EXPANDING THE PROTECTION AND PROMOTION OF MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT FOR COMMUNITIES AFFECTED BY THE REFUGEE EMERGENCY IN COX'S BAZAR, BANGLADESH

Program Evaluation

Final Report for the International Organization for Migration (IOM)

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EXECUTIVE SUMMARY

Beginning in 2017, the International Organization for Migration (IOM) implemented a holistic, comprehensive, and inclusive mental health and psychosocial support (MHPSS) program for the refugee and host community in Cox's Bazar, Bangladesh. The program was multi-layered and included social considerations for basic services (e.g., MHPSS sensitization campaigns), community and family support (e.g., community kitchens, cultural memory center), focused MHPSS services (e.g., individual and group counseling sessions), and specialized mental health services (e.g., medications and psychiatric care). This program aimed to strengthen national systems in MHPSS, increase MHPSS coverage, and strengthen the community-based development-oriented approach to MHPSS.

We aimed to evaluate the appropriateness, coherence, coverage, coordination, and connectedness of IOM's MHPSS program in the context of national and humanitarian systems in Cox's Bazar for the period of July 2019-December 2021. To accomplish this aim, we reviewed internal and publicly available IOM MHPSS program documents and reports; synthesized external literature identified through desk review; conducted 16 key informant interviews with community leaders, IOM staff, and governmental and non-governmental organization representatives involved in MHPSS; and facilitated 12 focus group discussions with community members stratified by age (adolescent, adult, elderly), gender (female, male), and population (refugee, host). Qualitative data was collected in October 2021.

IOM's MHPSS program was generally perceived as culturally appropriate, comprehensive, holistic, consistent with national and international MHPSS guidelines, and filled several gaps in existing services in Cox's Bazar. Participants described psychological and social impacts of the program that included relieving emotional distress, improving social connectedness, reconnecting with cultural practices and identity, and generating greater awareness about mental health and psychosocial wellbeing. Community members valued the participatory approach that was used to design and adapt the program. The community described the MHPSS program staff and volunteers as respectful and trustworthy, which facilitated the community's receptivity to the program. Focus group participants and key informants identified certain groups within the target population that experience more barriers to participation in the program and services more generally including the host community, women and adolescent girls, the elderly, and people with disabilities. IOM played an essential role in coordinating MHPSS services along with other stakeholders and established a strong referral system and capacity-building initiative.

We identified shared learnings that apply across sectors, stakeholders, and levels of care to improve overall MHPSS response. These include anticipating and avoiding potential harms associated with participation and/or program implementation; employing a participatory approach to promote appropriateness and mitigate harm; incorporating age, gender, and population considerations (e.g., gender norms, child protection, host-refugee community tensions); designing programs for sustainability by building local capacity and ownership; and integrating services to address co-occurring and related health and protection challenges (e.g., basic needs, livelihoods, gender-based violence, other social determinants of mental health).

ABBREVIATIONS AND ACRONYMS

CIC: Camp in charge
FGD: Focus group discussion
GoB: Government of Bangladesh
IASC: Inter-Agency Standing Committee
IOM: International Organization for Migration
IPCC: Intergovernmental Panel on Climate Change
KII: Key informant interview
mhGAP: Mental Health Gap Action Programme
MHPSS: Mental Health and Psychosocial Support
PFA: Psychological First Aid
RCMC: Rohingya Cultural Memory Centre
RRRC: Refugee Relief and Repatriation Commissioner
WASH: Water Sanitation & Hygiene program

INTRODUCTION

Background

Since 2017, over 700,000 Rohingya refugees have fled the Rakhine State in Myanmar into Bangladesh. Most Rohingya refugees are living in spontaneous settlements located in Cox's Bazar, including the districts (upazilas) of Teknaf and Ukhiya. Teknaf and Ukhiya are among the least developed districts in Bangladesh with limited infrastructure, poor living conditions, and high vulnerability to extreme climate events that threaten agriculture, livelihood opportunities and amplify food insecurity.

IOM has been providing technical assistance to the Government of Bangladesh on the response to migration throughout the country. IOM remains one of the leading agencies supporting the Rohingya refugee response in Cox's Bazar. Their role ranges from supporting programming across sectors including: WASH, health, protection, alternative energy sources, shelter/non-food items, and camp management (International Organization for Migration, 2019a). As part of this response, IOM has developed and implemented a multi-layered MHPSS approach that includes specialized mental health services, focused MHPSS, community and family support, and social considerations within basic services. The objective of the program was to scale up MHPSS programming to increase outreach capacity and improve service provision achieving a more ***holistic, comprehensive, and inclusive mental health and psychosocial response***. The target outcomes of this program included strengthening national systems in MHPSS through coordination and knowledge management, increasing MHPSS coverage through outreach services to the host and refugee communities and strengthening local capacity, and strengthening the community-based a development-oriented approach to MHPSS.

IOM's MHPSS program was implemented in Ukhiya and Teknaf refugee camps and surrounding areas for host communities in Cox's Bazar between July 1, 2019 and December 31, 2021. This evaluation will focus on examining the impacts of the program that occurred during this time frame as well as any impacts that have been sustained beyond this period. The target population will include both refugee and host community members in Cox's Bazar (specifically Ukhiya and Teknaf camps, as well as the surrounding host communities) and other stakeholders involved in program implementation (e.g., IOM staff, representatives from governmental and non-governmental agencies involved in MHPSS, etc.).

Purpose and Scope of the Evaluation

This evaluation aims to analyze the impact of IOM's mental health and psychosocial support (MHPSS) program implemented from July 1, 2019 to December 31, 2021 in Ukhiya and Teknaf settlements in Cox's Bazar.

The specific objectives of the program evaluation are to:

1. Describe the impact of the IOM MHPSS program on Rohingya refugees and the surrounding host community in Cox's Bazar.
2. Explore the appropriateness, coherence, coverage, coordination, and connectedness of the MHPSS program in refugee and host communities in Cox's Bazar.
3. Identify program strengths and weaknesses to inform adaptations and improve future implementation of MHPSS in Bangladesh.

Cross-cutting themes

The evaluation approach is informed by the following six cross-cutting themes:

1. *Do no harm*: While MHPSS programs do much good, critical reflection must consider any unintended hurt inflicted on program participants and the surrounding community to ensure the 'do no harm' principle. These topics include cultural and contextual appropriateness regarding security concerns, host and refugee tensions, stigmatization of vulnerable groups, inter-institutional coordination, as well as duplication of services, and proper accountability (Wessells, 2009).

2. *Expected and unexpected innovations and impacts*: Identifying intended as well as unintended impacts and innovations of the program, both positive and negative, will expand the understanding of the outcomes beyond what the objectives may have planned for (Bolton et al., 2007). The negative and positive lens will facilitate more lessons learned overall and provide deeper understanding of recommendations for future planning.

3. *Shared learning*: Opportunities for shared learning will be explored for humanitarian and national actors involved in MHPSS

4. *Gender*: Evaluating the program while paying particular attention to what extent gender equality is promoted and how gender is addressed will also connect back to contextual appropriateness and addressing marginalized groups.

5. *Children and adolescents*: The impact of MHPSS programs on the protection and wellbeing of children and adolescents will be explored.

6. *Sustainability*: Sustainability will examine the context of host and migrant populations, how they interact, ownership of the program and how it can be sustained long term, and efficiency regarding service delivery. It will also address the wider effects of this program as it relates to the environmental and organizational context in Cox's Bazar.

METHODOLOGY

Evaluation Questions

This evaluation is informed by five of the ALNAP program evaluation criteria (ALNAP, 2006). The specific outcomes and questions are described below and mapped to the methods of data collection in the Annex.

Outcome 1: Appropriateness is defined as the tailoring of a program to local needs, increasing ownership, accountability, and cost-effectiveness.

Questions:

1.1 How appropriate was the project to the target refugee and host communities regarding their needs?

1.2 How appropriate was the project to other key stakeholders?

1.3 Is the project sensitive and responsive to the given context?

1.4 How has the project strengthened the national system in the provision of MHPSS services through increased coordination and knowledge management?

Outcome 2: Coherence is defined as the compatibility with policies and other interventions within or across sectors and institutions

Questions:

2.1 How well does the project fit into existing national strategies and interventions of other stakeholders in the country and in the MHPSS sector?

2.2 How well does the project fit with international guidelines for MHPSS in humanitarian settings?

2.3 Do synergies and interlinkages with other IOM projects exist? Do these projects complement each other?

Outcome 3: Coverage is defined as the reach of the program to the intended target populations

Questions:

3.1 Were the planned objectives in the project document achieved?

3.2 What were the results achieved beyond the initially proposed results matrix?

3.3 What lessons have been learnt so far which can be applied to similar interventions in other IOM and other MHPSS programs, what were the challenges and solutions taken?

Outcome 4: Coordination is defined as the operational linkages among services and stakeholders in relation to the program

Questions:

4.1 How has the MHPSS response for refugees and affected host communities in Cox's Bazar been coordinated?

4.2 What was the role of IOM's MHPSS program in the coordination mechanism in Cox's Bazar?

<u>Outcome 5: Connectedness</u> is defined as ensuring the activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account?

Questions:

5.1 To what extent have activities implemented by the project contributed to resilience of affected communities and promote their self-sufficiency?

5.2 How has the project contributed to and supported the capacity of local resources?

Methods of Data Collection and Analysis

This evaluation includes three methodologies: desk review, in-depth key informant interviews, and focus group discussions. As described in the analysis plan, this study employs a sequential mixed-methods design to triangulate information about program impacts identified across these three data sources. First, we reviewed and analyzed existing program documents and used these findings to inform the qualitative key informant interviews and focus group discussions. Second, the focus group discussions and key informant interviews elaborated findings from the review of existing data and program documents, incorporated diverse perspectives on the program, and explored other program impacts. The procedures for each of these methodologies are described in detail below. The evaluation matrix (see appendix) elaborates further on the way that the evaluation objectives were accomplished by providing an overview of the ALNAP and OECD-DAC criteria and evaluation questions of interest to the IOM (ALNAP, 2006), as well as the methodology used for evaluation. All methods incorporated the six cross cutting themes outlined in the introduction.

1. Desk review

We reviewed existing project documents and data provided by IOM including MHPSS Assessment reports, the original program proposal and results matrix, project workplans, the 4Ws assessment, progress reports, and program implementation tools/forms/products. In addition we conducted a desk review of information through academic and grey literature databases. Relevant information included reports from other MHPSS programs implemented in Ukhiya and Teknaf, national mental health policies in Bangladesh, the structure of mental health and psychosocial services and stakeholders in Bangladesh, humanitarian policies or guidance regarding MHPSS in Cox's Bazar and more generally, etc. We followed the procedures for rapid MHPSS desk review in humanitarian emergencies (Greene et al., 2017; World Health Organization & United Nations High Commissioner for Refugees, 2012).

We extracted relevant information from program documents onto the five ALNAP and OECD-DAC outcomes: appropriateness, coherence, coverage, coordination, and connectedness (ALNAP, 2006). We narratively synthesized all codes within each outcome and reference the source material. Any available quantitative data was analyzed and presented descriptively.

2. Focus group discussions

Sampling: Participants for focus group discussions included: 1) refugee and host community members who participated in IOM's MHPSS program; and 2) refugee and host community members who did not participate, but were residing in the sites where IOM's MHPSS programs were operating. For participants who have participated in IOM's MHPSS program, we aimed to select a sample that covers the range of services offered by IOM (e.g., MHPSS sensitization campaigns, family dialogues, rituals/celebrations/healing ceremonies, focused counseling, and specialized mental health services). All focus groups will be stratified by gender (male, female), age (adolescent, adult, elderly), and population (refugee vs. host community member). IOM facilitated introductions to community leaders and representatives to assist in the participant selection and engagement process. This sampling strategy resulted in 12 focus group discussions with 91 individuals in total.

Table 1. Number of focus groups completed by age, gender, and population

	Rohingya Refugee Community		Bangladeshi Host Community	
	Female	Male	Female	Male
Adolescent	1	1	1	1
Adult	1	1	1	1
Elderly	1	2	1	0

Data collection: We collaboratively developed semi-structured focus group discussion guides (see appendix), which were designed to cover the cross-cutting themes, study outcomes, and preliminary findings from the desk review. Sample topics for the focus group discussion guides are provided in the evaluation matrix presented in the appendix. We train a team of research assistants to conduct the focus group discussions in pairs with the assistance of interpreters for interviews with Rohingya refugees. All focus group discussions took place in locations in the community that provided some privacy and the space to ensure we adhered to COVID-19 protocols for groups.

Data analysis: The research assistants debriefed after each day of the focus group discussions to review field notes. Using a thematic analysis approach, research assistants developed summaries of the audio recordings and field notes. Then, two members of the research team who were not involved in the data collection reviewed and coded the focus group discussion summaries. Codes were be categorized according to the five key ALNAP and OECD-DAC outcomes (appropriateness, coherence, coverage, coordination, and connectedness) and the six cross-cutting themes (do no harm, expected and unexpected impacts, shared learning, gender,

children and adolescents, and sustainability). We generated new themes to describe any codes that did not fit into these five outcomes or six cross-cutting themes.

3. Key informant interviews

Sampling: We conducted 16 in-depth interviews with a diverse set of stakeholders who possess expertise in the IOM MHPSS program, other related MHPSS services, the MHPSS needs and resources within the community, and the mental health system and policies in Bangladesh/Cox's Bazar. We recruited key informants to participate until we achieved theoretical saturation. We recruited key informants from each of the following stakeholder groups: 1) refugee and host community leaders and representatives; 2) IOM MHPSS program staff; and 3) representatives of other governmental and non-governmental agencies involved in MHPSS. Representatives of governmental and non-governmental agencies were identified through the 2021 4Ws MHPSS assessment in Cox's Bazar. Community leaders, IOM staff, and other personnel will be identified through IOM staff and based on recommendations by community leaders and focus group discussion participants.

Table 2. Number of key informant interviews by stakeholder group

Stakeholder group	# of KIIs
Refugee community leader/representative	1
Host community leader/representative	1
IOM Program Staff/Volunteer	8
Representative from inter-governmental agencies (excluding IOM) involved in MHPSS	2
Representative from Bangladeshi governmental agencies involved in MHPSS	3
Representative from non-governmental agencies involved in MHPSS	1

Data collection: We develop semi-structured interview guides informed by the preliminary findings from the desk review and focus group discussions. Sample topics for the key informant interview guides are provided in the evaluation matrix and the guides are included in the Appendix. All interviews were conducted in the preferred language of the key informant either in locations in the community that provide some privacy or remotely.

Data analysis: We followed a similar thematic analysis approach, whereby the research assistants produced summaries of the interviews using their field notes and the audio recordings. All interview summaries were coded by two research assistants. Codes included the five key ALNAP and OECD-DAC outcomes (appropriateness, coherence, coverage, coordination, and connectedness) and the six cross-cutting themes (do no harm, expected and unexpected impacts, shared learning, gender, children and adolescents, and sustainability). We generated new themes to describe any codes that did not fit into these five outcomes or six cross-cutting themes.

<u>COVID-19 Contingency Plans</u>

We adhered to all local and national recommendations related to COVID-19. Some key informant interviews were conducted remotely. Focus group discussions with community members were conducted in locations with enough space to ensure appropriate social distancing.

RESULTS

Desk Review: The context of mental health and psychosocial support needs and resources for Rohingya refugees in Cox's Bazar, Bangladesh

This review summarizes key findings from the UNHCR desk review originally published in 2018 (Tay et al., 2018; Tay et al., 2019), and adds to these findings with more recently published academic articles and reports. We identified 56 peer-reviewed publications and reports that describe the context of mental health and psychosocial support needs and resources for Rohingya refugees in Cox's Bazar, Bangladesh. The goal of this desk review of external documents was to provide an overview of cultural considerations and the context within which the IOM MHPSS program was implemented. In this section, we provide a brief overview of the general, MHPSS, and humanitarian context as it relates to Rohingya refugees in Cox's Bazar.

