IMPROVING ACCESS TO HEALTH, WATER AND SANITATION SERVICES, EDUCATION, AND FREEDOM FROM VIOLENCE IN COX'S BAZAR

END OF PROJECT EVALUATION

EVALUATION REPORT

Prepared by:

Proaction Alliance

July 2017

The final evaluation of this project – funded by the U.S. Department of State (Bureau for Population, Refugees, and Migration) – was produced at the request of the International Organization for Migration (IOM) and its implementing partners Action Contre La Faim, Handicap International, and Solidarités International. It was prepared independently by David Stone and Rezaul Karim.

CONTENTS

ABBREVIATIONS

ACF	Action contre la Faim (Action Against Hunger)
BPRM	Bureau of Population, Refugees and Migration (US Department of State)
CWC	Communications with Communities
DRR	Disaster risk reduction
FGD	Focus group discussion
HO	Handicap International
KAP	Knowledge, Attitudes and Practices
KII	Key informant interview
IOM	International Organization for Migration
ISCG	Inter Sector Co-ordination Group
NGO	non-governmental organisation
NPM	Needs and Population Monitoring
PDC	Parra Development Committee
SGBV	Sexual and gender-based violence
SHED	Society for Health Extension and Development
SI	Solidarités International
UMN	Undocumented Myanmar National
WASH	Water, Sanitation and Hygiene

ACKNOWLEDGEMENTS

Sincere thanks are expressed to all those people met during the course of this evaluation, who gave freely of their time to speak to the evaluation team and shared their experiences in such an open and helpful manner. Without your important insights, our work would not have been possible.

At IOM, we would like to express a very warm "*Thank You*" to Mr. Sarat Dash, Chief of Mission, for welcoming us and for giving us the opportunity to evaluate this highly relevant project. In Dhaka, particular thanks are shared to Sharif Faisal, M&E Officer and Ms. Taifa Binta Monir of the Programme Support Unit for their excellent support throughout this evaluation and for facilitating smooth arrangements at the field level. In Cox's Bazar, our work would not have been possible without support from Ms. Sanjukta Sahany, Head of Sub-Office, Ashutosh Karmakar, National M&E Officer, and other field-based colleagues.

The evaluation team received tremendous support from each of IOM's international partners and we would like to express a sincere 'Thank You' to the management of Action Against Hunger (Hildegarde Thyberghien, Deputy Country Director), Handicap International (Marcela Ondekova, Country Programme Co-ordinator), and Solidarités International (Helene Daniel, Country Director), in addition to their respective field teams. Your inputs have been truly informative in helping us put together a complete overview of the response, and our thanks again for taking time to speak with us on this.

Thank you all for the wonderful organization of this evaluation on the ground and for the opportunity to learn from this very successful project.

David Stone
Rezaul Karim

Executive Summary

Background and Project Purpose

Between December 1991 and March 1992, some 250,000 Rohingya* from Myanmar entered Bangladesh. Recognised as refugees on a *prima facie* basis by the Government of Bangladesh, the vast majority were repatriated to Myanmar in the following years. When the repatriation process ended in 2005, some 20,000 refugees remained in two registered camps in Cox's Bazar District.

In addition to this registered caseload, prior to events which took place in October 2016, over 200,000 additional Rohingya were believed to be living in makeshift settlements or mixed with host communities throughout Bangladesh. An outbreak of unrest in Rakhine State, however, triggered a significant displacement of people, with an estimated 87,000 Rohingya arriving in Cox's Bazar between October 2016 and June 2017. Categorised as "Undocumented Myanmar Nationals (UMNs)", a large majority of these people have settled in makeshift settlements and with host communities, while some have moved into the two registered camps.

IOM was mandated by the Government of Bangladesh to co-ordinate the humanitarian response for the displaced Rohingya community. Through this one-year project, funded by the U.S. Department of State (Bureau for Population, Refugees, and Migration), IOM and its implementing partners Action Contre La Faim, Handicap International, and Solidarités International have been working, together with local government and national organisations in makeshift settlements, the registered refugee camps, and selected villages.

This multi-sectoral project, subject of this evaluation, was designed to provide support primarily in terms of health, nutrition, water, sanitation and hygiene, capacity building, shelter, protection, and education, with IOM providing overall co-ordination.

"We came here in 1995 and will go home as soon as we get a chance to do so in safety and dignity."
Undocumented Myanmar National, Shamlapur

The Context

This project has taken place in a context that has experienced many direct and indirect impacts that needed to be considered in the course of this evaluation, including:

- The influx of UMNs in October 2016, which effectively doubled the size of the original caseload and stretched the humanitarian response capacity;
- An initial concern was the limited capacity of humanitarian actors, including the implementing agencies of this project, to respond at scale;
- The low level of literacy amongst beneficiaries meant that messaging and organising groups of people to take on certain activities was challenging;

* The largest Muslim group within Rakhine State self-identify under the term "Rohingya," a designation that is not accepted by the majority of the ethnic Rakhine population, and is not recognized by the central Government of Myanmar as one of the 135 official nationalities in the country. In order to preserve neutrality on the issue, IOM Myanmar alternatively refers to this group as "Muslim minority of Rakhine State." In line with the National Strategy of the Government of Bangladesh, IOM Bangladesh refers to unregistered members of this minority group as "Undocumented Myanmar Nationals".

- Restricted movement of people outside of camps or makeshift settlements limits any concerted opportunity for income generating activities which could represent an important source of income;
- Some restrictions were placed on space allocation for new arrivals: this had major impacts on the construction of shelter or WASH facilities;
- The large influx in October 2016 meant that that some activities, particularly those related to capacity building, were implemented at a late stage of the project; and
- In June 2017, Cyclone Mora struck many of the locations hosting displaced people, causing serious damage to the simple shelters and disrupting access to services*.

This project has made significant contributions to improving conditions in makeshift settlements, particularly in terms of providing clean water, health care and nutritional support.

This Evaluation

This independent evaluation was conducted in July 2017 and was based largely on a series of consultations with project beneficiaries – both displaced people from Myanmar as well as local host communities – project staff, and local government officials.

* According to the findings of the Multi Sector Rapid Assessment conducted on 30 May 2017 by the Inter Sector Co-ordination Group, 80 per cent of shelters in Balukhali Makeshift Settlement experienced "severe or partial damage", while 70 per cent of those in Kutupalong Makeshift Settlement were likewise affected. An estimated 50 per cent of shelters in both Leda Makeshift Settlement and Shamlapur were likewise damaged.

Key objectives of this evaluation were to:

- examine the effectiveness of the project in addressing the needs of the Rohingyas – including those who arrived since October 2016 – and the role that this project played in meeting humanitarian needs, amongst all other funding streams;
- examine the short- and medium-term impacts of the project activities among all target groups of beneficiaries, with a distinction being made between emergency and ongoing activities; and
- Identify key results, lessons learned, shortcomings and good practices for informing funding modality and required flexibility of future interventions.

Particular attention was given to assessing the relevance, effectiveness, efficiency and impact of the project thus far, with projections also being given to likelihood of sustainability. The reach of the project, in addition to the linkages and co-ordination between the different humanitarian actors supporting this initiative was also examined.

In total, 285 people (173 men and 112 women) participated in focus group discussions that were guided by a series of standard questions. Site visits allowed direct observations to be made on facilities provided through this project. Qualitative data from these approaches were supplemented with the results of a Knowledge, Attitudes, and Practices Survey conducted at the same time as this evaluation.

Snapshot of Observations

- ✓ This has been a comprehensive and well-integrated project that has responded to peoples' immediate needs.
- ✓ High quality support was provided by IOM and all partners on the ground.
- ✓ Changes of attitude and behaviour have been successfully achieved, e.g. hygiene promotion is appreciated amongst project beneficiaries and the level of open defecation is – at the time of this evaluation – low.
- ✓ The inclusion of host communities in receiving some degree of support was a positive move and clearly appreciated by local government.
- ✓ Trauma counselling has been highly appreciated amongst those who have received it.
- ✓ No health outbreak has been recorded since the initial outbreak of measles was dealt with following the 2016 influx. This has been an important achievement, particularly given the climate and living conditions, especially in makeshift settlements.
- ✓ In co-ordination with government services, almost 100 per cent of children under five have now been vaccinated.
- ✓ 92 per cent of respondents in a Knowledge, Attitudes, and Practices Survey acknowledged that their last-born child had received immunization vaccination through this project.
- ✓ A health user satisfaction survey conducted by IOM indicates peoples' appreciation of support provided through this project: 87 per cent of health users, for example, were fully satisfied with the treatment they received, while 92 per cent were fully satisfied with corresponding pharmacy services.
- ✓ In the same survey, 99.7 per cent of respondents stated that they would visit the healthcare facility again for future needs.
- ✓ A Handicap International satisfaction survey among people that received rehabilitation support indicates that 92 per cent of people with disabilities were satisfied with the services provided.
- ✓ Awareness raising by HI has resulted in some government institutions and NGOs installing disability friendly practices, e.g. wheelchair ramps at schools and clinics.
- ✓ 80 per cent of people with disabilities who benefit from this project have increased their household income, compared with baseline.
- ✓ The training model applied by IOM – once training was provided, follow-up by the trainers with individual institutions allowed close monitoring to see if learning was being applied – is seen as

an effective capacity strengthening approach.

- ✓ Capacity building for national NGOs has been essential, but their limits should not be tested.
- ✓ The "Model Mother Programme" run by ACF is a good example of community outreach and responsibility being taken at this level.
- ✓ Disaster risk reduction concerns have been considered, though the response still needs to be more comprehensive and consistent across all partners' programmes.
- ✓ Awareness raising and counselling through the Communications with Communities initiative have been effective in terms of outreach to communities and individuals.

"People were just barely surviving in conditions I cannot explain. We faced many problems – we had no food, no shelter or clean water and no latrines. Thankfully, this has now changed."

Project beneficiary

The evaluation – which remained fully conscious throughout of the complex context in which this project has been implemented – also analysed its findings in line with selected OECD-DAC criteria (Section 5 of this report). Top scores were assigned to the project in terms of its Relevance, Effectiveness and Impact, while high scores were also attributed for its Efficiency, Sustainability (particularly given its capacity building focus), Coverage, and Co-ordination. This bodes well for the ongoing and future programmatic interventions of IOM and its partners that implemented the project.

While this project has made significant contributions to peoples' health and security, at the time of this evaluation, the needs of the displaced Rohingya still far exceeded the support being provided. Some of the most pressing recommendations to stem from this evaluation follow below: these, and others are explained in more detail in Section 6.2. In moving into the follow-up project and overall humanitarian programming, IOM and its partners are urged to retain their emphasis on quality and to try and ensure greater consistency across the board in terms of delivering this support. Good coordination should remain at the forefront and this will hopefully be facilitated through the recently established Inter Sector Co-ordination Group.

Top-line Recommendations

1. Selection criteria being applied should be clearer to all beneficiaries.
2. More comprehensive and consistent support is required to improve conditions and ensure adequate coverage of, for example, children suffering from severe acute malnutrition, at some health facilities.
3. Psychosocial support needs to be made available more evenly amongst partners.
4. Project monitoring needs to be enhanced and be consistent.
5. Future hygiene/WASH promotion needs to extend to water handling and storage.
6. Continued emphasis needs to be given to co-ordination – at all levels – and in particular to ensuring cross-cutting issues are factored consistently into sectoral plans.
7. Disaster preparedness needs to be brought to the fore in all locations for both host and displaced communities.
8. Project activities should, where possible, be linked with government advocacy.
9. Partners should attempt to be proactive in bridging potential funding gaps to ensure there is no disruption in service delivery.
10. An environmental impact assessment should be considered for the respective aquifers providing water to camps and makeshift settlements.

CHAPTER 1
BACKGROUND, OBJECTIVES, AND KEY FINDINGS

1.1 Introduction

Between December 1991 and March 1992, some 250,000 Rohingya from Myanmar entered Bangladesh. Recognised as refugees on a *prima facie* basis by the Government of Bangladesh, the vast majority were repatriated to Myanmar in the following years. When the repatriation process ended in 2005, some 20,000 refugees remained in two registered camps in Cox's Bazar District – Nayapura Camp in Teknaf Upazila and Kutupalong Camp in Ukiah Upazila. In the intervening years, with population growth and additional arrivals, there are now some 35,000 refugees living in these camps.

In addition to this registered caseload, prior to events which took place in October 2016, the National Strategy on Myanmar Refugees and Undocumented Myanmar Nationals, formulated by the Government of Bangladesh, estimated that more than 300,000 Rohingyas were believed to have crossed the border and were living in Bangladesh, in makeshift settlements or with host communities. An outbreak of unrest in Rakhine State in October 2016 triggered a significant displacement of people, with an estimated 87,000 Rohingya arriving in Cox's Bazar between October 2016 and June 2017. Categorised as UMN, these people have settled mainly in makeshift settlements and with host communities, while smaller numbers have moved into the two registered camps. Table 1 shows the approximate numbers of UMNs in the different locations at the time of this evaluation. Table 1 shows the approximate numbers of UMNs in the different locations at the time of this evaluation.

IOM was mandated by the Government of Bangladesh to co-ordinate the humanitarian response for the displaced Rohingya community. Through a one-year project, which was funded by the US State Department (Bureau for Population, Refugees and Migration), IOM and its main implementing partners – Action Contre La Faim, Solidarités International and Handicap International – have been working, together with local government and national organisations in three makeshift settlements, the camps and selected villages.

Table 1. Approximate Numbers of UMNs in Different Locations at the Time of this Evaluation

UPAZILA	CAMP/SETTLEMENT/COMMUNITY	ESTIMATED NUMBER OF UMNs
Teknaf	Shamlapur	8,443
	Leda Makeshift Settlement	14,240
	Nayapura camp	19,230
	Host community	57,360 (+)
Ukhiya	Kutupalong camp	13,901
	Kutupalong Makeshift Settlement	79,479
	Balukhali Makeshift Settlement	20,016
	Host community	106,772

Sources: IOM, 2017; ISCG September 2017; UNHCR, 2017; http://reliefweb.int/sites/reliefweb.int/files/resources/50001ae09_0.pdf

Since this evaluation was conducted*, many more people have crossed the border into Bangladesh from Myanmar, again fleeing conflict and persecution.

Undocumented Myanmar Nationals have settled in a number of locations and circumstances: some are living amongst host Bangladesh communities (often paying rent for land on which to construct a shelter), while others have moved into either Nayapura or Kutupalong camps where they live with family members. A third group of UMNs have moved – are still moving – into makeshift settlements, some of which are also on the fringes of a registered camp. Other UMNs have undoubtedly moved to commercial centres such as Cox's Bazar.

Table 2 illustrates the number of UMNs believed to be residing amongst host communities in the two upazilas (a total in excess of 164,000 people) around the time of this evaluation.

