AHP Australian Humanitarian Partnership

Response to the Rohingya Humanitarian Crisis Phase II Evaluation

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Acknowledgements

Structure of the Evaluation Team

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List of Acronyms

ADB	Asian Development Bank
AHP	Australian Humanitarian Partnership
AHPSU	Australian Humanitarian Partnership Support Unit
ANGO	AHP Partner NGO
AWD	Acute Watery Diarrhoea
BGS	Bangla-German Sampreeti (Bangladesh NGO)
CBM	Australian branch of the international NGO formerly called Christian Blind Mission
CBO	Community-Based Organization
CBV	Community-Based Volunteers
CDD	Centre for Disability in Development
CiC	Camp-in-Charge
DFAT	Australian Department of Foreign Affairs and Trade
DPO	Disabled Persons Organisation
DSK	Dushtha Shasthya Kendra (Bangladesh NGO)
EiE	Education in Emergency
FAQC	Final Aid Quality Check
FGD	Focus Group Discussion
FIVDB	Friends In Village Development Bangladesh (Bangladesh NGO)
GBV	Gender-Based Violence
GC	Girls Committee
GFS	Girl-Friendly Space
GoB	Government of Bangladesh
HBL	Home-Based Learning Centre
HI	Humanity & Inclusion (US NGO)
IDI	In-Depth Interview
IPTT	Indicator Performance Tracking Table
J-MSNA	Joint Multi-Sector Needs Assessment
JRP	Joint Response Plan
KII	Key Informant Interview
M&E	Monitoring & Evaluation
MEAL	Monitoring, Evaluation, Accountability, Learning
MHPSS	Mental Health and Psychosocial Support
NGO	Non-Governmental Organisation
OPD	Organisation of People with Disability
PI	Plan International Australia

PPE	Personal Protective Equipment
PSEA	Protection from Sexual Exploitation & Abuse
PWD	Person with Disabilities
RRRC	Bangladesh Office of the Refugee Relief and Repatriation Commissioner
RTMI	Research, Training and Management International (Bangladesh NGO)
SRH	Sexual and Reproductive Health
TLC	Temporary Learning Centre
UN	United Nations
UNDP	United Nations Development Program
UNICEF	United Nations International Children's Emergency Fund
WASH	Water, Sanitation and Hygiene
WC	Women Committee
WGSS	Women and Girls Safe Space
WGSSQ	Washington Group Short Set on Functioning Questions
WWC	Women Watch Committee
YPSA	Young Power in Social Action (Bangladesh NGO)

Definitions

Inclusive Communities	Consortium formed by three AHP NGOs (Save the Children with CARE and Oxfam) and a non-AHP partner NGO (Humanity & Inclusion) in the AHP Rohingya Phase II response
Local Partner / Local NGO	NGOs which are not Bangladesh branches of international NGOs
End-of-Investment / Program Outcome	The desired development change that can be achieved within the timeframe of the investment
Longer-Term Results	Results beyond the timeframe of the program / investment

Contents

Executive Summary

To address the emergency humanitarian needs of displaced Rohingya people, the Australian Humanitarian Partnership (AHP) initiated the Rohingya Humanitarian Response in 2017, funded by the Australian Department of Foreign Affairs and Trade (DFAT). Phase I, which ended in 2018, was followed by Phase II in 2019. Phase II was a one-year humanitarian response to the ongoing humanitarian needs of Rohingya people and host communities, implemented by five AHP Partner NGOs (ANGOs): the Inclusive Communities consortium formed by Save the Children with Oxfam Australia and CARE Australia, World Vision Australia and Plan International Australia. More than AUD 10 million was allocated for Phase II to provide humanitarian support in the health, WASH (water, sanitation and hygiene), education and protection sectors. This evaluation was conducted on the Phase II program in order to assess the relevance, effectiveness, efficiency, coherence, inclusion, localisation, accountability, and the COVID-19 response of ANGOs, as well as to formulate action-oriented recommendations for Phase III of the program. With funding of about AUD 45 million, Phase III commenced in 2020 and will end in 2023.

To guide the assessment of the AHP response, the evaluation team developed a rubric – a framework that identified the expected standards or performance for each of the evaluation questions. A mixed-method research design was utilized considering both quantitative and qualitative data. Following a thorough desk review, data was collected in Ukhiya and Teknaf, Cox's Bazar, Bangladesh, through a survey of representative sample of beneficiaries (n=581); key informant interviews (KIIs) (n=56); in-depth interviews (n=10); focus group discussions (FGDs) (10); and observations at a number of sites across seven camps, including: Women and Girls Safe Spaces (WGSSs) (Camp 19), Temporary Learning Centres (TLCs) (Camp 4), Home-Based Learning Centres (HBLs) (Camp 23), WASH facilities (including latrines) (Camp 12), handwashing points (Camp 12), tap stands (Camp 12), healthcare centres (Camp 4, 18), and random households. This report was produced based on the insights derived from the interpretation and analysis of the data collected.

Main findings

Relevance

All activities undertaken by the ANGOs were found to be highly relevant considering their consistency with the overarching needs assessments (such as the Joint Response Plan 2019 (JRP), the Joint Education Needs Assessment 2018, and the Joint Multi-Sector Needs Assessment (J-MSNA) 2019), and with individual agency baselines and/or community consultations. Save the Children designed their health sector activities around Sexual and Reproductive Health (SRH) and Mental Health and Psychosocial Support (MHPSS), issues which were prioritized in JRP 2019. CARE responded to the critical need to prevent and mitigate Gender-based Violence (GBV) risks and empower of women and girls through gender-based services; these issues were highlighted as protection sector objectives in JRP 2019. Oxfam conducted needs assessments and facility mapping to determine beneficiary needs and response plans through community consultation. World Vision set its targets upon a baseline study coupled with community consultation and feedback from other actors. The activities of Plan International (PI) were also appropriate as they mainly focused on the needs prioritized in J-MSNA 2019. In addition, the community

outreach approach followed by ANGOs working in the health and protection sectors was highly appropriate considering the conservative social norms and mobility barriers of women and girls in the Rohingya community.

Seven months into the implementation of Phase II, the COVID-19 pandemic became a major threat to the lives and livelihoods of both the Rohingya people and host communities. All ANGOs swiftly integrated a COVID-19 response into their program. The appropriateness of the ANGO response was also reflected in the beneficiary survey: more than 80% of respondents across all ANGO beneficiary groups reported that the humanitarian activities were highly relevant to their needs. This was further supported by relevant sector coordinators who spoke highly of the relevance of ANGO activities.

Effectiveness

The Inclusive Communities consortium reported a beneficiary reach of 173,012 people, of whom about 68% were female, with support in the areas of education, health, protection, and WASH.

Save the Children reported a reach of 7000 boys and girls (including children with disability) with education support. Eighty-six percent (86%) of the parents surveyed showed satisfaction with the quality of education and shared positive feedback on Save the Children's learning centre space, educational material quality, and teacher quality. One hundred and fifty children were provided individualized education with technical support from US NGO Humanity & Inclusion (HI), a major step towards inclusive education given that many of these children had not had any educational access before. However, individualized education for children with disability was discontinued after Phase II ended, and parents reported that their children started forgetting what they had learned. In relation to health, Save the Children contributed to enhanced awareness of SRH issues such as menstrual hygiene, birth control, and contraceptive use as evidenced by the evaluation team's field data. Eighty-five percent (85%) of health beneficiaries surveyed showed a high level of satisfaction with the health support provided by Save the Children.

CARE also supported the beneficiaries through its health posts and outreach clinics. Beneficiaries opined that they have greater access to SRH knowledge and modern contraceptives. As for the outcome of women making their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care, the indicator target was partially achieved. On protection, CARE provided support to women and girls through their WGSSs and community-based awareness sessions. The Community Outreach Groups' strong role in building awareness of GBV and protection concerns and identifying and resolving GBV risks through community involvement was strongly felt by the beneficiaries. The evaluation team found that community awareness and knowledge of GBV issues increased as a result of CARE's activities. However, different forms of mental and economic abuse such as the use of abusive language and the psychological pressure for dowry by husbands are still not considered as GBV by the community. The outcome target on changing the attitudes of men and boys to reject intimate partner violence was underachieved (35% against the intended target of 40%). This was nevertheless good progress, as CARE reached about 3,000 men and boys through its men and boys engagement sessions.

Overall, 89% of CARE's protection and health beneficiaries surveyed showed a high level of satisfaction with the support received from CARE.

Oxfam's response focused on providing inclusive, gender-sensitive and sustainable WASH services to the Rohingya population. Oxfam installed, repaired and maintained WASH facilities, such as sanitation facilities, tube wells, and communal handwashing devices. The evaluation team's survey with Oxfam's beneficiaries revealed that 98% of the respondents (n=139) and all of the female respondents were highly satisfied with the WASH facilities provided by Oxfam. Oxfam's response also contributed to increased knowledge of hygiene behavior and practices in areas such as handwashing, safe water usage, and COVID-19 risks and precaution; this was substantiated by FGDs, observational visits, and surveys with targeted beneficiaries. While Oxfam did well in terms of achieving outcomes and output level targets, some of its WASH facilities (for example, handwashing devices, lights and taps) were stolen or damaged, indicating that its maintenance and monitoring could have been more robust.

World Vision planned to reach around 27,000 people with support in the areas of WASH and protection. It was successful in reaching around 26,000 people (48% women and girls) according to the monitoring reports. In its final report, World Vision states that it had provided access to adequate safe water and sanitation facilities to between 98.6% and 100% of the beneficiaries respectively in its project areas. This statement was triangulated by the evaluation team's survey, in which about 86% of the beneficiaries reported satisfaction with World Vision's WASH support, with the rest reporting moderate satisfaction. Beneficiaries stated that their demands for water and toilets had been fairly met by the WASH support of World Vision, whereas previously they had suffered greatly due to a lack of adequate water supply and toilets. While accessibility to and satisfaction with water and sanitation facilities were fairly high, the evaluation team found a few cases where common WASH facilities had been used by some individuals for private benefits. With regards to protection, the proportion of women representatives (including women with disability) in the Protection Committees and Water Management Committees was significantly increased from the baseline situation; this was a big step towards gender equality and empowerment. According to the beneficiaries as well as members of community forums, World Vision's response in protection was effective in upscaling the community's understanding of protection concerns such as GBV.

PI reprogrammed its activities due to the COVID-19 outbreak. PI's final report indicates that almost all of the targets set in the COVID-19 realignment components had been met at the end of the response. Notable activities of the NGO included life skills development in the host and Rohingya communities, and unconditional cash transfers for the host community to mitigate the negative economic impacts of the COVID-19 outbreak. A major achievement for PI was providing education and life skills opportunities to 1008 adolescents (494 boys and 514 girls). FGDs and informal discussions with community members indicated that previously there had been few opportunities for education or skill development for adolescents or youths in Camp 21 and 23. Many adolescent and youth beneficiaries lacked basic numeracy and literacy skills – skills which they were able to gain with support from PI.

The AHP response adequately contributed to the longer-term resilience of the affected communities and the broader recovery and stabilization efforts. This was achieved through their activities on developing

life skills (including marketable skills), community resilience, disaster preparedness, and prevention of disease outbreaks. Nevertheless, neither the Inclusive Communities consortium nor World Vision had a strong enough focus on activities which promoted social cohesion and responded to host community needs. These NGOs did not have any strategies for establishing social cohesion. There were some activities to promote social cohesion within the Rohingya community only. Even so, to a large extent, social cohesion was not really addressed. PI was a notable exception: it identified and responded to educational needs in the host communities, and during COVID-19 it provided unconditional cash transfers to vulnerable host community households.

In terms of risk management, all partners prepared risk management frameworks at the design phase, but systematic monitoring of the risks was not carried out during implementation. The evaluation team did not find any evidence of incidents of fraud, corruption, or abuse during the Phase II response. Overall, ANGOs were adequately effective in managing risk, fraud, and corruption.

When providing support, NGOs faced some barriers during the implementation phase. COVID-19-induced regulatory restrictions were a major barrier faced by all ANGOs. With respect to GBV- and SRH-related responses, deep-rooted traditional beliefs in the Rohingya community made it difficult to achieve substantial changes over the course of a short project period. In relation to healthcare, a key barrier to health-seeking behaviour was that some Rohingya beneficiaries tend to trust non-qualified private practitioners from the Rohingya community more than the doctors and healthcare providers at the health centres inside the camps. A major constraint faced while providing support to people with disability was related to the camp settings, particularly hilly terrain and the availability of adequate space. For WASH-related services, the monsoon season restricted movement to and within the camps, affected project activities (especially construction), and damaged WASH infrastructure. Furthermore, when women were given the role of managing WASH facilities, male community members sometimes disregarded the leadership role of women in camp decision-making.

With respect to the results framework, the intended end-of-program outputs and outcomes for the Inclusive Communities consortium and World Vision were clearly defined. However, PI's logframe was weak because its outcome indicators were broad, open-ended statements. These outcomes were not broken down into measurable and quantifiable targets. Therefore, it was difficult to measure the effectiveness of the response as the intended results themselves were not clearly measurable. In addition, all ANGOs had room for improvement in relation to focusing on longer-term results. Also, in some cases, outcome indicators did not adequately capture the deeper level of the benefits of project activities.

The monitoring and evaluation (M&E) plans and systems of the Inclusive Communities consortium and World Vision were well aligned with most of DFAT's M&E standards and were found to be adequate to assess the effectiveness and inclusion of the response. Inclusive Communities prepared a detailed M&E plan; initiated a Monitoring, Evaluation, Accountability and Learning (MEAL) Working Group; and adopted a uniform performance tracker to collect and report on sex-, age-, and disability-disaggregated data. Key weaknesses of the Inclusive Communities consortium were a lack of rationale behind indicator-wise targets and limited activities on the part of the consortium's MEAL coordinating body in harmonizing

MEAL plans of individual agencies, data validity checks, and MEAL capacity development. World Vision's project document clearly explained how it expected its activities to contribute to its expected outcomes, and it provided detailed indicator definitions and data collection tools. World Vision conducted a baseline study to determine indicator-wise targets and collected sex-, age- and disability- disaggregated data to monitor effectiveness and inclusion.

PI's M&E reports (including progress reports and the final report) presented the targets and achievements of project activities but not their results/outcomes. While gender-, sex- and disability-disaggregated data were presented for the total beneficiary size, disaggregated data for all the outcomes were not presented consistently in all the reports. PI did not have dedicated M&E staff and depended on local partners[1] for M&E data. Given this circumstance, assessment and development of local partner M&E capacity should have been conducted to ensure that the M&E system was more robust; this did not occur. Overall, PI's M&E practices were found to be less than adequate in assessing the effectiveness and inclusion of the response.

Coherence

AHP's Phase II response was found to be coherent with the UN response plan and the overall Rohingya response. This was evidenced by a strong alignment with JRP 2019, active participation and reporting in sector coordination (which is a key mechanism in ensuring coverage and standardized quality of services), and leadership in the overall humanitarian response. Phase II was also strongly aligned with the thematic priorities of Australia's humanitarian strategic objectives, specifically gender equality, disability inclusiveness, and protection. It was clear that existing needs were well aligned and substantially emphasized with coherent strategies during Phase II. Nevertheless, other needs – including early childhood development, adolescent learning, and establishment of hepatitis C and thalassemia treatment facilities – should be prioritized in a future response. Additionally, greater collaboration with Camp-in-Charges (CiCs) and local government authorities during the project design phase is needed to ensure greater harmony with Government of Bangladesh (GoB) priorities.

Efficiency

The program activities of Save the Children, World Vision, and CARE were implemented in accordance with the agreed timeline, beneficiary and geographic coverage, and resource utilization. The start of Oxfam's project was delayed due to regulatory issues, and it had to extend the project timeline. PI also faced delays in getting regulatory permission and had to reduce the geographic coverage of the project as it did not get CiC approval to work in all the camps as originally planned. These factors, combined with COVID-19-induced restrictions, caused budget underutilization for Oxfam and PI. The underutilized budget was used for COVID-19 realignment components, and this was duly communicated with the donor.

The governance mechanism and management arrangements were generally satisfactory for all ANGOs. For Inclusive Communities, there was an elaborate and well-structured governance mechanism which worked seamlessly in most situations. There were some incidents of communication gaps among the

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[1] In this report, the term 'local NGO/local partner' has been used to refer to those NGOs which are not Bangladeshi branches of international NGOs

partners and unresolved issues. Stakeholders also mentioned coordination gaps in terms of clarifying specific agency roles in common response areas. Management arrangements and coordination were found to be good for World Vision and PI.

The consortium approach of Inclusive Communities allowed partner NGOs to leverage the strengths of one another and thus add greater value to the response. For instance, HI provided disability mainstreaming and capacity development support to other consortium partners. While disability expertise could have been provided to these NGOs individually, the value addition of the consortium approach was that it allowed them to learn from a partner NGO over the project lifecycle instead of one-off training or capacity development initiatives. There were some areas, however, in which the consortium approach could have added greater value, such as sharing of learnings and experience among the consortium partners, joint advocacy, joint engagement with shared stakeholders, and resource sharing.

There was evidence of innovation and activities with potential for longer-term efficiency gains by the ANGOs. For instance, World Vision piloted 'Happy Corners', places of unity where men and women can discuss their community problems and possible solutions. Field Ready initiated foot-operated taps to prevent the spread of COVID-19. Overall, the AHP response achieved good value for money.

Inclusion

Between 89% and 93% of female beneficiary respondents were satisfied that the response was tailored to their specific needs. They felt safe in getting services and were able to exercise their rights. Robust gender-inclusive measures were evident from design and planning to implementation for all ANGOs. Even so, the limited role of women in camp governance decision-making continued to be a barrier. World Vision worked to improve the situation by increasing the participation of women in Protection and Water Management Committees; however, women's leadership was at times not accepted by the community. Overall, the AHP response was judged to be excellent in terms of gender inclusion.

Disability inclusiveness was considered from design and planning to implementation. Save the Children's inclusive education support through HI to 150 children with disability was exemplary, whereas World Vision's targeted measures such as including women with disability (21%) in 55 Women Watch and Protection Committees and in 18 Water Management Committees greatly contributed to disability inclusion. Additionally, the technical support and capacity development provided by HI (in the case of Inclusive Communities), CBM, and local NGO Centre for Disability in Development (CDD) (in the case of World Vision) also helped a great deal. Nevertheless, ANGOs were unable to reach their projected reach numbers of people with disability in relation to either adults or children. In many cases, ANGOs reported the absence of people with disability in the selected areas. For instance, World Vision conducted two surveys to identify people with disability and still could not reach its targeted numbers. PI's disability inclusiveness was found to be less than adequate as there was no assessment on barriers to inclusion, low technical skills of implementing partners, and no evidence that technical expertise had been engaged.

Barriers to disability inclusion for all ANGOs included geographic factors, organizational factors (such as insufficient technical expertise), an absence of effective organisations of people with disability (OPDs)

representing the voice of people with disability inside the camps, and the disadvantaged location of the shelters of people with disability.

Local Capacity and Leadership

All ANGOs engaged with and ensured the participation of diverse local stakeholders, particularly at the implementation phase. The activities contributed to the capacity development of different stakeholders such as local volunteers, committees, affected communities, and GoB stakeholders.

Through local partnerships, Save the Children, World Vision, Oxfam and PI involved local NGOs[2] in implementation and management. There was sufficient evidence that local partners influenced decision-making during implementation. However, a common weakness was the lack of an action plan or systematic activities for the capacity development of local NGOs and the involvement of local actors in planning and decision-making. Overall, the contribution of ANGOs towards local capacity and leadership was found to be adequate.

CARE's contribution to local capacity and leadership was found to be inadequate as it did not have a local partner; it did not contribute to the capacity development of local NGOs nor did it engage local actors in the planning, decision-making, or management of the response.

Accountability

About 92% of the beneficiaries believed that ANGOs listened to their feedback, while about 87% of the AHP Phase II beneficiaries felt that their feedback had been acted upon by ANGOs. Beneficiaries also stated that they were regularly consulted by ANGOs, and that they could constructively influence the activities. All ANGOs had sophisticated feedback and accountability measures, including door-to-door collection of feedback and complaints by MEAL assistants, focus group sessions, complaints boxes, and helplines. ANGOs prepared accountability reports based on the feedback and complaints they received. The beneficiaries of Inclusive Communities reported that there was enough scope to make constructive feedback and that the consortium NGOs consulted with them to understand their needs before providing their response. Members of community forums stated that World Vision held meetings with beneficiaries three times a week. PI's beneficiaries were also positive about providing their feedback to the NGO. The evaluation team found evidence of program activities being influenced by feedback from beneficiaries. Overall, ANGOs were found to have been accountable to the affected communities.

There are, however, some areas of improvement. Beneficiaries prefer face-to-face communication for giving feedback; they do not usually use complaints boxes, helplines, or other anonymous tools. Many beneficiaries were unfamiliar with the tools available to them. In addition, ANGOs did not inform the beneficiaries about the results of the various assessments undertaken during the implementation period.

COVID-19

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[2] In this report, the term 'local NGO/local partner' refers to those NGOs which are not Bangladeshi branches of international NGOs.

All ANGOs were quick to effectively integrate a COVID-19 response in their program activities. Save the Children's pivoted to home-based learning, while PI's one-to-one and small group learning sessions and unconditional cash grants were great examples of adaptability during the crisis. World Vision's project trained community and faith leaders in different sessions on a gender-inclusive COVID-19 response, including COVID-19 referral pathways, effective preventive measures, cultural behaviors to avoid, COVID symptoms, and social distancing. Oxfam formed and engaged youth groups and protection committees and provided training to raise awareness pertaining to the COVID-19 response. CARE conducted health awareness sessions with fewer participants and increased frequency, where participants such as Rohingya community leaders, religious leaders, and SRH outreach support group members were actively engaged. All responses were consistent with the Australian Government's COVID-19 Aid Strategy, 'Partnership for Recovery: Australia's COVID-19 Development Response'.

Assessment Summary

Below is a summary of assessments against the evaluation rubric for each of the five ANGOs.

Assessment Summary

1. Relevance
a) To what extent were the activities selected appropriate (consistency with the overarching need assessment conducted)?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

b) How well did the NGOs and their partners respond to needs assessment information provided as needs have changed?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

c) How relevant and appropriate was the assistance provided by Australian implementing partners from the perspective of affected communities (% beneficiaries reporting that the response was relevant and appropriate)?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

2. Effectiveness
a) To what extent were intended outcomes achieved?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

b) To what extent did Australian-funded activities promote longer-term resilience of affected communities and support broader recovery and stabilization efforts?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Excellent**

c) How effectively did the NGOs report and manage risk, fraud and corruption?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

d) How clearly defined were the intended outputs and outcomes for the AHP response?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Less than Adequate**

e) How adequate were the NGOs' M&E practices to measure outcomes, and to enable them to assess the effectiveness and inclusion of their response?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Less than Adequate**

3. Efficiency

a) To what extent was the response implemented according to agreed timelines, resources, coverage area and budgets?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

b) To what extent did the response achieve good value for money?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

4. Coherence

a) To what extent did the assistance align with Australia's Humanitarian Strategy and other key Australian government policies/priorities such as gender equality, disability inclusion and other vulnerable groups?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

b) To what extent were the project activities coherent with government priorities, UN response plan and the context of overall humanitarian response?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

5. Inclusion

a) To what extent were the needs of different groups of people (including age, gender, disability, ethnicity, etc.) considered in the design and implementation of the response, including in influence and decision-making roles?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

b) What did the AHP investment achieve in terms of protecting the safety, dignity and rights of women and girls and promoting gender equality?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

c) What did the AHP investment achieve in terms of addressing barriers to inclusion for people with disabilities so that they can benefit equally from the aid investment?

Save the Children	CARE	Oxfam	World Vision	Plan International

Good	Good	Good	Good	Less than Adequate

6. Local Capacity and Leadership
a) To what extent did the AHP investment support and strengthen local partners, including civil society and local government, and include their participation in coordination fora?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	Less than Adequate	Good	Good	Good

b) What evidence is there of local involvement in the planning, management and implementation of the response, including in influencing and decision-making roles?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	Less than Adequate	Good	Good	Good

7. Accountability
a) To what extent were implementing partners sufficiently accountable to, and engaged with, affected communities?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	Excellent	Excellent	Excellent	Excellent

b) What evidence exists of programs having been influenced by effective communication, participation and feedback from affected people and communities?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	Good	Good	Good	Good

8. COVID-19
a) To what extent have the agencies integrated COVID-19 considerations effectively into their response?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	Excellent	Excellent	Excellent	Excellent

b) To what extent did the agencies' COVID-19 assistance align with the Australian Government's COVID-19 Aid Strategy, 'Partnership for Recovery: Australia's COVID-19 Development Response'?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	Excellent	Excellent	Excellent	Excellent

Summary of Recommendations

Note: The recommendations below appear in summary form. Full details of the recommendations appear in Chapter 5. A better picture of how the recommendations connect with evaluation findings can be found in the Conclusion (Chapter 4), which has specific references to the recommendations in Chapter 5.

Thematic Area: Strategy and Way Forward
R1: During Phase III, DFAT and AHP should have end-of-program outcomes which are strategic and contribute towards results beyond the life of the response. Outcome indicators should also capture a greater depth of results. ANGOs should develop a time-bound Theory of Change, a robust results framework, and create a shared understanding and ownership of the program at all layers of program staff.

R2: DFAT, AHP and ANGOs should bring social cohesion, localisation, and accountability to the affected communities to the forefront of any future program. Identifying the factors which lead to tensions between the Rohingya and the host communities, undertaking activities to promote understanding and cohesion, and responding to the needs of host communities is important. As for localisation, making systematic capacity development of local NGO partners a core component of the future program, and harmonizing initiatives of all ANGOs through a localisation working group should be considered. In order to ensure greater accountability, beneficiaries need to be made aware of different tools/options regarding feedback and complaints, and they should be encouraged to use them.

R3: DFAT, AHP and ANGOs should consider the negative impacts on the beneficiaries caused by the discontinuation of a project or the time lag between two projects and undertake robust exit/transition strategies. The AHP consortium should form an exit/transition strategy implementation working group and engage local stakeholders (that is, the local government authorities, the local communities, beneficiaries and local partners) and strengthen their capacity in order to ensure their readiness for a proper handover at the end of the project.

Thematic Area: Monitoring and Evaluation

R4: The AHP consortium should have an enhanced role with regards to M&E data quality assurance, harmonization, and capacity development.

R5: ANGOs and their local partners should have dedicated M&E experts in the project and ensure sufficient resource allocation for M&E activities. Even if no dedicated M&E personnel are available, there should be team members who have sufficient M&E expertise. Assessment and capacity development of the M&E capacity of local partners/NGOs should be undertaken by the ANGOs.

R6: ANGOs should ensure an evidence-based target setting process for the intended outcomes. Using baseline studies to set indicators and targets for projects lasting longer than one year is recommended. In case a baseline study cannot be conducted, clear justifications and assumptions and available evidence supporting different targets need to be established and communicated in project documents.

Thematic Area: Consortium Governance

R7: The AHP consortium should strengthen the governance mechanism by establishing regular and effective communication among the partners from the very beginning of the response and by using consortium feedback mechanisms.

Thematic Area: Risk Management

R8: ANGOs should ensure systematic risk management by updating the risk matrix quarterly with the involvement of project stakeholders. The Consortium Management Unit can arrange quarterly meetings with ANGOs and stakeholders for risk reviews and arrange to gather field-level feedback on project risks and challenges from respondents such as frontline staff, the Self-Help Group, and the Community Outreach Group.

Thematic Area: **Inclusiveness**

R9.a: ANGOs should continue to promote gender equality in camp decision-making and governance structure by including women in community forums and committees and sensitizing the community so that women's leadership is increasingly accepted.

R9.b: ANGOs should have age-, sex- and disability-disaggregated targets at the output indicator levels.

R9.c: ANGOs need to undertake capacity development initiatives for their personnel and for beneficiaries with disability. Each ANGO should build up technical expertise, for instance, on how to identify and best communicate with people with disability (such as using sign language). Due to the limited presence of effective OPDs, ANGOs should pursue alternative means of empowering people with disability by forming and facilitating committees and forums for people with disability.

R9.d: Technical organizations need to conduct thorough assessments to identify people with disability across the regions of AHP interventions. ANGOs should use the Washington Group Short Set questions on functioning to identify people with disability. ANGOs can seek technical support on using these questions from technical organizations such as CBM.

R9.e: ANGOs should continue to focus on disability inclusiveness by having disability-targeted outcomes and making assessments and improvements at the organizational policy and human resources level, program level, and service delivery level.

R9.f: Some shelters of people with disability are located deep inside the camps. There is a need for advocacy with Camp-in-Charges, site management, and other actors to bring these shelters to areas of level ground and close to camp entrances. However, people with disability should always be consulted first as they have the right to live wherever they choose. Moreover, adequate lighting as well as an adequate number of toilets and bathing spaces around their shelters must be ensured.

Thematic Area: Sector-related Recommendations

R10.a: AHP, DFAT and ANGOs should pay greater attention to early childhood development and adolescent and youth education inside the camps since there are currently not enough interventions to meet the needs of these groups.

R10.b: Traditional social norms, such as acceptance of early marriage, are deep-rooted in the Rohingya communities; therefore, continuous work on awareness development will be required. At the same time, while community recognition of physical violence against women as GBV is increasing, mental and psychological abuse is not understood to be GBV by the community. ANGOs working on protection should address these issues as well. In addition to these, inter-sectoral coordination on GBV issues could engender better understanding across project staff working in different sectors.

R10.c: The role of adolescent and adult males in SRH and protection of women is extremely important. ANGOs working on health and protection should adequately include these groups in their program activities.

R10.d: ANGOs should work on better communication and trust-building with a view to encouraging Rohingya beneficiaries to seek health care from proper health facilities as well as to create awareness of the downsides of taking health services from unqualified practitioners. ANGOs should also consider initiating hepatitis C and thalassemia treatment for Rohingya beneficiaries.

R10.e: ANGOs need to engage with Camp-in-Charges and local authorities when conducting needs assessments and at the project design stage so that humanitarian organizations and government stakeholders are on the same page regarding the needs of affected communities. This may lead to greater coherence and expedite the approvals process.

R10.f: To ensure WASH facilities are not damaged, stolen, or used by individuals for private benefit, ANGOs working in WASH should increase their monitoring activities and engage nearby communities to share the responsibilities of management.

Thematic Area: Recommendations for DFAT in similar humanitarian crises

R11: A key lesson of the Phase II evaluation is that in humanitarian contexts that are similar to the Rohingya response, it is important to transition to multi-year funding after the immediate response phase. The one-year timeframe for Phase II was hampered by delays and interruptions in service, and it meant that Phase II mainly focused on delivering short-term humanitarian assistance to affected communities. It is understood that DFAT is now providing multi-year funding for the AHP response in Bangladesh. This recommendation therefore endorses this revised approach and encourages the use of relevant learnings from this evaluation of the Rohingya response to inform the multi-year response.
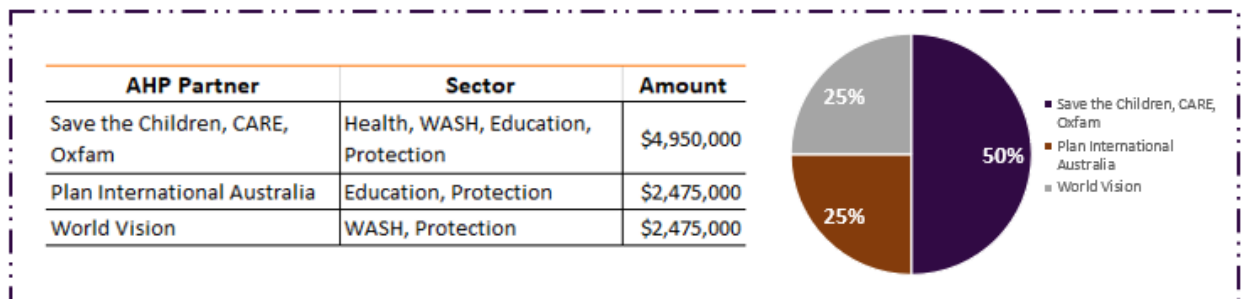
1. Evaluation Context

The Rohingya people – the world's largest stateless population – have been fleeing from discrimination and persecution in Myanmar into Bangladesh since 1971[3]. The crisis reached its tipping point in 2017, when persecution and violence led to a massive displacement of the Rohingya people. Since 2017, an estimated 745,000 Rohingya have crossed into the Cox's Bazar district of Bangladesh, making it the 'fastest growing refugee crisis in the world'[4].

To address the emergency humanitarian needs of displaced Rohingya people and host communities, the Australian Humanitarian Partnership (AHP) initiated the Rohingya Humanitarian Response in 2017, funded by the Australian Department of Foreign Affairs and Trade (DFAT). Phase I ended in 2018. In 2019, AHP announced more than AUD 10 million for Phase II – a one-year humanitarian response to the ongoing humanitarian needs of the Rohingya people and host communities, implemented by Plan International Australia, World Vision Australia, and the Inclusive Communities consortium led by Save the Children with CARE Australia and Oxfam Australia. The program provided humanitarian support on health, WASH, education and protection. During the implementation phase, the COVID-19 pandemic arrived as a major threat to the lives and livelihoods of the Rohingya people and host communities, compelling the implementing partners to shift their activities to a COVID-19 response. The COVID-19 response was funded from Phase II and Phase III.

Phase III is a three-year program which commenced in June 2020 with AUD 44 million DFAT funding. Phase III involves all ANGOs from Phase II forming the 'AHP consortium' along with the Caritas Australia-led CAN DO consortium. Hence, the Phase II evaluation provides a major opportunity for the NGOs to use the learnings from this evaluation to improve their response in Phase III.

Figure 1 below shows the funding allocated to the implementing partners in their respective sectors of the Phase II program.

Figure 1: Overview of partner-wise sectors and allocated funds[5]

AHP Partner	Sector	Amount
Save the Children, CARE, Oxfam	Health, WASH, Education, Protection	$4,950,000
Plan International Australia	Education, Protection	$2,475,000
World Vision	WASH, Protection	$2,475,000

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[3] The Lancet Global Health. May 2018. Humanitarian disaster for Rohingya refugees: impending natural hazards and worsening public health crises.
[4] J-MSNA, 2019
[5] Source: Terms of Reference of the Evaluation Study

In addition to these funds, in response to the COVID-19 pandemic, CARE, World Vision, and Save the Children were allowed to access early funding from Phase III in May 2020. Each of the NGOs asked for AUD 500,000 for COVID-19 preparedness and response activities in Cox's Bazar.

Technical/implementing NGOs completed their projects in the selected sectors (as illustrated above) in the Phase II response, partnering with ANGOs and local partners. Table 1 below shows the local partners for each ANGO.

Table 1: Local technical and implementing partners[6,7]

AHP Partners	Technical/Implementing Partners		
Save the Children	YPSA – providing education activities	HI – ensuring inclusion mainstreaming for the consortium	
CARE Australia			
Oxfam Australia	DSK, Shushilan – implementing WASH activities		
World Vision Australia	CBM, CDD – creating inclusive environments in community groups	BGS – creating accessible wash points	Field Ready – providing technical support for people with disability
Plan International Australia	FIVDB – providing services for quality education		

Inclusive Communities Consortium (Save the Children with CARE Australia and Oxfam Australia)

Save the Children formed the Inclusive Communities consortium with CARE and Oxfam (with HI as the disability inclusion technical partner) to support the Rohingya Response in Cox's Bazar for the project timeframe (August 2019 to November 2020[8]). Inclusive Communities focused on implementing an integrated and inclusive project, with activities delivered across the following sectors: health, education, protection, and water, sanitation and hygiene (WASH) services. The project covered 15[9] out of 34 camps in Cox's Bazar and adjacent host communities. The number of projected direct beneficiaries for the project was 163,697 (25% male, 75% female), including 4897 people with disability and 52,600 children (including 947 children with disabilities). In response to the COVID-19 pandemic, Save the Children and CARE were allowed to access Phase III funding, while Oxfam pivoted its remaining Phase II activities.

World Vision Australia

World Vision's project was designed to meet the immediate lifesaving needs of Rohingya refugees, including people with disability, through the provision of emergency WASH and protection support with a specific focus on GBV prevention from May 2019 to June 2020. World Vision implemented its project in

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[6] Humanity & Inclusion was involved in the Save the Children-led consortium
[7] Source: Project Implementation Plan and Final Report provided by the ANGOs
[8] As per the Terms of Reference, however, the timeline may have been impacted due to COVID-19
[9] Camps 4, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 26 and 27

Camps 13, 15 and 19 under Ukhiya Upazila (district sub-unit), Cox's Bazar District. The projected reach was 26,965 (52% male, 48% female), including 2492 people with disability and 5314 children. In response to the COVID-19 pandemic, World Vision aimed to meet the immediate lifesaving needs of Rohingya refugees and host community members in Camps 13, 15 and 19 through the provision of emergency WASH and protection support with a specific focus on GBV prevention.