General Context

1. Geographical Aspects
Cox's Bazar is a tropical, coastal, and densely populated region of southern Bangladesh along the Bay of Bengal and bordering Myanmar. Cox's Bazar in Bangladesh and Rakhine State in Myanmar, from where most Rohingya refugees have fled, are projected to be the hardest hit areas in Asia by climate change in the next few decades. In recent years, most of the tropical cyclones in Bangladesh made landfall in the Cox's Bazar region. Current Intergovernmental Panel on Climate Change (IPCC) projections suggest that the region will experience tropical cycles with increasing intensity and frequency (Ahmed, Simmons, Chowdhury, & Huq, 2021). Several investigations have found that the Rohingya influx of 2017 has had environmental impacts on the Teknaf Peninsula and Ukhiya sub-district of Cox's Bazar (Imtiaz, 2018; Quader, Dey, Malak, & Sajib, 2021).

2. Demographic Aspects
The Rohingya are a Muslim ethnic minority group primarily from the Rakhine State in Myanmar. The Rakhine state is one of the poorest in Myanmar with an estimated 78% of the population living in extreme poverty. Despite having lived in Myanmar for many generations, the government of Myanmar does not officially recognize the Rohingya as an ethnic group and has denied them citizenship since 1982 (Lee & Ware, 2016). The Rohingya remain the world's largest stateless population and one of the fastest growing refugee populations (Tay et al., 2019).

3. Historical and Political Aspects
In the eighth century, people living in the Bay of Bengal region of Myanmar converted to Islam under the influence of Arab traders in the region. Rohingya trace their history to this period, yet the government does not recognize Rohingya as an ethnic group in Myanmar (Kipgen, 2013; Tay et al., 2019). Nearly four decades ago, the Rohingya were deprived of and denied citizenship and nationality in Myanmar. The government placed restrictions on assembling in groups, travel,

religious practices, education, marriage, childbirth, healthcare, and community development activities (Riley, Akther, Noor, Ali, & Welton-Mitchell, 2020). Rohingya communities in Myanmar were heavily surveilled and policed. Their freedom of movement was limited and this restricted their access to basic services, including healthcare (Tay et al., 2019).

In October 2016, an armed group of Rohingya insurgents, the Harakah al-Yakin ('faith movement'), attacked border guard police in northern Rakhine State. In response, the government initiated a military operation in Rakhine State that the International Crisis Group described as indiscriminately attacked militants and civilians, committed human rights violations, and restricted humanitarian assistance from reaching the Rohingya. In August 2017, violence escalated again following an attack against police posts in northern Rakhine State, to which the government ordered a massive clearance operation by the Myanmar army. Communities were destroyed, thousands of people were killed, which led to thousands of Rohingya fleeing to Bangladesh (Amnesty International, 2016; International Crisis Group, 2016; Tay et al., 2019).

4. Religious Aspects

The Rohingya are a Muslim minority ethnic group from Rakhine State, Myanmar. They practice a conservative form of Sunni Islam. The Rohingya practice gender segregation ('purdah') in most daily activities, including education, prayer, and other religious practices. Elders are respected figures within the community as are *hafez*, who are individuals who have memorized the Quran and are related to prominent religious figures. *Hafez* are usually men, but a subset are women who are able to advise small groups of girls or women. Religion remains central to the Rohingya identity (Tay et al., 2019). Religious practices are also taught within *madrasas* ('religious schools').

There is a small group of refugees from Rakhine State who are Hindu. They are also not recognized as an official ethnic group in Myanmar and they do not self-identify as Rohingya. There are some reported tensions between Rohingya and this group of Hindu refugees from Rakhine State. Most of these refugees are living in refugee settlements that are separate from the Rohingya camps/settlements (Bhattacharyya, 2017; Tay et al., 2019).

5. Economic Aspects

Rohingya refugees live in extreme poverty. The host community in Cox's Bazar is also one of the least developed regions of Bangladesh and in a state of resource depletion with poor infrastructure. Since 2016, the host community has also seen an overall decline in annual income (Ullah, Asahiro, Moriyama, & Tani, 2021). Some subgroups, such as small to mid-size traders, benefited economically from the influx of Rohingya refugees into Bangladesh. However, other subgroups have felt neglected and harmed by the refugee response and humanitarian agencies, which has led to increased tensions between refugee and host communities in Bangladesh (ACAPS, 2018).

6. Gender and Family Aspects
Communities as well as social and religious practices are typically gender segregated. Marriage is accompanied by a dowry and is seen as the primary way for women to attain social and economic security. When women marry, they leave their family and integrate within their husband's family household. Women are typically discouraged from leaving or working outside of the household, particularly if alone. Some respected women in the community provide perinatal care and function as traditional birth attendants. In general, reproductive health services for women are quite limited, including in refugee camps in Bangladesh (Jeffries et al., 2021; Parmar, Jin, Walsh, & Scott, 2019; Sarker et al., 2020).

Other gender-related human rights violations are also commonly reported in the refugee camps/settlements. These include sexual violence, child marriage, and sexual exploitation in the camps. Gender-based violence and exploitation have significant social consequences, including being ostracized by the community and their family. While gender-based violence is more commonly reported among women, incidents are also reported by men and boys (Tay et al., 2019).

7. Cultural Aspects
The Rohingya closely align with Islamic customs and traditions. These include traditional clothing (Burqa, niqab, and hijab worn by women) and halal food. The Rohingya language is an Indo-Aryan language that is related to Chittagonian, a dialect of Bengali spoken in Chattogram. *Tarana* poems and songs are central to Rohingya culture. These poems/songs are used to express emotions (often despair, melancholy, and fear) and recall the history of the Rohingya. These songs are accompanied by traditional instruments including the *tobla* (small drums) and *juri* (a guitar-like instrument).

8. General Health Aspects
Rohingya refugees in Bangladesh face a range of public health issues, many of which are related to challenges meeting their basic needs, poor infrastructure and sanitation, and lack of access to health services. Prevalent issues include malnutrition, food- and water-borne illnesses, infectious disease, and gender-based violence. As of August 2021 there were around 20,000 cases and 200 deaths due to COVID-19 reported among refugees in Cox's Bazar. At this time, UNHCR and local health officials announced the beginning of a COVID-19 vaccination campaign in Cox's Bazar. Rohingya refugees have reported substantial misconceptions, but low levels of fear related to COVID-19. Fear and depressive symptoms during the pandemic were associated with difficulty accessing healthcare and food, having pre-existing non-communicable diseases, and recognizing the elevated risk of COVID-19 for older adults (Mistry, Ali, Akther, et al., 2021; Mistry, Ali, Irfan, et al., 2021; Mistry, Ali, Yadav, et al., 2021). Misconceptions and mistrust of infection prevention and control guidelines has been linked to Rohingya's prior experiences and exposure to potentially traumatic events (Akter, Dhar, Rahman, & Uddin, 2021).

The health services for refugees in Cox's Bazar are provided by over 100 entities, including the Ministry of Health/Government of Bangladesh, United Nations agencies, and national and

international non-governmental organizations (Tay et al., 2019). The health sector strategic advisory group chaired by the World Health Organization meets regularly to disseminate health information and coordinate health service delivery. The health system in the camps include basic health units, primary health centers, and secondary health facilities. Ukhiya and Teknaf health complexes, which are health facilities within the Bangladesh national health system, will accept emergency referrals.

Mental health and psychosocial support context

1. Epidemiological studies of mental disorders and risk/protective factors

Existing research has identified a range of existing mental health symptoms among the Rohingya population. Prevalent symptoms include depressed mood, loss of appetite, sleep problems, helplessness, grief, lethargy, fear, paranoia, hyper-alertness, anxiety, tension, explosive anger, behavioral disturbances, suicidal ideation, and somatic symptoms (headaches, back pain). These symptoms have been associated with functional impairment and lower quality of life among refugees, including both children and adults (Hossain et al., 2021; Tay et al., 2019). There have been studies reporting high prevalence estimates for psychiatric disorders, particularly for depression and post-traumatic stress disorder, however these studies have applied assessment tools that have not yet been validated in the Rohingya population. Comparative research has examined the relative prevalence of psychiatric conditions among Rohingya refugees in Bangladesh and Malaysia. This study found that symptoms of post-traumatic stress, depression, anxiety, and functional impairment were higher among Rohingya in Bangladesh as compared to those in Malaysia (Khan & Haque, 2021). Quantitative and qualitative research has identified a common set of risk factors for mental health problems among Rohingya refugees including: female gender, exposure to potentially traumatic events, poverty, shortage of food and shelter, breakdown in social norms and traditions, lack of access to healthcare and basic services, idleness and boredom, mobility restrictions, gender-based violence, mental health-related stigma, loss of identity, and exclusion (Tay et al., 2019).

Most existing research on mental health and psychosocial wellbeing among Rohingya refugees has focused on western concepts of mental disorder. A review of research and reports of clinical practices in Rohingya camps highlights the cultural manifestations of distress. This review recommends reconceptualizing the measurement and response to mental health problems to fit local concepts of distress and culturally appropriate responses to improve mental health and psychosocial wellbeing (Frounfelker et al., 2019).

2. Local expressions and idioms of distress

Local concepts of distress among Rohingya often relate to the mind ('dilor/mon') and soul ('foran/jaan/rooh') relationship. Somatic symptoms often accompany distress, which is often linked to spiritual possession, namely by Jinns, which are significant in Islam. Common idioms include *wushanti/ashanti/oshanti* ('restless/no peace of mind'), *monmora/cinta lager* ('feeling sad'), *mon horaf lager/dil hous khous lager* ('feeling low mood'), *chhoit lager* ('not feeling well, losing interest in things, restless mind'), *igaa cisciyaar/gaa bish lager* ('pain in the body'), *gaa*

zoler/gaa furer ('burning sensation in the body'), and *dishahara/hatfau aridiya/maayus* ('depression, hopelessness, and feeling of suffocating')(Tay et al., 2019). Severe mental illness and intellectual disabilities are more closely connected with disorders of the brain as opposed to the mind-soul conditions. Suicide ('khud-kush', 'nijore morito mone hor') is very stigmatized and condemned in Islam.

3. Explanatory models for mental health and psychosocial problems and major sources of distress
Mental health problems are described as relating to the brain (severe mental illness, intellectual disabilities), the mind-soul (common mental health problems – depressive and anxiety symptoms), or the body (somatic symptoms). These mental health problems are closely connected to a long history of trauma and displacement, including a loss of meaning, identity and coherence (Tay et al., 2019). Chronic exposure to human rights violations, including being prevented from religious and cultural practices or expression, history of trauma, as well as daily stressors experienced living in the camps in Cox's Bazar are seen as the factors that lead to symptoms of distress (Riley et al., 2020).

4. Concepts of the self/person
There is a division between the brain ('mogos/demag'), the mind ('dil-dilor/mon'), the soul ('jaan/foran'), and the physical body ('jism/gaa'). The mind is considered the origin of emotions, affect, reactions and attention. The brain is the source of memories, cognitions, and thoughts. The body is connected to both the brain and the mind and responsible for physical functions. The soul is associated with and largely governs the brain, the mind, and the body (Tay et al., 2019).

5. Help-seeking patterns
Rohingya refugees typically do not seek formal health for mental health problems, which may be due to lack of familiarity with western concepts of mental health problems and services. Services within the health sector are typically perceived as treating conditions that are perceived to have a physical origin. Additionally, stigma and shame related to mental health reduces treatment seeking behavior (Tay et al., 2019).

6. The mental health system – policy and legislative frameworks, formal mental health services, stakeholders
A mental health policy is embedded within the national health policy framework in Bangladesh. The 2011 Bangladesh National Health Policy described that the approach for addressing mental health applied a life course approach to health and equity. It described the importance of supporting women and marginalized populations, including people with disabilities and the elderly. In 2018, Bangladesh enacted the Mental Health Act, which replaced the 106-year old Lunacy Act of 1912. This updated act described efforts to protect the dignity of people living with mental health conditions, including providing access to healthcare, the right to own property, and to access rehabilitation supports. Then, in 2019, the Final Draft of the National Mental Health Policy was released. This policy considers the social determinants of mental health as an integral part of addressing the mental health needs in the population. This policy reinforced the

commitment of the Bangladesh government to mental health issues. The 2020-2030 Bangladesh Mental Health Strategic Plan aims to ensure the mental health and psychosocial wellbeing of all people of Bangladesh.

The mission of the 2020-2030 Bangladesh National Mental Health Strategic Plan is copied below:

> "*The mission of the strategic plan is to establish a sustainable, rights based, holistic, inclusive, multi-sectoral guidance to ensure provision of information and quality mental health services for promoting mental health and psychosocial wellbeing, prevention, treatment and rehabilitation of mental illness throughout the life course of the people of Bangladesh. This plan will be focused on a human-rights based approach, a community based mental health model to ensure services are most easily available and accessible where people reside, strengthening existing government system in heath and other sectors, equity, gender equality, self-empowerment, community and family support, enhancement and use of existing resources, participation of individuals affected with mental illness and their carer in the planning process. This will pave the pathway to reach the target of universal health coverage and achieving Sustainable Development Goals*." – Pg. 40 (Government of the People's Republic of Bangladesh, 2019)

The core principles of the Bangladesh National Mental Health Strategic Plan include: 1) universal health coverage; 2) equity and justice; 3) rights-based approach; 4) evidence-based practice; 5) life course needs; 6) multi-sectoral collaboration; 7) empowerment and community participation; 8) integrated inter-sectoral care; 9) quality assurance; and 10) community-based care. The Strategic Plan has defined four key objectives:

1. **To strengthen effective advocacy and partnership, leadership, and governance for mental health** by strengthening effective leadership and governance for mental health issues, ensuring representation of various stakeholders and coordination with multisectoral committees, establishing a regulatory body for mental health professionals, and addressing mental health in all policies.
2. **To provide sustainable, comprehensive, integrated, and responsive mental health and social care services in community-based settings** by providing mental health care at all levels of the health system, supporting the recovery of people living with mental health conditions, providing MHPSS to survivors of trauma and humanitarian emergencies, ensuring adequate treatment options are available in healthcare settings, giving special attention to children and adolescents with mental health conditions and neurodevelopmental disabilities, enhancing the availability of mental health professionals, updating the academic curriculum on mental health and substance use, addressing substance dependence and addictive disorders, and providing support services for caregivers of persons with mental health conditions through a multisectoral approach.
3. **To implement strategies for mental health promotion and risk reduction for mental health conditions** by promoting mental health and prevention mental health conditions by enhancing awareness and reducing stigma, reducing the risk and incidence of suicide and attempted suicide, and promotion socioemotional learning and development from early childhood.
4. **To strengthen information systems, monitoring, and implementation research for mental health** by promoting evidence generation and research.

Most of the national mental health budget in Bangladesh is earmarked for psychotropic medications and the maintenance of inpatient psychiatric facilities and psychotherapy is less commonly implemented within the health system (Tay et al., 2018). As reflected in the Strategic Plan, the government of Bangladesh is aiming to transition to more community-based care (Government of the People's Republic of Bangladesh, 2019).

The Strategic Plan mentions the Rohingya in an appendix and states that they experience mental illness due to their experience of forced displacement, but does not describe provisions for extending care and coverage to Rohingya refugees (Government of the People's Republic of Bangladesh, 2019). Access to mental health services for refugees globally is limited and Rohingya refugees display lower utilization rates than other refugee populations (Tay et al., 2018). Early in the Rohingya refugee response, the health sector established minimum standards for primary care. Strengthening community-based care improved access to MHPSS. Minimum standards also recommended the integration of mental healthcare into primary health services, but this was compromised by the limited availability of specialists or providers with mental health training (Jeffries et al., 2021). Numerous national and international organizations are currently providing health services for Rohingya refugees in Cox's Bazar. This includes MHPSS services, which are provided by 41 organizations according to a 4Ws assessment completed in May 2021. Many of these organizations provide MHPSS to both the host and refugee community.

In addition to these formal services, it is also common for Rohingya to seek help from traditional healers and religious leaders. These healing rituals often involve administering herbal or plant-based remedies, providing holy water, using non-invasive rituals (e.g., blowing smoke over the body), and/or reciting verses from the Quran to rid the person of spiritual possessions (Tay et al., 2018). There are different types of healers, most of whom are men, who treat a variety of problems.

Humanitarian context

1. History of humanitarian emergencies

In 1948, the Burmese achieved independence from Great Britain. At this time, some Rohingya were issued national registration cards. In 1962, the military assumed power through a coup d'etat and began systematically infringing on the rights of the Rohingya in Rakhine state. In 1974, the Rohingya were no longer allowed to vote and shortly after the military began Operation King Dragon. This operation aimed to purge 'illegal foreigners', which caused 200,000 Rohingya to flee into Bangladesh.