Table 2. Number of UMNs in Respective Host Communities in Teknaf and Ukhia Upazilas

UPAZILA	UNION	HOST POPULATION	NO OF UMNs IDENTIFIED	% INCREASE OF UMNs
Ukhia	Rajapalong	63,223	80,254	127
Ukhia	Jaliapalong	46,952	1,700	4
Ukhia	Palongkhali	38,134	23,803	62
Ukhia	Ratnapalong	28,947	370	1
Ukhia	Haludiapalong	54,158	645	1
Teknaf	Whykong	53,603	1,066	2
Teknaf	Nhila	44,863	29,602	66
Teknaf	Teknaf Sadar	68,101	5,300	8
Teknaf	Baharchara	35,485	10,163	29
Teknaf	Sabrang	50,655	11,229	22
Teknaf	Saint Martine	6,786	No data	No data

Notes: Host population figures estimated based on the 2011 census; Number of UMNs identified and percentage increase of UMNs based on NRM R4. Data source IOM NPM R4, July 2017.

What is common in all of these situations is that both UMNs and the host communities suffer from below average access to basic health services, clean and safer water, sanitation, and education facilities. Among the UMN population – which is largely composed of women and children – women face an elevated risk of being victims of domestic violence and sexual abuse, with limited access to family planning and maternal health care services.

As part of its National Strategy on Myanmar Refugees and Undocumented Myanmar Nationals, the Government of Bangladesh has given a mandate to IOM to provide and co-ordinate humanitarian services for the UMNs, mainly on **health, nutrition, water and sanitation**. Implementation of the strategy is the responsibility of a National Task Force, chaired by the Foreign Secretary.

Addressing the above-mentioned needs, IOM has secured funding from the US State Department – the Bureau for Population, Refugees and Migration – for a period of one year to address some of the most urgently identified needs (see Section 1.3 for further details). In this situation, IOM – and its implementing partners – work in all three situations described above.

* Shortly after this evaluation was completed a new wave of forcibly displaced people fled from Myanmar to Bangladesh. An estimated 300,000 people are thought to have been forcibly displaced at the time of writing this report.

As part of its response, IOM and partners have been providing access to clean water to UMNs, which has been especially important during the monsoon season.

1.2 Context

This one-year project has taken place in a context that has experienced many direct and indirect impacts that need to be considered in the context of evaluating work that has taken place. Some of the most relevant issues are listed below:

- a new influx of UMNs in October 2016 – effectively doubling the size of the caseload – stretched the humanitarian response capacity;
- the initial lack of a strategy on how to deal with new arrivals led to initial confusion and uncertainty in terms of response;
- IOM and its partners were, however, fortunate in being able to build on previous work in the respective communities, in addition to having an emergency response strategy in place;
- an initial concern was the limited capacity of national non-governmental organisations (NGOs) to support this humanitarian programme;
- the low level of literacy amongst UMNs has meant that messaging and organising groups of people to take on certain activities has been challenging;
- restricted movement of people outside of camps or makeshift settlements limits any concerted opportunity for income generating activities which could represent an important source of income for UMNs;
- similar restrictions were placed on space allocation for new arrivals: this had major impacts on the construction of shelter or WASH facilities, for example;
- a late announcement of the BPRM funding for this project (August 2016) resulted in a shortened period of implementation for some of IOM's partners;

- a short project/budget duration which meant that some events related to capacity building were still being implemented at a late stage of the project;
- in June 2017, Cyclone Mora struck many of the locations hosting displaced people, causing serious damage to the simple shelters and disrupting access to services*; and
- given the fact that the emergency response has been at the forefront of support during this project period, many people spoken with during this evaluation found it difficult to now discern between pre-influx and influx periods.

The evaluation team gave particular consideration to the above points throughout the evaluation, especially considering the short project timeframe in which this project has taken place.

1.3 Objectives

The specific objective of this project is to "*contribute to improving the health, nutrition, WASH and education conditions of undocumented Myanmar nationals and host communities in Ukhia and Teknaf upazilas of Cox's Bazar District, and strengthening the capacity of local institutions providing services to the UMNs and host communities in Cox's Bazar District in co-ordination/collaboration with other stakeholders*".

Indicators of achievement linked with this are the:

i) percentage of beneficiaries in Ukhia and Teknaf upazilas which have access to primary health care (disaggregated by UMNs/HCs and Upazila). The target in Teknaf is 70 per cent amongst UMNs and 80 per cent amongst the host community. In Ukhia, respective targets are 90 per cent and 60 per cent;
ii) percentage of beneficiaries in Ukhia and Teknaf upazilas that have access to adequate water supply (15 litres per person per day) for drinking, again disaggregated by UMNs/HCs and Upazila. Here the target is 90 per cent of the respective population; and
iii) percentage of UMN children enrolled in early learning and basic education. This target was not included in the project proposal, being subject to a baseline being conducted.

For the purpose of this evaluation, site visits and on-site consultations took place in both upazilas, as illustrated in the evaluation Itinerary (Annex II).

This project, funded by the BPRM, was managed by IOM Bangladesh. Government partners included the Ministry of Foreign Affairs, Ministry of Health and Family Welfare and the Department of Public Health Engineering. International partners in Bangladesh included the World Food Programme, Médecins sans Frontières (MSF), Action Contre La Faim (ACF), Solidarités International (SI) and Handicap International (HI). Co-operation agreements were established between IOM and each of the respective partners. While sub-contracting specific activities to ACF, SI and HI, IOM also directly implemented certain activities alongside these international NGOs, primarily in relation to WASH and health and, more recently following Cyclone Mora in June 2016, shelter. A number of national NGOs were also involved, in collaboration with either IOM or one of its international partners.

* According to the findings of the Multi Sector Rapid Assessment conducted on 30 May 2017 by the Inter Sector Co-ordination Group, 80 per cent of shelters in Balukhali Makeshift Settlement experienced "severe or partial damage", while 70 per cent of those in Kutupalong Makeshift Settlement were likewise affected. An estimated 50 per cent of shelters in both Leda Makeshift Settlement and Shamlapur were likewise damaged.

The project provided support to beneficiaries in many forms that included:

- health, including specific support to people with disabilities
- nutrition
- mental health and care practices
- WASH
- capacity building
- co-ordination/communications with communities
- protection;
- education
- shelter

Neither education nor shelter were examined as part of this evaluation.

This project sought to provide a wide range of support to both UMNs as well as host communities, with good uptake on features such as improving access to facilities such as schools and clinics for people with disabilities.

This evaluation focused on activities implemented from 1 July 2016 to 30 June 2017. It also takes into account the preliminary findings of a Knowledge, Attitude and Practice (KAP) Survey* conducted shortly after the present evaluation in July 2017. The latter was intended to gauge the current situation of UMNs in terms of Health, WASH, Sexual and other forms of gender-based violence, in addition to the use of community feedback mechanisms. The survey covered Leda Makeshift Settlement and Montila Host village in Teknaf Upazila and Balukhali and Kutupalong Makeshift Settlements as well as Hatimora, Purbo Painnasia, Jumpara and Telkhola host villages in Ukhiya Upazila.

Monitoring and reporting was assumed through the respective organisations, with overall monitoring and evaluation being the responsibility of IOM's internal M&E unit.

* A total of 1,160 people were consulted through FGDs and KIIs.

1.4 Evaluation

This independent evaluation, which covered the project period 1 July 2016 to 30 June 2017, inclusive, was undertaken at the request of IOM Bangladesh. Terms of Reference for this evaluation are presented in Annex I. It was conducted by two people, Dr David Stone, Director of Proaction Alliance, as Team Leader recruited by IOM, and Mr Rezaul Karim, a Bangladeshi Consultant hired directly by Proaction Alliance for the purpose of this assignment. The evaluation was accompanied throughout by project staff from IOM and its partners.

This evaluation was designed to assess the performance of the project and determine if the intervention was an effective and sound response to the needs of vulnerable people in Teknaf and Ukhiya upazilas, as well as Undocumented Myanmar Nationals in surrounding host communities. Specific effort was made to identifying tangible, evidence-based results and changes to peoples' livelihoods, behaviour and capacities, in addition to a comprehensive review of the project design and mode of delivery.

Key objectives of this evaluation were to:

- examine the effectiveness of the project in addressing the needs of the Rohingyas – including those who arrived since October 2016 – and the role that this project played in meeting humanitarian needs, amongst all other funding streams;
- examine the short- and medium-term impacts of the project activities among all target groups of beneficiaries, with a distinction being made between emergency and ongoing activities; and
- identify key results, lessons learned, shortcomings and good practices for informing funding modality and required flexibility of future interventions.

Particular attention was given to assessing the relevance, effectiveness, efficiency and impact of the project thus far, with projections also being given to likelihood of sustainability. The reach of the project, in addition to the linkages and co-ordination between the different humanitarian actors supporting this initiative was also examined. Specific note was taken in determining what changes have taken place in particular sectors or situations and in identifying where the project has contributed to any such change – deliberate and non-intentional.

The evaluation undertook consultations with a broad range of stakeholders on the ground, using a suite of appropriate methods which included direct observations, focus group discussions (FGDs) and key informant interviews (KIIs), as well as a comprehensive review of existing reports and project materials. The nature and format of these discussions were routinely tailored to meet specific situations and discussion groups.

Throughout the evaluation, emphasis was given to capturing the overall impact of the project's interventions, examining how the approach addressed the perceived needs as well as the effectiveness of specific activities over the course of the response thus far.

1.5 Snapshot of Key Findings

- ✓ This has been a comprehensive and well integrated project that has responded to peoples' immediate needs.
- ✓ High quality support was provided by both IOM and all partners on the ground.
- ✓ Changes of attitude and behaviour have been successfully achieved, e.g. hygiene promotion is

appreciated amongst project beneficiaries and open defecation is at a very low level – 5 per cent of KAP Survey respondents, July 2017.

- ✓ Inclusion of host communities in receiving some degree of support was a positive move.
- ✓ Trauma counselling has been highly appreciated amongst those who have received it.
- ✓ No health outbreak has been recorded since the initial epidemic of measles was dealt with following the 2016 influx. This has been an important achievement, particularly given the climate and living conditions, especially in makeshift settlements.
- ✓ 92 per cent of a KAP Survey respondents acknowledged that their last-born child had received immunisation vaccination through this project.
- ✓ A health user satisfaction survey conducted by IOM indicates peoples' appreciation of support provided through this project: 87 per cent of health users, for example were fully satisfied with the treatment they received while 92 per cent were fully satisfied with corresponding pharmacy services.
- ✓ In the same survey, 99.7 per cent of respondents stated that they would visit the health care facility again for future needs.
- ✓ A Handicap International satisfaction survey among people that received rehabilitation support indicates that 92 per cent of people with disabilities were satisfied with the services provided.
- ✓ Awareness raising by HI has resulted in some government institutions and NGOs installing disability friendly practices, e.g. wheelchair ramps at schools and clinics.
- ✓ 80 per cent of people with disabilities who benefit from this project have increased their household income, compared with baseline.
- ✓ The training model applied by IOM – once training was provided, follow-up by the trainers with individual institutions allowed close monitoring to see if learning was being applied – is seen as an effective approach to capacity strengthening.
- ✓ Capacity building for national NGOs has been essential, but their limits should not be tested.
- ✓ The "Model Mother Programme" run by ACF is a good example of community outreach and responsibility being taken at this level.
- ✓ CWC members are the frontline of this project, serving as an all-important interface with communities and individuals. This is an effective approach.
- ✓ Disaster risk reduction concerns have been considered though the response still needs to be more comprehensive and consistent across all partners' programmes.
- ✓ Field staff met as part of this evaluation were committed, educated in their relevant sector and led by values of humanity.

CHAPTER II
REPORT STRUCTURE

An overview of the context, some of the main findings of this evaluation and suggested recommendations have been presented above. Section 3 presents the methodology used in the approach and implementation of this evaluation, including an overview of those beneficiaries who were consulted and a description of the main tools used. The latter was essentially a combination of literature review, personal and group consultations with project beneficiaries and project staff, as well as direct observations on the ground in selected villages and settlements.

In addition to project beneficiaries, identified stakeholders include representatives from local government authorities IOM project staff as well as key practitioners and managers from each of the implementing partners. A list of project staff and government personnel consulted as part of this evaluation is given in Annex IV: beneficiaries consulted are deliberately not named to protect their identities. Questionnaires used to guide data collection are presented in Annexes V-IX.

Section 4 presents the main findings of this evaluation. It begins with an overview of the situation as it appears today, followed by an analysis of observations in relation to health, WASH, communications, co-ordination and disaster preparedness.

In Section 5, an analysis is presented on the evaluation's findings in the context of selected OECD-DAC criteria – Relevance, Effectiveness, Efficiency, Impact, Sustainability, Coverage and Co-ordination. This is followed in Section 6 by a short conclusion and a set of recommendations for consideration by IOM and its partners. These are intended to help IOM scale-up this form of humanitarian assistance to inform and empower it to respond to similar and even larger scale humanitarian crises, with the same quality of services.

This is followed by a list of materials consulted prior to, during and following the actual evaluation on the ground.

CHAPTER III
METHODOLOGY

Specific attention given to examining project design and achievements in terms of its relevance, effectiveness, efficiency, impact and potential for sustainability.

3.1 Overview

Contractual arrangements were concluded between the Team Leader and IOM on 13 June. Field deployment of the evaluation team happened on 2 July and fieldwork was concluded on 12 July. Please see Annex II for a detailed itinerary.

The adopted methodology was designed in consultation with staff from IOM in Dhaka and Cox's Bazar and discussed with partner organisations during the evaluation team's first introductory meetings. The following steps summarise work undertaken:

a) Initial briefing with relevant programme staff at IOM Dhaka and Cox's Bazar, as well as each of the three implementing partners in Dhaka. The scale and scope of the evaluation was discussed, with consideration of site visits as well as the desired/practical level of consultation. Based on this, a detailed itinerary was prepared and shared with IOM and its partners for additional comments and logistics planning.
b) As part of a desk review, background reports provided by IOM and partners were reviewed by the evaluation team. Data gaps or queries were discussed with IOM, in particular.
c) Based on the above, a proposed methodology and approaches were developed. This was largely based on a suite of participatory appraisal tools (see Section 3.3) to help identify and assess the impact of this project on individual household members and communities over the project's timeframe.
d) Several questionnaires were developed to guide interviews and discussions with different stakeholders (Annex V-IX). Specific attention was given by the evaluation team as to how individual/community questions/discussions might be managed, particularly in respect on confidentiality and culture.
e) A list was prepared of communities and stakeholder groups for consultation, taking account of different contexts, and respecting local culture. The sampling strategy attempted to ensure adequate and appropriate coverage of different stakeholders taking part in this project.
f) Additional interviews were conducted with staff from IOM and its partners as well as participating government services.
g) Further secondary data analysis was conducted as additional reference materials form partners came available.
h) An inception report was prepared by the evaluation team on 7 July 2017, providing a summary of the evaluation's objectives together with a narrative summarising the proposed methodology and lines of questioning anticipated. Timely and useful feedback was received on the report was incorporated into the methodology.