Plan International Australia
PI focused on social empowerment of adolescent girls and boys, education in emergencies, and provision of life-saving assistance. PI targeted around 43,000[10] direct beneficiaries, including those in Camps 21 and 23 as well as associated host communities in Cox's Bazar. The project started in August 2019 and was expected to finish by November 2020. In response to the COVID-19 pandemic, PI reconstructed its major focus to activities to mitigate the impacts of COVID-19.

As the response was nearing completion, and Phase III about to begin, an independently-led joint evaluation of Phase II and early work in responding to COVID-19 by the implementing agencies was conducted as a joint exercise between DFAT and ANGOs. Its aim was to encourage the learning and adoption of recommendations by ANGOs and to increase the accountability and transparency of the Phase III response.

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[10] For both Cox's Bazar and Northern Districts

2. Evaluation Overview

2.1 Evaluation Questions and Sub-questions

The evaluation criteria (relevance, effectiveness, efficiency, coherence, inclusion, local capacity/leadership, transparency and accountability, and learning from the COVID-19 response) are the bases of the evaluation questions and sub-questions formulated as below[11]:

1. Was the response appropriate and relevant?
   a. To what extent were the activities selected appropriate?
   b. How well did ANGOs and their partners respond to needs assessment information provided as needs changed?
   c. How relevant and appropriate was the assistance provided by Australian implementing partners from the perspective of affected communities?

2. Was the response effective?
   a. How clearly defined were the intended outputs and outcomes for the AHP response?
   b. To what extent were intended outcomes achieved?
   c. Did any unintended outcomes eventuate, either negative or positive? How responsive were the agencies when any unintended outcome occurred?
   d. What were the barriers and enablers to effective and efficient program design and achievement of the outcomes?
   e. To what extent did Australian-funded activities promote longer-term resilience of affected communities and support broader recovery and stabilization efforts[12]?
   f. How adequate were ANGO M&E practices to measure outcomes and to enable them to assess the effectiveness and inclusion of their response?
   g. How effectively did ANGOs report and manage risk, fraud and corruption?

3. How efficient was the response?
   a. To what extent was the response implemented according to agreed timelines, resources, coverage area and budgets?
   b. To what extent did the response achieve good value for money?

4. How coherent was the response?
   a. To what extent did the assistance align with Australia's Humanitarian Strategy and other key Australian Government policies/priorities such as gender equality, disability inclusion and other vulnerable groups?

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[11] The evaluation team did not consider 'Impact' as a separate criterion: 'impact' may not always be a feasible assessment criterion in emergency/humanitarian response since changes in socioeconomic and political processes may take many months or even years to become apparent (please see: https://www.alnap.org/system/files/content/resource/files/main/eha-2006.pdf) . Phase II projects were short-term projects which also changed their direction in the middle of their term towards emergency COVID-19 response. However, the evaluation team incorporated some key components of 'impact' such as impact dignity, safety, social cohesion, and gender inclusion. The Evaluation Rubric in **Annex A** details these components as standards of evaluation.

[12] Sustainability aspects of Phase II projects would be assessed in terms of 'longer term resilience of affected communities'. Hence, sustainability was not included as a separate evaluation question.

    b. To what extent were the project activities coherent with government priorities, the UN response plan, and the context of the overall humanitarian response?

5. How inclusive was the response?
   a. To what extent were the needs of different groups of people (including age, gender, disability, and ethnicity) considered in the design and implementation of the response, including in influence and decision-making roles?
   b. What did the AHP investment achieve in terms of protecting the safety, dignity and rights of women and girls and promoting gender equality?
   c. What did the AHP investment achieve in terms of addressing barriers to inclusion for people with disabilities so that they can benefit equally from the aid investment?

6. Did the response reinforce local capacity/leadership?
   a. To what extent did the AHP investment support and strengthen local partners, including civil society and local government, and include their participation in coordination fora?
   b. What evidence is there of local involvement in the planning, management and implementation of the response, including in influencing and decision-making roles?
   c. Is there any evidence of greater collaboration by AGOs with local partners beyond AHP programming as an outcome of the partnership created during the response?
   d. What factors or barriers hinder local capacity/leadership?

7. How transparent and accountable was the response?
   a. To what extent were implementing partners sufficiently accountable to, and engaged with, affected communities?
   b. What evidence exists of programs having been influenced by effective communication, participation and feedback from affected people and communities?

8. What can be learned from ANGOs' early work in relation to COVID-19?
   a. To what extent have ANGOs integrated COVID-19 considerations effectively into their response?
   b. What are the early successes, challenges and lessons regarding integrating COVID-19 that could help to inform ANGOs' response in Phase III?
   c. To what extent did ANGOs' COVID-19 assistance align with the Australian Government's COVID-19 Aid Strategy, 'Partnership for Recovery: Australia's COVID-19 Development Response'?

2.2 Methodology

To guide the assessment of the responses, the team developed an evaluation rubric – a framework that sets out criteria and standards for different levels of performance and describes what performance would look like at each level (See Annex A). The evaluation rubric was used as the guiding document throughout the evaluation process.

The evaluation methodology was established on both primary and secondary data collection (details in Annex E). The evaluation team used a mixed-methods approach, including a desk review of secondary literature, surveys, KIIs, FGDs, and observations. Key secondary sources included:

- DFAT's policies and standards;
- Project documents of ANGOs;
- Inter-Agency Standing Committee Standards;
- Needs assessments, scoping studies and survey reports, such as those published by different humanitarian organizations in the context of the Rohingya Response; and
- Other evaluation reports on the humanitarian response.

To operationalize the quantitative study, a household survey was conducted in Rohingya communities. According to the proposed sampling strategy, the total sample size was 581, and this sample was proportionally divided into different sub-populations and strata. Surveys were conducted by trained local enumerators with a mix of close-ended and open-ended questions. The breakdown of the surveyed sample is given below:

Table 2: NGO survey sample size

Agency	SC			CARE			Oxfam			WV			PI			Total
Beneficiary	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	
Adult without Disability	32	26	58	25	40	65	83	30	113	34	30	64	53	50	103	**403**
Child without Disability	42	41	83	0	5	5	5	0	5	0	5	5	5	6	11	**109**
Adult with Disability	5	7	12	4	1	5	12	5	17	2	7	9	2	4	6	**49**
Child with Disability	10	4	14	1	0	1	2	2	4	0	1	1	0	0	0	**20**
Total	89	78	167	30	46	76	102	37	139	36	43	79	60	60	120	581

Qualitative data was collected through 11 FGDs with beneficiaries as well as a total of 56 KIIs with internal stakeholders (such as ANGOs) and external stakeholders. To add to the rigour of the evaluation, observational and case study tools were used. The evaluation team undertook facility visits at different ANGO service points in various camps locations. The sites were WGSSs (Camp 19), TLCs (Camp 4), HBLs (Camp 23), WASH facilities (including latrines) (Camp 12), handwashing points (Camp 12), tap stands (Camp 12), healthcare centres (Camp 4, 18), ANGO field offices, and random households. To support the case studies, 10 In-depth Interviews (IDIs) were conducted with people with disability from the beneficiary pool. The breakdown of qualitative tools according to the participants is given below, while the list of interviewees appears in Annex D:

Table 3: Snapshot of data collection tools used

Tools	Total	Participant Breakdown	Location	Modality
KII and Team Meetings	56	DFAT Post: 2 ANGOs: 15 Sector Coordinator: 3 GoB Stakeholders: 2 Partner NGO: 7	Dhaka Based	Remote
		ANGOs: 5 Partner NGO: 9 Sector Focal: 1 Community Leaders and Committee Members: 12	Camp: 4, 10, 12, 13, 15, 18, 23	On-site
FGD	11	Male: 4 Female: 7	Camp: 4, 10, 12, 13, 15, 18, 23	On-site
IDI	10	People with disability: 10 (Family members and caregivers were interviewed additionally)	Camp: 4, 10, 12, 13, 15, 18, 23	On-site

2.3 Limitations

Low participation of female beneficiaries: Survey participation of female beneficiaries (46%) was slightly lower than that of male beneficiaries despite the evaluation team's strong focus on equal participation. Having grown up in a traditionally conservative society, Rohingya women and girls were generally less willing to talk even though the evaluation team deployed trained female enumerators to conduct surveys among female beneficiaries. This resulted in a relatively smaller number of surveys completed per day with female beneficiaries compared to male beneficiaries. In addition, the Bangladesh Office of the Refugee Relief and Repatriation Commissioner (RRRC) limited camp access, which meant that the evaluation team could not extend the time spent collecting field data to ensure equal participation.

To make up for the gap, the evaluation team prioritized female beneficiaries in the FGDs: six of the ten FGDs were conducted with female beneficiaries.

Barrier to conducting interviews with GBV survivors: The evaluation team was not able to reach GBV survivor beneficiaries of CARE and World Vision even though a few interviews were proposed in the initial methodology. The ANGOs did not allow the evaluation team to conduct interviews with GBV survivors so as to keep their information confidential and protect those beneficiaries. This was consistent with ethical standards, as the disclosure of GBV survivors' information to a third party would have violated their organizational policies and ethical considerations.

Limitation on reaching PI's host community beneficiaries: The evaluation team planned to conduct an FGD with PI's beneficiaries from the host communities. However, this was not possible within the permitted timeframe due to COVID-19. Schools were closed, and local partner Friends in Village Development Bangladesh (FIVDB) could not arrange the data collection sessions within the given time. Moreover, the host communities were situated in different areas and were found to be scattered during the on-site mission.

2.4 Validity of the Evaluation Results

- **Triangulation using multiple techniques and data from multiple stakeholders:** The evaluation team collected viewpoints from a number of stakeholders: from beneficiaries and local leaders and organizations to ANGOs and their implementing partners to different government and development sector stakeholders. Having data from diverse groups of stakeholders and using multiple techniques allowed the evaluation team to find similarities and differences through triangulating data within and between different stakeholder groups. The higher the similarities in responses from multiple respondent groups, the stronger the evidence was on the achievement of a specific evaluation question or a lack thereof. The evaluation rubric was developed in line with the evaluation and sub-evaluation questions, which were agreed to by the relevant stakeholders.

- **Greater weight on the perspective of beneficiaries:** The perceptions of various stakeholders in relation to humanitarian needs – and their responses – may be so contrasting that an evaluation team has to give greater weight to the responses of a particular stakeholder group. The evaluation team consciously decided to assign greater importance to the responses of the Rohingya beneficiaries. The evaluation rubric consists of a number of sub-evaluation questions and evaluation metrics/standards in which beneficiaries had prominent voices. In addition, the beneficiary survey, conducted with a representative sample of 581, was a major source of evidence to ensure that beneficiary perspectives were adequately captured.

- **Steps to mitigate researcher bias:** Given the strong qualitative component of a mixed-method approach, it is possible for the researchers' own biases, in terms of interpretation of the subjective reality as perceived by the beneficiaries, to emerge. To minimize this, the evaluation team adopted a peer debriefing approach, where the qualitative data were assessed independently by two groups of researchers: one group was involved in field data collection, while the other group did not go to the field but was well-informed about the humanitarian context. The two groups conducted a number of peer debriefings to discuss their independent findings and come to a consensus. This approach also helped the evaluation team to evaluate their findings jointly. Furthermore, the evaluation team included an international humanitarian evaluation expert who further validated the findings of the evaluation. Since the humanitarian expert did not share the same cultural orientation as the national consultants, their perspective also helped to mitigate researcher bias.

- **Finalisation of recommendations at the validation workshop:** The evaluation team proposed 11 recommendations based on the insights gathered from data collection throughout the evaluation period. During the validation workshop, the recommendations were further validated by over 40 workshop participants, including members of AHPSU, Australia-based NGOs, and local and implementing partners working in different functional roles such as coordination, inclusion, and M&E. During the workshop, the evaluation team presented its findings and contexts for the proposed recommendations. Participants were then divided into four groups and given three to four recommendations to work on. About 25 participants rated the recommendations in terms of priority, relevance, and achievability. In addition, the participants modified the recommendations and added additional ones, if necessary. At the end, the evaluation team finalised the recommendations based on the inputs given by the participants in the workshop.

Overall, when the collected data was triangulated from the targeted surveys, interviews and FGDs along with the documented evidence, the analysis showed consistent results between stakeholder groups. The evaluation team thus has a high degree of confidence in the evaluation results.

3. Evaluation Findings

ANGOs in the Phase II response had different geographic scope, sectors, activities, beneficiary populations, and programmatic approaches; therefore, the evaluation team assessed the performance of each ANGO against the evaluation rubric separately. This approach should allow each ANGO to reflect on its performance, focus on its strengths, and learn from its weaknesses to improve its activities in the next phase of the response. There were, however, some cross-cutting issues and collaboration and coordination works among ANGOs of the Inclusive Communities consortium[13], and the assessment of the consortium's performance was reflected through each partner's individual performances.

This chapter is divided into eight sections, each presenting findings on one of the eight evaluation criteria: relevance, effectiveness, efficiency, coherence, inclusiveness, local capacity and leadership, and COVID-19 response. Each section begins with a brief description of what is being evaluated and then provides a section summary. The section summary shows performance measures of all ANGOs against the sub-evaluation questions, and then provides a narrative summary. The section summary is followed by a detailed agency-wise narrative on the evaluation findings and the evidence.

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[13] Inclusive Communities involved HI as the technical partner on disability Inclusion mainstreaming. HI's main role was to provide inclusion mainstreaming support to other consortium partners. Therefore, HI's activities have not been evaluated separately in this evaluation report.

3.1 Relevance

This section presents an assessment of the relevance of ANGO programs and activities in addressing the priority needs of affected communities. The extent to which the responses were consistent with needs assessments, had an appropriate approach in the sociocultural context, and addressed the most pressing needs from beneficiary perspectives were critical components of the assessment. Assessment of the Phase II response on these critical components is presented in this section.

Section Summary

Performance against each sub-evaluation question
a) To what extent were the activities selected appropriate (consistency with the overarching needs assessment conducted)?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

b) How well did ANGOs and their partners respond to needs assessment information provided as needs changed?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

c) How relevant and appropriate was the assistance provided by Australian implementing partners from the perspective of affected communities (% beneficiaries reporting that the response was relevant and appropriate)?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

Narrative Summary
All activities were found to be highly relevant considering consistency with the overarching needs assessments such as JRP 2019, the Joint Education Needs Assessment 2018, the Joint Multi-Sector Needs Assessment 2019, and with individual ANGO baselines and/or community consultations. More than 80% of respondents across all ANGO beneficiary groups reported that the humanitarian activities were highly relevant to their needs. This was further supported by relevant sector coordinators who spoke highly of the relevance of ANGO activities. The community outreach approach followed in the health and protection response was highly appropriate considering the conservative social norms and mobility barriers of women and girls.

Major changes in the project context occurred due to the COVID-19 pandemic. All ANGOs swiftly integrated a COVID-19 response in their program.
(COVID-19 response is a separate evaluation criterion; 3.8 below contains detailed findings.)

Save the Children

JRP 2019 highlighted MHPSS and SRH as the needs for 2019–2020 in the context of the Rohingya refugee humanitarian response for the health sector. Save the Children designed its health sector activities around MHPSS and SRH. It focused on providing SRH services to adolescents from host and Rohingya communities, integrating MHPSS support for the service. Moreover, it undertook capacity development

with its staff with a view to providing SRH services. Notable activities carried out in the health sector by Save the Children[14] included:

- Delivery of SRH services, including antenatal care, postnatal care, adolescent sexual reproductive health, family planning counselling, and psychological first aid to adolescents from Rohingya and host communities (around 700 male and female beneficiaries directly reached through the SRH service);
- Provision of capacity development to Save the Children staff on SRH service provision;
- Integration of MHPSS into community- and facility-based SRH services;
- Provision of primary healthcare services (antenatal care, postnatal care, adolescent sexual reproductive health, family planning counselling, and psychological first aid) through four health posts; and
- Delivery of training and outreach activities such as courtyard sessions for adolescents, their caregivers, and community leaders.

According to the Joint Education Needs Assessment conducted in 2018, about 2000 additional educational facilities were required to meet the education needs of 462,367[15] deprived children living in the congested camps in the region, where around 39% of children aged 3–14 were not attending any type of education facility. Severe overcrowding adversely affects education in the camps. Moreover, the little space that is available is often prioritized for areas other than education. Besides a lack of space, sociocultural attitudes and norms also exacerbate the situation and hinder the education of children. To address this, Save the Children, along with HI, provided inclusive and age-appropriate, non-formal education through TLCs, HBLs and Girl-Friendly Spaces (GFSs) to Rohingya refugee children. The NGOs also arranged monthly parenting sessions and Community Education Committee meetings to support parental and community engagement in children's education. To improve the quality of learning, Save the Children provided training, monitoring, supportive supervision through weekly learning circles, and monthly Peer Learning Meetings for the teachers and facilitators[16].

The disability inclusion partner of the consortium, HI, ensured education for children with disability by identifying 150 children with disability[17] and providing them with support based on their individual needs, including basic learning materials, play-based materials, and activity-based materials for the education program of the ANGO.

From the FGD with female beneficiaries in Camp 18, the evaluation team learned that during Phase II, their most demanding need was education for their children. This need was met by the schools (TLCs) of local partner Young Power in Social Action (YPSA). This finding was further verified by the

> **84%** of the respondents (n=167) from Save the Children beneficiary pool stated that the activities of the NGO were relevant to their needs.

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[14] As per the Project Implementation Plan and IPTT
[15] Joint Response Plan 2019
[16] Source: IPTT and beneficiary
[17] As per the Final Report provided by Humanity and Inclusion

quantitative survey with 167 Save the Children beneficiaries, of whom 84% said that the response was relevant to their needs. These beneficiaries were looking forward to being self-reliant as they were not involved in any income-generating activities at that time.

> **FGD Participant, age 40**
> *'Last year, one of our most demanding needs was education for our children. Now this need has been met by the YPSA school.'*

Key Finding
Save the Children's response was relevant and addressed the priority needs of the refugee communities.

In providing its support, Save the Children also applied a relevant approach. For instance, the NGO adopted community outreach mechanisms in providing its health services, including SRH and MHPSS. JRP 2019 also highlighted the need to harmonize community outreach approaches. The education response strategy of JRP 2019 indicated a need to rehabilitate school infrastructure, to build teacher capacity, and to provide caregivers with parenting education so that they could support their children's learning, development, and wellbeing. Save the Children adapted its response so as to accommodate the approach recommended in JRP 2019.

Key Finding
Save the Children's approach was appropriate as the NGO adapted the required approach mentioned in JRP 2019.

CARE

Rohingya women and girls live in an extremely conservative, male-dominated society where they have little voice or decision-making power. Domestic violence is seen as a socially acceptable norm, and harmful practices such as early marriage, dowry and related violence are widespread[18]. The risk of sexual violence is also high: the Multi-Sector Needs Assessment II (January 2019) found that 47% of girls had fears related to sexual violence[19]. JRP 2019 highlighted the supply-side gap in GBV services, as only 43% of minimum service coverage had been achieved for urgently needed GBV case management and psychological support. In this context, "access to quality survivor-centred services, prevention and mitigation of GBV risks, and empowerment of women, girls and GBV survivors" were determined as a key Protection Sector Objective in JRP 2019.

CARE responded to the critical needs of response, prevention, and mitigation of GBV risks and empowerment of women and girls through its gender-based services, which included response activities (for example, GBV case management, lifesaving referrals, psychosocial counselling, life skills training), prevention activities (awareness sessions and Community Outreach Group mobilization), and risk

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[18] Joint Agency Research Report. August 2018. https://reliefweb.int/sites/reliefweb.int/files/resources/rr-rohingya-refugee-response-gender-analysis-010818-en.pdf

[19] Multi-Sector Needs Assessment – July 2018 and January 2019 comparison - All Camps, Ukhiya/Teknaf, Cox's Bazar, Bangladesh. https://reliefweb.int/sites/reliefweb.int/files/resources/68613.pdf

mitigation activities (safety audits and addressing safety risks[20])[21]. CARE also ensured the participation of male community members in GBV response activities to educate them about the negative impacts of GBV[22].

Another key component of CARE's response was the provision of SRH services. JRP 2019 highlighted the need to strengthen SRH services by providing "access to safe, voluntary family planning and maternal and newborn health services". CARE responded to this need by providing family planning services, including the oral contraceptive pill, contraceptive injections, condoms, and long-acting reversible contraception. CARE also provided maternal health care services which included antenatal care, postnatal care, pregnancy tests and other tests.[23]

A survey conducted with 76 CARE beneficiaries showed that 92% thought CARE's responses were relevant. An FGD with CARE's female beneficiaries revealed that health and protection were some of their pressing needs.

> **92%** of survey respondents (n=76) in CARE's beneficiary pool stated that the NGO's activities were relevant to their needs.

> **Key Finding**
> CARE's response was relevant and addressed critical and priority needs of the Rohingya communities.

CARE's response incorporated situational factors such as power relations, mobility barriers of women and girls, and the role of males in both protection and sexual and reproductive health. CARE adopted a community-based approach by forming and mobilizing Community Outreach Groups which reached men, women, girls and boys through door-to-door visits[24]. This approach enabled women and girls, many of whom were unable to access WGSSs or health posts for various reasons[25], to receive GBV- and SRH-related information at their shelters. This approach was appropriate given that JRP 2019 also set a high priority on a community-based approach to protection response and health[26].

> **Key Finding**
> CARE's community outreach approach was appropriate considering the conservative social norms and mobility barriers of women and girls.

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[20] Source: Reports on "Safety Audit & Community Risk Mapping". CARE assessed the conditions of latrines, lights, tube wells, water, etc., in their Safety Audits
[21] AHP Activation – Final Report; provided by CARE
[22] Source: IPTT (Output - 1.2.6), and KII with GBV Committee Leader
[23] Source: AHP Activation – Final Report, and FGD with female beneficiaries of CARE.
[24]Gender, Disability and Social Inclusion Action Plan and IPTT (Output 1.2.5)
[25] KII with Community Outreach Members
[26] JRP 2019

Oxfam

The programs of Oxfam established primarily the WASH sector and blended interventions of the protection sector with the assistance of local partners to ensure sustainable support for Rohingya refugees in the Ukhiya camps. Oxfam designed an integrated program, including support for pressing needs in relation to water access, upgrading and installation of sanitation facilities, and the development of hygiene awareness. JRP 2019 listed the most pressing needs:

- Water access: 56% of households had water access challenges, including distance and queuing time.
- Sanitation: 53% of households faced latrine access challenges, including distance, overcrowding, location, and overflowing.
- Hygiene practices: 35% of adults and 65% of children displayed poor hygiene practices due to a lack of soap for handwashing and the habit of open defecation.
- Hygiene promotion: The coverage of hygiene promoters, particularly female promoters, across the population remained low due to a lack of necessary skills and language proficiency to engage with Rohingya beneficiaries. The needs for hygiene kits were also severe in camps.
- Protection: 49% of girls and 40% of women reported feeling unsafe when using latrine facilities due to a lack of lighting and separate male and female facilities.

Oxfam's local partners, Shushilan and Dusta Shasta Kendra (DSK), conducted needs assessments and facility mapping to determine beneficiary needs through community consultation in their respective camp locations. The major needs were found to be repair and maintenance of tap stands; handwashing points and devices; repair and decommissioning of latrines; inclusive latrines and water points for person with disability and older beneficiaries; hygiene kits; hygiene awareness, especially considering acute watery diarrhoea (AWD), monsoon periods and COVID-19 awareness[27]. Apart from the core WASH needs, women and girls required separate latrine facilities and proper access of latrines and water points. In addition, some beneficiaries with disability required inclusive latrines, tap stands and handwashing points. COVID-19 led to urgent and significant changes in response approaches, such as one-to-one messaging and megaphone messaging to conduct awareness programs.

A total of 135 survey participants (out of 139) from Oxfam's beneficiary pool indicated that the responses were relevant and appropriate to their pressing needs. An FGD with female beneficiaries confirmed that latrines, hygiene kits and hygiene awareness were pressing needs. These needs were met by the

> **97%** of respondents (n=139) from Oxfam's beneficiary pool stated that the activities of the NGO were relevant to their needs.

installation/repair of latrines, the provision of hygiene kits, and the provision of training on hygiene practices.

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[27] KII with community leaders

> *FGD Participant, female, age 32*
> *'Sanitation facilities were becoming inaccessible due to overflowing. Most of the structures were damaged due to landslides and a lack of maintenance. These needs were met by Oxfam. The discomfort of women in using water and sanitation facilities reduced to a large extent.'*
>
> *Member of Latrine User Group, female, age 40*
> *'I, my family, and our relatives were anxious about the COVID-19 outbreak. We did not even know what to do, how to do. The NGO people (Oxfam's partners) reached me and provided soap, liquid hand wash, a bucket, etc. They also taught us how to maintain social distance, how to wash hands, etc.'*

World Vision

JRP 2019 identified the needs for WASH and protection sectors for the Rohingya refugees in Bangladesh. For the WASH sector, ensuring effective, sufficient, and equitable provision of life-saving water and sanitation services was given importance. In its program, World Vision prioritized access to safe water, environment (*sic*), and good sanitation and hygiene facilities and practices. JRP 2019 also foresaw the improvement of access to quality survivor-centered services by responding to individual needs; preventing and mitigating GBV risks; and empowering women, girls, and survivors of GBV for the protection sector. In line with this, World Vision focused on the enhancement of women's participation in decision-making and protection in refugee camps with a view to empowering women and mitigating GBV risks. The NGO followed a community-based approach with adequate representation of women in providing its services for both sectors, which was also indicated in JRP 2019 as the standard method[28].

Targets were set upon a baseline study conducted by World Vision coupled with community consultation and feedback from other actors. The baseline study also identified WASH and protection needs. The study set targets based on the overall situation for 2019–2020 for World Vision's response.

Furthermore, World Vision pivoted its activities towards COVID-19 response when COVID-19 started spreading in Bangladesh. Through community consultation, World Vision's implementing local partner NGO, Bangla-German Sampreeti (BGS), realized that people lacked awareness in the initial period of the COVID-19 outbreak. In response to this, World Vision restructured the procedure of awareness sessions (household reach and mobile communication instead of common discussion) and arranged for sessions centered around COVID-19 outbreak prevention[29].

The survey of World Vision's beneficiaries revealed that 89% of respondents found World Vision's responses relevant. The beneficiaries who participated in the FGD and KIIs also affirmed water and sanitation as their critical needs in 2019–2020 which had been fairly met by the activities of World Vision and BGS. They also voiced their concern regarding the

> **89%** of respondents (n=79) from World Vision's beneficiary pool stated that the activities of the NGO were relevant to their needs.

mosquito menace, which was a critical concern during the period as well. Furthermore, they wanted the

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[28] Source: Project Implementation Plan
[29] Mentioned in the Final Report provided by World Vision

education service for their children to be resumed, an activity which was impeded by the COVID-19 outbreak.

> **Women Watch Committee Member, male, age 30**
> *'Last year, water was my most critical need. We have adequate water supply now. However, I am now suffering from problems with children's education and mosquitoes.'*
>
> **WASH Committee Member, female, age 35**
> *'The demand for water and latrines was high last year. We had to suffer a lot for lack of water and latrines at that time. We are good now, thanks to the support of World Vision. We also received hygiene kits to protect us from the outbreak of COVID-19.'*

> **Key Finding**
> Given the needs identified in JRP 2019 and the baseline study, coupled with the changing needs during COVID-19 outbreak, World Vision's prime activities were appropriate and relevant to those needs.

Plan International

PI's response was designed to provide non-formal and age-appropriate education and life skills training to adolescents and youths inside the camps. Few Rohingya adolescents and youths had access to educational opportunities. J-MSNA 2019 stated that educational attendance dropped sharply for adolescent boys and girls after the age of 12[30]. In the 15–18 age group, only 2% of girls and 13% of boys were found to be attending a TLC regularly (4 days a week). For youths aged 19–24, educational attendance was almost non-existent. Interviews with relevant stakeholders, including those from the education sector, also revealed that the scope for youth and adolescent education was limited[31]. PI's response therefore was considered highly appropriate by these stakeholders.

PI worked not only to enhance access, it also addressed some of the underlying barriers to education inside the camps. One of the key barriers was that the benefits of education are not well recognized by the Rohingya. Forty per cent (40%) of parents of adolescent girls and 33% of parents of adolescent boys do not consider education appropriate for their children[32]. To sensitize the Rohingya community about the importance of education, PI conducted community dialogue with local leaders, imams, and parents on the benefits of non-formal education for adolescent girls/boys and youths[33]. It established home-based learning facilities (Adolescent and Youth Learning Clubs)[34]. The home-based learning approach was appropriate as it overcame two critical barriers to education: mobility barriers of adolescent girls and limited space availability for learning centres.

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[30] Joint Multi-Sector Needs Assessment (J-MSNA). August–September 2019
[31] Source: KII with Education Sector Coordinators
[32] 2019 Joint Response Plan For Rohingya Humanitarian Crisis
[33] AHP Bangladesh Activation – Plan International Australia Final Report
[34] Source: AHP Bangladesh Activation – Plan International Australia Final Report, verified through Field Observation, KII with teachers and facilitators

FGDs with male and female beneficiaries revealed that education was extremely important for adolescents and youths in their areas. All participants expressed their satisfaction that this need had been met. This finding from the FGDs was further verified by the quantitative survey with 120 Plan beneficiaries, of whom 96% said the response was relevant to their needs.

96% of survey participants (n=120) from PI's beneficiary pool said the activities of the NGO were relevant to their needs.

Male Participant, age 60
'Earlier, boys and girls in our area could not study. My children did not have any opportunity for education either. I am really happy that my children can now read and write.'

Key Findings
PI's program responded to a critically vulnerable beneficiary group (adolescents and youths), and the beneficiaries recognized the importance of PI's response in meeting the priority needs of their community.

3.2 Effectiveness

This section provides a systematic assessment of the overall programmatic approach and effectiveness of the Phase II response in measuring and achieving the desired results in the affected communities. The section assesses the following components:

- Achievement of results at the outcome and output levels with a significant focus on actual changes in the lives of the affected communities;
- Barriers or enablers;
- Longer-term resilience of the affected communities;
- Results framework and the M&E system; and
- Risk management, fraud, and corruption.

Section Summary

Performance against each sub-evaluation question

How clearly defined were the intended outputs and outcomes for the AHP response?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Less than Adequate**

To what extent were intended outcomes achieved?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

To what extent did Australian-funded activities promote longer-term resilience of affected communities and support broader recovery and stabilization efforts?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Excellent**

How adequate were ANGO M&E practices to measure outcomes and to enable them to assess the effectiveness and inclusion of their response?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Less than Adequate**

How effectively did ANGOs report and manage risk, fraud and corruption?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

Narrative Summary

All ANGOs met most of the intended outputs and outcomes. However, there are areas for improvement which will need greater supervision during Phase III.

As observed during field visits, a large portion of the contactless handwashing devices installed by Oxfam was damaged within a very short period due to a lack of maintenance.

In relation to men and boys rejecting intimate partner and domestic violence, CARE's achievement was slightly below the target; this particular indicator required a stronger focus in sensitizing the male community to address the issue.

In relation to the outcome on women making their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care, the indicator target was not achieved due to the deep-rooted traditional belief systems in Rohingya communities.

In relation to the education program of Save the Children, the NGO did an excellent job; however, children with disability might lack proper support in the future due to the discontinuation of the involvement of HI, the disability inclusion partner.

World Vision's WASH-related outcomes were all achieved. However, the evaluation team found that in a small number of cases, water had been taken from common water points to individual houses through pipes, and latrines were being privatized by some individuals by way of fencing.

PI completed all of the intended activities of the project (it did not have outcome-level specific targets).

Beneficiaries of all ANGOs were overwhelmingly satisfied with the support they received (more than 80% of survey respondents) and opined that the response affected their lives positively (almost all FGD participants).

One major weakness of Inclusive Communities and World Vision was the lack of sufficient focus on host community needs and activities to promote social cohesion between the Rohingya and host communities. No action plans or specific activities to promote social cohesion inside the Rohingya communities or between the Rohingya and host communities were found in any project document. This is an important component of longer-term resilience of the affected communities to which ANGOs should have contributed in Phase II. ANGOs did contribute adequately on other aspects of longer-term resilience, such as life skills of community members, community resilience, disaster preparedness, and prevention of disease outbreaks. PI contributed strongly to all dimensions of longer-term resilience. Notably, PI identified and responded to the educational needs in the host communities, and during COVID-19, provided unconditional cash transfers to vulnerable host community households.

In terms of risk management, all partners prepared a risk management framework at the design phase, but systematic monitoring of the risks was not adequate. The evaluation team did not find any evidence of incidents of fraud, corruption, or abuse during the Phase II response.

Major barriers for ANGOs included difficulties in obtaining regulatory approvals, COVID-19-induced restrictions, limited space for WASH or education infrastructure inside the camps, and hilly terrain. ANGOs took measures against many of these barriers, such as the home-based learning model adopted by PI (to mitigate the lack of space for TLCs), close coordination with CiCs, and COVID-19 response integration by all partners.

As for the results framework and M&E practices, the expected end-of-program outputs and outcomes for the Inclusive Communities consortium and World Vision were expressed in clearly defined quantitative indicators which could be measured for effectiveness of the response. The IPTT tracker of Save the Children and ITT tracker of World Vision allowed for the collection and reporting of sex-, age- and disability-disaggregated data, which is important for assessing inclusion. Overall, the results framework, M&E plans and systems of the Inclusive Communities consortium and of World Vision met most of DFAT's M&E standards.

Inclusive Communities could have done better in a number of areas: it was found to have a lack of focus on medium-term and long-term results, no rationale for indicator-wise targets, and a limited role of consortium MEAL

coordination in harmonizing MEAL plans of individual agencies, data validity checks, and MEAL capacity development.

PI's logframe was weak; its outcomes were broad, open-ended statements with no measurable indicators. PI did not have dedicated M&E personnel and depended on local partners for M&E data. In this instance, PI should have assessed and developed the M&E capacity of local partners in order to make the M&E system more robust.

Inclusive Communities Consortium

The Inclusive Communities consortium had a joint Project Implementation Plan, an M&E plan, and an M&E coordination mechanism. While individual agencies were responsible in carrying out activities in their part of the logframe, there was substantial scope for joint planning and collaboration. Therefore, the evaluation of the effectiveness of consortium ANGOs was undertaken using two lenses: consortium-level assessment and individual-level assessment.

Consortium-Level Assessment

Consortium-level assessment included an evaluation of the M&E plan, practices and coordination at the consortium level. In addition, the evaluation team looked into some other cross-cutting issues such as consortium-level risk management and social cohesion between the Rohingya and host communities.

Beneficiary Reach at Consortium Level

The consortium could reach its projected total number of people (163,000+) aggregately, and it did an excellent job of reaching children without disability, exceeding its targeted number by around 35,000. Yet the consortium fell short with regards to its ambitious projected direct beneficiary reach in some cohorts and segments. It was unable to reach its projected reach of the number of people with disability for either adults or children. Another segment where the consortium fell short was female adults without disability: it reached only around 63,034 against its target of around 85,000.

