Raising resilience in Rakhine

Evaluation summary: Community Based Health and Resilience - Health in Emergencies Programme

Photo: MRCS

Launched in January 2017, the 'Community Based Health and Resilience - Health in Emergencies (CBHR-HiE)' programme was designed to address some of the complex humanitarian, development and peace issues in Rakhine State. Aiming to reduce vulnerability, it supported communities to strengthen their resilience against shocks and stressors.

CBHR-HiE was one of the first programmes of Myanmar Red Cross Society (MRCS) to tackle longer term resilience goals in this fragile state. Supported by the International Federation of Red Cross and Red Crescent Societies (IFRC) , it supported communities in terms of health, water and sanitation, and disaster preparedness.

The CBHR-HiE team consisted of MRCS staff with significant experience in delivering community-based health and First Aid in other parts of Myanmar. On technical and management aspects, the team was supported by a Sittwe-based IFRC health delegate and sub-office team as well as MRCS headquarters.

How can community resilience strengthened under fragile conditions?

This snapshot gives some ideas, based on the lessons from a programme evaluation in Myanmar's Rakhine State.

CBHR-HIE: quick facts

Programme title
Community Based Health and Resilience - Health in Emergencies (CBHR-HiE)

Programme period
January 2017 – December 2019

Implementing agency
Myanmar Red Cross Society (MRCS), with technical support from the International Federation of Red Cross and Red Crescent Societies (IFRC)

Supporting Partner National Society Swedish Red Cross (SRC)

Donor: Swedish International Cooperation Agency (SIDA)

Budget: CHF 2,163,000

Beneficiaries
4,545 households (around 24,000 persons) across 28 Rakhine and Muslim villages. 20 villages are Rakhine and 8 are Muslim; beneficiary numbers were roughly equal for Rakhine and Muslim populations.

Evaluation snapshot

Two independent consultants evaluated the programme in September/October 2019. As travel restrictions prevented field research, this was based on a three-day workshop in Rakhine's capital of Sittwe. Representatives from 9 of the 28 target communities attended the workshop. While Muslim communities could not participate directly, village tract leaders provided secondary information.

The evaluation indicated that target communities are now more resilient than they had been prior to the project. The programme team managed to achieve significant outcomes - embedding a health focus into a wider and more holistic resilience frame.

This snapshot first presents the main lessons from the evaluation and then its findings. Furthermore, it includes three stories of change - thereby highlighting some of the changes the programme achieved.

1. Lessons learnt

1.1 For fragile contexts

Established trust and partnerships with the Ministry of Health and Sport (MoHS) proved beneficial as violence escalated.
The relationship between MRCS and the MoHS enabled a unique solution as violence in both townships escalated and access became restricted. While programme staff could no longer access target areas, the government's mid-wives (who were not affected by restrictions) were able to connect with previously trained MRCS volunteers. At the request of township medical officers (TMOs), these midwives collected local information and passed on new training material and advice to volunteers. Using this system, the programme retained its ability to reach remote communities.

Predictable and flexible funding supported effective programme planning and delivery.
Reliable funding from SRC supported both a stable staffing structure and strong community relationships. It also allowed flexibility and responsiveness needed in fluid operating conditions.

In a fragile context, a considerable investment in staff pays off.
Especially in a complex and fragile environment, programmes need stable and experienced staff. The programme had a much higher ratio of staff than similar MRCS interventions. While there could have been more shared roles with other Red Cross resilience projects in the state, the investment in staff capacity is identified as a success factor.

The multilateral channel for programming was very effective in this context.
IFRC provides much-needed support for partner national societies (in this case Swedish Red Cross) to programme intelligently and sensitively in Rakhine State.

The Rakhine context has many moving parts, sensitivities, as well as push and pull factors from external sources. To ensure that programmes can bridge the humanitarian, development and peace nexus, additional support, coordination, information and care is required - as supplied by IFRC in this case.

1.2 For resilience programming

Tapping the expertise of multiple MRCS departments/units pays off.
While the CBHR-HIE was hosted by the MRCS health department, a similar project nearby was under the auspices of the Rakhine Operations Management Unit (ROMU). Although these projects should ideally be pursued under one resilience umbrella (with shared staff and time to enhance coordination), the evaluation found that the engagement of the MRCS health department provided highly relevant capacities.