In 1982, the new citizenship law in Bangladesh identified 135 national ethnic groups and excluded Rohingya from this recognized list, rendering them stateless. Following a military crackdown and popular uprising, Burma became Myanmar and they renamed the Arakan State to Rakhine. The non-Rohingya Rakhine inhabitants became more powerful than the Rohingya inhabitants and there was an increase in the military presence in Rakhine State. Forced labor,

relocation, rape, execution, and torture were reported and 250,000 Rohingya fled to Bangladesh. In 1991, Operation Clean and Beautiful Nation was initiated by the military, which led to the persecution of Rohingya and the displacement of 260,000 Rohingya into Bangladesh. In 1992, Bangladesh ceased to recognize the refugee status of the Rohingya and began efforts to repatriate many of the refugees back to Myanmar.

In 2012, sectarian violence in Rakhine State killed more than 200 people and forced 140,000 Rohingya to flee internally displaced person camps leaving many Rohingya stranded in villages that were surrounded by military and other perpetrators of violence. Many Rohingya began fleeing by boat in unsafe conditions. Many drowned and, at the same time, humanitarian agencies working in this region started to be targeted by Buddhist extremists. Beginning in 2016, violence between Rohingya insurgents and the police/military triggered the exodus of 87,000 Rohingya into Bangladesh. A series of attacks in 2017 led to the systematic campaign of violence, known as 'clearance operations', in Rakhine. Over 700,000 Rohingya fled into Bangladesh (~600,000 in the first 3 months of the crisis). This added to the 200,000-300,000 refugees already in Bangladesh. The Government of Bangladesh has not reinstated their recognition of refugee status for the Rohingya, so considers them Forcibly Displaced Myanmar Nationals (FDMN). Many of these refugees integrate into existing camps; however, most take residence in makeshift settlements in Cox's Bazar.

2. Experiences with past humanitarian aid involving MHPSS

A range of non-governmental and governmental agencies provide MHPSS in response to the 2017 influx of Rohingya refugees in Cox's Bazar. Some organizations have been providing these services prior to the most recent arrivals. For example, Medecins San Frontieres (MSF) have been working in Cox's Bazar since 2009 delivering mental health counseling and psychiatric care to both the refugee and host population. Since the 2017 influx of refugees, MSF and other organizations have expanded their services geographically to cover the new settlements and also in scope to provide a broader range of services. Most of these organizations either provide focused psychological interventions or community-based psychosocial programs.

Description of IOM's MHPSS program

In 2017, IOM implemented a comprehensive MHPSS program in Cox's Bazar that aimed to scale-up MHPSS programming to increase outreach capacity in addition to improving service provision towards achieving a more holistic, comprehensive, and inclusive mental health and psychosocial response. One IOM staff member reported that:

> "Our program is a response to address the constant stress and anxiety and sometimes depression and other reaction to these crises. And we are doing what we can do. This program is trying to support, to help them cope with these extremely difficult circumstances." – IOM staff member KII

This program was filled key gaps identified through needs and service availability assessments including:

- Increase services and access to MHPSS in host communities
- Engage more professional staff to address gaps in specialized MHPSS services
- Coordinate and support establishment of inpatient care unit in Cox's Bazar
- Strengthen coordination and information sharing between MHPSS service providers in Cox's Bazar
- Coordinate among agencies that provide MHPSS services, unifications of requirements and titles among MHPSS staff to ensure they follow government recommendations

As of June 30, 2021, the program had activated or strengthened local resources that support psychosocial wellbeing and development in 100% of target communities. They had reached 96,424 individuals with facility- and community-based MHPSS (58% female, 42% male; in the latest reporting period - 21% host population, 79% Rohingya refugees). Achieving this objective was measured through three outcomes specified in IOM's results matrix and five of the OECD-DAC evaluation criteria (see Table 2)(ALNAP, 2006; International Organization for Migration, 2021b).

Table 2. Summary of result matrix outcomes, outputs, and indicators

<table>
<tr><th>Outcome</th><th colspan="2">Output and Indicators</th><th>Relevant OECD-DAC Evaluation Criteria</th></tr>
<tr><td rowspan="2">1. Strengthen the national system in the provision of MHPSS services through increased coordination and knowledge management</td><td colspan="2">Ind 1: A needs-informed national strategy to address MHPSS needs of displaced populations and local communities in place</td><td>Appropriateness
Coherence</td></tr>
<tr><td>Output 1.1 An implementation plan to address MHPSS gaps identified by the readiness assessment is developed jointly with GoB</td><td>Ind 1: # MHPSS service assessments conducted
Ind 2: A joint implementation plan to address gaps identified by assessment developed</td><td>Appropriateness
Coherence
Connectedness</td></tr>
<tr><td rowspan="2">2. Improve MHPSS coverage by adding and expanding outreach services and elements beyond the Rohingya and to the host community, as well as addressing the need to</td><td colspan="2">Ind 1: # of community members reached through the mobile MHPSS services</td><td>Coverage</td></tr>
<tr><td>Output 2.1 MHPSS service delivery offered to beneficiaries at refugee health facilities and points specifically chosen to improve host community access</td><td>Ind 1: # of MHPSS outreach teams delivering services
Ind 2: # of community health workers trained and supervised in the promotion of mental healthcare</td><td>Coverage</td></tr>
</table>

strengthen capacity to adequately detect and respond to mental health challenges		and provision of community-based services	
	Output 2.2 Strengthened capacity to identify, refer, treat and follow up on severe mental disorders	Ind 1: # of health professionals trained to improve the mental health response system Ind 2: # of MHPSS consultations/ referrals provided in the health facilities	Coverage
3. Strengthen the community-based and development approach of the MHPSS response	Ind 1: # of community members, both Rohingya and host communities, covered by MHPSS response		Coverage
	Output 3.1 Promote a sense of belonging in the Rohingya refugee community to restore social connections and wellbeing	Ind 1: # of community-based events to be conducted	Appropriateness Coverage Connectedness

The program was designed to be a multi-layered program that included mainstreaming of MHPSS into basic services, community and family support, focused MHPSS services, and specialized mental health services. Key informants differentiated IOM's programming as clinic-based (e.g., individual and group counseling) and field-based services (e.g., youth groups, art activities, dissemination/awareness programs). A list of key services provided within each of these layers is provided below (International Organization for Migration, 2020a):

<u>Social considerations of basic services</u>

- Mass MHPSS sensitization campaigns
- Training providers of basic services in MHPSS

IOM conducted mass sensitization and awareness raising campaigns to provide basic psychoeducation about mental health and psychosocial issues (including how to manage psychiatric emergencies and suicide risk), reduce stigma, suggest different coping strategies, and inform the community about available MHPSS programs. Many of the focus group discussion (FGD) participants reported learning about IOMs programs through these community awareness campaigns.

> "They talked about the human mind, we learned from them how to keep the mind well."
> – Adolescent male host community FGD

IOM used different strategies for publicizing their services and raising awareness about mental health. They included the use of volunteers to meet with communities, home visits, public messages, flyers, among other strategies. The reach of these awareness campaigns was amplified through word-of-mouth referrals and knowledge-sharing within communities. They also integrated other relevant messaging, including personal hygiene and COVID-19 prevention and control guidance, and mainstreamed MHPSS awareness and training across sectors.

<u>Community and family support</u>

Key activities:

- Support groups and family dialogues
- Rituals, celebrations, and healing ceremonies

- Creative and traditional art-based activities in the Rohingya Cultural Memory Centre (RCMC)

As described in the desk review, loss of identity and cultural practices were key risk factors for poor mental health and psychosocial wellbeing (Tay et al., 2019). A survey conducted by IOM found that 73% of respondents reported loss of cultural identity as one of the main sources of distress (International Organization for Migration, 2019b). Survey participants reported that strengthening a sense of identity, practicing their faith, and participating in group and community activities were key factors to promote psychosocial wellbeing and that prayers, music, and art were key aspects of coping (Rebolledo, 2019). With this information, IOM established the Rohingya Cultural Memory Center (RCMC). The RCMC was intended to provide a space for Rohingya to reconnect with their cultural and religious identities. They provided bi-weekly healing ceremonies in 10 refugee settlements (Rebolledo, 2019). IOM hired 12 staff members and trained 17 Rohingya cultural agents to establish the RCMC. Together they worked with 150 Rohingya artisans, collected more than 100 publications on Rohingya heritage, conducted workshops and storytelling sessions, developed a YouTube channel and website, and integrated other MHPSS activities into the RCMC program. The videos they produced included recipes and proverbs produced with the community (International Organization for Migration, 2019b, 2021f).

IOM also strengthened other community-based activities, such as sports and art programming for youth. They also implemented a community kitchen where 20 families would assemble and contribute different cooking items. They would cook together and share recipes with the other families within their community.

Focused MHPSS services and Case Management

- Individual family and group counseling in health facilities and during home visits
- Hotline and telecounseling services
- Training on psychological first aid (PFA) and basic counseling skills for health care staff

IOM provided individual, group, and telecounseling services delivered by senior counselors and other MHPSS staff. To enable the appropriate identification and referral of individuals requiring focused or specialized healthcare, IOM trained 240 healthcare staff and nine outreach teams in basic MHPSS response. This resulted in 13,583 consultations and referrals provided in healthcare settings. Individual and group counseling covered a range of mental health and psychosocial issues including psychoeducation and mental health awareness, parenting, self-care, stress management, and other topics.

Mental health specialized services

- Assessment and management of patients with MNS conditions by a certified psychiatrist and mental health gap action program (mhGAP) trained doctors
- Psychoeducation and PSS support for the patient’s family
- Referral system to form specialized clinical services
- Training on mhGAP and identification of persons with MNS conditions

An IOM psychiatrist evaluated 324 individuals with severe mental health conditions (n=248 host, n=76 refugees) through June 30, 2021. IOM facilitated additional referrals for consultation and treatment from a psychiatrist at the Ukhiya and Teknaf for individuals requiring specialized mental healthcare. Participants reported that a unique aspect of IOM's MHPSS program was the provision of free medication for mental health problems. This was not available from other MHPSS programs, particularly in the camp.

Evaluation Outcome 1: Appropriateness

Appropriateness is defined as the tailoring of a program to local needs, increasing ownership, accountability, and cost-effectiveness.

1.1 How appropriate was the project to the target refugee and host communities regarding their needs?

1.1.1 Increasing appropriateness through community-based participatory program design

IOM staff members described that the program was designed with input from the community to meet their needs. This process was iterative whereby IOM conducted initial assessments and consultations in the form of focus group discussions with community members and continued to seek input from the community throughout the phases of implementation. IOM also had suggestion boxes to provide a mechanism for anonymous feedback by community members.

> "Firstly, we conducted a needs assessment. Then, we analyzed the needs and prioritized them. On the basis of prioritization, we designed the program. Besides this needs assessment, we communicated with community leaders and stakeholders regularly. We involved them as a team member of our activities. Thus, we maintained a collaborative relationship to implement our MHPSS activities." – IOM Staff Member KII

> "We have very regular weekly meetings with specific groups where they share what they want to do in a session. Some of the activities are arts and crafts, and also henna tattoos which they used to do back in their country." – IOM Staff Member KII

> "We rely on the community. For the Rohingya Cultural Memory Center, we look for experts from community members. For shaping design of the program, community members are very much involved and they have ownership. We have many technical people like writers, artists, and singers. Everything is based on community feedback. IOM and community members work together for the Rohingya Cultural Memory Center." – RCMC Staff Member KII

The community-based participatory elements of the program, such as consultations and focus group discussions with community members, improved the fit of IOM's MHPSS program to the needs and the socio-cultural context for both the refugee and host community. Participants reported that they never experienced any difficulty engaging in cultural or religious practices while participating in the program. They appreciated that some aspects of the program were influenced by their customs, such as henna designs, mehendi, games, healing ceremonies, encouraging participants to read and recite the Quran, among others.

> "We are very happy to play Sollum [game played in Myanmar] here, feeling that I'm in my own country. It was possible only for IOM." – Adolescent male refugee FGD

> "They allow us to pray while the session is going on. They never forbid us to recite the Quran." – Adult female refugee FGD

Incorporating these cultural and religious elements to improve the appropriateness of the program also stimulated ownership and engagement. Several participants referred to IOM's mental health center as their home and a place that was comfortable and accessible to them.

> "It seems like my own place. I can express my words frankly." – Adult male host community FGD

Two key informants, one from IOM and another from another humanitarian organization, felt that the participatory approaches could be enhanced through better engagement with religious leaders and more regular and direct engagement with community members.

1.1.2 Culture, gender & age: Essential considerations for appropriate MHPSS programs

In general, the holistic and comprehensive approach that IOM took was considered culturally and contextually appropriate as well as relevant to the community's needs. However, there were specific activities, such as listening to certain types of music, that were less frequently utilized by Rohingya refugees due to religious restrictions. There were also age- and gender-specific activities.

For both the refugee and host community, adult women requested that MHPSS counseling be provided individually and in the home by female MHPSS staff (e.g., through home visits). This was related to gender norms that limit women from leaving the home and expressing certain issues in groups or public (e.g., marital conflict), which were also described in the desk review. It was also noted by elderly refugee women that not applying these gender-specific considerations may have negative impacts. For example, men may get upset if they find out that women are going to IOM to discuss marital issues, which could increase partner violence. Women also felt more comfortable speaking openly about certain sensitive topics in private settings with female MHPSS staff. However, in the Rohingya adolescent girl FGD, participants noted that they would prefer that individual sessions occur outside of the home because they weren't free to speak about certain issues within their home and it was less confidential. Certain activities were more appropriate for group sessions, such as enhancing social outcomes, skills training, livelihood activities, providing information about referrals, etc.

> "Girls have more problems because they can't get out of the house, they can't talk, and they have a lot of trouble." – Adolescent male refugee FGD

Most FGDs also described age considerations related to IOM's programming. Elderly men did not identify components of IOM's MHPSS program that were specific to them. They recommended

providing a separate space for elderly people to gather and share their thoughts. However, elderly refugee women reported that IOM included group sessions for elderly women to spend quality time with their grandchildren and tell stories to one another. During these groups, they sang traditional music (Hola and Tarana) and engaged in cultural traditions. They reported that these elements brought them happiness and peace.

There were certain topics and conditions that participants noted weren't covered in IOM's program, but were relevant to the community needs. These included women's mental health issues (e.g., support after divorce, parenting, self-care), psychosexual dysfunction, and substance use problems. Many of these problems were referred to as 'hidden problems' as they were more stigmatized issues in the community. They suggested providing a list of MHPSS services so people were aware of the specific programs that were available. Another stigmatized problem that IOM aimed to address was suicide. While addressing suicide is relevant to the community needs, one case example provided by a key informant highlights the importance of ensuring that the implementation of services provided by any organization is appropriate to the context to avoid doing harm.

> "A girl came for service in the camp office after a suicide attempt. Later a few staff members of the organization visited her home to provide support and her neighbors learned about the incident. Because everyone knows about her action, she again attempted suicide out of shame." – MHPSS Officer KII
>
> **Note: The case example above did not explicitly identify IOM as the organization and has not been verified.*

<u>1.2 How appropriate was the project to other key stakeholders?</u>

Most government and humanitarian stakeholders recognized the appropriateness of IOM's MHPSS program for Rohingya refugees and the emphasis they placed on cultural competency. There were some exceptions. One staff member who worked in RCMC described the impact that the lack of stakeholder recognition had on the implementation of their activities:

> "CIC [Camp in charge] and RRRC [Refugee Relief and Repatriation Commissioner] didn't see the MHPSS program as a mental health program and specifically, CIC thinks 'mental health is not health, and the Rohingya Cultural memory Centre is not connected with mental health' so it is a big barrier" – RCMC Staff Member KII

Despite the lack of support for some of the community-based psychosocial components of the program, government stakeholders perceived a gap in mental health promotion efforts:

> "I think there is a gap in mental health promotion. I see minimal effort in this regard. This is the weakness of this program. IOM should design the program in such a way that promotes mental health and boosts up wellbeing." – Government stakeholder KII

This may suggest misaligned perceptions of MHPSS promotion activities and a different interpretation of humanitarian principles between humanitarian and national stakeholders. Government stakeholders also reported the lack of emphasis on repatriation and relocation processes (e.g., the relocation of refugees to Bhasan Char) as a gap in IOM's MHPSS program.