Figure 2: Overview of actual vs projected beneficiary reach of Inclusive Communities

Risk

Projected vs Actual

Male_Actual Male_Projected Female_Actual Female_Projected
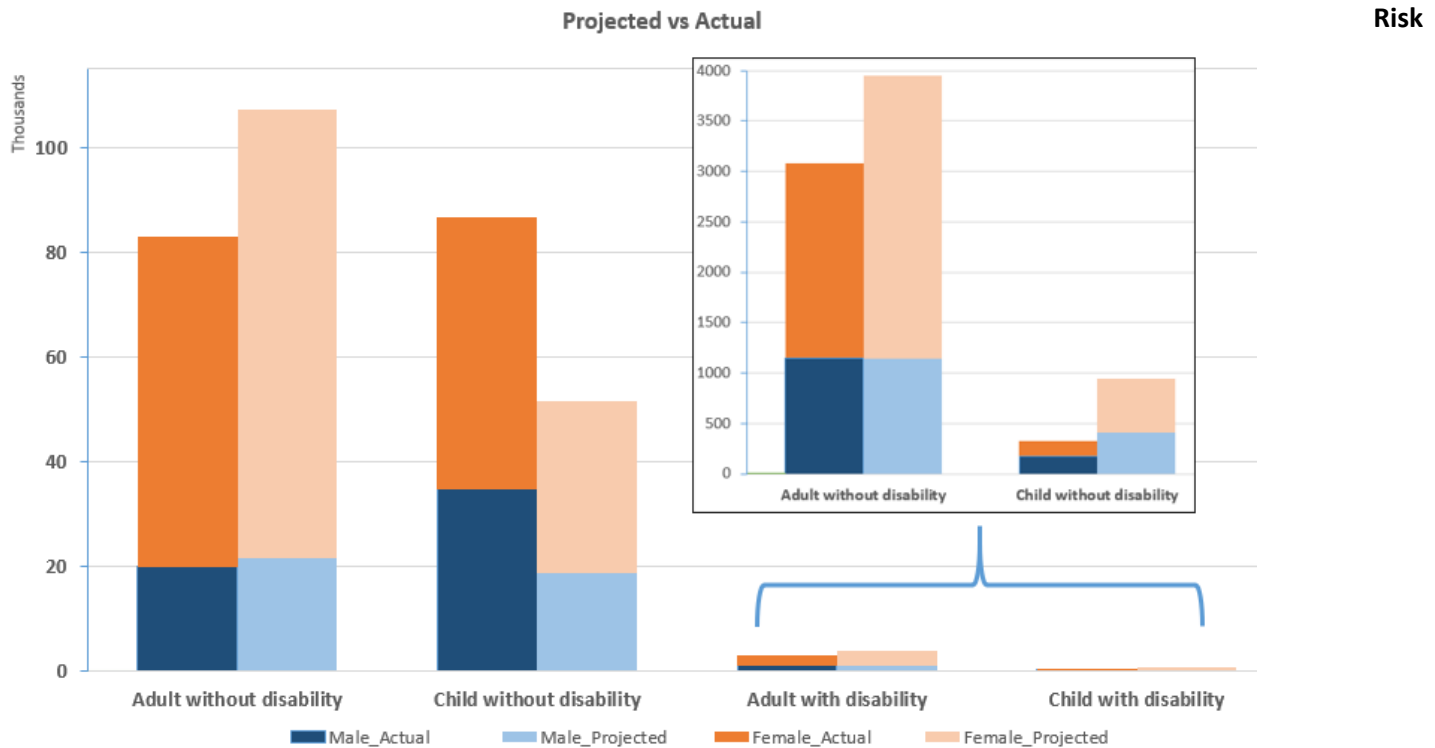
Management

All ANGOs prepared a risk matrix, identified project risks, categorized those risk ratings in terms of likelihood and potential impact, and prepared mitigation plans[35]. For most ANGOs, however, the risk matrix was merely a section of their planning documents: it was not systematically maintained through regular reviews of risks and changes in their likelihood or impact, nor by adjusting mitigation plans as necessary[36]. Interviews with consortium partners revealed that risk management, particularly monitoring, could have been more robust.

Social Cohesion

The December 2020 demonstrations by host community youths against NGOs, rumours in relation to the spread of COVID-19, and the rising tensions between the Rohingya and host communities during the pandemic demonstrate that social cohesion is of utmost importance. The Inclusive Communities response did not put sufficient focus on social cohesion. Social cohesion was not defined in the design documents nor was it incorporated in the project logframe. There was no common understanding of what needed to be done to achieve greater cohesion inside the Rohingya communities or between the Rohingya and host communities. At the same time, there was little attention towards identifying and responding to differential needs of the host community[37].

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[35] AHP Phase II Risk Management Framework provided by Save the Children
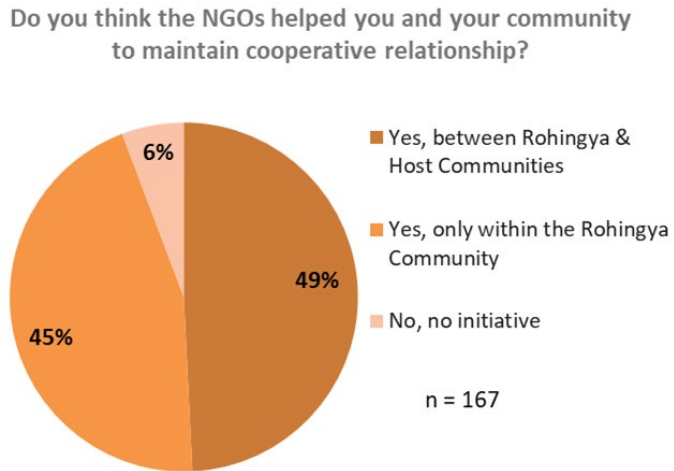[36] Source: Multiple KIIs with Consortium Partners.
[37] Source: Review of project documents (Project Implementation Plan, logframe, IPTT) and KIIs with consortium partners

> ***Consortium Partner***
> *'Social cohesion has many aspects. Whenever we try to implement any task, we engage both community members (Rohingya and host) and that's one of the parts. Only including volunteers from the host community is not total social cohesion. I think social cohesion was not focused on in Phase II. This needs to change in the multi-year program.'*

Surveys with the Rohingya communities illustrated the gap in activities promoting social cohesion. Only 49.2% of the consortium's beneficiaries felt that activities by the NGOs helped to maintain cooperative relationships between the Rohingya and host communities, while 5.8% said there were no initiatives promoting social cohesion at all.

Figure 3: Inclusive Communities' beneficiary responses on social cohesion (Source: Beneficiary Survey)

Do you think the NGOs helped you and your community to maintain cooperative relationship?

- Yes, between Rohingya & Host Communities — 49%
- Yes, only within the Rohingya Community — 45%
- No, no initiative — 6%

n = 167

M&E planning and coordination mechanism

The consortium had a stand-alone M&E plan that incorporated the program brief, a logical framework, performance expectations, and standards to be followed[38]. The M&E plan had a clear description of the investment, including an overview, goals, outcomes, duration, location, and beneficiaries. The MEAL plan matrix outlined the data collection and analysis methods, including indicator definitions, tools, and frequency of data collection; it also included specific dates in the MEAL task schedule. The MEAL plan set out guidelines for ethical considerations for data protection and informed consent, with sufficient attention to anonymity, voluntary participation, comfort, and verbal/written consent. The M&E system was designed to collect age-, sex- and disability-disaggregated data for different indicators. M&E planning was therefore well-aligned with most DFAT M&E standards[39].

In terms of MEAL coordination, the consortium adopted a clear and structured approach. The consortium MEAL manager and MEAL focal points from the consortium agencies were given clear responsibility to oversee the activities so that outcomes could be monitored at the consortium level. A MEAL working group was established. It would meet regularly to discuss various issues faced by the consortium partners and share learnings. The consortium developed a uniform performance tracker, called the Indicator

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[38] AHP Project MEAL Plan. 30 Sept 2019, provided by Save the Children
[39] DFAT Monitoring and Evaluation Standards. April 2017

Performance Tracking Table (IPTT)[40]. All consortium partner agencies used the same tracker – a simple tracker in Microsoft Excel which can continuously track progress against all indicators of all consortium members. Multiple key informants from consortium NGOs believed that the MEAL working group was effective in clarifying issues related to the IPTT, in updating sharing from individual partner agencies, and on common response areas.

While there was strong evidence of a robust M&E plan and coordination mechanism, the evaluation team also found some areas for improvement, particularly at the implementation level. There was some evidence of communication gaps in MEAL coordination. According to two KIIs, the position of consortium MEAL manager was vacant for more than a month. During this period, the consortium partners did not get the support they wanted. M&E personnel from different consortium partners also opined that the consortium should have played a greater role in harmonizing individual agency MEAL plans, data validity checks, and MEAL capacity development. According to one ANGO, there were regular learning and sharing M&E sessions internally, but these were not held at the consortium level as often as they should have been.

Another weakness of the M&E plan and system was the lack of rationale and assumptions behind different outcome targets[41]. Since no baseline study was conducted prior to the initiation of the Phase II response, according to DFAT M&E standards, the M&E plan should have provide the rationale behind the targets. This was a clear weakness of the M&E design.

> **Key Findings**
> There was considerable evidence of a very good quality M&E plan and coordination mechanism at the consortium level. There were, however, some execution-level weaknesses and deviations from DFAT's M&E standards. Overall, however, Inclusive Communities met most of DFAT's M&E standards.

Save the Children

Achievement of Outputs and Outcomes
The response from Save the Children had two broad outcomes in the education and health sectors. The outcome achievements are detailed below[42].

Outcome 4 – Education: Access to quality and inclusive learning opportunities, in a safe and protective environment, expanded and strengthened for Rohingya refugee children and the children of host communities.

Table 4: Outcome achievement summary[43]

Outcome Indicator	Target	Achievement against Indicator-target

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[40] AHP Project MEAL Plan and IPTT_AHP_DFAT (updated till November 2020) file
[41] Rationale behind indicator-wise targets were not provided in AHP Project Implementation Plan, the AHP Project MEAL Plan, or any other project document.
[42] Logframe, Project Implementation Plan
[43] Source: Final Report of Inclusive Communities Consortium

Outcome 4 – Education: Access to quality and inclusive learning opportunities, in a safe and protective environment, expanded and strengthened for Rohingya refugee children and host community children (20% target)			
4.1	% of school-aged boys and girls, including boys and girls with disabilities, within TLC/HBL/GFS catchment areas accessing quality, inclusive learning opportunities in a safe and protective environment	*7,005*	99.6%
4.2	% of teachers supported who display improved competencies in areas the support relates to	*60%*	96%
4.3	% of parents and caregivers attending parenting sessions who demonstrate improved engagement with their children's education	*50%*	98%

On education (Outcome 4), Save the Children attempted to enable an inclusive learning environment for the children in the targeted areas. It recruited and trained teachers, arranged awareness sessions for parents, and repaired and maintained TLCs and HBLs to ensure continuation of quality education for children[44]. Around 7000 boys and girls were enrolled in education facilities such as TLCs, HBLs, and GFSs[45], which met the intended target of Save the Children's response. One hundred and fifty children with disability were provided individualized education with technical support from HI. This was a major step towards inclusive education as many of these children had lacked access to education previously. As for education quality, the evaluation team's survey with parents showed that 86% (n=90) were satisfied with the education support that Save the Children provided to their children. Parents mentioned that the TLCs of Save the Children and its local partner had more space (than other TLCs), the educational materials were of good quality, and the teachers engaged the children with great sincerity.

> *FGD Participant, female, age 40*
> *'The education support from YPSA (implementing partner) has played a very positive role. Their teacher quality is better than other TLCs. They engage with us regularly about our children's education.'*
>
> *FGD Participant, male, age 35*
> *'I think the teachers are really sincere about our children's education. They care for every child. If a child does not understand something, they try as long as it takes to help him/her.'*

While the outcome on education was mostly achieved, the evaluation team also tried to understand why some parents were not satisfied with the quality of education. One issue was that the home-based learning environment during COVID-19 was different from a school environment. The home-based learning model, therefore, appeared to some parents to be more like private coaching than school. However, this was inevitable as the learning centers were closed by order of the RRRC office. Another major concern was shared by the parents of children with disability. During the Phase II response, HI provided individualized education to children with disability, support which ceased when the project ended. During field data collection, parents of these children stated that they had appreciated the

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[44] Source: IPTT and field visit
[45] Source: IPTT and the Final Report

educational support provided to their children. However, when the support ended, their children started to forget everything they had learned (Case Story 1 below). Therefore, the benefit of inclusive education provided during the Phase II response is unlikely to be sustained.

Case Story 1: Discontinued Support after Phase II Closure for Children with Disabilities

Amina Begum is a 12-year-old girl whose legs have been paralysed since birth. She lives in Block F, Camp 10 with six family members. She cannot go outside without help. Her mother said, "My daughter had a walking frame when we were in Rakhine, which she left there." Amina's mother added that she had asked several NGOs for a walking frame or a walking aid for her daughter, but she had not received one. Due to the lack of walking support, Amina could not go to school for the previous couple of years.

Amina is now a student at a YPSA TLC. She confirmed that she had received books, notebooks, bags, and pens from the TLC and used to attend the TLC before the outbreak of COVID-19. YPSA referred Amina to HI so that she could get support for her disability. HI recorded Amina's details and asked about the required support. "At the beginning of 2020, my daughter got a walking frame from HI," Amina's mother confirmed. She also stated that the therapists from HI provided physiotherapy for two months to her daughter to help with her rehabilitation. HI also provided Amina with toys, and the facilitators taught her basic life skills every time they came to provide therapy. Amina and her mother greatly appreciated these facilities from HI, with which she was getting back to a normal life.

Due to COVID-19, Amina had to stop going to school, but the teachers came to her home almost every week to teach her. She confirmed that the teachers taught her with great care. But HI stopped the therapy a few months ago. Amina is unable to walk properly due to the absence of therapy. Previously, HI had taught her mother how to provide therapy, but she had forgotten how to do it properly. According to her mother, Amina is now living with the burden of the disability that she had earlier. Amina's mother said, "My daughter needs longer-term support to cope with her disability; one or two months of support does not create a noticeable impact." Amina's mother is depressed because she does not know whom to approach for similar support since HI stopped giving support to them. Amina echoed her mother's words: "If I get longer-term support or a referral to another NGO, that would be good for my recovery."

Key Findings
Save the Children met its outcome level of targets in providing educational access to school-aged children, including those with disability. Parents were highly satisfied with the quality of Save the Children's educational support in terms of TLC space, material quality, and teacher quality. A major concern, however, was the discontinuation of educational support to children with disability after Phase II ended.

Outcome 2 – Health: Equitable and inclusive access to and utilization of quality and comprehensive primary health services improved, health system strengthened, and disease outbreak prevention supported for Rohingya refugee and host communities.

Table 5: Outcome achievement summary[46]

Outcome Indicator	Target	Achievement against Indicator-target

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[46] Source: Final Report of Inclusive Communities Consortium

	Outcome 2 – Health: Equitable and inclusive access to and utilization of quality and comprehensive primary health services improved, health system strengthened, and disease outbreak prevention supported for Rohingya refugee and host communities. *(All indicators are disability- and gender-sensitive)*		
2.3	% of adolescent boys and girls who attend SRH corners with increased knowledge of SRH	*70%*	89%
2.4	# of adolescent couples using family planning methods following counselling sessions	*625*	66% 414
2.5	% of staff who received training with increased knowledge of SRH	*80%*	80%
2.6	% of staff with increased awareness of MHPSS	*80%*	85%
2.7	% of community members/adolescents who received awareness raising demonstrating increased awareness of MHPSS	*50%*	75%

Save the Children's support on health (Outcome 2) was provided in health centres, including four SRH corners, and followed a community- and facility-based approach in providing family planning counselling and MHPSS services. As per the final report of Inclusive Communities, 89% of adolescent boys and girls who attended SRH corners had increased knowledge of SRH[47]. This was further validated by the evaluation team's FGD and KIIs with beneficiaries and stakeholders. Beneficiaries reported that Save the Children had arranged various awareness sessions on SRH, and as a result, they had increased awareness of SRH, including menstrual hygiene, birth control, and contraceptive use. Through open-ended questions in the beneficiary survey, the evaluation team also found evidence that Save the Children provided services on women's health, support for pregnant women, contraceptive kits, pills, and vaccines. The survey indicated that 85% (n=77) of the beneficiaries were satisfied with the health support provided by Save the Children. The monitoring data from IPTT and the final report confirmed that 414 adolescent couples adopted family planning after receiving counselling from Save the Children.

Overall, the beneficiaries were satisfied with the quality of the health support provided by Save the Children, though some respondents pointed out the problem of overcrowding and long queues at health posts, which forced them to wait for a long time when seeking health services.

> *FGD Participant, female, age 40*
> *'The education supports our children received and the health services we got were of good quality. However, we have to wait a long time when we go to the health post to get health care; pregnant women also suffer from the same problem.'*
>
> *Religious Leader (Imam), age 72*
> *'We get food support from WFP, health support from Save the Children and (local partner) RTMI, and education support from YPSA. I am satisfied with the quality of service I have received. Most of my needs have been met fairly.'*

Key Findings
Beneficiaries of health services were mostly satisfied with the support they received from Save the Children and its implementing partner. Save the Children's response contributed to an enhanced understanding of SRH and the adoption of family planning. Beneficiaries raised concerns about long queues at health facilities.

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[47] Source: Final Report of Inclusive Communities Consortium

Barriers or Enablers of the Project

KIIs with Save the Children revealed that there were some delays in activities due to the government-imposed restrictions during the COVID-19 outbreak. Moreover, the absence of CiCs at the camps eventually led to a delay in receiving permission for its activities. On the other hand, the strong community support system of Save the Children helped it to continue deliver its services even during the COVID-19 outbreak.

Another critical barrier for Save the Children's health program was the lack of awareness of appropriate health services among the Rohingya people. Rohingya beneficiaries sometimes tend to trust non-qualified private practitioners from Rohingya communities more than the doctors and healthcare providers at camp health centres. Such practices may bring unwanted outcomes for the Rohingya community. This is a common problem for all NGOs working in the health sector in the camps. Behavioural change will result from more community awareness and trust-building on healthcare.

Longer-term Resilience of Affected Communities

Although Save the Children initiated a number of capacity development initiatives for their health and education programs, empowering beneficiaries with life skills seemed less of a priority in the course of Phase II[48]; life skills education should be integrated in Phase III. At the same time, initiatives such as the recruitment and training of teachers will most likely strengthen the community to ensure effective education for Rohingya children.

With regards to disaster risk reduction, Save the Children provided awareness sessions together with other humanitarian agencies working in the camps[49]. Beneficiaries stated that they were better prepared to deal with natural disasters due to the various awareness sessions conducted by the NGOs; they had learned the

> **97%** of the respondents (n=167) from Save the Children's beneficiary pool stated that they were more aware about and prepared for natural disasters.

meaning of the danger signal given during natural disasters. Moreover, they mentioned that the CiC had made them aware of the threats of natural disasters. They had also learned how to be safe during natural disasters.

Results Framework

The evaluation team discovered that the expected outputs and outcomes of the Phase II response were sufficiently straightforward and well-defined. In line with DFAT's M&E guidelines, the end-of-program findings were expressed in terms of the quantitative changes predicted to occur at the end of the program. However, outcomes were based on short-term results such as increased access, improved teacher competency, and parents' improved engagement with their children's education. In addition to these, the response could have also pursued medium-term results such as quality of education, improved skill levels

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[48] Source: Review of the Project Implementation Plan
[49] Source: FGD with beneficiaries

of students, and satisfaction of children and parents regarding teacher competency. Nevertheless, the evaluation team also understood the hurdles of integrating all of these into a one-year program.

Key Findings

The intended outputs and outcomes were well-defined, described in measurable indicators, and easily understood by the project team. However, a greater depth of outcomes could have been assessed such as students' skill levels and satisfaction of children and parents with teacher competency.

CARE

Achievement of Outputs and Outcome

CARE's response had two broad outcomes in protection and health. It was intended to deliver assistance to a total of 20,209 direct beneficiaries[50].

Outcome 1 – Protection: Inclusive protection programming to Rohingya refugee and host communities effectively delivered.

Outcome 2 – Health: Equitable and inclusive access to and utilization of quality and comprehensive primary health services improved, health system strengthened, and disease outbreak prevention supported for Rohingya refugee and host communities.

Table 6: Outcome achievement summary[51]

Outcome Indicator		Target	Achievement against Indicator-target
Outcome 1 – Protection: Inclusive protection programming to Rohingya refugee and host communities effectively delivered			
1.1	# of women with and without disability with access to safe space	*4392*	123% 5404 (2107 girls; 3297 women)
1.2	# of GBV risks reported by community groups	*60*	107% 64
1.3	% of men and boys who report rejecting intimate partner violence and domestic violence	*40%*	35%
1.4	% of people (male/female) trained who have increased knowledge of GBV prevention and protection	*80%*	100%
Outcome 2 – Health: Equitable and inclusive access to and utilization of quality and comprehensive primary health services improved, health system strengthened, and disease outbreak prevention supported for Rohingya refugee and host communities. *(All indicators are disability- and gender-sensitive)*			
2.1	% of women aged 15–49 who make own informed decisions regarding sexual relations, contraceptive use, and reproductive health care (SDG indicator 5.6.1)	*50%*	80%*

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[50] AHP Activation – Final Report provided by CARE
[51] Source: Final Report of Inclusive Communities Consortium

2.2	% of demand satisfied for modern contraceptives among women aged 15–49 (SDG indicator 3.7.1)	*70%*	100%

* The data retrieved from Inclusive Communities' final report was not validated by the evaluation team's own data and analysis.

CARE's support on protection (Outcome 1) was provided through its WGSSs and community-based awareness sessions. According to CARE's monitoring reports, a total of 5404 women and girls were provided access to a safe space, exceeding CARE's intended target by 23%. FGD participants spoke highly of the WGSSs, where they could open up and talk about protection concerns, consult with and seek support from CARE's service providers, and learn from other women while their children played nearby. They also received SRH and health-related information in the WGSSs. The approach of integrating SRH and GBV was effective and appreciated by the affected communities.

> **Female Participant, age 40**
> *'In* Shanti Khanas *(WGSSs), we can talk with other women in our community on different domestic issues and seek assistance from CARE's* apa *(NGO worker) in a safe environment.'*
>
> **Female Participant, age 50**
> *'Every Monday a doctor visits the* Shanti Khana *and provides us with health services. It is good that we can receive different services at a place where we feel safest.'*

A major achievement of CARE's protection-related response was enhancing community awareness on GBV and building community-based protection mechanisms through CARE's outreach groups. According to CARE's final report, 100% of male and female beneficiaries who were trained on GBV prevention and protection had enhanced knowledge of these issues. This outcome was corroborated by the evaluation team's field data. All participants of FGD sessions indicated that they were aware of issues such as GBV, child marriage, dowry, and abuse. Community Outreach Groups' door-to-door awareness sessions strongly contributed to enhancing community awareness on protection. These groups also played an active role in identifying GBV- and protection-related risks and resolving the issues through engagement with the community. According to CARE's final report, 64 GBV risks were reported by these groups, a number which exceeded its intended target. The role of Community Outreach Groups in identifying and resolving protection risks was further validated by key informants and FGD participants.

> **FGD Participant, female, age 45**
> *'People are now more aware of different important issues like GBV, child marriage, and hygiene issues because of the awareness sessions provided by community groups.'*
>
> **GBV Committee Leader, male, age 60**
> *'I have been part of some situations where we found that an early marriage was going to take place. We then tried to prevent such things from happening and were successful… GBV incidents increased during COVID-19 because the number of awareness sessions was low. When the outreach teams are more active, these incidents go down.'*

Although community awareness and knowledge of GBV was certainly enhanced, it was less than perfect. The evaluation team found that both beneficiaries and Community Outreach Groups understood GBV in terms of physical abuse only. Other forms of mental or economic harm, such as the use of abusive language and psychological pressure for dowry by husbands, were not understood to be GBV. At the same time, CARE's outcome target on changing the attitudes of males so that they reject intimate partner violence was also under-achieved. Only 35% of men and boys reported rejection of intimate partner violence against the intended target of 40%. However, this can still be considered significant progress given the traditional belief system in Rohingya communities and the fact that about 3000 beneficiaries were reached through men and boys engagement sessions. This shows that continuous engagement with the male members of the Rohingya community will be needed to change their knowledge of and attitude towards GBV and protection.

On health (Outcome 2), CARE supported beneficiaries through their health posts and outreach clinics. Door-to-door visits by Community Outreach Groups included SRH information (including referral service-related information) and engaged women, men, girls, and boys. Beneficiaries reported having greater access to SRH information through outreach groups and safe spaces, as well as access to modern contraceptives. As for the outcome on women making their own informed decisions regarding sexual relations, contraceptive use and reproductive health care, CARE's final report states 80% achievement. This data, however, was not validated by the evaluation team's data and analysis. The FGD with female beneficiaries revealed that Rohingya women had not yet achieved sufficient decision-making power in their households to make their own informed decisions on sexual relations and contraceptive use. A baseline study conducted by CARE (October 2020) with similar project areas to that of the Phase II response showed that only 9% of female respondents could make their own decisions regarding contraceptive use, and only 23% could make joint decisions with their spouses. The same study also asked female respondents if they had the decision-making power to say 'no' to sexual intercourse; only 11% said they did.

> **Key Findings**
> Community understanding of GBV needs to be increased along with continuous awareness building of harmful practices such as early marriage and dowry. Sensitizing male community members to reject intimate partner violence and accept women's choices in sexual relations and contraceptive use is important.

Overall, the vast majority of CARE's beneficiaries (89%) expressed satisfaction with protection and health-related support. CARE had set a target of reaching 20,209 direct beneficiaries and, at the end of the response, had reached 22,400 people. Despite the

> **89%** of the respondents (n=76) from CARE's beneficiary pool showed satisfaction with the support they received.

severe restrictions at the camps due to the COVID-19 pandemic, CARE's beneficiary reach exceeded its projected beneficiary size. In terms of achieving outputs, CARE's monitoring tracker and final report indicated that its response met or exceeded most of them[52].

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[52] ALL_IPTT_AHP_DFAT (updated till November 2020) file, and AHP Activation – Final Report

Barriers and Enablers of the Project

During KIIs with CARE's project staff, the security concerns in the camps and the COVID-19 pandemic were cited as major barriers. At the same time, the end-of-project outcome was about changing people's deep-rooted beliefs, attitudes and practices on GBV and SRH. Bringing substantial changes to deeply held beliefs was always going to be difficult over such a short project period. Another major barrier was managing regulatory approvals from various GoB stakeholders. According to CARE, these barriers were adequately considered during the project planning phase by adopting an appropriate strategy for managing relationships with GoB stakeholders.

Longer-term Resilience of Affected Communities

Community Outreach Groups formed and facilitated by CARE contributed to developing a community resilience mechanism against GBV and other protection risks in the communities. These community leaders are now taking active roles in protection and can continue to play a crucial role in the future, when the Rohingya people are repatriated to Myanmar.

> *FGD Participant, male, age 30*
> *'The* majhi*, the imam and the elders of our community work with the committee members to deal with problems in our community.'*

CARE provided life skills training to 1048 women and girls in areas such as numeracy and literacy, decision-making, sewing and problem-solving[53]. The community awareness and meeting sessions, particularly those in the rainy season, included educational content on

> **95%** of the respondents (n=76) from CARE's beneficiary pool stated that they were more aware of and prepared for natural disasters.

preparedness in case of landslides, cyclones and other natural disasters[54]. Of CARE's surveyed beneficiaries, 96% said that these activities had made them more aware and prepared for natural disasters.

The evaluation team found that the host community response needed more focus. CARE's program did not address host community needs in Phase II, despite it having other donor-funded programs in host communities[55]. In light of the deteriorating relationship between the Rohingya and host communities, future programming should include adequate components on the differential needs of the host communities.

Results Framework

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[53] Source: ALL_IPTT_AHP_DFAT (updated till November 2020) file
[54] Source: FGDs with beneficiaries, KIIs with field level staff
[55] KII with CARE staff

The evaluation team found the intended outputs and outcomes for CARE's AHP response sufficiently clear and well-defined. In accordance with DFAT's M&E standards, the end-of-program results were articulated in terms of quantitative changes that were expected to happen at the end of the program.

Despite the above-mentioned points, the evaluation team found some scope for improvement in the logframe[56]. For some programmatic activities, only short-term outcomes were included in the log frame. For instance, Outcome 1.2 (# of GBV risks reported by community groups) could have been categorized as a short-term or immediate outcome. A more results-oriented approach would have been to monitor what happens after the risks had been identified, such as the percentage of risks addressed or whether vulnerable women felt safer after receiving assistance from CARE. The need for a stronger results focus in the logframe was also highlighted in an interview with CARE's project staff.

> **CARE Staff Member**
> *'There needs to be more emphasis on ensuring the service is received by beneficiaries. When someone is referred from a health post, there is a follow-up to know whether they have received the treatment, but there is no indicator for it.'*

Key Findings
The intended outputs and outcomes were well-defined, described in measurable indicators, and were easily understood by the project team. There was still some scope for improvement in terms of capturing the actual benefits or results of some activities.

Oxfam

Achievement of Outputs and Outcomes
Oxfam's response set one broad outcome in the WASH sector and was expected to provide support to a total of 44,988[57] beneficiaries (men, women, girls, and boys, including people with disability).

Outcome 3 – WASH: inclusive and gender-sensitive sustainable WASH services and facilities for Rohingya refugee population ensured

Table 7: Outcome achievement summary[58]

Outcome Indicator	Target	Achievement against Indicator-target

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[56] Source: Review of CARE's component of the logframe in the AHP Project MEAL Plan
[57] Save the Children's Combined Program Implementation Plan
[58] Source: Final Report of Inclusive Communities Consortium

Outcome 3 – WASH: Inclusive and gender-sensitive sustainable WASH services and facilities for Rohingya refugee population ensured			
3.1	% of population that increased their knowledge on hygiene practices and behavior	*80%*	100%
3.2	% of women and girls satisfied with the upgrading and social architecture activities	*80%*	100%

The final report of the Inclusive Communities consortium states that 100% of Oxfam's beneficiaries had increased knowledge of hygiene practices and behaviours. The evaluation team tried to understand to what extent this outcome was achieved through FGDs with Oxfam's beneficiaries and random observation visits to beneficiary households. The observational visits revealed that households had soaps and were using safe water. FGD participants shared that they knew more about handwashing and safe water usage as well as COVID-19 risks and required precautions. Hence, the evaluation team has a high level of confidence in relation to the achievement of Outcome 3.1 as stated in the final report.

As for Outcome 3.2, Inclusive Communities' final report states that 100% of women and girls were satisfied with the upgrading and social architecture activities. According to the evaluation team's survey with Oxfam's beneficiaries, 98% of respondents (n=139) and all of the female respondents were highly satisfied with the WASH facilities provided by Oxfam. The beneficiaries who took part in FGDs conducted by the evaluation team expressed their satisfaction with regards to the quality of the WASH facilities, including repair and desludging services. Separate male/female latrine facilities were made available; these were safe and accessible to female beneficiaries.

> *FGD Participant, female, age 25*
> *'I can use a separate latrine for females which is comfortable and safe. There are also handwashing points near the latrine.'*
>
> *Local leader (***Majhi***), male, age 50*
> *'Our latrine required desludging and repairing so we informed the NGO through volunteers. The staff repaired and desludged it within a few days.'*

Overall, Oxfam reached 49,500 beneficiaries with their WASH-related services against the intended target of 44,988 people. As for the output targets, the following achievements appear in the IPTT:

- 110 sanitation facilities (30 inclusive) were constructed; intended target met.
- 832 latrines were decommissioned against a target of 600.
- 325 latrines (68 transformed to be inclusive) and 80 bathing facilities were repaired against a cumulative repair target of 260 facilities.
- 7364 rounds of disinfecting of water and sanitation facilities were conducted against a target 6000 rounds.
- Around 260 tube wells, including 184 shallow tube wells, were repaired.
- 500 communal handwashing devices were installed, at which 9360 units of soap were distributed; the initial target was met by Oxfam, but as Oxfam observed during implementation, beneficiaries required more units of soap.

- Oxfam trained 125 community health volunteers on COVID-19 and AWD prevention.
- 363 personnel were equipped with personal protective equipment (PPE), meeting the target.
- 107 billboards were installed against a target of 100 billboards.
- 18,542 units of hygiene kits were distributed against a target of 2000 units because COVID-19 increased the need for additional kits.

During COVID-19, Oxfam had to increase its focus on crucial needs such as disinfection of facilities, distribution of hygiene kits, installation of contactless handwashing devices, installation of billboards, volunteer training on COVID-19, and an awareness building program.

While Oxfam achieved most of its output targets, the evaluation team found that in some cases the WASH facilities had been damaged or stolen. Field observation revealed that a large portion of the contactless handwashing devices had been damaged within a very short period due to a lack of maintenance. Through interviews with community leaders, it was found that installed solar lights and taps were stolen frequently even though the *jimmadar* (dedicated facilities maintenance person) was supposed to prevent this. Community members suggested stronger monitoring and engagement with nearby households in relation to the maintenance of the facilities. Some beneficiaries also reported that they did not get enough soap for handwashing points.

> ***Observational Visit Result***
> *During an observational visit, 8 out of 10 contactless handwashing devices were found to be damaged. Only one* jimmadar *was responsible for the maintenance of these devices, which had put a lot of strain on him. Households nearby stated that maintenance would have been better had they been given the responsibility to look after the facilities instead.*
>
> ***Local leader (*Majhi*), male, age 53***
> *'Tap stands are being repaired and handwashing points have been established, though we do not get enough soap for handwashing points.'*

> **Key Findings**
> Oxfam's response contributed effectively to increased awareness of hygiene practices and COVID-19 awareness. Oxfam's WASH facilities were of high quality in general, leading to a high level of satisfaction among beneficiaries. However, there were instances of WASH facilities being damaged or stolen, indicating that maintenance and monitoring could have been more robust.

Barriers and Enablers

Oxfam faced an initial delay due to DFAT's global funding suspension. The COVID-19 outbreak in March 2020 resulted in additional delays in starting the implementation. To start the implementation, local partners required FD-7 approval from the Bangladesh NGO Affairs Bureau; this took one month.

With respect to geographic barriers, both Camps 12 and 19 are situated in a frequent landslide zone. Thus, the WASH infrastructure of these camps required recurrent repairs. According to beneficiaries, latrines were damaged frequently because of insufficient access to water on the hill tops. People used less water in the latrines, which got damaged as a result. The area is very congested; this makes it difficult for NGOs

to find suitable locations for WASH facilities, spaces which the community agrees to sacrifice for the construction of such facilities.

Communication inside the camps is challenging for diverse reasons. Female beneficiaries prefer to speak with female NGO staff instead of male staff. However, there are too few female staff with technical and language proficiency in the context of the camps. The mobile network is very poor in almost every area of the camps, and this led to severe communication challenges during COVID-19 for those agencies wishing to rely on remote communication.

With these barriers as a backdrop, an enabling factor was the helpfulness of most of the people. Most of the people receiving support displayed interest and enthusiasm. They helped the field staff of Oxfam's partners in program implementation by nominating locations, sharing feedback, and maintaining guided practices.

Longer-Term Resilience of Affected Communities

All WASH interventions, including latrine construction, repairs and desludging, installation of handwashing devices, and hygiene promotion were implemented with the full engagement and participation of communities, other camp WASH actors and local authorities. Oxfam conducted training sessions on life skills in relation to personal hygiene management, using latrines, prevention of AWD and other relevant WASH concepts. In particular, Oxfam undertook training to ensure user understanding before providing any infrastructural support; for instance, prior to the allocation of a Biofil toilet, beneficiaries were informed through a series of courtyard discussions that using detergent inside such a facility was prohibited.

Almost all the participants (99%) from Oxfam's beneficiary pool stated that they became more conscious of and prepared for natural disasters after receiving training or attending awareness programs. An interview with community-based volunteers (CBVs) indicated that the volunteers and committee members were trained on "communication with the community during emergencies";

> **99%** of the respondents (n=139) stated that Oxfam's training and awareness programs increased their preparedness for and consciousness of natural disasters.

this training helped them to develop their capacity on remote communication and remote monitoring of community-based protection issues.

Short, integrated awareness sessions were initiated by Oxfam at the start of the COVID-19 period. These helped beneficiaries understand the risks and necessary protocols to minimize the early risk of infection. Youth were engaged with other community-based structures and groups for the COVID-19 response, and Oxfam tried to support adolescents and youth who were discovered during this emergency response. As the camps are located near host communities, socioeconomic tensions between them and the Rohingya refugees are very common. This situation became severe during the COVID-19 crisis. Oxfam needed to conduct increased intervention in host communities to ensure community wellbeing and cohesion.

Results Framework

The evaluation team determined that most of the intended outputs and outcomes for Oxfam's response were adequately clear and well-defined. In line with DFAT's M&E guidelines, the end-of-program findings were expressed in terms of the quantitative changes predicted to occur at the end of the program.

World Vision

World Vision and its partners aimed to reach around 27,000 beneficiaries (final reach was around 26,000)[59]. The NGO followed a community engagement approach which aimed to ensure the effective response of the program with the participation of the beneficiaries.

Moreover, World Vision attempted to engage its local partners in the planning and implementation of its response. This allowed the NGO to provide its support to the affected communities effectively.

