Australian Humanitarian Partnership

Response to the Rohingya Humanitarian Crisis

Evaluation

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Australian Aid

AHP Australian Humanitarian Partnership

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Abbreviations

AHP	Australian Humanitarian Partnership
CBM	(formerly Christian Blind Mission; now known as CBM)
CFS	Child Friendly Spaces
CHS	Core Humanitarian Standard on Quality and Accountability
CHV	Community Health Volunteer
C-MAMI	Community Management of Acute Malnutrition in infants
DFAT	Australian Department of Foreign Affairs and Trade
ESQ	Evaluation Sub-Question
FGD	Focus Group Discussion
GBV	Gender-Based Violence
ISCG	Inter Sector Coordination Group
IYCF-E	Infant and Young Child Feeding in Emergencies
JRP	Joint Response Plan for the Rohingya Humanitarian Crisis
KEQ	Key Evaluation Question
KII	Key Informant Interview
MEAL	Monitoring, Evaluation and Learning
MCH	Maternal Child Health
MHPSS	Mental Health and Psychosocial Support
NFIS	Non-food items
NGO-AB	NGO Affairs Bureau (of Government of Bangladesh)
RRRC	Office of the Refugee Relief and Repatriation Commissioner
SRH	Sexual and Reproductive Health
TBA	Traditional Birth Attendant
TLC	Temporary Learning Centre
TWB	Translators Without Borders
UASC	Unaccompanied and Separated Children
UNDP	United Nations Development Program
UNHCR	United Nations High Commissioner for Refugees
WASH	Water, Sanitation and Hygiene
WFP	World Food Program

WFS	Women Friendly Spaces
YPSA	Young Power in Social Action

Executive Summary

This evaluation was commissioned to assess whether the Australian Humanitarian Partnership (AHP) response to the Rohingya humanitarian crisis has been effective, efficient and relevant to the needs of affected communities. Through the AHP, a total of AUD 6 million was provided to Oxfam and Save the Children (hereafter, Save) to each lead implementation of 12 month projects.

The need for the response relates to the mass exodus to Bangladesh in late August 2017 of Rohingya people escaping severe violence in northern Rakhine State, Myanmar. New arrivals peaked at 20,000 per day in early September, with a total of more than 727,000 refugees arriving since, bringing the total number of refugees to approximately 923,000 people.

DFAT's AHP response was flexible and un-earmarked, allowing for integrated programing, which in turn allowed a focus on priority sectors of health, nutrition, WASH, protection and education - with a cross-cutting focus on gender, children and disability inclusion. Successful applicants were Save and Oxfam (working in partnership with CARE and CBM):

- Oxfam/CARE's aim was to reach a total 116,360 people through a gender and protection focused WASH approach, with CARE providing access to information and services related to women's wellbeing and in response to Gender Based Violence
- Save aimed to work across nine outcome areas to reach a total of 155,418 beneficiaries, based on an integrated approach built around Save's Health Posts that included emergency health, nutrition, protection, education and WASH activities.

Main findings

The headline conclusion of this evaluation is that projects funded through the AHP were acutely relevant to priority needs and have provided important, sector-leading support to refugee Rohingya communities that will collectively reach more than 250,000 people by activation closure. Primary areas of contribution have been WASH (notably gender-focused WASH), health provision (notably mother and child health), protection and education (through temporary learning spaces). An important aspect of this success was that funding made available through this activation was longer term (12 months), with flexibility to adapt approaches during implementation.

While both projects placed strong focus on gender and disability inclusion in their proposals, disability inclusion in implementation remains a substantial challenge. However, gender programming is strong across all supported partners, based on a multi-faceted suite of approaches, including deliberate work to enlist men in support of women's priorities.

Efforts to localise approaches have proven challenging due to factors including highly bureaucratic approaches put in place for NGO operations, limited local capacity, and an insufficient number of appropriately qualified local NGOs to partner through.

Appropriateness

In the immediate period following the refugee influx, both UNHCR and IOM undertook rapid assessments of refugee needs that highlighted the following as urgent priorities:

- ensuring access to food, shelter, health and clean drinking water in all sites
- access to health care for people with specific needs, including pregnant women

- community mechanisms to ensure women's protection enhanced.

Given the close alignment of Oxfam/CARE and Save approaches to these priorities, it is assessed that activities supported through the AHP were relevant to priority needs. Furthermore, they were initiated in close collaboration with coordination mechanisms. This perspective is endorsed by affected communities who view AHP supported activities as relevant to their personal priority needs, and commonly view AHP programming as being of higher quality than those offered by other providers in their camp context.

It is also noted that activities align with Australia's humanitarian strategy given their focus on gender and women's empowerment, protection and disability inclusion. Willingness of DFAT to support projects in making evidence-based strategic shifts in approach was also cited as 'appropriate' and widely praised by grantees and other actors.

Effectiveness

The evaluation team considered the overall programming landscape of AHP partners when assessing effectiveness, before drilling down into specific AHP achievements. This was seen as important since AHP activities commonly benefit significantly from 'add ons' and 'value add' of the recipient organisations' broader capacity and approach.

Save has sophisticated structures, capacity and tools already in place that support an integrated approach and synergies across its nine different outcome areas. These structures helped Save to be ambitious in its AHP proposal, where it proposed to reach a total of 155,418 beneficiaries in total (with projections that final reach will be around 140,000). This approach is underpinned by multi-faceted community engagement that aims to ensure presence and trust within communities from which awareness raising of services can occur.

Notable results of Save's AHP work include:

- establishment and maintenance of 60 Temporary Learning Centres (TLCs)
- providing access to mental health and psychosocial support for children
- training of parents in relation to child protection issues, notably those faced by girls
- provision of MCH services to more than 50,000 women, babies and infants.

The above achievements of Save were further reinforced by activities related to shelter, food, non-food items, WASH, nutrition and broader provision of primary health services.

Generally speaking, AHP-supported NGOs within the Rohingya response have value-added to them through the broader programming effort of the organisation's overall response. Save's leadership in the education sector advances overall education programming through advocacy and higher level technical inputs related to curriculum development and teacher training. CARE is a key contributor to the Gender in Humanitarian Action Working Group. Similarly, Oxfam plays a leading role within the WASH sector in both hydrological assessments and fecal sludge management, which in turn inform approaches throughout the WASH sector that positively impact environmental and water quality outcomes.

Oxfam/CARE utilisation of AHP funding was two phased, involving an initial mobilisation period where emergency WASH services were set up to address immediate, life saving needs, and a second phase focused on supporting settlement in camps through construction of latrines, installation of deep tube wells and hand pumps, construction of women's spaces and repair and maintenance of WASH facilities. Both phases worked in close collaboration with the WASH sector working group,

where Oxfam was a key advisor to organisations less experienced in emergency WASH programming. Given this scenario, AHP funding has helped model higher quality WASH performance to the broader sector.

Notable results of Oxfam's AHP work include 55,000 people having access to safe and adequate water and sanitation facilities, through use of deep tube wells, latrines and bathing cubicles – as well as improved knowledge of health and hygiene practices. Oxfam's approach is underpinned by a sophisticated and inclusive community engagement approach that has resulted in strong lines of communication and levels of community ownership of both WASH facilities and key issues of importance such as women's rights and protection.

CARE's focus helps ensure access to information and services that both protect and raise awareness of the rights of women, and also respond to GBV-related trauma, and its ongoing prevalence. While the most visible and high profile aspect of CARE's AHP approach is its Women Friendly Spaces (WFS), the actual centrepiece of their approach is broad-based community awareness raising promoting the rights of women. Importantly, the approach places priority on inclusion of men and boys, as well as community and religious leaders, which has helped quash negative rumours and relieved their initial concerns related to WFS.

While there was logic and potential complementarity in the proposed approach of Oxfam and CARE at the time of design, this was largely lost when camp rezoning resulted in Oxfam and CARE activities being split across different camps. This is regrettable (and beyond the control of Oxfam and CARE) since clearer day to day synergies potentially existed.

Inclusiveness

Clear emphasis was placed in the design of both projects on ensuring the needs of women and girls and people with disabilities were met. Gender and protection considerations are central to all Oxfam programming. CARE's approach is specifically aimed at reducing and responding to GBV. Save's integrated model is woman and child focused, working along a continuum from antenatal support to advocating the rights of young women and girls.

In implementation, gender relevant approaches across both projects have been sophisticated, well resourced and relevant to context and outcomes proposed. In particular, the Oxfam/CARE approach has succeeded in positioning gender as central to its whole approach. This includes achieving 50% Rohingya women representation in its community mobiliser teams, allowing depth of awareness raising in relation to priority women's issues, and strong traction in their target areas in support of women's participation and empowerment.

When asked to reflect on the gender focus of AHP activities, affected communities spoke across both projects of the cultural sensitivity of approaches, citing this as key to their ability to raise gender issues in a manner appropriate to the conservative social norms of the Rohingya. Feedback was also provided that efforts to include men and male leaders was both culturally appropriate and strategic, as evidenced by support generated amongst male community and religious leaders by CARE in support of women's voice and protection.

While emphasis was placed on integrating disability within approaches, this has proven difficult to implement, resulting in very low numbers of reported disabled beneficiaries. While this relates in part to inadequate systems for identification of disability, it is clear that further strengthening of disability programming is required. Difficulties relate to an intersection of issues related to intense crowding and space issues within camps; cultural attitudes and also the hilly, sandy physical nature of the site. Importantly, each organization either has in place (Oxfam/CARE with CBM) or is seeking

(Save with Humanity & Inclusion) advanced technical support to enhance organisational capacity in relation to disability.

Efficiency

Both projects cite the importance and value the speed with which DFAT's AHP Rohingya activation was prepared and signed off, since it allowed organisations to quickly have meaningful longer term programs in place that were catalytic in terms of further resource mobilisation. While there was clarity in the strategy of each project, timelines were significantly impacted by coordination issues – notably FD-7 obstacles that affected staffing, procurement and camp access for NGOs. Resistance of the Government of Bangladesh to cash-based funding is another constraint on efficiency, as is reluctance to allow multi-year program funding.

The overall assessment of the evaluation is that both projects provided value for money based on being active on the ground very early in the response, quality of implementation, their contribution to coordination within priority sectors, and through the value added to AHP supported activities by each organisation's broader suite of response activities.

Localisation

AHP partners have worked in alignment with coordination mechanisms at national (the National Task Force chaired by the Ministry of Foreign Affairs) and local (the Office of the Refugee Relief and Repatriation Commissioner) levels, including compliance with all bureaucratic requirements. While this relationship proved problematic for NGOs in the earliest days of the response, agencies are now reporting more functional relationships.

However, efforts to integrate local partners within coordination mechanisms have proven difficult. Such was the sudden onset of the crisis, agencies found it difficult in the earliest stages to find appropriate and available local partners to work through.

Save's primary local implementation partner is Young Power in Social Action (YPSA), which they have sub-contracted to oversee implementation of the TLCs. This involved a clear and strong focus on capacity building for education programming. Finding it difficult to identify local organisations to partner with, Oxfam instead focused on efforts to utilise Rohingya within their program, in order to strengthen community structures within the camps, as well as develop skills that are transferrable in the future.

Moving forward, it is felt that AHP partners should work to strengthen capacity around key constraints to localisation such as gender focused protection, with a view to local partners assuming greater responsibility for program delivery in the future.

Accountability

Both projects place significant emphasis on accountability, and have established multiple mechanisms to allow feedback from affected people. Despite this intent, achieving broad based accountability has proven challenging for both projects. This relates primarily to language and literacy issues, but also cultural norms that restrict women's voice and mobility. Child contribution to feedback mechanisms has also proven challenging, which has led Save to pilot more child friendly approaches to ensure their input and feedback.

Oxfam's accountability approach is centred around 'listening groups', whose input guides bi-weekly meetings with local authorities. This appears to help elicit feedback and initiate action in relation to community needs. Save has multiple accountability channels in place, including world leading innovations aimed at ensuring the voice of women and children.

Conclusion and Recommendations

The core finding of this evaluation is that all activities supported through the AHP were relevant to priority needs and implemented in a form that was effective and responsive to the complex needs of affected communities. It is further noted that despite urgent ongoing needs, there appears to be a looming funding gap that will force many smaller actors to close operations, with expectations that larger NGOs will pick up the slack. This is likely to quickly place the response – particularly NGOs – under acute funding pressure in early 2019.

Recommendation One: Moving Forward

> ***Recommendation 1a:*** *Given acute, ongoing needs of the affected population and the effectiveness of the program to date, a new, follow on AHP Rohingya response funding window should be initiated urgently by DFAT.*

Each of the six pre-selected AHP partners already implement sizeable Rohingya response programs, and have capacity to effectively and efficiently deliver more sizeable programs than those allowed through the initial AHP funding round. It is also noted that there will be increased demands placed on larger, technically specialised NGOs to both fill gaps posed by the withdrawal of smaller agencies and address maintenance and decommissioning needs of facilities previously managed by these smaller agencies.

> ***Recommendation 1b:*** *Consideration should be given by DFAT to increasing funding to AHP partners, based on the rationale of needing to support continued implementation of current activities, as well as providing space for filling gaps posed by the withdrawal of smaller actors.*

Given general agreement that ongoing support will be required for at least the next three years, there would be a range of efficiencies enjoyed by a shift to multi-year funding. While it is understood that the Government of Bangladesh has opposed this, it is also reported that there are signs of a willingness to shift on this – possibly enhanced by completion of the electoral process.

> ***Recommendation 1c:*** *Options for framing a new AHP activation as multi-year (based on annual plan approval) should be explored by DFAT, based on the rationale that such an approach would support enhanced program efficiency and effectiveness (given it would allow for longer term planning and approaches).*

Currently, it is widely accepted that certain camps are disadvantaged by their remoteness (for e.g. camps 13, 19 and 20) and the reality that provider agencies find it easier to work in camps serviced by main roads. This disadvantage could potentially worsen given it was often these more remote camps that smaller agencies were directed to by coordination mechanisms.

> ***Recommendation 1d:*** *Given that certain camps are known to be disadvantaged by their location compared to others, DFAT should give consideration to including camp remoteness and disadvantage as a selection criteria for future AHP activations.*

Opportunities exist for AHP supported activities to occur in a more truly programmatic form, given that the work under the AHP of CARE, Oxfam and Save currently has a shared focus on gender and

protection, despite each approaching it from a different angle. A more programmatic approach could be encouraged through focusing AHP support on a designated geographic section, that each agency brings its specialised skills to. For example, currently each organisation is active in the southern section of Kutupalong refugee camp.

> ***Recommendation 1e**: DFAT and the AHP partners should consider the pros and cons of focusing a new AHP response on a specific geographic area (i.e. specific camps) in order to address disadvantage and leverage an area development approach that enables different partners to benefit from each other's capacities and learning.*

Recommendation 2: Inclusion and protection

An important lesson learnt through this evaluation is that within conservative cultural contexts such as the Rohingya, deliberate, well resourced strategies are needed to support women's inclusion and empowerment. This is reflected in the joint response plan describing the Rohingya Response as first and foremost a 'Protection crisis'.

> ***Recommendation 2a:** DFAT should more explicitly emphasise AHP second phase funding as being (broadly) gender and protection focused, with more deliberate mechanisms in place for knowledge sharing, research of issues of common interest, and cross-organisational peer support aimed at maximising understanding of each partner's specific area of technical expertise.*

> ***Recommendation 2b**: DFAT and AHP partners should ensure space within gender programming for organisations to further progress work with men, teenage boys, community leaders and religious leaders, given the positive results achieved to date (especially by CARE) of mobilising men in support of women and children's protection.*

As described within this report, despite the best intentions, AHP partners have all struggled in terms of disability inclusion due to both practical issues of camp management and terrain, as well as limited capacity within AHP partner organisations. While this is unfortunate, each partner has realistic plans in place to strengthen their performance in this area moving forward, including partnering with specialist disability organisations to help strengthen their capacity for disability inclusion.

> ***Recommendation 2c:** Included in the assessment criteria of any new AHP applications should be the degree to which applicants can present a plausible strategy for overcoming the many constraints known to exist in relation to disability inclusion in the context of the Rohingya response, including strategies for development of human capacity to better identify and support people with disability.*

Strong outreach is key to addressing the lack of mobility experienced by many young women. A conclusion of this evaluation is that high quality, gender focused community outreach and mobilisation is critical in terms of achieving high quality programming outcomes. This includes the need to ensure a role in this process for Rohingya volunteers, despite challenges posed by literacy, educational attainment and cultural norms.

> ***Recommendation 2d:** Emphasis should be placed within any future responses (through AHP) on further strengthening community outreach capacity as a strategy to facilitate improved gender and protection outcomes, given that many women are largely confined to their homes and unable to attend external meetings.*

AHP partners have already demonstrated their capacity to undertake important, relevant, high quality research – often jointly. Joint studies bring different, often complementary perspectives to

complex issues, as can be seen in the *Rohingya Refugee Response Gender Analysis* jointly undertaken by Save and Oxfam (and Action Contre la Faim).

> ***Recommendation 2e**: Integrate funds within AHP for research and dissemination in relation to gender in refugee settings, including consideration of the role of men and teenage boys in supporting and progressing positive gender outcomes and reducing GBV (noting that such research could be an important, general resource helping inform future AHP activations)*

Recommendation 3: Advocacy

The current camp context has multiple, negative environmental impacts. Leading issues relate to concerns around deforestation of the broader area as refugees seek firewood, given the Government of Bangladesh refusal to allow the use of gas for cooking. The use of wood as fuel is also impacting the health and quality of life of women who are often confined to very small, confined spaces due to the practice of *purdah.*

Groundwater quality is also deteriorating due to the pressure being placed on it by shallow wells and 60,000 latrines being constructed in a very small area.