Findings from this evaluation were strongly influenced by the range of interviews and discussions held with UMNs, representatives from host communities, government representatives and staff from IOM and its main implementing partners.

i) Logistic planning and preparation for fieldwork.
j) Site visits (data collection, additional consultations and observations) were conducted with UMNs in the two registered camps, as well as those residing with host communities and in makeshift settlements. Direct observations, together with KIIs and FGDs, allowed for a comprehensive – and triangulated – series of data to be gathered.
k) Field surveys were completed by 11 July 2017. Further consultations were conducted with IOM and implementing partner project staff.
l) At the end of the evaluation in Bangladesh, a validation/debriefing meeting was organised on 13 July 2017 with IOM and partner staff in Dhaka to present preliminary observations, gather additional information and clarify any misunderstanding.
m) Based on the above, a draft report, based on a structure proposed in the Inception Report, was submitted to IOM, taking account of findings from the July 2017 KAP Survey.
n) With feedback received from both the draft report and debriefing meeting, this final evaluation report was prepared.

3.2 Team Composition

This evaluation was conducted by David Stone and Rezaul Karim (Proaction Alliance), in close collaboration with staff from IOM on the ground, as well as their international NGO partners Translation assistance was provided by representatives from both IOM and its partners. Every effort was made to ensure impartiality and independence of consultations and discussions held with project beneficiaries and staff/representatives from IOM and its partners.

Given the number of questions and different groups of beneficiaries that were anticipated, and in

order to reach an acceptable level of coverage and minimise bias, after a few initial joint meetings, the evaluators then divided their time between different of people and actual site visits. As a principle, the Evaluation Team ensured that they remained open and flexible to accommodate any eventual changes in the itinerary that might have been required.

The evaluation was accompanied in the field by field staff from IOM and/or its implementing partners. These occasions also allowed the evaluation team to conduct additional, organisation-specific interviews.

Annexes V-IX outline a consolidated list of evaluation questions that relate specifically to the nature of activities provided to beneficiaries. Annex X is a reference list of questions posed throughout the evaluation as these addressed issues relating specifically to the selected OECD-DAC criteria.

3.3 Tools

A suite of participatory tools was used in this evaluation, drawing on particular methods for specific situations. This was intended to help ensure adequate coverage of primary and secondary data, together with qualitative and quantitative approaches. The approaches applied are outlined below.

TOOL	INTENDED AUDIENCE	DESCRIPTION
Individual Interviews	• Project beneficiaries • Project staff • Community leaders • Government departments • Other	Along with direct observation, key informant interviews will help provide a comprehensive overview of the project, from different angles. Interviews will focus not only on the impact of the interventions but also the quality of the implementation process, the nature of relationships with partners and so forth. Interview approaches will be adapted according to the particular audience.
Direct Observation	Beneficiaries	Intentional, guided observation to confirm or challenge information offered during interviews, as well as project documentation.
Focus Group Discussions	• Project beneficiaries • Project staff • IOM partners	FGDs will be used to increase the quantity of the input, given the limited time period of the evaluation. This will provide a broader sense of the quality of the process and its impact and should help inform how widespread the observations at household level are likely to hold true.
Document Review	Project staff	To take place throughout the evaluation. On site document review to happen in co-operation with the project manager to verify, for example, specific indicators and achievements.

Team members followed broad, agreed lines of enquiry for field data collection, to help ensure a degree of consistency, define the extent of interventions and identify lessons from this project.

CHAPTER IV
MAIN FINDINGS

4.1 Scope of Evaluation

Fieldwork was conducted from 4-12 July 2017 (Annex II), with site visits being conducted with project beneficiaries in each of the three makeshift settlements, UMNs at both of the registered camps and in selected village communities. Interviews were also held in clinics and hospitals, as well as with government representatives.

In addition to field observations and random meetings with household beneficiaries, separate meetings were also arranged with representatives from IOM and its international partner staff. Regrettably, at the time of this evaluation and due to funding challenges, SI's work in Teknaf had been put on hold and staff laid off. This unfortunately restricted the evaluation team's ability to get quality first-hand information on past activities.

A breakdown of the main sectoral activities for which IOM and its main implementing partners were responsible for is shown in Table 3, particularly to illustrate the scope of their engagement as part of this project.

Table 3. Main Sectoral Activities of IOM and its International Partner Organisations

UPAZILA	LOCATION	HEALTH	WASH	CAPACITY BUILDING	NUTRITION	SGBV	DRR	EDUCATION
Teknaf	Shamlapur	ACF IOM	ACF SI IOM	ACF HI IOM	ACF	ACF SI HI IOM	SI	HI
	Leda Makeshift Settlement	ACF IOM HI	ACF IOM SI	ACF HI IOM	ACF	ACF SI HI IOM	SI	HI
	Nayapura Camp	ACF HI	ACF SI	ACF HI	ACF	ACF SI HI	SI	HI
	Host Community	IOM	IOM	IOM		IOM		
Ukhiya	Kutupalong Camp	ACF HI	ACF IOM	ACF HI	ACF	ACF SI HI		HI
	Kutupalong Makeshift Settlement	ACF IOM HI	ACF IOM	ACF IOM HI	ACF	ACF SI HI IOM		HI IOM
	Balukhali Makeshift Settlement	ACF IOM HI	ACF IOM	ACF IOM HI	ACF	ACF SI HI IOM		HI IOM

	Host Community	ACF HI IOM	ACF IOM	ACF HI IOM	ACF	ACF SI HI IOM		HI

As part of this evaluation, 285 people participated in focus group discussions that were guided by a series of standard questions (Table 4). Of this total, 173 men took part in the discussions (24 from host communities and 149 people who were either registered refugees or UMNs), while 112 women (22 from host communities and 90 who were either refugees or MNs) likewise contributed to findings.

Table 4. Project Beneficiaries Who Participated in Focus Group Discussions

UPAZILA	LOCATION	MEN	WOMEN
Teknaf	Shamlapur	7 (UMN)	8 (UMN)
	Shamlapur	11 (HC)	6 (HC)
	Shamlapur (Parra Development Committee)	9 (UMN)	4 (UMN); 1 (HC)
	Shamlapur	22 (UMN)	1 (UMN)
	Shamlapur	7 (UMN)	8 (UMN)
	Nyapara Registered Camp	11 (refugees)	5 (UMN)
	Nyapara	7 (HC)	9 (HC)
	Nyapara	-	12 (UMN)
	Nyapara	-	18 (UMN)
	Nyapara	6 (HC)	6 (HC)
Ukhiya	Balukhali Makeshift Settlement	14 (UMN)	10 (UMN)
	Balukhali Makeshift Settlement	26 (UMN)	4 (UMN)
	Kutupalong Registered camp	12 (UMN)	2 (UMN)
	Kutupalong Registered camp	15 (refugees)	-
	Kutupalong Makeshift Settlement	16 (UMN)	14 (UMN)
	Kutupalong Makeshift Settlement	10 (UMN)	4 (UMN)
TOTAL		173	112

4.2 Key Observations

At the time of this evaluation, over 110,000 people were thought to be hosted in three major makeshift settlements – Kutupalong and Balukhali in Ukhiya Upazila and Leda in Teknaf Upazila, while some 51,000 UMNs were living in host communities in both upazilas (ICSG, July 2017).

Overall, this has been a comprehensive and well-integrated project that has responded to peoples' immediate needs. This is especially noteworthy given the short timeframe in which activities have been implemented and with due consideration of the unanticipated influx of UMNs, late 2016. Undoubtedly, the high quality of support provided by both IOM and its partners on the ground has been a major factor in ensuring that this response provided immediate assistance to some of those most in need.

Though faced with difficulties such as physical space within settlements, the provision of latrines, combined with a strong awareness programme on hygiene quickly brought an end to open defecation and general improvement of the physical environment.

Among the many achievements of this initiative are definite changes of attitude and behaviour: many people spoken with as part of this evaluation expressed their wholehearted appreciation for the awareness they have received, for the knowledge they have learned and for the many services being provided to them, mostly for the first time in their lives. The medical support people freely receive has been a transformation for many families, and in particular women and children. At the same time, hygiene promotion is widely appreciated amongst project beneficiaries and open defecation is now at a very low level – 5 per cent of KAP Survey respondents, July 2017. The latter alone is a major achievement in just a few months of awareness raising activities by IOM and its partners.

Similar acclaim needs to be highlighted for the fact that no health outbreak has been recorded since an initial epidemic of measles was dealt with. This has been an important achievement, particularly given the climate and living conditions especially in makeshift settlements. Today, as a result of the joint vaccination campaign organized by the government and IOM, almost all children under five have received a vaccine against six major illnesses. 92 per cent of KAP Survey respondents acknowledged that their last-born child had received immunisation vaccination through this project.

Collected around the time of this evaluation, a selection of indicators of achievement from the three makeshift settlements are summarised in Table 5. While these do illustrate some high levels of completion there is nonetheless some degree of inconsistency in some of the activities across the three locations.

Table 5. Status of Achievement against Selected Indicators in Makeshift Settlements (July 2017)

SECTOR	INDICATOR	FINDINGS AT KUTUPALONG MAKESHIFT SETTLEMENT	FINDINGS AT BALUKHALI MAKESHIFT SETTLEMENT	FINDINGS AT LEDA MAKESHIFT SETTLEMENT
WASH	Main source of drinking water	90% pump well	100% pump well	81% water tap
	Main source of non-drinking water	90% pump well	70% pump well	81% water tap
	Drinking water treated	16%	19%	80% tab/powder treated
	% of gender-segregated latrines	45%	17%	99%
Food	Main food source	73% UN/INGO distribution; local market	100% UN/INGO distribution; local market	99% UN/INGO distribution; local market; fishing
	% or people having more than one meal per day	80%	81%	79%
	% of people having diversified diet	75%	70%	67%
	Primary income source	78% Irregular daily labour	100% Irregular daily labour	86% Irregular daily labour
Health	Main concerns	Watery diarrhoea; skin infection; fever; lice	Watery diarrhoea; skin infection; fever; lice	Watery diarrhoea; fever; lice; respiratory
	% of people that have access to vaccination	100%	100%	100%
Education	% of people receiving non-formal education	100%	86%	100%
Safety, Dignity and Respect for Individual Rights	% of blocks where children report not feeling safe	15 (Off-site, market, latrines)	8 (Latrines, off-site, collecting firewood)	7 (Off-site, transportation, market)
	% of blocks where women report not feeling safe	17 (Latrines, off-site, washrooms)	8 (Latrines, off-site, washrooms)	7 (Off-site, firewood collection, latrines, washrooms)
	Places where UMNs feel movement restriction	Crossing checkpoints, going to work, markets, collecting firewood	Crossing checkpoints, going to work, markets, collecting firewood	Crossing checkpoints, going to work, markets
	No of blocks with access to protection incident reporting mechanism	14	8	5
	No of blocks with access to GBV services	7	2	1

Source: KAP Survey; IOM NPM Round 4 July 2017

One of the defining activities in this project was the inclusion of host communities in receiving some degree of support. This was seen as a very wise and positive move and has been appreciated by the participating communities as well as government. Welcomed services have primarily been in connection with health, access to safe water, hygiene improvements as well as dedicated support for people with physical disabilities.

User satisfaction surveys indicate peoples' appreciation of support provided through this project: 92 per cent of people with disabilities said that they were satisfied with the services provided by the HI supported rehabilitation surveys. Awareness raising again by HI has also resulted in some government institutions and other NGOs implementing this project installing disability friendly practices, e.g. wheelchair ramps at schools and clinics. According to the same surveys, 80 per cent of people with disabilities who benefit from this project have increased their household income, compared with baseline.

The following sections provide additional insights to the main components of this project, which include separate findings from the independent KAP survey.

4.2.1 Communications and Co-ordination

The project has seen the use of different awareness raising techniques being used by IOM and its partners, all seemingly to good effect. Some 88 per cent of the KAP Survey respondents stated that the various community forms organised made an effort to address people concerns, a sentiment which was equally shared across all locations surveyed. IOM's Communicating with Communities (CWC) members are the frontline of this project, serving as an all-important interface with communities and individuals. This has an effective approach, while similar outreach from IOM's international and, the evaluation understands, its national partners as well has also been noteworthy given the context and scale of need.

The "Model Mother Programme" run by ACF is another good example of community outreach and responsibility being taken at this level.

Workers from different NGOs were seemingly very active in engaging with community members (according to 60 per cent of survey respondents) while staff from IOM played a slightly lower role (49 per cent). Sessions with NGO workers were promoted most in Balukhali (77 per cent), but also in Kutupalong (71 per cent) and Leda (54 per cent), while similar figures for IOM staff were 77 per cent, 63 per cent and 52 percent, respectively. Courtyard meetings and community outreach programmes were both widely used practices for sharing information.

"*We act as the eyes and ears for people [in the settlement] for rapid screening and referral*."
Field Assistant, Teknaf Health Clinic

People also showed a keen awareness of the community feedback mechanism put in place through this project. The majority of survey respondents (68 per cent) said that they could provide feedback face-to-face to concerned people. Knowledge of complaint boxes, in contrast was, in contract, very low: 3 per cent of those surveyed in the makeshift settlements claimed to be unaware of any option to provide feedback, while a further 9 per cent said that they were unaware of a complaint box mechanism. Of those who were aware of the system, however, 92 per cent expressed their satisfaction with it while 6 per cent stated that they were "not satisfied" (KAP Survey, 2017).

An essential part of this project – given the level of appropriate expertise available in-country to deal with a situation such as this – has been capacity building for local NGOs. In this respect, the training model applied by IOM and some of its international partners is seen as an effective coaching approach: once training was provided, direct follow-up by the trainers with individual institutions allowed close monitoring to see if learning was being applied. Having such expertise on-hand to backstop any identified areas of concern was an important step to have taken.

At the same time, while provided capacity building was seemingly well appreciated (the scope of this evaluation did not extent to assessing local NGO* partners), staff from participating agencies did remark several times to the evaluation team that "*the limits of those national partners should not be tested*".

While the comments above highlight many effective approaches towards communications and co-ordination, one issue which many people were not happy with was the way in which people were selected for specific assistance, for example, hygiene kits (see Section 6.6 Coverage).

4.2.2 Health

This project has allowed several different contributions to be made in the health sector. Findings from the KAP Survey showed that more than half (57 per cent) of respondents reported to be attending IOM-supported health facilities. Very few people (0.4 per cent of the total number of people consulted were not attending health facility.

Through a range of interventions – including supporting government health facilities – this project has provided high quality services to both host communities and UMN, services which are highly appreciated by health users.

In terms of maternal health, timely and regular sessions of antenatal care are important in order to identify and deal with any pregnancy-related complications. In this regard, women showed a good appreciation of the need for frequent check-ups, with 65 per cent of female respondents acknowledging that they should make at least four visits before giving birth (KAP Survey, 2017). Similar responses were given by women from the makeshift settlements and host villages. At the

* It was, however, reported that one national NGO, SHED, has now started to successfully raise some independent funding from an international donor. This is a welcome sign and recognition of the capacity building support it has received through this project, in addition to its own performance.

same time, however, an equal number of women in both situations (11 per cent in each) reported that they did not receive and antenatal care services during their last pregnancy. Of those who did receive attention, 57 per cent of cases were at a NGO run hospital and 27 per cent at an IOM supported facility.

Most women surveyed (84 per cent) gave birth to their last child at their home. The reason for this was reported as the baby being born earlier than its due date. While for some, this indicated that they did not have enough time to reach a health centre prior to delivery, other reasons given were a lack of money (mentioned by 16 per cent of respondents) and the distances involved (15 per cent). Surprising differences were found between the three makeshift settlements, with 96 per cent of home births taking place in Balukhali compared with 59 per cent in Leda.

