboration and better referrals from villages to health centres and better utilization of health centres by villagers. A steering committee has been set up that meets monthly to discuss bottlenecks and further intervention and training plans. The fact that for the first time modest support was provided had a great impact on morale and satisfaction.

RA 3.10: Participating health institutes have improved or developed curricula on inclusion that are being applied.

TEA has provided training for (i) the various village health volunteers and traditional birth attendance; (ii) staff of the three health centres in the area; (iii) staff of the provincial hospital in mental health; and (iv) staff of the Savannakhet Health Science College (curriculum development and students). With support from GIP, a new curriculum for nursing staff in the area of mental health was developed and tested with good results. Consensus was that this was a major achievement that was presented at the National Medical Nursing Teacher meeting. Hopefully this inclusion of a (practical) mental training curriculum in all nursing schools in Lao PDR will effectively influence a new national (mental) health policy.

RA 3.11: Targeted health centres reach 1200 more marginalised people.

As a result of this comprehensive training at the various levels (see above), access and utilization of (district and provincial mental health services) has increased as well as boosting quality of care to the patients. Health Centres now reach more than 1200 clients per year. The establishment of the Mental Health Unit in Savannakhet is the first outside the capital Vientiane. Staff received thorough preparations in Vientiane and in Thailand mental health

training institutions. It is now attending patients from within the Province that never had proper access to mental health care before.

RA 3.12: Concrete steps taken and progress shown in making national and local health guidelines and/or policies more inclusive

The development of the mental health curriculum for nurses that will be proposed for becoming the national curriculum in mental health is a good example of impact on national policies. The improved relations and trust between caregivers (staff at village, health centre level and district levels) and stakeholders / policy makers (province and national level) are another example how major improvements in patient care can be made in harmony among all partners.

Sri Lanka

Marginalised groups in Sri Lanka, targeted by the TEA programme are old people, people with special needs and recipients of mental health services. Training and awareness programs by the Sri Lanka senior partners focus their interventions on (i) various CBOs, health care volunteers, families and (ii) government officers (such as nurses and doctors). Three senior partners are mentioned Sarvodaya, HelpAge and Suwasetha. The Department of Social Services is involved in Health Clinic related activities (mainly testing) through CBOs in Southern (4 CBOs), Northern (3 CBOs) and North-Central Province (4 CBOs)

RA 3.8: 80% of the targeted NGO/CBO reach marginalised people with increased or better variety of services.

In all three provinces an impressive variety of activities have been undertaken. The evaluation report highlights as most important the health care training programs, where members from the various CBOs were trained in topics such as: visual or speech impairment, assessment of disability condition of people with special needs, mobility training for people with special needs, awareness raising on mental health, health advocacy, psychological development and training in non communicable diseases.

The information was then used by health care volunteers conducting home visits to identify people with special needs or recipients of mental health services and raise awareness (social stigma) on these disabling conditions. Where serious conditions were found in people with special needs or recipients of mental health services, the local committee was asked to become involved and referral was organised where necessary.

Medical doctors, nurses and matrons were trained in care for older people, people with special needs or recipients of mental health services. They also participated in the health clinics organised by the CBOs themselves.

Whereas no specific data on the results are provided, the report provides convincing information that all these 11 CBOs in the three provinces have reached marginalised people and increased awareness, services and referrals.

RA 3.9: 75% of the health actors involved (NGOs, CBOs and institutes) in comprehensive care programmes perceive that relationships have intensified and are stronger.

All three provinces report that the TEA programme has contributed to the training of a total of 95 health care volunteers, that fulfil important functions in becoming a bridge between the community and the formal health system of health centres and hospitals. Relations are cordial and allow for effective referrals of older people, people with special needs and or recipients of mental health services. As the health care volunteers are really volunteers, concerns were expressed as to the sustainability of the volunteer work. If a health care volunteer finds a paid job, he/she will leave his/her health job.

RA 3.10: Participating health institutes have improved or developed curricula on inclusion that are being applied.