> ***Recommendation 3a:** DFAT should work with ISCG to lobby the Government of Bangladesh in support of cooking gas provisions for refugee households as an environmental management and gender protection approach to be trialed through AHP agencies' programs – underpinned by a joint study by AHP partners of its impact.*

Efficiency of the overall Rohingya response is undermined by the inability to utilise cash-based programming.

> ***Recommendation 3b:** DFAT should continue to coordinate with other leading donors and agencies to advocate for cash-based programming, on the basis of cost effectiveness and suitability to context.*
>
> ***Recommendation 3c:** While it is highly unlikely that a green light will be given for a full roll out of cash-based programming in the short term, both DFAT and AHP partners should aim for any future responses to include sufficient flexibility to allow AHP partners to adapt projects as required should agreement to introduce cash based programming be reached.*

Recommendation 4: Health/WASH

AHP support to ensuring good health of the affected population has been multi-faceted and included a significant gender focus. Given the scale and crowded context of the affected population, high quality WASH programming remains an imperative if disease is to be kept at bay. There are particular ongoing needs related to fecal sludge management and decommissioning of inferior toilet systems and shallow wells, which both pose serious health and environmental challenges. The need for primary health services also remains acute, including systems capable of addressing the complex cross-section of psychosocial health needs presented by the affected population – which are widely reported as currently being under-serviced.

> ***Recommendation 4a:** Further AHP support to health and WASH should be nuanced and target in on clearly identified gaps and needs within current service provision, including the need to cover work undertaken by organisations now departing due to funding issues.*

Recommendation 5: Education

Including support for progressing educational opportunities of children and youth is seen as consistent with a gender focused program – especially efforts to promote girls' educational access. Various constraints to education currently exist. These relate to the general reluctance of the Government of Bangladesh to support formal schooling, as well as specific issues related to educational participation of girls aged 11 and older, and the current ban on any form of education provision to children and youth aged 15 and above.

> ***Recommendation 5a:*** *Emphasis should be placed within the overall approach of any new responses to develop strategies aimed at increasing education participation rates of girls aged 11-14.*
>
> ***Recommendation 5b:*** *DFAT should continue to advocate alongside other leading donors and agencies for educational opportunity to be available for the 15-18 year old cohort (both girls and boys).*

Recommendation 6: Localisation

Utilisation of local partners has been limited within the AHP to date. Given that the response has now normalised to a significant extent from the chaotic early days, and also that it appears likely that many smaller international agencies will soon withdraw (or have already left), opportunities are now emerging to more easily engage local partners.

> ***Recommendation 6a:*** *Moving forward, emphasis should be placed on 'smart localisation' based on AHP partners more deliberately supporting Bangladeshi partners to strengthen capacity around complex issues such as gender focused protection, with a view to local partners assuming greater responsibility for program delivery in the future.*

Allied to increased use of local partners is the ongoing importance of continuing to provide meaningful support and opportunities for host communities within the response.

> ***Recommendation 6b:*** *Strategies for inclusion and support to host communities should be included as a criteria for assessment of future AHP applications.*

1. Evaluation context

1.1 Background

Since creation of the State of Burma (now Myanmar) in 1948, Rohingya populations have been denied citizenship and faced widespread discrimination, including denial of legal documentation and identification papers. This has contributed to longstanding marginalization and vulnerability of Rohingya people, even before the acute violence of this most recent crisis. Over recent years, this has led to a massive movement of Rohingya people from their homes to take refuge in neighbouring Bangladesh. Despite their numbers and the underlying vulnerability of Bangladeshi people in the area where refugees have landed, the people and Government of Bangladesh (GoB) have welcomed Rohingya refugees with generosity and open borders. However, the extraordinary speed and scale of the recent influx has presented an enormous humanitarian challenge.

1.2 Current context

Since 25th August 2017, more than 727,000 Rohingya refugees have crossed from northern Rakhine state of Myanmar into Bangladesh fleeing large scale violence and human rights abuses. There are now approximately 923,000 Rohingya refugees residing in Cox's Bazar District, Chittagong Division, Bangladesh. This includes the nearly 200,000 who fled Myanmar during earlier periods of violence. The pace of new arrivals made this crisis the fastest growing refugee crisis in the world and has resulted in settlements with the highest concentrations of refugees globally. Given this context, GoB generosity and efforts in hosting such a large and complex refugee population needs to be acknowledged and applauded.

The 2018 Joint Response Plan for the Rohingya Humanitarian Crisis (JRP) reports that almost the entire refugee population is living in two upazilas (sub-districts) of Cox's Bazar district, with 82 percent of refugee households in Ukhia upzila and 18 percent in Teknaf upzila. 52 percent are women and girls, and 55 percent are under 18 years of age.[1] Ukhia and Teknaf are areas prone to disasters such as cyclones, flooding and, increasingly, the risk of landslides due to indiscriminate deforestation of hills to provide both shelter and firewood for refugees.[2] In this context, the monsoon season poses a serious spike in vulnerability for people living in the area.[3]

The speed and scale of the refugee influx has put great strain on the host population. Cox's Bazar district is one of Bangladesh's poorest, with high levels of food insecurity and limited livelihood opportunities. Ukhia and Teknaf are amongst Bangladesh's 50 'most socially deprived upazilas'.

The 2018 JRP estimates a total of 336,000 people in need in Bangladeshi host communities in these most vulnerable districts.[4] An assessment carried out in December 2017 by UNDP and UN Women reported that the host community had almost universally negative views of the Rohingya.[5]

While camp conditions have improved significantly in the year since the influx commenced, there are still urgent, ongoing needs. These include the immediate need for further improvements in food

[1] Joint Response Plan for the Rohingya Crisis Mar-Dec 2018, p.11

[2] DFAT is supporting trials through the IOM SAFE project distributing gas cookers and LPG as an approach to reduce deforestation.

[3] Rohingya Refugee Response Joint Agency Report; Recognizing and Responding to Gender Inequalities; Aug 2018. P. 4

[4] Joint Response Plan for the Rohingya Crisis Mar-Dec 2018. P.9

[5] UNDP and UN Women: Social Impact Assessment of the Rohingya Refugee Crisis into Bangladesh. Key Findings and Recommendations (6th December 2017).

support, shelter, non-food items, drinking water quality, access to hygiene items and gender sensitive sanitation facilities. In addition, children are exposed to considerable protection risks, including separation and trafficking, and are unable to undertake formal schooling. Urgent needs also exist in relation to medical support, including mental health and psychosocial support (MHPSS).

Predictably, the arrival of an additional 727,000 people to the existing refugee population has further depressed the price of labour in the area and has increased food prices.[6] However, it has also opened up job opportunities for local community members, based on recognition amongst agencies of the importance of inclusion of host communities in programming and strategic thinking.

Depletion of water and firewood supplies is also significantly affecting living conditions and livelihoods of host communities. The use of wood as fuel is also impacting the health and quality of life of women who are often confined to very small, confined spaces due to the practice of *purdah.*[7] Groundwater quality is also deteriorating due to the pressure being placed by shallow wells and 60,000 latrines having been constructed in a very small area.

Donor context

Coordination of the Rohingya response occurs in Dhaka through the Strategic Executive Group, and at local level through the Office of the Refugee Relief and Repatriation Commissioner and the Inter-Sector Coordination Group (ISCG). ISCG is jointly led by the International Organization for Migration (IOM) and the UN Refugee Agency (UNHCR). As of 9th October 2018, ISCG reported 106 organisations active in ten sectors in the Cox's Bazar area, working with Rohingya populations across 34 camps, with two thirds of these organisations being international.[8] A map detailing camp locations and site management responsibilities is attached as Annex One.

Historically, the government has favored relief work occurring through UN agencies rather than INGOs. This has posed difficulties for NGOs in obtaining relevant government permissions. Before launching any new projects, all non-UN agencies must obtain approval from the Government through a process known as FD-7 (Foreign Donations – Form 7). The NGO Affairs Bureau (NGO AB) in Dhaka approves the FD-7s, which once approved, must be shared with the RRRC, District Commissioner and respective Camp in Charge authorities, (through the responsible site management organization). These also need to be renewed six monthly, which presents another burdensome bureaucratic procedure for NGOs to work through.

This bureaucratic procedure has caused significant delays in NGO programming. However, there are indications that the process is now running more smoothly, with NGOs better understanding the process and initiating strategies that mitigate against delays.

To date, all funding has been shorter term in nature, with maximum programming windows of just 12 months, in accordance with GoB stipulations. The implication of this context is that most funding windows are due to come to an end between December 2018 and March 2019, with agencies reporting grave concerns at how few donors have funding windows ready to follow on. This presents a very real likelihood of multiple agencies facing a simultaneous financial crisis, due to gaps between funding windows, which will in turn contribute to reduction in urgently needed services provided to affected communities.

Key Finding: Despite urgent ongoing needs of the Rohingya refugee population, it appears likely that many larger NGOs will come under acute funding pressure in early 2019 due to

[6] ACAPS Host Community Thematic Review January 2018

[7] The custom found in some Muslim and Hindu cultures of keeping women from being seen by men they are not related to, by having them live in a separate part of the house. In this case, purdah requires that women remain within very small tents with little ventilation.

[8] https://www.humanitarianresponse.info/en/operations/bangladesh/iscg-4w-dashboard

many donors not having successor programs in place.

Another important development in the response is that many of the smaller international NGOs that were able to mobilise funding in the immediate aftermath of the influx, are now facing financial difficulties with many likely to soon withdraw. This ironically has the potential to simplify coordination arrangements, given the need to coordinate fewer actors and the likelihood that those that remain will be those more experienced in longer term humanitarian work. However, fewer actors will also likely put pressure on service delivery – especially in the short term.

Political context

As recently as September 2018, the Bangladeshi Foreign Minister reiterated that refugee status will not be awarded to any new Rohingya entering the country. Since then, an agreement reached during an October meeting of the Bangladesh-Myanmar Joint Working Group led to a request being made of UNHCR to assess the intention and willingness to return of some Rohingya refugee families cleared for return by the Government of Myanmar.[9]

However the reality of the current situation is that the overwhelming majority of the refugee population express anxiety about their future, explaining that while they wish to return, they will not agree to do so until questions of citizenship, legal rights, and access to services, justice and restitution are addressed. As of 15th November 2018, no refugee family had expressed their willingness to UNHCR to return to Myanmar at this time. Furthermore, UNHCR assesses that current conditions in Rakhine State are not conducive to the voluntary, safe, dignified, and sustainable return of refugees from Bangladesh.[10]

The politics of the current context are significant, since the Governments of Bangladesh and Myanmar suggest publicly that safe return might soon be possible. However, the views of literally all stakeholders questioned during the evaluation was that the overwhelming proportion of the current refugee population will remain in Bangladesh for at least the medium term (2-3 years), and that there would be significant efficiency and effectiveness gains in both donors and the GoB accepting that reality.

Gender context

The Rohingya are a conservative community, with social and cultural norms that create tensions around the efforts of international organisations to support women's empowerment and enhanced mobility. Women generally experience barriers to freedom of movement and access to and control over resources, with girls' access to the range of services on offer and mobility restricted once they reach puberty. An increase in opportunities in the camp context for paid work for women is also reported to have resulted in increased domestic violence in the home and harassment outside it. [11]

A Rapid Gender Analysis conducted by CARE in September 2017 reported that, in one camp, every woman and girl was either a survivor of sexual assault or a witness to it from their time in Myanmar. The same report also added that women now felt relatively safe in camps in Bangladesh.[12] Such findings have been validated through a range of subsequent research, including Oxfam's September

[9] UNHCR Bangladesh Operational Update; 1-15 November, 2018, p. 2

[10] UNHCR Bangladesh Operational Update; 1-15 November, 2018, p. 2

[11] Ripoll (2017) Social and cultural factors shaping health and nutrition, wellbeing and protection of Rohingya people within a humanitarian context. Social Science in Humanitarian Action, October 2017

[12] CARE. Rapid Gender Analysis. September 2017.

2019 study "One Year On: Time to put women and girls at the heart of the Rohingya response".[13] However, various reports have since shown that crowded settlements, a lack of appropriate WASH facilities and increased vulnerability are putting women and girls at continued risk of GBV, including sexual harassment, assault and sexual violence with hundreds of incidents reported weekly.[14]

Furthermore, women's mobility is restricted by the observance of *purdah*, which limits their ability to access aid or GBV services, a problem compounded by the stigma faced by GBV survivors and the limited information to which women have access. The crowded nature of the camp, insecurity, access and cost of burqas, and also the recent trauma experienced by so many women and girls also factor in to mobility restrictions. Adolescent girls are particularly vulnerable to GBV threats which restricts mobility, and subsequently their access to services and information is even more limited.[15]

1.3 Australian support to the Rohingya response

In the two months following onset of the crisis in late August 2017, DFAT announced a package of support totaling $30 million AUD to a cross-section of multilateral and NGO partners. This assistance supported Rohingya communities on both sides of the border, with programming in both Rakhine State, Myanmar and in Cox's Bazar, Bangladesh. Since then, there have been periodic additional commitments made by DFAT. As of mid October 2018, total cumulative DFAT commitments to the Rohingya crisis have totaled $70 million AUD (including some in-Myanmar work with Rohingya communities). Primary recipients of support have been UNHCR, IOM and WFP.

Australian Humanitarian Partnership support to the Rohingya response

The AHP is a partnership between the Australian Government and six pre-selected Australian NGOs (CARE, Caritas, Oxfam, Plan International, Save the Children and World Vision). It aims to *save lives, alleviate human suffering and enhance dignity during and in the aftermath of conflict, disasters and other humanitarian crises by harnessing the networks and access of Australian NGOs*.[16]

The AHP activation in relation to the Rohingya crisis focused on activities within Cox's Bazar for a duration of up to 12 months. The criteria specified 1/ that a maximum of two AHP lead partners would receive funding and 2/ given the complex operating environment, only partners with existing operational approval to implement response activities in Bangladesh would be considered.

Save the Children Australia and Oxfam Australia (partnering with CARE) were selected as the implementing partners. Activities commenced in October 2017. In summary:

- Oxfam aimed to support a total of 116,360 of the most vulnerable men, women, girls, boys and people with disabilities so that basic water, sanitation and hygiene needs are met, in a protective environment, especially for women and girls. CARE's focus was connecting women and girls to GBV services, including efforts to increase the safety of girls and women through establishment of four Women Friendly Spaces. Disability advice was provided to the project by CBM. (Total Funding - AUD$3 million)
- Save aimed to support 155,418 people to provide immediate life-saving aid (shelter, non-food items, emergency health and protection, and WASH), leading in to longer-term support to meet the ongoing needs of vulnerable Rohingya children and families through integrated

[13] D. Sang; One Year On: Time to put women and girls at the heart of the Rohingya response; Oxfam, Sept 2018

[14] Rohingya Refugee Response Joint Agency Report; Op.Cit. P. 10

[15] Rohingya Refugee Response Joint Agency Report; Op.Cit. P. 11

[16] See https://dfat.gov.au/aid/topics/investment-priorities/building-resilience/humanitarian-policy-and-partnerships/Documents/ahp-factsheet.pdf

programming through health, nutrition, WASH, education and protection services. (Total Funding - AUD$3 million)

Evaluation report structure

- The initial section of the report – the Evaluation context - is intended to be introductory and will consider the current status of the response, the overall context of the evaluation and details of Australia's overall contribution to the Rohingya response.
- This section is followed by an outline of the key evaluation questions and sub-questions, and description of the evaluation methodology.
- The findings section will consider each KEQ in detail. Discussion of the different approaches of AHP supported organizations, how AHP funds were used and the effectiveness of these approaches will occur within the 'effectiveness' sub-section of the findings. Other sub-sections will be used to focus specifically on the issues of relevance, inclusion, efficiency, localization and accountability.
- The final section will detail conclusions and recommendations on AHP programming in relation to the Rohingya response.

2. Evaluation Overview

2.1 Purpose of evaluation

The purpose of the evaluation was to assess the AHP Rohingya response in Cox's Bazar including:

- the relevance of the response
- the effectiveness, timeliness and efficiency of the response
- whether the response reinforced local capacity and identification of the major challenges that constrained implementing partners in relation to localisation
- the extent that the response met the needs of those most vulnerable due to gender, disability and other social disadvantage.

The evaluation was tasked with delivering a set of findings about the AHP response. There was also a request to provide broader future-focused recommendations for the AHP, including how responses can effectively consider and respond to the needs of vulnerable groups, support local capacity, and achieve transparency and accountability to affected populations and other relevant stakeholders. Lessons from this evaluation are expected to inform future AHP activations within the context of protracted crises and complex operating environments.

Evaluation Questions

The following key evaluation questions (KEQs) and sub-evaluation questions (SEQs) were detailed in the evaluation TOR, which was endorsed by the AHP Evaluation Steering Committee. These were structured around the 'Core Humanitarian Standard on Quality and Accountability' (CHS) – a globally agreed set of humanitarian standards that guide delivery of humanitarian assistance.