1.3 Is the project sensitive and responsive to the given context?

1.3.1 Ongoing participation of community members to increase sensitivity and responsiveness

IOM employed a participatory approach to the development and implementation of their program. This approach was intended to increase ownership, participation, and ensure the appropriateness of their programming. Refugee community members, including community leaders and elders, reported that their opinions and suggestions were sought prior to program implementation. This participatory approach resulted in community-based programs that were largely consistent with cultural values and traditions. For example, the RCMC was designed to enable participation of women by ensuring activities that respected the Rohingya culture and traditions.

> "At IOM, Rohingya women can work indoors wearing hijab and burka. It is not improper."
> – female RCMC cultural agent (International Organization for Migration, 2021f)

Participants frequently referred to 'feeling heard and supported' (Elderly female, refugee community FGD), which made them feel good and participate in the program. Most community members felt that they could share their opinion about the program with IOM staff. One focus group with elderly females from the host community reported being afraid to provide too much feedback for fear that they would lose the services provided by IOM, but this was an exception to the common theme of feeling able to share feedback. Participants in most FGDs reported that IOM was responsive to their suggestions by making efforts to adapt their programs.

1.3.2 Sensitivity of IOM MHPSS staff: Promoting trust, respect, and dignity

Several of the FGDs identified specific IOM volunteers who were central to building community trust in the program and facilitating engagement and continued participation. At first there was some mistrust between the community and humanitarian actors, but that appeared to change with respect to IOM over time. The MHPSS program staff and volunteers were described as respectful, treating the community with dignity, and believing their stories. Community and religious leaders also felt that their roles in the community were respected by IOM volunteers. Male FGD participants felt comfortable expressing their feelings and opinions with them and felt confident that this information would be kept confidential. Adolescent refugee girls also

reported that IOM MHPSS staff and volunteers protected their autonomy by always asking them if they were interested in participating prior to starting a session and inquiring about their preferences in relation to the session topic and format.

> "We could ventilate our emotions to IOM staff, they were not bothered about our issues, they heard us attentively, and we felt very happy to share with them" – Adolescent male host community FGD

A similar response was shared by an adolescent Rohingya boy:

> "IOM staff connected with us, we can ventilate our emotions with confidentiality, they receive us gently, and it also motivates us to express ourselves." – Adolescent male refugee FGD

Adolescent girls also explained that they hadn't had a place to express their feelings, particularly related to their current home environment. IOM's group sessions provided a safe space for them to share these feelings:

> "We have a very small room where all of our families live together. This often makes us sad and we cannot say this to anyone. When our parents scold us we feel angry and bad. Only when an MHPSS volunteer comes to our home to provide a group session can we share our sorrows with her and that makes us so happy." – Adolescent female refugee FGD

One medical provider from the host community noted the high levels of stigma related to mental health and how the community typically doesn't share their thoughts or emotions. However, he noticed that people felt comfortable sharing with the MHPSS team, which was an indication of the appropriate implementation of the program and the impacts it had on reducing stigma.

1.3.3 Contextual factors affecting program engagement and implementation

Several FGD participants and KIIs mentioned aspects of the refugee camp context that made program implementation and engagement difficult. One IOM staff member acknowledged that it is difficult for community members to prioritize or engage with psychosocial activities when their basic needs are not met. Community members suggested further integration of MHPSS services with other programming, such as skills and livelihood programs, basic needs services, etc. to make the program more relevant for the context. Refugee adolescents who had not been to school due to COVID-19 school closures requested that educational activities be integrated with MHPSS.

> "Some [Rohingya] did not get a chance to bring their clothes. Even some left their children in Myanmar. We cannot heal them by providing medicines to them. There is no chance to do it. In this case, MHPSS services are needed." – Clinical doctor KII

> "Mental health is not a single issue. There are several issues. For example, gender-based violence, protection, and health issues are connected with mental health issues. Here, livelihoods can play a prominent role. Therefore we need to provide an integrative support for the patients." – IOM Staff Member KII

During COVID-19, IOM made adaptations to their programming to adhere to infection prevention and control guidelines. They adapted their implementation of community campaigns and other focused programs to ensure continuity of services was maintained in the communities while also reducing risk of community transmission. They rented vehicles and bicycles along with microphones to spread community messaging and reduced the size of their group activities. Some activities, such as those delivered through the RCMC, were not permitted to operate during the COVID-19 lockdown period. There were other dynamic contextual challenges that affected implementation of the program including a fire in the camp, flooding and other emergencies, and violence. These events affected both program implementation as well as community members' safety and their willingness to participate in programs.

<u>1.4 How has the project strengthened the national system in the provision of MHPSS services through increased coordination and knowledge management?</u>

IOM coordinated care for individuals requiring specialized services in partnership with the Bangladesh national health system. Several participants described the coordination and referrals between organizations as a strength of the program.

> "Imagine that I am a complete human being. I do not have any illness. If I get sick, I mean psychologically, if village people treat me as mad, then IOM provides the treatment. IOM has an office in the hospital, they work in the field and the office. They have a counselor sister who provides counseling to the patients. If that patient's condition does not improve, then they refer the patient to Teknaf health complex. IOM gives the transportation for the patient. And the treatment cost and transportation cost are completely free." – Adult male host community FGD

IOM also built capacity of providers within the national system. They collaborated in the mhGAP training of primary care providers in the management of mental health conditions who were working in refugee and host community clinics. In KIIs, physicians described how this training enhanced their ability to identify and refer individuals with psychological problems to IOM's MHPSS program. Several key informants noted the importance of the national system adopting IOM's program in order for it to be sustainable. One key gap remaining in the national health system that could compromise the adoption of this comprehensive program was the presence of providers who were trained to provide specialized mental healthcare, which IOM was currently

providing. Key informants also noted the lack of a knowledge management and dissemination platform, which they indicated is a missed opportunity that could be leveraged by the national health system.

Evaluation Outcome 2: Coherence

Coherence is defined as the compatibility with policies and other interventions within or across sectors and institutions

2.1 How well does the project fit into existing national strategies and interventions of other stakeholders in the country and in the MHPSS sector?

2.1.1 Alignment of IOM's MHPSS program with national mental health policy and systems

IOM is working alongside the government to align the National Mental Health Policy with the MHPSS system in Cox's Bazar. The National Mental Health Policy includes guidance for service delivery within national health systems during emergencies, such as disasters and the arrival of refugees. Government stakeholders perceived IOM's program to complement the government efforts and align with existing policies for emergency response. A host community leader remarked that IOM's program also contributes to government efforts to ensure better health for all people in the country. However, they noted that the primary gap in the program is that this service doesn't exist in every ward within Cox's Bazar, which creates issues of accessibility for people who live in wards (i.e., host community members) that lack IOM's program. One MHPSS officer also perceived a misalignment between IOM's specialized mental health services and the National Mental Health Policy with regard to the use of certain psychotropic medications that they believed were not included in Bangladesh's 'green list' for approved medications. Through consultation with IOM staff, it seems this may have been a misunderstanding as these additional psychotropic medications have been approved (i.e., are on Bangladesh's 'green list'), but are beyond the essential drug list. Regardless, it is important to note that this perception of misalignment did exist and should be clarified to avoid concerns about incompliance with Bangladesh's national policies.

2.1.2 Gaps and overlap in MHPSS in national and humanitarian systems

Representatives from the refugee and host community reported that IOM's MHPSS program filled a gap in services within the national and humanitarian system. Several key informants identified other MHPSS programs that were operating, primarily in the camp where there were approximately 40-50 organizations providing MHPSS, yet they often described the ways in which IOM's program was unique. There were fewer MHPSS programs similar to IOM's program available in the host community. One FGD participant from a host community that only has one other organization implementing MHPSS according to the most recent 4Ws assessment - UNICEF program of children and adolescents (International Organization for Migration, 2021a) - described that:

> "Other organizations give us things. These organizations do not ask us about our headache and sorrow. Only IOM does that. Mental support is the best support there is. If there is no peace of mind everything feels terrible. That is why I come to these group sessions." – Adult female host community FGD

IOM's program was described as more comprehensive and accessible than the other MHPSS services offered in Cox's Bazar. The fact that IOM's MHPSS team included specialized mental health care providers who were able to provide medication and that there was an established referral system differentiated them from other organizations providing MHPSS in the camps. Most other organizations with an MHPSS program provided basic counseling and would refer moderate or severe cases of mental health problems to IOM. Filling this gap in specialized mental health services was a gap identified in early assessments conducted by IOM when designing their MHPSS program.

> "It is different because the services provided work in a comprehensive and multi-layered way…As there is basically no counseling at health facilities including MHPSS and of course specialized services. There are huge gaps in Cox's Bazar and Ukhiya, and no psychiatrist in Ukhiya or Teknaf from the Government site. IOM ensure support with a psychiatrist, with medicine, and with a referral system." – IOM Staff Member KII

> "When we go to provide services in a new area now, if there's any other MHPSS actor, we try to include and coordinate with the existing organization. For example, in the beginning we learnt from all the actors that there is a gap for the psychiatric service." – IOM Staff Member

In one FGD with adolescent girls from the host community, participants reported that people in their community are seeking MHPSS services from IOM for issues that they previously would address through traditional faith healers. Adult male refugees, however, reported that some community members continued to seek care from traditional healers instead of attending IOM sessions. This topic didn't arise in other FGDs, but it is unclear the extent to which IOM coordinated with traditional healers and the positive or negative impacts that this might have on participant and community outcomes as well as sustainability.

> "Previously people used to take the person to a faith healer. Now they come here." – Adolescent female host community FGD

> "I came to know about [IOM's MHPSS program] when there was a session going on in our yard. A lot of people now come and talk. Also, the pregnant women. A lot of good things happened after IOM came here. People used to go see faith healers and they stopped that. We inform others about the services. We inform others after we feel better." – Adolescent female host community FGD

2.2 How well does the project fit with international guidelines for MHPSS in humanitarian settings?

Government stakeholders, humanitarian actors, and healthcare providers expressed that IOM maintained international standards for MHPSS and humanitarian response, including maintaining confidentiality, providing services to the refugee and host community regardless of age and

gender, and not requesting money for services. Several key informants and focus groups also described that IOM provided services across all four layers of the Inter-Agency Standing Committee MHPSS pyramid, which no other organization has achieved. One IOM staff member noted that this alignment is deliberate and a priority for IOM in order to uphold the 'do no harm' principle:

> "IOM is very vigilant not to create any harmful practices. The service is very aligned and provides regular capacity building training to the team and also provides training on both IASC guidelines and on various codes of conduct. So I can say the program is very aligned with existing policies." – IOM Staff Member KII

To some key informants, the national and international MHPSS guidelines were incompatible. Specifically, an MHPSS officer suggested that implementing both national guidelines and Rohingya response guidelines can produce problems given the different community dynamics. This individual suggested the need for a functional plan that is representative of the context.

> "For example, in a camp if we cannot ensure women's safety from her husband by giving her a new shelter or making her independent, she is not protected, so the protection work here is more paper based." – MHPSS Officer KII

<u>2.3 Do synergies and interlinkages with other IOM projects exist? Do these projects complement each other?</u>

IOM made efforts to collaborate with sectors and IOM services outside of MHPSS to improve the coherence of the program. For example, the RCMC conducted weekly workshops in partnership with IOM's protection and gender-based violence programs and conducted women's embroidery groups (International Organization for Migration, 2019b). IOM's MHPSS program worked collaboratively with the family planning and sexual and reproductive health (SRH) services. One IOM staff member reported that MHPSS staff worked with SRH staff to address the psychological health issues associated with child marriage. They also educated the communities along with the SRH team about the negative impacts of child marriage and the dowry system. This IOM staff member noted that there seemed to be a decline in public dowries, but thought that it is possible that these practices continued privately.

Elderly male Rohingya refugees who participated in FGDs noted that IOM did more than provide MHPSS, but they also strengthened local infrastructure and provided support in other aspects of refugees' lives. Specifically, IOM was involved in repairing and building houses and roads, providing protection services, supporting basic needs, and treating physical health conditions in addition to providing MHPSS.

> "We always come to IOM. Here we get treatment for physical diseases and psychological problems. I will say, it is a double service." – Elderly male, refugee community FGD

IOM volunteers were also credited for improving access to information about MHPSS and non-MHPSS services in the communities.

> "One of the major impacts is getting all the information. Everyone in the camp knows where they can get everything when in need. IOM's volunteers help all by giving information such as where we can get housing materials and where we can get medicine." – RCMC Member KII

Evaluation Outcome 3: Coverage

Coverage is defined as the reach of the program to the intended target populations and objectives.

3.1 Were the planned objectives in the project document achieved?

IOM achieved most of the objectives and outcomes specified in the results matrix. The remaining outcomes that have not yet been accomplished require coordination with the Government of Bangladesh (GoB), including developing a strategy and implementation plan to implement the National Strategy in Cox's Bazar and fill key gaps in MHPSS identified in the readiness assessment. Below is a summary of their progress on the stated objective, outcome, and output indicators as of the latest interim report dated June 30, 2021 (International Organization for Migration, 2021b):

3.1.1 OBJECTIVE: Scale-up MHPSS programming to increase outreach in addition to improving service provision toward achieving a more holistic, comprehensive, and inclusive mental health and psychosocial response

- Achieved: 100% of targeted communities in Ukhiya and Teknaf camps and surrounding communities were reached (n=97,424 people reached; 58% female, 42% male; in latest reporting period: 21% host, 79% Rohingya)

IOM achieved its objective of scaling up MHPSS programming in host and refugee communities. UN employees and IOM staff remarked that IOM's approach was very inclusive and expansive.

> "I think those whom we offer, so, people from Rohingya and host communities, people of all ages, people of all different groups, social groups. So we provide nondiscriminatory services not prioritizing some groups over others unless that's based on vulnerability, of course." – IOM staff member KII

> "The program was initiated for the Rohingya community, everybody of the community, male and female, elder and young, to ensure the continuity of Rohingya cultures and practices. The beneficiaries of our cultural education by engaging them in the Rohingya context by the Rohingya Cultural Memory Centre Museum experiencing all healing restoration of their dignity." – RCMC Staff Member KII

> "There are 12 primary health centers and health posts. Every one of them has a mental health service and all of them are managed by IOM. IOM's service is also provided through volunteers, psychosocial workers, and community outreach volunteers and more. IOM is the second largest MHPSS service provider in camps and IOM also implements their service directly." – MHPSS Officer KII

When asking about coverage by gender and community (refugee vs. host), FGD and KII participants generally agreed that more services were provided to the refugee relative to the host population. However, when asked about whether males or females utilized services more frequently, men often reported that males were more likely to utilize MHPSS services, while females would report that women were more likely to utilize services. It is also important to note that the types of services that were sought often varied by gender with males seeking services to address 'wrong deeds, such as substance abuse.' Women were more likely to seek services that were provided by female MHPSS staff.

> "I have seen women coming more to access the service. However, interestingly when it came to receiving medications, men seemed to be coming more than women." – Government representative KII

3.1.2 OUTCOME 1: Strengthen the national system in the provision of MHPSS services through increased coordination and knowledge management

- Ongoing: IOM is coordinating with the GoB/MoHFW on the way to implement National Strategy to the context of Cox's Bazar.
- **Output 1.1:** An implementation plan to address MHPSS gaps identified by the readiness assessment jointly developed with GoB
    - Achieved: Assessment of needs and resources has been completed (International Organization for Migration, 2021a, 2021c)
    - Ongoing: A joint implementation plan to address gaps identified by the assessment is being discussed with GoB

IOM staff members reported coordination with the government at multiple levels. IOM also contributed to the development of the National Mental Health Strategic Plan/Policy. FGD participants reported reliable referrals between IOM and health facilities operated by the national health system. One participant described the story of his sister who benefited from these linkages between IOM and the national health system:

> "My sister was sick. We could not sleep in the night. Even surrounding people could not sleep in the night. My sister shouted all day and night instead of sleeping. We used to tie her with an iron chain. My sister had been suffering from that mental problem for more than two years. We spent a lot, even we sold land for her treatment. We visited the hospitals and spent a lot. But it did not work. We have completed treatment services from IOM free of cost [including referrals to Teknaf health complex]. Now my sister is well." – Adult male, host community FGD

3.1.3 OUTCOME 2: Improve MHPSS coverage by adding and expanding outreach services and elements beyond the Rohingya and to the host community, as well as addressing the need to strengthen capacity to adequately detect and respond to mental health challenges

- Achieved: 28,987 individuals reached through mobile MHPSS services (145% of target; 66% female, 34% male; 16% host community, 84% refugee community). Access to MHPSS services increased

during the last year especially with telecounseling, the hotline, and increased outreach by new mobile teams and community volunteers.