The main achievement under this outcome has been the introduction of a diploma course in gerontology in the National Institute of Social Development (by senior partner HelpAge). The course has been formally approved by the Grant Commission (30 credits). Hopefully the course will provide the staff to take care and manage the various elders homes and adult care centres that at the moment have no adequate qualified staff (15% of the 300 elders homes and the 65 adult care centres have no qualified staff to run the institution).

RA 3.11: Targeted health centres reach 1200 more marginalised people.

There are no firm figures available to assess the utilization of health services by the three target groups. However, anecdotal information from a doctor in a hospital tells of an increase in older people attendance by about 20% and poor health conditions of those that stay at home (ulcers, bedsores, wounds). Inclusion of TEA related interventions in national policies has not yet been achieved, but might be feasible over a longer time period.

RA 3.12

Concrete steps taken and progress shown in making national and local health guidelines and/or policies more inclusive

As overall conclusions, the evaluation report states that remarkable achievements have been made in result area 3: the training programs have improved knowledge and skills of health care volunteers, CBO members and families to provide better services to older people, people with special needs and recipients of mental health services. At least 68 people with special needs have been identified in the communities at some 450 people with special needs received treatment. The training of health staff has improved the quality of treatment of these three groups in the hospitals where TEA has been active. Relations between the communities, the health care volunteers and the health and local government institutes have improved positively.

Tajikistan

GIP coordinates the TEA programme in Tajikistan. With three staff members, it has implemented the programme over the 5 years (since 2011). A total of 7 CSOs were selected for the TEA interventions:

1. Central Asia Gerontology Centre (CAGC) in Dushanbe*[1]

2. NGO Centre for Mental Health and AIDS (MHAIDS) in Hissar district* (Home Care). MHAIDS left TEA programme; since May 2014 it is called "Centre for Civil Initiatives, funded by the EU.

3. NGO Imkoniyat (IGA for people with disabilities)*

4. Leage of Disabled Women, NGO Ishtirok (IGA for people with disabilities)*

5. Centre of Social Support of Mental Health (CSSMH) in Dushanbe, "We want a decent life"*. (Through Self-help Groups for PMHP)

6. Bobojon Gafurov district (Sugd Province, start in 2013, desk review)

7. Tajikabad district (start 2013, desk review)

Tajikistan (population 7.8 million) gained independence from Soviet Union in 1991. The government expenditure on health is very low (2% GDP), but out of pocket costs 90% whereas the poverty is high (38%). (Mental) health very low priority for the government, policy still institutionally focused. Elderly, Disabled and recipients of mental health services receive hardly any support. Voices of marginalised are not heard.

The TEA programme experienced a troubled first year, delaying the start of the baseline and the various interventions until late 2012. With the evaluation already in mid 2014, the actual intervention period (in three out of the five interventions) has been only some 2,5 years.

RA 3.8: 80% of the targeted NGO/CBO reach marginalised people with increased or better variety of services.

Of the seven selected CSO's by GIP, five are involved in health and 3 were evaluated in depth. They all reached marginalised people, but with varied quality and effectiveness. It appears the target is met, but the scope of the interventions was limited. MHAIDS in Hissar district (rural) reached 165 households with home care and medical check-up by a multidisciplinary team, but as AIDS was their core business, the mental health part proved difficult and was not well implemented.

CSSMH (self-help) targeted a group of 12 recipients of mental health care and addressed the needs as they expressed it themselves. One of the problems was lack of adequate facility for the groups and no funding.

[1] *These five CSOs were included in the 2014 country evaluation, but just three in RA3.

RA 3.9: 75% of the health actors involved (NGOs, CBOs and institutes) in comprehensive care programmes perceive that relationships have intensified and are stronger.

This topic has not been explicitly addressed, but partners of the TEA programme perceive improved relations by participating in the Ministry of Health and Social Protection platform and referrals for people with mental health problems by CSSMH in Dushanbe.

RA 3.10: Participating health institutes have improved or developed curricula on inclusion that are being applied.