Evaluation Criteria	Key Evaluation Question and Sub-Questions
Appropriateness	1. **Was the AHP response appropriate and relevant (link to CHS 1 & 6)?**

Evaluation Criteria	Key Evaluation Question and Sub-Questions
	a. To what extent were the activities selected appropriate (i.e. did we select the right activities in the right locations on the right sectors?) b. To what extent was information on needs and priorities addressed in the planning? c. c. Has the response adequately responded to needs assessment information provided (both initially and over the course of implementation, as needs have changed), and how relevant has the assistance been from the perspective of affected communities? d. d. To what extent did the assistance complement/align with Australian Humanitarian Strategy and other key Australian government policies/priorities such as gender equality, disability inclusion and other vulnerable groups?
Effectiveness	**2. Was the AHP response effective (CHS 2)?** a. How clearly were the intended outputs and outcomes of the response defined, and to what extent have they been achieved? b. To what extent did Australian-funded activities promote longer-term resilience of affected communities and support broader recovery and stabilisation efforts? c. What were the barriers and enablers to effective and efficient project design and management?
Inclusiveness	**3. How inclusive was the AHP response?** a. How were activities designed and implemented to meet the needs of different groups of people (considering age, gender, disability and other social disadvantage)? b. What did the AHP response achieve in terms of protecting the safety, dignity and rights of affected people, promoting gender equality and addressing barriers to inclusion, including for people with disabilities, ethnic minorities and indigenous populations?
Efficiency	**4. How efficient (cost-effective) was the AHP response (CHS 2, CHS 9)?** a. To what extent was the response implemented according to agreed timelines and budgets? b. In what ways was the response implemented to achieve good value for money?
Capacity	**5. Did the AHP response reinforce local capacity/leadership (CHS 3, CHS 4, CHS 6)?** a. To what extent did the AHP investment support strengthen local partners, including civil society (e.g. local women's organisations, disabled people's organisations, etc..), local government engagement and coordination and avoided negative effects? b. To what extent were implementing partners sufficiently accountable to, and engaged with, affected communities, local government and coordination mechanisms? Is there evidence of programs having been influenced by effective communication, participation and feedback?

Evaluation Criteria	Key Evaluation Question and Sub-Questions
	6. How transparent and accountable was the AHP response (CHS 4, CHS 5)? a. To what extent were implementing organisations sufficiently engaged with and accountable too affected people? b. What evidence exists of the projects responding to feedback, participation and engagement?

2.2 Team structure

The evaluation team was led by an independent consultant, engaged by Save as Team Leader. The team also included representatives from each of Oxfam, Save and DFAT, who brought a range of technical, country and contextual expertise to the evaluation. The Team Leader was responsible for final decisions in relation to methodology, development of data collection tools, data analysis, formulation of findings and recommendations, report writing and ensuring overall output quality.

2.3 Methodology

The evaluation methodology was guided by the need to address the KEQs and SEQs outlined above. The Evaluation included an 11 day field trip (22 October to 2 November 2018) to undertake interviews with participating organisations, project beneficiaries and other key informants (GoB, UN agencies, coordination clusters, other NGOs). An AHP Steering Committee, consisting of DFAT and AHP member representatives, was established to oversee development and implementation of the evaluation, with technical support provided by the AHP Support Unit.

While this evaluation needed to place focus on the detail of activations that occurred through the AHP Rohingya response, it was regarded as vital that analysis take into account the broader landscape of response programming in Cox's Bazar given its complexity, the number of different actors and the rapidly changing circumstances of the context.

It was also regarded as methodologically important to accommodate the reality that all of the organisations supported through the AHP have far larger overall programs in place funded by multiple donors, whose funding often overlaps the same sectors and/or beneficiary cohorts of those targeted through the AHP. Within this context, it is common that mechanisms such as AHP benefit from and contribute to individual agencies' overall program.

More generally, the very crowded context of the Rohingya response raises challenges in terms of attributing results specifically to AHP investments. This is particularly the case in sectors such as WASH, health and non-food items (NFIS)/Shelter which each have more than 40 members within their respective coordination clusters.

It was also agreed as important that the evaluation reflect strong understanding of the current dynamics of the response in terms of coordination, government relations, relationships with host communities, linkages with and between different Australian investments, and analysis of the shifts and directions of the sector as a new year approaches.

Methods

This evaluation used a mixed-method approach and drew on multiple data sources in order to develop valid and reliable findings. The methodology consisted of the following components.

a) **A document review and synthesis** was conducted to scope start-up and progress reporting, identify further documents, understand shifts in approach during implementation, and identify key informants relevant to the current response context.

b) **Semi-structured interviews** were conducted during the field work, involving 24 key informant interviews (KIIs) and 24 focus group discussions (FGDs), involving a total of 128 women, 156 men and 12 girls. These included:
   - government officials (2 KIIs)
   - UN agencies (4 KIIs)
   - NGOs (3 KIIs and 1 FGD)
   - extensive meetings with staff across CARE, Oxfam and Save
   - representatives of affected communities.

Annex Two contains a list of these consultations. Annex Three contains interview guides used by the team to work through the KEQs systematically with different informant groups.

Evaluation team members took comprehensive notes during interviews, which the Team leader synthesised as a first step in data analysis. Key themes from the interviews were arranged against the SEQs and collated in an evidence matrix to guide data analysis. Preliminary findings were presented to relevant staff of CARE, Oxfam and Save on 2nd November 2018 in Cox's Bazar.

All community level consultations were undertaken with required introductions and permissions. Interviews were not recorded.

2.4 Evaluation limitations

The primary limitation faced by the evaluation team was limited time in the field, given the need to comprehend a complex, rapidly changing context and the contribution of two ambitious projects (involving three partners all working in different locations). 3.5 days was allocated for engagement of each project. A total of five days was spent in Kutupalong camp. However these days were abbreviated by daily travel (3 hours) to and from the camp and the security protocol of needing to leave the camp no later than 4pm. Time limitations were managed through targeted identification of interviewees and use of secondary data to support triangulation of findings. Despite this approach, there were inevitably gaps in terms of thorough engagement of project staff and beneficiaries, particularly children and disabled people.

3. Evaluation findings

3.1 Appropriateness of activities

While onset of the crisis was sudden, the humanitarian sector immediately viewed it as certainly being a protracted crisis with complex, multi-faceted needs. Given this context, programming over the first twelve month period needed to be two phased, with an initial focus on life saving, immediate needs that would transition to longer term support more typical of a protracted crisis.

In its 2017 Rapid Protection Assessment, UNHCR prioritised the following three needs, based on the population's perspectives and overall assessment findings. These same needs were similarly described in the ISCG Multi-Sectoral Rapid Assessment.[17]

- Ensure continued access to FOOD, SHELTER, HEALTH and CLEAN DRINKING WATER in all sites, including spontaneous settlements and in host communities.
- Specifically ensure access to HEALTH CARE for people with specific needs, including pregnant women.
- Continue set-up of sex segregated WASH FACILITIES and establish community mechanisms to ensure privacy is respected and protection is enhanced.[18]

Government, UN and NGO actors interviewed as part of this evaluation spoke very positively of the AHP being the first funding mechanism to provide longer term funding to the crisis. This allowed for more efficient and effective programming to occur; helped set a precedent that was used by UN agencies and NGOs to advocate for more donors to commit to longer term funding; and also allowed participating agencies to build momentum and leverage additional funding in target sectors based on AHP funding having allowed them to already commence programming. At the same time, AHP funded programming occurred in alignment with overarching systems for coordination.

The scope of the AHP Rohingya activation was also flexible. Criteria for AHP applications required submissions that responded to sectors prioritised within initial needs assessments of the UN: health, nutrition, WASH, protection and education in emergencies, with activities expected to include focus on gender, children and disability inclusion. This breadth allowed applicants to draw on previous experience and play to their organisational strengths. This was particularly significant to this context, given that Save, CARE and Oxfam had long standing programs and relationships in Bangladesh (and the Cox's Bazar area), and were therefore well placed to identify appropriate approaches within their key sectors of experience for scaling up of activities. In the case of Save, they were one of the five founding members of the ISCG – the body responsible for coordination of services to the earlier influx of Rohingya refugees prior to August 2017.

> **Key Finding:** DFAT's early commitment to flexible, unearmarked longer term funding was key to the success of the activation, and was also used to encourage other donors to establish longer term funding mechanisms

Given the sudden nature and scale of the influx (and the fact that many arrived with just the clothes they had on their back), needs of the arriving refugees were multi-faceted. However, despite areas of need being broadly defined by coordination agencies, the areas of focus identified by Oxfam (working with CARE) and Save were of acute relevance to the most urgent needs posed by a refugee influx that peaked at more than 20,000 new arrivals daily.

[17] ISCG Multi-Sectoral Rapid Assessment; September 17 2017

[18] UNHCR Rapid Protection Assessment; October 15 2017.

Oxfam's depth of experience in emergency WASH activities was particularly relevant to a context where water borne disease could have easily gained traction with devastating consequences. Furthermore, a WASH approach that integrated gender and protection was particularly appropriate to the context, given the conservative nature of the Rohingya community and the trauma that women had experienced. Inclusion of CARE within Oxfam's approach further added to their AHP application, given the plan for CARE to focus specifically on ensuring women and girls access to services and WFS focused on responding to the GBV that so many women and girls had experienced. CBM was also mobilized to provide advice in relation to disability inclusion.

Save's application to the AHP proposed an integrated approach over the first 90 day period of the project to addressing the immediate needs of arriving families, through provision of shelter, non-food items, emergency health and protection, and WASH. This laid the ground for longer-term integrated programming working out of Save's nine Health Posts, providing health, nutrition, WASH, education and protection services. Save's decision-making was informed by their longstanding presence in Cox's Bazar, including experience operating and implementing programs in registered camps with UNHCR, informal settlements and host communities with earlier Rohingya arrivals.

Key Finding: All activities supported through the AHP were relevant to priority needs identified within initial needs analysis assessments of UNHCR, IOM and other key actors. Planning and location of activities occurred in line with overall response coordination.

Feedback from affected communities is that AHP supported activities are responding to priority needs, notably in terms of access to safe water and sanitation facilities, reliable systems for health care and through support to education. Notably, community remembers regard Save and Oxfam programming to be of higher quality than that provided by other service providers in their area. For example, "it is known that Oxfam wells are more reliable and safer than wells drilled by other organisations" and that "Save schools are the best available for my children".

Key Finding: Affected communities view AHP supported activities as relevant to their priority needs, and view the programming of AHP supported partners as being of higher quality than those offered by other providers in their camp context.

Feedback was also provided in relation to both projects that gender approaches are culturally sensitive, as evidenced by active support from male community leaders for efforts focused on ensuring women's voice and protection. One community leader speaking of CARE's work in relation to GBV said 'we didn't understand the purpose of the WFS when they opened, so we blocked participation, but now we understand their value and encourage women and girls to participate'.

Key Finding: Affected communities respect AHP partners for their cultural sensitivity and ability to raise gender issues in a manner that is appropriate to the conservative social norms of the Rohingya.

AHP supported activities align with Australia's humanitarian strategy given their strong focus on gender equality and women's empowerment, protection and disability inclusion. Each project has strong monitoring systems in place, including a commitment to knowledge generation through research related to key subjects, as seen in the highly regarded Joint Agency Rohingya Refugee Response Gender Analysis released in August 2018, to which Oxfam and Save were two of four co-authors.[19] Importantly, this knowledge informs broader research on gender and protection and is also the basis for national-level advocacy on gender issues within the response that other response actors draw from and provide support to.

Activities also align with AHP priorities in terms of:

[19] Rohingya Refugee Response Joint Agency Report; Recognizing and Responding to Gender Inequalities; Aug 2018

- Gender performance being strong across all three organisations, with clear and deliberate strategies in place to ensure women's inclusion and voice
- Genuine commitment exists to support disability inclusion (though partners acknowledge significant difficulties in terms of rolling out 'good disability programming' in the context)
- From a slow start, greater focus is now being placed on localisation and host community engagement (see 4.4 below), with each being given greater priority as the response progresses (see 4.5 below)
- Accountability measures are in place - though their effectiveness is uncertain given language and literacy constraints (to be discussed below at 4.6)

While AHP partners de facto benefit from other aspects of Australia's Rohingya response (notably food distribution of WFP), there are currently no deliberate efforts to directly link AHP approaches to different elements of Australian funded programming. This 'untied approach' is commendable in the highly complex environment, given such a directive would further complicate programming.

Key Finding: AHP supported activities align with objectives of the Australian Humanitarian Strategy, including each partner placing priority on gender and disability inclusion.

3.2 Effectiveness of activities

This section takes a light touch look at the overall approach to the Rohingya response of each AHP supported organisation, before looking in detail at what has been specifically achieved through the AHP funding provided through each project. The section will also attempt to consider:

- the value add from broader organisational systems and capacity already in place
- the rationale underpinning shifts in approach during implementation
- strengths and weaknesses of approaches as determined by affected populations and other informed actors
- barriers and enablers to effective and efficient project design and management, and
- the overall contribution of the AHP to longer-term resilience of affected communities and stabilisation efforts.

Save the Children

Save's overall Rohingya response strategy is to ensure Rohingya children and their families are supported in their basic human rights. This occurs through provision of food and NFIS, shelter and kitchen kits, WASH support, establishment of TLCs, and to provide case management services for at-risk or unaccompanied children, including mental health and psycho social support (MHPSS).

In its Rohingya Crisis Response Strategy 2017-20, Save identifies the following areas of focus for its overall response effort:

Sector	Target
Child protection	60,000 individuals
Education	46,400 refugee children 50,000 host community children

Sector	Target
Food security and livelihoods	560,000 individuals for food 20,000 individuals for livelihoods
Health (integrated with Nutrition, WASH, Community Health and MHPSS)	160,000 individuals
Nutrition (prevention and treatment of acute malnutrition)	100,000 individuals
Shelter, NFI and settlements	50,000 (provide direct shelter) 300,000 (indirect – through settlements)
WASH	200,000 receive hygiene kits 80,000 WASH promotion beneficiaries
Cross cutting elements	Community engagement and mobilization Gender sensitivity MHPSS Conflict sensitive programming Monitoring, Evaluation and Learning (MEAL)

The Save AHP proposal detailed nine outcome areas with the aim of reaching 154,418 beneficiaries. These outcome areas more or less overlaid Save's overall response strategy described above. Individual outcomes identified were Shelter/NFIS/ Food; WASH; Health and nutrition; education; and five inter-connected protection focused outcomes related to the specific issues of:

- unaccompanied and separated children (UASC)
- reducing exploitation of children in general
- providing MHPSS support
- supporting caregivers in protecting children
- establishing community mechanisms in support of child protection.

The overall program is underpinned by a sophisticated monitoring system that allows for precise disaggregation of results by different donor contribution.

An important element of the early nature of the AHP funding was that it provided resources that helped Save build momentum across these different outcome areas, which they used to leverage other donors, contributing to Save now running the largest NGO program of the response.

Key Finding: Save AHP activities were clearly defined and had value added to them through the organisation's broader suite of integrated response activities, mechanisms and staffing. When underachievement occurred, this mostly related to FD-7 related delays or reallocation of funding to support broader program efforts i.e. dynamic management of

AHP funds to either fill gaps or avoid duplication related to other donor efforts.

AHP support to Save also allowed for two phased programming, with an initial stage focused on ensuring shelter and access to food and NFIS of 4,700 households (23,500 individuals). This target was exceeded with 6,200 households being provided tarpaulins, rope, kitchen and hygiene kits, and supplementary food packages.

The central challenge for Save is to achieve meaningful integration across its ambitious spread of different program components. The ambition and breadth of Save's program contributes to significant challenges in terms of FD-7 management, given that the organisation needs to negotiate and manage multiple FD-7s simultaneously.

Breadth of Save programming presents other management challenges too, in terms of difficulties faced by staff, volunteers and Community Mobilisers in keeping abreast of the different elements and capacities of Save's approach.

Key Finding: Despite the breadth of sectors supported through AHP funded programming, Save is able to implement an integrated program that benefits from synergies between sectors. Its sophisticated approach to monitoring is also able to disaggregate results.

Save's strategy for program integration is based on using Save supported Health Posts as the centrepoint for program implementation. Save currently runs nine Health Posts across eight different camps. A standard Health Post has two doctors, two paramedics, a midwife, a family planning assistant, an MHPSS counsellor and a clinic aid (responsible for data management). In the case of the Health Post visited during the evaluation (in Camp 18), programming was supported by 19 health volunteers, 25 nutrition volunteers and five traditional birth attendants (TBAs) who are able to work across the target community, raise awareness of Save services, identify emerging issues in the community and also help identify protection issues. Working across all health posts are four clinical health supervisors with specialist skills, two health information management coordinators and a sexual/ reproductive health advisor who assist with strategy, coordination and trouble shooting.

Save supported Nutrition Centres are stand alone in their management, but are always closely located, if not side by side with Health Posts. These support basic supplementary feeding programs, but also offer specific services related to infant and young child feeding in emergencies (IYCF-E), and treatment of malnutrition. Nutrition Centres are primarily staffed by women (85%) with specialisation in community management of acute malnutrition in infants (C-MAMI), IYCF-E and outpatient support. Users express appreciation for the convenience of this spread of services being co-located, and the reliability and quality of services. In terms of impact, Save has observed significant reductions in malnutrition rates across its Nutrition Centres with severe acute malnutrition having reduced from 3.5% in April 2018 to 1.4% by November, and moderate acute malnutrition reducing from 19% to 12% in the same period. However, Save also notes that reversals can quickly occur related to small shocks such as the monsoon restricting movement of people.

Focus is also placed on young women and lactating mothers in order to raise awareness of the importance of breast feeding in the first few days after delivery, given a traditional misconception amongst the Rohingya the early (colostrum filled) flow of breast milk should be thrown away. However, it is proving difficult to get women to visit health centres in the very important first few days after birth. In this instance, Save is working with men to raise awareness of the importance of a health check for new mothers during this period.

WASH programming also draws off the Health Post, with WASH messaging provided to people while they wait to attend Health Posts or Nutrition Centres. This allows multiple people to be engaged easily, supports peer to peer education and also helps pinpoint specific issues and locations relevant to water borne disease. Child protection programming also connects with the health post in terms of identifying UASC, vulnerable children and care givers and connecting them to culturally

appropriate care options. Key health messages are also provided to parents and children while in attendance at Health Posts, and through Save programming more generally.