- **Output 2.1:** MHPSS service delivery offered to beneficiaries at refugee health facilities and points specifically chosen to improve host community access
    - Achieved: 9 outreach teams are delivering services (129% of target)
    - Achieved: 240 community health workers trained and supervised in the promotion of mental healthcare and provision of community-based services (120% of target; 75% female, 25% male)
- **Output 2.2:** Strengthened capacity to identify, refer, treat, and follow up on severe mental disorders
    - Achieved: 109 health professionals trained to improve the mental health response system (436% of target; 59% female, 41% male)
    - Achieved: 13,583 MHPSS consultations/referrals provided in the health facilities (272% of target; 63% female, 37% male)

Participants consistently reported that IOM's program increased access to MHPSS in both the refugee and host community and that they were satisfied with these services. Many participants noted some other organizations that provided MHPSS, but they were not considered as comprehensive or as accessible as IOM's program. While IOM did reach members of the host community as part of this program, including through mobile MHPSS services, many host community members did not feel that access to MHPSS services was equitable between the refugee and host community. These perceptions were not necessarily specific to IOM, but were a dissatisfaction with many services related to the humanitarian response. IOM staff members also acknowledged that services were not always equally available to the refugee and host population. One IOM staff member suggested that the history of inequitable service delivery between the host and refugee community has created tensions that are difficult to alleviate even if services are provided to both communities equally. This tension was the primary source of dissatisfaction in relation to the program among host community members, particularly adults and the elderly.

> "It's very good that the refugee community is getting help from IOM, but they receive a lot more services than the host community." – Adult female host community FGD

> "They are being offered more services than us. They are staying in our areas and receiving more. People in the community are not taking it as a good step. We do not have any objection providing services to them, but we are talking about the balance. This should not happen. It is creating dissatisfaction. Besides, they occupied our lands, led deforestation activities, and we cannot fish in the rivers due to their arrival now." – Male host community leader KII

> "Unfortunately that is the situation for the last four years where this kind of imbalance of services creates tension. However sometimes this tension is more perceived than the reality in some cases. But this is really perceived by the host communities that the

> Rohingyas have access to everything and we have access to nothing." – IOM Staff Member KII

IOM increased capacity of MHPSS providers operating in the national and humanitarian systems. Physicians reported having been trained by IOM in basic identification and management of mental health problems, which improved their ability to detect these issues and appropriately refer them to IOM's MHPSS service. Community members were trained to provide psychosocial support, community outreach services, among other activities.

3.1.4 OUTCOME 3: Strengthen the community-based development approach of the MHPSS response

- Achieved: 67,437 community members (Rohingya and host) covered by the MHPSS response (225% of target; 55% female, 45% male)
- **Output 3.1:** Promote a sense of belonging in the Rohingya refugee community to restore social connections and wellbeing
    - Achieved: 1,439 community-based activities and events conducted (480% of target). Adaptation to COVID-19 regulations reduced the size of gatherings. IOM implemented a larger number of smaller community-based group events, which resulted in surpassing the original number of events conducted.

Achieving this outcome was supported by findings from FGDs with adolescent, adult, and elderly community members who participated in the program. For example, one elderly male refugee community member referenced the community/collective kitchen program that brought 20 families together to contribute cooking items, recipes, and cook together. This participant described how the community kitchen strengthened community bonds. Generally, these community-based group sessions promoted social cohesion and connections in the community.

> "We, community people, live together. We used to make chaos and conflicts. Then, IOM's volunteers conducted many sessions with us. They taught us to stay together. Men and women understood their messages. After that, the frequency of chaos and conflicts has been decreased." – Elderly male, refugee community FGD

Qualitative assessments conducted among Rohingya who participated in the RCMC revealed that the rituals and healing ceremonies helped to promote psychosocial wellbeing, security, sense of belonging, and social connections by strengthening community members' sense of identity (International Organization for Migration, 2019b; Rebolledo, 2019).

In FGDs with adolescents, participants noted that group activities brought youth together and fostered a sense of connection and social support among their peers, including between youth from the refugee and host community:

> "We were scattered before IOM. Now we can play together, share our views with others. If anyone has a problem, we can help them." – Adolescent male host community FGD

> "People used to say, this is not your country. Go back to your own. Sisters [IOM volunteers] advised us not to use these sentences and mingle with them. Now there is increased harmony." – Adolescent female host community FGD

Rohingya adult and elderly FGD participants also reported that the relationship between the refugee and host communities was good. However, in FGDs with host community adults, they often felt that tension between the host and refugee community was still a challenge.

> "They come to our places. They take care of us. But at the outset they were terrified and took time to mingle. Now we have a good bond. We gossip, visit to them. – Adult female refugee FGD

<u>3.2 What were the results achieved beyond the initially proposed results matrix?</u>

There were several impacts and outcomes of IOM's MHPSS program that extended beyond the original results matrix. These included: 1) increased knowledge and awareness about mental health and psychosocial wellbeing; and 2) improved mental health and psychosocial wellbeing. Participants also described improved community connectedness and social outcomes, which are described in Section 3.1, Outcome 3.

3.2.1 Increased awareness about mental health and psychosocial wellbeing

FGD participants often reported that the program increased their knowledge, understanding, and awareness about mental health and psychosocial issues. It also equipped them with information that they were able to share with others in their community.

> "We were unaware about our mind, how it works? How do we keep our mind fresh? Now we know about the mind, we can keep our mind cheerful by playing." – Adolescent male host community FGD

> "We learned from volunteers of IOM about mental health and share knowledge in our community. Now our community knows what mental health is." – Male adolescent refugee FGD

> "Here, the rate of education is very poor. I mean, most of the villagers are not well-educated. Before IOM's MHPSS service they considered mental problems to mean that people are mad. Mad means people who speak inappropriately and cannot keep their clothes on. Community people treat mental cases like this. Now, awareness among people starts to increase because of different sessions and trainings conducted by IOM." – Host community physician KII

> "At the Rohingya community, the impacts of IOM's mental health service are very noticeable. Almost every family knows about mental health facilities in the camps and IOM played a very big role in it." – MHPSS Officer KII

3.2.2 Improved mental health and psychosocial wellbeing

Community members who participated in IOM's MHPSS program reported positive experiences and impacts on mental health and psychosocial wellbeing. According to the IOM fact sheet, 98% of participants engaging in general MHPSS services reported the support as being helpful for their wellbeing (International Organization for Migration, 2020a). This was supported by FGDs with refugee and host community members of all ages who generally reported being satisfied with their experience with IOM's MHPSS program. Specific psychosocial impacts included a range of outcomes including perceived reductions in suicide attempts, aggressive behavior toward children, child behavioral issues, family conflict, tension, loneliness, stress, and anxiety. Participants also felt that the program improved coping and communication skills, peace of mind, empowerment, and made them feel more relaxed. Elderly male refugees reported that they learned about the negative impacts of gender-based violence. When describing the psychosocial impacts, many participants referenced problems of the mind, which is consistent with existing literature on idioms of distress and explanatory models of mental health problems among the Rohingya (see Desk Review).

> "Our mind is like a balloon. Tension works as air that inflates the balloon. We have different kinds of tension. Day by day these tensions increase, thus it inflates the balloon. One day the balloon explodes. Our mind condition was like this balloon. We could not share anything; nobody listened to our feelings. Now IOM MHPSS staff listen to our feelings. Inflation of our mind has reduced by sharing our unexpressed feelings with IOM staff." – Elder male, refugee community FGD

> "There is a huge difference in mental health status of Rohingya people between their current and earlier situation. Earlier situation, I mean the situation during the influx, they were extremely restless. They came here because of the brutal torture by the Army of Myanmar. They were afraid. They thought that the same condition would be here in Bangladesh. They lived their life with continuous fear. Now they talk with us with a smiling face. I think their restlessness has decreased and acceptance has increased." – Physician in a refugee camp clinic KII

> "Whenever I get angry with my husband now, I remember what I have learned from the meetings. Nowadays I do not outburst as much as I used to and we don't quarrel as much." – Adult female host community FGD

> "I used to beat my children whenever they made a mistake and now I try to talk to them. I was tense about my children and husband's behavior, about how I will manage food for my family and education for my children. I used to feel dizzy due to tension, but by

participating in the meetings [group sessions] I have learned a lot and I feel much better now." – Adult female host community FGD

<u>3.3 What lessons have been learnt so far which can be applied to similar interventions in other IOM and other MHPSS programs, what were the challenges and solutions taken?</u>

3.3.1 Factors that promoted engagement and participation in IOM's MHPSS program

Many participants reported that the community outreach and awareness campaigns were the reason they became aware and participated in IOM's MHPSS programming. Community members credited these community outreach and awareness activities for reducing stigma and increasing help-seeking. The degree of awareness seemed to be higher among Rohingya relative to the host community. FGD participants also reported that word-of-mouth recommendations from their neighbors who had previously received MHPSS from IOM often facilitated their trust and engagement in the program as well as enhancing the reputation of IOM. Seeing individuals who improved or recovered from mental health problems after participating in IOM's MHPSS program also improved individual's receptivity to the program. Continued engagement in the program was enhanced by IOM's staff, who were described as attentive and created a positive experience for participants. Another facilitator of engagement in MHPSS services was that the services were provided at no-cost and transportation was often covered for participants.

> "Mental health is like other conditions, like getting malaria, fever, or other ailments that you have. So you need to, first of all, identify that mental health is not an extraordinary issue. It is like any other condition. So you need people to know that it is a condition that can be supported, and they recovered from it. And these services are available and accessible for them." – IOM Staff Member KII

3.3.2 Barriers to engagement and participation in IOM's MHPSS program

When asked about barriers, participants reported varied experiences. Adolescent boys did not identify any barriers to participation and didn't perceive that other groups (adolescent girls, elderly people) experienced barriers either. This was in contrast to some of the experiences of adolescent girls, adult women, and the elderly, who reported experiencing barriers to participation. Barriers included having a job/work that made it difficult to attend activities, socio-cultural and religious barriers, and restrictions imposed by the family, particularly for women and girls. There were also specific activities, such as listening to music, that were less utilized by the refugee community due to religious restrictions.

> "Allah did not want them to be here, that's why they could not come. Sometimes people get relocated or they move from one camp to another. Others cannot manage time after doing household activities and receiving ration. Some are busy with their personal work. That's why they cannot come here and talk. Those who manage come and gather together." – Elderly female refugee FGD

There were also issues related to the accessibility of the program, particularly for host community members, people with disabilities, pregnant women, and the elderly. The facilities were often located further away for the host community and they reported sometimes being stopped by the policy when going to facilities located within the camps. IOM staff noted this barrier and suggested that IOM increase their activities in more remote areas that had less access to the program. Both the refugee and host community reported that services often had long wait times. Participants in the elderly refugee FGD reported that if anyone had difficulty accessing IOM's MHPSS services, the community would help them or they were able to call a phone number provided by IOM and a volunteer would help them access services. A consistent recommendation was to increase the number of MHPSS staff and volunteers. IOM staff also reported some of the logistical and operational barriers to delivering services (particularly specialized mental health services), such as the cost of procuring medical equipment and drugs, managing licensing issues for providers, among others.

> "The program is very useful, but the space is very narrow. We have to sit and wait there for a long time in a queue until our turns come. But that does not bother us because we get to talk about our mind's problem after the wait. We can bear this." – Adult female refugee FGD

> "One volunteer went to the block and a mother of two children died and they asked to come to IOM with the volunteer, but when they came to IOM the volunteer was not able to receive them because they are too busy to serve elsewhere. By increasing the number of volunteers, this kind of problem can be solved, and participants also come." – Adult male refugee FGD

Often the barriers experienced by participants were gendered. For example, there was a high level of stigma related to mental health particularly among men who perceived that having a mental disorder made them weak and vulnerable and reduced their likelihood of seeking support. Adult women from the host and refugee community reported that their household chores, parenting obligations, attending to other relatives, fear of leaving the home unattended due to potential theft, and gender norms (e.g., husband not allowing his wife to attend) precluded their participation in certain activities. Women with children who sought facility-based MHPSS services, specifically counseling, often found it difficult to participate due to childcare and disruptions. These participants suggested that IOM arrange a safe space for children to play while the mother is attending an MHPSS session. Adolescent girls reported being harassed on their way to attend IOM's MHPSS programs, including by one of the IOM security guards. However, this was not reported and/or noticed by adolescent boys:

> "Sometimes boys disturb the young girl participants on the way when they try to come for the meeting. That's why parents don't want us to go to group meetings. Neighbors also make insulting comments about why we are coming to the session. But they don't understand the importance of group sessions." – Female adolescent refugee FGD

> "We saw adolescent girls get services and there was no hustle to receive MHPSS services. They came to IOM easily" – Male adolescent refugee FGD

To reduce parents' resistance to girls attending group sessions, participants recommended that IOM implement family group sessions, including with elderly family members, so they will all appreciate the value of the program and understand what girls are doing during the sessions. Girls felt that these types of informative family group sessions would prevent family members from restricting girls' participation in IOM's MHPSS activities.

There were also important age considerations that related to participation. As described above, adolescents often faced family and social restrictions that prevented them from attending sessions, which was partly due to their age and gender. Elderly people also had trouble accessing MHPSS services. Elderly FGD participants reported that if they needed support specific to elderly people they would visit other NGOs.

> "IOM's program reflects Rohingya cultural beliefs, but to some extent they may contextualize their program according to age and gender more appropriately." – Child Protection NGO Staff Member KII

Evaluation Outcome 4: Coordination

Coordination is defined as the operational linkages among services and stakeholders in relation to the program

4.1 How has the MHPSS response for refugees and affected host communities in Cox's Bazar been coordinated?

The MHPSS working group in Cox's Bazar is the primary coordinating entity for activities relating to MHPSS in the camp. The working group includes governmental and non-governmental representatives. Some key informants noted that there are coordination challenges. Namely, approvals from camp and government authorities often created delays in implementing programs and coordinating referrals among implementing organizations.

> "CIC, RRRC office on Cox's Bazar, they think MHPSS is not a basic need. Sometimes they don't approve the access of every volunteer. Sometimes they feel hesitant to approve activities." – RCMC Staff Member KII

The working group has articulated referral systems in camps and host community districts. One IOM staff member described that each camp was assigned one MHPSS focal person who managed referrals and coordination with other organizations within that camp. IOM volunteers were also equipped with information about the available MHPSS and non-MHPSS services in the communities that they may use to make referrals for community members. The MHPSS working group developed a referral slip for medical consultations that all sectors and organizations use to track and accept referrals. However, certain barriers exist that can compromise the functionality of these referral systems including transportation, legal complications, among others.

In the host community, one community leader was unaware of any coordination efforts among organizations working in MHPSS.

4.2 What was the role of IOM's MHPSS program in the coordination mechanism in Cox's Bazar?

4.2.1 MHPSS Coordination

IOM co-leads the MHPSS working group in Cox's Bazar along with representatives from UNHCR. IOM has worked closely with UNHCR and has participated in visits to health facilities, conducting assessments and mappings, having conversations with psychologists and other MHPSS staff, among other coordination and leadership activities. One IOM staff member explained that IOM uses the MHPSS working group platform to invite stakeholders to MHPSS workshops and trainings. Government stakeholders attribute their inclusion in the MHPSS working group to IOM. They reported that there wasn't much coordination in MHPSS prior to IOM's arrival, but they succeeded in bringing government stakeholders, including the Refugee Relief and

Repatriation Commissioner (RRRC) into these initiatives. IOM staff and government stakeholders considered this coordination as essential to the success of the MHPSS system:

> "Liaising with the government without involving the RRRC cannot be useful. There is no way to ignore RRRC in this context." – Government stakeholder KII

In addition to coordinating service provision, the MHPSS working group conducted the 4Ws assessment, developed the Emergency Preparedness and Response Plan and the assessment and research subgroups, and contributed to initiatives of the Health Sector and the National MHPSS Task Force (International Organization for Migration, 2020b). IOM participated in mhGAP training for primary care providers that was implemented in coordination with the government.