CAGC developed training manuals for social workers and doctors (60 in Dushanbe and 20 in Gafurov) on care for the elderly that had a positive effect on social workers and patients. Curricula were developed for nurses and family doctors in cooperation with Tajik Medical University. Ministry of Health and Social Protection provided official certificates of achievement. The establishment of gerontology rooms further strengthened the work of CAGC. MHAIDS started with the Department of Psychology and Tajik National University curriculum & manual development focusing on recipients of mental health care (later supported by NGO Centre for Psychological Assistance and TMAC). The selection of the staff to provide gerontology services in the health staff initially was meant to be done by CAGC, but was taken over by the Ministry of Health and Social Protection, thus reducing the likelihood they will become involved in gerontology, as they might become employed in other government services.

RA 3.11: Targeted health centres reach 1200 more marginalised people.

There have not been specific objectives in the TEA programme

that targeted Health Centres.

RA 3.12: Concrete steps taken and progress shown in making national and local health guidelines and/or policies more inclusive

GIP negotiated a MoU with Ministry of Health and Social Protection that promoted attention for mental health and formalised the establishment of gerontology rooms nationwide (in every Primary Health Care facility). It improved relations with the Ministry and created a platform for NGOs that work with vulnerable groups. Such a cooperative relation is a unique achievement in Tajikistan, allowing for dialogue and information sharing. CAGC was tasked to monitor and report on implementation of this Order of the Minister of Health and Social Protection. A database of elderly only exists in 4 HCs and the use of these gerontology rooms is still quite low (despite the presence of a medical doctor).

Vietnam

The office of MCNV in Hanoi has implemented interventions in result area 3 in three (four) Provinces:

1. Quang Tri (598,000): Community Managed Health Development Programme (CMHD);

2. Phu Yen (860,000): Community Managed Health Development Programme (CMHD);

3. Khanh Hoa (1,157,000): Community Managed Health and Livelihood Development Programme (CMHLD);

4. (Cao Bang (507,000): Only a result area 3 intervention with very small budget and no baseline or final evaluation done. It is hardly included in the country evaluation report analysis.

Beneficiaries are marginalised people, including organised in older people organisations, disabled people's organisations, recipients of mental health services, all through Village Health Workers Associations (VHWA), that are province-wide associations with hundreds of members in hundreds of villages. In the pilot projects the village health worker associations of the TEA programme work with six commune health centres. They work in these three provinces through VHWA that cooperate with a total of 33 CBOs and 4 NGOs, participating in the TEA programme (CSOs bring benefits not only for members but also for their communities in general).

RA 3.8: 80% of the targeted NGO/CBO reach marginalised people with increased or better variety of services.

There is substantial increase (5-6 times) between 2011 and 2014 in the amount and variety of health education and communication by village health workers associations (participants - events from 51-1,647 to 178-5000) with more diversified services and towards more official sources (health centres, broadcasts, campaigns), but there are differences among the provinces in the extent to which village health workers provide inputs (in time and duration) and are capable of linking with disabled people's organisations and older people's associations and making a difference between marginalised and non-marginalised populations in the evaluated villages.

RA 3.9: 75% of the health actors involved (NGOs, CBOs and institutes) in comprehensive care programmes perceive that relationships have intensified and are stronger.

All six communal health centres included in the survey report stable or improved relations with disabled people's organisations and older people associations, but the relation with village health workers associations are still weak in four out of six community health centres. Community health centres cooperate with village health workers' associations, disabled people organisations and older people associations to implement community based rehabilitation for people with disabilities, comprehensive care for older people's associations and for recipients of mental health services. In general changes in the level of cooperation between providers (=community health centres) and community organisations (CBOs and

NGOs) are not apparent (due to differences in starting points), when comparing support to community health centres with control community health centres.

RA 3.10: Participating health institutes have improved or developed curricula on inclusion that are being applied.

In Quang Tri secondary medical school, both learning hours have been added to existing curriculum of nurses plus assistant doctors and teacher's skills and revision of training curricula has been done in areas such as geriatric mental health, care for the elderly and rehabilitation of people with disabilities. More work will be needed if communication and leadership skills of teachers are to last.

RA 3.11: Targeted health centres reach 1200 more marginalised people.