As with all facilities in the camps, the major constraint faced by Health Posts and Nutrition Centres is a lack of space, meaning that facilities are by necessity cramped and crowded. This appears to be managed very well by Save in terms of i/ processes that ensure a smooth flow of services and ii/ sufficient staffing availability to work people through as quickly as possible. However, space also presents a challenge in terms of providing clients optimal levels of privacy. A further challenge at the health posts is that men's attendance is low, which is thought to relate in part to men being culturally uncomfortable being in such close proximity with the large numbers of women who are either at the Health Post themselves to receive care, or accompanying their child(ren). It also likely relates to the worldwide phenomenon of men being less likely to seek out medical care.

In order to support educational access for Rohingya children, TLCs have been established to help restore a sense of normalcy and stability to children's lives. Teachers come from both the host community as well as the Rohingya community and have received training to deliver non-formal education, drawing from Save's extensive experience globally in support of literacy, numeracy and social and emotional learning in emergencies interventions.

Save's child protection, involving training of all staff in relation to the principles of child protection in general, and issues specific to the Cox's Bazar context. While child protection is approached as a whole of organisation responsibility, specifically skilled child protection teams are also in place to lead efforts.

Supporting the overall approach of Save is a network of volunteers and community mobilisers who maintain a constant presence in target communities, acting as awareness raisers in relation to Save services, but also as sentinels in terms of identifying emerging needs and households at risk within target communities. Overall, Save has recruited 25 Community Mobilisers per Health Post, of which 50% are female and 30% from the host community.

Volunteers also encourage community participation in mechanisms such as WASH Committees which are key to management and safety around WASH facilities. Similarly, Education Committees encourage households to utilize TLCs including efforts to ensure girls participation and act as a conduit for communications with local *Madrasa* (Islamic learning centres). While this network of volunteers is an important resource, a conclusion of the evaluation team was that volunteers and community mobilisers could contribute more if better supported to fully understand the overall programming approach and capacity of different Save activities. This assessment is based in the difficulty that many within different volunteer cohorts had in describing other facets of Save operations, and subsequent missed opportunity for these volunteers to raise awareness of the whole of Save's programming approach. One mobiliser highlighted that while 'we receive a lot of training already, we need constant refresher training to stay in touch with new strategies of Save'.

Effectiveness of health and nutrition services

Evaluation team observations of activities occurring within Save health and nutrition centres were positive. Facilities appear to be well structured, welcoming, respectful of the needs of women and finely tuned to capture and respond to patients that might need special attention (related to malnutrition, mental health concerns, protection concerns, etc.) through direct response or referral.

Key results of AHP funding in relation to health and nutrition (measured against initial targets) are affected by the fact that Save needed to identify other donors to cover services due to FD-7 related delays in relation to AHP support. Delayed recruitment of staff to their nutrition program also contributed to delays and under-achievement against planned results.

Save AHP Health and nutrition activity description	Target	Actual

Children u/5 receiving MCH services	64,687	51,177
Pregnant and lactating women receiving MCH services	25,471	17,688
Children 0-6 screened for acute malnutrition	2,009 male 2,091 female	129 male * 121 female *
Children enrolled in C-MAMI program	37 male 76 female	22 male 20 female
# of participants receiving IYCF-E training (as trainers of trainers)	12 male 13 female	20 male 18 female
# of community volunteers receiving training sessions on C-MAMI	22 male 23 female	22 male 23 female
# caregivers of children u/ 24 months receiving IYCF-E counseling and health services	8,189	0 *

* = activity covered through other donors in response to FD 7 delays

Key Finding: Users of Save Health and Nutrition centres express appreciation for the convenience of these being co-located, and the reliability and quality of services.

WASH

As mentioned, Save's WASH programming is integrated with health and nutrition programming, focusing on access to safe water, sanitation and hygiene improvement. Given the presence of many actors in WASH, Save was able to draw on other donors in relation to construction of deep wells for drinking water, and focused AHP funds on sanitation and hygiene. This shift explains the variation in the numbers below. Save utilised AHP funds to support establishment of WASH Committees who supported identifying suitable location of facilities, and also undertook training in operation and maintenance of facilities. Health and hygiene awareness sessions were also integrated within the approach and were able to access significantly more people than originally anticipated. Save also introduced gender segregated latrine and bathing facilities which are very well received by both women and men. Space is provided in these bathing units for cleaning and washing clothes, and a simple menstrual pad management and disposal system is now being trialled in some women's facilities. AHP funded WASH facilities have been augmented and made safer through the provision of solar lighting by other donors.

Save AHP WASH activity description	Target	Actual
# of people benefiting from accessible emergency latrines	5,000	5,100
# of people benefiting from bathing units	8,640	5,920
# of individuals participating in Health and Hygiene awareness sessions	21,000	33,750

Child Protection

Save is co-chair of the Child Protection Cluster with UNICEF and is recognised globally as a leading authority in the sector. While child protection achievements through the AHP are impressive, they represent only a small proportion of the different elements that comprise Save's overall approach to child protection in the Rohingya context. Save works to mainstream child protection throughout

its approach, with community mobilisers, teachers, health workers and target community members all provided training in relation to identifying potential protection issues.

However, there are also dedicated Child Protection Case Workers who are community based, and work to achieve full coverage of households within the blocks that they are responsible for. Key to Save's approach are Community Based Child Protection Committees. These commonly include *Imams* and *Majhis*[20] (community leaders) and focus on addressing key known risks (nutrition, caregiver capacity), while also acting as sentinels for identification of non-typical risks related to mental health and vulnerability to exploitation. The most common protection issues faced are early marriage of girls, trafficking of teenagers into labour (often onto fishing crews), domestic violence, GBV and issues related to households that are simply unable to cope with their living situation.

Save strategically uses its Emergency Preparedness Planning processes as an opportunity to raise awareness amongst parents of child protection issues. This approach allowed for significant over achievement with 4,888 parents reached against a target of just 600.

Another general resource supporting Save's child protection approach is its team of Community Mobilisers (totalling more than 250 people) who work across different sectors in support of messaging and engagement at community level in relation to Save's integrated programming model. This team are in the community daily, going door to door to speak with households to raise awareness, understand needs and identify acute disadvantage and other issues of concern. While the Child Protection Case Workers see the Community Mobilisers as a vital asset (particularly women Community Mobilisers), they also expressed concerns to the evaluation team regarding their capacity to identify protection risks and believe their role could be better leveraged if provided more specific training on child protection.

MHPSS is another aspect of child protection of particular importance to this context, given the violence that occurred prior to and in the process of seeking refuge – particularly women and girls. Save work in the MHPSS space is focused on supporting children to best manage their experience. In cases of further need, Save refers to higher service providers. Performance measurement with regards to MHPSS is based on a monitoring tool developed by Save's MHPSS Advisor, to be used at baseline and end-line with all children participating in PSS sessions. However, this tool proved difficult to use for many of the data gatherers resulting in Save developing a simpler approach to retrospectively assess whether children's wellbeing had increased following MHPSS support.

More generally speaking, actors right across the Rohingya response express concern that the system for MHPSS is inadequate to needs and that it is likely that many needs are going unmet at this point in time. A recent UNHCR study highlighted a range of challenges related to MHPSS service provision. These mostly revolve around issues related to the still limited understanding of Rohingya cultural norms, conceptualisation of psychological problems and help seeking behaviour. The crowded nature of the camp can also compromise confidentiality.[21] It is expected that the new JRP will aim to address weaknesses in MHPSS service provision through pressing agencies to be more deliberate in their approach and performance measurement.

Save AHP Child Protection activity description	Target	Actual
Appropriate protective care in place for 15% of registered UASC	90	90
60% of children reached through PSS programmes reporting that interventions have been beneficial in helping reduce stress	660 60%	1,065 75.5%
# of parents trained on Positive Discipline in Everyday Parenting	600	516

[20] Majhis are traditional leaders in charge of blocks (standardly 100 people) within the camp

[21] UNHCR; A review for staff in mental health and psychosocial support programmes for Rohingya refugees, Nov 2018

# of parents trained on other child protection issues	600	4,888

Education

The final pillar of Save's integrated approach is education. Save is a co-chair of the education cluster, where it is playing a lead role in trying to progress several core issues related to teacher accreditation; an agreed curriculum framework; standardised teacher conditions and advocacy with the GoB on increased space for education in camp settings. Providing education is complex in the context of the Rohingya response given significant restrictions imposed by the GoB around 'formal education', including a strict ban on any form of education being provided to those aged 15 and above. Save gets around these restrictions by working with children 14 and under in 'temporary learning centres'. Advocacy in relation to the needs (and risks) associated with this cohort is a recommendation of this evaluation.

Other issues related to education include the quality of teaching; the difficulty recruiting suitably qualified Rohingya teachers; and the language of tuition (given Rohingya is not a written language). There has also to date been no agreed curriculum due to the constraints imposed on education, but this is now being addressed at cluster level, with Save playing a lead role. While Islamic schools (*Madrasa)* also provide education, their quality is unreliable and is often narrowly focused. Within the Rohingya context, Save supported Education Committees work to engage *Madrassa* with the aim of ensuring children the capacity to attend both. This was confirmed in a meeting with caregivers, where it was widely agreed that 'most children go to the *Madrasa* early in the morning, and then the TLC later in the day'.

A weakness to date of the camp teaching system has been the absence of diagnostic testing of individual teacher capacity. Save is now developing that capacity to assess its own teachers, and then using this testing to provide training to teachers to address weaknesses.

There are also camp wide concerns regarding levels of participation of girls (especially the 11-14 year old cohort) in learning centres. However, Save reports that this varies from centre to centre and is dependent upon the quality of outreach undertaken with the community. In the case of Save, more than 45% of TLC participants are girls, which they link to the multi-faceted approach they have to community engagement and high quality dialogue with parents, care givers and consultations with religious authorities.

Another widely raised concern relates to teachers leaving the Bangladeshi system to benefit from the better pay on offer for teaching in the camps. Save sees this as a serious issue, and is aiming for it to be addressed through efforts to standardise conditions for teachers across the education sector, taking into account the acute importance of not destabilising local schools and antagonising host communities.

Save currently supports 100 TLCs (of which 60 are AHP funded). These provide three two hour shifts five days per week to 4-6 year olds; 7-10 year olds; and 11-14 year olds. This work occurs in partnership with a Bangladeshi NGO, YPSA. Teaching occurs in pairs with a Chittagonian speaking host community teacher (who has completed the Bangladeshi higher school certificate) working alongside a Rohingya person (who has at least grade eight qualification).

In most TLCs, both host and Rohingya teachers have had no previous teaching experience. In response, Save has initiated a program of teacher professional development involving a mix of structured trainings and on the job mentoring. Save initially ran trainings on foundational skills including classroom management, pedagogy, psycho-social support and teaching literacy and numeracy skills. Save also organises monthly peer learning meetings which bring teachers from different TLCs together. These are an effective and efficient forum for addressing common issues observed in TLCs, without needing to organize a structured training.

Assessments identify that through structured trainings and mentoring, teachers have improved an average of 67.5% across six areas of teaching practice measured by Save. The six areas were lesson planning, positive relationships with student, positive discipline and classroom management, active teacher strategies, and checking for student understanding.

Key Finding: Save work in the education sector is multi-faceted, drawing off its work supporting TLCs to inform sector needs related to teacher quality, training and certification, as well as much needed curriculum development.

Save AHP Education activity description	Target	Actual
# of TLCs % of targeted children enrolled in TLCs	60 TLCs 95%, including 3,145 boys and 3,695 girls, totaling 6,840 children	60 TLCs 93%, including 3,480 boys and 2,910 girls, totaling 6,390 children
% of targeted teachers who improve teaching practices in the TLCs	100% including 90 female teachers	67.5%; 120 teachers, including 56 Rohingya
# of parents and caregivers who have increased knowledge on how to support their children's learning, development and well-being	270 males 2,430 females	180 males 4,960 females 100% of sample report increased knowledge

All of the above achievements need to be understood within the context of Save's integrated approach, meaning that different elements of the program benefit from and reinforce each other. This is particularly the case in terms of child protection, which is advanced through Save's work in each of shelter/food/NFIS; WASH; education; health and nutrition. Save 'investments' also have value added to them through broader programming efforts. For example, Save leadership in the education sector advances education programming in general through advocacy and higher level technical inputs related to matters such as curriculum development. In this context, AHP investments in education can be seen as having broader impact than just those children who sit in AHP supported TLCs, since the approaches being rolled out in those centres are helping inform higher level education reforms.

Key Finding: Save's integrated approach to the Rohingya response is ambitious and responds holistically to a suite of identified needs, that align closely with the organisation's mandate of supporting children to attain their right to survival, protection, development and participation. Affected communities report that strategic support and inclusion of parents within Save's development approach helps strengthen household and community resilience, and progresses child wellbeing.

Oxfam (with CARE)

The AHP is one of four different projects on which Oxfam and CARE collaborate within the Rohingya response. This broad based collaboration is cited as having helped ensure smooth, shared programming and facilitated heightened awareness of the relative strengths of each organisation.

Oxfam overview

As with Save, the commitment through AHP of early, longer term funding is regarded by Oxfam as catalytic in helping them scale up their response to full capacity. It also helped model integrated WASH-protection approaches aimed at meeting the needs of at least 24,500 households monthly.

This modelling was significant given that many WASH active agencies were relatively new to WASH in complex humanitarian settings such as the Rohingya response.

Specific focus on gender focused WASH was acutely relevant to needs defined within initial UN rapid assessments, given the acute trauma and violence experienced by many women and girls when fleeing Myanmar. More generally, Oxfam maintains sector leading capacity with regards to WASH and mainstreaming of gender within its approach. This includes efforts to promote women's agency through establishment of women's groups within the camps, and efforts to sensitize and mobilize the male leadership of communities in support of women's rights and inclusion. An aspect of Oxfam's commitment to gender has been the undertaking of important research projects focused on the needs of women within the crisis and opportunities to better engage and empower women.

CARE's support to the creation of WFS aligns with and complements Oxfam's approach to support women. Provision of a safe place for women to access confidential counselling and GBV related services was acutely relevant to needs, given the trauma experienced by a high proportion of women during the crisis and in the process of seeking refuge. WFS also support women to better organise and advocate. For example women have advocated for improved bathing facilities, and better access to women's hygiene kits – both of which are commonly cited as urgent outstanding needs within the response.

However, the full potential of Oxfam and CARE's programming complementarity was undermined to a significant degree when rezoning of camp boundaries led to Oxfam and CARE activities being split off into different camps under different site management. Despite this, CARE has been an important provider of GBV training to Oxfam, based on learning achieved through AHP funded WFS.

> **Key Finding:** While there was strong logic, complementarity and a potential continuum in the proposed approach of Oxfam and CARE at the time of design, this was largely lost when camp rezoning resulted in Oxfam and CARE activities being split across different camps.

AHP funding also supported collaboration of Oxfam and CARE with CBM in relation to disability, which resulted in strengthening of staff capacity to better identify disabled people based on application of the Washington Group methodology. This has led to increased identification in the number of households affected by disability, which in turn has highlighted the need to better respond to the specific needs faced by such households.

AHP support also facilitated collaboration of Oxfam and CARE with Translators Without Borders (TWB) in relation to communications. This input has strengthened programming of both organisations beyond just AHP supported activities. In particular, TWB's glossary provides text and audio translations in 'app form' of the five languages key to the response — Rohingya, English, Bengali, Chittagonian, and Burmese. This app provides high quality translation in each language of key terms relevant to gender, GBV and WASH, thus strengthening responsiveness and quality of engagement with affected communities, especially women. It also brings value as a tool widely used by many organisations across the response.

Given its long history in WASH, Oxfam is a highly regarded contributor to the sector, and plays an important leading role in sector coordination, as well as a valued support role to the cluster. Given that many actors involved in WASH chose to focus on sanitation and hygiene elements ('soft WASH'), Oxfam saw its value add in being more focused on 'hard WASH', including water supply and fecal sludge management. On the latter, Oxfam has partnered with UNHCR, providing vital technical assistance to a UNHCR funded mega fecal sludge management unit capable of covering the needs of 300,000 people in an environmentally responsible way.

Currently Oxfam plays a lead role within the WASH cluster helping assist in preparing the 2019 JRP and WASH sector strategy. In an interview with staff of the WASH cluster, Oxfam was appreciated for its reliable support to coordination efforts within the sector. Furthermore, Oxfam is recognised

for its commitment to ongoing innovation throughout its WASH programming, with initiatives ranging from 'biofill' latrines (which use worms to facilitate self composting) to the large scale fecal sludge management systems described above.

Oxfam is also innovative in terms of its use of vouchers that allow refugees to use local trader shops (run by host communities) to procure WASH items. This AHP funded initiative is a good example of integrated programming that links up different program aspects in a form that strengthens host community relations. Generally speaking, Oxfam is working to use the AHP to trial and shift towards cash/voucher systems as a solution that engages the host community (traders).

Oxfam also assumes a leadership role at camp level, where it is the camp focal point for WASH across all six camps (3, 4, 4 ext, 12, 19 and 22) that it works in. This is increasingly significant as coordination responsibilities have been significantly devolved over the course of 2018 in response to weaknesses in higher level coordination systems. Specifically, the role of camp level WASH coordination is of increasing importance as the need for latrine decommissioning increases in a context where the organisations responsible for management of those latrines are now withdrawing due to funding issues. Decommissioning of shallow wells, and a focus on the safer, more environmentally friendly deeper wells is also now being supported and, to a significant degree, led by Oxfam. This situation has Oxfam increasingly expanding into new blocks within camps to ensure ongoing access to high quality WASH for all.

> **Key Finding:** It is thought likely that many smaller actors will soon withdraw due to funding issues, leaving gaps in service provision and facility repair, maintenance, desludging and decommissioning that larger NGOs such as Save, Oxfam and CARE will be approached to fill.