Equally important to antenatal care, postnatal care support was also examined: in this instance, more women in the makeshift settlements received this assistance compared with host communities – 50 per cent and 27 per cent, respectively.

One of the most consistent forms of support provided to children has been the mass immunisation, with92 per cent of the KAP Survey respondents who had children acknowledging that their child had been vaccinated. Others are in relation to the school nutrition programmes and mass awareness raising on issues such as diarrhoeal prevention and treatment.

Project beneficiaries have also been able to benefit from various health promotional activities: according to the KAP Survey findings, 48 per cent of those surveyed reported that they had participated in one or more health promotion session. Issues covered addressed the treatment of diarrhoea (85 per cent of respondents), vaccinations (47 per cent) and antenatal care and postnatal care (43 per cent).

4.2.3 WASH

Activities undertaken in relation to WASH are believed to have been a key intervention in terms of improving and safeguarding peoples' health and lifestyle. Had WASH not been an integral part of this project there would have been a high certainty of outbreaks of waterborne diseases. In addition, without this support, the most vulnerable members of the communities would almost certainly have gone without help.

Deep tube wells provide water for drinking (76 per cent of KAP Survey respondents) and washing (73 per cent). Shallow tube wells and public tap stands serve as secondary sources of drinking water for 14 per cent and 10 per cent of the sampled population, respectively. The situation is, however, different in each of the three makeshift settlements. In Balukhali, 100 per of recipients mentioned that deep tube wells were their source of water, compared with 87 per cent of those surveyed in Kutupalong and just 12 per cent in Leda Makeshift Settlement.

Following the October 2016 influx, from a situation of wide scale open defecation both in and around makeshift settlements, today the situation has been transformed by the installation and maintenance of pit latrines. According to the 2017 KAP Survey, 93 per cent of respondents admitted to now having access to a latrine, despite the high concentration of people in the crowded makeshift settlements. Only 6 per cent of survey respondents mention that they do still practice open defecation, of whom the vast majority were living in Balukhali Makeshift Settlement.

The combination of hard engineering (latrines and washing facilities) and soft awareness raising and training skills has been particularly important and relevant. This is especially so given peoples'

previous knowledge of appropriate sanitation practices as well as the low level of literacy* amongst the Rohingya community. The creation and training of Water Committees has equally served an important role in the respective communities, as members now play an important role in mobilising others to, for example, attend hygiene awareness sessions as well as help maintain the equipment and facilities in good working order. Seventy per cent of the KAP Survey respondents, for example, acknowledged having attended WASH promotion activities. In the makeshift settlements, issues discussed were in relation to hygienic latrines (83 per cent of the surveyed community), hand washing (69 per cent), safe water (62 per cent) and waste disposal (22 per cent).

As a result of such awareness raising, most KAP Survey respondents (94 per cent) reported that the wash their hands after using a latrine and before eating (93 per cent). The majority of respondents in makeshift settlements (85 per cent) reported that they used soap and water to wash their hands after defecation. A similar practice was mentioned before eating – 70 per cent of people in the same locations.

Hand washing practices were also widely reported amongst children: 89 per cent of children reported washing their hands with soap and water after different activities – 94 per cent of them before eating, 88 per cent after defecation, 74 per cent after eating, 39 per cent when their hands were dirty and 38 per cent after playing. Little variation was observed in this instance across the different locations.

Women are mainly responsible for collecting water each day: only in 14 per cent of cases in the makeshift settlements were husbands report to fetch water. The average time people have to queue for water is 19 minutes in the makeshift settlements (KAP Survey, 2017). The quality of water is generally good: 63 per cent of survey respondents said they did not have to sterilise the water before drinking it.

Continuing challenges that need to be addressed relate to space as the already crowded conditions in the makeshifts makes it difficult to plan for additional pit latrine construction. The unplanned nature of the makeshift settlements too is a major challenge, especially during the rainy season where surface water becomes a hazard, flooding homes and significantly increasing the risk of slope erosion.

While significant progress has started to happen in relation to improving WASH access and facilities for disabled people, more attention needs to be given to this sector. Better design practices are needed in some facilities to allow more space and easier access for people confined to wheelchairs, for example. Closer co-ordination is needed on this between HI and IOM and ACF, in the respective settlements and villages.

4.2.4 Disaster Preparedness and Reduction

As part of the original project proposal, it was anticipated that the capacity of institutions and communities – in targeted areas of Teknaf Upazila – would be strengthened in terms of disaster reduction. This included the development of an early warning system, strengthening the capacity of volunteer groups – in connection with the Upazila Disaster Management Committee and, together with a local NGO, organising a DRR awareness raising campaign.

* The KAP Survey found that more than two-thirds (68 per cent) of respondents were illiterate.

As pressure for building space increases people are forced to construct shelters in vulnerable locations. IOM and partners have already helped some families relocate from unstable situations.

The awareness campaign, planned to coincide with National Disaster Preparedness Day (10 March 2017) was gauged to have been an effective intervention and attended by more than 300 people. Separate training was also provided to two local NGOs, to 200 field staff in total, of who 77 per cent were women. Participants register a 49 per cent knowledge improvement as a result of this training, in addition to which disaster preparedness messages are now being included by one of the local NGOs in the World Food Programme's project that it also helps implement.

While the evaluation notes that disaster risk reduction concerns have been considered as part of this project there is a great need for broader, targeted and more consistent support across all partners' programmes. This is seen as particularly important given the ever-present threat of cyclones and heavy rains, together with the crowded conditions and sometimes unstable terrain in the makeshift settlements, in particular. In going forward, this should be elaborated in conjunction with the respective Disaster Management Committees.

CHAPTER V
COMMUNICATION CHANNELS AND SOURCES

Table 6 summarises the findings of the evaluation team based against the OECD-DAC criteria, which have a scale of 0-4, and defined as shown below:

0 "*Low or no visible contribution to the criteria*";
1 "*Some evidence of contribution to this criteria but significant improvement required*;"
2 "*Evidence of satisfactory contribution to this criteria but requirement for continued improvement"*;
3 "*Evidence of good contribution to this criteria but with some areas for improvement remaining*"; and
4 "*Evidence that the contribution is strong and/or exceeding that which was expected by the intervention*".

Table 6. Summary of Attributed Scores to this Project (according to OECD-DAC Criteria)

CRITERIA	ATTRIBUTED EVALUATION SCORE
Relevance	4
Effectiveness	4
Efficiency	3
Impact	4
Sustainability	3
Coverage	3
Co-ordination	3

Based on the above, the evaluation acknowledges the high quality of work which has been behind this project on the ground as well as in relation to back-up technical and administrative support. In addition, the impact that each of the various activities have had, in particular through their diversity and complementarity, is a prominent aspect of this project's design and implementation.

5.1. Relevance {Criteria Score 4}

This project has operated with poor, often traumatised and at-risk displaced families, in addition to host communities which have thus far been overlooked in terms of development assistance. Discussions with beneficiaries – both UMNs and members from host communities – confirmed the absolute relevance of this project by addressing and meeting peoples' priority needs in a timely and comprehensive manner. In part, this response was based on a series of informed needs assessments for the various sectors.

The nature of the activities provided was also highly relevant: many of the beneficiaries would not have had such support in the past. Representatives from the Rohingya community, for example, previously would have had no access to trauma counselling, education and medical facilities. The fact that all medical facilities receive high numbers – from 100 to 400 – patients each day is testimony to the popularity and relevance of the offered facilities. Representatives from host communities likewise singled out the fact that pregnant women are now able to receive regular check-ups as being a major change from their previous situation.

Likewise, in the past, UMNs would not have had any recourse to sexual or gender-based violence: now they do and this is widely acknowledged and appreciated. Acceptance of the community complaints mechanisms has been high and complaints seem to be being dealt with quickly and efficiently.

"*This project has provided us with dignity*".

Project beneficiary

The project, and in large part the dedicated field teams of all partners on the ground, has made an important contribution towards lowering and avoiding tensions, both within the displaced community itself as well as with host community members and others. Field staff are always available to listen and counsel: the referral systems in place, which sometimes requires close co-ordination between project – and other – partners is effective and well monitored.

"*We don't feel any physical threats but local people tease us*".

Project beneficiary

Significant changes have also taken place within communities and households. While in the past, people would rarely discuss problems or search for solutions to their situations, today – as a result of this project – people initiate meetings, join meetings and openly express their thoughts and opinions before their peers. Many peoples' self-esteem, dignity and confidence have increased significantly as a result of these experiences. This is seen as being of particular benefit to many women who have experienced rewards from discussing a number of issues with others, including home hygiene and early marriages. For many, this has been the first time they would have come together to talk openly about these issues.

Several personal stories shared with the evaluation team attest to the relevance of targeted support to individuals' needs. Several people, for example, commented on their appreciation for the trauma counselling they received through IOM's partners. Language therapy has also helped other who, formerly, would not leave their homes as they could not make themselves understood to others. Now, as a direct result of assistance, they are able to communicate more effectively and with renewed confidence have started to get out and meet people. While perhaps not numerous, these examples of how this project has helped transform peoples' lives for the better are a striking illustration of its absolute relevance to both disadvantaged UMNs and local people at this point in time.

At government level, high levels of appreciation were expressed for what this project has achieved. Strengthening of the local government medical services, in particular, has been highly appreciated.

Any action taken in connection with disaster preparedness and building resilience is of obvious relevance to both host communities as well as the displaced population. This was illustrated during the cyclone events which preceded this evaluation.

5.2. Effectiveness {Criteria Score 4}

Within the restrictions of time, budget and the incidence of the humanitarian influx, this project has strived to be as effective as possible. Aided by the fact that both IOM and its international partners were already working with at least some of the communities – some structures were in place on the ground ahead of the October 2016 influx – the rapid response to the influx in particular has been effective.

The programme adopted an effective strategy of implementation from the outset, based in large part on timely needs assessments. Implementing partners played to their respective strengths but each also knew when to refer a certain case onwards if necessary.

Overall project effectiveness in terms of planning, the mutually supportive approaches taken in delivery, as well as internal (IOM) and interagency co-ordination and internal monitoring are now considered to be at a high level (but see also Section 5.6 Co-ordination). A case in point is where WASH support in a given location might be being implemented by IOM and, for example, ACF in both Kutupalong and Balukhali. In these instances, both agencies agreed to a common approach, design and standard, which greatly simplified the entire implementation and monitoring process.

Working through the Parra Development Committees (PDCs) has also been an effective entry point at the community level as these structures:

- monitor latrines and tube wells and inform IOM on any issues relating to the use and management;
- alert health personnel to emergencies;
- assist with community mobilisation, for example in relation to hygiene awareness and training;
- inform IOM on any SGBV issues; and
- liaise between the host and settlement communities.

This project was clearly on track to achieving its targets before the influx happened. While some of the initial targets were exceeded given the unanticipated scale of new arrivals, others have fallen behind, particularly in relation to sanitation given the crowded situations and limited space for latrine construction. What is important to note though, even in this instance, is that the project has resulted in behavioural changes amongst most beneficiaries, e.g. hygiene and sharing responsibilities for cleaning/maintaining facilities, which is often a challenging task.

On the ground, the appreciation by different community members for staff from this programme was clearly visible. According to a survey carried out in June 2017, 87 per cent of respondents said that they were fully satisfied with the treatment they received from IOM facilities (BRAC, 2017). While there is always room for improvement and expansion of support, the programme was careful to avoid building dependencies and promising beyond what it could deliver. This was an important approach from the outset and has set a hopeful precedent for other organisations to follow.

5.3 Efficiency {Criteria Score 3}

Despite the many factors that contribute to this being a highly complex operational setting, this project has allowed IOM and its partners to provide a very timely response meeting initial basic needs. Despite some initial concerns over inter-agency co-ordination, the good working relations established between key partners led to some of them sharing site responsibilities: ACF and IOM both working on WASH in Balukhali and HI and ACF addressing the needs of people with disabilities in WASH in the respective settlements. There was seemingly no overlap or no duplication of activities, which is a very positive observation.

Clinics that were visited as part of this evaluation seemed to be operating in a very efficient manner. As mentioned in the BRAC 2017 Healthcare Survey, 65 per cent of respondents chose to attend IOM supported facilities on account of there being a qualified doctor or nurse there. Being able to receive free medicine was the second reason to visit such facilities. Almost 80 per cent of those who took part in the same survey said they had to wait for more than one hour to receive a consultation with the physician, though this depended strongly on the time of day, with morning periods always being

the busiest recorded.

Overall, however, such facilities are highly appreciated. Today, according to several doctors spoken with, these facilities have some of the highest levels of safe births each month in Bangladesh: there has not been a single death because of a lack of health support. Linked with this professionalism, the referral systems put in place between IOM and its implementing partners – and even some others such as Médecins sans Frontières – is reportedly working very well, with effective implementation and follow-up.

"*People are now getting access to multiple health support systems through this project, from personal hygiene to a referral system. Everything is being supported and tracked."*

IOM Staff Member

Providing support to structures such as the PDCs has been both appropriate (in terms of empowering people from within respective communities) as well as efficient. Now, instead of depending on external services or support, to the extent that members are able to, they now try and solve internal community/family disputes, while also providing many other services to communities.

5.4 Impact {Criteria Score 4}

Overall, and within a short period of time, this project has clearly had a significant impact on its intended beneficiaries. As evidenced from comments and feedback from project beneficiaries, social impacts were predominantly mentioned, these being in relation to:

- increased awareness and more open discussions being held within families and communities on the subject of early marriage, with an already noted reduction of this happening in some instances;
- decreased mortality of mothers and children, partly a result of the above but also on account of better access to quality medical services;
- in most areas where this project has intervened, there has been almost 100 per cent immunisation of children under 5; and
- An increasing number of people are showing interest in educating their children.

In addition, by mobilising people to meet and discuss issues in common, several host communities visited positively reported on the fact that community members were now working together to improve and maintain key facilities and services such as internal roads, latrines and drainage channels.

"*This project has made a very positive impact on the ground: it has been a lifeline for our Rohingya community…*"

Project beneficiary

"*We feel safe for the first time in a long while…*"

Project beneficiary

5.5 Sustainability {Criteria Score 3

With a project period of just one year and considering the circumstances which the project's intended beneficiaries have experienced, achieving any degree of sustainability was always going to

be a challenge. Progress has, nonetheless, been made in some areas, which is important if this project is extended into 2018 and even scaled-up at some point in the future.

One of the most serious constraints to achieving sustainability in this context is the fact that there are almost zero options available to the displaced community for livelihood promotion. Casual labour is one of the most common sources of income generation for UMNs: many local farmers and fishermen have taken advantage of this available work force to expand their respective livelihood activities.

Tangible changes have, however, happened in some instances and will likely continue to be upheld. The project's support to government medical facilities, for example, has been a significant boost to local amenities and improvements to infrastructure will help enable such systems to continue to operate in the future. Recognition for the need for improved disability access and subsequent installation of ramps and support structures to schools, school toilet facilities and within clinics has been a positive approach by partners in this project as well as government services.