Figure 4: Overview of actual vs projected beneficiary reach of World Vision
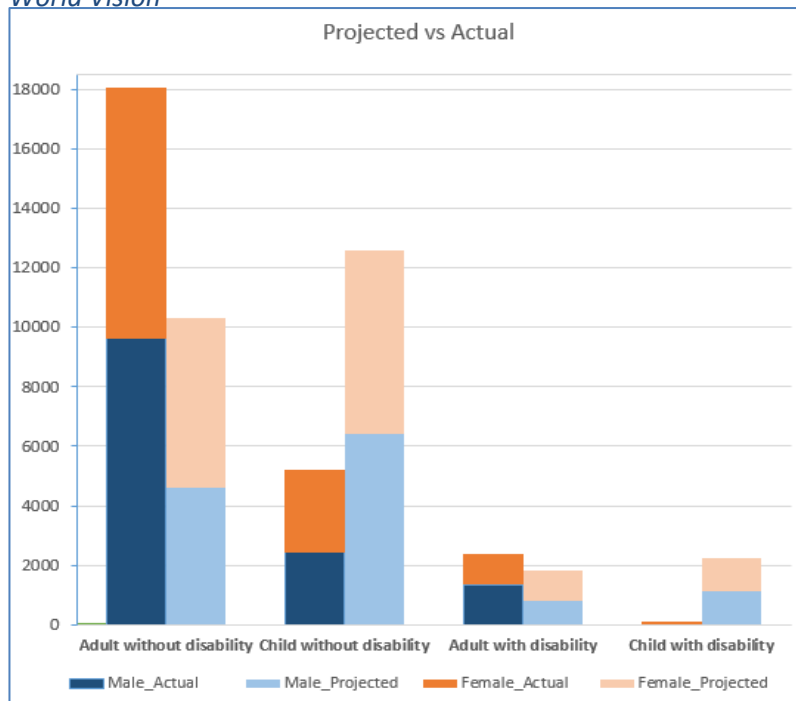
Achievement of Outputs and Outcomes

World Vision reached its targeted total beneficiaries with 25,774 people (48% women and girls) reached. However, the number of children with disability reached was lower than that projected. This was due to the absence of children with disability in the camps[60]. World Vision's implementing partner, BGS, attempted to identify people with disability and undertook surveys twice in order to identify people with disability with the support of disability inclusion partners CBM and CDD. However, the NGO was able to identify only 2% of the total beneficiaries as people with disability[61].

World Vision's response had three broad outcomes in protection and WASH.

Outcome 1: Targeted vulnerable populations (women, girls and boys, including those with disability) have improved access to safe water, environment (*sic*), and good sanitation and hygiene facilities and practices.

Outcome 2: Women's participation in decision-making and protection in refugee camps is enhanced.

Outcome 3: Improved access to and use of safe spaces, psychosocial support and referral services for women and men (adolescent girls, older women and women with disability)

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[59] Source: Final Report of World Vision
[60] KII with field staff
[61] Source: Final report of World Vision

With regards to outcome indicators, World Vision reached most of its targeted numbers, as stated in its ITT. The differences were mostly the result of the delay in providing support to the beneficiaries[62] caused by the outbreak of COVID-19.

Table 8: Outcome achievement summary[63]

	Outcome Indicator	Baseline	Target	Achievement against Indicator (June 2020)
Outcome 1: Targeted vulnerable populations (women, girls and boys, including those with disability) have improved access to safe water, environment (*sic*), and good sanitation and hygiene facilities and practices				
1.1	Proportion of beneficiaries who access and use adequate safe water (20 litres per person per day as per cluster agreement)	53.6%	*100%*	96.8%
1.2	Proportion of the targeted population reporting access to and use of a latrine	99.4%	*100%*	100%
1.3	% of population with improved knowledge, attitudes and practices on general hygiene practices at household level	63.4% safe water 50.3% sanitary latrine 29.7% hand wash	*95%*	91.5% safe water 91.8% sanitary latrine 97.9% hand wash[64]
1.4	Proportion of people with disability reporting use of appropriate and safe water and sanitation facilities and hygiene solutions	25.8% safe water 53.7% sanitation facilities 22.2% hygiene solution	*80%*	91.5% safe water, 100% sanitation facilities, 96.8% hygiene solution[65]
1.5	Reduced risk of water-borne related diseases in the targeted areas	(67.4% households reported diarrhoea is the most prevalent water-borne disease)	*75%*	67% have had no water-borne diseases diagnostic in last 10 ten months
Outcome 2: Women's participation in decision-making and protection in refugee camps is enhanced				

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[62] Source: Final report and KII with World Vision

[63] Source: Final Report and outcome assessment conducted by World Vision, sample size of the outcome assessment consists of 88% women and 71% persons with disabilities

[64] WASH-related services were provided for approximately 10,000 beneficiaries, from whom World Vision selected a sample of 95 people to conduct outcome assessment (Outcome Indicators 1.1, 1.2, 1.3)

[65] World Vision and its technical and implementing partners identified 161 people with disability for WASH-related intervention

2.1	Proportion of women representatives in protection committees and water management committees in the targeted areas	11.11% Protection Committee 15.15% Water Management Committee	*60%*	45% women and 55% men in Women Watch & Protection Committees (40 committees); 95% women and 5% men in Water Management Committee (18 committees)
2.2	Proportion of women with disabilities in protection committees and water management committees	33.3% Protection Committee 0% Water Management Committee	*40%*	21% women with disabilities in Women Watch & Protection Committees (55 committees) and Water Management Committees (18 committees)
2.3	Proportion of male authority figures, including men with disabilities, showing interest in engaging in discussions around women's empowerment and protection in their communities	100%	*100%*	100%
Outcome 3: Improved access to and use of safe spaces, psychosocial support and referral services for women and men (adolescent girls, older women, and women with disability)				
3.1	Proportion of women and girls, boys and men, who have access to and use safe, appropriate and accessible protection services	Women: 94.1% Girls: 72.2% Boys: 68.8% Men: 70.4%	*95%*	Women: 95.8% Girls: 90.5% Boys: 65.3% Men: 68.4%
3.2	Proportion of persons reporting access to and use of psychosocial services, referral services, proportion of women and girls, boys and men, engaging in coffee corners	Psychosocial support: Women: 71.% Girls: 53.8% Boys: 52.7% Men: 53.5% Referral services: Women: 71% Girls: 53.9% Boys: 53% Men: 51.9%	*85%*	Psychosocial support: Women: 87.1% Girls: 86.1% Boys: 57.4% Men: 60.4% Don't know 10.9% Referral services: Women: 96% Girls: 86.1% Boys: 82.2% Men 89.1%

		Physical: 95.7% Sensory: 68.4% Intellectual: 67.8% Mental: 71.8%		
3.3	Proportion of people with disability reporting access to and use of appropriate and safe protective services	Physical: 95.7% Sensory: 68.4% Intellectual: 67.8% Mental: 71.8%	*96%*	95.8%

World Vision's support on WASH (Outcome 1) was provided through establishing WASH facilities, providing WASH equipment, forming inclusive Water Management Committees, and arranging awareness sessions on WASH. The NGO installed 18 water collection points; repaired or installed 100 handwashing facilities; arranged eight training sessions for Water Management Committees; constructed 100 toilets; provided home-hygiene items for 150 people with disability; and conducted hygiene awareness sessions with the participation of beneficiaries including male, female and people with disability. As per the final report of World Vision, 98.6% and 100% of beneficiaries had access to adequate safe water and toilets respectively in its project areas. World Vision's beneficiaries expressed overwhelmingly positive opinions of the NGO's efforts. Around 86% of the beneficiaries reported that they were 'fully satisfied' with World Vision's WASH support, whereas the rest felt that they were 'mostly satisfied' with the WASH support. Similar opinions were also collected from FGDs with WASH beneficiaries: beneficiaries stated that their demands for water and toilets had been fairly met by the WASH support of World Vision. They also stated that they had previously suffered a lot due to an inadequate water supply and a lack of toilets.

> ***WASH Committee Member, female, age 35***
> *'I have been a member of this committee (WASH Committee) for the past year. I need to attend meetings once every two months. At WASH committee meetings, I learned about hygiene, COVID-19 awareness, latrine cleanliness, etc.; I spread these learnings to the community members later on.'*
>
> ***WASH Committee Member, male***
> *'Last year the demand for water and latrines was high and now it has been fairly met. We are also satisfied with the quality of the support received from World Vision.'*
>
> ***Local Leader (*Majhi*), age 27***
> *'We suffered a lot due to problems with water supply and toilets last year (prior to World Vision's response). Now those are fairly addressed as the BGS water network provided a deep tube well and World Vision provided toilets for our community.'*

Although no issues concerning accessibility of toilets and water supply were reported by beneficiaries, during the field visit the evaluation team learned from some of the local beneficiaries that individuals had been redirecting water through pipes into their houses, and that beneficiaries in the area were unable to access the water supply properly. Similarly, some people had put fences around nearby latrines and, in doing so, had made them available only for their personal use. Although there were few such instances, these issues prevented the community from obtaining the full benefit of the support provided by World Vision. To mitigate these issues and ensure that all targeted community members received proper service, BGS monitored and tried to resolve these issues with the participation of community members. In most

cases, the issues were resolved; however, a small number of such temporary situations occur recurrently[66].

World Vision arranged training for its staff on the delivery of WASH services. Forty-five beneficiaries out of 48 reported that NGO personnel were sincere and friendly when responding to the beneficiaries' needs and queries. Seven out of ten people with disability interviewed believed that the NGO considered their special needs while providing support. The WASH committee members also reported satisfaction; they had learned about topics such as hygiene, COVID-19 awareness, and latrine cleanliness. These individuals also shared their learnings with the community afterwards.

In terms of its support on protection (Outcomes 2 and 3), World Vision focused on engaging female members in decision-making and protection as well as improving safe spaces for female members by forming Women Watch and Protection Committees. The NGO conducted three trainings on gender disability rights and inclusion; established four coffee corners and WGSSs; and conducted 19 trainings on protection and psychosocial support. The beneficiary survey revealed that 38 out of 43 female beneficiaries believed that World Vision's response met the special social needs of women and girls. The evaluation team asked World Vision's protection beneficiaries if they felt safer at the time of the survey compared to 2019, prior to World Vision's protection response: all 43 members replied in the affirmative. They also stated that they got to learn about protection-related issues from World Vision's response.

Women Watch Committee Member, female, age 29
'By joining this committee, we have learned about the implications of early marriage and gender-based violence. I think awareness sessions decrease GBV frequency because people are more aware of it than before.'

Women Watch Committee, person with disability, age 30
'I am satisfied with the quality of overall services. Also, these committees have played a very positive role in our community. Different kinds of violence have decreased a lot after the formation of the Women Watch committee.'

According to the beneficiaries as well as members of community forums, the NGO's response was effective in upscaling the community's understanding of protection concerns, such as GBV. At the same time, various activities undertaken by the community forums played a positive role in reducing these events to a certain extent: forum members believed that the rates of occurrence of abusive behaviour towards women as well as instances of child marriage had decreased following the formation of Women Watch and Protection Committees.

Barriers and enablers to effective and efficient programs
One of the major constraints that World Vision faced while providing support for people with disability was related to the camp settings, especially the terrain and the availability of space. The camp setting had

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[66] The evaluation team found two cases in which the facilities had been privatized by local influential persons. In both cases, the problems were addressed after these were identified during monitoring visits by the implementing partner.

limitations and caused difficulties in the building of latrines which provided for the needs of all types of disabilities. It also posed a major challenge for the participation and equal representation of this marginalized group[67].

Another barrier was COVID-19. The outbreak led to delays, while restrictions in activities hampered attempts to reach the project goal as the outbreak limited opportunities for public engagement and community gatherings. In addition, COVID-19 restrictions led to limited mobility in the camps, and this hindered the activities related to WASH device installation. For instance, World Vision's partner, Field Ready, made a foot-operated tap prototype which it handed over to CDD for field testing. However, as COVID-19 restrictions were rolled out, CDD was unable to relocate the tap and get user feedback. For similar reasons, the NGOs were unable to obtain raw materials for WASH devices[68].

KIIs with implementing partners revealed that access to water on hill tops was problematic. As a result, latrines established on hill tops required more maintenance. These issues relating to water access for all were exacerbated due to violations of the regulations imposed by community forums. This was primarily because the majority of the Water Committee members were women, and community people tend to neglect rules set by women. Another problem was the ongoing theft of essential WASH items, including taps, pipes, and solar bulbs.

The monsoon season restricted transport to the camps, affected smooth project delivery, especially construction, and damaged WASH infrastructure. Other barriers related to the behaviour and attitudes of community members: some male community leaders discouraged female community members (especially adolescent girls) from participating in project activities in the initial stage. World Vision and its partners worked with community leaders and the concern was resolved[69].

Longer-term resilience, broader recovery, and stabilization efforts
World Vision initiated empowerment and skill-building activities (handicraft, tailoring) among 350 women to promote women's participation in decision-making and self-empowerment. Of those surveyed, 81.67% of participants reported that they were satisfied with the skill-building training and their ability to graduate from the program after acquiring a transferable skill[70]. Such initiatives can help the community members to become self-reliant and stabilize economic conditions.

[67] KII with implementing partner
[68] Source: Final Report of World Vision
[69] Source: KII with implementing partner
[70] Source: Final Report of World Vision

With a view to enhancing social cohesion among the community people, World Vision piloted 'Happy Corners', places of unity where men and women can discuss their community problems and possible solutions[71]. Although at the time of this evaluation this initiative was at a nascent stage and only being piloted, such community meet-up places can enhance social cohesion. The KIIs and the FGD also revealed that beneficiaries were positive with regard to the communal relationship among the Rohingya people in

their camps. However, many people were skeptical about the relationship with the host community. Surveys with the Rohingya community also revealed gaps in activities promoting social cohesion among the Rohingya and the host community people. Only 54.4% of the beneficiaries of World Vision felt that the NGO's activities had helped to maintain cooperative relationships between the Rohingya and host communities. As few as 6.3% of the beneficiaries said that no initiatives promoting social cohesion were included. In a complex humanitarian situation where violent confrontations are quite prevalent[72], World Vision should have placed greater emphasis on establishing social cohesion between the communities.

Figure 5: World Vision's beneficiary responses on social cohesion (Source: Beneficiary Survey)
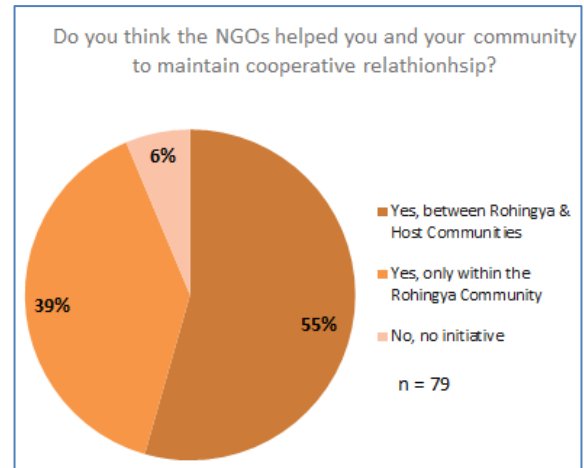
With regards to natural disasters, the beneficiaries believed that they were better prepared at the time of the survey compared to their time of arrival at the camps. They credited this to the various natural disaster preparedness awareness sessions arranged by the NGOs, including those of World Vision, which they said

97% of the respondents (n=79) from World Vision's beneficiary pool stated that they were more aware about and prepared for natural disasters.

had increased their knowledge of the various warnings and shelters in case of natural disasters. However, the danger of landslides remains, with beneficiaries mentioning several occurrences. They also sought support to build guide walls and plant trees around major landslide areas. Ninety-seven per cent (97%) of World Vision's beneficiaries surveyed said that these activities had made them more aware of and prepared for natural disasters.

Risk, Fraud, and Corruption

World Vision discussed issues related to risk in its monthly meetings[73]; however, the NGO did not report and manage these issues systematically. With regards to fraud and corruption, no such issues emerged during the implementation of World Vision's support, according to the beneficiaries.. Nevertheless, the

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[71] Source: Field observation and final report

[72] Example of violent incidents, Source: ECHO Daily Flash (24 August 2019): https://reliefweb.int/report/bangladesh/bangladesh-violent-incidents-rohingya-refugee-settlements-dg-echo-ngos-echo-daily

[73] KII with technical and implementing partners

beneficiaries stated that they did not know where and how to file complaints with regards to fraud and corruption if they had found any.

Results Framework and M&E Practice

World Vision conducted a baseline study encompassing all of the camps included in the program scope to obtain the baseline figures for different outcome indicators. The NGO used these to gather baseline values for most of the key outcome indicators it intended to achieve during the project. The study was done on a sufficiently large sample size using a mix of qualitative and quantitative approaches.

Integrating the baseline values, World Vision identified and set the outcome indicators, which described what each of the major outcomes meant, why they were necessary, and how different activities would contribute to these outcomes[74]. In the absence of a theory of change, these descriptions effectively clarified the ways in which different activities were related to the desired outcomes.

For instance, for Outcome 2 (women's participation, including the participation of women with disability, in decision-making and protection in refugee camps is enhanced), the project implementation plan first set out the context for important linkages between WASH and gender. Next, it described the current situation regarding women's participation in camp governance and decision-making. Finally, it described how it would adopt UNHCR's Protection Committee model to respond to the male-dominated '*majhi*[75]-led' camp governance system. It also described how community outreach activities, such as awareness sessions on the rights of women and people with disability and inclusive participation in community decision-making through Protection Committees, would lead to the desired outcomes.

However, the MEAL plan of World Vision's Phase II response included specifics only about the indicators (definitions, frequency of data collection, tools, and responsible persons); it was not a sufficient stand-alone document to represent the overall approach to be applied to the M&E practice and coordination mechanism[76].

A MEAL plan should include a strategy and schedules of how information gathered through the M&E system will be shared with a wider audience, such as beneficiaries, government stakeholders, other humanitarian organizations, and local implementing partners. Such a strategy for World Vision would have ensured increased transparency and far more opportunities for the receipt of feedback from a broader stakeholder group.

The evaluation team identified another shortcoming through discussions with World Vision's partner organizations. While output and outcome indicators had adequate clarity on paper, they were considered differently among the partners. For instance, some people thought that the disability inclusion indicators

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[74] Source: Logframe
[75] A *majhi* is a Rohingya man who has been appointed as a camp section leader by GoB
[76] Source: MEAL plan provided by World Vision

were the responsibility of CBM and CDD only; however, these were indicators of World Vision and their partners, with CBM and CDD providing the support necessary to achieve them.

Plan International

Achievement of Outputs and Outcomes

Providing education to adolescents and youths (non-formal education and life skills) and associated activities, such as community awareness development, facilitator training, and the provision of educational kits, were major components of the response. Due to the COVID-19 pandemic, all kinds of education programs were restricted in the camps by the camp authority. Hence, PI had to adapt and reprogram its activities so that vulnerable communities could be supported without increasing the risk of COVID-19 transmission[77]. For instance, the 80 HBLs established by PI had to be closed from 18 March 2020. When restrictions eased a few months later, PI moved to individual and one-to-one education and small group sessions on life skills, conducted by their education facilitators[78]. Also, in order to support vulnerable host community families suffering from COVID-19-induced economic hardships, PI provided emergency cash grants to 656 households in Teknaf.

PI's final report indicated that almost all of the targets set in the COVID-19 realignment components were met at the end of the response. The total actual direct beneficiary numbers were close to the targeted beneficiary numbers of the project, indicating strong adaptability on the part of PI[79].

The major achievement of PI's response was providing life skills training and education to 1008 adolescents (494 boys and 514 girls) inside Camps 21 and 23. FGDs and informal discussions with community members indicated that previously there had been few

> 100% of PI's beneficiaries surveyed during data collection (n=120) were satisfied with PI's activities.

opportunities for education or skills development for adolescents and youths in those camps. Many adolescent and youth beneficiaries lacked basic numeracy and literacy skills. After acquiring these skills from HBLs, they then used them in their daily lives. Beneficiaries in Camp 23 stated that their children had received basic education after joining PI's learning centres. Many Rohingya youths worked in the shops of the bazaar of Camp 21, and they were happy that they could count better than before. The quantitative survey of 120 PI beneficiaries showed that all of them were satisfied with PI's activities.

> **Student, male, age 16**
> *"We have received books,* khata *(notebooks), pencils, pens, a water bottle, a bag, two pairs of shoes… We have learned mathematics. Parents' meetings were also arranged…. The NGO conducted awareness sessions on COVID-19.It also provided us with masks and hand sanitizers."*

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[77] Source: KII with Plan International and AHP Bangladesh Activation – Plan International Australia Final Report
[78] Source: KII with Plan International and FIVDB and verified through field observation and discussion with beneficiaries
[79] AHP Bangladesh Activation – Plan International Australia Final Report

PI also engaged with parents and the communities to enhance their understanding of the importance of adolescent education. Rohingya society is traditional in that early marriage is prevalent and the education of adolescent girls is not prioritized. Therefore, ensuring access to education for 514 adolescent girls through the Adolescent and Youth Learning Clubs was a major achievement.

Barriers and Enablers of the Project

The COVID-19-induced restrictions were a key barrier to the project, and compelled PI to reprogram its activities. The service providers of both FIVDB and PI could not access the camps immediately after the lockdown. Although restrictions later eased and PI resumed its realigned component, the overall achievement of the project was hindered by COVID-19-related barriers. Other barriers also affected the program. The adolescent boys and young men of Camp 23 were more inclined towards fishing (as the camp is near the sea[80]) instead of educational activities. Fishing offered them an immediate livelihood opportunity whereas the financial return of life skills development activities was not as easily discernable. Religious and cultural norms created barriers, particularly for adolescent girls and young women. To mitigate these barriers, PI raised community awareness through meetings with parent groups, religious leaders, and the *majhis*.[81]

Longer-term Resilience of Affected Communities

PI's response had the potential to contribute meaningfully to the longer-term resilience of the affected communities. Both Camps 21 and 23 are in Teknaf and are prone to natural disasters. Camp 21 is located in a hilly area and is susceptible to landslides[82]. Camp 23 is very close to the sea and is at risk of coastal hazards.

> **96%** of respondents (n=120) from PI's beneficiary pool stated that they were more aware about and prepared for natural disasters.

The life skills sessions delivered to adolescents and youths included lessons on disaster preparedness. In FGDs, beneficiaries stated that their awareness of disaster preparedness increased after attending these life skills sessions. Life skills training, including sessions on disaster preparedness, had made the community more resilient to shocks and uncertainties, and enabled them to handle crises better. Beneficiaries also revealed that they were better prepared than ever to deal with any natural disaster; at PI's learning centres, they had learned about various natural disasters and about what to do during natural disasters, such as earthquakes. COVID-19 integration in programming activities, such as the distribution of hygiene kits to learners and broadcasting COVID-19 messaging on local cable TV and on Radio Naf, contributed to a reduction in the spread of COVID-19.

PI contributed to social cohesion by having a significant focus on meeting the needs of the host community. Unconditional cash grants to vulnerable households, such as poor and extremely poor families and households headed by women and widows, ensured

> **83%** of survey participants from PI beneficiary pool stated that PI activities helped to maintain a cooperative relationship between the Rohingya and host communities.

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[80] Source: KII with multiple Interviews with Plan International

[81] Same as 64 above

[82] Source: Field observation and discussion with community members.

that the marginalized host community also felt included and felt less frustration and resentment towards humanitarian organizations and the Rohingya population in general. Surveys of PI's Rohingya beneficiaries revealed that 83% believed that PI's activities helped to maintain cooperative relationships between the Rohingya and host communities. This is a high number compared to the survey responses of other NGO beneficiaries, and there could be other explanatory variables in place. Camp 23, where most surveys for PI were conducted, is a unique place since there is already intermingling as well as higher levels of communication between the two communities. PI's activities further supported the cooperative relationship between the Rohingya and host communities through their activities.

Risk, Fraud, and Corruption

PI made a comprehensive risk register for the project that included a risk rating, existing controls and a mitigation plan[83]. Another risk assessment was conducted with the participation of project stakeholders on safeguarding/child protection during project activities[84]. There was sufficient attention to identifing and managing risk. The evaluation team found evidence of follow-through on the risk mitigation plan. In terms of monitoring and continuous review of the risk register, the evaluation team found some gaps. The KIIs revealed that the project team could not conduct a comprehensive review in the later phases of the response due to COVID-19-related disruptions. Beneficiary-level interviews did not mention any cases of fraud, corruption or unethical conduct by project stakeholders[85].

Results framework and the M&E System

The end-of-program outcome indicators for PI's response in the camps were expressed in terms of open-ended broad statements.

Outcome 1.1: Enhanced resilience through education in life skills development to promote social empowerment of young people, especially adolescent girls and boys and young women and men, including those with disability.

Outcome 1.2: Increased access to safe, inclusive and quality non-formal learning opportunities (literacy, numeracy and life skills).

These outcomes were not broken down into measurable and quantifiable targets. Therefore, it was difficult to measure the effectiveness of the response as the intended results themselves were not clearly measurable. The output was also a broad statement, and all targets were set at the activity level.

At the same time, Key Performance Indicators (in the M&E Plan) were mostly determined in terms of the number of activities or people reached[86]. Had some of the indicators been expressed in percentage form,

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[83] AHP Bangladesh Activation Project: Risk Register. 15 November 2019
[84] Safeguarding/Child Protection Risk Assessment Form provided by Plan International
[85] There was untriangulated information that there were some errors in a few cash transfers. The evaluation team could not collect enough information to come to a conclusion
[86] Monitoring and Evaluation Plan AHP Activation – Protected Crisis Response Project provided by Plan International Bangladesh

it would have allowed the project stakeholders and the evaluation team to understand the actual coverage of PI's response in the camps they worked in.

As for the project's M&E system, PI had a standalone M&E plan which sufficiently clarified the overall objectives and goals of the project, working areas, overall strategy, and implementing partners; however, the outcomes were not defined in a way that could be measured. The M&E plan described the major components of the MEAL system, major steps in the monitoring process (on-site visits, post-distribution monitoring, monthly output monitoring, annual outcome monitoring, etc.), sources and means of verification, and assumptions for different indicators. The plan also included a section on reporting structure that presented the frequency of major monitoring reports. The evaluation team found evidence that M&E activities followed the plan as evidenced by the regular quarterly report, the post-distribution monitoring report, and the final report.

While the M&E system followed some of the good practices and M&E standards set by DFAT[87], there were still many shortcomings. Given the weak logical framework, the M&E reports (including the progress reports and the final report) presented only the targets and the achievements of project activities[88]. Monitoring the results or the outcomes of these activities was not carried out sufficiently. At the same time, the final report specified the total number of beneficiaries by age, sex and disability status, but indicator-wise disaggregated data was not provided in the final report or in the progress reports.

In terms of conducting M&E activities, PI depended on implementing partners. PI did not have a dedicated M&E person for the project[89]. The implementing partner's M&E focal person maintained the management information system and other databases, while PI's M&E team members from Teknaf validated the data. Since PI had to rely on their implementing partner for data, the project's M&E plan should have set clear guidelines regarding responsibilities of both organizations in the M&E process, methods of data validation, quality assurance, triangulation, and the required safeguarding and ethical measures for data collection. At the same time, assessment of the partner's M&E processes and capacity development was needed. These elements were missing[90].

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[87] DFAT Monitoring and Evaluation Standards. April 2017.
[88] Based on a review of AHP Bangladesh Activation – Plan International Australia Final Report, 3 Quarterly Reports on activities from January to September.
[89] Source: KII with Plan International and FIVDB
[90] Source: FGDs with beneficiaries, KIIs with field level staff

3.3 Efficiency

This section presents the findings on the efficiency of the ANGOs in terms of resource utilization, beneficiary coverage and timelines. The section also highlights the extent to which the response achieved good value for money. Assessment of value for money was done through a review of the governance and management arrangements, budget variations over the project timeline, and development innovations.

Section Summary

Performance against each sub-evaluation question
To what extent was the response implemented according to agreed timelines, resources, coverage area and budgets?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

To what extent did the response achieve good value for money?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

Narrative Summary
Little to no deviation in terms of resource utilization, beneficiary coverage, and timelines was observed. When such deviations were found, they were mostly due to external factors such as FD-7-related delays, CiC disapproval, and COVID-19-induced restrictions. There is evidence that the programmatic operational processes and budgets underwent regular review by ANGOs.

The governance mechanisms and management arrangements were generally good for all ANGOs. For Inclusive Communities, there was an elaborate and well-structured governance mechanism which worked seamlessly in most situations. There were some coordination gaps mentioned by the consortium stakeholders, particularly in terms of clarifying specific agency roles in common response areas. Good management arrangements and coordination were reported by other ANGOs as well.

The response by Inclusive Communities achieved good value for money as partners could leverage each other's strengths (as exemplified by HI's disability inclusion mainstreaming support to other partner agencies). Innovations such as the 'Happy Corners' of World Vision and initiatives with long-term utilization potential such as PI's curriculum developed for youth and adolescent education are testament to the innovativeness and efficiency of these ANGOs.

The financial documents of ANGOs show no major deviation. There were some instances of budget underutilization (for PI and Oxfam) created due to the late start of the project.

Inclusive Communities Consortium

The evaluation team looked into the efficiency of the consortium and individual responses of the consortium partners. At the consortium level, the assessment was done through a comparative analysis of the advantages or value addition against the disadvantages or coordination problems of the consortium approach. At the individual level, efficiency analysis included determining the extent to which individual

agencies provided good quality services and met the planned timelines, resources, and beneficiary coverage targets.

Value for Money

One of the major value additions of the consortium approach was that the partner agencies could leverage the expertise and strengths of one another. Based on the individual areas of strength, partner agencies worked on capacity development across the consortium[91]. CARE supported consortium partners in gender and GBV mainstreaming through training on gender in emergencies, GBV, protection from sexual exploitation and abuse (PSEA) and referral across the consortium. With expertise in disability inclusiveness, HI chaired the Technical Inclusion Working Group and supported cross-disability issues across MEAL, gender, MHPSS and protection[92]. HI supported other consortium partners by conducting barriers-and-facilitators assessments and by providing training to other consortium agency staff on disability inclusion[93].

While disability expertise could have been provided to these agencies individually, the value addition of the consortium approach was that it allowed them to learn from other partner agencies over the project lifecycle instead of one-off training or capacity development initiatives. For example, the Technical and Inclusion Working Group formed by the consortium allowed the partners to learn and collaborate on mainstreaming of gender and disability inclusion. Most key informants from consortium agencies believed that the consortium added great value, especially in terms of enhancing capacity in disability inclusion. Additionally, partner agencies regularly met in different consortium working groups and committee meetings to share their concerns and strive to find solutions jointly. Most key informants of the consortium partners stated that, overall, this approach built a foundation of collaboration and shared learning for a future response in the Rohingya humanitarian crisis.

KIIs with DFAT personnel revealed that the consortium approach was preferred as it ensured smooth communication between the donor and NGOs by establishing a single point of communication. From the donor's point of view, the consortium approach was efficient.

There were some areas, however, in which the consortium had potential for greater value addition. One aspect was the sharing of learning and experience among the consortium partners. This related mainly to common thematic areas. For instance, if multiple consortium partners are working on similar sectors, there is scope for learning service standards, processes and innovation, etc. from one another. According to some key informants, learning and experience sharing did not happen as much as it should have. One justifiable explanation is that, during COVID-19, agencies were more focused on delivering services under strict restrictions and the risk of exposure. Another area where the consortium could have played a greater role was joint advocacy. Some key informants mentioned that it was not prioritized sufficiently,

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[91] Source: Multiple KIIs with consortium partners
[92] Source: Inclusive Communities Technical Inclusion Working Group Brief, provided by Save the Children.
[93] Source: 'Key Findings from School/TLCs Facilitators and Barriers Assessment' provided by Save the Children, 'Inclusion Assessment of CARE Bangladesh' provided by CARE, and AHP Activation – Final Report of HI

and that the COVID-19 pandemic made the joint advocacy agenda even more difficult. Moreover, there was no utilization of shared resources or joint engagement with shared stakeholders.

Coordination

The Inclusive Communities consortium developed a governance framework which among other things included the governance structure, formation and responsibilities of different working groups and committees and the roles and responsibilities of the consortium manager[94]. Save the Children's Cox's Bazar team led the consortium in Bangladesh. There were four groups in the governance framework: the Steering Committee, the Operations Working Group, the Technical and Inclusion Working Group, and the Communications and Advocacy Working Group. Each group had clearly defined rules of formation as well as protocols for communication, meetings and decision-making. The evaluation team found evidence of regular meetings and communication among the consortium partners and discussion on critical areas of the response[95].

Most informants from the consortium partners spoke positively about efficiency in coordination. Regular communication through meetings among the consortium partners reportedly improved collaboration and coordination over time.

> ***Consortium Partner***
> *In my experience, communication was better in this consortium than with other NGOs. Regular meetings happened and there was good coordination. In-depth discussion on what to do next, and who will do which part, occurred frequently.'*

Despite the positives mentioned by most respondents, coordination was not seamless. Two respondents pointed to coordination gaps. One said that when they raised concerns with the consortium, these concerns were not always resolved in a timely fashion, if at all. Another respondent talked about communication gaps among the consortium partners and stressed the importance of clarifying the roles of each partner.

> ***Consortium Partner***
> *"In Phase II, there was a component of our program on which we needed support from another partner (name kept anonymous). At the end, we did not get support and could not work on that component at all. I think there should have been better clarity in terms of which partner would address which issue."*

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[94] Inclusive Communities Governance Framework. 24 November 2019.
[95] Source: Review of Meeting Minutes of Steering Committee, Operations Working Group, Technical and Inclusion Working Group.

Timeline, Resources and Coverage

Save the Children

The IPTT tracker indicated that Save the Children began its response in June 2019 and completed all operations by June 2020. The project was done within the schedule without any significant deviations. NGO personnel also confirmed this during a KII.

The financial records given to the evaluation team explicitly indicated that Save the Children's response was achieved within the budget available. Although there were some variations on a few items, the evaluation team did not find any unusual or noticeable differences that could have had an impact on the overall use of resources.

CARE

The IPTT tracker showed that CARE initiated its program in July 2019 and finished all activities by June 2020. The project was completed strictly within the timeline with no major deviations. This was also confirmed in KIIs with CARE staff. In terms of beneficiary coverage, the total direct beneficiaries were slightly higher than the total planned direct beneficiaries. CARE covered all the geographical areas that it had included in the project geographic scope.

The financial documents provided to the evaluation team showed that CARE's response was completed within the available budget. While there were certain variations on a few items, the evaluation team did not find any unusual or noticeable differences that could have made an impact on overall resource utilization. Discussions with CARE staff revealed that they could have conducted internal learning and sharing activities which could have contributed to the programmatic review and course-correct measures to improve value for money.

The evaluation team asked CARE's beneficiaries if they had observed any mismanagement or waste of resources in CARE's activities. During participatory discussions, no beneficiary mentioned that they had observed any issue of mismanagement or resource wastage. Beneficiaries also stated that they had received quality services in a timely manner and had not faced hurdles in accessing services.

Oxfam

Oxfam initiated its program in March 2020 and ended in December 2020, even though the proposed timeline was April 2019 to October 2020[96]. For this, Oxfam extended the timeline as a no-cost extension phase from October to December 2020. The objective of this extension was to utilize unspent funds. The project was started late due to a DFAT fund suspension and the outbreak of COVID-19. Although FD-7 approvals and other Bangladesh NGO Affairs Bureau approvals can take up to two months, local partners arranged the approvals within the shortest possible time because they had a good working relationship

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[96] KII with local partner staff

with the authorities by being the sector focal points in their respective camps. Oxfam covered the beneficiaries of Camps 12 and 19 as it had proposed.

In terms of value for money, Oxfam demonstrated evidence of both efficient and inefficient utilization of resources. On-site observations and interviews with partners found that new infrastructure was made with good quality materials. Shushilan's interventions evidenced a remarkable innovation of reusing spare materials. For example, its staff did not throw out damaged superstructures of latrines and bathing facilities, instead reusing them to make guide walls to protect infrastructures from landslides. Billboards and posters containing COVID-19 messages were remarkably visible in the camps. In terms of inefficiency, the evaluation team observed that a large portion of the contactless handwashing devices had been damaged soon after installation and remained so due to a lack of maintenance.

The evaluation team discussed with the beneficiaries whether they had noticed any mismanagement or waste of resources. Beneficiaries confirmed that they had not observed such issues; rather, they had received good quality support in a timely and safe manner.

> **Key Findings**
> The project faced a time lag in the initial phase, but it tried to recover comprehensively through extending the time. All other resources were utilized well except the inefficient management of handwashing points. Reuse of spare parts in protecting structures provided good value for money.

World Vision

Value for Money
World Vision's community-based approach helped it achieve greater efficiency. The NGO developed the community's capacity and provided necessary assistance. As such, World Vision not only ensured effective participation of the community people, it also rendered greater value addition. In terms of innovation, the NGO established 'Happy Corners' where men and women could gather and discuss various problems and solutions as well as learn about the different services offered by World Vision, including referral services[97]. Such an approach apparently assisted World Vision to create awareness more efficiently.