CARE overview

CARE launched its programming in Cox's Bazar in September 2017 with an initial focus on nutrition, food, and NFIS distributions. CARE is responsible for Site Management in Camp 16, but also undertakes programming in five other camps (11, 12, 13, 14 and 15). According to its Rohingya Response Strategy of April 2018, CARE's priority sectors are as follows:

Top Priority Sectors:

- Protection/ GBV: (focusing on both response and prevention)
- WASH: (focussing on WASH Infrastructure and rehabilitation and Hygiene Promotion)
- Shelter/ NFIS Distributions (focus on NFIS distribution, shelter construction and upgrade)

Secondary Priority Sectors:

- CMAM – focussing on technical and advisory support in collaboration with UNICEF
- SRH (Sexual Reproduction Health) focusing on Primary Health care/ SRH services through i/ management of four clinical treatment centres, and ii/ mobile and outreach programs

CARE's value add to the Oxfam AHP submission was specifically focused on protection and GBV. This dovetailed with Oxfam's gender sensitive, protection focused WASH work. Establishment of WFS in the severely space constrained context of the camps also provided privacy and an important vehicle for women to share information, discuss needs, seek support and develop strategies to address GBV which continues to be a widespread problem within the crowded camps.

In specific relation to GBV and protection, CARE's approach involves:

- Establishing both static (WFS) and mobile safe spaces (through outreach) for women and girls that allow for safety audits, consultations and other GBV relevant activities (counselling, referral, etc.).

- Improving community based approaches to prevention of GBV, including counselling, referral pathway development and case management services, as well as Sexual Reproductive and Maternal Health services
- GBV awareness raising and outreach in the community, through sessions that promote gender equality, GBV awareness, knowledge of the particular risk and vulnerabilities for women and girls, the value of 'safe spaces', and the availability of GBV response services
- Establishment of Community protection groups that provide a space for the community to discuss and collate information on areas of insecurity in the camp, as well as safety audits with women and girls to identify areas of concern.
- Distribution of dignity and infant kits to women and girls of reproductive age that complement other components.

AHP activities implemented by Oxfam/CARE

Oxfam utilisation of AHP funding was two phased. An initial mobile period supported provision of emergency type approaches and facilities focused on addressing immediate, life saving needs. The second phase focused on support to communities as they settled into their camps through construction of family shared latrines, provision of clean water through installation of deep tube wells attached to hand pumps, mobilization/ engagement of local communities in support of WASH, construction of women's spaces (protected laundry and bathing spaces), provision of operation and maintenance of existing WASH facilities, and de-sludging (safe disposal of faecal waste) of latrines' pits. Both phases were undertaken in close collaboration with the WASH sector working group. Given this scenario, AHP funding has helped model and benchmark higher quality WASH performance to the broader sector.

> **Key Finding:** Oxfam's work in the WASH sector is multi-faceted, and includes significant macro level work related to hydrological assessments and fecal sludge management. Being active at most points of the sector makes Oxfam an important voice within camp WASH committees where it is able to model and support other actors to achieve better outcomes.

A strength of Oxfam's approach has been its ability to quickly adapt to changing circumstances, including the number of donors present in the WASH sector. For example, the extreme population density of most camps, the steepness of the terrain and the very heavy monsoonal rains experienced across July-August are all issues of acute importance to WASH approaches that Oxfam was quickly able to adapt their approach to. Acute challenges and needs related to disability inclusion were also identified as soon as communities began to settle.

In response, Oxfam sought an early contract amendment from DFAT that reflected these early contextual shifts. This led to a shift in AHP funding emphasis from arriving communities towards settled communities, including strengthening its focus on protection and gender issues. There was also increased funding allocated from the AHP grant to the sub-grant with CBM and their local counterpart, Centre for Disability in Development. This shift allowed for a full disability assessment of Oxfam and CARE programming to be undertaken, followed by a series of trainings and capacity-building sessions for staff, and integration of disability within the AHP project MEAL plan.

Revised project outcomes for AHP funding are as follows [22]:

[22] All outcome one beneficiaries are also reached through outcome two activities. Outcome three activities (implemented by CARE) represent a totally different cohort, meaning that the targeted number of individuals reached across the project totals 116,360.

- **Outcome One**: Estimated 59,750 of the most vulnerable women, men, girls and boys, recently displaced from Myanmar to Cox's Bazar, including those with disabilities, benefit from having their basic water, sanitation and hygiene needs met
- **Outcome Two:** 76,360 women, men, girls and boys, including those with disabilities, and older people in spontaneous settlements, refugee camps and host communities have increased knowledge and awareness of good hygiene practice by the end of the project
- **Outcome Three:** At least 40,000 women, girls, boys, and men, including those with disabilities, have access to information and protection services through an information and education campaign and the provision of dignity and infant kits *(through CARE)*

This revised approach reflected the changed situation of the camps in terms of:

- The relatively rapid settlement of people into camps, meaning that the shift from support to emergency needs to longer term settlement could occur more quickly than planned.
- Rezoning of camp boundaries, requiring Oxfam and CARE activities to be implemented with greater autonomy than originally envisaged.
- Greater emphasis being placed on local level coordination, and the need for sector leading agencies such as Oxfam and CARE to assume greater responsibility for local coordination, given the technical weaknesses of other actors. e.g. taking action to address and remediate sub-standard sanitation and sludge management systems initially put in place.

With these adaptations, Oxfam's AHP funded gender sensitive WASH approach was enhanced in terms of its relevance to context. It also ensured a sophisticated, multi-faceted and inclusive approach that responded responsibly to coordination challenges. Importantly, Oxfam's WASH work addresses urgent needs related to sustainability of sanitation systems, and provides modelling of approaches and technologies that have been adopted by other WASH sector actors in terms of sustainability and appropriate environmental management.

WASH user groups established by Oxfam are responsible for monitoring and basic management of WASH facilities in their area, including keeping well areas clear; connecting with maintenance teams as required and keeping children from using shallow wells (which carry a greater disease threat). WASH user groups also undertake awareness raising with women, men and children.

AHP supported maintenance teams led by a Public Health Engineer are constantly moving around the community responding to needs. Users of facilities speak of "Oxfam wells being known to have 'better water'", and are satisfied that maintenance and desludging of toilets occurs with quality in a timely manner. There is also great enthusiasm for the 'Bio-Fill' worm-toilet system introduced by Oxfam, given that it doesn't smell, reduces the number of flies and does not require desludging (if managed appropriately). An interview with an AHP supported Water Point Management team highlighted that teams do not consistently have access to a full range of tools. They regard this to be an inefficiency reducing capacity to respond to 'easy to fix' issues identified in their day to day work.

Concerns expressed by WASH facility users include a desire for latrines to be gender disaggregated, while recognising at the same time that chronic space issues restrict options. It is also noted that use and satisfaction with facilities by women and the disabled correlates closely with proximity i.e. higher levels of dissatisfaction when facilities are not in the immediate proximity of the residence.

The WASH User Group structure is supplemented by Oxfam's system of 'Listening Groups' which allow feedback on program performance and community issues from six different cohorts: women, men, girls, boys, the elderly and traditional birth attendants. While these groups provide feedback on WASH facilities, they also provide input more generally in relation to food and nutrition security; issues arising with food distribution; health and hygiene; security and the performance of community leadership (the *Majhi* structure). When possible, Oxfam responds to concerns directly.

When concerns sit outside Oxfam's programming capacity, information is passed on to camp management, and also monitored to determine if action has been taken.

Key Finding: Oxfam's approach to community engagement is sophisticated and inclusive, and has resulted in strong lines of communication and levels of action and ownership of both WASH facilities and key issues of importance such as women's rights and protection.

An important aspect of Oxfam WASH performance relates to Oxfam having directed AHP resources, at the request of Camp management, to the repair, refurbishment and decommissioning of WASH facilities that were either poorly constructed in the first place by other WASH actors, or where upkeep has ceased due to the responsible organisation pulling out of the camp. This approach has involved Oxfam desludging of 1,549 latrines and decommissioning of 188 emergency latrines, augmented by establishment of 356 latrine user groups (10 - 15 persons each, with 50% female participation representing 5 households sharing the latrine).

Oxfam/CARE Outcome One activities	Target	Actual
59,750 individuals (vulnerable men, women, girls and boys) reached through the provision of safe water and sanitation facilities	41,000 individuals will be provided access to safe water and sanitation facilities	55,176 individuals have access to safe water and sanitation facilities, through use of deep tube wells
	70 deep tube wells installed	78 deep tube wells installed across camps 12 and 19
	50 water point attendants trained in maintenance	50 water point attendants support water point maintenance
	59,750 individuals will be provided with equitable access to sanitation facilities	38,725 individuals in camp 12 and camp 19 benefited from latrine dislodge (not counting latrine decommissioning to avoid double counting)
	220 women's bathing cubicles installed	130 women's bathing cubicles installed (in addition, Oxfam repaired 218 cubicles in response to WASH sector requests)
	7,500 women have access to protected bathing cubicles	3,250 women have access to protected sanitation

Oxfam's Outcome Two focuses on health awareness, including the provision of both personal and latrine hygiene kits. Central to the approach are community based volunteers (CBVs) who work with Oxfam's health and hygiene promotion team in relation to hygiene promotion to encourage behaviour change. Of the 151 CBVs recruited and trained by Oxfam under the AHP, 75 are female. Importantly, all 16 CBV supervisors (who are also volunteers) are women. All are Rohingya.

The purpose of this model, was to firstly empower the affected community with knowledge, capacity in relation to health and hygiene management, and voice to influence Oxfam programming decisions. However, it also provided eyes and ears in the community that were of critical importance to monitoring the effectiveness of approaches, refining strategy and also in helping identify action needing to be taken by engineering teams.

CBVs also formed an important aspect of Oxfam's gendered approach to WASH, with all volunteers provided training relevant to promoting women's rights and safety. Approaches included women

only demonstrations focused on the use of the washable sanitary pads (used during menstruation) that formed part of the sanitation kits being distributed.

Key messaging focused on the importance, use and maintenance of latrines; risks posed by open defecation; disease control (e.g. acute watery diarrhoea and diphtheria); water point management; food hygiene; and awareness raising in relation to water point differentiation in terms of drinking water and domestic use water. Efforts to tailor awareness raising to the needs of children occurred through utilisation of a local NGO, Action for Theatre, who used innovative theatre based approaches to engage children around sanitation issues.

Key Finding: The importance placed by Oxfam on recruiting Rohingya staff with 50% female representation is impressive, and is central to the strong relationships it appears to have developed throughout its target communities. .

Oxfam/CARE AHP Outcome Two activities	Target	Actual
76,360 people reached through health awareness campaign, knowledge products and hygiene materials	76,360 people reached through health awareness campaign, knowledge products and hygiene materials	55,300 people reached through health awareness campaign, knowledge products and hygiene materials
	1350 latrine cleaning kits provided	1240 latrine cleaning kits provided
	2500 full hygiene kits provided	2500 full hygiene kits provided
	Soap kit replenishment provided to 15,272 families	11,800 households receive monthly soap allocation, drawing on AHP and other donor support
	150 Community Based Volunteers trained, provided incentives and receive kits to support their work	151 Community Based Volunteers trained, provided incentives and receive kits to support their work

Outcome Three (implemented by CARE) aimed for at least 40,000 women, girls, boys, and men (including those with disabilities) having access to information and protection services through an information and education campaign, and the provision of dignity and infant kits. This target was surpassed, with 43,865 individuals receiving information around women's wellbeing, notably family planning, menstrual hygiene and management of issues related to GBV.

As with Oxfam and Save, CARE has also played an important role at sector level through its contribution to the Gender in Humanitarian Action Working Group.

While the most visible and high profile aspect of CARE's approach is the WFS, the actual centrepiece of their approach is broad based community awareness raising of issues relevant to promotion of the needs and rights of women. Importantly, the approach places priority on inclusion of men and boys, as well as community and religious leaders. Initial concerns amongst some men in the community related to 'immoral' WFS have been largely overcome through abovementioned efforts to establish clear lines of communication with male leaders within the community.

During the evaluation, the team was able to meet with various Men's Watch Groups established by CARE. These included a Men's Watch Group comprised of community elders and *Imams* who spoke persuasively and in detail of their support for CARE's work, their ability to contribute and why they choose to contribute. Younger male outreach workers are also supporting awareness raising

amongst men, including younger men. Beyond facilitating support for women to attend the WFS, engagement of male leaders aims to counter the prevailing cultural narrative in relation to GBV.

This approach is building awareness of the various needs of women and girls, ranging from the need to reduce the prevalence of GBV, to family planning, to disaster preparedness and the value of MHPSS services in supporting women and girls who have experienced trauma. When actual GBV issues are identified, trained outreach workers support women to access psychological first aid available through WFS, and also facilitate referral to higher level services when required.

Key Finding: CARE's work is responsive to the complex needs of Rohingya women, and strategically works to ensure support from men (including community and religious leaders) to help ensure women's safety and access to much needed services.

Oxfam/CARE AHP Outcome Three activities	Target	Actual
At least 40,000 women, girls, boys, and men, including those with disabilities, have access to information and protection services through an information and education campaign and the provision of dignity and infant kits	40,000 women, girls, boys, and men of reproductive age receive information and education materials on GBV, sexual exploitation and abuse, protection and sexual and reproductive health and rights.	43,865 individuals (24,580 women, 7975 girls, 8117 men and 3139 boys) have been reached by information through house to house visits, awareness sessions inside and outside the WFS.
	7,500 women and girls of reproductive age receive dignity kits, and 4,000 mothers receive infant kits for hygiene.	7890 women and girls have received dignity kits, and 3200 women and girls have received infant kits.
	40,000 women and girls, including those with disabilities, have information and access to protection services.	32,555 women and girls reached through outreach visits and awareness raising sessions (outside and inside WFS). 6670 women and girls (2763 adult women and 3907 girls below 18,) have received information on services available to those who have experienced violence, and participated in confidential group discussions about different forms of GBV, family planning, health and hygiene. 436 women and girls have been referred to GBV and other non-GBV services. 1,309 women and girls have received psychosocial support. 430 have received psychological first aid.

Barriers and enablers to effective and efficient project design and management

Weaknesses in Response coordination

Very experienced humanitarian workers speak of the Rohingya response being one of the most complex humanitarian scenarios they have encountered. This relates in large part to the sudden

onset of the emergency, the number of people seeking refuge and subsequent congestion given the limited footprint available for refugee settlement. Space constraints contribute to poor living conditions and impact protection given extremely high population density. This restricts capacity to establish facilities and other services, impacts community cohesion and exacerbates protection issues. It also restricts the capacity of humanitarian actors to respond to feedback from affected populations. For example, Oxfam would happily construct gender disaggregated WASH facilities and Save expand the size of their Health Posts and TLCs were there room to do so.

Another obstacle to programming reported by all project partners (as well as other informants) relates to Response coordination (undertaken jointly by UNHCR and IOM), which was reported by many to be inadequate and an impediment to high quality programming – especially in the earliest stages of the response. The Humanitarian Practice Network observed in October 2018 that "the withdrawal of the OCHA office at the beginning of the crisis and the lack of designation of a Humanitarian Coordinator have left the response without some of the more important coordination tools, including for financial tracking and information management, cluster/sectoral coordination and pooled funding, which would normally support a more strategic approach to coordination and provide the ability to identify gaps in response, deploy pooled funding to support localisation and address key funding gaps."[23] One experienced humanitarian aid worker summed up the thoughts of many when saying "coordination architecture has been ineffective and desperately needs to be fixed given overall implications for an aid effort where sector management has really struggled'.

While difficult to establish causality, many point to macro level leadership and coordination weaknesses to explain a lack of progress on key issues such as:

- Advocacy and acceptance of the need for medium to longer term planning (and funding)
- Securing GoB support for cash based programming
- Commitment to education for all, including those aged 15 years and older

Coordination weaknesses have especially impacted NGOs who work under a different regulatory framework to UN agencies. Humanitarian access, visa issues and FD-7 restrictions have all been time consuming and contributed to programming delays. To add further complexity, frustrations faced by international NGOs relate in large part to historic tensions between the Bangladeshi political establishment and local civil society –exacerbated by 2018 being an election year for Bangladesh. Challenges also relate to local systems for humanitarian coordination having been set up to respond to local natural disasters, and not the complex international crisis posed by the Rohingya response. As the response has progressed, there has been some progress made in relation to FD-7 and access issues as different parties better understand the processes needing to be followed, though each remains a time consuming and delaying aspect of NGO programming.

Key Finding: While weaknesses in response coordination impact all actors, they have especially impacted NGOs who must engage the complex and time intensive FD-7 process.

Similarly, sector coordination has also progressed (from a very low base) over the course of the response. Decentralisation of coordination to camp level has aided those camps where strong site management is in place. Meetings with site management authorities highlighted the important role played by 'experienced humanitarian actors' such as Save, Oxfam and CARE in supporting coherent, effective sector coordination at camp level.

In terms of program enabling, each of Save, Oxfam and CARE speak of the key role played at multiple levels by outreach workers and community based volunteers. In all cases, there is an intention to further strengthen this aspect of organisations' programming, including an increased

[23] https://odihpn.org/magazine/current-context-rohingya-crisis-bangladesh/

focus on supporting Rohingya people into such roles. Implicit in this discussion is the need to strengthen and bring far greater focus to localisation efforts, to be discussed below at 4.5.

3.3 Inclusiveness of activities

The 'effectiveness' section above already highlights many of the successes and challenges related to inclusion. This section will focus more specifically on responding to the two SEQs sitting beneath the question of 'how inclusive was the AHP?', looking at gender, disability and other issues of social disadvantage. Analysis will occur at both a general level and also at organisational level.

How were activities designed and implemented to meet the needs of different groups of people?

Across both projects, clear emphasis was placed in design on ensuring the unique needs of women and girls were reflected in strategy. In both projects, responsiveness to women's needs is central to the proposed project approach. Gender and protection considerations are central to all Oxfam WASH programming. CARE's approach is specifically aimed at reducing and responding to GBV experienced by women. Save's integrated model is woman and child focused.