Current MRCS structures do not provide for the integrated support required for resilience programmes.
The CBHR-HiE programme required staff and technical expertise from various MRCS departments (Health, Organisational Development, Disaster Management, WASH, First Aid and Safety, ROMU, and Restoring Family Links (RFL)). However, only full-time support from the health department was available during the programme. Systems need to enable technical staff of one department to temporarily work full time on a programme that is under the auspices of another department.

Resilience programmes require a longer implementation period.
The evaluation finds that three years are too short for resilience programming, especially when the frequent disruptions of a fragile context are factored in.

1.3 For this specific project

More attention is required around 'safe' and 'clean' water.
Some water sources upgraded through the programme were still not potable; further emphasis on treatment/filtration before drinking is therefore required.

There was some confusion regarding the MRCS volunteer and community volunteer policy and functions.
Many community volunteers expressed that they would like to be registered Red Cross volunteers but were not adequately supported to register. Community volunteers had less support than registered Red Cross volunteers. MRCS should strive to recruit a diverse volunteer base that is representative of all communities.

2. Evaluation findings

Relevance
MRCS provided significant input for vulnerable communities, both Muslim and Rakhine, across Mrauk U and Minbya townships. All communities had acute needs in 2016, including health, WASH and livelihoods. Villages lacked basic

Villagers gathering to analyse their capacities and vulnerabilities. Photo: MRCS

infrastructure and the residents faced many difficulties due to poverty. At 41.6%, Rakhine State ranks second in poverty incidence rates in Myanmar (Myanmar Living Conditions Survey 2017, Word Bank).

Even if some households are classified as non-poor, they remain vulnerable to falling into poverty, particularly in the face of unanticipated negative shocks. Based on the study's various findings, the programme was deemed highly relevant.

Efficiency
The CBHR-HiE programme was able to absorb and spend the investments very efficiently. Spending rates against plans were extremely high, and activities were implemented despite various delays and restrictions in access to programme areas.

The programme was heavy in human resources - almost 43% of the budget was allocated to personnel costs. This included costs for one international delegate, 28 MRCS programme staff, volunteer support expenses and some indirect personnel contributions. Human resource costs were twice the MRCS standard. However, the evaluation finds that in view of the complex context and strong performance of the programme, this investment in staff may be justified - the programme managed to deliver in the face of challenging circumstances.

Effectiveness
Regarding the programme set-up, the evaluation found that the team succeeded in robust planning and design, in managing implemen-

tation throughout times of crisis and adverse conditions, and in recruiting and maintaining highly experienced staff members. Co-operation amongst MRCS departments (health, disaster management, organisational development) could be improved.

The CBHR-HiE achieved only some of its output targets. All outcome targets require updated data and will need to be measured when access its restored in both target areas (Muslim and Rakhine).

Sustainability

Analysed as a function of local ownership (willingness and capacity of communities to continue maintain outcomes) and of an enabling environment, the sustainability of programme outcomes is found to be rather high.

Early engagement of communities in planning (the Integrated Community Assessment for Building Resilience, ICABR) and the requirement of local contributions to infrastructure and household latrines fostered willingness.

In terms of capacity, the potential of seed funds to communities and grants to mother support groups is recognised. The nearby MRCS branches as well as better linked health officials may form part of an enabling environment.

Despite the positive outlook over the short to medium term, the evaluation makes a strong case for complementary consolidation efforts – ranging from refresher courses to a more full-fledged programme extension.

MRCS conducted a needs assessments with households across all target villages. Photo: MRCS

1. The Resilience Star was developed by IFRC as part of its 'Road Map to Community Resilience' in 2017. It can be used either as a summative tool or for initial quick assessments (that can be the starting point for further in-depth assessments and planning).
2. The version for the evaluation featured two data points (2016 and 2019) and not just one as in the standard version.

3. Measuring resilience

In an effort to measure resilience, the evaluators applied the Resilience Star. The tool was first developed by IFRC in 2017 and updated in 2019 under the resilience dashboard initiative.[1] In this global debut of the updated version, the Resilience Star was adapted to evaluation purposes.[2]

MRCS and IFRC staff were trained in this tool in Yangon and then assisted the external consultants to conduct nine sessions with the sampled communities during the Sittwe workshop.