The technical partners for disability inclusion provided World Vision with the assistance necessary to mainstream activities towards people with disability, including essential training on the identification of people with disability for staff involved in the project[98]. Moreover, the NGO also managed to conduct an outcome assessment[99] in this one-year program despite deferred actions and potential delays due to strict COVID-19 restrictions imposed by GoB; this is also a testament to its efficiency.

According to KIIs with the WASH sector coordinator, World Vision ensured smooth communication between the sector and the NGO by establishing a single point of communication. From the partner's

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[97] KII with implementing partner and beneficiaries
[98] KII with technical partner and Final Report
[99] Outcome Assessment Report provided by World Vision

point of view, the NGO's approach was efficient as well, except in a few instances in which World Vision took slightly more time to implement the partner's recommendations.

There were, however, some areas where World Vision had potential for greater value addition; for example, sharing of learning and experience among the technical and implementing partners. However, such sessions were difficult to arrange during COVID-19 as the agencies were more focused on delivering services under strict restrictions and the risk of exposure[100].

The majority of the informants from World Vision's partners were positive with respect to its efficiency in coordination as they believed that regular communication through periodic meetings resulted in fruitful outcomes for the program of World Vision.

Time, Resources and Coverage
As per the IPTT provided by World Vision, the NGO started its program in May 2019 and finished all activities by June 2020. This timeframe was also mentioned in its design documents. With regards to beneficiary coverage, the total direct beneficiaries were identical to those projected, other than the number of children with disability – there was an absence of children with disability in the targeted regions. World Vision also covered the entire targeted geographic scope.

The evaluation team gathered from a discussion with a technical partner that there had been delays in the implementation of a recommendation provided by that partner.

The beneficiaries stated that they had received World Vision's services in a timely manner, and that the necessary items and services were of good quality.

Plan International

Value for Money
The governance structure of the response placed PI as the lead agency for reporting to and communicating with the donor organization. The implementation of the response in Cox's Bazar was overseen and managed by PI Bangladesh, with FIVDB playing a key role in the execution of project activities[101]. Interviews with stakeholders from PI Bangladesh and FIVDB revealed that communication and governance were smooth and efficient for much of the project. However, communication management became difficult due to COVID-19-induced restrictions. For instance, as field visits and meetings became more difficult to organise, partner agencies moved to virtual meetings twice a month. Moreover, communication between PI Bangladesh and FIVDB was hampered by a poor mobile network and internet connection surrounding the camp areas[102].

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[100] KII with partners
[101] KII with Plan International
[102] KII with Plan International and FIVDB

Despite the challenges, the adaptation of the project during COVID-19 restrictions, such as moving learning centres to flexible small group sessions and delivering one-to-one education at the learners' houses, showed signs of great flexibility and innovation. There were also indications that some activities and learnings from Phase II would contribute to the next phase, and that PI's response would achieve greater efficiency over the course of time. For instance, due to the absence of an approved curriculum for adolescent and youth education, PI had to develop one in the Phase II response[103]. The curriculum can now be used in PI's future response as well as by other partners of the DFAT-funded consortium.

Time, Resources and Coverage

PI's response initially had four camps (23, 24, 25, 26) and the associated host community areas in its project's geographic scope. However, it could only manage regulatory permission to work in Camps 21 and 23 and in the nearby host communities. PI had to narrow its geographic space and enhance the beneficiary base in the approved areas[104]. Overall, the total direct beneficiary size at the end of the program was very close to that targeted during the design phase[105]. There was also a delay in starting the project due to the time lag in getting permission from the RRRC and the CiCs. Due to the delay, recruitment of project staff took place later than was originally planned[106]. The late induction of project staff and the late start of some activities, such as the development of a training module for learning centre facilitators and their training itself, along with HBL learning sessions resulted in a positive budget variance and an underutilization of the budget[107]. The situation was aggravated further as from March 2020, humanitarian activities inside the camps on most sectors, including education and protection, were restricted. The combination of the delayed start and COVID-19-related restrictions meant that some activities could not be carried out; this left an unspent budget. PI then reprogramed its activities to incorporate a COVID-19 response, and the unspent budget was utilized in the realigned component[108].

There were indications that PI attempted to achieve greater efficiency. For example, partner meetings regularly discussed operational approaches, budgetary issues, and execution-level challenges which potentially contributed to greater efficiency. PI used mobile financial services for cash distribution to vulnerable host community households. The use of mobile financial services allows efficient transfer of monetary support into the hands of beneficiaries while allowing them to maximize their choices in their recovery from the COVID-19-induced economic crisis[109].

The evaluation team discussed with Rohingya beneficiaries whether they saw any incidents of mishandling or wastage of resources. None of the Rohingya beneficiaries mentioned any such incident. The beneficiaries also showed awareness of the complaints boxes and stated that they would use them if necessary.

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[103] AHP Bangladesh Activation – Plan International Australia Final Report and KII Plan International
[104] Same as 90 above
[105] Same as 91 above
[106] FIVDB_AHP_Budget variance report_Jan-Mar'20
[107] FIVDB Budget Variance Reports provided by Plan International
[108] KII with Plan International
[109] AHP Bangladesh Activation – Plan International Australia Final Report

3.4 Coherence

This section measures whether the Phase II response was coherent with the Australian Humanitarian Strategy and was appropriately aligned with the context of the overall humanitarian response.

Section Summary

Performance against each sub-evaluation question

To what extent did the assistance align with Australia's Humanitarian Strategy and other key Australian government policies/priorities such as gender equality, disability inclusion and other vulnerable groups?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

To what extent were the project activities coherent with government priorities, UN response plan and the context of overall humanitarian response?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

Narrative Summary

Phase II was strongly aligned with the thematic priorities of Australia's humanitarian strategic objectives, specifically gender equality, disability inclusiveness, and protection. The response was found to be coherent with the UN response plan and the overall Rohingya response as evidenced by strong alignment with JRP 2019, active participation and reporting in sector coordination (which is a key mechanism in ensuring coverage and standardized quality of services), and leadership in the overall humanitarian response. Nevertheless, some other needs – including early childhood development, adolescent learning, and the establishment of hepatitis C and thalassemia treatment facilities – should be prioritized in a future response; this was strongly recommended by the education sector coordinator and GoB stakeholders. Additionally, greater collaboration with Camp-in-Charges and the local government authorities during the project design phase was needed to ensure greater harmony with GoB priorities.

As mentioned in DFAT Humanitarian Standards, Australia's humanitarian strategic objectives are informed by thematic priorities that are central to the efficacy of all Australian aid. These thematic priorities include gender equality, disability inclusiveness, protection, private sector engagement, and MEAL. ANGOs need to follow these standards in providing their response.

All ANGOs were found to be aligned with the thematic priorities of the Australian humanitarian strategies, particularly gender equality, disability inclusiveness and protection. Inclusive Communities utilized CARE's expertise to ensure gender mainstreaming in different phases of the response, given CARE's previous experience and competence in thematic areas in the context of the Rohingya humanitarian response. Moreover, CARE took an active role in protection along with GBV mainstreaming within the consortium. To integrate its response on disability inclusion, the consortium utilized HI as the disability inclusion partner. HI provided various forms of support across the consortium, including capacity development of consortium staff on disability inclusiveness, technical support for identification of people with disability, and assessment of barriers and facilitators.

PI's response was mainly on protection and resilience of adolescents and youths with a strong focus on gender inclusiveness and equality. World Vision emphasized gender and disability inclusion in all of its activities on the two sectors of WASH and protection. World Vision conducted needs assessments with a particular focus on the needs and barriers faced by women and people with disability. It established a number of community forums with a large number of female representatives. For disability inclusion, World Vision partnered with disability inclusion partners CBM and CDD, who provided technical support to establish disability mainstreaming in all of their activities.

As for coherence with the UN response plan and the overall humanitarian response, all partner agencies were strongly aligned with the needs and strategic priorities set in JRP 2019 (details provided in the 'Relevance' section). At the operational level, ANGOs were active in sector coordination inside the camps and, in the process, they ensured coherence with the overall humanitarian response. Sector coordinating bodies collected monthly data from all agencies working in the camps, provided gap analysis and advice, informed other agencies on coverage, and ensured minimum standards in quality. All AHP partners spoke highly of the active participation of the ANGOs and their local implementing partners in sector coordination.

> **Health Sector Coordinator**
> *'Save the Children and CARE are exemplary partners. They ensure their updates are provided in a timely manner; they contribute to collective exercises when it comes to strategic planning and collaborating in technical form. They also supported the health sector team for specific technical components. These two partners were professional and reliable.'*
>
> **WASH Sector Coordinator**
> *'I am positive about World Vision's activities. They regularly report to us and provide assistance to the beneficiaries as per our suggestions most of the time.'*

Some ANGOs were also highly praised by sector coordinators and other humanitarian organization representatives for their leadership. Save the Children was praised for its strong role as a co-lead in the education sector. Similarly, PI's commendable efforts in highlighting the importance of early childhood development were mentioned as a strong point.

> **Education Sector Stakeholder**
> *'PI put the education sector front and centre in a number of interventions at the Cox's Bazar level. They conducted webinars where the education sector was brought front and centre, and major activities were done on parental development for early childhood education.'*

Overall, ANGO activities were found to be coherent with the UN response plan and the overall humanitarian response. However, external stakeholders also mentioned other areas for future interventions. The education sector coordinator emphasized adolescent learning and early childhood development, and suggested that ANGOs should include these areas in a future response.

As for coherence with GoB stakeholders, feedback was mostly positive, but some gaps were also pointed out. ANGOs generally worked closely in coordination with the CiCs and local authorities. The evaluation

team found documentary evidence of coordination meetings with GoB stakeholders which was further corroborated by interviews with GoB stakeholders. However, GoB stakeholders stated that local government officials and CiCs were not always engaged in the project design phase. The needs assessments conducted by the humanitarian organizations were not always shared with the CiCs and local authorities; they usually learned about humanitarian projects when these were already designed and approved by the donor. While projects had to be endorsed by the GoB through the approval (FD-7) process, GoB officials working in the field should have also been engaged adequately during the design phase to achieve greater harmony and alignment.

As for emerging needs, a GoB official emphasized the importance of hepatitis C and thalassemia treatment facilities as the number of cases had been increasing. He also mentioned the need for one or two field hospitals with surgery and gynaecology treatment facilities in the camp area. These emerging needs were suggested as considerations for a future response.

3.5 Inclusion

This section illustrates the extent to which ANGOs incorporated inclusive programming to support and provide equal access to vulnerable groups, particularly women, girls and people with disability. This section looks at both mainstreaming and specific targeted actions by ANGOs that promoted DFAT's thematic priorities on gender equality, women's empowerment, and disability inclusiveness.

Section Summary

Performance against each sub-evaluation question
To what extent were the needs of different groups of people (including age, gender, disability, ethnicity, etc.) considered in the design and implementation of the response, including in influence and decision-making roles?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

What did the AHP investment achieve in terms of protecting the safety, dignity and rights of women and girls and promoting gender equality?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

What did the AHP investment achieve in terms of addressing barriers to inclusion for people with disabilities so that they can benefit equally from the aid investment?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Less than Adequate**

Narrative Summary
Between 89% and 93% of female ANGO beneficiary respondents were happy on different questions of gender inclusiveness, such as whether the response was tailored to their unique needs, whether they had felt safe in obtaining services, and whether they could exercise their rights better. Strong gender inclusive measures were evident from design and planning to implementation for all ANGOs. The community outreach approaches followed by ANGOs were highly appropriate in reaching out to women and girls, given the mobility barriers and cultural restrictions in Rohingya communities. CARE's involvement of adolescent boys and men in GBV-related activities was attributed (by beneficiaries) to a reduction of GBV incidents and harmful practices such as early marriage and dowry.

Some barriers that still exist include the limited role of women in decision-making in camp governance. World Vision worked to improve the situation by increasing the participation of women in Protection and Water Management Committees; however, female leadership is not always accepted by the community.

As for disability inclusiveness, Save the Children's inclusive education support through HI to 150 children with disability and World Vision's targeted measures, such as including women with disability (21%) in 55 Women Watch and Protection Committees and in 18 Water Management Committees, contributed greatly to disability inclusion. The Inclusive Communities consortium received support from HI on disability mainstreaming support and training, and World Vision received the same from CBM and CDD. PI's disability inclusiveness was found to have been less than adequate as there was no assessment of barriers to inclusion; implementing partners had low technical skills; and there was no evidence of engaging technical expertise.

Overall, only 61% of people with disability in the survey said that ANGOs had fully considered their special needs. The challenges of disability inclusion were evident as none of the ANGOs could meet their targeted beneficiary size for people with disability. This can be attributed to external factors such as camp geography (hilly terrain), distance to different service points, disadvantaged locations of shelters of people with disability, and to organizational factors such as frontline staff without technical expertise and limitations in identifying people with disability. Lastly, ANGOs stated that they could not involve OPDs as there were no effective OPDs representing the voices of people with disability in the camps. For this, they had to adopt alternative measures. For example, World Vision ensured that representatives of people with disability were included in their community forums, including Water Management Committees and Women Watch Committees. The NGO also included an OPD consultant to correctly identify the needs of and provide the response to people with disability.

In line with the inclusion standards of the evaluation rubric, women, girls and people with disability were asked to comment if support from ANGOs had met their special needs; whether positive changes had occurred in their ability to exercise rights; and whether they could access support safely.

Table 9: Female and person with disability beneficiaries response summary[110]

Questions	Female	Female with Disabilities	People with disability
Percentage of people with disability who believed that ANGOs had fully considered their special needs	-	65%	61%
Percentage of beneficiaries who had felt safe in getting assistance from ANGOs	93%	90%	88%
Percentage of female beneficiaries who thought the support had met the special needs of women and girls	91%	84%	-
Percentage of beneficiaries who stated that positive changes had occurred in their ability to exercise rights after getting support from ANGOs	89%	90%	90%

n of females = 264   n of females with disabilities = 31   n of people with disability = 69

The table above shows that the vast majority of female beneficiaries responded positively to these three questions, presenting strong evidence on gender inclusiveness from the beneficiary perspective.

As for disability inclusion, mixed responses were received in the beneficiary survey. Only 61% of respondents with disability believed that their special needs had been fully considered by the NGOs. Similar responses were also received from females with disability (65%). The figure shows that there is room for improvement in tailoring the response to meet the unique needs of people with disability. Eighty-eight per cent (88%) of people with disability said that they had felt safe in getting assistance from ANGOs and 90% said that positive changes had occurred in their ability to exercise rights.

Moreover, beneficiary reach against the intended target of people with disability was also low. For instance, Save the Children was unable to reach its projected reach of the number of people with disability for either adults or children. The target was around 4000, whereas the NGO provided support to 3100 beneficiaries only. Likewise, World Vision failed to meet its target for children with disability.

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[110] Source: Beneficiary Survey

To mainstream and ensure inclusion of gender and people with disability, the approach of the Inclusive Communities consortium was to include NGOs with substantial expertise in their respective areas. CARE mainly provided support with regards to gender mainstreaming and HI provided support to mainstream activities directed to people with disability[111].

Gender Equality and Empowerment

Save the Children utilized a gender assessment conducted by CARE and identified the various needs of females that had to be addressed during the 2019–2020 period. The NGO attempted to ensure that women received equal benefits in their response. Gender-based outcomes were identified and included in Save the Children's response, while other outcomes were also gender-inclusive[112]. For example, it targeted both male and female beneficiaries in providing SRH services (Output 2.3); it trained its staff on SRH service provision – 67 were female out of 112 staff (Output 2.4); and it ensured significant female participation in awareness sessions on MHPSS (Output 2.5). The NGO also initiated a number of capacity development programs where most of the participants were women.

Although gender-related issues were mentioned in the risk matrix, the evaluation team considers that a more comprehensive process should have been included during the implementation phase to update and monitor the risk matrix.

Through an FGD with female beneficiaries, the evaluation team attempted to understand their perspective. Beneficiaries stated that Save the Children's activities towards females had made a significant contribution to raising awareness about the safety, dignity and rights of their community, helping them to become more aware of those issues through various sessions on health, safety and protection awareness.

According to JRP 2019, protection concerns, including safety threats in learning facilities, had impacted on the participation of female students, particularly young learners aged 6–14. Consequently, 40% of parents of adolescent girls reported that education was not appropriate for their children.

Save the Children had a number of policies to ensure protection of women and children in providing its services in thematic areas including health and education, such as a child safeguarding policy, an anti-harassment policy, and a policy on PSEA, focusing on the following goals[113]:

- To safeguard children throughout its work
- To reinforce key messages and expectations related to ensuring a safe working environment for all of its personnel, with a particular emphasis on sexual harassment
- To protect adults from sexual exploitation and abuse, including direct or indirect beneficiaries of its programming and adults in the wider communities in which it operates

The beneficiaries also considered as safe the process of being provided benefits by Save the Children.

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[111] Source: Document on Inclusive Communities Technical Inclusion Working Group
[112] Logframe and IPTT
[113] Documents on these policies were provided by Save the Children

> ***FGD Participant, female, age 40***
> *'We feel safe getting assistance from Save the Children, for both health services and education for our children. Also, we are more aware of our rights after the various sessions conducted by them.'*

One issue the evaluation team identified was that of women's access to life skills training. This seemed to be a low priority in Save the Children's response as no indicator or activities showed any engagement of women or girls participating in life skills training or similar activities.

Disability Inclusiveness

Save the Children ensured that its disability inclusion partner, HI, was actively involved in coordination mechanisms, needs assessments, and the development of humanitarian needs. HI identified the needs for education support for people with disability, and these needs were discussed with the education team of Service Civil International (a Belgian NGO), YPSA, and other education partners[114]. For the education services of Save the Children, HI identified inclusion barriers through barriers-and-facilitators assessments. HI conducted these assessments in 18 TLCs and accessibility audits in 8 TLCs. It discussed its findings with Service Civil International and YPSA to improve the overall accessibility standards of 60 TLCs with an agreed technical support plan[115].

HI also initiated a capacity development program on disability inclusion, including the identification of people with disability by means of the WGSSQ questionnaires for internal staff of the Inclusive Communities consortium. HI conducted 24 training sessions, which included a total of 127 participants from Save the Children[116].

HI identified 150 children with disability and provided services appropriate for their individual needs. Children with disability and their parents were satisfied with the education services provided by Save the Children and HI because they felt that they had received essential materials (including books, notebooks, play-materials, bags, pens, wheelchairs, etc.) to continue their education.

> ***Mother of a child with disability, age 38***
> *'At the beginning of 2020, my daughter got a walking frame from HI. The therapists from HI provided my daughter with physiotherapy for two months; this helped her with her rehabilitation. HI also provided her with toys, and the facilitators taught her basic life skills every time they came to provide therapy.'*

Although the majority of beneficiaries were satisfied with the disability inclusion approach, some beneficiaries from Camp 18 voiced concerns about how the needs of people with disability in their camp had been addressed: they felt that many people with disability in Camp 18 had not been identified by Save the Children.

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[114] Source: KII with Save the Children
[115] Source: Document on Inclusive Communities Technical Inclusion Working Group
[116] Report provided by HI

> ***Religious Leader (Imam) of a Madrasa in Camp 18, age 72***
> *'There are some children with disability in my madrasa; however, they have never received any special benefits from any NGO.'*

During KIIs with people with disability, the evaluation team received opinions regarding the absence of implementation. The team also found that people with disability faced immense difficulties while visiting doctors as many camps are situated in hilly areas and hospitals are far away from their homes (Case Story II below). Moreover, people with disability were not given any priority and had to wait for a long time in order to receive treatment from doctors, which was a burden for them. In addition to this, people with disability had to attend hospitals in person in order to receive medication, which was extremely difficult for many.

Case Story II – Person with disabilities faces hurdles when visiting health centres

Ali is 66 years old. He came from Rakhine, Myanmar with his family in August 2017. His family settled in Camp 4, Block F. Ali was injured in an accident and lost the use of his legs. He cannot walk alone so he has to stay inside all day. He thinks his eyes are affected by cataracts as his vision is blurry. Ali had been a *muezzin* (a caller to prayer in a mosque). Now, he is unable to go anywhere due to his disabilities.

Ali mentioned that he suffered from other health issues such as acid reflux, high blood pressure, and frequent colds and fevers. He has to see a doctor at a health centre at least 2–3 times a month, an experience which is troublesome for him. As Ali's house is situated on the top of a hill, it is difficult for him to go to the health centre without a walking aid. Several NGOs had visited him to learn of his situation, but none had provided him with an assistive device. Thus, he has to rely on his family members to go outside and to the health centre. Ali has a health card from Save the Children's health centre with which he can get a basic check-up, a prescription, and treatment from the NGO's doctor.

Ali confirmed that he could not get advanced treatment for his legs or eyes. The standard medications he receives for his fevers, cough and acid reflux from the NGO's health centre are not always sufficient. In relation to receiving priority in treatment, Ali said: "Yes, I get priority if there is not a long queue, but sometimes I need to wait for 30–40 minutes based on the length of the queue. But the staff and doctors take a lot of care inside the centre. I am satisfied in the sense that the health support is far better than before." According to Ali, there is an opportunity for him to obtain advanced treatment in good clinics and hospitals through referrals of the health centre doctor, but he has not got this support yet. He added that the community volunteers and the *majhi* took care of him by visiting frequently.

Ali is satisfied with the quality of Save the Children's current health centre support. But he will be more satisfied if he gets a walking aid or a folding wheelchair as well as advanced treatment for his legs and eyes. 'It would really help me if the doctor visited my home when I need emergency support,' Ali said. He then added, 'There are some medical practitioners in our community who take 500 to 1000 taka at a time if they make a home visit, which is not affordable at all; so I will be happy if this is done by the NGO's doctors.'

CARE

Gender Equality and Empowerment

CARE principally focused on gender-based support through their GBV and sexual and reproductive health and rights interventions in selected camps where around 70% of beneficiaries are female. CARE's response was informed by multiple gender analyses, such as its Myanmar Refugee Influx Crisis – Rapid Gender Analysis Report 2017. Informed by an analysis of barriers, CARE adopted a community outreach approach which ensured that its services reached women and girls at their own shelters. It was also evident that CARE continued to monitor the special needs of women beneficiaries when the situation changed. For instance, CARE conducted four gender safety audits to mitigate GBV in the community by identifying the situation in relation to women- and girls-focused services, risk zones, and needs assessments for women and girls in Camps 11, 12, and 16[117].

Community risk mapping was undertaken with the participation of women, girls, boys, men, community volunteers, imams, *majhis*, and community leaders. CARE's female outreach groups took an active role in providing gender-based support to the community. These initiatives were a strong indication of the involvement of women at the design and implementation phases. A strong focus on inclusion was also observed in the M&E system. A number of outputs were specifically tailored to the unique needs of women. CARE collected disaggregated data by age and sex for each indicator[118].

The evaluation team found evidence of appropriate gender inclusion strategies and strong consideration of inclusiveness at all levels of the program cycle, including design, implementation and the M&E system. FGD respondents stated that the special needs of women were identified and strongly supported by CARE. The GBV and SRH services were mentioned along with CARE's other initiatives to create awareness about the safety and security of women in the community. Female beneficiaries did not mention any safety concerns while receiving CARE's services.

> *Female Participant, age 48*
> *'If there is a pregnant woman or someone who is not in a condition to go to hospital, CARE's doctors and volunteers support them and treat them at their home.'*

Disability Inclusiveness

CARE's response was informed by an inclusion analysis conducted by HI, which looked into environmental and physical barriers, communication barriers, attitudinal barriers and institutional barriers, and provided recommendations for achieving disability inclusiveness[119]. Based on the analysis of barriers and with support from HI, training was provided to 45 members of the CARE Bangladesh team on areas such as inclusive humanitarian response, disability data collection, inclusive health, education and MHPSS, GBV

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[117] Reports on safety audits and risk mapping, and workshop on safety audits and risk mapping sharing.
[118] Sources: Logframe in the Project Implementation Plan, and IPTT Tracker
[119] Inclusion Assessment Report by HI, provided by CARE Bangladesh

programming, and communication tools.[120] CARE implemented the WGSSQ in its M&E processes. Overall, there seemed to be a strong consideration for disability inclusiveness in all phases of the program cycle.

Another aspect in assessing disability inclusion was gauging the extent to which people with disability and OPDs were engaged and enabled in various phases of the cycle. Interviews with Community Outreach Group members revealed that one or two people with disability were included in all groups to ensure their participation and involvement in the humanitarian response. Beneficiaries also talked positively about CARE in terms of responding to the special needs of people with disability, ensuring that they received equal access to services.

> **Female Participant, age 35**
> *'If a person has disabilities and wants to visit health centres for health services, volunteers from CARE carry them to the health centres.'*

Although CARE's overall response can be considered inclusive, there was scope for improvement. People with disability often have mobility barriers and may not be able to gain access to health posts or WGSSs. Therefore, identifying persons with such accessibility barriers and providing them with targeted support is important. By the end of the program, CARE had provided support to 65 people with disability although it had set an ambitious target of 800[121]. This indicates that a future response needs to have more focus in reducing accessibility barriers.

Oxfam

Oxfam's partners ensured that they had a balanced participation of male and female beneficiaries, including people with disability, when conducting the needs assessment and the context analysis in terms of gaps in WASH support. In block-wise community consultations, people with disability were included along with community leaders, especially female leaders, to understand the needs for WASH facilities and the level of interest in capacity development training on hygiene practices.

To develop an integrated community development program, the implementing partners established 110 latrine user committees and 390 community handwashing device groups in which women played a key role by being the majority of members[122]. The objectives behind prioritizing women in committees were to enhance the leadership of women, to decrease the power practices in the male-dominated community, and to increase women's opportunities to receive support. The project established significant mechanisms to ensure the participation of women, girls, people with disability and other vulnerable groups in receiving WASH facilities and capacity building training. Oxfam undertook a number of notable activities:

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[120] AHP Activation – Final Report of HI
[121] AHP Activation – Final Report of CARE Bangladesh
[122] KII with latrine user group member

- A total of 3194 people with disability, elderly and pregnant women were identified in Camps 12 and 19 and were provided beneficiary-specific WASH and protection support.
- The IPTT to November 2019 indicated that 1868 girls (49% of total adolescent beneficiaries) and 1672 women (52% of adult beneficiaries) including 54 of people with disability had received safe sanitation facilities in Camps 12 and 19.
- The IPTT to November 2019 indicated that 110 sanitation facilities were constructed (100% of the target achieved) with the participation of women, girls, elderly and persons with disability in the design process.
- The IPTT to November 2019 indicated that 8599 female beneficiaries (49% of the total), including 18 people with disability and their caregivers, were reached through training and awareness sessions on monsoon preparedness and AWD awareness.
- In addressing the challenges of sanitation accessibility for people with disability, 30 inclusive latrines were installed, and 68 traditional latrines were transformed to be more inclusive through the installation of ramps, railings, chairs, handles, etc.
- Project staff and CBVs provided 628 referrals (majority for health, food and water security and WASH) to Rohingya refugees, of which 68% were provided to female Rohingya beneficiaries.

Oxfam commenced implementation during the COVID-19 pandemic, when access to camps was subject to restrictions. Hygiene kits and awareness building training were pressing needs, especially among women and people with special needs. Oxfam collaborated with other agencies working with people with special needs, site management, and community leaders to upgrade inclusion criteria in all activities; one consequence of this was that Oxfam staff were trained by HI. Interviews with Oxfam staff evidenced that an assessment for the WASH needs of people with disability and location mapping were conducted, but that there was not enough time to implement all necessary physical interventions by the end of the project.

> **Staff, Oxfam's Implementing Partner**
> *'We received training on inclusion and implemented the learnings into disability assessment, but we could not start implementation on learning due to a lack of time in Phase II.'*

Beneficiaries regarded Oxfam's support as positive. They said that the needs of people with disability were prioritized during the course of the NGO's response, as together with its implementing partners, Oxfam established ramps, railings, stairs and handles to ensure better access to latrines for people with disability (Case Story III below). Moreover, Oxfam installed accessible handwashing devices near the homes of people with disability. It also trained people with disability on how to use these facilities. Beneficiaries also mentioned that Oxfam staff regularly asked them about their wellbeing.

> **Male Adolescent (person with disabilities), age 14**
> *'Previously, there was a general latrine close to my house which was inaccessible to me. Oxfam established a ramp, railing, stairs and a handle to improve my access.'*

Many of the shelters of people with disability are located in areas of challenging terrain or deep inside the camps. These locations make it difficult for NGOs to provide assistance and for people with disability to receive it. Moreover, they require people with disability to commute a lot, which is burdensome for them. To address this, staff from Oxfam suggested that shelters of people with disability be relocated to flat areas near camp entrances following consultation and coordination with CiCs, site management, and other actors.

Case Story III – WASH support for person with disabilities by Oxfam

Bablu is a 16-year-old boy who lives with five family members in Camp 12. He contracted polio when he was two years old and this affected his legs: they are thin and undernourished, and he cannot stand straight. Bablu cannot talk due to the effects of polio also. Movement and communication difficulties are severe challenges in his daily life.

According to his father, Bablu had three main issues with accessibility: the path to the nearby latrine was broken, the facility was quite far his home, and the structure was not accessible to him. His parents had to take him to the latrine all the time. The situation became even more difficult in the rainy season when the path got slippery and dangerous. Addressing the challenges faced by Bablu and his family, Oxfam established a latrine near their house following community consultation. The NGO made a ramp and a railing for him so that he could use them to access the WASH facilities. In addition, Oxfam provided stairs, handles, a chair and a solar light to make the facility more accessible to Bablu.

His father said, 'My son can go to the latrine alone by using the ramp and the railing. He can use the stairs to easily enter the latrine; and he can use the handle and the chair to balance while walking.' His father confirmed that Oxfam's facilitators had taught the family hygiene behaviours such as washing hands, using soap and detergent, keeping the house clean, and cleaning the latrine, which were necessary because of COVID-19. His father showed a handwashing device installed by Oxfam which was made accessible through the construction of stairs and a separate tap. 'Along with these sanitation facilities, Oxfam provided soap and buckets to ensure contactless hygiene maintenance,' his father said.

Bablu is very happy as his priority WASH needs have been met. His parents also appreciated the WASH support of Oxfam. Responding to questions regarding barriers and recommendations for improvement, Bablu's father said: 'The handwashing device has been broken for some days due to poor maintenance by the *jimmadar*, and so the NGO should focus on facility maintenance.' Bablu's mother added, 'The tap stand is far from the house, so we have difficulties bringing water from there; hence, the latrine and handwashing device are getting damaged due to a lack of water.'

Key Findings
Oxfam comprehensively addressed the inclusion principle through ensuring a balanced participation of male and female beneficiaries; prioritizing the needs of girls, women, people with disability and other vulnerable groups; and facilitating sanitation access with proper hygiene training. Nevertheless, there remained outstanding inclusive sanitation needs that it had to meet.

World Vision

Gender Equality and Empowerment

World Vision conducted needs assessments to identify women's needs and interests through FGDs and current response plans, ensuring that interventions were focused on defending their needs and rights in coordination with like-minded organizations, site management, protection partners, and local government bodies for greater impact[123].

All of World Vision's activities were directed towards girls and women in order to address gender-based issues, including GBV. World Vision took a range of measures to ensure proper protection and GBV support; it also ensured that women got equal benefits from the program. The project brought a significant comprehensive approach to prevention, response, women's empowerment and skill-building in emergency response within the GBV sector. Notable activities undertaken by World Vision included[124]:

- The project formed 55 Women Watch Committees (WWC) and Protection Committees (PCs), and provided training on effective representation and decision-making for the committee members in Camps 13 and 15.
- Through WGSSs, the project delivered awareness sessions and non-specialized psychosocial support to women and adolescent girls, including people with disability and beneficiaries attending skill-building activities.
- Safe and accessible environments at 'Happy Corners' and WGSSs created avenues for social networking, information and resource exchange, enhancing dignity, protection, and inclusion.
- Women Watch Committee and Protection Committee teams conducted household-level visits and sensitized communities to prevent domestic violence. They also referred 110 individuals for psychosocial services, especially those facing serious challenges.
- All project staff received PSEA training so as to ensure response-wide protection from sexual exploitation and abuse networks.
- Managers received 183 cases of feedback/complaints (mainly of a generic nature), and the accountability team addressed 100% of them.

In addition to these activities, gender-based outcomes were identified and included in World Vision's response, where all the outcomes were gender-inclusive as well. For instance, Outcome 2 of the program was directed at the enhancement of women's participation in decision-making and protection in refugee camps. Beneficiaries also viewed this effort positively as they believed the prevalence of GBV had been reduced after the formation of community forums.

Furthermore, World Vision initiated empowerment and skill-building activities among 350 women to ensure women's participation in decision-making and self-empowerment. The majority of the participants reported that they were satisfied with the skill-building training and were able to complete the training with a transferable skill, such as tailoring and making handicrafts.

In an FGD, female beneficiaries reported that women were able to participate actively in periodic meetings of community forums, and that the NGO took follow-up action after receiving their feedback. During the meetings, NGO staff asked them about the condition of bathing facilities, solar lights,

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[123] Gender Action Plan of World Vision
[124] Final Report and KII with partner NGOs and beneficiaries

washrooms, etc. Female beneficiaries believed that World Vision took significant measures to ensure the safety, dignity and rights of women.

> **Female Member, Women Watch Committee, age 29, Camp 13**
>
> *'Women are heard in different meetings; NGO staff talked about specific facilities for females as well.'*

Beneficiaries stated that women got equal benefits to men in World Vision's response: NGO staff did not display any notable discrimination against female beneficiaries in the provision of support. Even so, female beneficiaries sought support for the provision of separate toilets for male and female community members. However, the

> **88%** of female respondents (n=43) surveyed believed that the support from World Vision met the special social needs of women and girls

evaluation team, during its field visit, realized that building separate toilets for women was quite impossible considering the lack of space in the camps. NGO staff and beneficiaries themselves also validated this fact.

Disability Inclusiveness

World Vision had two disability inclusion partners – CBM and CDD – who were mainly responsible for the inclusion of people with disability across the thematic sectors of World Vision[125]. World Vision included around 47 people with disability in its community forums. These committees also focused on the needs of people with disability. For example, 27 toilets (out of 100) had custom-made changes made to them in line with the needs of people with disability[126].

To ensure inclusion of people with disability in their program, World Vision initiated capacity development activities. For example:

- CBM and CDD provided technical support in making the existing WASH and protection modules inclusive and helped trainers/facilitators at different field levels to practise inclusive facilitation techniques.
- CDD and CBM conducted a training on Disability Specific Data Collection for BGS hygiene promoters, field facilitators, a technical officer and a WASH engineer

Moreover, CDD involved an OPD consultant who helped to provide on-site support and sensitization to staff, organized people with disability, and improved their voice in program delivery[127].

World Vision identified barriers for people with disability with the participation of community forums and local partners. CBM, with the support of its implementing partner CDD, conducted accessibility audits, supported the baseline assessment, and conducted capacity building. It also provided hands-on support and sensitization at different levels to create an inclusive service for all, including people with disability[128].

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[125] Source: Project Implementation Plan and KII with World Vision and technical partners
[126] Final report and FGD with beneficiaries
[127] KII with technical partner (also mentioned in the Final Report)
[128] Source: Final Report and FGD with beneficiaries

Local partners addressed the needs of vulnerable communities based on FGDs and consultations with local government authorities for WASH and GBV facilities to women, men, adolescents, and especially to people with disability. As a result of the barriers identified for people with disability when accessing its services, World Vision undertook the following activities:

- The project prioritized common and significant accessible toilets in coordination with all consortium partners in Camps 13 and 19.
- Distribution of home hygiene products and assistive devices to older people and persons with disability.

Beneficiaries stated that the inclusion of people with disability in community forums was fruitful in ensuring that they received proper support from the NGO. Such an approach was also useful in getting their opinions and views before providing support. Beneficiaries felt that the NGO's activities made a significant contribution to raising awareness about the safety, dignity, and rights of their community.

Beneficiaries also said that the needs of people with disability were considered in the course of NGO activities (Case Story IV below). However, they raised concerns regarding access to advanced medical treatment for people with disability given that they had to travel to Cox's Bazar Sadar sub-district (about 30 kilometres away) for advanced medical services.

Moreover, people with disability wanted NGOs to take initiative in providing assistive devices, such as wheelchairs and prostheses, that would help them overcome obstacles. Other beneficiaries said it would have been better for World Vision to have provided special facilities in some latrines for people with disability, such as ramps, railings, and commodes. Overall, the process of receiving benefits from World Vision seemed safe to the beneficiaries.