4.2.2 Coordination of MHPSS and other non-MHPSS services

IOM also managed multi-sectoral coordination and referrals beyond MHPSS in effort to meet the needs of the community more holistically. Participants described extensive referral networks for other health and non-health concerns that were facilitated with IOM. One participant described her experience coming to IOM's MHPSS services with physical complications. While she was waiting in line for MHPSS services, a volunteer identified the severity of her physical health problems and referred her immediately to a medical doctor and a psychologist who coordinated her mental and physical health needs through IOM. Similarly, women who had experienced gender-based violence reportedly sought services through IOM, who helped connect them with SRH providers and other services. Another participant described that IOM advised her on where to get education for her child.

> "IOM refers us to where we can get appropriate services if it doesn't have it. That is helpful." – Adult female refugee FGD

IOM regularly attended the protection sector meetings as part of the strategic advisory group within the camp. However, one IOM staff member reported that coordination with protection had been a greater challenge than working with the health sector. IOM also engaged with stakeholders and partners in the host community. One participant, a madrasa teacher in the host community, shared that they were invited to participate in IOM meetings. This participant then provided space for MHPSS activities, particularly group sessions, to occur at the schoolyard. Another key informant, a Rohingya imam, described how he engaged with IOM and ultimately integrated what he had learned from these interactions into his religious activities:

> "After learning from IOM's program, I talked about mental health issues in 'Khutbah' in Jumah prayer on Friday as well as different discussions in the mosque with community people" – Rohingya Imam KII

Another area of opportunity is improving coordination among stakeholders involved in implementing IOM's MHPSS program. Many of the FGDs and KIIs described the "facility-based" (e.g., specialized and focused mental health services) and the "field-based" (e.g., community and

family supports, social considerations for basic needs services) as distinct programs. One staff member from the RCMC described her activities as non-clinical, but explained the RCMC program as disconnected from IOM's "facility-based" activities.

> "I am [role omitted for anonymity] of the Rohingya Cultural Memory Center. It's not a clinical project and I'm not from an MHPSS background. We have limited engagement with MHPSS field activities conducted by the MHPSS team, including the counselors, social workers, and community focal points." – RCMC Staff Member KII

Evaluation Outcome 5: Connectedness

Connectedness is defined as ensuring the activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account?

5.1 To what extent have activities implemented by the project contributed to resilience of affected communities and promote their self-sufficiency?

5.1.1 Resilience, self-sufficiency & sustainability

Key informants noted the incredible resilience displayed by the Rohingya community.

> "There is a huge difference in mental health status of Rohingya people between their current and earlier situation. Earlier situation, I mean the situation during the influx, they were extremely restless. They came here because of the brutal torture by the Army of Myanmar. They were afraid. They thought that the same condition would be here in Bangladesh. They lived their life with a continuous fear. Now they talk with us with a smiling face. I think their restlessness has decreased and acceptance has increased." – Physician in a refugee camp clinic KII

Factors related to implementation of IOM's MHPSS program were also described as promoting this resilience. Across FGDs, participants reported feeling respected and engaged with IOM's MHPSS program. The community was consulted about the implementation of the program. Participants noted that they were treated with dignity and autonomy by IOM MHPSS staff and volunteers. Adolescent refugee girls reported that IOM staff always asked whether they were interested in participating prior to beginning a session and gave them the flexibility to engage in their own cultural and religious practices, which promoted resilience and self-sufficiency.

Community members appreciated that IOM provided services that extended beyond MHPSS and improved other aspects of the community, namely infrastructure development (e.g., building and repairing houses and roads). A host community leader and an IOM staff member recommended that IOM's program must integrate with other services, such as livelihood and financial programs, in order to be sustainable. Many community members were concerned about program sustainability and reported feeling fearful about what would happen when the program ends. Government stakeholders described concerns about sustainability and emphasized the necessity of community ownership:

> "Instead of scaling up plans, IOM is working on ensuring tangible supports. The program will not continue for decades. The community should own the program. There should be an exit and scale up plan. In addition, there needs to be an action plan as well." – Government stakeholder KII

5.1.2 Host community perceptions of connectedness & sustainability

In FGDs with host communities, participants reported both positive and negative impacts of the Rohingya refugee response on the self-sufficiency and resilience of host communities. Most of the negative remarks were not specific to IOM's program, but rather reflected the impact of the broader humanitarian response. For example, host community members reported that there have been some advantages to infrastructure, such as improved roads, as well as new services.

> "Now we get mental health services, it is only possible after the Rohingya came" – Adolescent male host community FGD

There were mixed perspectives on how the Rohingya response impacted livelihood opportunities with some participants reporting that there were new and different jobs available, and others reporting that the Rohingya response had reduced livelihood opportunities.

> "We are having some trouble in living. Rohingya work for little money so our poor man [day laborer] don't earn much. Sometimes they don't get any work." – Adolescent male host community FGD

Participants also noted the negative impacts on environmental sustainability and the deforestation that occurred to develop the refugee camps and settlements.

> "Forests are being cut down. Nature is being destroyed, and our land is being used to make Rohingya houses." – Adolescent male host community FGD

> "They are being offered more services than us. They are staying in our areas and receiving more. People in the community are not taking it as a good step. We do not have any objection providing services to them, but we are talking about the balance. This should not happen. It is creating dissatisfaction. Besides, they occupied our lands, led deforestation activities, and we cannot fish in the rivers due to their arrival now." – Male host community leader

5.2 How has the project contributed to and supported the capacity of local resources?

5.2.1 Strengthening human resources for MHPSS

FGD participants and key informants repeatedly described the limited human resources, ranging from volunteers to specialized mental health providers, to be a major barrier to MHPSS service delivery and access. One physician working in a clinic in the camps reported that demands and expectations for IOM's program are growing, but IOM doesn't have enough resources to meet this demand.

IOM has implemented a series of trainings and developed tools to promote capacity-building. IOM collaborated on an mhGAP training for non-governmental organizations, implementers, and healthcare providers in the refugee and host community. These trainings were conducted in partnership with government stakeholders and experts from Dhaka University. Physicians who

participated in the training learned to identify and appropriately refer people with mental health and psychosocial problems to relevant services, such as IOM's program. IOM has employed a task-sharing model where they have also trained and supervised refugee and host community members to be psychosocial counselors and focal points. They have created a series of training materials including competency checklists that can be used to promote MHPSS volunteers from unskilled to semi-skilled and skilled facilitators (International Organization for Migration, 2021d, 2021e). IOM also trained Rohingya cultural agents to work at the RCMC in a variety of roles (International Organization for Migration, 2019b). One Rohingya woman who works as an artist for the RCMC described the skills she has gained through this experience:

> "We came to Bangladesh and became skilled [from the RCMC]. We know a lot now. We can use these skills when we return home." (International Organization for Migration, 2021f)

> "IOM is trying to train a lot of volunteers and key persons from the community to become lay counselors. So that when we are not available people can turn to them to seek support. Majhi, Imam, and traditional healers are big resources and support systems for the community. So the program lets them know about MHPSS and how to refer when a person needs MHPSS service. For example, there was an invitation for training to the untrained midwife in Leda camp. To improve IOM's service, more work in host communities is needed and including service to the school system, providing capacity building training to the community will sustain the service more." – IOM Staff Member KII

Other stakeholders described the importance of training and coordinating with stakeholders outside of the health sector. For example, a doctor working in the national health system supported the multisectoral coordination of MHPSS noting that:

> "Mental health is not only confined in the health sector. Mental health sessions are needed for authorities and responsible persons of schools, madrasas, and religious institutions. MHPSS team needs to gather them together and provide trainings on mental health topics." – Host community doctor KII

Several recommendations related to capacity building centered on the role of government stakeholders and systems. One physician working in the camps noted the importance of also including government service providers in the trainings:

> "It would be great if IOM organizes training to government service providers. Training on basic counseling will be very effective. If we counsel our patients at least for five minutes during our consultation, there will be a huge impact on the patient's life." – Refugee clinic physician KII

> "To sustain the service, the program has to be run by national staff who know and understand the context of Bangladesh because foreigners have difficulty understanding its culture and needs." – MHPSS Officer KII

5.2.2 Aligning training resources and infrastructure with government policies to promote sustainability

Government stakeholders suggested that IOM's capacity building efforts focus on existing policies and curricula developed through the government in order for the program to be sustainable. Key informants recognized the utility and quality of the IOM training modules/manuals, but were skeptical whether the government would adopt these modules/manuals. Some critiques of IOM's training were that it was lengthy (days to months) and should be kept to five days. They also suggested that the referral pathway be strengthened and this would require stronger coordination with the government. Key informants from IOM also mentioned the importance of longer-term funding mechanisms to support the sustainable development and implementation of comprehensive MHPSS programs in humanitarian settings.

IOM staff members noted the need to strengthen capacity and generate ownership of the program to promote its sustainability and scalability to other regions in Bangladesh:

> "Emergencies keep on coming . Those [lack of human resources, resources, etc.] are factors that affect our normal operations." – IOM Staff Member KII

> "I think IOM's MHPSS program is highly replicable. The MHPSS handbook is standardized with trusted and improved tools. The Rohingya Cultural Memory Center is a new dimension. Its program, structure, design, the methodology is replicable in another place. This ethnographic museum may be established in Cox's Bazar, Chattogram, Sylhet, also in Dhaka. It brings the dignity of the host community as well as Rohingya." – RCMC Staff Member KII

Conclusions

Based on the data obtained through this program evaluation, IOM accomplished the overall objectives of the multilayered, comprehensive MHPSS program in Cox's Bazar. Continued efforts are required to complete objectives related to outcome 1, 'Strengthen the national system in the provision of MHPSS services through increased coordination and knowledge management,' which requires ongoing coordination with the government to develop an MHPSS implementation plan. Generally, the program achieved a culturally appropriate, coherent, coordinated, and connected program with large-scale coverage. These conclusions therefore draw on the six cross-cutting themes of this program evaluation and aim to highlight program strengths and areas of opportunity.

1. *Do no harm*: The program was considered acceptable by most participants included in this evaluation. IOM maintained efforts to provide MHPSS services to both the refugee and host population. Yet, this remained the greatest source of tension and dissatisfaction reported by participants, particularly adult and elderly host community members. This dissatisfaction was not described as being specific to IOM's program, but rather the humanitarian response more broadly. Efforts to improve equitable access to care for host community members could alleviate these tensions and prevent future harm to the social dynamics among refugee and host communities in Cox's Bazar. Other recommendations for reducing the risk of harm include considering the impact of the program on modifying certain socio-cultural practices (e.g., changing help-seeking patterns and engagement with traditional healers, discouraging practices – such as dowries – that may ultimately continue privately and without social accountability/monitoring), protecting privacy and reducing stigma in the implementation of MHPSS interventions (e.g., ensure privacy in consultations with individuals with stigmatized conditions, such as a recent suicide attempt, to avoid public identification and shame), and incorporating child protection considerations (e.g., ensuring adolescent girls are safe when seeking MHPSS).

2. *Expected and unexpected innovations and impacts*: The impacts expected by IOM as defined by their results matrix were largely achieved. These included scaling up the MHPSS program, strengthening the national health system in the provision of MHPSS, expanding MHPSS coverage, and strengthening a community-based development approach to MHPSS (including social connectedness). Other impacts that were reported by participants included increased awareness and knowledge relating to MHPSS and improvements in mental health and psychosocial wellbeing. Additional achievements of the program included IOM's leadership in coordination that resulted in a functional referral system, generating community participation and ownership in MHPSS programs, successfully applying a multi-sectoral and integrated approach to addressing MHPSS along with other basic needs and services, and co-creating an MHPSS program that fit the needs of the community and nimbly adapted to cultural and contextual dynamics.

3. *Shared learning*: This program evaluation revealed critical insights that may be applied to other MHPSS and humanitarian response programs. First, this evaluation reinforced the

central and essential role of MHPSS staff in building trust, being respectful, and maintaining the dignity of refugee and host populations. Second, the participatory approach employed by IOM that prioritized an emic perspective in the design of programs facilitated the achievement of key evaluation outcomes, particularly appropriateness and coherence. Furthermore, hiring community members as staff for programs served as a bridge between the community and the MHPSS program.

4. *Gender*: Gender must be considered in the implementation of MHPSS programs. Gender impacted access, appropriateness, participation/utilization, and impacts of MHPSS programs. Many of the gender dimensions that impacted these aspects of implementation were closely related to culture. Community members who participated in FGDs provided strong recommendations for incorporating gender considerations into the implementation of MHPSS, which further reinforces the importance of applying a participatory approach and ensuring representation of all genders in the design of MHPSS programs.

5. *Children and adolescents*: Barriers and facilitators to participating in IOM's MHPSS program differed among adolescents, adults, and elderly community members. Often these differences also varied by gender within age groups. Program accessibility must consider the ability of certain ages to participate as well as the acceptability (e.g., whether it is acceptable for adolescent girls to participate in a group session outside of the home).

6. *Sustainability*: Sustainability was described in three dimensions: people, the program, and the environment. Sustaining improvements in mental health and psychosocial wellbeing, particularly interpersonal impacts of the program, requires alleviating sources of social tension between and within refugee and host communities and equipping communities with information and access to services to address the social determinants of their mental health (e.g., basic infrastructure and security). Regarding program sustainability, most stakeholders agreed that it was important to generate ownership and capacity in communities and among national staff/government stakeholders to ensure that MHPSS programming may be sustained. However, participants questioned whether government stakeholders would adopt IOM training and program resources. IOM also emphasized the importance of long-term funding mechanisms that enable scalable, sustainable programming. However, coordination challenges between governmental and humanitarian stakeholders as well as different priorities were noted that could compromise the sustainability of the program. Throughout implementation, IOM has trained a cadre of community volunteers and focal points; however, a plan for maintaining this infrastructure was not articulated in the interviews. Participants repeatedly mentioned the need to increase human resource capacity, including by training more national health providers and community members. Regarding environmental sustainability, refugee and host community members acknowledged the impact of the humanitarian response on deforestation and livelihood opportunities (e.g., fishing was no longer possible or limited). Environmental sustainability was directly

linked to the other dimensions of sustainability as it was a driver of social tension and disruption to program implementation. While not attributed to IOM's program specifically, addressing these environmental concerns and mitigating their consequences (e.g., through alternative livelihood opportunities) is necessary for the MHPSS program and its impacts to be sustained.

APPENDIX

1. Workplan, logistics & support
2. Evaluation Matrix
3. Focus group discussion and key informant interview guides
4. Terms of Reference
5. Documents received
6. References

1. Work Plan

Table 3 describes the original workplan for the evaluation, including the timeline and focal points. The evaluation methods were sequenced to ensure that the qualitative interviews were informed by the desk review documents that had been received by the time the fieldwork had commenced or by prior focus group discussions/in-depth interviews. In Table 3, we also describe the distribution of work and responsibilities across Dhaka University and Columbia University personnel. Due to some delays in executing the contract, we have experienced a delay of approximately two weeks from the work plan described below.

Table 3. Work plan

	October				November		
	3-9	10-16	17-23	24-30	31-6	7-13	14-19
Desk review							
Review IOM documents and external resources							
Focus group discussions (n=12)							
Focus group discussion guides							
Conduct focus group discussions							
Transcription, coding & analysis							
Key informant interviews (n=15+)							
Key informant interview guides							
Conduct key informant interviews							
Transcription, coding & analysis							
Reporting							
Inception report							
Draft final report and presentation							
Final reporting and presentation to IOM							

The deadlines for completing these activities have been described in the service agreements and are provided below (Table 4). Please note that these deadlines are contingent on executing the service agreements to enable funds to be released for data collection costs. Thus, the expected final report is expected to be submitted approximately two weeks after the deadline described below.