> **Key Finding:** Across both projects, sophisticated approaches were outlined within designs aimed at ensuring the unique needs of women and girls were reflected in strategy.

Emphasis was also placed across both project designs on integrating disability inclusion within their approach. While proposed approaches seemed appropriate on paper, they have proven difficult to implement. This relates to an intersection of issues related to intense crowding and space issues within camps, cultural attitudes and also the hilly, sandy physical nature of the site. However, each organisation acknowledges that their own staffing capacity as a key constraint to disability inclusion.

> **Key Finding:** While emphasis was placed on disability inclusion across both proposals, this has proven difficult to implement. Importantly, each organization either has in place (Oxfam/CARE with CBM) or is seeking (Save with Humanity & Inclusion - previously Handicap International) technical support to enhance organizational capacity in relation to disability. However, this support has not yet paid dividends in terms of actual achievements.

In terms of other social disadvantage, Save provides a range of services focused on supporting UASC, female headed households and children living with care givers. Oxfam's programming model includes the elderly as one of six cohorts they consult through their 'Listening Group' modality. CARE's intensive gender focus, includes specific approaches aims at identifying and supporting women who have experienced severe trauma.

Oxfam/CARE

The AHP proposal put forward by Oxfam and CARE was based on a program of gender sensitive WASH that included both engineering and public health elements, with technical support provided to both partners from CBM in terms of disability inclusion being embedded in the approach.

Oxfam's focus was to provide technical input on emergency WASH response activities to improve access to and utilization of safe water supplies and sanitation facilities, and CARE's supporting interventions were to include community mobilization and a public health information and education campaign focused on women's rights and GBV. The point of interface between the two components was responding to the complex needs of women and girls, including efforts to ensure their participation and representation. Specific attention was made to ensure the entire intervention was undertaken through a gender and disability-sensitive lens.

Both Oxfam and CARE had a network of CBVs and outreach workers in place who were active in target communities, both in terms of dissemination of information and monitoring of vulnerability. While 50% of volunteers are women, the work of male volunteers is also focused on progressing gender issues, with male volunteers tasked with raising awareness of women's needs and right with men in their communities. Outreach and CBVs also help address the acute lack of mobility faced by many women, including awareness raising on psychosocial services available to women and girls. Advocacy amongst men to help facilitate enhanced mobility is another approach employed.

This approach has helped map vulnerability, including identification of households where disabled people reside. Approaches aimed at ensuring disability inclusive implementation are guided by an action plan developed with support from CBM Bangladesh and their local partner CDD.

Save the Children

Save's integrated approach is focused on a suite of approaches relevant to the needs of women and children, including specific focus on maternal health and protection of women and girls. Inclusion of marginalised groups can be seen within their proposed AHP beneficiary selection criteria:

- at household level - on female-headed households, households with pregnant and lactating women, undernourished children, children under 2 years, UASC, people living with disability and elderly people;
- at community-level – on host communities with high numbers of newly arrived households with a special focus on children with disabilities and other vulnerable groups such as UASCs.

Cutting across the Save approach is an outreach capacity that facilitates identification of vulnerable households. Outreach by Community Mobilisers also allows for engagement of women in their household, thus responding to mobility constraints posed by the context and providing opportunity to assess whether or not disability or a protection risk exists within the household.

Monitoring systems are able to track beneficiaries by gender, whether or not they are categorised as UASC and other key demographic variables, such as host community versus Rohingya refugee.

Save has a Gender and Disability Action Plan in place that aims to ensure:

- gender balance of MEAL staff in the Cox's Bazar office
- capacity to disaggregate data by gender, age and vulnerability
- analysis of post distribution monitoring data to identify degree that inclusion is being adequately addressed
- systematic integration of gender analysis within all standardised data collection tools
- integration of gender analysis within planning
- regular auditing of data - in collaboration with child protection – to identify risks and provide recommendations for safe programming
- gender and disability considerations are factored in to accountability approaches
- gender is mainstreamed in all sector-level Quality Benchmarks

While approaches to gender inclusion appear strong, Save acknowledges weakness implementing their disability programming intentions.

What has the AHP response achieved in terms of promoting gender equality and addressing barriers to inclusion, including for people with disabilities?

In relation to inclusion, the overall performance of both projects is remarkably similar. Each has highlighted gender and protection as central to their approach, and developed technical strategies that have placed priority on the needs of women and girls within targeted sectors. Similarly, while both proposals stated a clear intention to place emphasis on supporting people with disability, all parties have faced significant challenges in implementation relating to a confluence of issues related to staff capacity, the sudden onset of the crisis and the local environment and terrain.

Efforts to promote gender inclusion and empowerment in Save programming proved challenging. While approaches were in place that aimed to access and include women in trainings, meetings and community structures (such as WASH Committees), these were often undermined by pre-existing cultural norms around women's participation in public fora. Most significantly, this context restricted Save capacity to recruit female Rohingya volunteers in support of their program.

Over the course of implementation this situation improved, as trust was developed through household level engagement, interaction with community leaders and general exposure of communities to Save services. This has resulted in improved capacity to recruit female volunteers and increased levels of participation of women in trainings and meetings.

One important aspect of Save's gender work has been its effectiveness in advocating for girls participation in TLCs. Save's success in maintaining close to 50% female participation amongst its oldest age group (11-14 year olds) is in stark contrast to other education providers who are reported to commonly experience a marked drop off of female participation as girls get older.

It is interesting to note that Oxfam and CARE faced fewer challenges in terms of women's inclusion in activities and recruitment of female volunteers, including Rohingya women. This appears to relate to the fact that gender was THE core theme of their approach, whereas it was one of many issues being progressed within Save's ambitious integrated approach. By having gender at the centre of their approach, both Oxfam and CARE have been able to achieve strong traction in their target areas in support of women's participation and equality and empowerment. They have also been able to recruit Rohingya women into key roles.

In September 2018, Oxfam released "One Year On: Time to put women and girls at the heart of the Rohingya response"[24], which was launched by the Australian High Commissioner alongside the Bangladeshi Ministry of Foreign Affairs. This report is now being actioned in terms of informing broader research on gender and protection, and also as a tool to support national-level advocacy on issues of importance to Rohingya women and girls.

Central to the approach have been deliberate, well resourced strategies aimed at raising awareness amongst men, notably male leaders, Imams and *Madjhis,* of issues related to women's wellbeing and empowerment. This appears to have reaped rewards, based on the ability of male leaders to clearly articulate issues affecting women's wellbeing, and their support for strategies aimed at supporting women, such as WFS, reducing GBV and participation on decision-making bodies established by CARE and Oxfam.

> **Key Finding:** Deliberate engagement and awareness raising amongst male leaders in support of more broadbased participation of women in project activities and strategies to combat GBV are achieving positive results that respond to key concerns of women.

While efforts are being made by Oxfam to improve access to WASH facilities for people living with disability, the reality is that it is difficult to relocate well sites once installed, meaning that the major request of disabled people – to be located nearby WASH facilities – cannot be easily met. Oxfam is now receiving advisory support from CBM to develop disability friendly WASH facilities. In its AHP mid term report, the Oxfam/CARE project projected that 9,200 people living with disabilities would

[24] D. Sang; One Year On: Time to put women and girls at the heart of the Rohingya response; Oxfam, Sept 2018

benefit from activities by project end. However, only 918 had actually been engaged at that mid point, with only very limited reporting on disability included in subsequent project reporting.

While all Save AHP programming was intended to be disability inclusive, only 187 people (120 adults and 67 children) of the 138,187 people reached by Save's AHP funding were 'defined' as living with disability. This underperformance is openly acknowledged by Save, though it is also thought to relate to inadequate systems for tracking disability, with different sectors adopting different methods based on their scope of work with heavy bias on those with severe physical disability. This experience is cited as key in the organisation globally pursuing an alliance with Humanity and Inclusion to mainstream disability inclusion in programming moving forward, as well as to help develop capacity of Save staff with regards to disability.

Key Finding: Targets set by both projects to engage people living with disability have not been met, which relates to a confluence of issues around organisational capacity, competing priorities and the unforgiving terrain of the camp.

3.4 Efficiency (cost-effectiveness) of activities

One aspect of efficiency within rapid onset crises is the ability to quickly prepare simple, relevant processes for accessing funding. It is therefore significant that the AHP activation was the first longer term funding initiative opened for applications in relation to the Rohingya response. The speed with which this funding opportunity occurred is cited as significant by both projects since it:

- supported a prompt, multi-faceted response to a complex rapid onset crisis
- provided the first opportunity to consider longer term programming needs
- enhanced opportunities to leverage funding, given that AHP funding allowed organisations to demonstrate they were already active and on the ground for at least the next 12 months

This is cited as an important cost efficiency consideration in relation, since it encouraged other donors to commit in ways that augmented and complemented AHP funded proposals.

Key Finding: The speed and relevance with which the AHP Rohingya activation was prepared and signed off allowed organisations to quickly have meaningful programs in place that were catalytic in terms of further resource mobilisation.

Timelines and budgets

While there was clarity and relevance to context in the vision and strategy of each project, timelines were significantly impacted by coordination issues described above – notably FD-7 obstacles which affected staffing, procurement and camp access. This was especially the case in the earliest stages of the response when the context was at its most frenetic and timeliness was paramount.

Being the largest NGO operating within the Rohingya response, Save was particularly impacted by the challenges posed by FD-7s and also because it worked across multiple sectors, implementing multiple projects and therefore requiring multiple FD-7s.

While the Oxfam project was also affected by FD-7 issues, they have worked to restrict the total number of FD-7s needing to be managed at any one time, and have dedicated a staff member to liaison with the Office of the Refugee Relief and Repatriation Commissioner. This appears to have been effective in helping progress projects through bureaucratic processes.

Another factor impacting implementation of the Oxfam project was the redrawing of camp boundaries, which resulted in Oxfam and CARE no longer implementing AHP activities in the same

camp. This forced a major rethink of implementation strategy, which was articulated in a revised strategy approved by DFAT in April 2018.

Key Finding: Complexity related to the GoB's FD-7 process has contributed to multiple implementation challenges that have undermined efficiency of AHP projects.

Despite being more heavily impacted by FD-7s, Save has been able to close out its AHP funding within the designated period, whereas Oxfam sought a no cost three month extension. Both projects expect to fully utilise and acquit all funds provided through the AHP activation.

Value for money

Given time constraints, the ability for the evaluation team to thoroughly assess cost effectiveness was limited. Undertaking methodical value for money analysis in relation to rapid onset crises is complex, given the imperative to respond rapidly and the myriad unknowns related to access, procurement and coordination. Measuring value for money within the Rohingya context is particularly complex, given that many of the programming restrictions related to the context actually undermine cost efficiency and effectiveness.

Space restrictions affect all programming decisions and contribute to approaches that are often not optimal or efficient. For example:

- many facilities that would ideally be dedicated to a specific approach need to be used in a multi-purpose format
- while additional WASH facilities could address concerns expressed by women and disabled people, it is often difficult to find space for additional facilities
- efforts to progress psychosocial health are undermined by the intense crowding of the camps, where little privacy or quiet is available
- population density is a leading factor restricting women's mobility, with the crowded nature of the camp cited as dangerous for women

The political context of Bangladesh that the Rohingya response occurs within is also contributing to programming inefficiency. While all key informants met during this review expect the majority of the refugee population to still be resident in Cox's Bazar in three years time, no longer term planning or programming can occur given the GoB's insistence on one year project cycles. There are however hopes that these restrictions might ease once the 2018 Bangladesh election is settled.

The GoB's reluctance to allow cashed based programming is another programming inefficiency, in both qualitative and quantitative terms. Direct food distribution is a cumbersome and costly process that WFP is very keen to move beyond. Cash based programming would also likely stimulate the local economy, presenting employment and other livelihood opportunities.

AHP activations

Both AHP consortia received a AUD 3 million grant, with successful applicants able to commence implementation within eight weeks of the late August 2017 spike in the crisis. This helped ensure timely response to a rapidly unfolding, complex crisis.

Both AHP supported projects enjoy efficiencies from core capacity their organisation's brought to the response, in terms of people, materials, resources and administrative structures.

The Oxfam/CARE project aimed to reach a total of 116,360 people through its AHP grant:

- 76,360 people through the provision of access to health awareness campaign, knowledge products and hygiene materials (of which 59,750 people would be provided safe water and sanitation facilities)
- 40,000 people access to information and protective services related to women's wellbeing and in response to GBV.

Beneficiaries of the Oxfam/CARE project speak very highly of the quality of services provided, and compared service provision very favourably to that available through other organisations. Oxfam's WASH approach is also noted for its active consideration of environmental issues, including leadership within camps on efforts to decommission shallow wells and also its use of environmentally friendly 'biofill' latrines, which are self composting.

Save's grant supported work across nine outcome areas with the aim of reaching a total of 155,418 beneficiaries in total. Actual number of beneficiaries reached in the final assessment is expected to be less than 10% under that target, which relates primarily to shifts in approach related to avoidance of overlapping the work of others, staffing challenges and FD-7 restrictions. It is also noted that those who directly benefited from AHP funding very often also benefit from other elements of Save's broad suite of services.

Save's administrative and management capacity is strong, with complex systems in place to monitor program performance, expenditure and disaggregate results by donor.

As described above, the quality of services provided by Save appeared to the evaluation team to be of a very high standard. This perspective was reinforced by service users and third party informants (such as the protection cluster).

In the case of each project, organisations have played an increasingly important role in support of improved coordination, which has a flow on effect throughout the key sectors of WASH, education and protection.

Key Finding: It is assessed that both projects provided value for money in terms of being active on the ground very early in the response, their quality of implementation, their contribution to coordination within priority sectors, and through the value added to AHP supported activities by each organisation's broader Rohingya response suite of activities.

3.5 Efforts to strengthen local capacity

It is important to firstly note that a priority of the mid term review of the Joint Response Plan is to further strengthen and develop a roadmap to localisation within the response. Despite this, the mid term review says little of how this should be achieved, while acknowledging the need for continued improvement on this front.[25] This recognition of the challenge but lack of progress in its resolution was reflected in the feedback of a wide variety of informants to this evaluation.

As described above, AHP partners have worked in alignment with local coordination mechanisms set in place by the RRRC, including compliance with all FD-7 requirements. While this relationship proved extremely problematic for NGOs in the earliest days of the response, greater shared understanding now appears to exist with agencies reporting more functional relationships.

At sector level, strong coordination was observed between the WASH sector and the local Department of Public Health and Engineering, with Oxfam playing an important supporting role to this relationship, through provision of high level technical advice around hydrology and fecal sludge management.

[25] Mid Term Review - Joint Response Plan for the Rohingya Humanitarian Crisis; March – December 2018, p. 9

However, efforts to integrate local organisations within Rohingya response efforts have proven difficult for most international organisations involved in the response – including AHP partners. Such was the sudden and complex nature of the Rohingya crisis that organisations found it difficult in the earliest stages to find local partners to work through. Larger Bangladeshi NGOs (such as BRAC) set up their own operations, whereas smaller NGOs local to the Chittagong area were quickly snapped up as partners and soon reached their operational capacity.

Organisations interviewed through this evaluation spoke of the moral dilemma of balancing the urgent need for responsiveness to an influx that peaked at more than 20,000 people per day with the need to support localisation. These same organisations (UN and NGO) mostly acknowledge that priority was given to the former at the expense of that latter, and that this set in place approaches that to date have not been sufficiently adapted to return focus to strengthening of local institutions.

Efforts to draw on the capacity of the arriving Rohingya themselves have been undermined by a ban imposed by the GoB on their employment. Even without this ban, language, literacy and capacity issues restricted the role that the affected community could play in earliest stages of the response.

Localisation efforts have also been undermined by the short term funding options preferred by many donors, which make long term investment in local capacity development problematic.

> **Key Finding:** Efforts aimed at strengthening capacity of local organisations have been limited due to i/ the urgency of high quality service delivery, directly, ii/ the limited number of relevantly skilled local organisations and iii/ the impact of a range of bureaucratic and contextual constraints that complicated localization efforts.

Given this context, it has been very common for international organisations to directly draw staff from host communities and the broader Chittagong area, given that Chittagonian language is similar to Rohingya (estimated at 80% overlap). It has also been common for international organisations to work systematically with local NGOs to support them to scale up their response capacity, with a vision of leaving a strengthened local civil society in place once the crisis recedes.

Save's primary local implementation partner was YPSA, which was originally established as an NGO in 1991 in response to a cyclone that severely affected Chittagong Division. Despite YPSA not having a history of working in education, Save sub-contracted them to oversee 100 Temporary Learning Centres (TLCs) – of which 60 were funded through the AHP grant. In an FGD with YPSA, management and staff spoke positively of the support they had received from Save to strengthen their organisation's capacity to oversee a sizeable education program. This included a strong training focus, which included a range of approaches for measuring and enhancing teacher quality and performance. Peer learning approaches were also cited as invaluable in a context where local Bangladeshi teachers worked alongside Rohingya.

While there was a focus from Save on strengthening YPSA's technical education capacity, YPSA staff spoke of a need for support to strengthen their management capacity in terms of human resource management, budgeting and program monitoring. In relation to M&E, the YPSA staff member responsible for monitoring spoke in detail of 'how' he collected data for use by Save, but was unable to explain 'why' he was gathering the data, beyond having been asked by Save to do so. This anecdote seemed to highlight an opportunity for Save to more profoundly support organizational development and localization, through supporting YPSA in terms of better understanding the project cycle, donor dynamics and approaches to resource mobilization.

Within its education work, Save and YPSA have also worked to establish lines of communication with local *Madrassa* in an attempt to coordinate teaching times, and also mobilise support for girls' education – especially girls in the 11-14 year old cohort.