> **WASH Committee Member, Camp 19**
> *'There is a disabled person in my camp. An NGO wanted to build a latrine for him, but it was not possible due to a lack of space. Although he was given a chair to use in the latrine, he did not feel comfortable in it.'*

Although World Vision put in its best efforts to identify and locate persons with disability, the number of children with disability was lower than that projected. This was due to the absence of children with disability in the camps. World Vision's implementing partner, BGS, attempted to identify people with disability and undertook surveys twice in order to identify people with disability with the support of disability inclusion partners CBM and CDD. However, the NGO was able to identify only 2% of the total beneficiaries as people with disability.

Case Story IV – World Vision's WASH and protection support for a person with a disability

Asma is 30 years old and has hearing difficulties. She lives with five family members in Camp 15. Prior to the start of Phase II activities, she had few opportunities to engage in any type of income-

generating activity or social activity; she was depressed as she was not able to participate in any social activities or earn for her family.

She was encouraged by the community-based volunteers to go to World Vision's WGSS. 'I had lost hope,' said Asma, 'as I had asked other NGOs for treatment for my hearing difficulties but I did not get support.' She added, 'I found hope when I saw some other women getting help from World Vision's *apa* (WGSS facilitator).' Asma was interviewed and counselled over a number of days. Asma was thrilled to receive a hearing aid from World Vision. Now she can hear properly and participate in social gatherings. She also learned about opportunities for women to acquire new skills, such as learning to sew and make handicrafts. She had a prior interest in handicrafts and sewing, which enabled her to learn those skills from other women in the WGSS. She also got necessary materials like needles and threads for making handicrafts. Now she can make hats and other items for household decorations. This has turned into a new avenue of part-time income. Moreover, Asma got a burqa and an umbrella from World Vision, which met her needs as well.

During the period of COVID-19 restrictions, the WGSS was closed. This disappointed Asma as she could not discuss her problems with the facilitators or other women like her. Earlier, she had attended quite a few meetings of World Vision and had learned a lot about topics such as personal hygiene management, GBV, family planning, WASH behavior, and COVID-19. In the WGSS and at other meetings, World Vision's staff treated her with care and took her feedback on receiving support. Asma said, 'I had an opportunity to share thoughts on current support and for the improvement of support.'

Asma expressed her utmost satisfaction with World Vision's WASH and protection facilities. She had minor complaints about the service she had received during the COVID-19 outbreak. She thinks that she did not receive regular communication and got no materials for handicrafts. She said, 'I would request the NGO to increase the frequency of meetings. I also would like them to provide me with materials for sewing and handicrafts.'

Plan International

Gender Equality and Empowerment

PI's response was structured around the comprehensive analysis conducted as part of PI Bangladesh's Cox's Bazar Program Framework 2019–20. This was based on several different needs assessments, including a rapid needs assessment (December 2018) for education in emergencies and gender. The framework which informed the design phase put significant focus on education and protection of adolescent girls and women. As part of the Phase II response, PI intended to provide education and life skills training to adolescent girls and young women so that they could be better informed, more self-reliant, and more resilient against GBV, early marriage and human trafficking.

A comprehensive risk assessment on safeguarding and child protection was conducted by PI. It identified protection risks, including those faced by women (such as the risk of sexual and economic exploitation), as well as mitigation strategies[129]. PI's engagement with the local community on developing 'safe passage' routes and 'walking partners for female learners' was another important step in reducing the risk of violence. Furthermore, the life skills sessions had an additional module called 'Champions of Change',

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[129] Safeguarding / Child Protection Risk Assessment Form provided by Plan International

which incorporated messages on child protection, GBV, and gender equality[130]. In the entire project cycle, a strong focus on inclusive measures targeting different genders was evident. The strong focus on gender-inclusive measures was further evidenced by the fact that about 55% of PI beneficiaries were female.

Female beneficiaries spoke positively about life skills sessions which made them more aware about their rights and dignity. Female FGD respondents stated that attending Youth Clubs enhanced their knowledge and awareness of GBV, gender equality and rights. None of the beneficiaries expressed any safety concerns for girls and women when getting support from PI.

> ***Female Participant, age 17***
> *'There are separate learning centres for male and female students. I do not see any risk in attending the learning centres. The teachers are very warm, and no one at the centre treated us badly.'*
>
> ***Facilitator, age 20***
> *'In addition to subjects like Mathematics and Burmese, students also learn about issues such as child marriage, dowry, and hygiene. Their awareness of these issues has increased a lot after attending the learning centres.'*

Disability Inclusiveness

PI's Disability, Gender and Social Inclusion Action Plan laid out disability inclusion strategies in areas such as design and planning, M&E and accountability, coordination with actors, and the internal capacity of PI Bangladesh and partner agencies. According to key informants, disability status was a key criterion used in beneficiary selection. These measures indicated a strong focus on disability inclusiveness in the design phases. During the implementation phase, PI identified and provided benefits to 39 children and 60 adults with disability.

These measures showed that inclusiveness was adequately considered from design and planning to implementation (Case Story V below). However, the evaluation team found that there were some major weaknesses of the response, mostly at the implementation phase and to a lesser extent at the design phase. One weakness of the response was that there was no analysis of barriers for people with disability that could have informed the response. The implementing partner had strong intentions in disability inclusion but lacked technical expertise in this area[131]. Therefore, capacity development for the implementing partner in areas such as M&E, accountability, communication and service delivery for disability inclusion was necessary. The local partner arranged training for its project staff on WGSSQ, but overall technical expertise remained low.

According to the Disability, Gender and Social Inclusion Action Plan, CBM was to provide technical input throughout the project implementation as necessary. The evaluation team did not find any information regarding the technical input received from CBM in the project documents or from interviews with project

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[130] Source: AHP Bangladesh Activation – Plan International Australia Final Report, and discussion with Rohingya beneficiaries
[131] KII with implementing partner and discussions with field staff

stakeholders. Furthermore, the evaluation team did not find any evidence of involvement with OPDs or people with disability in the project decision-making which was mentioned in the Disability, Gender and Social Inclusion Action Plan. When discussed with project stakeholders, it was revealed that while they had intended to engage with and empower OPDs and people with disability, COVID-19 restrictions and the consequent realignment shifted their focus to meeting more emergency needs.

Beneficiary feedback was generally positive. Parents stated that they were happy that their children were included in the education program. They wanted these activities to be expanded and continued.

Case Story V – Life skills support from Plan International for an adolescent with disability

Hossain is a 17-year-old boy who has an intellectual disability (confirmed by his mother). He lives with his family of five in Camp 23. His mother said, 'Sometimes he behaves like a child, he cries for silly reasons, and he does not know the basic life skills such as putting on clothes, counting numbers, etc.' Hossain faced bullying and harassment by some of the community people. Hence, he was not allowed to go outside of his home, which created more mental anguish for him. His family members were concerned about his future.

FIVDB (PI's partner) reached out to him to mainstream him in the education program. The primary objective was to engage him in social gatherings and teach him life skills so that he could lead a normal life. Hossain's father said, 'We felt blessed as our son got an opportunity to learn, although we were skeptical about how he would get on.' The facilitator took Hossain to the learning centre regularly and asked his parents to come with him. The centre provided him with student kits which contain books, notebooks and pens. Initially, he was taught basic life skills such as counting numbers, identifying objects, washing hands, dressing, personal care, etc. He then got the opportunity to go to the learning center as a student for around one month. Some of his classmates used to tease him by calling him 'Pagla Hossain' (*pagla* means 'mad'). The facilitator noticed this and asked the students to stop. The facilitator took special care to teach Hossain. For example, at times the facilitator would act out something for him to boost his understanding. His teacher enabled all the students to do tasks and play in groups which established good relationships among them. After the outbreak of COVID-19, the facilitator visited Hossain's home and delivered lessons to 2–3 students.

His parents are satisfied with the support of PI; however, they have one recommendation they would like to be considered. Hossain's mother said, 'Our son had been improving very slowly but suddenly the education facility in the learning center was stopped, then it reopened, and now it has been off for the last two months again.' His father added, 'I think disabled children like my boy need continuous support to improve; hence, longer-term and regular support is required.'

3.6 Local Capacity and Leadership

This section provides an assessment of the Phase II response in terms of how diverse local stakeholders such as local NGOs, community leaders, religious leaders, opinion leaders, local government officials and others were engaged; how their participation was ensured in different phases of the response; and the extent to which initiatives strengthened and enhanced the capacity of these local stakeholders. Additionally, this section canvasses barriers in local capacity/leadership development and learnings that can be utilized for a future response.

Section Summary

Performance against each sub-evaluation question
To what extent did the AHP investment support and strengthen local partners, including civil society and local government, and include their participation in coordination fora?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Less than Adequate**	**Good**	**Good**	**Good**

What evidence is there of local involvement in the planning, management and implementation of the response, including in influencing and decision-making roles?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Less than Adequate**	**Good**	**Good**	**Good**

Narrative Summary
All ANGOs engaged with and ensured the participation of diverse local stakeholders, particularly at the implementation phase. Activities contributed to the capacity development of different stakeholders, such as local volunteers, committees, the affected communities, and GoB stakeholders. Through local partnership, Save the Children, World Vision, Oxfam and PI involved local NGOs in implementation and management. However, a common weakness was the lack of an action plan or systematic activities on capacity development of local NGOs and the involvement of local actors in planning and decision-making.

CARE's contribution to local capacity and leadership was found to be inadequate as it did not have local partnership and did not contribute in capacity development of local NGOs or engage local actors in planning, decision-making and management of the response.

Key barriers to local capacity development included finding qualified local partners, specifically in technical areas such as GBV response and disability-inclusive education.

Save the Children

Save the Children maintained close coordination with local education-in-emergencies organization, YPSA, in the Rohingya humanitarian context[132]. It partnered with YPSA in relevant interventions and worked on a number of projects. This opened up the scope of skill transfer to YPSA and built trust between the two

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[132] KII with Save the Children and YPSA

NGOs. Eventually, this sort of partnership leads to empowerment, which will help the local partner formulate coherent strategies and provide an effective response to affected communities.

In its education program, Save the Children provided support through YPSA. To ensure the development of local leadership, Save the Children utilized a participatory approach, providing training, monitoring, and supportive supervision for teachers and facilitators through monthly peer learning meetings. The NGO also conducted monthly parenting sessions to support paternal and community engagement to ensure children's education. However, there was no clear strategy outlining how and when activities would be handed over to the relevant departments and what the consortium partners would do in case of challenges.

Save the Children initiated capacity development programs for CBV and local teachers on providing education services and awareness sessions. Moreover, Save the Children mandated training on protection for relevant staff, including those of implementing partners, CBV, and the enumerators of the evaluation team conducting field activities in the camps[133].

In KIIs, beneficiaries mentioned the positive impacts of capacity development initiatives as well as the overall accountability system for the beneficiaries set up by the NGO.

> **Religious Leader, Camp 18, age 72**
> *'I think that our capacity has increased due to the support of the NGOs. Now, our children are learning; previously they were excluded from education.'*

In the health program, the NGO recruited and engaged local volunteers to provide SRH services. However, there was no evidence of Save the Children involving a local partner for its health program during the course of the project. From a localisation perspective, this approach might have hindered effective needs identification and the formulation of a coherent strategy for health programs in its response.

CARE

CARE incorporated local capacity development in its programmatic activities. It provided capacity strengthening support to about 100 camp actors and stakeholders (including a GoB official) on gender- and disability-inclusive GBV principles, and safe and ethical referrals[134]. CARE engaged with the Community Outreach Group, Girls Committee and Women Committee at an early stage of its response[135]. By developing and strengthening the Community Outreach Group, CARE contributed to local leadership and capacity development to a certain degree. In interviews, Community Outreach Group members indicated that they felt confident about their capacity and ability to contribute to their community.

> **Community Outreach Group Member**

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[133] Source: Final Report and KII with Save the Children
[134] IPTT Tracker of CARE
[135] Final Report, and document on participant counts of meeting with Community Outreach Group , Girls Committee & Women Committee

> *'On the topic of protection of women, the awareness and capacity of the* majhis *(local leaders), imams (religious leaders), and committee members has increased. Now we can discuss these issues with others and disseminate our knowledge to others."*

Despite the above-mentioned evidence of CARE's contribution to local capacity and leadership, there were significant areas for improvement. There was not enough evidence of CARE involving local partners in activities other than implementation of the project. The participation of local actors in design, planning and management was not adequate. In terms of local partnership, CARE did not have any local partner for GBV and protection services. It had partnered with local NGO RTMI for provision of SRH services, but this arrangement was discontinued due to compliance problems[136]. In the end, CARE's response did not achieve much in terms of engaging local NGOs in planning, management and implementation of the response. Similarly, there was no capacity development of local NGOs during the process. Overall, CARE's contribution to local capacity and leadership was found to be less than adequate.

Discussions with CARE personnel revealed that finding local NGOs with technical expertise in GBV response was difficult. Nevertheless, capacity development of local NGOs is crucial for localisation.

Oxfam

Oxfam Australia engaged Oxfam Bangladesh as the local country branch to lead the field-level implementation process by establishing worthwhile coordination and effective communication among the partner's staff. Oxfam Bangladesh was also responsible for maintaining technical support flow throughout the intervention period as well as ensuring quality in accountability. Oxfam partnered with Shushilan and Dusta Shasta Kendra (DSK) as local partners to carry out the field-level implementation. Key responsibilities of the local partners included operational activities such as fulfilling indicator-based targets, providing training to staff and volunteers, monitoring interventions, recording feedback, and reporting to Oxfam. Oxfam allocated a total of 40% of funds to its local partners (31% to Shushilan; 9% to DSK)[137].

It was evident that Shushilan and DSK had prior organizational rapport with Oxfam in the WASH sector, mostly in host communities and in other areas in Bangladesh. The partners had extensive WASH sector experience as well as expertise in working in the humanitarian context, especially in the Rohingya context. Shushilan and DSK took on the WASH sector focal roles in Camps 12 and 19. Though Oxfam had sole responsibility for the design of the program and setting of outcome indicators, the partners were involved in implementation planning in a changed context, preparation of structural designs, and mobilization of resources. The notable supports and training provided by Oxfam were:

- Technical support;
- Validation of structural facility designs;
- Content development and validation support for awareness programs;
- Training on COVID-19 protocols, gender inclusion, and people with disability inclusion (training on assessment of people with disability was conducted by HI);

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[136] KII with CARE
[137] Final Report (prior to the NCE), August 2020

- Training on M&E, evidence-based reporting, sharing of learnings; and
- Coordination support to achieve targets efficiently.

Oxfam also enabled its partners to coordinate and get comprehensive training and support from the Disaster Risk Reduction Committee and site management to develop staff capacity to work in the monsoon context. The partners developed a good working relationship with CiCs and site management. This helped them achieve smooth functioning, hassle-free entry-exit, and quick approvals.

Training on community feedback reporting, session arrangement, hygiene practices and COVID-19 awareness was arranged for CBVs and committee members. These capacity-building workshops enhanced the capacity of committee members directly and of the community people indirectly. Oxfam and its local partners undertook the following capacity-building activities for beneficiaries[138]:

- 125 community health volunteers were paid a stipend and received training on personal hygiene management, AWD and COVID-19.
- 25 Rohingya laborers were engaged and developed their capacity to repair and maintain WASH infrastructure.
- Protection committees, latrine user groups and communal handwashing device user groups were trained on community engagement, hygiene practices, WASH infrastructure maintenance and operation as well as COVID-19 awareness.

> **Key Findings**
> Oxfam improved the capacity of local partners in terms of technical understanding, operational planning, gender inclusion, inclusion of people with disability and working protocols in a changed context (due to COVID-19). Local partners empowered the CBVs and committee members by providing technical and leadership training to create community resilience.

Beneficiary interviews with people with disability revealed that life skills training was a pressing need despite Oxfam's indifference towards it. Interviews with program staff revealed that field staff were poorly oriented to outcome indicators and managerial decisions; this showed a gap in systematic orientation, on-boarding and coordination.

> **Staff, Oxfam's Implementing Partner**
> *'Though there was no systematic structure for training and coordination, we received good technical support and operational training for program implementation. Also, beneficiary-level stakeholders were trained on pressing WASH issues with Oxfam guidelines, though the people-with-disability cluster remained under reach.'*

> **Key Findings**
> Oxfam incorporated the localisation principle ('as local as possible, as international as necessary'), but some shortcomings were evidenced, such as excluding local partners from program design, paying less consideration to enhancing the leadership of people with disability, and ignoring a structured training process for field staff. Nevertheless, local partners and beneficiary groups were empowered to implement the program with Oxfam's

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[138] KII with local partner's staff

World Vision

World Vision implemented its activities by partnering with BGS, CBM, CDD, and Field Ready. BGS was responsible for implementation of WASH activities in selected camps. CBM and CDD supported the consortium in creating inclusive services for people with disability. Field Ready was responsible for innovative, cost-effective solutions for World Vision's support[139]. According to World Vision, the NGO allocated 42% of funding to local partners.

Besides the above-mentioned partners, World Vision established a number of community forums, including Women Watch Committees, Protection Committees, and Water Watch Committees, which included people with disability as members[140].

Word Vision worked with local partners during the planning phase as well. For instance, BGS, CBM and CDD were involved, through technical support, in the design and construction of WASH and protection facilities and in creating inclusive environments for people with disability in community groups. Although World Vision implemented its activities through local partners, the evaluation team identified an absence of explicit outcomes supporting localisation[141].

World Vision arranged training for local organizations in line with project requirements. For instance, World Vision's WASH implementing partner, BGS, was unable to identify a sufficient number of people with disability in the selected camps. To address this issue, CDD and CBM conducted a one-day training on disability-specific data collection for BGS hygiene promoters, field facilitators, technical officers and WASH engineers. After the training, BGS undertook the survey again and identified people with disability with a four-fold increase from the previous survey[142].

World Vision enabled the affected communities to participate in implementing their response in a significant way. Its project provided training on effective representation and decision-making for community forums in Camps 13 and 15[143]. It also established a water networks system at Camp 19 under the supervision of the Water Management Committee. These community forums were formed and capacitated with hands-on support so that they could continue some of their essential activities even after the project period.

With regards to ensuring the participation of local actors, World Vision's project trained community and faith leaders in different sessions on a gender-inclusive COVID-19 response, including inclusive COVID-19 referral pathways and effective preventive measures, COVID-19 symptoms, cultural behaviors to avoid, and social distancing[144]. Its role in the community included mobilizing the Rohingya community to stay safe and prevent the transmission of COVID-19 as well as promoting community responsiveness to a gender-inclusive COVID-19 response.

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[139] Final Report and KII with the partners
[140] Final Report, KII with the partner NGOs, and FGD with beneficiaries
[141] From review of logframe
[142] Final report and KII with technical partner
[143] FGD with members of community forums
[144] Final report and FGD with beneficiaries

> ***Female Women Watch Committee Member***
> *'The NGO safely handled GBV cases and trained committee members on how to handle GBV cases. Thus, the trained members gained capacity in handling protection issues.*

Local partners believed that they had gained some sort of expertise by partnering with ANGOs; however, the evaluation team found no evidence of a systematic approach being followed to ensure capacity enhancement of local partners. Moreover, high staff turnover was another major concern for the local partners when trying to ensure proper outcomes flowing from the training provided to them[145].

Beneficiaries provided feedback on the support they had received from World Vision. Members of the Women Watch Committee believed that they had gained the ability to influence community people, spread awareness and practise GBV protocols as per training learnings. However, some of the beneficiaries opined that besides training, active engagement of local leaders and elderly people in the ANGOs' work plan could have produced better results. They also suggested engaging community leaders more in the planning stage by arranging more meetings with them.

Plan International

PI partnered with FIVDB for project implementation and, in the process, contributed to greater ownership and capacity development of the local partner. While FIVDB was engaged after the design documents were already completed, there was evidence of strong involvement and participation of FIVDB in the implementation phase. KIIs with stakeholders from both NGOs revealed that FIVDB played an important role in the decision-making process for the COVID-19 realignment. PI stakeholders stated that workshops/meetings with FIVDB on budget planning and reporting contributed to their overall capacity development. However, PI lacked an action plan on localisation or systematic activities for capacity development of the local implementing partner. PI's contribution towards localisation could have been improved had it undertaken a systematic approach.

There was strong evidence of participation and capacity development of diverse local stakeholders in various phases of the project cycle. Youth Club activities enhanced the capacity of adolescents and youths, with life skills sessions and leadership and teamwork learning activities. Involvement with parent groups, community elders and religious leaders contributed to greater community acceptance and ownership. Capacity development of local leaders, CBVs, and education facilitators from the Rohingya community also potentially contributed to local leadership. PI worked closely with local government authorities – the Deputy Commissioner and the Upazila Nirbahi Officer (the sub-district CEO) – particularly in their host community response[146]. Beneficiary selection for unconditional cash transfers in the host community was done in close coordination with local government officials[147].

Overall, the evaluation team found considerable evidence that PI's actions had helped to enhance local capacity and leadership during different phases of the response.

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[145] KII with partner NGO

[146] Source: Multiple KIIs with PI, and Final Report.

[147] Same as 130 above

3.7 Accountability

This section measures the extent to which ANGOs engaged with affected communities, took feedback from them, and adjusted their programs based on that feedback. It also includes an assessment of the feedback and accountability systems, and the extent to which affected communities were aware of and able to use such systems.

Section Summary

Performance against each sub-evaluation question
To what extent were implementing partners sufficiently accountable to, and engaged with, affected communities?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

What evidence exists of programs having been influenced by effective communication, participation and feedback from affected people and communities?

Save the Children	CARE	Oxfam	World Vision	Plan International
Good	**Good**	**Good**	**Good**	**Good**

Narrative Summary
A vast majority (greater than 80%) of Phase II beneficiaries felt that their feedback was taken regularly and acted upon by the ANGOs. Beneficiaries stated that they were regularly consulted by the NGOs, and that they could constructively influence NGO activities. All ANGOs employed sophisticated feedback and accountability measures, including door-to-door collection of feedback and complaints (F&C) by MEAL assistants, focus group sessions, complaints boxes and helplines. Based on the feedback and complaints, accountability reports were prepared by ANGOs. The evaluation team found evidence of program activities being influenced by feedback from beneficiaries. Overall, ANGOs were found to be accountable to the affected communities.

There were, however, some areas of improvement. Beneficiaries usually prefer face-to face communication when providing feedback, and usually do not use complaints boxes, helplines or other anonymous tools. Many beneficiaries were unfamiliar with the feedback mechanisms available to them.

A survey of female beneficiaries of the Phase II response showed that 91% of the respondents felt that their feedback was taken by ANGOs, while 84% said that actions had been taken in response to that feedback. Ninety-three per cent (93%) of male beneficiaries stated that ANGOs took their feedback, and 90% of male respondents said that actions had been taken based on that feedback. With regards to people with disability, 94% said that ANGOs took their feedback, and 83% felt that actions had been taken based on their comments. This was strong evidence that affected communities felt that they were heard and valued by ANGOs.

Figure 5: Beneficiary response on accountability questions[148]

n of female = 264   n of male = 317   n of people with disability = 69
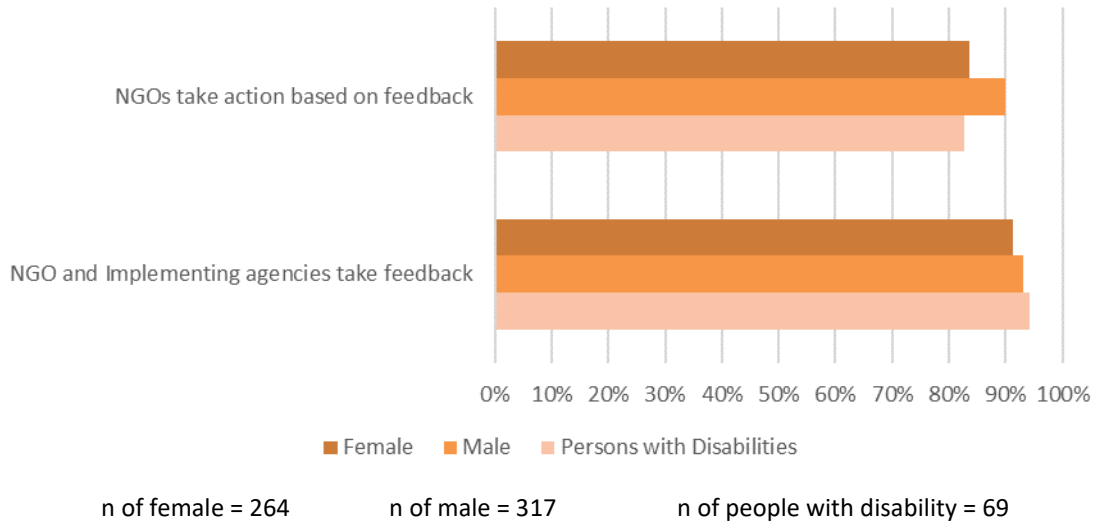
Inclusive Communities Consortium

The consortium aimed to put a number of mechanisms in place to communicate with beneficiaries and adjust the consortium's response accordingly. The mechanisms included a toll-free hotline; helpdesks; suggestion and complaints boxes; systematic inclusion in post-distribution monitoring; interviews and FGDs; door-to-door collection of feedback and complaints by MEAL assistants, especially around distribution times; and a child-friendly complaints, feedback and response mechanism. The consortium partners also had a dedicated accountability team to collect feedback from the consortium.

An FGD with female beneficiaries and KIIs with community members about Save the Children revealed that the NGO occasionally took beneficiaries' views and opinions into account before providing assistance. However, some beneficiaries said that they did not see the NGO responding to their feedback. All of the beneficiaries said that the NGO did not inform them about the results of the various assessments undertaken during the implementation period.

> **Community Leader, male**
> *'In some cases, the NGO takes our opinion to know about our most pressing needs, but most of the time we don't get any feedback after those surveys or interviews. The NGOs don't provide the results of different evaluations to us.'*

CARE's beneficiaries were positive about the scope of making constructive feedback. They also believed that the NGO consulted with them before providing its response. However, the evaluation team found a lack of awareness among the beneficiaries regarding the filing of complaints. Many of them did not know where to complain or to whom. CARE's beneficiaries also stated that the NGO did not inform them about

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[148] Source: Beneficiary Survey

the results of the various assessments it had undertaken during the implementation period. Similar opinions were provided by Oxfam beneficiaries as well.

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Key Findings
The evaluation team identified the effectiveness of the various feedback mechanisms used by ANGOs in aggregate. The team found that beneficiaries felt most comfortable providing feedback verbally during meetings. They were reluctant to use complaints boxes, and beneficiaries could not easily recall the telephone number given. Beneficiaries said that ANGOs did not inform them about the assessments they had undertaken.

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World Vision

In the design phase, World Vision aimed at setting a proper accountability mechanism, guided by Core Humanitarian Standards and Humanitarian Inclusion Standards, by which the NGO would collect feedback from the community. The NGO committed to generating monthly reports which would inform part of the overall programmatic lessons learned, and implementation would be adapted as a way to ensure responsiveness of the overall operations[149].

During the implementation phase, as part of its accountability mechanisms, World Vision's project conducted eleven Accountability-to-Affected-People sessions: seven information sharing sessions and four feedback sessions. In these sessions, World Vision collected feedback on the quality of services; feedback on awareness of child marriage, domestic violence, and sexual harassment; updates from community forums; feedback on critical issues related to GBV; and feedback on the overall impact of its response[150].

A needs assessment was conducted through an FGD with the participation of the beneficiaries. The NGO set a provision for reporting directly to the prevention facilitator to increase accountability and safeguarding for committee members of community forums, including the Women Watch Committee[151].

World Vision used the following mechanisms to collect feedback and complaints:
- Helpdesk: a temporary helpdesk assistant was assigned to collect and manage cases for this project.
- Suggestion boxes: installed in different locations in the community.
- Face-to-face communication: beneficiaries provided feedback to NGO staff.

World Vision considered feedback from beneficiaries and project participants. Members of community forums stated that World Vision used to arrange meetings three times a week before COVID-19, but that changed to three times a month[152] after. They also believed that the NGO accepted their opinions so as to identify needs before providing any assistance, and that they were able to comment on improving the activities of the NGO. For example, their views and opinions were taken prior to the provision of latrine

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[149] Source: Project Implementation Plan
[150] Source: Accountability reports Provided by World Vision
[151] Source: Final Report
[152] FGD with beneficiaries

and water services. Another instance of World Vision acting on feedback was an increase in the number of sewing machines provided. As a result, the number of participants for skill building activities increased. However, beneficiaries stated that they were not informed about the results of various assessments undertaken by the NGO.

> **Women Watch Committee Member, age 29, Camp 13**
> *'Committee members meet 4–5 times a month with World Vision staff. They then go home and discuss what they had learned in the meetings.'*

The evaluation team gathered similar opinions from local partners also. World Vision arranged a coordination meeting at least once a month, during which various thematic issues were discussed to properly engage with local partners. Local partners also stated that their recommendations were taken into consideration in the project. However, the partners did not receive any information about MEL findings. Partner NGOs suggested that World Vision needed to give greater consideration to identifying and getting feedback from people with disability while providing support to them.

Upon receiving feedback from beneficiaries, World Vision prepared a monthly accountability report incorporating the key issues that emerged, learnings, recommendations, and follow-up activities in thematic areas, including WASH and GBV[153].

Plan International

PI incorporated good feedback collection processes to gauge the feedback and recommendations of beneficiaries. These processes also aimed to give beneficiaries a feeling of ownership. PI entrenched a child-friendly feedback mechanism in both camp locations and host communities, which included collating students' viewpoints via systematic procedures inside learning centres. PI regularly collected verbal and written feedback from youth leaders in training and awareness sessions. Community outreach sessions and courtyard discussions enabled diverse beneficiary cohorts, such as people with disability, *majhis* (community leaders), imams (religious leaders) and *murrubis* (respected local elders), to share feedback on support and recommendations for future support directly to facility providers.

To accommodate restrictions related to COVID-19, PI allocated phone numbers for beneficiaries to share their thoughts remotely. Beneficiaries were fully informed about the options for providing feedback during an initial group discussion. Overall, there were three mechanisms by which feedback could be provided: verbal feedback over the phone, written feedback to staff, and direct verbal feedback to staff.

FIVDB confirmed that beneficiary feedback was instrumental in realigning its approaches to support. For example, in different community consultation sessions, guardians of girls asked for a separate learning centre, a gender-specific facilitator, burqas as uniforms, and a separate path to the learning centre. These requests were successfully incorporated into the implementation plan.

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[153] Supporting documents provided by World Vision

> **FGD Participant, male, age 28**
> 'FIVDB approached us to share our thoughts about awareness sessions and education programs for our children. I participated in a couple of interviews and some FGDs where I gave feedback on the supports. Some of my ideas were acted upon: the NGO selected a good location for the learning centre, provided uniforms to students, and increased teaching time in line with our opinions.'
>
> **FGD Participant, male, age 55**
> 'Through meetings, individual interviews, household visits and utthan boithoks *(yard meetings/FGDs)*, the NGO took feedback from us on the scope of support improvement. Though we have seen that some of our opinions were considered, the NGOs did not inform us of the results of our opinions formally.'

3.8 COVID-19

In response to the COVID-19 outbreak, DFAT was quick to respond through ANGOs in the selected camps. Save the Children, CARE and World Vision were given opportunity to access early funding from the Phase III package, and Oxfam and PI pivoted their activities to centre around COVID-19 response activities.

Furthermore, DFAT developed 'Partnerships for Recovery: Australia's COVID-19 Development Response', outlining priority action items such as health security, stability, and economic recovery. In their Phase II response, ANGOs were expected to provide support encompassing these key action items.

Section Summary

Performance against each sub-evaluation question
To what extent have the agencies integrated COVID-19 considerations effectively into their response?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

To what extent did the agencies' COVID-19 assistance align with the Australian Government's COVID-19 Aid Strategy, 'Partnership for Recovery: Australia's COVID-19 Development Response'?

Save the Children	CARE	Oxfam	World Vision	Plan International
Excellent	**Excellent**	**Excellent**	**Excellent**	**Excellent**

Narrative Summary
All ANGOs were quick to effectively integrate a COVID-19 response in their program activities. Save the Children's shift to home-based learning, and PI's one-to-one and small-group learning sessions and unconditional cash grants were great examples of adaptability during the crisis. All responses were consistent with the Australian Government's COVID-19 Aid Strategy, 'Partnership for Recovery: Australia's COVID-19 Development Response'.

Inclusive Communities Consortium

During the COVID-19 outbreak, the Inclusive Communities consortium made an effort to integrate a COVID-19 response into their program, maintaining the recommended health protocols amid government-imposed restrictions. For instance, Save the Children relied on an alternative approach in providing education services to children: facilitators went to the homes of the children, delivering educational messages to three or four children at a time. CARE conducted health awareness sessions with fewer participants but with increased frequency: 25 participants – Rohingya community leaders, religious leaders, and SRH Outreach Support Group members – were actively engaged. Oxfam pivoted its planned activities to respond to the COVID-19 crisis and had to start its project during the COVID-19 outbreak due to a delay caused by a DFAT funding suspension. The NGO formed and engaged youth groups and protection committees, and provided training to raise awareness of the COVID-19 response. The consortium also established 'flu corners'. The evaluation team learned from an informal discussion with a camp doctor that NGO staff provided updates on pregnant women and their condition, especially if cases were critical.

Health Sector Coordinator

> *'Save the Children established a specific capacity for caring for severe patients with COVID at severe acute respiratory infection isolation and treatment centres which were set up in a coordinated way with health sector partners up to a thousand beds.'*

The consortium took active measures to protect its staff as well as beneficiaries. Partner NGOs provided PPE and personal hygiene materials to their staff, measured patient temperatures at mobile outreach clinics, restricted group size to five people, and maintained social distancing.

While the NGOs attempted to provide their services actively, the outbreak affected many of their responses. For instance, CARE reduced its protection presence by 50% as the NGOs had permission only for essential lifesaving services. Some beneficiaries observed a slight increase in GBV cases as the number of GBV awareness sessions was lower during the outbreak period.

> ***GBV Committee Leader, male, age 60***
> *'GBV incidents increased during COVID-19 since the number of awareness sessions was low. When the outreach teams are more active, these incidents go down.'*

Twenty-eight participants out of 30 expressed positive responses to the support provided by Inclusive Communities ANGOs. Almost all of them were satisfied with support in relation to COVID-19. According to them, all ANGOs sufficiently incorporated their pressing needs regarding awareness sessions, hygiene promotion, hygiene kits, protection and WASH facilities during the COVID-19 emergency.

World Vision

World Vision pivoted its activities towards the COVID-19 response during the course of the outbreak. World Vision restructured the procedure of its awareness sessions and arranged sessions centred on COVID-19 outbreak prevention while maintaining GoB-mandated social distancing orders[154]. The project trained community and faith leaders in different sessions on a gender-inclusive COVID-19 response, including inclusive COVID-19 referral pathways and effective preventive measures, COVID-19 symptoms, cultural behaviours to avoid, and social distancing. World Vision reached about 2200 beneficiaries[155] in terms of COVID-19 awareness. In addition to the awareness sessions, PPE was also provided to caregivers and community people through World Vision's COVID-19 response.

An FGD with the Women Watch Committee in Camps 15 and 19 revealed that almost all the participants (9 out of 11) were satisfied with the COVID-19-integrated WASH and protection support. The respondents said that they had received masks, soaps, and buckets from World Vision. While some of the committee said that these items 'fairly' met their needs, others said they were 'not adequate'. After further exploration, the evaluation team realized the differences in responses were due to the differences in the number of family members: the NGO had provided the same number of kits to the beneficiaries regardless of the number of family members. Moreover, the number of kits distributed in Camp 15 and Camp 19 was

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[154] Source: Final report and KII with implementing partner
[155] Final report of World Vision

not the same; for instance, each family in Camp 15 received three soaps per month, whereas in Camp 19 each family got 15 soaps per month.

Female WASH Committee Member, age 35

'After COVID-19, our family received 15 soaps per month, including 7 handwashing soaps and 8 laundry detergents. Since not all families have the same number of members, it is seen that households with fewer members are left with soap in their house and those with more family members are not getting enough soaps.'

Plan International

During the outbreak phase of COVID-19, PI focused on a realignment of its implementation plan through consultation with FIVDB, community volunteers, teachers and members of Youth Clubs. PI emphasized COVID-19-specific awareness programs, billboards, household information, education and communication materials, and dignity kits while redesigning a course of action which served the priorities of GoB and brought endorsement for PI.