There are eleven dimensions in the Resilience Star that altogether represent a resilient community *(see illustration)*. To facilitate the Resilience Star, each village was asked about each dimension in relation to their village. A number of indicator questions were asked for each dimension, which were converted to scores between 0.0 (very low) and 1.0 (very high). This was done for 2016 (before the project) and 2019 (after the project). If there was a change in scores between 2016 and 2019, the community was asked to explain the changes and to describe the attribution of change.

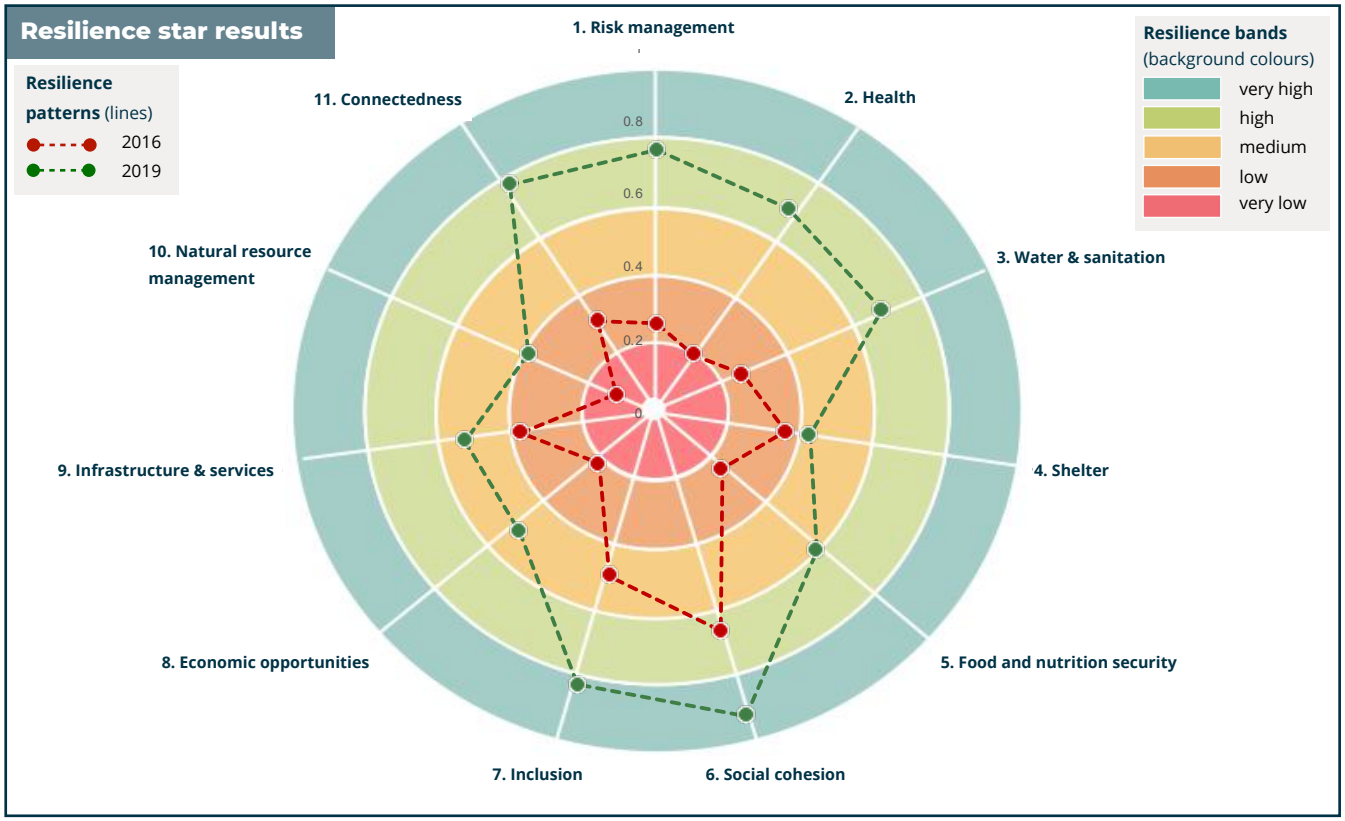
Resilience star results

The illustration shows the summary resilience results from the nine sampled villages (not including Muslim villages). The red and green lines show the 2016 and 2019 scores, respectively.