In terms of soft skills learning, the fact that beneficiaries from both the host and displaced communities have embraced hygiene promotion has been a very positive result from this project: respondents to interviews conducted as part of this evaluation unanimously stated that people would continue to practice what they had learned in future. Going a step further, the skills and kit equipment provided to communities in terms of hand pump/tube well maintenance will continue to help ensure that people are able to access safe drinking water in the future.

Training provided to local NGO partners – while not evaluated per se as part for this evaluation – will certainly have had a significant impact on improving their performance, and will allow them to continue to exercise these skills well after this project. The manner in which IOM and its international partners provided such training is also to be applauded given the additional monitoring and back up support provided to such organisations once initial training had been concluded.

5.6 Coverage {Criteria Score 3}

As mentioned earlier, the deliberate inclusion of some host communities as part of this project was seen as being highly appropriate by the evaluation team. Not only has this provided much needed direct support to host community members, but it has likely also contributed to fostering good relationships with the displaced group of people. These same points were also flagged in an interview with Md Ali Hossain, the District Commissioner in Cox's Bazar.

While the extent of coverage possible was obviously restricted by financial resources and, to some degree, technical support capacity, one of the few – but most commonly noted – complaints from beneficiaries was in relation to the selection of beneficiaries for certain items, for example, hygiene kits.

"*Before [this project] I knew nothing about artificial limbs. Now, thanks to this work I actually have one and can resume active work*."

Project beneficiary

While it is clear that needs far outstrip what level of support is currently available, a clearer and more easily understood system needs to be developed and presented to communities in future, prior to further distributions. This needs to be developed in full consultation with representatives from both the host and Rohingya communities, in association with government services.

5.7 Co-ordination {Criteria Score 3}

At the request of the Government of Bangladesh, specifically the Ministry of Foreign Affairs, IOM undertook responsibility for the co-ordination of the humanitarian response for UMNs in and around makeshift settlements in Cox's Bazar District.

As part of this overall process, inter-agency co-ordination was initially undertaken by IOM. Early in this project's implementation, however, partner organisations aired discontent with this arrangement as, effectively, the co-ordination function was closely and directly linked with both management and implementation. According to some of IOM's partners "*Their voices were not being heard at co-ordination meetings, they could not influence the agenda and their opinions were not reflected in decisions taken*".

In a constructive effort to improve this situation, and with separate funding from other donors, an Inter Sector Co-ordination Group (ISCG) was established in April 2017, and is supported today by a team of six people. This is intended to serve as a wholly independent structure and is not project related, a move which appears to have started to have some quite positive impacts.

The ISCG has since put in place a number of prized tools and undertaken various surveys, including Needs and Population Monitoring (NPM). This is deigned to consistently gather, monitor and share information to provide a better understanding of the movements and evolving needs of people on the move, whether in a makeshift settlement of host community, or on the move. The NPM captures information at a sectoral level with on-line updates being provided: https://cxbcoordination.org. At present, coverage of the NPM is restricted to Teknaf and Ukhiya upazilas so does not represent the overall Rohingya population.

Co-ordination between government services and IOM is also believed to be effective and both parties respect the other. The highly effective mass vaccination of children under 5, for example, would not have been possible without government assistance. Regular co-ordination meetings between IOM and the government's Deputy Commissioners, for example, help keep everyone informed of progress and challenges.

As an indication of its good working relationship and overall satisfaction with its implementing partners, at the time of this evaluation, IOM had already selected the same Health partners for the continuation of this project in 2017-2018.

CHAPTER VI
CONCLUSIONS/RECOMMENDATIONS

6.1 Concluding Remarks

This project has responded well to a sudden emergency in which many restrictions and complexities only made the response situation more difficult than it otherwise might have been. While extremely frustrated of the situation on the ground, communities – both recently arrived UMNs and members of the host community – are appreciative of what this project has thus far achieved, though the scale of need is still considerable. Thus far, however, the relevance of this BPRM project is seen as a completely appropriate response to peoples' needs.

IOM and its implementing partners have placed an obvious emphasis on delivering quality support. Part of this has been achieved through effective co-ordination which, after a slightly rocky start, has seemingly become good and is widely appreciated at all levels – between IOM and the government and IOM and its implementing partners. This needs to remain at the forefront of the operation and, now, with the ISCG structure evolving and maturing with time, this is likely to continue to approve and become more proactive.

More refinement could be applied to consistency at some facilities, such as clinics: many seem to be excellent but some of the facilities in others were seen to be in poorer condition. Findings from the 2017 KAP Survey showed a strikingly large number of disparities across the three makeshift settlements, in particular, with figures from Leda Makeshift Settlement often featuring as the least well supported or informed.

The training and capacity building for partners should continue as before in the follow-on project, with clearly defined programmes and interventions for specific partners. Again, consistency in delivery of support should be at the fore of these agencies interventions. Given the exposure that all communities have to the natural elements, DRR should be a core topic addressed by all agencies working under IOM's mandate.

6.2 Recommendations

6.2.1 Selection criteria being applied should be clearer to all beneficiaries

IOM and its partners should improve upon past methods used to inform beneficiaries as to who and why they had been selected to receive specific report. Many people were not satisfied by explanations given surrounding the distribution of Dignity Kits following Cyclone Mona, even if it was the most vulnerable individuals who were targeted. More timely communication and greater transparency is required.

6.2.2 Children affected by severe acute malnutrition need more comprehensive support in some instances

Nutrition Centres, such as that at Kutupalong, lack a medical doctor. As a result, it is difficult for SAM-affected children to receive adequate services. When such children are referred to a medical centre, they only receive medical support not nutritional support, which results in them taking a much longer period of time to recover. If medical doctors cannot be recruited for all ACF operated nutrition centres, a better form of referral with accompanied nutritional support should be

considered.

6.2.3 Psychosocial support needs to be made available and supported more evenly amongst partners

Psychosocial support has been appreciated by a considerable number of the UMNs spoken with as part of this evaluation. While some beneficiaries have clearly appreciated this, others have not been given this opportunity. More consistent application of psychosocial support is therefore required, particularly in relation to trauma healing and conflict resolution within families. While recognising that not every partner is equipped to provide such support, IOM should evaluate how best to achieve broader and more consistent psychosocial support.

6.2.4 Attention needs to be given to improving physical conditions in some clinics and health centres

While the quality of health and nutritional services provided through this project is generally at a very high standard, some centres are less well catered for. Specifically, in Kutupalong and Leda Community Clinics, the space and environment of the delivery room should be improved, while in Kutupalong ACF's nutrition centre is located in a low-lying area which makes it difficult to maintain hygiene during the rainy season. The extension of lighting systems inside latrines should also be expanded, when possible.

6.2.5 Future hygiene/WASH promotion needs to extend to water handling and storage

Attention needs to be given to improving the cleanliness and mode of storage and use of water from the time it is collected to when it is used. While many people reported that they do not treat the water they receive, insufficient attention has thus far been given to raising awareness on clean storage and use of cups for drinking.

6.2.6 Continued emphasis needs to be given to co-ordination – at all levels – and in particular to ensuring cross cutting issues are factored consistently into sectoral plans

Inter-agency co-ordination – through the ISCG – needs to be maintained at the highest level possible to ensure partner satisfaction and comprehensive coverage of all sectors. Cross-cutting themes (gender, environment, DRR) need to be consistently considered by sector leads in co-ordination. At present, there is a risk that some issues might not be being considered by a specific sector if a representative of a cross-cutting theme is not present at a specific inter-agency co-ordination meeting.

6.2.7 Disaster preparedness needs to be brought to the fore in all locations

While SI has been the main partner to promote DRR-related awareness raising in Teknaf Upazila, this needs to be applied to all communities in all locations through the respective partners – national and international. Information being transmitted, as well as practical actions to consider taking should be contextualised for all communities.

6.2.8 Project activities should, where possible be linked with government advocacy

Some actions taken by the project should be in future linked with advocacy measures with local government, for example DRR. The mainstreaming of physical structures to enable greater access for people with disabilities to facilities such as schools and clinics is a good example to mirror in this respect.

6.2.9 Partners should attempt to be proactive in bridging funding gaps

While donor notification might be delayed, where possible partners should try and anticipate this (based on 2016 experience) to avoid disruption of services.

6.2.10 Project monitoring needs to be enhanced and be consistent

Consistent monitoring needs to be ensured by all agencies in going into the next phase of this project. An indicator-based monitoring guideline should be developed to provide an overarching framework for all participating agencies.

6.2.11 An environmental impact assessment should be considered for the respective aquifers providing water to camps and makeshift settlements

The continued presence of a significant number of refugees, coupled with the recent swell of UMNs into specific locations in both Teknaf and Ukhiya upazilas has meant that considerable quantities of water are now being extracted from underground reservoirs on a daily basis. While some ground water level monitoring is being undertaken by IOM, it is advisable (together with UNHCR and government services) to conduct a comprehensive EIA to ensure that supplies will not become exhausted in the dry season as this would have costly implications, e.g. water trucking. The longer term needs of those host communities also should not be put at risk from excessive water extraction. In some, near coastal, situations, this could start to lead to saltwater intrusion into the aquifer.

6.2.12 Training events should be scheduled as early as possible in the project time period

Future planned training through the next phase, or future iterations, of this project should attempt to deliver training as early as possible within the time period, unless this happens to be linked with some specific activity taking place later in the timeframe. This will allow time to monitor how the training experience is being put into practice.

6.2.13 Training for partner agencies should include local administration, where possible and appropriate

In official camp situations, partners organising training events in Nayapura and Kutupalong camps should invite the Officer in Charge, and/or some of his staff, to participate in training events to build their capacity as well as to keep them well informed of what activities are underway within the camps. This will help enable a common understanding and increase co-ordination and collaboration further.

6.2.14 Volunteer beneficiaries promoting specific messages should be provide with some form of visibility

Some form of visibility materials (e.g. T-shirts) should be provided to community mobilisers such as those members of PDCs, to give them some added degree of recognition. In addition to serving as a form of responsibility within that society, this will also help demonstrate that their function is being recognized and appreciated by the respective agencies with whom they work.

6.2.15 CWC teams need better infrastructure support in Makeshift Settlements

At this stage of the project, as the situation continues to evolve, good and open communications remain essential for the beneficiaries to understand what is happening. IOM's CWC teams play an important and recognised role in this. Given the important, and appreciated, role that CWC field staff provide, better infrastructure should be provided for meeting spaces with some space set aside for confidential consultations, while recognising that any permanent type of structure is likely to not happen.

6.2.16 Depending on future decisions re Settlement existence, IOM might wish to consider introducing clean cooking devices

Respiratory problems are the number 1 ailment treated by doctors – partly on account of the weather, but also to some degree by the fact that people are using damp leaves (government restriction on collecting wood) and plastic as fuel. Within the confines of their homes, this is dangerous for women's' and children's' health. In addition to posing a potential fire threat during the dry season. Clean, fuel-efficient cooking stoves should be considered in such situations, to boost the already successful biogas appliances that are operating – though at a small scale – in the makeshift settlements.

BIBLIOGRAPHY

BRAC. 2017. IOM Healthcare Facilities. User Satisfaction Survey. Draft June 2017.

ISCG Situation Report July 2017 http://cxbcoordination.org/wp-content/uploads/2017/08/1707_ISCG-Sitrep_Final-1.pdf

IOM Needs and Population Monitoring July 2017 (Round 4); http://www.cxbcoordination.org

IOM Project Proposal to the US Department of State. Award No S-PRMCO-16-VC-1164. 4 August 2016.

IOM Project Proposal: Modification to "Improving Access to Health, WATSAN Services, Education and Freedom from Violence in Cox's Bazar". 1 March 2017.
IOM. 2017. IOM Health Care Facilities: User Satisfaction Survey, June 2017.

Improving the Quality of Life for Persons with Disabilities and their Families in Refugee Camps and Surrounding Communities. Project Period September 2016 – June 2017.

Improving Living Conditions of Vulnerable UMNs and Hot Communities through WASH and DRR activities in rural and urban areas of Teknaf Upazila, Cox's Bazar District. Project period June 2016-June 2017.

Nutritional, Psychosocial and WASH Support for the Registered Refugee Camps and Host Communities in Teknaf and Ukhiya, Cox's Bazar District, Bangladesh. Project period June 2016-June 2017.

Improving Access to Health, WATSAN Services, Education and Freedom from Violence in Cox's Bazar. Project period 1 January 2017 – 31 March 2017.

UNHCR Bangladesh Fact Sheet March 2017. http://www.unhcr.org/50001ae09.pdf

ANNEX

ANNEX I. TERMS OF REFERENCE FOR THIS EVALUATION

Independent Final Evaluation of
'Improving access to health, water & sanitation services, education, and freedom from violence' project in Cox's Bazar, Bangladesh

Background

There were approximately 200,000 Undocumented Myanmar Nationals (UMNs) and registered refugees living in makeshift settlements, official camps, and mixed with host communities in Cox's Bazar until October 2016. Recent outbreak of unrest in the Rakhine State of Myanmar triggered an influx of UMNs crossing the border in Teknaf and Ukhiya. As a result, an estimated additional 74,000 newly arrived UMNs are living in Cox's Bazar as of April 2017.

Both UMNs – recently arrived and long-term residents alike – and the host population suffer from below average access to basic health, water and sanitation services. Amongst the UMN population, women face an elevated risk of being victims of domestic violence and sexual abuse, with limited access to family planning and maternal health care services. Nutritional deficiencies and lack of comprehensive support for mental health adds to the vulnerability of the affected communities.

In this context, partner organizations Action Against Hunger, Handicap International (HI), Solidarites International (SI), and the International Organization for Migration (IOM) are addressing the basic humanitarian needs of UMNs and host communities in the Cox's Bazar district, specifically in Ukhiya and Teknaf Upazilas (and surrounding areas with a heavy UMN presence). This is done through provision of increasing access to health, nutrition, and water, sanitation and hygiene (WASH) services, improving awareness of common hygiene and health issues, work to build community and duty bearer support for the reduction of gender based violence, building the service delivery capacity of local Non-Governmental Organizations (NGOs), co-ordinating NGO service delivery, establishing and maintaining strong community links, and supporting overall co-ordination to identify needs, analyse gaps, and ensuring service delivery across all sectors.