After taking a pause because of the COVID-19 realignment, PI enabled staff to reopen the education program through alternative approaches. For instance, because TLCs were closed, PI teachers visited learners' house regularly to provide caregiver-led one-to-one support. Due to the COVID-19 crisis, this project conducted small group-based (3–5 members) awareness sessions on COVID-19-related life skills; delivered COVID-19 awareness messaging via SMS and social media; and presented radio talk shows for adolescents and radio programs on positive parenting. Most of these were components of remote community engagement mechanisms, though the actual impact of remote communication was difficult to measure. PI also continued to communicate with learners and advocate key messages in order to prevent child labour, child marriage, and school dropouts. Activities related to COVID–19 responses were popular with community members, despite COVID-19 stopping the implementation of many project activities; this was evidenced by FGDs and interviews with key stakeholders.

FGDs with adolescent beneficiaries revealed that 10 out of 12 participants were satisfied with education and protection support from PI during COVID-19. Their responses in relation to awareness sessions, hygiene promotion and kit distribution evidenced that PI's support integrated a COVID-19 response which met the pressing needs of beneficiaries.

Remote communication with beneficiaries was a barrier in the early period of COVID-19. It was mitigated through regular touch-base actions and follow-ups via facilitators and CBVs. In host communities, people had little awareness of digital banking systems, making it challenging to transfer funds. This was mitigated through the financial service provider's awareness campaigns.

FGD Participant, female, age 20

'My mates and I got sanitary pads during COVID-19. We learned about COVID-19 protocols through the facilitator at home, which was very helpful for females. Also, the CBVs visited our house frequently to check up on our status.'

Education Facilitator, age 45
'During COVID-19, learning centres were closed. I was instructed to visit learners' homes but continue to maintain hygiene and distancing protocols. I provided teaching facilities such as coaching to children and counselling to parents on a roster basis.

4. Conclusion

The response of all ANGOs was found to be highly relevant to the priority needs of the affected communities and coherent with the UN response plan, the overall humanitarian response, and the thematic priorities of Australia's humanitarian strategic objectives. As the COVID-19 pandemic became a major threat to the lives and livelihoods of the Rohingya people and host communities, all ANGOs were quick to effectively integrate a COVID-19 response in their program activities. Beneficiaries felt strongly that the support from ANGOs had met their priority needs, and opined that these supports should be continued. In addition to the existing support, early childhood development, establishment of hepatitis C and thalassemia treatment are some key areas which ANGOs need to work on in a future response **[Recommendation (R) 10.a, 10.d]**. As for coherence with GoB stakeholders, greater collaboration with Camp-in-Charges and local government authorities during the project design phase is important **[R10.e]**.

As for effectiveness, all ANGOs were able to meet most of the outcome level targets, and beneficiaries were highly satisfied with the support they had received. Some areas in which ANGOs fell short and will need to focus on in the Phase III response are: building community awareness of GBV in relation to economic and psychological harms to women; sensitizing male community members to reject intimate partner violence and accept women's role in SRH-related decisions; monitoring to reduce incidents of damage to and theft of WASH facilities; and ensuring that common WASH facilities are not used for private benefit **[R 10.b, 10.c, 10.f]**.

The Phase II response adequately contributed to longer-term resilience of the affected communities through activities on life skills development, community resilience, disaster preparedness and prevention of disease outbreak. Two areas in which ANGOs (except for PI) needed to have greater focus was meeting the needs of the affected host community and improving social cohesion between the Rohingya and the host communities [**R2**]. At the same time, it was found that ANGOs had more focus on short-term results of their activities and were not strategic enough to have end-of-program outcomes which were connected with results beyond the life of the project. When defining outcome indicators, ANGOs could have focused on a greater depth of results of their activities [**R1, R6**].

With regards to M&E practices, the Inclusive Communities consortium and World Vision met most of DFAT's M&E standards in measuring the effectiveness and inclusion of the response but fell short in some areas. For Inclusive Communities, the weakness involved limited activity at the consortium level in harmonizing individual agency M&E plans, M&E capacity development of partner agencies, and data validity checks. [**R4**]. PI's M&E activities had many shortcomings, such as a weak logical framework, poorly defined outcome indicators, inadequate reporting on sex-, age- and disability-disaggregated data on outcomes, and inadequate M&E expertise utilized in project implementation [**R5**]. Across all ANGOs, systematic monitoring of risk was not performed adequately [**R8**]. In addition, the exit/transition strategy was found to be less than adequate as evidenced by the discontinuation, at the end of Phase II, of education to children with disability who had received support from HI/Save the Children during Phase II [**R3**].

The Phase II response was mostly efficient in terms of alignment with the agreed timelines, beneficiary and geographic coverage, and resource utilization. The few deviations that were found were caused mostly by external factors, such as delays in obtaining regulatory approval and COVID-19-induced restrictions. The governance mechanism and arrangements were generally good, and the consortium approach of Inclusive Communities allowed different partner agencies to leverage the strength of one another to some extent. However, there were some incidents of communication gaps and unresolved issues, as well as low levels of clarity regarding individual agency roles in common response areas **[R7]**.

All ANGOs performed excellently in terms of gender inclusiveness. Even so, the role of women in decision-making in camp governance is still limited and not always accepted by male members of the Rohingya communities **[R9.a]**. There was less disability inclusion than was intended despite good efforts by ANGOs, as exemplified by HI/Save the Children providing individualized learning to children with disability and World Vision increasing the representation of people with disability in different community forums. All ANGOs fell short in reaching the intended number of beneficiaries with disability. Further, only 61% of survey respondents with disability felt that their special needs had been fully considered by ANGOs; this indicates that more work needs to be done on disability inclusion. Barriers to disability inclusion included geographic factors, organizational factors (such as a lack of technical expertise), an absence of effective OPDs representing the voice of people with disability inside the camps, and the disadvantaged location of the shelters of people with disability. **[R9.b, R9.c, R9.d]**.

All ANGOs engaged with and ensured the participation of diverse local stakeholders, particularly at the implementation phase. There was, however, no action plan or systematic activities on capacity development of local NGOs and the involvement of local actors in planning and decision-making. In particular, CARE did not contribute sufficiently to developing local capacity and leadership as it did not have partnership with local NGOs for the Phase II response **[R2].**

As for accountability, all ANGOs had sophisticated feedback and accountability measures, and the beneficiaries felt strongly that their feedback had been regularly taken and acted upon. However, it was also found that beneficiaries had been either unaware of or reluctant to use many of the available feedback tools, such as complaints boxes and helplines. Moreover, it was also found that beneficiaries had not been informed about different results of the various assessments undertaken by the ANGOs **[R2]**.

5. Recommendations

Based on the evaluation findings on the strengths and improvement areas of the Phase II response, the evaluation team has developed the following recommendations. The recommendations are intended to be used by DFAT, AHP and ANGOs to strengthen the AHP Phase III multi-year response. They have been structured thematically: Strategy and Way Forward, Monitoring and Evaluation, Consortium Governance, Risk Management, Inclusiveness, and Sector-related issues. The recommendations can also provide guidance to other donors and implementing organizations for developing and managing future interventions in the Rohingya crisis.

<table>
<tr><td>Thematic Area: Strategy and Way Forward</td></tr>
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Recommendation 1: During Phase III, DFAT and AHP should have end-of-program outcomes which are strategic and contribute towards results beyond the life of the response. Outcome indicators should also capture a greater depth of results.
  a. Develop a time-bound Theory of Change**,** clearly laying out specific, measurable, and achievable end-of-program outcomes and how these are connected with results beyond the life of the response.
  b. Ensure that the results framework can be used to monitor a greater depth of results and outcomes of the response in addition to the outputs and activities.
  c. ANGOs should ensure that there is a shared understanding and ownership of the program logic at all layers, from management to senior program staff to field-level staff. Hence, the program objectives, outcomes, and rationale for different activities should be clearly communicated in a systematic manner to field staff and periodically reviewed with them.

Recommendation 2: DFAT, AHP and ANGOs should bring social cohesion, localisation and accountability to the affected communities to the forefront of any future program. Specific actions may be:
  a. Identify the factors which lead to tensions within and between the Rohingya and the host communities, and incorporate activities to promote understanding and cohesion.
  b. Understand and respond to host community needs to mitigate underlying socioeconomic factors that lead to tension and resentment towards Rohingya communities and humanitarian workers.
  c. Give localisation due attention by making it a core component of the results framework. Outline specific activities and results of localisation components, which may include systematic planning and activities on capacity development of local NGOs in areas such as operational and strategic management, inclusion (including disability inclusion), M&E and reporting. Some primary steps may include:
      i. Form a consortium localization promotion working group with representatives from all ANGOs.
      ii. Harmonize consortium initiatives across all partners to promote localization.
  d. DFAT and AHP may direct/require ANGOs to form local partnerships in all projects and report on fund allocation to local implementing partners. ANGOs should attempt to include implementing partners at the design stage and in decision-making as well as in consortium-level coordination workshops and meetings.
  e. Complaints and feedback mechanism tools (such as complaints boxes and helplines) are ineffective if beneficiaries are unfamiliar with them or are reluctant to use them. ANGOs must therefore continuously create community awareness about these tools and keep them adequately visible to all. ANGOs should conduct awareness sessions on anonymity, privacy and the effectiveness of these tools to motivate

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beneficiaries to be more responsive. They should also ensure community engagement in implementation and decision-making.

Recommendation 3: DFAT, AHP and ANGOs should consider the negative impacts on beneficiaries caused by the discontinuation of a project or the time-lag between two projects, and develop a robust exit/transition strategy. Specific actions may include:
   a. Develop exit/transition strategies at the design phase and monitor the risks of project discontinuation, fund depletion or time-lag to allow a timely response.
   b. The AHP consortium should form an exit/transition strategy implementation working group with representatives from all ANGOs.
   c. To boost sustainability, engage local stakeholders, such as local government authorities, local communities, beneficiaries, and local partners, and strengthen their capacity in order to ensure their readiness for a proper handover and assumption of control at the end of a project.

Thematic Area: Monitoring and Evaluation

Recommendation 4: The AHP consortium should have an enhanced role with regards to M&E data quality assurance, harmonization, and capacity development. Specific actions may include:
   a. The AHP consortium can identify MEAL capacity gaps of individual agencies and plan on addressing those gaps in a systematic manner. This can happen as a separate activity or as part of regular MEAL harmonization meetings at which agencies review the MEAL processes and the strengths and weaknesses of each other's MEAL systems. Based on these reviews, MEAL system benchmarks can be established, and capacity development plans can be prepared.
   b. Consortium M&E coordination bodies can play an important role in reviewing inclusive MEAL plans and systems of individual agencies and harmonize them to achieve greater effectiveness.
   c. Consortium M&E coordination bodies can have a greater role in reviewing the data quality assurance and data triangulation methods of individual agencies and undertake visits and spot checks to review individual agency performance over the project period.

Recommendation 5: ANGOs and their local implementing partners should have dedicated M&E experts in the project and ensure sufficient resource allocation for M&E activities. ANGOs should undertake assessment and capacity development of the M&E of local implementing partners. Specific actions include:
   a. Review the database management process, the data quality assurance system, ethical guidelines, etc. of the local partner, and provide guidance on improvement.
   b. Review the capacity of M&E personnel of local implementing partners and undertake M&E workshops and capacity development training.

Recommendation 6: ANGOs should ensure evidence-based target setting for intended outcomes. Specific actions may be:
   a. Use baseline studies to set indicators and targets for projects lasting longer than one year. In case a baseline cannot be conducted, clear justifications and assumptions behind different targets need to be established and communicated in project documents.
   b. Document explanation of causal linkages, available evidence of the linkages, and assumptions and risks.

Thematic Area: Consortium Governance
Recommendation 7: The AHP consortium should strengthen the governance mechanism by establishing regular and effective communication among the partners from the very beginning of the response and by using consortium feedback mechanisms. Specific actions may include: a. Clarify roles and responsibilities of the partners by setting up regular communication and coordination mechanisms, including Standard Operating Procedures, from the beginning of the project. b. Set up a consortium feedback mechanism which can be accessed and used by mid- to senior-level project staff who have visibility with respect to consortium governance. Feedback may go to the Cox's Bazar Steering Committee and/or the Australian Reference Group, which can play an active role in addressing concerns.

Thematic Area: Risk Management
Recommendation 8: ANGOs should ensure systematic risk management by updating the risk matrix at regular intervals with the involvement of project stakeholders. Specific activities could be: a. Review and update, at least quarterly, the risk matrix (usually created at the design stage) by monitoring for any new risks, determining if either the likelihood or impact of any previously identified risks has changed and if mitigation plans are still working. The Consortium Management Unit (CMU) can arrange quarterly meetings with ANGOs and stakeholders for a risk review. To gather field-level insights on risks and implementation challenges, consultation group work with frontline staff, the Self-Help Group, and the Community Outreach Group can also be arranged. This approach may contribute towards greater accountability as well.

Thematic Area: Inclusiveness
Recommendation 9.a: ANGOs should continue to promote gender equality in camp decision-making and governance structures by including women in community forums and committees as well as advocating for gender inclusion in camp governance structures through relevant sectors, including site management, and by sensitizing the community so that women's leadership is increasingly accepted. **Recommendation 9.b:** ANGOs should have age-, sex- and disability-disaggregated targets at output indicator levels. **Recommendation 9.c:** ANGOs need to undertake capacity development initiatives for their personnel and for beneficiaries with disability. Each ANGO should build up technical expertise; for example, by learning how to identify people with disability or how to best communicate with people with disability (such as by using sign language). Due to the limited presence of effective OPDs at the camps, ANGOs should pursue alternative means of empowering people with disability by forming and facilitating committees and forums for people with disability. Supporting these committees, enhancing their capacity and leadership, and connecting them with camp authorities could lay the foundations for meaningful engagement with people with disability.

Recommendation 9.d: Technical organizations need to conduct thorough assessments to identify people with disability across the regions of AHP interventions. ANGOs should use the Washington Group Short Set questions on functioning to identify people with disability. ANGOs can seek technical support on using these questions from technical organizations such as CBM.

Recommendation 9.e: ANGOs should continue to focus on disability inclusiveness by having disability-targeted outcomes and making assessments and improvements at the organizational policy and human resources level, program level, and service delivery level.

Recommendation 9.f: Some shelters of people with disability are located deep inside the camps. There is a need for advocacy with Camp-in-Charges, site management, and other actors to bring these shelters to areas of level ground and close to camp entrances. However, people with disability should always be consulted first as they have the right to live wherever they choose. Moreover, adequate lighting as well as an adequate number of toilets and bathing spaces around their shelters must be ensured.

Thematic Area: Sector-related Recommendations

Recommendation 10.a: AHP, DFAT and ANGOs should pay greater attention to early childhood development and adolescent and youth education inside the camps since there are currently not enough interventions to meet the needs of these groups.

Recommendation 10.b: Traditional social norms, such as acceptance of early marriage, are deep-rooted in the Rohingya communities; therefore, continuous work on awareness development will be required. At the same time, while community recognition of physical violence against women as GBV is increasing, mental and psychological abuse is not understood to be GBV by the community. ANGOs working on protection should address these issues as well. In addition to these, inter-sectoral coordination on GBV issues could engender better understanding across project staff working in different sectors.

Recommendation 10.c: The role of adolescent and adult males in SRH and protection of women is extremely important. ANGOs working on health and protection should adequately include these groups in their program activities. To strengthen and encourage their participation, ANGOs could:
- Engage these groups in door-to-door outreach activities related to SRH and protection.
- Incentivise participants for greater participation by arranging entertainment activities.
- Involve religious and community leaders.
- Integrate relevant lessons for adolescents in learning centers and for teachers in teacher learning centers.

Recommendation 10.d: ANGOs should work on better communication and trust-building with a view to encouraging Rohingya beneficiaries to seek health care from proper health facilities as well as to create awareness of the downsides of taking health services from unqualified practitioners. ANGOs should also consider initiating hepatitis C and thalassemia treatment for Rohingya beneficiaries.

Recommendation 10.e: ANGOs need greater engagement with Camp-in-Charges and local authorities when conducting needs assessments and at the project design stage so that humanitarian organizations and government stakeholders are on the same page regarding the needs of the affected communities. This may lead to greater coherence and expedite the approvals process.

Recommendation 10.f: To ensure WASH facilities are not damaged, stolen, or used by individuals for private benefit, ANGOs working in WASH should increase their monitoring activities and engage nearby communities to share the responsibilities of management.

Thematic Area: Recommendations for DFAT in Similar Humanitarian Crises

Recommendation 11: A key lesson of the Phase II evaluation is that, in humanitarian contexts that are similar to the Rohingya response, it is important to transition to multi-year funding after the immediate response phase. The one-year timeframe for Phase II was hampered by delays and interruptions in service, and it meant that Phase II mainly focused on delivering short-term humanitarian assistance to affected communities. It is understood that DFAT is now providing multi-year funding for the AHP response in Bangladesh. This recommendation therefore endorses this revised approach and encourages the use of relevant learnings from this evaluation of the Phase II response to inform the multi-year Phase III response.

Annexes

A. Evaluation Rubric

1. RELEVANCE

Evaluation Questions (with subsets)	Standards			
	Satisfactory		Unsatisfactory	
	Excellent	Good	Less than Adequate	Poor
Key Evaluation Question: Was the response appropriate and relevant?				
Sub-Evaluation Questions (Probing questions)				
a) To what extent were the activities selected appropriate?	There is strong evidence that demonstrates the activities are consistent with the overarching needs assessments conducted.	There is considerable evidence that demonstrate the activities are consistent with the overarching needs assessments conducted.	There is weak evidence that demonstrates the activities are consistent with the overarching needs assessments conducted.	There is almost no evidence that demonstrates the activities are consistent with the overarching needs assessments conducted.
b) How well did the NGOs and their partners respond to needs assessment information provided as needs have changed?	There is strong evidence that demonstrates the response displayed very good flexibility in adapting to changes effectively all the time.	There is considerable evidence that demonstrates the response displayed flexibility in adapting to changes effectively most of the time.	There is little evidence, or the evidence demonstrates that the response displayed very little flexibility in adapting to changes effectively.	There is no evidence, or the evidence demonstrates that the response was not able to adapt in response to changes in the context.
c) How relevant and appropriate was the assistance provided by Australian implementing partners from the perspective of affected communities?	Almost all (81%–100%) beneficiaries reported that the response was relevant and appropriate to their needs.	Well above half (66%–80%) of the beneficiaries reported that the response was relevant and appropriate to their needs	About half (41%–65%) of the beneficiaries reported that the response was relevant and appropriate to their needs	Almost none (0%–40%) of the beneficiaries reported that the response was relevant and appropriate to their needs

2. EFFECTIVENESS

Evaluation Questions (with subsets)	Standards			
	Satisfactory		Unsatisfactory	
	Excellent	Good	Less than Adequate	Poor
Key Evaluation Question: Was the response effective?				
Sub-Evaluation Questions (Probing questions)				
a) How clearly defined were the intended outputs and outcomes for the AHP response?	The response had end-of-investment output and outcomes statements that were clear, realistic, and measurable and met all aspects of the DFAT standard.	The response had end-of-investment outputs outcome statements that met almost all aspects of the DFAT standard.	The investment had end-of-investment outcomes statements that met few aspects of the DFAT standard.	The investment had end-of-investment outcomes statements that did not meet the DFAT standard.
	There is strong evidence that demonstrates the response achieved all of	There is considerable evidence to demonstrate that the response achieved	The evidence is weak, or it demonstrates that the response achieved few of	There is no evidence, or the evidence demonstrates that the response did not meet

b) To what extent were intended outcomes achieved	the intended end-of-investment outcomes.	almost all of the intended end-of-investment outcomes.	the intended end-of-investment outcomes.	any of the intended end-of-investment outcomes.
	Almost all (81%–100%) beneficiaries are satisfied in line with response activities, consistent with the end of response outcomes.	Well above half (61%–80%) of the beneficiaries are satisfied in line with response activities, consistent with the end of response outcomes.	About half (41%–60%) of the beneficiaries are satisfied in line with response activities, consistent with the end of response outcomes.	Almost none (0%–40%) of the beneficiaries are satisfied in line with response activities.
c) Did any unintended outcomes eventuate, either negative or positive? How responsive were the agencies when any unintended outcome occurred?	N/A			
d) What were the barriers and enablers to effective and efficient program design and achievement of the outcomes?	N/A			
e) To what extent did Australian-funded activities promote longer-term resilience[156] of affected communities and support broader recovery and stabilization efforts?	There is strong evidence that the activities promoted enhanced social cohesion between and within Rohingya and host communities by improving understanding and relationship, fostering durable life skills and strengthening market linkages[157].	There is considerable evidence that the activities enhanced social cohesion between and within Rohingya and host communities by improving understanding and relationship, fostering durable life skills and strengthening market linkages.	The evidence is weak, or it demonstrates the response has very few examples of enhancing social cohesion between and within Rohingya and host communities by improving understanding and relationship, fostering durable life skills and strengthening market linkages.	There is no evidence that the activities enhanced social cohesion between and within Rohingya and host communities by improving understanding and relationship, fostering durable life skills and strengthening market linkages.
	There is strong evidence that owing to the response, affected communities are more prepared to respond to climate change adaptation and disaster risk reduction efforts and there has been improvement to programs	There is considerable evidence that owing to the response, affected communities are more prepared to respond to climate change adaptation and disaster risk reduction efforts and there has been	The evidence is weak, or it demonstrates the response has very negligible contribution towards affected communities being more prepared to respond to climate change adaptation and	There is no evidence that owing to the response, affected communities are more prepared to respond to climate change adaptation and disaster risk reduction efforts.

[156] Resilience was assumed to be a composition of three factors in line with the Joint Response Plan 2020, the AHP Phase III design document and DFAT's thematic priority as detailed on the DFAT website:
- The first two factors (social cohesion and climate change/disaster risk adaptation) were extracted from both the AHP Phase III design document and JRP 2020.
- The third factor, that is, *private sector engagement* was extracted from DFAT's thematic priority narrative which states: '*We (DFAT) will find ways to encourage greater investment by businesses in disaster-prone and crisis-affected regions **to promote resilience** through economic activity.*'

Moreover, as per the FAQC document, private sector engagement is a priority policy area that **must** be considered in aid quality checking.

[157] This refers to livelihood/cash opportunities for Rohingya beneficiaries and how their economic activities can be linked with the broader market system in Cox's Bazar where they are hosted.

	and infrastructure to mitigate spread of disease[158].	improvement to programs and infrastructure to mitigate spread of disease.	disaster risk reduction efforts. There has been almost no improvement to programs and infrastructure to mitigate spread of disease.	There has been no improvement to programs and infrastructure to mitigate spread of disease.
	There is strong evidence that the response could encourage greater investment by private sector businesses in the crisis-affected regions to promote resilience through economic activity, draw on the additional capacity offered by private sector partners; and promote innovation.	There is considerable evidence that the response could encourage greater investment by businesses in the crisis-affected regions to promote resilience through economic activity, draw on the additional capacity offered by private sector partners; and promote innovation.	There is weak evidence that the response could encourage greater investment by businesses in the crisis-affected regions to promote resilience through economic activity, draw on the additional capacity offered by private sector partners; and promote innovation.	There is no evidence that the response could encourage greater investment by businesses in the crisis-affected regions to promote resilience through economic activity, draw on the additional capacity offered by private sector partners; and promote innovation.
f) How adequate were the NGO's M&E practices to measure outcomes, and to enable them to assess the effectiveness and inclusion of their response	There is strong evidence of a very good quality M&E plan meeting all of DFAT's M&E standards including triangulation to ensure data quality, routinely tracked performance against the baseline[159], reaching the most marginalized as part of the M&E system and collecting data on priority thematic areas under FAQC matrix such as climate and disaster risks, gender equality, disability, etc.	There is considerable evidence of a very good quality M&E plan meeting almost all of DFAT's M&E standards including triangulation to ensure data quality, routinely tracked performance against the baseline, reaching the most marginalized as part of the M&E system and collecting data on priority thematic areas under FAQC matrix such as climate and disaster risks, gender equality, disability, etc.	There is negligible or weak evidence of a very good quality M&E plan meeting all of DFAT's M&E standards including triangulation to ensure data quality, routinely tracked performance against the baseline, reaching the most marginalized as part of the M&E system and collecting data on priority thematic areas under FAQC matrix such as climate and disaster risks, gender equality, disability, etc.	There is no evidence of a very good quality M&E plan meeting all of DFAT's M&E standards including triangulation to ensure data quality, routinely tracked performance against the baseline, reaching the most marginalized as part of the M&E system and collecting data on priority thematic areas under FAQC matrix such as climate and disaster risks, gender equality, disability, etc.
	There is strong evidence that demonstrates there was a very good degree of attention to the use of performance information to support management decision-making, learning and reporting on all investment outcomes.	There is considerable evidence that demonstrates there was a good degree of attention to the use of performance information to support management decision-making, learning and reporting on almost all investment outcomes.	The evidence is weak, or it demonstrates there were some examples of the use of performance information for management decision-making but, overall, there was little attention to uses other than for reporting.	There is no evidence, or the evidence demonstrates that no attention was given to obtaining performance information.
	There is strong evidence that demonstrates optimal budget (4-7% total	There is considerable evidence that demonstrates almost all of the budgetary	The evidence is weak, or it demonstrates there was little budget made available for M&E.	There is no evidence, or the evidence demonstrates that there was no

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[158] This is important to add in the context of COVID-19.
[159] FAQC suggests inclusion of this indicator that: whether very good-quality baseline data was collected in respect of all investment outcomes and performance was routinely tracked against the baseline.

	budget[160]) was available and used to implement the M&E system.	requirements to implement the M&E system were met.		dedicated budget for M&E.
g) What are the existing strengths and weaknesses of each of the NGO projects as relevant to the inception deliverables for the Phase III response - e.g. in regard to M&E, localization, disability inclusion, and gender inclusion?	N/A			
h) How effectively did the NGOs report and manage risk, fraud and corruption?	There is strong evidence that risks were well managed with controls being effective at reducing the likelihood of the risks occurring or reducing the consequence of the risk when it occurred; partners were involved in the review of risks, and on a regular basis.	There is considerable evidence that risks were adequately managed with controls being effective at reducing the likelihood of the risks occurring or reducing the consequence of the risk when it occurred; partners were involved in the review of risks, and on a regular basis.	There is weak evidence, or the evidence demonstrates that risks were documented in a risk register, but controls were implemented or were ineffective at reducing the likelihood of risks occurring, or reducing the consequence of the risk; partners did not engage in the risk review process in a regular manner.	There is no evidence, or the evidence demonstrates that there were no formal risk management processes, or the implementing partner managed all the risks; partners did not engage in the risk review process at all.
	There is evidence of strong measures in place to prevent, detect and deal with fraud, corruption, trafficking[161] (drug or human) or terrorism financing. No case of fraud or corruption reported by partners and beneficiaries.	There is evidence of good measures in place to prevent, detect and deal with fraud, corruption, trafficking (drug or human) or terrorism financing. Very few cases of fraud or corruption reported by partners and beneficiaries.	There is evidence that there were less than adequate measures in place to prevent, detect and deal with fraud, corruption, trafficking (drug or human) and terrorism financing leading to failure in preventing major fraud and corruption cases.	There is no evidence, or the evidence demonstrates that investment had no measures in place to prevent, detect and deal with fraud, corruption, trafficking (drug or human) and terrorism financing, many cases of fraud or corruption reported by the partners and beneficiaries.

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[160] Range mentioned in the FAQC document

[161] In the context of Rohingya response, drug and human trafficking is a comparatively high prevalent risk

3. EFFICIENCY

Evaluation Questions (with subsets)	Standards			
	Satisfactory		Unsatisfactory	
	Excellent	**Good**	**Less than Adequate**	**Poor**
Key Evaluation Question: How efficient was the response?				
Sub-Evaluation Questions (Probing questions)				
a) To what extent was the response implemented according to agreed timelines, resources, coverage area and budgets?	There is strong evidence that the response made very good use of available time and resources in relation to all end-of-investment outcomes.	There is considerable level of evidence that demonstrates the investment made good use of available time and resources in relation to almost all end-of-investment outcomes.	The evidence is weak, or it demonstrates that the investment made less than adequate use of time and resources in key areas.	There is no evidence, or the evidence demonstrates that the investment made very poor use of time and resources.
	There is strong evidence that the programmatic approach, operational process and budget underwent regular review to improve efficiency.	There is considerable evidence that the programmatic approach, operational process and budget underwent regular review to improve efficiency.	There is strong evidence that the programmatic approach, operational process and budget underwent regular review to improve efficiency.	There is strong evidence that the programmatic approach, operational process and budget underwent regular review to improve efficiency.
b) To what extent did the response achieve good value for money?	There is strong evidence that demonstrates the governance and management arrangements were very good, or very efficient overall.	There is considerable level of evidence that demonstrates the governance and management arrangements were good, or efficient overall.	There is little evidence, or the evidence demonstrates that the governance and management arrangements had major limitations from efficiency point of view.	There is no evidence, or the evidence demonstrates that the governance and management arrangements were very poor.
	Financial records demonstrate no deviation in the budget; all funds were very well managed over the life of the investment.	Financial records demonstrate a limited deviation in the budget; budget deviations were dealt with by routine operations; funds were well managed over the life of the investment.	Financial records demonstrate a moderate deviation in the budget, planned expenditure or timelines which threatened implementation and value for money.	Financial records demonstrate a stark deviation in budget, which seriously undermined implementation and value for money.
	There is strong evidence of 'development innovation[162]' whereby the response deployed innovative, non-traditional approaches helping to achieve good value for money.	There is considerable evidence of 'development innovation' whereby the response deployed innovative, non-traditional approaches helping to achieve good value for money.	There is little evidence of 'development innovation' whereby the response deployed innovative, non-traditional approaches helping to achieve good value for money.	There is no evidence of 'development innovation' whereby the response deployed innovative, non-traditional approaches helping to achieve good value for money.

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[162] Consideration of innovation is a priority policy area that must be considered in FAQCs. According to the FAQC document, **development innovation** means a **new approach** to an aid investment that has not been trialled within the relevant operating environment before, with the potential to be **cheaper, faster or better** (e.g. more inclusive) which indicates the traits of efficiency/value for money

4. COHERENCE[163]

Evaluation Questions (with subsets)	Standards			
	Satisfactory		Unsatisfactory	
	Excellent	Good	Less than Adequate	Poor
Key Evaluation Question: How Coherent was the response?				
Sub-Evaluation Questions (Probing questions)				
a) To what extent were the project activities coherent with Government priorities, UN response plan and the context of overall humanitarian response?	There is strong evidence that the project activities are coordinated and complementary to those of the government, UN agencies, and other humanitarian actors.	There is considerable evidence that the project activities are coordinated and complementary to those of the government, UN agencies, and other humanitarian actors	There is weak evidence that the project activities are coordinated and complementary to those of the government, UN agencies, and other humanitarian actors	There is low or no evidence that the project activities are coordinated and complementary to those of the government, UN agencies, and other humanitarian actors
b) To what extent did the assistance align with Australia's Humanitarian Strategy and other key Australian government policies/priorities such as gender equality, disability inclusion and other vulnerable groups?	There is strong evidence that all outcomes remained aligned with Australia's policy priorities and national interest over the lifetime of the investment.	There is considerable evidence that all outcomes remained aligned with Australia's policy priorities and national interest over the lifetime of the investment.	The evidence is weak, or it demonstrates that few of the outcomes remained aligned with Australia's policy priorities and national interest over the lifetime of the investment.	There is no evidence, or the evidence demonstrates that the investment was not aligned with Australia's policy priorities and national interest over the lifetime of the investment.

5. INCLUSION

Evaluation Questions (with subsets)	Standards			
	Satisfactory		Unsatisfactory	
	Excellent	Good	Less than Adequate	Poor
Key Evaluation Question: How inclusive was the response?				
Sub-Evaluation Questions (Probing questions)				
a) To what extent were the needs of different groups of people (including age, gender, disability, ethnicity etc.) considered in the design and implementation	There is strong evidence that inclusive measures targeting different genders are evident in all stages of the program cycle (design, implementation, M&E) and are informed by an analysis of the barriers to inclusion in relevant locations/sectors.	There is considerable evidence that inclusive measures targeting different genders are evident in all stages of the program cycle (design, implementation, M&E) and are informed by an analysis of the barriers to inclusion in relevant locations/sectors.	There is weak evidence that inclusive measures targeting different genders are evident in all stages of the program cycle (design, implementation, M&E) and are informed by an analysis of the barriers to inclusion in relevant locations/sectors.	There is no evidence that inclusive measures targeting different genders are evident in all stages of the program cycle (design, implementation, M&E) and are informed by an analysis of the barriers to inclusion in

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[163] This evaluation question considers the consistency of the intervention with other actors' interventions in the same context. This includes complementarity, harmonisation and coordination with others, and the extent to which the intervention is adding value while avoiding duplication of effort.

of the response, including in influence and decision-making roles?				relevant locations/sectors.
	There is strong evidence that inclusive measures targeting people with disability are evident in all stages of the program cycle (design, implementation, M&E) and are informed by an analysis of the barriers (including attitudinal, environmental and institutional barriers that prevent people with disability from accessing humanitarian programs and services) in relevant locations/sectors.	There is considerable evidence that inclusive measures targeting people with disability are evident in all stages of the program cycle (design, implementation, M&E) and are informed by an analysis of the barriers (including attitudinal, environmental and institutional barriers that prevent people with disability from accessing humanitarian programs and services) in relevant location/sectors.	There is weak evidence that inclusive measures targeting people with disability are evident in all stages of the program cycle (design, implementation, M&E) and are informed by an analysis of the barriers (including attitudinal, environmental and institutional barriers that prevent people with disability from accessing humanitarian programs and services) in relevant locations/sectors.	There is no evidence that inclusive measures targeting people with disability are evident in all stages of the program cycle (design, implementation, M&E) and are informed by an analysis of the barriers (including attitudinal, environmental and institutional barriers that prevent people with disability from accessing humanitarian programs and services) in relevant locations/sectors
	There is strong evidence that people with disability and DPOs were enabled to engage in identification of barriers to inclusion, and to participate in decision making and implementation processes in all stages of the program cycle.	There is considerable evidence that people with disability and DPOs were enabled to engage in identification of barriers to inclusion, and to participate in decision making and implementation processes in all stages of the program cycle.	There is weak evidence that people with disability and DPOs were enabled to engage in identification of barriers to inclusion, and to participate in decision making and implementation processes in all stages of the program cycle.	There is no evidence that people with disability and DPOs were enabled to engage in identification of barriers to inclusion, and to participate in decision making and implementation processes in all stages of the program cycle.
	Almost all (81%–100%) of the female beneficiaries report that the intervention was tailored to their unique needs.	Well above half (61%–80%) of the female beneficiaries report that the intervention was tailored to their unique needs.	About half (41%–60%) of the female beneficiaries report that the intervention was tailored to their unique needs.	Almost none (0%–40%) of the female beneficiaries report that the intervention was tailored to their unique needs.
	Almost all (81%–100%) of the people with disability beneficiaries report that the intervention was tailored to their unique needs.	Well above half (61%–80%) of the people with disability beneficiaries report that the intervention was tailored to their unique needs.	About half (41%–60%) of the people with disability beneficiaries report that the intervention was tailored to their unique needs.	Almost none (0%–40%) of the people with disability beneficiaries report that the intervention was tailored to their unique needs.
	There is strong evidence that appropriate strategies for gender equality and protecting the safety, dignity and rights of women and girls were in	There is considerable evidence that appropriate strategies for gender equality and protecting the safety, dignity and rights of	The evidence is weak, or it demonstrates that the response implemented very few activities for protecting the safety, dignity and rights of	There is little or no evidence, or it demonstrates several major gaps i.e. no strategy for promoting gender

b) What did the AHP investment achieve in terms of protecting the safety, dignity and rights of women and girls and promoting gender equality?	place and clearly stated within the program's documentation with strong evidence that strategies achieved all intended outcomes.	women and girls were in place and clearly stated within the program's documentation with strong evidence that strategies achieved almost all intended outcomes.	women and girls and promoting gender equality and these were not linked to a coherent programmatic strategy or implementation plan.	equality or protecting the safety, dignity and rights of women and girls, and no programming for gender results.
	Almost all (81%–100%) female beneficiaries reported positive changes in their lives in terms of safety, dignity and ability to exercise equal rights due to the response.	Well above half (61%–80%) of the female beneficiaries reported positive changes in their lives in terms of safety, dignity and ability to exercise equal rights due to the response.	About half (41%–60%) of the female beneficiaries reported positive changes in their lives in terms of safety, dignity and ability to exercise equal rights due to the response.	Almost none (0%–40%) of the female beneficiaries reported positive changes in their life in terms of safety, dignity and ability to exercise equal rights due to the response.
	There is strong evidence local partners and beneficiary organizations increasingly prioritize the rights of women and girls and have taken action on inclusive programming in their own policies and practices.	There is considerable evidence that demonstrates an improved awareness, capacity, or ownership of local partners or beneficiary organizations on prioritizing the rights of women and girls in their own policies and practices.	The evidence is weak, or it demonstrates few examples where local partners or beneficiary organizations have been influenced positively on prioritizing the rights of women and girls in their own policies and practices.	There is no evidence, or the evidence demonstrates local partners or beneficiary organizations did not have a commitment or capacity for gender equality outcomes as expected.
c) What did the AHP investment achieve in terms of addressing barriers to inclusion for people with disabilities so that they can benefit equally from the aid investment?	There is strong evidence that appropriate strategies for addressing barriers (including attitudinal, environmental and institutional) to inclusion for people with disabilities were in place and clearly stated within the program's documentation with strong evidence that strategies achieved all intended outcomes.	There is considerable evidence that appropriate strategies for addressing barriers (including attitudinal, environmental and institutional) to inclusion for people with disabilities were in place and clearly stated within the program's documentation with strong evidence that strategies achieved almost all intended outcomes.	The evidence is weak, or it demonstrates that the response implemented very few activities for addressing barriers (including attitudinal, environmental and institutional) to inclusion for people with disabilities and these were not linked to a coherent programmatic strategy or implementation plan.	There is no evidence, or it demonstrates several major gaps i.e., no strategy for addressing the barriers (including attitudinal, environmental and institutional) to inclusion of people with disabilities.
	Almost none (0%–5%) of the beneficiaries with a disability report feeling unsafe accessing assistance.	Few beneficiaries (6%–15%) with a disability report feeling unsafe accessing assistance.	Some of the beneficiaries (16%–30%) with a disability report feeling unsafe accessing assistance.	A lot of beneficiaries (31%–100%) with a disability report feeling unsafe accessing assistance.
	There is strong evidence that the program engages quality disability inclusion expertise which has led to improvements in the quality and scope of the investment's outputs and	There is considerable evidence that the program engages quality disability inclusion expertise which has led to improvements in the	There is weak evidence that the program engages quality disability inclusion expertise which has led to improvements in the quality and scope of the investment's outputs. The	There is no evidence that the program engages quality disability inclusion expertise which has led to improvements in the quality and

facilitated learning opportunities for the Implementing partners.	quality and scope of the investment's outputs and facilitated learning opportunities for the Implementing partners.	implementing partners did not have access to sufficient expertise on disability inclusion and thus learning was not facilitated.	scope of the investment's outputs. The implementing partners did not have access to sufficient expertise on disability inclusion and thus learning was not facilitated.