The summary results of the resilience star points to improvements on all eleven dimensions. Major advances were recorded in terms of health and risk management (+0.48 each), connectedness (+0.44), as well as water and sanitation (WASH, +0.42).

It is clear that communities had been extremely vulnerable, with many dimensions indicating acute needs in 2016. The number of dimension scores falling into the 'low' or 'very low' bands was reduced from nine in 2016 to one in 2019.

A large positive change is evident in risk management, health, water and sanitation, inclusion and connectedness.



Not all positive changes were attributed to the programme, but many communities listed CBHR-HiE as a contributing factor.[3]

In line with the programme design, the role of the CBHR-HiE was particularly prominent in the dimensions of health, risk management and WASH. Greater health knowledge, improved health-seeking behaviour and immunisation rates, risk reduction plans, early warning systems, as well as greater latrine usage were chiefly attributed to the programme.

4. Into the future

The experience of the CBHR-HiE programme shows that resilience programming works. That it can work under the difficult circumstances that have prevailed in Rakhine State over the past years is largely credit to the programme team, which has demonstrated talent, dedication and adaptive qualities to deliver a programme against such adverse conditions.

Three main points (practical, managerial, and strategic) can be drawn from the experience of the CBHR-HiE programme.

The **practical** point concerns the immense needs of communities in today's Rakhine State: while the programme achieved progress towards a more resilient Rakhine (along the lines of multiple dimensions in the resilience star), the holistic tool of the resilience star illustrates that further needs and vulnerabilities remain. Some outcomes also require extended support to consolidate and extend impact.

The **managerial** point relates to the set-up of human resources: as the CBHR-HiE experience indicates, it pays off to invest in a highly experienced team. In adverse conditions, programme planners need to factor in the comparatively high human resource costs - even if they exceed common standards and benchmarks.

Finally, the **strategic** point regards the direction that MRCS seeks to take in future. Implementing the MRCS Resilience Framework will not be easy, particularly in conflict affected areas of the country.

While there was some collaboration between the various MRCS departments, an even more integrated structure is required for smooth resilience programming. Red Cross branches will always be at the forefront of such efforts – and it is evident that they will need to play a more central concern in the resilience roll-out.

The CBHR-HiE has made progress - yet, the road to resilience in Rakhine State remains long.

3. Communities attributed improvements to a range of factors, including interventions by the government and other organisations as well as an increase in remittances from family members who now work elsewhere.

U Ba Saw Oo (48) lives in Kan Phe village with his wife and their two sons, as well as his sister. He trades paddy, rice, and betel nut, and is also the administrator of Satkyar Oat Su village tract.

The administrator | U Ba Saw Oo

STORIES OF CHANGE

My name is U Ba Saw Oo, I am a village tract administrator of Satkyar Oat Su village tract. With 40 households, my village of Kan Pae is the smallest village of the five villages in the tract. The tract has 1,100 households in total. This village is Rakhine, the other four villages are Muslim.

We have all lived together under my supervision since 2006. In 2012, very intense ethnic-based violence occurred in our state. Our village tract, unlike others, was safe. When it became known that we were safe and peaceful during that crisis, I was investigated twice by the district level to see how I handled our two communities in my village tract. My answer for both investigations was simple, "trusting each other and protecting each other is the solution".

Since becoming a village tract administrator, I have been very curious how to improve health knowledge and disaster preparedness for our community and to look for ways to protect us all from all types of hazards.
In 2017, I was informed that the project, 'Community Based Health Resilience and Health in Emergency' would be implemented by Myanmar Red Cross in my village tract for all five villages.

Changes I have observed: Our knowledge in health, disaster risk management, personal hygiene and environmental sanitation has improved due to the CBHR programme across my village tract. To change one's behaviour through talking and education is an enormous feat. It is the most difficult thing to change personal concepts and to then impact behaviour. This could be due to the very patient and active listening habits of the project staff, effective project planning against the project timeline and strong mobilisation skills of the project.

The next visible change concerns female participation within the Muslim communities. Muslim communities have rules and their beliefs and ethnic restrictions that forbid women from visiting a place where there are five or more men gathered. This restricted women from participating in community affairs. With the education and facilitation by the project on the modern flow of women's

participation, more women can now participate in community events and discussions, although it is still a challenge to have women contribute to decisions there.