This target has been surpassed. Over 2600 people received check-ups or home based care by staff of community health centres with support by village health workers in mobilization, screening, and detection. An increase of elderly and people with disabilities were attended and over 4000 people were screened on mental health problems (170/1815 = 9% in 2013 and 42/ 3022 = 14% in 2014). Similar increases were found for screening of people with disabilities, recipient households reportedly were satisfied. It seems that utilization by marginalised groups was higher than by non-marginalised (in the studied villages). Specific training to village health workers by province and district authorities was given to 45 village health workers (in mental health), 131 village health workers (in people with disabilities) and to 146 village health workers (in elderly care). Thanks to the TEA intervention, an annual budget has been allocated for care for the elderly to all districts (including control districts) by the provincial health department.

RA 3.12: Concrete steps taken and progress shown in making national and local health guidelines and/or policies more inclusive

The TEA programme supported lobby and workshops of disabled people organisations and older people associations to influence policy by community health centres, district and provincial health authorities. Also preliminary evidence and information collection was also undertaken at provincial and district levels, the aim being to improve access to social, economic and health development of marginalised populations. This lobbying has often been successful: provincial health department, some district people committees and the secondary medical school.

Another new approach in community mental health has been initiated by Danang Regional Mental Hospital by actively involving the family in the care for the mental patients.

Table 1: Estimated outcome target area achievements (as of mid/end 2014)

	Georgia	Lao PDR	Sri Lanka	Tajikistan	Vietnam
RA 1.1. Civil society development in Civicus terms	AP	Not applicable CIVICUS was not used	AP (for senior CSOs involved, no data on CBO)	AP	AP
RA 1.2. progress in CSO development in terms of 5C method	AP	AP	AP	AP (for three CSOs surveyed)	AP (senior) and ALE (junior)
RA 2.3 increased/better services by 80% of CSOs in TEA	AP	AME	AP	AME	AP
RA 2.4 Indicators list available for microfinance	Not applicable	Not applicable	AP	Not applicable	AP
RA 2.5 MFIs reach 25% more marginalised persons	Not applicable	Not applicable	No data available	Not applicable	AP
RA 2.6 INFI services provided	AP	AP	AP	AP	AP
RA 3.8 increased/better services by 80% of CSOs in TEA	AP	AP	AP	AP	AME
RA 3.9 75% of actors cooperate better/ relation stronger	AP	AME	AP	AP	AP
RA 3.10 Curricula improved or developed	AP	AP	AP	AP	AP
RA 3. 11 Health centres reach 1200 more marginalised persons	Not documented	AP	No data provided	Not applicable	AME
RA 3.12 National and local health guidelines/ policies more inclusive	AP	AP	AP	AP	AP

AP: achieved according to plan (as of mid/end 2014) NA: Not achieved or far less than expected (as of mid/end 2014)

AME: achieved more than envisaged (as of mid/end 2014) ALE: Achieved less than expected (as of mid/end 2014)

Appendix 2: List of persons interviewed for the synthesis evaluation of the TEA programme

Person	Function and Entity
Marijke Roes	Desk officer DSO, Ministry of Foreign Affairs NL
Cas van der Horst	Embassy of the Netherlands Vietnam
Pamela Wright	Director MCNV NL
Sebastian Dinjens	TEA programme director, MCNV NL
Akke Schuurmans	Programme coordinator MCNV NL
Francisca Goedhart	Director GIP NL
Katia Assoian	Programme coordinator GIP NL
C. Koornneef	Programme coordinator GIP NL
Caroline van Dullemen	Director World Granny
Darejan Jana Javakhishvili	Director GIP Georgia
Nino Makhashvili	GIP Georgia
Ana Akhvlediani	Elkana Georgia
Somphao Bounnaphol	Director MCNV Laos
Iain Bromage	MCNV Laos
Sharon Fernando	TEA coordinator, Sarvodya Sri Lanka
Senadipatige Sumanasiri	Sarvodya Sri Lanka
Zalina Shanaeva	GIP Tajikistan
Behzod Yatimov	GIP Tajikistan
Ho Sy Quang	Director MCNV Vietnam
Tran Le Hieu	MCNV Vietnam
Nguyen Ngoc Lan	MCNV Vietnam
Nguyen Thang Tung	MCNV Vietnam

Appendix 3: Conference report TEA conference Colombo 2015

Summary TEA conference Sri Lanka 9-12 February 2015

The annual TEA conference was held to discuss progress among the five TEA countries, exchange best practices and in particular to find a common approach for the implementation in the final year of the TEA funded programme period. Also fundraising and communication was put on the agenda in order to exploit the successes in the various countries.