The objective of the project is aimed to be achieved through the realization of nine inter-connected outcomes:

1. **Health:** UMNs' and HCs' health needs – including those of persons with disabilities – are met by strengthened health care services
2. **Nutrition:** There is increased effective detection, treatment, and prevention of under-nutrition among under five children, adolescent girls, and pregnant and lactating women in targeted communities/villages and refugee population of Cox's Bazar District
3. **Mental Health and care practices**: The most vulnerable UMNs and HCs have improved their psychosocial well-being and caregiving practices
4. **Water, Sanitation, and Hygiene:** UMNs and HCs have sufficient access to and proper utilization of safe water and improved sanitation facilities in Cox's Bazar, including in healthcare facilities
5. **Capacity Building:** Capacity of local NGOs is enhanced to provide quality humanitarian services meeting international standards with close co-ordination with development partners and INGOs under the Capacity Building Framework
6. **Co-ordination/Communications with Communities (CwC):** The Government of Bangladesh co-ordinates humanitarian interventions in the Cox's Bazar District in order to adequately address the critical humanitarian needs of the UMNs and host community population

7. **Protection / Gender-Based Violence (GBV):** Duty bearers – they include IOM staff, health care providers, government officials, and community members – demonstrate enhanced GBV-related support and care for beneficiaries who are vulnerable to and have survived violence
8. **Education:** UMN children at the aged between 4 and 14 years old have access to early learning and basic education and acquire basic literacy, numeracy and life skills
9. **Shelter and Non-Food Items (NFIs):** UMNs and their hosts have improved wellbeing through accessing shelter and other essential basic supplies in Ukhiya and Teknaf Upazilas of Cox's Bazar district

Evaluation Objective

The objectives of this evaluation are to:

- Assess the overall performance of the project and to determine if the intervention has been an effective and sound response to vulnerable populations in Ukhiya and Teknaf
- Examine the effectiveness of the project in addressing the recent influx emergency response and the role this project played in that response amongst all other funding streams
- Examine the short- and medium-term impacts of the project activities among all target groups of beneficiaries
- Identify key results, lessons learned, shortcomings, and good practices for informing funding modality and required flexibility of future interventions

Evaluation Criteria

The five OECD/DAC criteria are expected to be applied to the proposed evaluation. More specifically:

- **Relevance:** The extent to which the outcomes of the project are consistent with requirements, needs, priorities, and policies of the respective stakeholders
- **Effectiveness:** The extent to which the project's outcomes were achieved, accounting for their relative importance
- **Efficiency:** The extent to which the intervention logic was coherent and realistic, contributing to value-for-money, cost efficiencies, and timeliness the project was able to achieve
- **Impact:** Positive and negative primary and secondary effects produced by the project – directly or indirectly, intended or unintended
- **Sustainability:** The extent to which benefits from the project are expected to be continued upon completion

In addition, the following evaluative criteria for humanitarian assistance should also be considered:

- **Coverage:** The reach of the project to UMNs facing life-threatening suffering in the project locations, providing them with assistance and protection proportionate to their needs
- **Co-ordination:** The need for different actors involved in an emergency response to co-ordinate

Deliverables

1) **Inception Report** outlining the evaluation methodology and a final work plan
2) **Draft Evaluation Report** with key findings, specific recommendations, lessons learned, and good practices
3) **Final Evaluation Report** (40 pages maximum) including an Executive Summary, with gender equality and protection explicitly addressed throughout

Timeline

An international evaluator will conduct this final independent evaluation by **30 June 2017,** with approximate engagement of **30 working days**. The assignment will require travel to project locations in **Cox's Bazar, Bangladesh**.

Communication

The selected firm/consultant(s) will liaise with and report to the evaluation focal points of the four partner agencies.

Required Qualifications

- A Master's degree (or equivalent advanced university degree) in Evaluation, Social Science, Policy Studies, International Relations, Development Management, or a related field
- Minimum 10 years of experience in evaluating humanitarian crisis response projects, covering multiple facets of such interventions, including health, WASH, nutrition, and protection
- A track record of evaluating projects in Bangladesh and/or South Asia highly desirable
- Independence from the four agencies and other stakeholders involved
- Strong analytical, verbal, and report writing skills in English. Knowledge of Bangla an advantage
- Willing to undertake in-country travel in Bangladesh related to the assignment
- Good knowledge of UN, IOM, and NGO mandates and programmes, preferably in the Cox's Bazar context

How to apply

Selection of the independent evaluator will be done jointly by the evaluation focal points of the four partner agencies and will be based on the strength of the qualifications provided by potential candidates. Interested consultants are requested to send their proposal in English – not exceeding 10 pages in total – detailing the following:

- ☐ An updated CV
- ☐ Technical expertise in the subject matter
- ☐ A detailed presentation of relevant background and experience in the evaluation of humanitarian projects relevant to this assignment
- ☐ Proposed approach and methodology, including sampling strategy of any survey foreseen
- ☐ Work plan including deliverables and detailed timeframes
- ☐ A statement of availability for the entire duration of the assignment
- ☐ Total budget, inclusive of all relevant items
- ☐ Two previously undertaken evaluation reports (the 10-page limit does not apply to these)

The proposal and all supporting documents should be emailed to: *DhakaJobs@iom.int* by **Saturday, 6 May 2017.** Please mention **"Independent Final Evaluation CXB"** in the subject line.

ANNEX II. EVALUATION ITINERARY

DATE	ACTIVITY	RESPONSIBLE	LOCATION
2 July	International travel London – Dhaka (Team Leader)	DS	
2 July	• Meeting of Team Leader and National Consultant • Project briefing with IOM Project Management • Initial planning for field deployment	DS/RK IOM/DS/RK IOM/DS/RK	Dhaka
3 July	• Introductory meetings with ACF, HI and SI • Flight bookings and logistics	DS/RK and IOM partners DS/RK	Dhaka
4 July	• Travel to Cox's Bazar • Meeting with IOM	DS/RK	Cox's Bazar
5 July	• UMN and host community consultations • Discussions with ACF, SI, HI	DS/RK	Shamlapur
6 July	• UMN and host community consultations • Meeting with Officer in Charge • Discussions with ACF, SI, HI	DS/RK	Nayapura
7 July	• Preliminary data analysis and consolidation • Planning for remainder of mission	DS/RK	Cox's Bazar
8 July	• UMN and host community consultations • Discussions with ACF, HI	DS/RK/IOM	Balukhali Makeshift Settlement
9 July	• UMN and host community consultations • Meeting with Officer in Charge • Discussions with ACF, HI	DS/RK/IOM	Kutupalong Camp
10 July	• UMN and host community consultations • Discussions with ACF, HI	DS/RK/IOM	Kutupalong Makeshift Settlement
11 July	• UMN and host community consultations • Discussions with ACF, HI • Debriefing with IOM (Imani Hotel)	DS/RK/IOM	Kutupalong Host Community
12 July	• Travel to Dhaka	DS/RK	Cox's Bazar to Dhaka
13 July	• Debriefing with IOM partners	DS/RK	Dhaka
14 July	International travel (Team Leader)	DS	Dhaka to London

DS: David Stone; RK: Rezaul Karim

ANNEX III. EVALUATION TEAM PROFILE

David Stone has been working in the humanitarian arena for more than 25 years, primarily in the context of environmental and livelihood security with refugees and internally displaced people, worldwide. A zoologist by training, David is Director or Proaction Alliance, an international NGO which addresses community-based disaster preparedness, climate change adaptation and resilience through the creation and support of local and appropriate solutions.

Rezaul Karim has 25 years of experience working in the non-government development sector in Bangladesh focusing, since 2013, on organisational capacity building and disaster management. Prior to this, from 2004-2013 he worked with Action Aid Bangladesh mainly on a project for DIPECHO action plans supported by ECHO. His last position was Programme Manager. Of late, Rezaul has conducted independent scoping studies, mid-term and final evaluations with Practical Action, Action Aid, the Hong Kong Red Cross and IFRC and the Myanmar Consortium for Community Resilience. He has a 1st class Master's degree in Geography and Environment from Jahangirnager Public University (1989).

ANNEX IV. PEOPLE MET AS PART OF THIS EVALUATION

NAME	POSITION	ORGANISATION
Mr Sarat Dash	Chief of Mission	IOM Dhaka
Faisal Sharif	Monitoring and Evaluation Officer	IOM Dhaka
Pravina Gurung	Programme Officer	IOM Dhaka
Taifa Binta Monir	Administration Officer	IOM Dhaka
Ishita Shruti	Programme Officer Capacity Building	IOM Dhaka
Marcela Ondekova	Country Programme Co-ordinator	Handicap International
Md Shafiqul Islam	Co-ordinator ER & DRM	Handicap International
Md Mostak Ahmed	Technical Advisor Rights and Inclusion	Handicap International
Helene Daniel	Country Director	Solidarités International
Hildegarde Thyberghien	Deputy Country Director	ACF Dhaka
Md Abdul Malek	Programme Manager FSL & DRR	ACF Dhaka
Eric Rheinstein	Head of Department, WASH	ACF Dhaka
Sanjukta Sahany	Head of Sub Office, Cox's Bazar	IOM
Ashutosh Karmakar	National M&E Officer	IOM Cox's Bazar
Ms Margo Baars	ISCG	IOM
Ms Sharmin Akter	ISCG	IOM
Dr Ferdousi Sultana	Medical Officer	IOM Cox's Bazar
Saikat Biswas	National Co-ordination Officer	IOM Cox's Bazar
Dr Mohiuddin H Khan	National Programme Officer	IOM Cox's Bazar
Abdullah Al Mamum	Field Assistant	IOM Shamlapur
Md Mirjahan Mithu	Field Assistant	IOM Shamlapur
Stephen Waswa Otieno	Project Officer (WASH)	IOM Cox's Bazar
Md Mizanur Rahman	National Programme Officer (WASH)	IOM Cox's Bazar
Dr Niranta Kumar Das	Medical Co-ordinator	IOM Teknaf
Salia Akter	S.V.	Mukti Cox's Bazar
Mira Bamua	H.P.	Mukti Cox's Bazar
Jothsna Farrana	H.P.	Mukti Cox's Bazar
Rawshan Zannat	Field Assistant (CWC)	IOM
Asadur Rahman	Field Assistant (CWC)	IOM
Dr Raisul Islam	Medical Officer	IOM
Md Abdul Mazed	Project Assistant WASH	IOM
Machano	Project Assistant WASH	IOM
Abdul Malek	Programme Manager, Food Security & Livelihoods	ACF
Moammad Shajahan Siraj	Deputy Programme Manager - WASH	ACF
Kazi Jahangir Alam	Project Officer WASH	ACF
Md Sahab Uddin Shihab	Senior Project Officer	ACF (Shamlapur)
Belal Uddin	Project Officer WASH	ACF
Habibur Rahman	Project Officer WASH	ACF

NAME	POSITION	ORGANISATION
Dr Nai May Prue	Medical Officer	IOM
Md Moazzem Hossain	Disability Officer	Handicap International (Nayapura Camp)
Setu Paul Rajib	Inclusion Officer	Handicap International
Mahedi Hasan	Disability Officer	Handicap International
G.M. Mosharaf Hossain	Senior Project Officer	ACF (Nayapura Camp)
Bulbul Ahmed Sarkar	Project Officer	ACF (Nayapura Camp)
Md Ali Hossain	Deputy Commissioner, Cox's Bazar	Government official
Mohammad Saiful Islam Mazumder	Senior Assistant Secretary and Camp In Charge	Government official

ANNEX V. GUIDING QUESTIONS FOR FOCUS GROUP DISCUSSIONS WITH HOST COMMUNITIES

Note: UMNs are referred to as "*Burmaya*" by local people

Introduce the team and our purpose.
Thank people for making time to come to the meeting and share information.

1. Are you aware of any form of external support being provided to this community since the arrival of UMNs? If "Yes", do you know the name of the project or organisation that is supporting this? If "Yes", what is the project doing?

2. Have you, as the Host Community, ever been asked what your most important needs were in terms of dealing with eth increased population? If "Yes", what were these?

3. Have any of these needs been addressed by this project? If "Yes", to what extent have the needs you identified been addressed under this project? **[Estimate a figure, e.g. 50%]**

4. Has your personal or family situation changed since the UMNs first came here? If "Yes" is this in a positive or negative way? Please explain.

5. What has been the most important type of support you have received since the UMN caseload came to this location?

6. Are any of your needs not being met by this project?

7. Overall, has the project had any impact in reducing peoples' needs? Yes/No. **[Estimate a figure, e.g. 50%]**

8. Are any of you involved in supporting the delivery of activities supported by this project? Please explain.

9. Has the support – training and awareness raising – you have received through this project helped you establish any community committee? If so, is/are these working? Do you think they will continue to work after this project?

10. Compared with one year (12 months) ago, how would you compare your situation today: 0 = No change, 1 = Much worse, 2 = Much better?

Thank people for their time and remind them that no comments will be linked with individuals. Remember to get the names of all participants.

ANNEX VI. GUIDING QUESTIONS FOR FOCUS GROUP DISCUSSIONS WITH PROJECT BENEFICIARIES

Introduce the team and our purpose.
Thank people for making time to come to the meeting and share information.
Information shared with us will not be attributed to any one individual.

1. Are you aware of any support being provided to this community? If "Yes", do you know the name of the project or organisation that is supporting this? If "Yes", what is the project doing?

2. When you came here, were you asked what you most important needs were? If "Yes", what were these?

3. Have any of these needs been addressed by this project? If "Yes", to what extent have the needs you identified been addressed under this project? **[Estimate a figure, e.g. 50%]**

4. Has your personal or family situation changed since you first came here? If "Yes" is this in a positive or negative way? Please explain.

5. What has been the most important type of support you have received since coming to this location?

6. Are any of your needs not being met by this project?

7. Overall, has the project had any impact in reducing peoples' needs? Yes/No. **[Estimate a figure, e.g. 50%]**

8. Are any of you involved in supporting the delivery of activities supported by this project? Please explain.

9. Compared with one year (12 months) ago, how would you compare your situation today: 0 = No change, 1 = Much worse, 2 = Much better?

Thank people for their time and remind them that no comments will be linked with individuals. Remember to get the names of all participants.

ANNEX VII. GUIDING QUESTIONS FOR KEY INFORMANT INTERVIEWS WITH PROJECT BENEFICIARIES

Explain who you are and request permission to ask some questions
This is a voluntary exercise: people should not feel obliged to answer questions

1. Have you received any support since you came to this location? Do you know which project or organisation is providing this? If "Yes", what activities is the project supporting?

1. When you first came to this location, were you consulted about your immediate needs? If "Yes", what were these?

2. To what extent have the needs you identified been addressed under this project? **[Estimate a figure, e.g. 50%]**

3. Are you involved in implementing part of this project? If "Yes", please explain how.

4. Have you seen any changes (positive or negative) since this project started in the past 12 months? Please explain the benefits further.

5. What has been the single most important type of support provided by this project?

6. What needs are not being met by this project?

7. Has the project had any impact in reducing your needs? Yes/No. **[Estimate a figure, e.g. 50%]**

8. Compared with one year (12 months) ago, how would you compare your personal situation today: 0 = No change, 1 = Much worse, 2 = Much better?

Thank the person for their time.
Remember to get the person's name.

ANNEX VIII. GUIDING QUESTIONS FOR DEPUTY COMMISSIONER INTERVIEWS

Introduce purpose of this evaluation.

Ask permission to ask some questions.

1. Has the PRM Project helped address key needs for UMNs and Host communities? If "Yes", how?
2. What has the role of local government been in addressing the needs of the UMN caseload?
3. What has your role as DC been in co-ordinating activities within the makeshift locations and between UMNs and the host communities? (DTF = District Task Force)
4. How has your office co-ordinated with IOM?
5. Has this co-ordination been successful? If "Yes", on a scale of 1 (poor) to 4 (excellent) how would you rate this co-operation?
6. What, if any, changes have you seen as a direct result of this project?
7. Which sector has been the best addressed?
8. What are some of the remaining challenges you, as local government, foresee? How will you address these?

Thank you for your time. Is there anything else you would like to add to our discussion?