The most significant change is the coverage of latrines, their use in our villages, and environmental sanitation. Before the project, we practiced open defecation. The latrine coverage for all five villages was less than 10%. Now the latrine coverage here is more than 75% for all the population. I also have to mention our community participation - because the project supported around 60% of our latrines. Then after the community saw these latrines being built, 15% more were built by the villagers by themselves.

Now due to the current context and crisis, instead of the MRCS staff visiting our villages, the Red Cross community volunteers have to go to town once or twice a month to attend health education sessions. Muslim community volunteers cannot travel to town due to their movement restrictions; our village representatives have to travel to their villages and train them again.

Both communities are happy with this arrangement, and it is going very well. Our community depends more and more on Red Cross community volunteers - not only due to the current crisis situation but also for the daily first aid support and health education.

Sustainability: I have no doubt that the programme activities will be sustainable in my community, especially for the Muslim community: they already have more of a habit to use water when using the latrine than the Rakhine community. The Rakhine community did not have the habit of using water at the latrine, due to scarcity of water. Now our communities have enough water through the programme and knowledge for both health and sanitation, so this valuable change in latrine coverage and usage will last forever.

We are united. To have our people from different backgrounds staying together longer, we have deep mutual respect in the community. We trust and protect each other. In. our minds, we are one group. We feel connected to all, as if we were relatives.

The midwife | Htay Htay Khine

Htay Htay Khine works as a midwife in Minbya township.

I am a midwife posted in Kwe Gyo rural health sub-center (RHsC) in Minbya township. My name is Htay Htay Khine. I am single and am a Minbya native. My parents are school teachers in Minbya.

I have been staying in Kwe Gyo sub-centre since I was posted here in 2015. I go back to my parent's home in Minbya every month during the time of monthly meetings, medicine orders, training and the monthly reporting. Kwe Gyo is my second posting as a midwife.

In 2017, I heard that there was a programme in some of my catchment area villages. I have six villages in my sub-centre catchment area; all are Rakhine villages.

Out of the six villages, four are Red Cross programme villages, but I had not been engaged in the programme. In mid-2018, I got the instruction from the township medical officer to engage with the programme activities to deliver monthly small group health education sessions on maternal and child healthcare a well as nutrition for pregnant women and mothers with children under five.

I organised this group and provided health education sessions in every programme village. This was the first contact with the programme. Thereafter, Red Cross community volunteers helped me in the activities of prevention and control for dengue and mobilising the community for immunisations.

I usually collect quarterly data reports on population, latrine coverage and number of water sources in the community together with the auxiliary midwife, community health worker and malaria volunteers. I started to notice the Red Cross programme when I found out that the latrine coverage in the programme villages rose dramatically and reached up to 65.7% from 14% (in 2017) for the whole sub centre coverage in 2018.

The next change was that the drinking water ponds were fenced. I also noticed that the community has gained much health knowledge which impacts on the utilisation of healthcare services. This means that people visit us earlier than usual. The process of immunisation also became smoother.

In 2015 and 2016, all the villages in my catchment area had a dengue outbreak. In 2018, with the support of Red Cross volunteers, we suggested to the village tract administrator to announce that there would be fine for every house where the Red Cross found any larvae in the household storage water.

Then all households were monitored by Red Cross volunteers. They applied larvicide to all households that stored water. Through this initiative, 2018 was the year in which my area was free from dengue outbreaks.

Going forward: There is no conflict in my catchment area. We just hear the conflict and the sound of the explosions, and we lost the internet network completely. I would like to support the programme more, but it is not possible for me to assist in health education for every village, every month. I can organise the Red Cross volunteer team for the same activity support in the future too.

To improve: There are still some households in the villages that drain their toilet pipe directly into the river. It would be good if these latrines could be moved. And I also wish this programme be extended to other villages.

The volunteer | Nyo May

As a volunteer, I was assigned to give health education sessions. The topics I cover are burns and scald, diarrhoea, respiratory tract infections and immunisation. I also provide first aid services to minor injuries and emergency first aid care. Being a tailor, I also talk about health education topics to my customers when they visit to have their dress made!

It is not very easy for me to move around for health education sessions due to my disability. Many people listen to my health education sessions, but some people did not want to attend in the beginning. Now they rely on me more as time goes by. I will be there as a Red Cross community volunteer after the programme has finished. I will continue to deliver health education sessions in my village.

IFRC

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