Table 4. Proposed deadlines

Reports	Tentative Deadline
1. Inception Report	October 12, 2021
2. Drafting Data Collection Tools prior to field activities	October 19 (focus groups); October 26 (key informant interview guides)
3. Presentation of initial findings	November 14, 2021
4. Draft Report	November 10, 2021
5. Final Report	November 19, 2021

6. Final Presentation	November 19, 2021

LOGISTICS AND SUPPORT

IOM agreed to provide internal documents to be included in the desk review. In addition, IOM provided a recommended list of individuals (from IOM and other stakeholders) who can be considered for key informant interviews. IOM representatives provided support for the field visit activities including arranging focus group discussions and key informant interviews, communicating with potential respondents, securing spaces to conduct focus group discussions, etc.

2. Evaluation Matrix

<table>
<tr><th>QUESTIONS OF INTEREST TO IOM</th><th>DESK REVIEW SOURCES</th><th>FOCUS GROUP DISCUSSION AND KEY INFORMANT INTERVIEW TOPICS</th></tr>
<tr><td colspan="3">APPROPRIATENESS: Tailoring of program to local needs, increasing ownership, accountability, and cost-effectiveness; relevance</td></tr>
<tr><td>How appropriate was the project to the target refugee and host communities regarding their needs?

How appropriate was the project to other key stakeholders?

Is the project sensitive and responsive to the given context?

How has the project strengthened the national system in the provision of MHPSS services through increased coordination and knowledge management?</td><td>Assessment Reports: Characterize the needs of refugees and host community members

Program Proposal: Review the original target outcomes described in the proposal and results matrix</td><td>Refugee and host community members, leaders and representatives:
• Expected and unexpected positive and negative impacts of the program and whether they align with target outcomes and why they were successful or unsuccessful
• Whether and how the program and its modalities were appropriate for or hindered the needs of participants, including special populations: women, children, elderly, people with disabilities, etc.
• Whether and how the program and its modalities reflected/supported Rohingya cultural beliefs, practices, identity, and community structure
• How much say/ownership participants feel they have in the program
• How comfortable participants feel expressing their needs to program staff

IOM program staff:
• Expected and unexpected positive and negative impacts of the program and whether they align with population needs
• Lessons learned about appropriate MHPSS services in this population and context
• Why certain elements of the program were successful
• How these lessons learned could be incorporated into MHPSS moving forward
• Expected and unexpected challenges or obstacles resulting from unforeseen events, why the challenges happened, how these challenges impacted the program, and strategies used to mitigate the challenges

Other stakeholders (government, UN agencies, NGOs, etc.):</td></tr>
</table>

<table>
<tr><td></td><td></td><td>• Relevance and alignment of the program with the context, needs and priorities of the refugees, surrounding community, and country
• How lessons learned could inform broader MHPSS programming or policy moving forward</td></tr>
<tr><td colspan="3">COHERENCE: Compatibility with policies and other interventions within or across sectors and institutions</td></tr>
<tr><td>How well does the project fit into existing national strategies and interventions of other stakeholders in the country and in the MHPSS sector?

How well does the project fit with international guidelines for MHPSS in humanitarian settings?

Do synergies and interlinkages with other IOM projects exist? Do these projects complement each other?</td><td>4Ws Assessment: Classify the types of interventions, agencies, and actors identified in the 2021 4Ws assessment. Examine which aspects of IOM’s MHPSS program filled existing gaps or overlapped with other programs. Identify potential incompatibilities across MHPSS programs.

Other secondary sources: Review national MH policy in Bangladesh, MH system and types of services and actors, etc. Refugee relevant refugee policies including those relating to refugee health, protection, etc</td><td>IOM program staff:
• How other IOM programs in Cox’s Bazar interacted with this MHPSS program (e.g., referrals, sharing resources, shared impacts)
• Challenges in implementation of the program that related to policy, structural barriers, or inter-institutional/inter-program factors and how the program adapted to address these challenges
• if and how coordination was aligned with those that focus on the environment

Other stakeholders (government, UN agencies, NGOs, etc.):
• How the program fits with Bangladeshi national policy and health/protection systems
• How the program fits with humanitarian policy and health/protection sectors in Cox’s Bazar
• How the program fits with international guidance for MHPSS
• Which aspects (if any) of the program fills gaps in MHPSS programming in Cox’s Bazar and if there is any overlap of aspects already well covered by other actors</td></tr>
<tr><td colspan="3">COVERAGE: Reach of the program to intended target populations</td></tr>
<tr><td>Were the planned objectives and outcomes in the project document achieved?

What were the results achieved beyond the initially proposed results matrix?

What lessons have been learnt so far which can be</td><td>Program Proposal and Progress Reports: Compare to examine whether objectives and outcomes were achieved (complemented by qualitative interviews). Progress reports will also be reviewed to identify any unexpected results and lessons learned that were identified in the interim reports.</td><td>Refugee and host community members, leaders and representatives:
• For program participants: which types of IOM services they utilized and why and if certain vulnerable groups were unable to reach certain services
• For other community members: which IOM services they are aware of and feel would be beneficial for them
• Expected and unexpected positive and negative outcomes of program and whether they align with target outcomes (from program proposal and progress reports)</td></tr>
</table>

<table>
<tr><td>applied in similar interventions in other IOM and other MHPSS programs, what were the challenges and solutions/actions taken?</td><td></td><td>Whether the program reached the populations most in need of services. Which groups had difficulty accessing the program? Which groups benefited more/less from the program?
If and how vulnerable or marginalized populations were taken into consideration: women, children, elderly, people with disabilities, etc.
Criteria/Indicators used to monitor benefits
IOM staff:
Expected and unexpected impacts of the program and whether they align with program outcomes
How program implementation and outcomes were documented; Processes for accountability
How highly vulnerable and marginalized populations were targeted
Lessons learned about implementation: challenges, strategies, opportunities, etc.
Other stakeholders (government, UN agencies, NGOs, etc.):
Perceived impact of the program and how it could be improved
Whether expectations of the program were met</td></tr>
<tr><td colspan="3">COORDINATION: Operational linkages among services and stakeholders in relation to the program</td></tr>
<tr><td>How has the MHPSS response for refugees and affected host communities in Cox’s Bazar been coordinated?

What was the role of IOM’s MHPSS program in the coordination mechanism in Cox’s Bazar?</td><td>4Ws Assessment and Progress Reports: Review existing documents for evidence of coordination, partnerships, and participation/representation of the program in the health and protection sector’s coordination activities

Secondary sources: Review documents and literature that describe how the health, protection, and other relevant sectors coordinate implementing</td><td>IOM staff:
Coordination and engagement techniques and strategies with other actors involved in MHPSS in Cox’s Bazar
Referral pathways among IOM’s program and other related programs in Cox’s Bazar
Participation in coordination meetings, relevant working groups, etc.
Other stakeholders (government, UN agencies, NGOs, etc.):
To what extent was there awareness of the program and the services that were available
How referrals to IOM’s MHPSS services were handled
Impact of IOM’s MHPSS program on other implementing agency activities and operations</td></tr>
</table>

	agencies and their services in Cox's Bazar	
CONNECTEDNESS: Ensuring the activities of a short-term emergency nature are carried out in a context that takes longer-term and interconnected problems into account		
To what extent have activities implemented by the project contributed to resilience of affected communities and promote their self-sufficiency? *How has the project contributed to and supported the capacity of local resources?*	**Progress Reports** and **Project Tools:** Review these resources to describe any interim results and contributions of the project. This will include review of the implementation plan (program output), which was developed by IOM for use by the government.	**Refugee and host community members, leaders and representatives:** • Innovations developed by the community and how these innovations were stimulated or otherwise influenced by the MHPSS program • If and how the community has felt ownership of program elements • Expected and unexpected impacts of the program for participants, the refugee community, and the host community • Elucidate mechanisms by which the program may improve resilience, self-sufficiency, and contribute to the strengthening of local resources/capacity. • Program strengths and how it can be improved • Inclusion and impacts on both the refugee and host community **IOM program staff:** • Perceptions of program impacts on resilience, self-sufficiency and strengthening of local resources/capacity • Innovations and adaptations during program implementation and why they were incorporated • If and how the program has supported environmental sustainability • expected and unintended effects on the environment and local resources **Other stakeholders (government, UN agencies, NGOs, etc.):** • Perceptions of program impacts on resilience, self-sufficiency and strengthening of local resources/capacity • Feasibility of adopting the implementation plan developed by IOM as part of the program

3. Focus Group Discussion and Key Informant Interview Guides

FOCUS GROUP DISCUSSION GUIDE

Date:	____________________	Number of Participants:	____________________
Location:	____________________	Research Assistant(s):	____________________ ____________________
Population:	___Refugee ___Host Community ___Male ___Female		

STUDY INFORMATION

Thank you for joining us for this discussion. My name is ________________________ and I will be facilitating the discussion today. The goal of our discussion today is to talk more about IOM's mental health and psychosocial support program in Cox's Bazar. I am an external evaluator and am not affiliated with IOM. I am very interested in your opinions about IOM's mental health and psychosocial support program, your awareness of or participation in the program, and your suggestions for how it could be improved.

If you agree to participate, we will talk as a group for approximately 90 minutes. I will ask some questions about your knowledge and perceptions of the program. We will not ask you directly about your personal experiences or participation in the program, but rather about your perspective about the program and the experience of people who participated in your community more generally. You do not need to share anything with the group that you are not comfortable disclosing. Please note that there are no 'right' or 'wrong ' answers to the questions. We will not be collecting any personal identifying information from you during this conversation and we will not link any of the statements you share with us today to your name or identity. We will do everything we can to keep what you say confidential. As a member of this group we also ask that you do not share any information you hear today from other people with anyone outside of the group. You are free to participate in this discussion or not. You do not have to answer any questions that you don't want to answer and you may stop participating at any time. Your participation in this discussion will not impact your ability to participate in programs provided by IOM or other agencies. Do you have any questions? [Refer to informed consent procedures specified by University of Dhaka IRB]

INTRODUCTION

Thank you for agreeing to participate in this discussion. We are interviewing several groups like this one. We will also be conducting in-depth interviews with individuals involved in implementing IOM's mental health and psychosocial program, as well as other stakeholders involved in mental health or the response in Cox's Bazar. We would like to first learn more about this program by talking with you.

1. Can you tell us about the activities that were implemented by IOM as part of their mental health and psychosocial support program?

Probes:

- How did you learn about IOM's mental health and psychosocial support program?
- Can you describe some of the activities that were part of the program, regardless of whether you participated in them?
- What do people in your community think about IOM's mental health and psychosocial support program? Why would they choose to participate in this program's activities? Why would they choose not to participate in this program's activities?
- Which of these activities were most/least utilized by the community?
- What type of people in the community would utilize these services? Were there differences by age or gender? For example, were older or younger people more likely to participate? Were there differences in participation and utilization between men and women?
- Which groups of people had trouble accessing the program activities? What barriers did they face to accessing these program activities? Are there different barriers experienced by people of different genders or ages?
    - *[Note for the facilitator: Groups could relate to demographics (age, gender), clinical characteristics (people with more severe mental health or psychosocial problems, people living with disabilities), or other characteristics (e.g., proximity to service site, etc.)]*

2. What were some of the impacts of IOM's mental health and psychosocial support program?

Probes:

- Were there any other unexpected (positive or negative) impacts of the program on psychological, social, or other dynamics? What were they?
- How did the program impact the relationship or the refugee and hots community?
- What were some of the strengths/weaknesses of the program? How could it be improved?
- How do you think IOM's mental health and psychosocial support program could improve the psychological and social wellbeing of communities as well as their resources, skills, and knowledge in Cox's Bazar?
- Which groups of people in the community benefited the most/least from IOM's program? Were there differences between gender or age groups?
    - *[Note for the facilitator: Groups could relate to demographics (age, gender), clinical characteristics (people with more severe mental health or psychosocial problems, people living with disabilities), or other characteristics (e.g., proximity to service site, etc.)]*

3. How was IOM's mental health and psychosocial support program different from other programs in Cox's Bazar?

Probes:

- What other services are available in the camps in Cox's Bazar that are similar to IOM's mental health and psychosocial support program? How are they similar?
- What is missing from IOM's mental health and psychosocial support program that could improve its impact in the community?

- How well did IOM's mental health and psychosocial support program impact the major needs affecting the community (MHPSS and other related needs)? How could the program have better addressed the needs of the population?

4. How was the community involved in the design and implementation of IOM's mental health and psychosocial support program?

Probes:

- How much say or ownership did community members have in the program? Were community members and participants comfortable expressing their needs and preferences to program staff?
- Did IOM's mental health and psychosocial support program reflect Rohingya cultural beliefs, practices, identity, and community structure?
- What aspects of the program were inspired and led by the community? How did these aspects contribute to the overall success of the program?

5. Were there any aspects of the program's implementation or impacts that were unique for [Insert Group: adolescent/adult/elderly men/women]?

[Note for facilitator: Customize this question for the type of focus group (e.g., if interviewing adolescent boys, ask them about how the program implementation and impacts were unique for adolescent boys)]

Probes:

- Were [insert group] involved in the design and implementation of the program?
- What aspects of the program did [insert group] participate in?
- How did the program impact the wellbeing of [insert group]? What other impacts did the program have in this group?
- How well did the program address the major mental health, psychosocial, or other salient needs of [insert group]?

6. Is there anything else you'd like to share with us about the program?

Thank you for your time. We are very grateful for what you have shared with us. As a reminder, we will keep this information confidential and we ask that you also do not share what you have heard from other members of this discussion with anyone else.

KEY INFORMANT INTERVIEW GUIDE

IOM PROGRAM STAFF

Date: ____________________________	Location: ____________________________
Research Assistant(s):	Role:

STUDY INFORMATION

Thank you for joining us for this interview. My name is ________________________ and I work as part of a team who will be serving as external evaluators of IOM's mental health and psychosocial support program in Cox's Bazar. I am very interested in your opinions about IOM's mental health and psychosocial support program and your suggestions for how it could be improved.

If you agree to participate, we will talk for approximately 60 minutes. I will ask some questions about your experiences and perceptions of the program. Please note that there are no 'right' or 'wrong ' answers to the questions. We will not be collecting any personal identifying information from you during this conversation besides your role and we will not link any of the statements you share with us today to your name or identity. We will do everything we can to keep what you say confidential. You are free to participate in this interview or not. You do not have to answer any questions that you don't want to answer and you may stop participating at any time. Do you have any questions? [Refer to informed consent procedures specified by University of Dhaka IRB]

INTRODUCTION

Thank you for agreeing to participate in this interview. We are interviewing several other IOM staff members, stakeholders, and community members. We would like to first learn more about this program by talking with you.

1. How would you describe IOM's mental health and psychosocial support program to someone who is not familiar with it?

Probes:

- What are some of the key activities of the program?
- How were the activities connected or integrated with each other?
- Who is the program intended for and who utilized these services? Were there differences by gender or age? What were some of the barriers in accessing the program?
- Which groups had trouble accessing the program? What were the barriers they faced to participation?

2. How was IOM's mental health and psychosocial support program different from other services available in Cox's Bazar?

Probes:

- What gap did IOM's program fill in Cox's Bazar?
- Were there other programs that were similar? Please describe these programs and how they compared to IOM's program.
- How was IOM's mental health and psychosocial support program linked with other programs and services in Cox's Bazar?

3. How did individuals engage with the program?

Probes:

- How did individuals learn about the program?
- Was this program part of any referral pathways from other programs in Cox's Bazar? How were those referral pathways established?
- What strategies did you and other IOM staff use to engage with other stakeholders, implementers, organizations, and coordination groups?
- Did the program involve the community prior to implementing activities? If so, how?
- Were there certain aspects of the program that participants favored over others?

4. What were some of the adaptations and innovations to the program that were made during implementation?

Probes:

- Who designed and decided on these adaptations/innovations? What was the role of the community, IOM staff, and other stakeholders in this adaptation/innovation process?
- How was the community involved in the design and implementation of the program?
- What were some of the challenges in implementing the program? Did you face any barriers related to policy or structural factors, inter-institutional and coordination factors, program-specific factors? How was the program adapted to address these challenges? Were there any challenged that were unable to be solved by adaptations?
- How were these adaptations and any other lessons learned during implementation documented?