ANNEX IX. INSTITUTIONAL INTERVIEWS CONDUCTED BY PROJECT OUTCOME

1. IOM

1.1 GENERAL

1. What have been the main sectors you have been working in?

2. Which locations/sites have you been working in with these sectors?

3. Has there been any change to this scale/scope of work since this project started? If "Yes", please explain.

4. Has your support been delivered through national NGOs or directly? If "Through a national NGO" how effective do you think this has been? If "Direct" do you think this has been the most suitable approach?

1.2 OUTCOME ANALYSIS

1.2.1 OUTCOME 2. WASH – UMNs AND HCs HAVE SUFFICIENT ACCESS TO AND PROPER UTILISATION OF SAFE WATER AND IMPROVED SANITATION FACILITIES

1. Was WASH an appropriate intervention in this project's support? If "Yes", why? If "No" what would have been more appropriate?

2. What were the priority WASH needs in your operational area? [Water provision; Hygiene; safety = quality…]

3. How were these needs identified, assessed and analysed? [water quality testing – at outset and repeated again? Monitoring of water quality and draw down…]

4. Was this done in consultation with project beneficiaries – UMNs and host community households?

5. Was specific attention given to identify and address the most vulnerable people (women, elderly, disabled)? If "Yes" how. And how effective has the response been?

6. Was your response through this PRM supported project then a direct response to these identified needs?

7. On a scale of 0 (Poor) – 5 (Excellent) how successful was the programme in reaching the most vulnerable members of the communities? What reasons would you give to support this?

8. How effective has your support been in delivering WASH to Sphere standards? [Quantity/quality/access]

9. What were the biggest challenges in WASH support to targeted communities in a timely way?

10. How efficient were the approaches used during the implementation of the WASH programme?

11. How cost-effective was the WASH programme? Examples? Could cost-effectiveness have been improved?

12. Do you think that the provided WASH support will contribute to longer term development and sustainability? If "Yes" can you give some examples? If "No", what could have been done differently to perhaps increase the likelihood of sustained responsibility?

13. How would you describe the level of co-ordination with other partners on this WASH aspect of the project? On a scale of 0 (Poor) to 5 (Excellent) how would you grate this level of co-operation? **PROBE**: Could this co-ordination have been improved in any way?

14. How would you describe the level of co-ordination with other partners on this WASH aspect of the project? On a scale of 0 (Poor) to 5 (Excellent) how would you grate this level of co-operation? **PROBE**

15. What additional actions could have been addressed to better serve peoples' water supply needs during the initial phases of this project?

16. If you were to turn back the clock and design this intervention anew, is there anything you would change? If "Yes" What and Why?

1.2.3 OUTCOME 5. SGBV – DUTY BEARERS DEMONSTRATE ENHANCED GBV-RELATED SUPPORT AND CARE FOR BENEFICIARIES WHO ARE VULNERABLE TO AND HAVE SURVIVED VIOLENCE

1. What measures did you take to ensure that SGBV was consistently addressed through your project activities?

2. What measures did you take to ensure that SGBV was consistently addressed through your partner's project activities? How was this monitored?

3. Did you take particular care to ensure that vulnerable members of the UMN community – elderly, children, women and disable persons – were not at risk to obvious SGBV pressure?

4. What, if any, has been the most effective approach or action taken through this project to promote and help ensure that people are receiving some safeguards against SGBV?

5. To what extent have your local partners been involved in and responsible for promoting and ensuring that SGBV prevention is prioritized through this project? Has this been effective?

6. In the current context, would you advocate for any changes to the approaches taken to promoting SGBV in a future project of this type?

7. What has been the main challenge to promoting and ensuring SGBV protection in the current context? Do you feel that this has been adequately addressed? If "No" what else could or should have been done to improve this situation?

OUTCOME 3. CAPACITY BUILDING – CAPACITY OF THE GOVERNMENT AND LOCAL NGOs IS ENHANCED TO PROVIDE HUMANITARIAN SERVICES MEETING INTERNATIONAL STANDARDS WITH CLOSE CO-ORDINATION WITH DEVELOPMENT PARTNERS AND INGOs UNDER THE CAPACITY BUILDING FRAMEWORK

1. What actions have been taken through this project to build/strengthen the capacity of local government services in support of the overall response to the UMNs?

2. Has this been effective? If "Yes" can you give some examples? If "No" could you suggest reasons why this was so?

3. What actions have been taken through this project to build/strengthen the capacity of local NGOs in support of the overall response to the UMNs?

4. Has this been effective? If "Yes" can you give some examples? If "No" could you suggest reasons why this was so?

5. Overall, through the capacity building support you have provided do you know if international humanitarian standards, e.g. Sphere, have been met in this project? Can you give examples?

6. What are any outstanding needs in terms of building/strengthening the capacity of either local government or local NGOs to enable them to take on more responsibility in project management in the current situation?

OUTCOME 4. CO-ORDINATION – THE GOVERNMENT OF BANGLADESH CO-ORDINATES HUMANITARIAN INTERVENTIONS IN COX'S BAZAR DISTRICT IN ORDER TO ADEQUATELY ADDRESS THE CRITICAL HUMANITARIAN NEEDS OF THE UMNs AND HC POPULATION

1. How has co-ordination been ensured between IOM and the government? Has this been effective? Could additional measures/steps have been taken to make this more effective?

2. How has co-ordination been ensured between IOM and your implementing partners? Has this been effective? Could additional measures/steps have been taken to make this more effective?

3. How have you ensured that you implementing partners are equally co-ordinating with local NGOs?

4. Has the role of the CBWG (Co-ordination based Working Group?) been effective? Have you had any feedback form partners on this? Could the performance of this structure have been improved?

5. What has worked best in terms of project or inter-agency co-ordination, and why?

6. What, if anything, has not worked as well as anticipated in terms of co-ordination, and why?

7. Could anything have been done better?

COVERAGE

1. How extensive was the coverage of households/individuals reached through this project (estimate)?

2. Do you think that the response level achieved [by your organisation] was appropriate in the current context?

3. Apart from funding, what were/are the main restriction that prevented greater coverage from being reached?

LESSONS LEARNED

1. What are the key learning /recommendation points to improve future programme performance in this context?

2. What are the strengths, weaknesses, opportunities and constraints you have experienced when working with, and though ***local actors***, in a response such as this?

3. What was your experiences of working with local government in this response?

4. Can you give examples of compliance with quality and accountability standards? CHS/Sphere/Do No Harm?

Finally, what has been the most significant achievement for you personally from this project.

Thank You!

2. ACF (WASH, NUTRITION AND PSYCOSOCIAL SUPPORT)

2.1 GENERAL

1. What have been the main sectors you have been working in?

2. Which locations/sites have you been working in with these sectors?

3. Has there been any change to this scale/scope of work since this project started? If "Yes", please explain.

4. Has your support been delivered through national NGOs or directly? If "Through a national NGO" how effective do you think this has been? If "Direct" do you think this has been the most suitable approach?

2.2 SPECIFIC QUESTIONS AS STATED IN THE PROJECT PROPOSAL (P9)

Have the following been achieved?

a) Increase effective detection, treatment and prevention or under nutrition among under 5 children, adolescent girls, pregnant and lactating women in targeted communities/ villages and refugee population of Cox's Bazar District?

b) Re-inforce the quality of the prevention and treatment of acute malnutrition through providing mental health and care practices support to groups of targeted care givers of malnourished children, pregnant women and their families, traditional birth attendants and community?

c) Promote psychosocial well-being through psychosocial and psychological intervention to the general refugee population of registered camps including disabled children and to enhance the capacity of community members and local agency.

d) In line with the management of under nutrition into the community based nation/health service system (CC, FWC) all patients from targeted OTPs and schools will benefit from better access to safe drinking water, proper hygiene and sanitation services.

2.3 OUTCOME ANALYSIS

2.3.1 OUTCOME 1. HEALTH: UMNs AND HCs HEALTH NEEDS ARE MET BY STRENGTHENED HEALTH CARE SYSTEMS

1. Was Health and Health Needs an appropriate intervention in this project's support? If "Yes", why? If "No" what would have been more appropriate?

2. What were the priority Health needs in your operational area?

3. How were these needs identified, assessed and analysed?

4. Was this done in consultation with project beneficiaries – UMNs and host community households?

5. Was specific attention given to identify and address the most vulnerable people (women, elderly, disabled)? If "Yes" how. And how effective has the response been?

6. Was your response through this PRM supported project a direct response to these identified needs?

7. On a scale of 0 (Poor) – 5 (Excellent) how successful was the programme in reaching the most vulnerable members of the communities? What reasons would you give to support this?

8. How effective has your support been in delivering Health support to Sphere standards?

9. What were the biggest challenges in providing Health support to targeted communities in a timely way?

10. How efficient were the approaches used during the implementation of the Health programme?

11. How cost-effective was the Health support programme? Examples? Could cost-effectiveness have been improved?

12. Do you think that the provided Health support will contribute to longer term development and sustainability? If "Yes" can you give some examples? If "No", what could have been done differently to perhaps increase the likelihood of sustained responsibility?

13. How would you describe the level of co-ordination with IOM on this Health aspect of the project? On a scale of 0 (Poor) to 5 (Excellent) how would you grade this level of co-operation? PROBE

14. How would you describe the level of co-ordination with government on this Health aspect of the project? On a scale of 0 (Poor) to 5 (Excellent) how would you grade this level of co-operation?

15. Did you work with any other NGO in delivering this support? If "Yes", how was this co-ordinated and was it effective?

16. What additional actions could have been addressed to better serve peoples' Health support needs during the initial phases of this project?

17. If you were to turn back the clock and design this intervention anew, is there anything you would change? If "Yes" What and Why?

2.3.2 OUTCOME 2. WASH – UMNs AND HCs HAVE SUFFICIENT ACCESS TO AND PROPER UTILISATION OF SAFE WATER AND IMPROVED SANITATION FACILITIES

1. Was WASH an appropriate intervention in this project's support? If "Yes", why? If "No" what would have been more appropriate?

2. What were the priority WASH needs in your operational area? [Water provision; Hygiene; safety = quality…]

3. How were these needs identified, assessed and analysed? [water quality testing – at outset and repeated again? Monitoring of water quality and draw down…]

4. Was this done in consultation with project beneficiaries – UMNs and host community households?

5. Was specific attention given to identify and address the most vulnerable people (women, elderly, disabled)? If "Yes" how. And how effective has the response been?

6. Was your response through this PRM supported project then a direct response to these identified needs?

7. On a scale of 0 (Poor) – 5 (Excellent) how successful was the programme in reaching the most vulnerable members of the communities? What reasons would you give to support this?

8. How effective has your support been in delivering WASH to Sphere standards? [Quantity/quality/access]

9. What were the biggest challenges in WASH support to targeted communities in a timely way?

10. How efficient were the approaches used during the implementation of the WASH programme?

11. How cost-effective was the WASH programme? Examples? Could cost-effectiveness have been improved?

12. Do you think that the provided WASH support will contribute to longer term development and sustainability? If "Yes" can you give some examples? If "No", what could have been done differently to perhaps increase the likelihood of sustained responsibility?

13. How would you describe the level of co-ordination with IOM on this WASH aspect of the project? On a scale of 0 (Poor) to 5 (Excellent) how would you grate this level of co-operation? PROBE

14. Did you work with any other NGO in delivering this support? If "Yes", how was this co-ordinated and was it effective?

15. What additional actions could have been addressed to better serve peoples' water supply needs during the initial phases of this project?

16. If you were to turn back the clock and design this intervention anew, is there anything you would change? If "Yes" What and Why?

2.3.3 NUTRITION

1. Has there been any change in the detection rate of under nutrition amongst children, adolescent girls and pregnant and lactating women since this project began? FIGURES

2. Has this service been equally available to refugees, UMNs and members of host communities?

3. Has the quality of the prevention of acute malnutrition been improved as a result of this project?

4. Has the quality of the treatment of acute malnutrition been improved as a result of this project?

5. Has psychosocial support been available to people in need on a timely and consistent basis?

6. Has the number of nutrition- or stress-related referrals changed since the start of this project? If so, has this increased or decreased, and what accounts for such change?

2.3.4 OUTCOME 5. SGBV – DUTY BEARERS DEMONSTRATE ENHANCED GBV-RELATED SUPPORT AND CARE FOR BENEFICIARIES WHO ARE VULNERABLE TO AND HAVE SURVIVED VIOLENCE

1. What measures did you take to ensure that SGBV was consistently addressed through your project activities?

2. What measures did you take to ensure that SGBV was consistently addressed through your partner's project activities? How was this monitored?

3. Did you take particular care to ensure that vulnerable members of the UMN community – elderly, children, women and disable persons – were not at risk to obvious SGBV pressure?

4. What, if any, has been the most effective approach or action taken through this project to promote and help ensure that people are receiving some safeguards against SGBV?

5. To what extent have your local partners been involved in and responsible for promoting and ensuring that SGBV prevention is prioritized through this project? Has this been effective?

6. In the current context, would you advocate for any changes to the approaches taken to promoting SGBV in a future project of this type?

7. What has been the main challenge to promoting and ensuring SGBV protection in the current context? Do you feel that this has been adequately addressed? If “No” what else could or should have been done to improve this situation?

OUTCOME 3. CAPACITY BUILDING – CAPACITY OF THE GOVERNMENT AND LOCAL NGOs IS ENHANCED TO PROVIDE HUMANITARIAN SERVICES MEETING INTERNATIONAL STANDARDS WITH CLOSE CO-ORDINATION WITH DEVELOPMENT PARTNERS AND INGOs UNDER THE CAPACITY BUILDING FRAMEWORK

7. What actions have been taken through this project to build/strengthen the capacity of local government services in support of the overall response to the UMNs?

8. Has this been effective? If “Yes” can you give some examples? If “No” could you suggest reasons why this was so?

9. What actions have been taken through this project to build/strengthen the capacity of local NGOs in support of the overall response to the UMNs?

10. Has this been effective? If “Yes” can you give some examples? If “No” could you suggest reasons why this was so?

11. Overall, through the capacity building support you have provided do you know if international humanitarian standards, e.g. Sphere, have been met in this project? Can you give examples?

12. What are any outstanding needs in terms of building/strengthening the capacity of either local government or local NGOs to enable them to take on more responsibility in project management in the current situation?

OUTCOME 4. CO-ORDINATION – THE GOVERNMENT OF BANGLADESH CO-ORDINATES HUMANITARIAN INTERVENTIONS IN COX’S BAZAR DISTRICT IN ORDER TO ADEQUATELY ADDRESS THE CRITICAL HUMANITARIAN NEEDS OF THE UMNs AND HC POPULATION

8. How has co-ordination been ensured between IOM and the government? Has this been effective? Could additional measures/steps have been taken to make this more effective?

9. How has co-ordination been ensured between IOM and your implementing partners? Has this been effective? Could additional measures/steps have been taken to make this more effective?

10. How have you ensured that you implementing partners are equally co-ordinating with local NGOs?

11. Has the role of the CBWG (Co-ordination based Working Group?) been effective? Have you had any feedback form partners on this? Could the performance of this structure have been improved?