During the first day of the conference emphasis was put on describing the main achievements per result area: capacity building, livelihood support/microfinance as well as health support for marginalized groups. Striking feature was the widespread positive involvement of health authorities thus forming the basis for sustainable outcomes after the TEA funding will end. Also it would already now entail the potential to reach a wider group of people outside the now often quite limited number of beneficiaries in the countries. The typical approach of the civil society/community groups involved in this project is to prove to the authorities that better service delivery for previous unpopular groups such as the elderly and the disabled is possible. The introduction of international best practices, international experts and the relevance of international agreements has many times helped the acceptance by the authorities.

In terms of civil society strengthening the main common impact mentioned is the increased self-confidence based on self-esteem after the marginalized groups received attention which in turn has improved the communication skills and the capacity to speak up for themselves. Also the element of solidarity among the groups has generally led to renewed energy to improve their own fate in cooperation with the local or district authorities.

The microfinance aspects of various interventions have been developed along the way. Basically the informal character of the credit groups and joint investments in projects implied inventing rules and regulations by TEA itself. The INFI part of TEA served that purpose. At this point it is not clear how this assistance was provided, upon demand or coordinated for the 5 countries by MCNV. More information will be provided.

The second day visits were paid to elderly groups in the countryside in Sri Lanka. Presentations were made on the Cinnamon and Tea projects, growing small plants in order to sell them later at a higher prize after proper care in the nursery. Although participants were not interviewed because of the collective character of the visit and the language barrier, it could be seen that the participants were proud, seemed very involved and energetic. The market for the products is available and the profits redistributed to community members in need of humanitarian assistance. The microfinance/livelihood interventions seem to resemble a model of social enterprise. In Sri Lanka a positive element is the formation of an association of village development communities in a way taking over the coordination by the TEA partners in Sri Lanka. Also in terms of advocacy for microfinance for elderly positive steps were made by the MFI's in terms of raising the age limit to be able to receive credit to 70 years. At the TEA conference a microfinance expert from Accion, Josh Goldstein, was present to study the experiences with TEA . Also in other countries microfinance to marginalized groups is being undertaken. Part of the discussion was the application of sound standards in microfinance, the Social Performance Measures for financial institutions were applied to the work within TEA. This is done with enthusiasm even though the method is not

really aimed at civil society groups and informal lending schemes. This exercise was conducted on day three of the conference.

The fourth day of the conference was devoted to formulate and discuss plans for 2015, the last remaining year of TEA. Special attention will be given to marketing and communication on the successes in the country programmes. Often it was mentioned that the international cooperation among the five countries should be used to attract future funding. Also the importance to assemble and describe all the project interventions on the website was suggested. The various implementing organisations will almost all in one way or another continue with parts of the TEA programme. As this will be also determined by the availability of funding for the various activities it of course remains to be seen how this can materialize.

For the evaluation exercise of Carnegie Consult the conference provide an opportunity to speak to each of the five country teams and discuss the findings in the country evaluation reports. The findings in the report were thus tested, triangulated, and also it was asked how the studies could lead to recommendations for the future. The interviews are used in the summative report of the Carnegie evaluation.

The draft summative part of the evaluation work was distributed to the teams for testing on factual errors and where possible updates in the size of the beneficiary groups.

Last but not least the methodological constraints were discussed of establishing outcome predictions when the TEA programme as such has not been finalized yet.

Appendix 4: Terms of Reference of the assignment

External document

Appendix 5: Overview of evaluation process (drafted by MCNV)

External document