5. What were some of the impacts of IOM's mental health and psychosocial support program?

Probes:

- Were there any other unexpected impacts of the program? What were they?
- What were the negative impacts of the program?
- How do you think IOM's mental health and psychosocial support program could improve resilience, self-sufficiency, and local resources and capacity?
- What types of people in the community benefited the most/least from IOM's program?
- What were some of the impacts of the program outside of those experienced by community members who participated in the activities? For example, were there any impacts on the broader community or environment (e.g., geographic area, resources, etc.)?
- What aspects of program implementation and impacts do you think are sustainable?
- Did the program impact the cultural belief practices of the community?

- Did the program properly take into account different issues related to age/gender?

6. What are some of the key lessons you learned during implementation?

Probes:
- What were some of the strengths/weaknesses of the program?
- What are some of your suggestions for improving the program?
- What would need to be altered in order to increase the likelihood that a program like this could be sustained and adopted in Cox's Bazar or other contexts?

7. Is there anything else you'd like to share with us about the program?

Thank you for your time. We are very grateful for what you have shared with us. As a reminder, we will keep this information confidential.

KEY INFORMANT INTERVIEW GUIDE
STAKEHOLDERS

Date:	____________________________	Location:	____________________________
Research Assistant(s):		Organization & Role:	

STUDY INFORMATION

Thank you for joining us for this interview. My name is ________________________ and I work as part of a team who will be serving as external evaluators of IOM's mental health and psychosocial support program in Cox's Bazar. I am very interested in your opinions about IOM's mental health and psychosocial support program and your suggestions for how it could be improved.

If you agree to participate, we will talk for approximately 60 minutes. I will ask some questions about your experiences and perceptions of the program. Please note that there are no 'right' or 'wrong ' answers to the questions. We will not be collecting any personal identifying information from you during this conversation besides your role and we will not link any of the statements you share with us today to your name or identity. We will do everything we can to keep what you say confidential. You are free to participate in this interview or not. You do not have to answer any questions that you don't want to answer and you may stop participating at any time. Do you have any questions? [Refer to informed consent procedures specified by University of Dhaka IRB]

INTRODUCTION

Thank you for agreeing to participate in this interview. We are interviewing several other stakeholders including community members, IOM program staff, and others to learn about their experience with the program. We would like to learn more about your perspective of this program, including lessons we can learn to improve the program and mental health and psychosocial support programming more broadly.

1. Could you please describe your role or involvement in IOM's mental health and psychosocial program in Cox's Bazar? If you were not directly involved in the program, could you please describe what you know about the program and how it was related to your work?

Probes:
- How did you become aware of IOM's mental health and psychosocial support program?
- What other stakeholders were involved in the design and implementation of IOM's mental health and psychosocial support program?
- How was this program related to other activities you are involved in (e.g., work, etc.)?

2. How relevant was IOM's program to the needs in Cox's Bazar?

Probes:

- How appropriate was IOM's program to the local context and the needs and priorities of refugees? How appropriate is the program for different refugee groups (e.g., gender, age, people living with a disability)?
- How appropriate was IOM's program to the needs and priorities for the surrounding host community in Bangladesh? How appropriate is the program for different host community groups (e.g., gender, age, people living with a disability)?
- How did the program reflect or support Rohingya cultural beliefs, practices, identity, and community structure? How appropriate were these activities to the Cox's Bazar context in Bangladesh?

3. How well did the program align with existing policies and systems?

Probes:

- How did the program fit with Bangladeshi national policy and health/protection systems?
- How did the program fit with humanitarian policy and the health/protection sector in Cox's Bazar?
- How did the program fit with international guidance for mental health and psychosocial support?
- What gap did IOM's program fill in Cox's Bazar?
- Were there other programs that were similar? Please describe these programs and how they compared to IOM's program.
- What were some of the barriers that people faced to participation in the program?

4. How connected was IOM's program with other services and systems?

Probes:

- How was IOM's mental health and psychosocial support program linked with other programs (e.g., other MHPSS, health, protection programs, etc.) and services in Cox's Bazar? How was IOM's program linked with other services delivered by humanitarian organizations? How was IOM's program linked with other national systems (e.g., the Bangladesh health system)?
- How was the implementation of IOM's program coordinated with other humanitarian and national services and systems?

5. What were some of the impacts of IOM's mental health and psychosocial support program?

Probes:

- Were there any other unexpected impacts of the program? What were they?
- What were the negative impacts of the program?
- How do you think IOM's mental health and psychosocial support program could improve resilience, self-sufficiency, and local resources and capacity?
- What were some of the impacts of the program outside of those experienced by community members who participated in the activities? For example, were there any impacts on the broader community, operational context, or environment?
- How did this program impact other humanitarian or national programs and operations?
- Were your expectations of the program met?

6. What is the potential for adoption and sustainability of the program?

Probes:

- What aspects of program implementation and impacts do you think can be sustained?
- What is the feasibility of adopting the implementation plan developed by IOM as part of this program?
- What would need to be altered in order to increase the likelihood that a program like this could be sustained and adopted in Cox's Bazar or other contexts?
- What actions are needed at the policy and systems level to promote the adoption and sustainability of this program?

7. Is there anything else you'd like to share with us about the program?

Thank you for your time. We are very grateful for what you have shared with us. As a reminder, we will keep this information confidential.

4. Terms of Reference – Original (Combined International and Local Consultant ToR)

Annex A – Terms of Reference

Evaluation of project "Expanding the protection and promotion of mental health and psychosocial support for communities affected by the refugee emergency in Cox's Bazar, Bangladesh"

Commissioned by: IOM Cox's Bazar Office in coordination with Swedish International Development Cooperation Agency (Sida)

Managed by: Project Officer (MHPSS), IOM Cox's Bazar in coordination with Monitoring and Evaluation Officer, IOM Cox's Bazar and Head, Mental Health, Psychosocial Response and Intercultural Communication, Global, IOM, Brussels.

Evaluation context

International Organization for Migration (IOM) is implementing a multisectoral response program in one of the world's largest humanitarian crisis in Cox's Bazar, Bangladesh. In early 2021, 717,219 Rohingya arrivals have been recorded since 2017, making it a total of 877,710 Rohingya present in Cox's Bazar and 1,3 million people in need of support. The mass displacement of Rohingya refugees who fled Myanmar in search of safety added a burden to an already restrictive and resource-limited setting. UN agencies and humanitarian actors, alongside the Government of Bangladesh (GoB), provide services to the refugee and host populations in Cox's Bazar area. Mental Health and Psychosocial Support (MHPSS) has been offered in Cox's Bazar by IOM since the beginning of the crisis in 2017 to support both affected communities. The MHPSS program's priorities have included: coordination with the Government of Bangladesh and other stakeholders on strengthening MHPSS services in Cox's Bazar for Rohingya refugees and host communities; awareness raising activities on MHPSS at the community level; increased availability of MHPSS services within the health system, including Ukhiya and Teknaf Upazila health complexes, Primary Health Centers (PHCs), health posts, quarantine, isolation and treatment centers, and palliative care services; increased provision of multilayered and community based MHPSS, including outreach mobile psychosocial support (PSS)-services, support groups, traditional and cultural activities, sport and play, non-formal educational activities, rituals and celebrations and community support systems strengthening in order to support collective meaning-making processes around the displacement crisis.

Within the larger program IOM currently implements the project "Expanding the protection and promotion of mental health and psychosocial support for communities affected by the refugee emergency in Cox's Bazar, Bangladesh" funded by the Swedish International Development Cooperation Agency (Sida) started in 2019 and for 2 years, with the objective of scaling-up MHPSS provision increasing outreach capacity and improving service provision towards achieving a more holistic, comprehensive and inclusive mental health and psychosocial response. The programming works towards three priority outcomes in order to meet this objective:

1. Strengthen the national system in the provision of MHPSS services through increased coordination and knowledge management

2. Improve MHPSS coverage by adding and expanding outreach services for the host community, as well as addressing the need to strengthen local capacities to adequately detect and respond to mental health challenges

3. Strengthen the community-based approach of the MHPSS response, and its development aspects.

The following outputs of the project will be the basis for the evaluation:

Output 1.1.: An implementation plan to address MHPSS gaps identified by the readiness assessment in developed jointly with the Government of Bangladesh (GoB).

Output 2.1.: MHPSS service delivery offered to beneficiaries at refugee health facilities and points specifically chosen to improve host community access.

Output 2.2.: Strengthened capacity to identify, refer, treat and follow up severe mental disorders amongst affected communities.

Output 3.1.: Promote a sense of belonging in the Rohingya refugee community to restore social connections and well-being.

Evaluation purpose and objective

The final external evaluation will analyze the programming impact of the project and draw lessons from its implementation over the last two years. This evaluation is going to inform future project design, provide lessons learned accountability to beneficiaries and the donor. The findings incorporated to the final evaluation report should summarize activities of the project, show the achieved results, strengths and weaknesses, sharing best practices and lessons learned from implementation to inform about areas for improvement and a way forward for future MHPSS programming in Bangladesh. The findings will be shared with partner organizations, donors and relevant stakeholders. Additionally, the evaluation results are going to be incorporated in the final narrative report to the commissioning organization Sida.

Evaluation scope

The evaluation will cover the 24 months of project implementation from 1st July 2019 – 30 June 2021. The evaluation will be conducted in Cox's Bazar, Ukhiya and Teknaf refugee camps for the impact on Rohingya communities and surrounding areas for host communities.

The evaluation should identify how cross cutting themes are incorporated within the evaluated project, such as gender mainstreaming, community empowerment and -local government capacity and gaps.

Evaluation criteria

The project evaluation is going to use the ALNAP and OECD-DAC Criteria to assess for Appropriateness, Coherence, Coverage, Coordination and Connectedness.

Evaluation questions

Appropriateness:

- How appropriate was the project to the target refugee and host communities regarding their needs?
- How appropriate was the project to other key stakeholders?
- Is the project sensitive and responsive to the given context?
- How has the project strengthened the national system in the provision of MHPSS services through increased coordination and knowledge management?

Coherence:

- How well does the project fit into existing national strategies and interventions of other stakeholders in the country and in the MHPSS sector?
- Do synergies and interlinkages with other IOM projects exist? Do these projects complement each other?

Coverage:

- Were the planned objectives and outcomes in the project document achieved?
- What were the results achieved beyond the initially proposed results matrix?
- What lessons have been learnt so far which can be applied in similar interventions in other IOM and other MHPSS programs, what were the challenges and solutions/actions taken?

Coordination:

- How has the MHPSS response for refugees and affected host communities in Cox's Bazar been coordinated?
- What was the role of IOM's MHPSS program in the coordination mechanism in Cox's Bazar?

Connectedness:

- To what extent have activities implemented by the project contributed to resilience of affected communities and promote their self-efficiency?
- How has the project contributed to and supported capacity of local resources?

Evaluation methodology

Two experts (one international and one national) should be engaged to the evaluation process and provide a detailed proposed methodology to address the evaluation objectives. The evaluation will use a largely qualitative methodology using tools that can include, but not limited to:

- Desk review of project documentation, such as project reports

- Qualitative interviews with beneficiaries of MHPSS activities. The consultants must ensure that all groups affected by the project's activities (especially vulnerable groups such as women, children/youth, ppl. with disabilities, etc.) are actively included in the evaluation and that the interviews are conducted in a gender-sensitive and age-appropriate way. Translation to the local language(s) is mandatory.
- Focus group discussions with beneficiaries and host community members.
- Qualitative interviews with key stakeholders and staff of the program.
- Analysis of project information collected over 24months of the project.

Ethics, norms and standards for evaluation

The evaluation will capture cross cutting issues such as gender and sustainability, and will follow the IOM Data Protection Principles, UNEG norms and standards for evaluations, and relevant ethical guidelines. The consultant guarantees that all beneficiary groups and sub-groups of the project (including host community members) are represented in the evaluation process. The process has to be designed and implemented in a community-based and participatory manner, as outlined in the *IOM Manual on Community-based Mental Health and Psychosocial Support in Emergencies and Displacement*.[1] The evaluation also applies the ethical principles outlined in the *IASC Monitoring and Evaluation Guidance*.[2] When being in direct contact with beneficiaries (and staff/partners) of the project, measures to prevent an infection with COVID-19 are taken for all people involved.

Evaluation deliverables

- Inception report;
- Draft data collection tools;
- Presentation of the initial findings;
- Draft evaluation report submitted for comments;
- Final evaluation report;
- Final presentation of evaluation report;
- Evaluation brief (according to the template);
- Management response, partially filled out (template will be provided by IOM).

Specifications of roles

- Role of IOM: logistical support regarding transportation to the field sites and office space in Cox's Bazar if needed; facilitating contacts to relevant key informants such as partner organizations, beneficiaries, other MHPSS-actors in Bangladesh; the provision of IOM-internal documents needed for the evaluation, regular exchange with the evaluation team; availability of relevant IOM staff for

[1] IOM Manual on Community-Based Mental Health and Psychosocial Support in Emergencies and Displacement | International Organization for Migration

[2] IASC Common Monitoring and Evaluation Framework for MHPSS Programmes in Emergency Settings_0.pdf (interagencystandingcommittee.org)

interviews and requests; review of the inception report, draft evaluation report, and the final report (regarding compliance with the donor requirements and the ToR).

- Role of consultant: conducting desk review of relevant literature, documents and reports; preparing inception report, conducting key informant interviews with beneficiaries of the project, with key stakeholders and key staff from the program in accordance with the ethical principles mentioned under 7, preparing draft and final evaluation reports, conducting presentation of initial and final findings.

Time schedule

Activity	Responsible party	Number of days	Tentative timing
Desk review and analysis of relevant documentation	Contractor, IOM providing relevant internal documents	16	1 – 16 September 2021
Implementation of the field evaluation methodology in Cox's Bazar, Ukhiya and Teknaf and presentation of initial findings; submission of draft evaluation report for comments	Contractor with support of IOM	21	17 September – 7 October 2021
Submission of final evaluation report and presentation of final findings	Contractor	10	8 – 17 October 2021

Evaluation budget

The evaluation budget should be included to the financial proposal described in RFP-S and will be subjected to final negotiation among the parties. Field coordination with local authorities will be provided by IOM but all other logistical costs that are not specified in section 9 are required to be included in the proposal.

Evaluation requirements

Service Provider/Consulting Firm is expected to have a full range of expertise to deliver the expected outputs. If deemed necessary, Service Provider/Consulting Firm might associate with individual consultants or entities in a joint venture or sub-consultancy, as appropriate. Competences required for an individual consultant or the lead of a team to be considered for selection are:

Experience:

- Experience in conducting evaluations of multi-disciplinary MHPSS programs with a community-based and participatory approach;
- Experience in conducting evaluations for psychosocial and mental health or related interventions in emergencies at an international level;
- Experience in the culturally sensitive adaptation and implementation of MHPSS-interventions and evaluations;
- Demonstrated experience and knowledge of United Nations (UN) and international organization structures;
- At least five years of professional experience in project/programme evaluation;
- Experience and expertise in remote evaluation methods;
- Good understanding of Mental Health and psychosocial Support and Public Health;
- Familiarity with development and humanitarian contexts of Bangladesh and/or the region a distinct advantage;
- Practical knowledge regarding the local culture and traditions in Bangladesh / of the beneficiary groups is an asset;
- Abilities to work under pressure and meet deadlines;
- Strong analytical and report writing skills and abilities to clearly present findings and practical recommendations.

Excellent written and verbal communication skills in English.

Submission of application

Requirements for submitting an application for a company or research organization are specified in Request for Proposal for Service (RFP-S) form.

5. Documents Received

We received the following documents from IOM to support the desk review:

1. Four narrative reports covering progress of the project from July 1, 2019 - July 30, 2021
2. Work plans
3. Assessment reports, including needs assessment, assessment of services availability, and 4Ws assessment
4. Full proposal
5. Report on implications related to COVID-19 for the project
6. Bangladesh National Mental Health Strategic Plan
7. Fact sheets of IOM's MHPSS activities and the Rohingya Cultural Memory Centre
8. Manuals and guidelines: collective kitchen structure, community activities with women, community-based support groups, early marriage awareness/psychoeducation, family dialogues, conflict mediation groups, healing ceremonies, COVID-19 psychoeducation, suicide prevention, tele-counseling, vaccine hesitancy awareness, and world mental health day awareness/psychoeducation.
9. Rohingya Cultural Memory Centre videos
10. Program tools: checklist for semi-skilled volunteers, checklist for skilled volunteers, senior counselor MHPSS assessment tool, MHPSS follow-up token

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