12. What has worked best in terms of project or inter-agency co-ordination, and why?

13. What, if anything, has not worked as well as anticipated in terms of co-ordination, and why?

14. Could anything have been done better?

COVERAGE

4. How extensive was the coverage of households/individuals reached through this project (estimate)?

5. Do you think that the response level achieved [by your organisation] was appropriate in the current context?

6. Apart from funding, what were/are the main restriction that prevented greater coverage from being reached?

LESSONS LEARNED

5. What are the key learning /recommendation points to improve future programme performance in this context?

6. What are the strengths, weaknesses, opportunities and constraints you have experienced when working with, and though ***local actors***, in a response such as this?

7. What was your experiences of working with local government in this response?

8. Can you give examples of compliance with quality and accountability standards? CHS/Sphere/Do No Harm?

Finally, what has been the most significant achievement for you personally from this project.

Thank You!

3. SOLIDARITES INTERNATIONAL

3.1 GENERAL

1. What have been the main sectors you have been working in?

2. Which locations/sites have you been working in with these sectors?

3. Has there been any change to this scale/scope of work since this project started? If "Yes", please explain.

4. Has your support been delivered through national NGOs or directly? If "Through a national NGO" how effective do you think this has been? If "Direct" do you think this has been the most suitable approach?

3.2 SPECIFIC QUESTIONS AS STATED IN THE PROJECT PROPOSAL (P9)

a) Is there a demonstrated improved access to sufficient and safe drinking water, sanitation facilities and improved hygiene practices amongst 2,195 HH?

b) Have DRR capacities at the institutional and community levels increased in the targeted areas?

3.3 OUTCOME ANALYSIS

3.3.1 OUTCOME 2. WASH – UMNs AND HCs HAVE SUFFICIENT ACCESS TO AND PROPER UTILISATION OF SAFE WATER AND IMPROVED SANITATION FACILITIES

1. Was WASH an appropriate intervention in this project's support? If "Yes", why? If "No" what would have been more appropriate?

2. What were the priority WASH needs in your operational area? [Water provision; Hygiene; safety = quality…]

3. How were these needs identified, assessed and analysed? [water quality testing – at outset and repeated again? Monitoring of water quality and draw down…]

4. Was this done in consultation with project beneficiaries – UMNs and host community households?

5. Was specific attention given to identify and address the most vulnerable people (women, elderly, disabled)? If "Yes" how. And how effective has the response been?

6. Was your response through this PRM supported project then a direct response to these identified needs?

7. On a scale of 0 (Poor) – 5 (Excellent) how successful was the programme in reaching the most vulnerable members of the communities? What reasons would you give to support this?

8. How effective has your support been in delivering WASH to Sphere standards? [Quantity/quality/access]

9. What were the biggest challenges in WASH support to targeted communities in a timely way?

10. How efficient were the approaches used during the implementation of the WASH programme?

11. How cost-effective was the WASH programme? Examples? Could cost-effectiveness have been improved?

12. Do you think that the provided WASH support will contribute to longer term development and sustainability? If "Yes" can you give some examples? If "No", what could have been done differently to perhaps increase the likelihood of sustained responsibility?

13. How would you describe the level of co-ordination with IOM on this [[***WASH***]] aspect of the project? On a scale of 0 (Poor) to 5 (Excellent) how would you grate this level of co-operation? PROBE

14. Did you work with any other NGO in delivering this support? If "Yes", how was this co-ordinated and was it effective?

15. What additional actions could have been addressed to better serve peoples' water supply needs during the initial phases of this project?

16. If you were to turn back the clock and design this intervention anew, is there anything you would change? If “Yes” What and Why?

3.3.2 DRR RELATED QUESTIONS

1. Do you think that the DRR support provided through this PRM project has been appropriate to address the needs of the host communities and UMNs?

2. Were people consulted in the design of the approach or materials being promoted?

3. Has there been any change in the attitude of people towards disaster risk preparation since the start of your work?

4. How have you co-ordinated with the local Disaster Management Committee in preparing and delivering DRR-related messages?

5. During the recent cyclone, was there any evidence that people were better prepared to deal with the impacts of a hazard?

6. Were vulnerable and disabled people prioritised during the awareness raising and practical training activities that you conducted?

7. What are some of the main challenges you have experiences in promoting disaster preparedness amongst the host community and UMNs? How have these been addressed.

3.3.3 OUTCOME 5. SGBV – DUTY BEARERS DEMONSTRATE ENHANCED GBV-RELATED SUPPORT AND CARE FOR BENEFICIARIES WHO ARE VULNERABLE TO AND HAVE SURVIVED VIOLENCE

1. What measures did you take to ensure that SGBV was consistently addressed through your project activities?

2. What measures did you take to ensure that SGBV was consistently addressed through your partner’s project activities? How was this monitored?

3. Did you take particular care to ensure that vulnerable members of the UMN community – elderly, children, women and disable persons – were not at risk to obvious SGBV pressure?

4. What, if any, has been the most effective approach or action taken through this project to promote and help ensure that people are receiving some safeguards against SGBV?

5. To what extent have your local partners been involved in and responsible for promoting and ensuring that SGBV prevention is prioritized through this project? Has this been effective?

6. In the current context, would you advocate for any changes to the approaches taken to promoting SGBV in a future project of this type?

7. What has been the main challenge to promoting and ensuring SGBV protection in the current context? Do you feel that this has been adequately addressed? If “No” what else could or should have been done to improve this situation?

OUTCOME 3. CAPACITY BUILDING—CAPACITY OF THE GOVERNMENT AND LOCAL NGOs IS ENHANCED TO PROVIDE HUMANITARIAN SERVICES MEETING INTERNATIONAL STANDARDS WITH CLOSE CO-ORDINATION WITH DEVELOPMENT PARTNERS AND INGOs UNDER THE CAPACITY BUILDING FRAMEWORK

1. What actions have been taken through this project to build/strengthen the capacity of local government services in support of the overall response to the UMNs?

2. Has this been effective? If "Yes" can you give some examples? If "No" could you suggest reasons why this was so?

3. What actions have been taken through this project to build/strengthen the capacity of local NGOs in support of the overall response to the UMNs?

4. Has this been effective? If "Yes" can you give some examples? If "No" could you suggest reasons why this was so?

5. Overall, through the capacity building support you have provided do you know if international humanitarian standards, e.g. Sphere, have been met in this project? Can you give examples?

6. What are any outstanding needs in terms of building/strengthening the capacity of either local government or local NGOs to enable them to take on more responsibility in project management in the current situation?

OUTCOME 4. CO-ORDINATION – THE GOVERNMENT OF BANGLADESH CO-ORDINATES HUMANITARIAN INTERVENTIONS IN COX'S BAZAR DISTRICT IN ORDER TO ADEQUATELY ADDRESS THE CRITICAL HUMANITARIAN NEEDS OF THE UMNs AND HC POPULATION

1. How has co-ordination been ensured between IOM and the government? Has this been effective? Could additional measures/steps have been taken to make this more effective?

2. How has co-ordination been ensured between IOM and your implementing partners? Has this been effective? Could additional measures/steps have been taken to make this more effective?

3. How have you ensured that you implementing partners are equally co-ordinating with local NGOs?

4. Has the role of the CBWG (Co-ordination based Working Group?) been effective? Have you had any feedback form partners on this? Could the performance of this structure have been improved?

5. What has worked best in terms of project or inter-agency co-ordination, and why?

6. What, if anything, has not worked as well as anticipated in terms of co-ordination, and why?

15. Could anything have been done better?

COVERAGE

1. How extensive was the coverage of households/individuals reached through this project (estimate)?

2. Do you think that the response level achieved [by your organisation] was appropriate in the current context?

3. Apart from funding, what were/are the main restriction that prevented greater coverage from being reached?

LESSONS LEARNED

1. What are the key learning /recommendation points to improve future programme performance in this context?

2. What are the strengths, weaknesses, opportunities and constraints you have experienced when working with, and though ***local actors***, in a response such as this?

3. What was your experiences of working with local government in this response?

4. Can you give examples of compliance with quality and accountability standards? CHS/Sphere/Do No Harm?

Finally, what has been the most significant achievement for you personally from this project.

Thank You!

4. HANDICAP INTERNATIONAL

4.1 GENERAL QUESTIONS

1. What have been the main sectors you have been working in?

2. Which locations/sites have you been working in with these sectors?

3. Has there been any change to this scale/scope of work since this project started? If "Yes", please explain.

4. Has your support been delivered through national NGOs or directly? If "Through a national NGO" how effective do you think this has been? If "Direct" do you think this has been the most suitable approach?

4.2 SPECIFIC QUESTIONS AS STATED IN THE PROJECT PROPOSAL (P9)

a) Have services for persons with specific needs been strengthened?

b) Has peaceful co-existence with host communities been promoted? How? Has it been effective?

c) Lessons learned?

4.3 OUTCOME ANALYSIS

4.3.1 QUALITY OF LIFE

1. Have satisfaction surveys shown an appreciation for the services being provided though HI? If "Yes" can you give some examples?

2. Are referral cases receiving adequate attention and follow-up support from the referral service?

3. Has the quality and level of support provided by rehabilitation services increased during the project period? Examples please.

4. Is there evidence that other organisations/services within the locations where HI is working have started to mainstream access facilities for disable people? If "Yes" please give examples.

5. Are more children with disabilities now able to engage in outside activities? If "Yes" please give examples.

6. Are more adults with disabilities now able to engage in outside activities? If "Yes" please give examples.

7. Are people seeking trauma counselling or psychosocial support reporting their satisfaction with the treatment they are receiving?

4.3.3 OUTCOME 5. SGBV – DUTY BEARERS DEMONSTRATE ENHANCED GBV-RELATED SUPPORT AND CARE FOR BENEFICIARIES WHO ARE VULNERABLE TO AND HAVE SURVIVED VIOLENCE

1. What measures did you take to ensure that SGBV was consistently addressed through your project activities?

2. What measures did you take to ensure that SGBV was consistently addressed through your partner's project activities? How was this monitored?

3. Did you take particular care to ensure that vulnerable members of the UMN community – elderly, children, women and disable persons – were not at risk to obvious SGBV pressure?

4. What, if any, has been the most effective approach or action taken through this project to promote and help ensure that people are receiving some safeguards against SGBV?

5. To what extent have your local partners been involved in and responsible for promoting and ensuring that SGBV prevention is prioritized through this project? Has this been effective?

6. In the current context, would you advocate for any changes to the approaches taken to promoting SGBV in a future project of this type?

7. What has been the main challenge to promoting and ensuring SGBV protection in the current context? Do you feel that this has been adequately addressed? If "No" what else could or should have been done to improve this situation?

OUTCOME 3. CAPACITY BUILDING – CAPACITY OF THE GOVERNMENT AND LOCAL NGOs IS ENHANCED TO PROVIDE HUMANITARIAN SERVICES MEETING INTERNATIONAL STANDARDS WITH CLOSE CO-ORDINATION WITH DEVELOPMENT PARTNERS AND INGOs UNDER THE CAPACITY BUILDING FRAMEWORK

1. What actions have been taken through this project to build/strengthen the capacity of local government services in support of the overall response to the UMNs?

2. Has this been effective? If "Yes" can you give some examples? If "No" could you suggest reasons why this was so?

3. What actions have been taken through this project to build/strengthen the capacity of local NGOs in support of the overall response to the UMNs?

4. Has this been effective? If "Yes" can you give some examples? If "No" could you suggest reasons why this was so?

5. Overall, through the capacity building support you have provided do you know if international humanitarian standards, e.g. CHS, have been met in this project? Can you give examples?

6. What are any outstanding needs in terms of building/strengthening the capacity of either local government or local NGOs to enable them to take on more responsibility in project management in the current situation?

OUTCOME 4. CO-ORDINATION – THE GOVERNMENT OF BANGLADESH CO-ORDINATES HUMANITARIAN INTERVENTIONS IN COX'S BAZAR DISTRICT IN ORDER TO ADEQUATELY ADDRESS THE CRITICAL HUMANITARIAN NEEDS OF THE UMNs AND HC POPULATION

1. How has co-ordination been ensured between IOM and the government? Has this been effective? Could additional measures/steps have been taken to make this more effective?

2. How has co-ordination been ensured between IOM and your implementing partners? Has this been effective? Could additional measures/steps have been taken to make this more effective?

3. How have you ensured that you implementing partners are equally co-ordinating with local NGOs?

4. Has the role of the CBWG (Co-ordination based Working Group?) been effective? Have you had any feedback form partners on this? Could the performance of this structure have been improved?

5. What has worked best in terms of project or inter-agency co-ordination, and why?

6. What, if anything, has not worked as well as anticipated in terms of co-ordination, and why?

7. Could anything have been done better?

COVERAGE

1. How extensive was the coverage of households/individuals reached through this project (estimate)?

2. Do you think that the response level achieved [by your organisation] was appropriate in the current context?

3. Apart from funding, what were/are the main restriction that prevented greater coverage from being reached?

LESSONS LEARNED

1. What are the key learning /recommendation points to improve future programme performance in this context?

2. What are the strengths, weaknesses, opportunities and constraints you have experienced when working with, and though ***local actors***, in a response such as this?

3. What was your experiences of working with local government in this response?

4. Can you give examples of compliance with quality and accountability standards? CHS/Do No Harm?

Finally, what has been the most significant achievement for you personally from this project.

Thank You!

ANNEX X. GUIDING QUESTIONS IN RELATION TO SELECTED OECD/DAC CRITERIA

RELEVANCE

- Was the project – and its planned scope of activities – relevant, and is it still relevant today?
- Are the activities being promoted/supported relevant to peoples' needs?
- Are there some activities which no longer need to be supported? If so, which ones?
- Are there differences in the context since the time the project was designed and today? Are there unmet needs that the project should consider?
- Is the manner in which the project support is being delivered to communities appropriate and relevant, e.g. the work of IOM's implementing partners?
- To what extent are the original objectives of the project still valid?

EFFFECTIVENESS

- Have the project objectives been achieved?
- What specific outcomes can be attributed to this project? Are these intended or unexpected?
- To what extent has the selected beneficiary group been reached?
- To what extent have women been specifically addressed in this project?
- Has the intended inclusion of people with disabilities in this project been effective?
- What have been the main challenges experienced during the project implementation period? What has been done to overcome these and minimise their impact?
- How has the delivery of support to communities been monitored? How often was this done, and by who? Has this been effective?

EFFICIENCY

- What is the project expenditure to date compared with the planned budget?
- Are the objectives going to be met in a cost-efficient way?
- Has the project been implemented in a cost-effective way? Could any other approach have been more cost-effective?
- How would you describe the relations between project administration staff and field programme staff? Are there any institutional/programmatic changes you would suggest to improve this?

IMPACT

- Will this project make a positive contribution towards peoples' well-being?
- If "Yes", what positive change(s) can you already identify?
- If "No", why is this? What, if any, measures could have bene taken to overcome this?
- What are some of the direct and visible changes that have occurred as a result of this project, that can be directly attributed to this project support?
- Are there any opportunities that you see were missed in either planning or implementing this project?

SUSTAINABILITY

- To what extent will the positive impacts or changes brought about through this project continue beyond the end of the project period?
- What changes are most likely to continue?
- What, if any, changes are unlikely to continue? What needs to happen to reverse this situation?
- What specific actions have been taken to support sustainability?
- What were the main factors that influenced the achievement or non-achievement of sustainability?

- What actions have been taken to enable community members to continue new learning or practices?