Save also invests in local capacity development through the support it provides to its camp based local team which ranges from people with technical capacity drawn from the local community to

volunteers drawn from the Rohingya community. While every effort has been made to utilize Rohingya whenever possible, Save has encountered difficulties identifying refugees with a sufficient skill base to be relevant to the needs of their program. In Save's case, this relates in large part to their program often being quite technical in nature, requiring strong numeracy and literacy.

Save is also undertaking sector leading work with local authorities in relation to curriculum development and teacher accreditation, which has the potential to help address many known weaknesses of the current education context of both host and refugee communities.

Despite its strong history of working through local partners, Oxfam has also found it difficult to identify local organizations with which to partner. Instead, Oxfam has focused on efforts to primarily utilize Rohingya within their program, in order to strengthen capacity that can both add to strengthened community structures within the camps, as well as skills that are transferrable in to the future. This approach is more straightforward for Oxfam than Save given that local staff are primarily placed in roles of awareness raising and community mobilization – not technical roles.

Oxfam's approach is also more deliberate in terms of establishing functional relationships with local Bangladeshi authorities such as the RRRC and Camp in Charge representatives. Through these relationships, Oxfam raises awareness of key issues and challenges faced, with the aim of ensuring support across the camp in achieving their resolution. Oxfam also demands that its camp based leadership participate in all camp coordination activities, where they are noted for their active role in working to strengthen camp coordination and management, and relationships between Camp in Charge authorities and Site Management. Oxfam is also proactive in its reporting of planning and results to local authorities, which seems to be an effective strategy in terms of strengthening management capacity and achieving active support of authorities for its program priorities. Oxfam believes that this approach is central to it facing fewer FD-7 issues than other organisations.

At a macro level, Oxfam (working with UNHCR) has worked closely with the Ministries of Water Management and Public Engineering to design a holistic water management plan for the overall camp area. While this higher level work has not drawn on AHP funding, Oxfam WASH activities at local level benefit from macro level plans agreed with the GoB, as well as the relationships established with government engineers.

CARE's approach at community level is very similar to that of Oxfam, though in Camp 16 it is actually responsible for Camp Management. Given the sensitivity of advocacy related to GBV, CARE has invested heavily in building relationships and awareness with male community leaders, in order to enlist them as advocates and supporters. This has involved a range of capacity building efforts, including work through local mosques where Imams have often spoken at Friday prayers of issues related to women's wellbeing and safety.

CARE sought to build local capacity working with an initial local partner, Prottayshi. In tracking implementation and outcomes, CARE decided in 2018 to conclude activities through direct implementation. In CARE's ongoing GBV and protection programming, work is now going through YPSA and the Bangladeshi Women's Lawyer's Association to promote localization and strengthen local capacity in case management, gender responsiveness and gender mainstreaming.

Key Finding: Despite limited progress to date in terms of local partnering, changing circumstances in terms of smaller international agencies withdrawing and local civil society capacity having strengthened opportunities for renewed efforts in support of localisation.

3.6 Accountability

Strategic Objective Two of the JRP is to ensure the wellbeing and dignity of Rohingya refugees and affected host communities. Within the JRP is a Protection Framework which highlights the importance of humanitarian actors being accountable to affected communities through effective,

transparent and honest community participation and through the availability of information and an active complaints and feedback mechanism.[26]

Despite this priority placed on accountability, the mid term review of the JRP noted that achievement against Strategic Objective Two has been 'sparse', and highlights the need for strengthened accountability to affected populations, and a more participatory approach across the response to enhance the well-being and dignity of refugees and affected host communities. [27]

Within the AHP, both projects place significant emphasis on ensuring accountability, and have established multiple mechanisms to help ensure accountability to affected people. Despite this intent, there is acknowledgement that achieving broad based accountability has proven challenging for both projects. Challenges are cited as relating primarily to language and literacy issues, but also cultural norms which restrict women's mobility.

Save have invested in multiple channels for information sharing, participation, and feedback. Multi-faceted community engagement is central to program planning and establishing lines of communication with affected communities and other actors of relevance. These consultations occur at both community and sector levels, allowing for triangulation of findings.

All MEAL findings are supposed to be shared back to communities through field supervisors and community mobilisers – though based on evaluation team meetings with community members, this appears to be an unreliable system with many community leaders unaware of this commitment. MEAL assistants are also tasked with collecting feedback through a door to door approach that aims to ensure the voice of women affected by mobility constraints.

The following mechanisms are used for collecting feedback and complaints:

- helpdesks – permanently staffed at food distribution points and primary health care centres, and temporarily staffed during shelter/WASH distributions. Save are additionally planning to establish helpdesks at all of its nutrition and health posts.
- voice recorders - piloted only, with scale up planned
- systematic inclusion of feedback mechanisms within post distribution monitoring, exit interviews and FGDs
- door to door collection of feedback and complaints by MEAL Assistants, especially around distribution times; and
- piloting of child friendly feedback systems, using adapted versions of Save's existing child participatory data collection tools. This is based in realisation that very small numbers of children were accessing existing mechanisms. (Significantly, this is the first attempt by any agency to do this systematically in any response context, with results of the approch eagerly anticipated by the Accountability subsector)
- Plans are also in place within Save to strengthen the involvement of Community Mobilisers in capturing feedback and complaints data.

Feedback and complaints are processed (including categorisation), analysed and referred to sector teams/other teams within Save on a weekly basis (within 24hrs for Child Safeguarding-related and other complaints that require an urgent response). Feedback and complaints that relate to external actors are referred to the Field Coordination team for management and onward referral. Feedback and complaints are reported on through a

[26] Mid Term Review - Joint Response Plan for the Rohingya Humanitarian Crisis; March – December 2018, p. 9

[27] Mid Term Review - Joint Response Plan for Rohingya Humanitarian Crisis; March – December 2018, p. 25

monthly Accountability report, and the Accountability team works with the Field Coordination team close the feedback loop as required/feasible.

Key Finding: Save has multiple accountability measures in place, including strategies aimed at facilitating the voice of women and children in planning processes. These have supported important shifts in approach in relation to WASH facilities and operating procedures of Health Posts and Food Distribution centres.

While Save recognises the need to further improve its accountability approach, there are already important indicators of success, such as 80% of all respondents in their target areas now being aware of their food and non food entitlements.

Oxfam prepares monthly accountability reports that collate different information gathering and accountability approaches into a coherent form that details suitable responses to the collective feedback. Central to Oxfam's accountability approach is its system of 'Listening Groups', which draw feedback from key cohorts within a community – women, men, girls, boys, the elderly and traditional birth attendants. These are designed to provide feedback to Oxfam on its core program area of water, sanitation and hygiene and protection, but also other aspects of camp life such as food distribution, nutrition status and the performance of local authorities. When issues are raised that are beyond Oxfam programming capacity, they are raised with camp management for resolution – meaning that the Listening Group model benefits organisations beyond just Oxfam.

Oxfam also has in place a system of bi-weekly meetings with Camp in Charge authorities and local *Majhis,* which allows for two way exchange of information and provides a forum for enlisting support for priorities emerging from the Listening Groups. Examples of responsiveness from Oxfam to accountability measures include the introduction of fresh food vouchers for new mothers; increase in the number of latrines; improvements and repairs to latrines and bathing cubicles for women; desludging of latrines' pits and increased priority placed on decommissioning of shallow wells, and introduction of new deeper wells that better align with needs of women in terms of their location and design.

Key Finding: Oxfam's accountability approaches of listening groups working in tandem with bi weekly meetings with local authorities is holistic in terms of eliciting feedback and initiating action in relation to community needs, particularly in relation to strengthening community capacity to support improved protections outcomes.

In camp 16, where CARE is responsible for site management, a hotline has been developed to support feedback on camp issues. CARE also engages its community watch groups to get feedback on program performance. Confidential feedback mechanisms are also available within WFS.

CARE also regularly collects feedback through focus group discussions within the women's friendly spaces, camp management, and through the community watch groups. Inputs helped drive activities offered in the women's friendly spaces and promote infrastructure enhancement initiatives within the camps that promoted the security of women and girls.

CARE's relationship with and support to Translators without Borders is another important accountability investment, given the important role played by the multi-lingual app to facilitate clearer communication – particularly with women on women's health issues.

Key Finding: CARE's partnership with Translators without Borders has contributed to development of a multi-lingual app that has the potential to strengthen accountability measures through it facilitating clearer communication – especially with women.

4. Conclusions and Recommendations

The following section draws together key conclusions and subsequent recommendations emerging

from review of the AHP Rohingya activation. Their aim is to provide broader future-focused recommendations for the AHP, including consideration of how responses can effectively respond to the needs of vulnerable groups, support local capacity, and achieve transparency and accountability to affected populations and other relevant stakeholders.

The core finding of this evaluation is that all activities supported through the AHP were relevant to priority needs and implemented in a form that was effective and responsive to the complex needs of affected communities. It is further noted that despite urgent ongoing needs of the Rohingya refugee population, there appears to be a looming funding gap that will force many smaller actors to close down their operations, with subsequent expectations that larger NGOs will be able to pick up the slack. This is likely to quickly place the response under acute funding pressure in early 2019.

4.1 Recommendation One: Moving Forward

> ***Recommendation 1a:*** *Given acute, ongoing needs of the affected population and the effectiveness of the program to date, a new, follow on AHP Rohingya response funding window should be initiated urgently by DFAT.*

Each of the six pre-selected AHP partners already implement sizeable Rohingya response programs, and have capacity to effectively and efficiently deliver more sizeable programs than those allowed through the initial AHP funding round. It is also noted that there will be increased demands placed on larger, technically specialized NGOs to both fill gaps posed by the withdrawal of smaller agencies and address maintenance and decommissioning needs of facilities previously managed by these smaller agencies.

> ***Recommendation 1b:*** *Consideration should be given by DFAT to increasing funding to AHP partners, based on the rationale of needing to support continued implementation of current activities, as well as providing space for filling gaps posed by the withdrawal of smaller actors.*

Given general agreement that ongoing support will be required for at least the next three years, there would be a range of efficiencies enjoyed by a shift to multi-year funding. While it is understood that the GoB has opposed this to date, it is also reported that there are signs of a willingness to shift on this – possibly enhanced by completion of the electoral process.

> ***Recommendation 1c:*** *Options for framing a new AHP activation as multi-year (based on annual plan approval) should be explored by DFAT, based on the rationale that such an approach would support enhanced program efficiency and effectiveness (given it would allow for longer term planning and approaches).*

Currently, it is widely accepted that certain camps are disadvantaged by their remoteness (for e.g. camps 13, 19 and 20) and the reality that provider agencies find it easier to work in camps serviced by main roads. This disadvantage could potentially worsen given it was often these more remote camps that smaller agencies were directed to by coordination mechanisms.

> ***Recommendation 1d:*** *Given that certain camps are known to be disadvantaged by their location compared to others, DFAT should give consideration to including camp remoteness and disadvantage as a selection criteria for future AHP activations.*

Opportunities exist for AHP supported activities to occur in a more truly programmatic form, given that the work under the AHP of CARE, Oxfam and Save's currently has a shared focus on gender and protection, despite each approaching it from a different angle. A more programmatic approach could be encouraged through focusing AHP support on a designated geographic section, that each agency brings its specialized skills to. For example, currently each organization is active in the southern section of Kutupalong refugee camp.

***Recommendation 1e**: DFAT and the AHP partners should consider the pros and cons of focusing a new AHP on a specific geographic area (i.e. specific camps) in order to address disadvantage and leverage an area development approach that enables different partners to benefit from each other's capacities and learning.*

4.2 Recommendation 2: Inclusion and protection

An important lesson learnt through this evaluation is that within conservative cultural contexts such as the Rohingya, deliberate, well resourced strategies are needed to support women's inclusion and empowerment. This is reflected in the JRP describing the Rohingya Response as first and foremost a 'Protection crisis'.

***Recommendation 2a:** DFAT should more explicitly emphasise AHP second phase funding as being (broadly) gender and protection focused, with more deliberate mechanisms in place for knowledge sharing, research of issues of common interest, and cross-organisational peer support aimed at maximizing understanding of each partners' specific area of technical expertise.*

***Recommendation 2b**: DFAT and AHP partners should ensure space within gender programming for organisations to further progress work with men, teenage boy, community leaders and religious leaders, given the positive results achieved to date (especially by CARE) of mobilizing men in support of women and children's protection.*

As described within this report, despite the best intentions, AHP partners have all struggled in terms of disability inclusion due to both practical issues of camp management and terrain, as well as limited capacity within AHP partner organisations. While this is unfortunate, each partner has realistic plans in place to strengthen their performance in this area moving forward, including partnering with specialist disability organisations to help strengthen their capacity for disability inclusion.

***Recommendation 2c:** Included in the assessment criteria of any new AHP applications should be the degree to which applicants can present a plausible strategy for overcoming the many constraints known to exist in relation to disability inclusion in the context of the Rohingya response, including strategies for development of human capacity to better identify and support people with disability.*

Strong outreach is key to addressing the lack of mobility experienced by many young women. A conclusion of this evaluation is that high quality, gender focused community outreach and mobilization is critical in terms of achieving high quality programming outcomes. This includes the need to ensure a role in this process for Rohingya volunteers, despite challenges posed by literacy, educational attainment and cultural norms.

***Recommendation 2d:** Emphasis should be placed within any future responses (through AHP) on further strengthening community outreach capacity as a strategy to facilitate improved gender and protection outcomes, given that many women are largely confined to their homes and unable to attend external meetings.*

AHP partners have already demonstrated their capacity to undertake important, relevant, high quality research – often jointly. Joint studies bring different, often complementary perspectives to complex issues, as can be seen in the *Rohingya Refugee Response Gender Analysis* jointly undertaken by Save and Oxfam (and Action Contre la Faim).

***Recommendation 2e**: Integrate funds within AHP for research and dissemination in relation to gender in refugee settings, including consideration of the role of men and teenage boys in*

supporting and progressing positive gender outcomes and reducing GBV (noting that such research could be an important, general resource helping inform future AHP activations)

4.3 Recommendation 3: Advocacy

The current camp context has multiple, negative environmental impacts. Leading issues relate to concerns around deforestation of the broader area as refugees seek firewood, given the GoB refusal to allow the use of gas for cooking. The use of wood as fuel is also impacting the health and quality of life of women who are often confined to very small, confined spaces due to the practice of *purdah.*

Groundwater quality is also deteriorating due to the pressure being placed on it by shallow wells and 60,000 latrines being constructed in a very small area.

Recommendation 3a: *DFAT should work with ISCG to lobby the GoB in support of cooking gas provision to refugee households as an environmental management and gender protection approach to be trialed through AHP agencies' programs – underpinned by a joint study by AHP partners of its impact.*

Efficiency of the overall Rohingya response is undermined by the inability to utilize cash based programming.

Recommendation 3b: *DFAT should continue to coordinate with other leading donors and agencies to advocate for cash based programming, on the basis of cost effectiveness and suitability to context.*

Recommendation 3c: *While it is highly unlikely that a green light will be given for a full roll out of cash based programming in the short term, both DFAT and AHP partners should aim for any future responses to include sufficient flexibility to allow AHP partners to adapt projects as required should agreement to introduce cash based programming be reached.*

4.4 Recommendation 4: Health/WASH

AHP support to ensuring good health of the affected population has been multi-faceted and included a significant gender focus. Given the scale and crowded context of the affected population, high quality WASH programming remains an imperative is disease is to be kept at bay. There are particular ongoing needs related to faecal sludge management and decommissioning of inferior toilet systems and shallow wells, which both serious health and environmental challenges. The need for primary health services also remains acute, including systems capable of addressing the complex cross-section of psychosocial health needs presented by the affected population – which are widely reported as currently being under-serviced.

Recommendation 4a: *Further AHP support to health and WASH should be nuanced and target in on clearly identified gaps and needs within current service provision, including the need to cover work undertaken by organisations now departing due to funding issues.*

4.5 Recommendation 5: Education

Including support for progressing educational opportunities of children and youth is seen as consistent with a gender focused program – especially efforts to promote girls' educational access. Various constraints to education currently exist. These relate to the general reluctance of the GoB to support formal schooling, as well as specific issues related to educational participation of girls

aged 11 and older, and the current ban on any form of education provision to children and youth aged 15 and above.