6.   LOCAL CAPACITY/LEADERSHIP

Evaluation Questions (with subsets)	Standards			
	Satisfactory		Unsatisfactory	
	Excellent	Good	Less than Adequate	Poor
Key Evaluation Question: Did the response reinforce local capacity/leadership?				
Sub-Evaluation Questions (Probing questions)				
a) To what extent did the AHP investment support and strengthen local partners, including civil society and local government, and include their participation in coordination fora?	Almost all Women's organizations, DPOs, and government stakeholders feel that they are able to constructively influence the program, and evidence is available as to where this has happened.	Some women's organizations, DPOs and government stakeholders feel that they are able to constructively. influence the program, and evidence is available as to where this has happened.	Women's organizations, DPOs, and government stakeholders feel that they are limitedly able to constructively influence the program, and limited evidence is available as to where this has happened.	Women's organizations, DPOs, and government stakeholders feel that. they are not able to influence the program.
	Women's organizations, DPOs, and government stakeholders' internal capacity has been very strongly strengthened through the program.	Women's organizations, DPOs, and government stakeholders 'internal capacity has been considerably strengthened through the program.	Women's organizations, DPOs, and government stakeholders' internal capacity has been limitedly strengthened through the program.	Women's organizations, DPOs, and government stakeholders' internal capacity has not been strengthened. through the program.
b) What evidence is there of local involvement in the planning, management and implementation of the response, including in influencing and decision-making roles?	There is strong evidence that demonstrates involvement of diverse local stakeholders in the planning, management and implementation of the response, including in influencing and decision-making roles	There is considerable evidence that demonstrates involvement of diverse local stakeholders in the planning, management and implementation of the response, including in influencing and decision-making roles	The evidence is weak, or it demonstrates that participation of diverse local stakeholders in the planning, management and implementation of the response was weak	There is no evidence that demonstrates involvement of diverse local stakeholders in the planning, management and implementation of the response
	There is strong evidence that demonstrates a very high level of ownership of the response by local partners and beneficiaries	There is considerable evidence that demonstrates a high level of ownership of the investment by local partners and beneficiaries	The evidence is weak, or it demonstrates that local Partner and beneficiary ownership were weak	There is no evidence, or the evidence demonstrates that the investment did not encourage ownership by partners and beneficiaries

c) Is there any evidence of greater collaboration by AHP NGOs with the local partners beyond AHP programming as an outcome of the partnership created during the response?	N/A
d) What factors or barriers exist that hinder local capacity/leadership?	N/A

7.   TRANSPARENCY AND ACCOUNTABILITY

Evaluation Questions (with subsets)	Standards			
	Satisfactory		Unsatisfactory	
	Excellent	Good	Less than Adequate	Poor
Key Evaluation Question: How transparent and accountable was the response?				
Sub Evaluation Questions (Probing questions)				
a) To what extent were implementing partners sufficiently accountable to, and engaged with, affected communities?	Almost all (81%–100%) beneficiaries report being able to provide input on the services they received.	Well above half (66%–80%) of the beneficiaries report being able to provide input on the services they received.	About half (41%–65%) of the beneficiaries report being able to provide input on the services they received.	Almost none (0%–40%) of the beneficiaries report being able to provide input on the services they received.
b) What evidence exists of programs having been influenced by effective communication, participation and feedback from affected people and communities?	All program partners have effective feedback mechanisms in place and analyze data coming from these mechanisms regularly. There is strong evidence that data from feedback mechanisms have been used to make programmatic changes.	All program partners have feedback mechanisms in place and analyze data coming from these mechanisms. There is some evidence that data from feedback mechanisms have been used to make programmatic changes.	All program partners have feedback mechanisms in place, but data from these mechanisms are only limitedly analyzed. There is limited evidence that data from feedback mechanisms have been used to make programmatic changes.	Not all program partners had feedback mechanisms in place and data was not analyzed.

8. LEARNING FROM COVID-19 RESPONSE

Evaluation Questions (with subsets)	Standards			
	Satisfactory		Unsatisfactory	
	Excellent	Good	Less than Adequate	Poor
Key Evaluation Question: What can be learned from the agencies' early work in relation to COVID-19?				
Sub-Evaluation Questions (Probing questions)				
a) To what extent have the agencies integrated COVID-19 considerations effectively into their response?	There is strong evidence that the agencies integrated COVID-19 considerations in adapting their programs, system and infrastructure.	There is considerable evidence that the agencies integrated COVID-19 considerations in adapting their programs, system and infrastructure.	There is little evidence that the agencies integrated COVID-19 considerations in adapting their programs, system and infrastructure.	There is no evidence that the agencies integrated COVID-19 considerations in adapting their programs, system and infrastructure.
	Almost all (81%–100%) of the beneficiaries are satisfied with the way COVID-19 considerations have been incorporated in the response.	Well above half (61%–80%) of the beneficiaries are satisfied with the way COVID-19 considerations have been incorporated in the response.	About half (41%–60%) of the beneficiaries are satisfied with the way COVID-19 considerations have been incorporated in the response.	Almost none (0%–40%) of the beneficiaries are satisfied with the way COVID-19 considerations have been incorporated in the response.
b) What are the early successes, challenges and lessons regarding integrating COVID-19 that could help to inform the agencies' response in Phase III?	N/A			
c) To what extent did the agencies' COVID-19 assistance align with the Australian Government's COVID-19 Aid Strategy, 'Partnership for Recovery: Australia's COVID-19 Development Response'?	There is strong evidence that the agencies' COVID-19 assistance aligns with the Australian Government's COVID-19 Aid Strategy.	There is considerable evidence that the agencies' COVID-19 assistance aligns with the Australian Government's COVID-19 Aid Strategy.	There is little evidence that the agencies' COVID-19 assistance aligns with the Australian Government's COVID-19 Aid Strategy.	There is no evidence that the agencies' COVID-19 assistance aligns with the Australian Government's COVID-19 Aid Strategy.

B. Snapshot of Survey Data

Save the Children = 167   CARE = 76   Oxfam = 139   Inclusive Communities = 382

World Vision = 79   Plan International = 120   Total = 581

Questions	Response	Save the Children	CARE	Oxfam	Inclusive Communities	World Vision	Plan International	Total
Rate your level of satisfaction in line with the activities of the NGOs.	Good	85%	89%	98%	90%	89%	100%	92%
	Moderate	12%	11%	1%	8%	9%	0%	7%
	Bad	3%	0%	1%	2%	3%	0%	1%
Rate your level of relevance to your needs in line with the activities of the NGOs.	Good	84%	92%	97%	90%	89%	96%	91%
	Moderate	13%	8%	2%	8%	9%	4%	7%
	Bad	3%	0%	1%	2%	3%	0%	1%
Do the NGO and Implementing agencies take opinion from you and your communities to know your priority needs before providing support?	Yes	87%	91%	96%	91%	94%	96%	92%
	No	10%	5%	2%	6%	3%	4%	5%
	Don't know	4%	4%	2%	3%	4%	0%	3%
Did you see the NGOs take any action as a result?	Yes	84%	83%	94%	87%	80%	93%	87%
	No	11%	8%	6%	9%	10%	4%	8%
	Don't know	5%	9%	1%	4%	10%	3%	5%
Do you think the support from the NGO met your/your community's priority needs?	Entirely	50%	59%	79%	63%	57%	54%	60%
	Only a little	4%	5%	2%	3%	10%	1%	4%
	Mostly	45%	36%	19%	34%	33%	45%	36%
	No inititive	1%	0%	0%	1%	0%	0%	0%

Questions	Response	Save the Children	CARE	Oxfam	Inclusive Communities	World Vision	Plan International	Total
Do you believe the NGO considers equal participation of male and female to provide support?	Entirely	92%	87%	95%	92%	96%	89%	92%
	Moderate	8%	12%	4%	7%	4%	11%	8%
	Only a little	1%	0%	0%	0%	0%	0%	0%
	Not at all	0%	1%	1%	1%	0%	0%	0%
Do you believe the NGO considers the concerns and needs of people with disabilities to provide support?	Entirely	67%	68%	88%	75%	86%	36%	69%
	Moderate	19%	30%	11%	18%	10%	25%	18%
	Only a little	8%	0%	1%	4%	1%	18%	7%
	Not at all	6%	1%	0%	3%	3%	21%	7%
State your agreement with the following statements regarding the support provided by NGOs (multiple):/The services were of good	Yes	85%	74%	91%	85%	65%	89%	83%
	No	15%	26%	9%	15%	35%	11%	17%
State your agreement with the following statements regarding the support provided by NGOs (multiple):/The services were provided in	Yes	77%	75%	58%	70%	71%	86%	73%
	No	23%	25%	42%	30%	29%	14%	27%
State your agreement with the following statements regarding the support provided by NGOs (multiple):/The services provided were	Yes	75%	80%	57%	69%	76%	96%	76%
	No	25%	20%	43%	31%	24%	4%	24%
State your agreement with the following statements regarding the support provided by NGOs (multiple):/Staff of the service providers	Yes	81%	87%	65%	76%	91%	98%	83%
	No	19%	13%	35%	24%	9%	2%	17%
Do you think AHP responses helped you and your community to maintain cooperative relationships with _____ communities?	Yes, between Rohingya & Host Communities	56%	57%	37%	49%	54%	83%	57%
	Yes, only within the Rohingya Community	38%	37%	58%	45%	39%	8%	36%
	No, no initiative	6%	6%	5%	6%	7%	9%	7%

Questions	Response	Save the Children	CARE	Oxfam	Inclusive Communities	World Vision	Plan International	Total
Do you think you and your community became more conscious and prepared for the natural disasters after receiving training/attending awareness programs of AHP?	Yes	97%	95%	99%	97%	97%	96%	97%
	Moderate	3%	4%	1%	3%	1%	3%	3%
	Don't know	0%	1%	0%	0%	1%	1%	1%
Do you feel safe in getting assistance from the NGO?	Yes	92%	93%	91%	92%	94%	99%	94%
	Moderate	5%	4%	7%	5%	3%	1%	4%
	Not at all	3%	0%	1%	2%	0%	0%	1%
	Don't know	0%	3%	0%	1%	4%	0%	1%
Do you feel your lives are better, compared to 2019?	Very good	59%	70%	88%	71%	61%	63%	68%
	Moderately good	28%	20%	7%	19%	20%	25%	20%
	No change	7%	8%	3%	5%	10%	1%	5%
	Bad	7%	3%	2%	4%	9%	11%	6%
Do you think the support from the NGO meets the special social needs of women and girls?	Yes	84%	93%	92%	89%	94%	94%	91%
	Moderate	8%	4%	5%	6%	6%	6%	6%
	Not at all	0%	1%	1%	1%	0%	0%	0%
	Don't know	7%	1%	2%	4%	0%	0%	3%
Do you feel safer now, compared to 2019?	Yes	92%	91%	98%	94%	94%	98%	95%
	Moderate	7%	9%	2%	5%	6%	2%	5%
	Not at all	1%	0%	0%	1%	0%	1%	1%
Do you think you and your community are more aware about your rights after getting support from AHP?	Yes	99%	99%	100%	99%	92%	94%	97%
	No	1%	0%	0%	1%	1%	1%	1%
	Don't know	0%	1%	0%	0%	6%	5%	2%
What changes have occurred in your ability to exercise your rights after getting support from the NGOs?	Yes	92%	88%	96%	93%	90%	93%	92%
	Moderate	5%	7%	4%	5%	5%	3%	5%
	Don't know	2%	5%	0%	2%	5%	4%	3%

C. List of Interviewees

Key Informant Interviews with ANGOs, Local Partners and Sector Coordinators

Organization	Designation	Date	Modality
Humanity & Inclusion	Deputy Project Manager	28 December	Remote
Save the Children	Focal Person	30 December	Remote
Oxfam	Public Health Engineer	4 January	Remote
World Vision	Project Manager	6 January	Remote
Humanity & Inclusion	Deputy Project Manager	7 January	Remote
Save the Children	M&E Personnel	24 January	Remote
Humanity & Inclusion	MEAL Officer	19 January	Remote
World Vision	M&E Personnel	24 January	Remote
Oxfam	M&E Personnel	09 January	Remote
Oxfam	Protection Team Leader	14 January	Remote
CARE	MEAL Coordinator	17 January	Remote
CARE	SRH Program Manager	17 January	Remote
CARE	GBV Sector Lead	17 January	Remote
Humanity & Inclusion	Senior Officer	13 January	On-field
DFAT Post	Humanitarian Adviser	27 January	Remote
DFAT Post	Humanitarian Program Manager	28 January	Remote
Centre for Disability in Development	Inclusion Officer	28 January	Remote
Centre for Disability in Development	Inclusion Officer	28 January	Remote
CBM International	Humanitarian Program Officer	27 January	Remote
Plan International	Project Manager	8 February	Remote
Plan International	Project Coordinator	7 February	Remote
Save the Children	Medical Officer	6 January	On-field
Save the Children	Medical Officer	6 January	On-field
Save the Children	Medical Assistant	12 January	On-field
YPSA	Field Facilitator	7 January	On-field
Humanity & Inclusion	Speech & Language Therapist	11 January	On-field
Shushilan	Project Manager	10 January	On-field
DSK	Team Lead	14 January	On-field
BGS	Focal for WASH Consortium	13 January	On-field

CARE	SRH Coordinator	12 January	On-field
CARE	GBV Coordinator	13 January	On-field
FIVDB	Field Facilitator	14 January	On-field
FIVDB	Project Coordinator	14 January	On-field
CARE	GBV Case Worker	9 February	Remote
CARE	GBV Coordinator	8 February	Remote
Plan International	Accountability Specialist	24 February	Remote
UNICEF	Education Sector Focal	25 February	Remote
WHO	Health Sector Coordinator	22 February	Remote
ACF	WASH Sector Coordinator	25 February	Remote
FIVDB	Project Coordinator	7 February	Remote
Shushilan	WASH Sector Focal	11 January	On-field
GoB Stakeholder (Camp-In-Charge)		8 April	Remote
GoB Stakeholder (RRRC Office)		7 May	Remote

Key Informant Interviews with the Representatives from Beneficiaries

NGO	Beneficiary Group	Gender	Age	Camp
CARE	President, GBV Committee	Male	60	12
Oxfam	Majhi	Male	50	19
Oxfam	President, WASH Committee	Male	50	19
Plan International	Teacher	Male	19	23
Plan International	Committee Member	Male	34	23
Save the Children	Majhi	Male	48	4
Save the Children	Religious Leader	Male	72	18
World Vision	Protection Committee Member	Female	29	13
World Vision	President, WASH Committee	Male	40	19
World Vision	Secretary, Women Watch Committee	Male	33	15
World Vision	Majhi	Male	27	19
World Vision	Member, WASH Committee	Female	35	19

In-depth Interviews with People with Disabilities

NGO	Beneficiary Group	Gender	Age	Camp
Save the Children	Person with Disability	Female	12	10
Save the Children	Person with Disability	Female	6	10
Save the Children	Person with Disability	Male	66	4
Plan International	Person with Disability	Male	17	23
Plan International	Person with Disability / Teacher	Male	34	23
Oxfam	Person with Disability	Male	14	12
World Vision	Person with Disability	Female	30	15
World Vision	Person with Disability	Male	30	15
World Vision	Person with Disability	Male	30	15
World Vision	Person with Disability	Male	27	15

Focus Group Discussions with Beneficiaries

NGO	Beneficiary Group	Gender	Camp
CARE	Awareness Session Participants	Male	13
CARE	Protection Beneficiary	Female	12
Oxfam	Majhi	Male	12
Oxfam	WASH and Protection Beneficiary	Female	19
Plan International	Students	Female	23
Plan International	Committee Member	Male	23
Plan International	Students	Female	23
Save the Children	Beneficiary	Female	18
Save the Children	Caregivers of Children	Female	13
World Vision	Wash Committee Member	Male	19
World Vision	Member, Women Watch Committee	Female	15

D. Field Trip Map
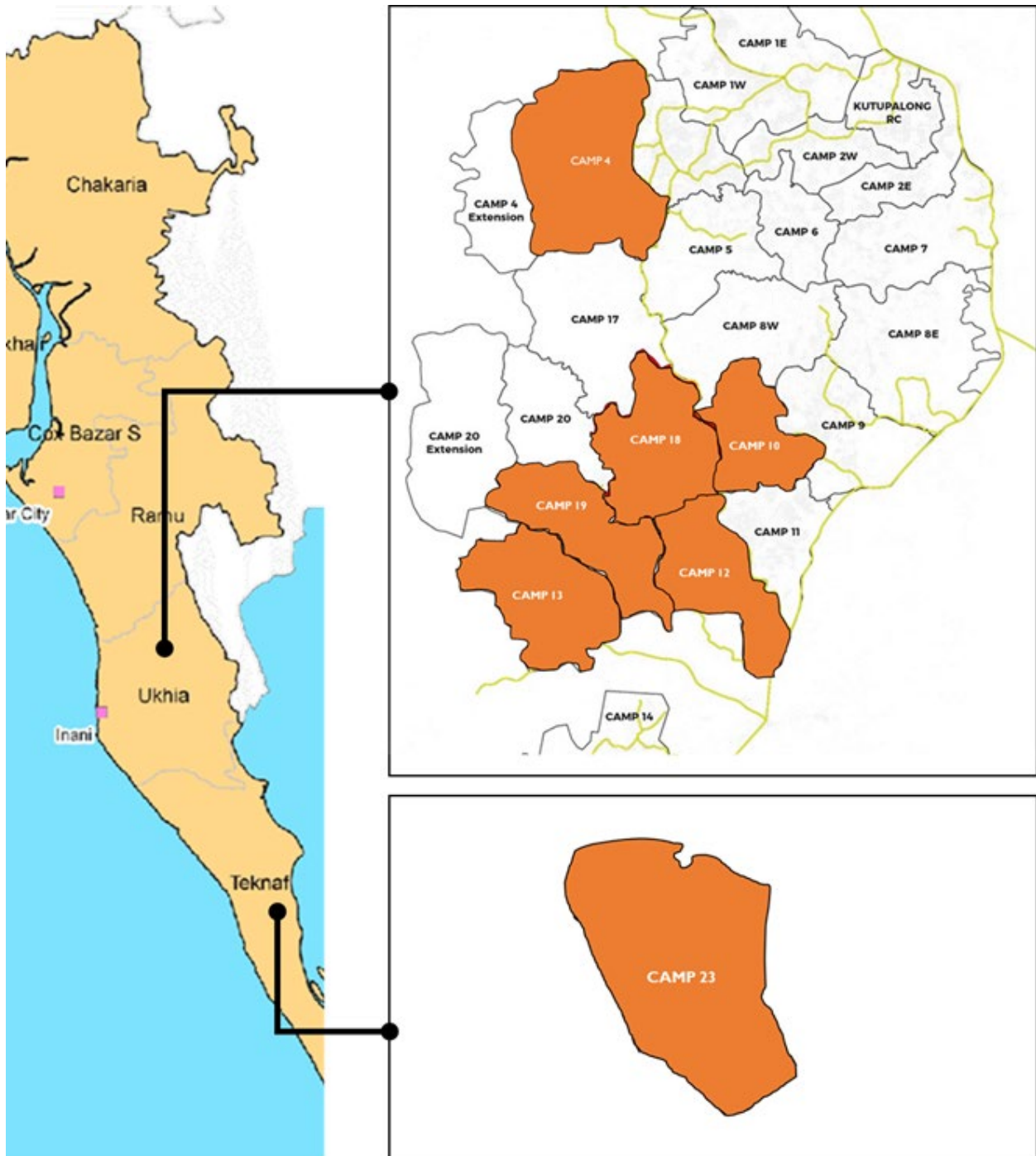
E. Methodology

The evaluation rubric was used as the guiding document for the whole evaluation. The evaluation methodology drew upon both primary and secondary data collection. A mixed method approach was followed – both quantitative and qualitative tools were considered. To operationalize the quantitative study, a household survey was conducted inside the Rohingya camps. According to the proposed sampling strategy, the total sample size was 581, and this sample was proportionally divided into different representative sub-populations and strata. Surveys were conducted by trained local enumerators with a mix of closed-ended and open-ended questions.

Qualitative data was collected through mini-FGDs with beneficiaries as well as KIIs with a representative sample of internal stakeholders (such as ANGOs) and external stakeholders. To add to the rigour of the evaluation, observational and case study tools were used. The evaluation team also undertook extensive desk research to develop the evaluation rubric, to develop data collection tools, and to utilize secondary data sources for accumulating evidence. Key secondary sources included:

1. DFAT's policies and standards;
2. Project documents of ANGOs;
3. Blanket documents, such as those published by different humanitarian organizations in the context of the Rohingya Response; and
4. Other evaluation reports on the humanitarian response.

Data collected from primary and secondary sources was critically analyzed through relevant tools and communicated through key deliverables. Though this was an independently led evaluation, consultations with key stakeholders helped to validate findings and recommendations significantly.

Preparatory Phase

Desk Review: Systematic Review and Meta-analysis

A desk review was instrumental in developing the study tools, identifying key sources, identifying gaps and refining evaluation plans. Key secondary sources were as follows:

Cluster 1: DFAT's Policies and Standards: Various standards, frameworks and guidelines were reviewed to ensure alignment with the Australian Government's (DFAT's) general work vision and global humanitarian standards. These included, but were not limited to:

- DFAT Monitoring and Evaluation Standards
- DFAT Aid Evaluation Policy
- DFAT Aid Programming Guide 2016
- Final Aid Quality Ratings Matrix
- DFAT COVID-19 Aid Strategy: 'Partnerships for Recovery: Australia's COVID-19 Development Response'

Cluster 2: ANGO Project Documents: ANGO project reports helped to build the foundation for an understanding of the AHP response and to guide the evaluation framework and data collection tool preparation. The list of documents reviewed (and which was shared with ANGOs through briefing notes as well) was as follows:

- AHP Activation – Annual Report, AHP Activation – Final Report, AHP Project Implementation Plan, AHP Risk Assessment Register
- Evaluation reports – internal and external
- Policies and action plans, including MEAL plan, gender inclusion action plan, disability inclusion action plan, child-safeguarding policies
- Needs assessment reports and scoping reports (sectoral and multi-sectoral)
- Project Implementation Plans
- Interim and final progress reports
- A summary of the history of the AHP activation and project, including agreed changes
- After Action Reviews and 'lessons learned' exercises
- Post-distribution monitoring reports
- Examples of cost analyses that would have been helpful for the evidence base to answer the evaluation question about cost effectiveness
- Contingency plans/protocols and strategies in response to COVID-19
- Audit reports
- Other documents examining the needs of the affected population and gaps in current humanitarian assistance in Cox's Bazar so as to ensure a broad evidence base for the evaluation

Cluster 3: **Other Documents:** Reports on selected sectors published by various humanitarian organizations, service providers, and relevant Bangladesh government departments were reviewed to reflect broader evidence of the affected communities in the evaluation:

- Joint Response Plans for 2019 and 2020
- Joint Multi-Sector Needs Assessments for 2018 and 2019
- Gender Analysis Reports
- Inter-Sector Coordination Group reports and cluster guidelines
- Reports published by the Bangladesh Department of Disaster Management, National Plan for Disaster Management, annual constituency budget, and other sectoral planning documents of local government bodies/line ministries

Cluster 4: Reference Documents: Some reference documents were followed in the design of the evaluation plan for the purpose of maintaining globally accepted standards and practices in evaluating humanitarian actions. Two documents shared by AHP which were referred to:

- Mid-Term Evaluation of the Building Peaceful Futures Program – Iraq, March 2020
- Response to the 2018 Papua New Guinea Highlands Earthquake, Evaluation, August 2019

Data Collection Tool Preparation

The evaluation rubric was used as the basis for preparing data collection tools. An extensive desk review also helped to shape the structure of questionnaires and checklists. Given the qualitative and quantitative nature of this assignment, the evaluation team developed both structured and semi-structured data collection tools to conduct surveys, KIIs and mini-FGDs.

Utilizing the insights gathered from the evaluation questions checklist, the desk review and the inception meeting, the evaluation team prepared a survey questionnaire incorporating a mix of categorical questions, a few contingency/filtering questions, and open-ended questions. About 80–85% of the questions were closed in order to reduce survey conduction time and to complete the data collection of

such a large sample within the evaluation timeline. The remaining open-ended questions asked for narrative responses from the respondents to capture their perception through words and quotes.

The qualitative checklist included mostly open-ended, narrative-style questions and probing cues. To design the data collection tools, the evaluation team followed ethical guidelines and global standards, especially for children, women, and people with disability. The evaluation team prepared the following:

Quantitative:
- A structured questionnaire to conduct the beneficiary survey

Qualitative:
- Checklists to conduct KIIs with ANGOs, DFAT, GoB stakeholders and other humanitarian actors
- A checklist to conduct in-depth interviews with people with disability
- Checklists to conduct mini-FGDs with beneficiaries, volunteers, local leaders, etc.

Enumerator Selection and Training

The evaluation team recruited male and female enumerators from the Cox's Bazar-based enumerator network of Inspira Advisory & Consulting Ltd. The enumerators had the following characteristics:

- University students in their 4th year of study
- Language proficiency in Rohingya, Bengali and English
- Previous experience of working in the Rohingya humanitarian context on 2–3 projects
- Possession of electronic devices (smartphones) and access to a stable internet connection

The core team facilitated proper on-boarding and training to the selected enumerators. The training workshop covered project on-boarding and training on accepted principles, norms, and practices for collecting data. After the training workshop, enumerators were asked to complete practical tasks.

Critical considerations for training:

- Enumerators were trained remotely via virtual meeting platforms
- Topics covered in the training: introductions and project overview, review of survey protocols, review of data collection tools, research standards and confidentiality, eliciting good data, time management, respondent fatigue (ensuring the respondents are fully aware of the value of their participation) and mock interviews
- As part of the training process, the enumerators, in the presence of the trainer, took turns in explaining to others the various items in the questionnaire. Practical sessions were arranged both in class and in the field
- A key focus was ensuring that enumerators were aware of the ethical standards of research/evaluation and special considerations when interviewing children, people with disability, and females.
- Technical training on using software (such as KoBo Toolbox) was part of the training

Testing and Piloting of Data Collection Tools

The core evaluation team validated the data collection tools through a round of cross-checking by AHPSU, ANGOs and technical experts. The data collection tools were then reviewed by the protection, inclusion and gender expert of the evaluation team, who also assessed if the language used in those tools was appropriate for the collection of sensitive information and suitable for surveys with children. After the English-language version of the data collection tools was finalized, the data collection tools were translated to Bengali.

The data collection tools were then tested through a round of pilot surveys. The piloting round took place in targeted locations with a small sample of beneficiaries. Thirty surveys were conducted in the piloting phase. The sharing of learnings from the pilot surveys took place during a session with the enumerators.

Quantitative Study

Beneficiary Survey

Sampling Strategy: Two-Stage Cluster Sampling was applied for the quantitative survey. In designing the survey, camps were considered as the Primary Sampling Units (PSUs), while households were considered as the Secondary Sampling Units (SSUs). The sample size was proportionally distributed across different important Tabulation Groups (sub-populations).

Desired Target Population: Beneficiaries of the projects: N=198,635 (as per the Project Implementation Plan documents of the three consortia).

The sample size was computed using Cochran's Simple Random sampling formula (Cochran, 1977) described as follows:

$$\frac{\frac{z^2_{(\alpha,n-1)}p(1-p)}{d^2}}{1+\frac{1}{N}(\frac{z^2_{(\alpha,n-1)}p(1-p)}{d^2}-1)}$$

- *Where z = z score for 95% confidence interval (we recommended 95% instead of 99% as it increased the sample size in our settings 4-fold) and the value is 1.96 (see 'z score' table)*
- *p = the test proportion/key indicator. In this evaluation study, the sub-question of 'beneficiary satisfaction in line with response activities and end-of-response outcomes' was considered a key indicator for determining sample size. However, the anticipated proportion did not exist at the time, hence, p=0.50 was used*
- *1–p = 0.50*
- *(p, q = 0.50, 0.50))*
  - *d = Margin of Error which was set at 5%. A lower margin of error (such as 3%) combined with an adjustment for design effects would have significantly increased the sample size and budget*
  - *N is the total number of Beneficiaries: 198,635*

Thus, the sample size using simple random sampling was computed as 384 (rounding up by taking the ceiling).

Design effects cannot be determined before the survey is done. Usually, a design effect[164] 1.5 to 2 is assumed in designing the sample size. In this study, the Deff was set at 1.5.

$$n_{Cluster} = Deff \times n_{srs}$$

- $n_{cluster}$ = Sample size for cluster sampling, 576
- $Deff$ = Design effect, 1.5
- n_{srs} = Sample size for simple random sampling, 384

Although the sample size was determined as 576, the evaluation team conducted surveys with 581 respondents.

Calculation

Field-level Sampling Tactics
The PSUs were 17 refugee camps. At the first stage, seven camps were selected. In the ideal scenario, the camps should have been randomly selected. However, given the context of the COVID-19 pandemic and intensified barriers from regulatory authorities as well as the need to increase efficiency in data collection, the evaluation team selected camps in consultation with ANGOs instead of a randomization[165]. This consultative selection of the camps also helped to make the sampling more inclusive: randomly selecting camps might have led to the omission of important beneficiary cohorts, including adults and children with disability, and activities critical to the evaluation.

Tabulation Group
The main tabulation groups were Agency, Sex, Children-Adults, and Disability. The distribution of the sample size (581) across these tabulation groups follows the proportions of these groups to the total number of beneficiaries.

Agency	SC			CARE			Oxfam			WV			PI			Total
Beneficiary	M	F	T	M	F	T	M	F	T	M	F	T	M	F	T	
Adult without Disability	32	26	58	25	40	65	83	30	113	34	30	64	53	50	103	403
Child without Disability	42	41	83	0	5	5	5	0	5	0	5	5	5	6	11	109
Adult with Disability	5	7	12	4	1	5	12	5	17	2	7	9	2	4	6	49
Child with Disability	10	4	14	1	0	1	2	2	4	0	1	1	0	0	0	20
Total	89	78	167	30	46	76	102	37	139	36	43	79	60	60	120	581

Qualitative Study

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[164] Deff (Design Effect) indicates, primarily, how much clustering there is in the survey sample. Deff expresses how much larger the sampling variance (square of the standard error) for the stratified, cluster sample is compared to a simple random sample of the same size.

[165] The evaluation team consulted with ANGOs on how to identify blocks and sub-blocks inside selected camps. However, the households surveyed were selected randomly by the evaluation team. ANGO staff were not present while surveys were being conducted at the household level.

Qualitative data was collected through 11 FGDs with beneficiaries as well as 56 KIIs with internal stakeholders (such as ANGOs) and external stakeholders. To add to the rigour of the evaluation, observational and case study tools were used. The evaluation team undertook facility visits to different ANGO service points at various camps locations, such as Child-Friendly Spaces, Women-Friendly Spaces, TLCs, health posts, and hard WASH infrastructure locations, including handwashing points. To support the case studies, ten in-depth interviews (IDIs) were conducted with people with disability from the beneficiary pool. The breakdown of qualitative tools according to the participants appears below:

Table: Snapshot of data collection tools used

Tools	Total	Participant Breakdown	Location	Modality
KIIs and Team Meetings	56	DFAT Post: 2 ANGOs: 15 Sector Coordinator: 3 Partner NGO: 7 GoB Stakeholder: 2	Dhaka Based	Remote
		ANGOs: 5 Partner NGO: 9 Sector Focal: 1 Community Leaders and Committee Members: 12	Camps: 4, 10, 12, 13, 15, 18, 23	On-site
FGDs	11	Male: 4 Female: 7	Camps: 4, 10, 12, 13, 15, 18, 23	On-site
IDIs	10	People with disability: 10 (family members and caregivers were also interviewed)	Camps: 4, 10, 12, 13, 15, 18, 23	On-site

Observation

The evaluation team undertook facility visits to different ANGO service points at various camp locations. The sites included WGSSs (Camp 19), TLCs (Camp 4), HBLs (Camp 23), healthcare centres (Camps 4 and 18), WASH facilities, including latrines, handwashing points and tap stands (Camp 12), ANGO field offices, and random households. Consideration was given to the fact that some sites, such as TLCs, were closed temporarily due to COVID-19. Nevertheless, active sites such as health posts and Women-Friendly Spaces were visited. These sites were visited for observational purposes, to oversee the structures, the service delivery modes, the behaviour of service providers, etc. The observation team extracted insights through informal conversations with local people and site operators. Observers took notes which were useful as probing questions for KIIs. Observation also supported the triangulation of information.

Ethical Guidelines

A strict adherence to a high set of ethical standards was maintained, given the project's specific focus on females, children and beneficiaries with disability. Data collection was also guided by the 'do no harm' protection principle of humanitarian assistance. All evaluation tools were subject to ethical approval from the evaluation team's protection, inclusion and gender expert before data collection commenced.

Privacy: The evaluation team ensured that data collection was done individually and privately, so that respondents felt comfortable answering questions without any predominance. For instance, the absence of husbands was ensured in the course of conducting surveys with female adults.

Informed consent: Prior to the data collection, the informed consent of all potential participants and respondents was ensured. The enumerators explained to the respondents the purpose of the evaluation; their role within the evaluation; what information was being sought from them; and how the data collected would be kept confidential. Respondents were given the liberty of participating or not participating in the research. With respect to the participation of children, informed consent was gained from their parents/caregivers.

Confidentiality: Respondents maintained complete anonymity. Responses and comments have been presented in a summarized form in this evaluation report, and no respondents have been identified by name or any other identifying characteristics aside from approximate age and gender. For the FGDs, the participants' real names were not recorded.

Managing distress: Female enumerators were deployed to collect data from children and female respondents. Due to the sensitive nature of some questions, the survey questionnaires were reviewed and validated by the protection, inclusion and gender expert to ensure that those questions did not cause any distress to respondents. The enumerators were properly trained to deliver the message that the respondents could discontinue at any time.

Impartiality: The data collection team remained as impartial and objective as possible. They allowed participants to express their own views and opinions without interruptions or suggestions, and to engage voluntarily at all times.

Credibility: The data collection team was responsible for the safeguarding of the credibility of the study by acting fairly and credibly towards research subjects; by providing an accurate and transparent description of the potential risks or discomforts of and the anticipated benefits derived from the study; and by ensuring a fair selection of research respondents, representing diverse age ranges and varying levels of exposure to explicitly defined vulnerability factors and other social factors.