> ***Recommendation 5a:*** *Emphasis should be placed within the overall approach of any new responses to develop strategies aimed at increasing education participation rates of girls aged 11-14.*
>
> ***Recommendation 5b:*** *DFAT should continue to advocate alongside other leading donors and agencies for educational opportunity to be available for the 15-18 year old cohort (both girls and boys).*

4.6 Recommendation 6: Localisation

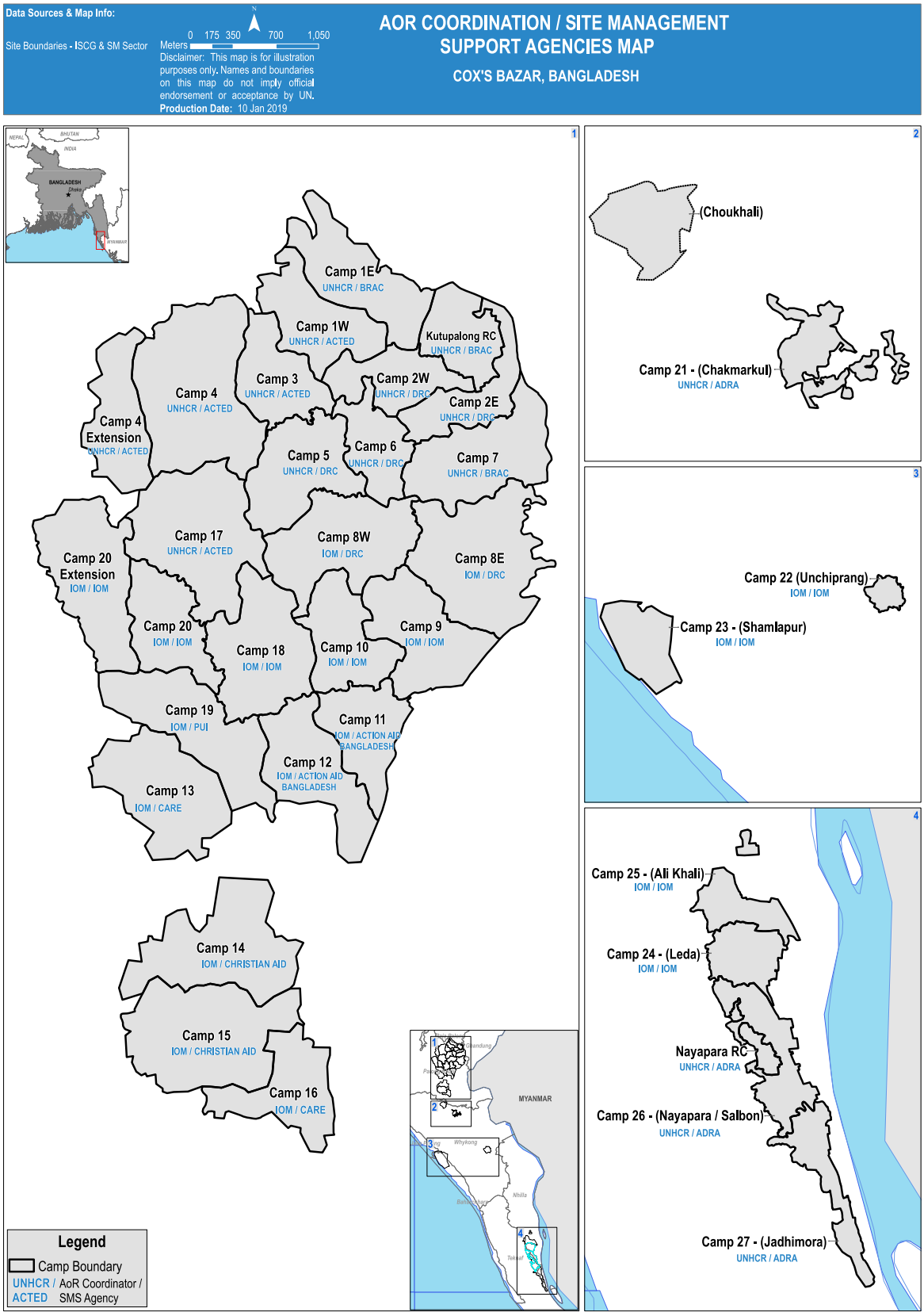
Utilisation of local partners has been limited within the AHP to date. Given that the response has now normalized to a significant extent from the chaotic early days, and also that it appears likely that many smaller international agencies will soon withdraw (or have already left), opportunities are now emerging to more easily engage local partners.

> ***Recommendation 6a:*** *Moving forward, emphasis should be placed on 'smart localisation' based on AHP partners more deliberately supporting Bangladeshi partners to strengthen capacity around complex issues such as gender focused protection, with a view to local partners assuming greater responsibility for program delivery in the future.*

Allied to increased use of local partners is the ongoing importance of continuing to provide meaningful support and opportunities for host communities within the response.

> ***Recommendation 6b:*** *Strategies for inclusion and support to host communities should be included as a criteria for assessment of future AHP applications.*

Annex 1: Map of camp locations and site management responsibilities



Annex 2: Evaluation Schedule

Monday, 22nd October

1pm	Evaluation team arrives Cox's Bazar
2-3pm	Martha Wilkes, Senior Ops Manager
3-4pm	Hasina Akhter – Community Safe Guarding
4-5pm	Eugene Angoro, Awards Coordinator
5-6pm	Security Briefing with Towfique
6-7pm	Caroline Chiedo, Nutrition Senior Programme Manager & Dawit Hagos, Nutrition TA
7-8pm	Maheen Chowdhury, Distribution Director

Tuesday, 23rd October

8-9am	Laura Rana, M&E Coordinator
9-10am	Clive Omoke, Health Advisor
10am-11am	Geoff Poynter, Response Team Leader
11am-12pm	Fareeda Miah, Education in Emergencies Advisor
1pm-2pm	Lunch break
2-3pm	Preparatory work with translators
3-4pm	Fareeda Miah, Eie Advisor (EiE Senior PM is leaving this week)
4.30-6.00pm	Zef Kapoor, Assistant Response Manager, WFP
6-7pm	Debrief with Laura Rana (MEAL TA), including discussion on proposed additions/changes to schedule (if needed)

Wednesday, 24th October Field work - Camp 18

8-9am	Meeting with Health Post team
9-10am	FGDs with beneficiaries accessing health services – 9-11am (i.e. 1 hr with males, 1 hr with females)
10am-11am	
11am-12pm	FGDs with Community Mobilisers and Field Supervisors
12.30pm-1.30pm	FGD with WASH committee members

1.30-pm-2.30pm	Visit latrines and female friendly bathing units & meeting with female beneficiaries / observe part of a hygiene
2.30-3.30pm	Meeting/FGD with Child Protection team
5.30pm	Return to CXB

Thursday, 25th October Field work - Camp 13

7.30am	Depart CXB
9.30-10.30am	Observe food distribution and BSFP nutrition centre activities
10.30am-11.30am	interviews with mothers receiving CMAM-I support
11.30am-12pm	Observe Child Friendly Spaces
12.15pm-1.15pm	FGD with mothers/female caregivers
1.15pm-2.15pm	FGD with fathers/male caregivers
2.30-3.30pm	FGD with IP staff (YPSA)
4pm	Return CXB

Friday, 26th October

10am-11.30am	Peter Guest, Emergency Coordinator, WFP

Saturday, 27th October

10am-11.30am	Berta Travieso, Emergency Manager UNICEF, and Child Protection Cluster lead
4.30pm-6pm	Clementine Novales – CARE AHP lead

Sunday, 28th October

9.00am – 11.00am	Presentation on Oxfam humanitarian programme and DFAT project to discuss on context, programme, advocacy, accountability, funding etc
	Initial briefing with key informants from Oxfam - Humanitarian Programme Coordinator/Programme Lead - Funding Coordinator - Policy and Advocacy - Government Liaison Manager - WASH (PHE and PHP) - EFSL - Protection - Gender - Monitoring, Evaluation, Accountability and Learning - Area Manager

11.30am – 12.30pm	Deputy Secretary Mohammed Shamsud Douza; Office of the Refugee Relief and Repatriation Commissioner
12.30pm – 2.00pm	Lunch break
2.00pm – 3.00pm	Meeting WASH Cluster
3.00 – 4.00 pm	Ritthick Chowdury; Executive Engineer; Department of Public Health and Engineering
4.30pm – 5.30pm	Albert Tonon, CBM and Ms Tamida Akhter, Centre for Disability and Development (Bangladeshi NGO)

Monday, 29th October Field work – Camp 12

7.30am – 9.30am	Travel to camp 12, Oxfam implementing areas
10.00am – 11.00am	Meeting with Site Management in Camp 12 (ActionAid)
11.00am – 12.30pm	FGD – Water user groups (in charge of monitoring, O&M of water point/deep tube well)
12.30pm – 1.30pm	FGD – Listening group (community accountability and feedback on WASH programme)
1.30pm – 2.30 pm	FGD – Women group (DFAT beneficiaries)
2.30pm – 3.30pm	FGD – Men group (DFAT beneficiaries)
3.30 – 5.30pm	Return to Cox's Bazar

Tuesday, 30th October Field work – Camp 19

7.30am – 9.30am	Travel to camp 12, Oxfam implementing areas
10.00- 11.00am	Meeting with Site Management in Camp 19 (IOM)
11.00am – 12.30pm	FGD – Latrine user groups (in charge of hygiene promotion, latrine monitoring and O&M)
12.30pm – 1.30pm	FGD – Local pump mechanics (in charge of water point repairing)
1.30pm – 2.30 pm	FGD – Community based volunteers (in charge of daily hygiene promotion, distribution, monitoring)
2.30pm – 3.30pm	FGD – Oxfam WASH staff (day to day implementation of project)
3.30pm – 5.30pm	Return to Cox's Bazar

6.00pm	Meeting with NGO Platform

Wednesday, 31st October

7.30am – 9.30am	Travel to camp 12, CARE implementing areas
10.00am-12.00am	Visit 2 safe spaces - Women and girls inside WFS (female only, beneficiaries of women friendly space) - Imam and Majhis in the blocks - Adolescent boys
12.00am – 13.00pm	Meeting with project staff and volunteers
1.00pm – 2.00pm	Travel to camp 16, CARE implementing areas
2.00pm – 3.00pm	FGD with community watch groups (male group)
3.00pm – 4.00pm	FGD with community watch groups (female group)
4.00pm – 6.00pm	Return to Cox's Bazar

Thursday, 1st November

7.30am – 1.00pm	Data analysis and debrief workshop preparation
1.00pm-4.00pm	Evaluation wrap up workshop

Friday, 2nd November

7.30am	Depart CXB

Annex Three – Interview Guides

Interview questions are informed by the document review and are designed with specific focus on assembly of an evidence base that supports the Review Team to answer the Review questions. While the questions below will be addressed in all interviews, the approach to interviews will deliberately be open ended enough for interviewees to include additional information that they regard to be relevant to the Rohingya response, but which might not fit within the questions detailed below.

In addition to this overview of questions, specific guides will be prepared that draw from these questions and tailor to the specific context of different interviewees.

NO.	EVALUATION QUESTION & SUB-QUESTIONS	INTERVIEWEE GROUP
EQ 1	**Was the AHP response appropriate and relevant?**	
SQ 1a	To what extent were the activities selected appropriate (i.e. did we select the right activities in the right locations on the right sectors?) • How were sectors and activities identified? What evidence was gathered/drawn upon to justify the need for intervention in these sectors and activities? • How were locations identified? What evidence was gathered/drawn upon to justify the need for these activities in these locations? • Was decision-making integrated within broader response planning mechanisms? • Have the activities implemented by the AHP partner responded to needs faced by your household and community? How? • Do these activities remain important to your household and community today? • What more is needed to better address need in relation to these activities?	Implementing partners, Coordinating bodies, Working Groups Affected communities
SQ 1b	To what extent was information on needs and priorities addressed in the planning? • What were the main information sources drawn upon in decision-making? • Did your organisation undertake direct research into needs and priorities? • What were the key other sources that you drew from?	Implementing partners

NO.	EVALUATION QUESTION & SUB-QUESTIONS	INTERVIEWEE GROUP
	• What is your assessment of the quality of that initial needs assessment work (both yours and others)? -	
SQ 1c	Has the response adequately responded to needs assessment information provided (both initially and over the course of implementation, as needs have changed), and how relevant has the assistance been from the perspective of affected communities? • How do these activities respond to needs and priorities identified? • How have your approaches changed over the course of the response? • What were the factors that demanded a change in your approach?	
SQ 1d	To what extent did the assistance complement/align with Australian Humanitarian Strategy and other key Australian government policies/priorities such as gender equality, disability inclusion and other vulnerable groups? • How does your approach complement/align with the Australian Humanitarian Strategy? • Does your approach contribute to gender equality? If so how? • Does your approach contribute to disability inclusion? If so how? • Does your approach contribute to the needs of other vulnerable groups? If so how? • Do the AHP partner's activities contribute to gender equality? If so how? • Do the AHP partner's activities contribute to disability inclusion? If so how? • Do the AHP partner's activities contribute to the needs of other vulnerable groups? If so how?	Implementing partners Affected communities
EQ 2	**Was the AHP response effective?**	
SQ 2a	How clearly were the intended outputs and outcomes of the response defined, and to what extent have they been achieved? • Looking back, do you regard the outputs and outcomes of your response as being sufficiently clear and defined? • To what extent have they been achieved? • Where outputs and outcomes have not been achieved, what have been the contributing factors?	Implementing partners

NO.	EVALUATION QUESTION & SUB-QUESTIONS	INTERVIEWEE GROUP
	• Can you describe the approach of the AHP partner to me? • What plans does the AHP partner have to support your community? • What have you been told will be contributed and achieved through their assistance?	Affected communities
SQ 2b	To what extent did Australian-funded activities promote longer-term resilience of affected communities and support broader recovery and stabilisation efforts? • How does your agency see medium and longer term needs of affected communities? • How has your approach addressed medium and longer term needs of affected communities? • How do you define resilience in this context? • How has your approach contributed to resilience of affected communities? • What has been the contribution of the AHP partner to your community in terms of strengthening the community and building resilience? • Can you describe examples of how AHP partner support has helped strengthen your community? • Have activities adequately taken into account the needs of women?	Implementing partners, Coordinating bodies, Working Groups Affected communities
SQ 2c	What were the barriers and enablers to effective and efficient project design and management? • What have been the major challenges managing a program in this context? • What strategies have been employed within management approaches to address challenges? • What more needs to be done to strengthen activity management?	Implementing partners
EQ 3	**How inclusive was the AHP?**	
SQ 3a	How were activities designed and implemented to meet the needs of different groups of people (considering age, gender, disability and other social disadvantage)? • How do you define different disadvantaged groups within this context? • How does the approach disaggregate and respond to the needs of different community cohorts? • How have issues of social disadvantage specifically been addressed in the activity? • How does your approach contribute to gender equality? • How does your approach contribute to disability inclusion?	Implementing partners, Coordinating bodies, Working Groups

NO.	EVALUATION QUESTION & SUB-QUESTIONS	INTERVIEWEE GROUP
	• How does your approach respond to the needs of children and youth? • How does your approach contribute to the needs of people living with a disability? • Has the AHP partner's activities contribute to gender equality? • Has the AHP partner's activities responded to the needs of children and youth? • Has the AHP partner's activities contribute to disability inclusion?	Affected communities
SQ 3b	What did the AHP response achieve in terms of protecting the safety, dignity and rights of affected people, promoting gender equality and addressing barriers to inclusion, including for people with disabilities, ethnic minorities and indigenous populations?	
	• What results have been achieved in terms of supporting disadvantaged groups?	Implementing partners, Coordinating bodies, Working Groups

	• What change has been achieved in terms of improving the safety, dignity and rights of:
	  ○ Women
	  ○ People living with disability
	  ○ Children	

	• Has the AHP partner contribution to your community affected people's feeling of safety, dignity and awareness of rights? If so, specifically which groups within the community have benefited? And which require more focused support?	Affected communities
EQ 4	**How efficient (cost-effective) was the AHP response?**	
SQ 4a	To what extent was the response implemented according to agreed timelines and budgets? • To what extent was the response implemented according to agreed timelines and budgets? • Where there has been deviation, what have been the major factors?	Implementing partners
SQ 4b	In what ways was the response implemented able to achieve good value for money? • How do you define value for money in this context? • What challenges have been faced in terms of procurement? • How could value for money be improved moving forward?	Implementing partners

NO.	EVALUATION QUESTION & SUB-QUESTIONS	INTERVIEWEE GROUP
EQ 5	**Did the AHP response reinforce local capacity/leadership?**	
SQ 5a	To what extent did the AHP investment support strengthen local partners, including civil society (e.g. local women's organisations, disabled people's organisations, etc..), local government engagement and coordination and avoided negative effects? • Has the AHP supported activity included local partners? • What approaches have been employed to strengthen local leadership? • What have been the obstacles to partnering with local entities? • What have you done to try and position for greater inclusion of local partners moving forward? - • Does the AHP partner sufficiently utilize local partners? • Are there local actors that you believe could contribute more than is currently the case? • Are there organisations emerging in your community? How could they best be supported? • What could be done to assist women to better organize and collaborate in support of community issues?	Implementing partners, local partners, local government, Coordinating bodies, Working Groups Affected communities
SQ 5b	To what extent were implementing partners sufficiently accountable to, and engaged with, affected communities, local government and coordination mechanisms? Is there evidence of programs having been influenced by effective communication, participation and feedback? • What has been your approach to engagement and inclusion of affected communities, local government and coordination mechanisms? • What challenges have you faced in terms of engagement and inclusion of affected communities, local government and coordination mechanisms? • What have you done to overcome these challenges? • To what degree has the AHP partner effectively engaged with you? • Do you have any suggestions as to how this engagement could be improved? - • To what degree has the AHP partner effectively engaged with you? • Do you have any suggestions as to how this engagement could be improved?	Implementing partners, Local government, Coordinating bodies, Working Groups Local communities

NO.	EVALUATION QUESTION & SUB-QUESTIONS	INTERVIEWEE GROUP
	• Do you feel listened to in this relationship? Are there examples of the AHP partner adapting its approach in response to your input?	
EQ 6	**How transparent and accountable was the AHP response?**	
SQ 6a	To what extent were implementing organisations sufficiently engaged with and accountable to affected people? • What has been your approach to ensuring accountability to affected communities, local government and coordination mechanisms? • What challenges have you faced in terms of communicating with and remaining accountable to affected communities, local government and coordination mechanisms? • What have you done to overcome these challenges? • To what degree has the AHP partner effectively communicated its approach to you? • Do you have any suggestions as to how this engagement could be improved? • Do you feel listened to in this relationship? • To what degree has the AHP partner effectively communicated its approach to you? • Do you have any suggestions as to how this engagement could be improved? • Do you feel listened to in this relationship?	Implementing partners, Local government, Coordinating bodies, Working Groups Local communities
SQ 6b	What evidence exists of the projects responding to feedback, participation and engagement? • Are there examples of you adapting your approach in response to partner input? • Are there examples of the AHP partner adapting its approach in response to partner input	Implementing partners, Local government, Coordinating bodies, Working Groups, Local communities