"Integrated Emergency Humanitarian Response to the Rohingya Population in Cox's Bazar"

Cover pic: camp 18 /RedR India

ENDLINE EVALUATION REPORT 2018

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ACKNOWLEDGEMENT

The Evaluation has been completed due to the immense help and kind support extended by many individuals involved in the project. We would like to thank Christian Aid Bangladesh team for all the coordination work, logistical arrangement and inputs provided during the Evaluation process. Our special thanks to Md Mokhlesur Rahman Sagar, MEAL Manager/ Christian Aid, Bangladesh for arranging and coordination all the work for the Evaluation process and being available for any support even after the working hours. We would also like to thank Salam Bhai for organizing all the meetings within a short notice. Special thanks to Vivek Chemmacherik, Senior Emergency Response Manager, Christian Aids and Maruf, Programme Development and Funding Manager, Christian Aids Bangladesh for their valuable inputs and supports. We would also like to thank Elicia, Interim Consortium Manager, Mr Saiful Islam, Sector Specialist Protection, Mr Saidur M &E Officer, Mr Munir- WaSH Sector Specialist, Mr Subroto Sarkar, Previous Consortium Manager for giving us time for interviews and giving us honest opinions about the project.

The Evaluation would not have been completed without the support from the partner organisations as well. We would like to thank the field team of the partner organization for organizing the FGD meetings within their hectic programme activity. Special thanks to Mr Zakaria, M&E Officer, DAM, Mr Albert Sudip Bhattacharjee, Programme Officer (Emergency Response) World Vision, Mr Arshad Hossain, MEAL Coordinator, Concern Worldwide, Mr Rokman Programme Coordinator, GUK, Mr Samsul Alam, MEAL Officer, GUK, Mr Mahbub, Project Manager, GUK for giving time for interviews even during the holidays.
We would also like to extend our gratitude to Ms Jasmeen Apa and Mr Moyeuddin for all the translation during the FGDs.

Lastly but not the least we would like to thank the community members for giving us time and sharing their experience. We are extremely grateful to all the individuals who were part of this process and giving time especially since it was a holy month of Ramadan.

Finally, we are grateful to our RedR India team for reviewing the process, analyzing the quantitative data and providing valuable inputs in the report.

----The Evaluation Team

Akhilesh Kumar Bakshi

Angom Delhi Rose

ABBREVIATIONS

ANC	Ante Natal Care
CAID	Christian Aid
CiC	Camp in - charge
CWW	Concern World Wide
DAM	Dhaka Ahsania Mission
DEC	Disasters Emergency Committee
DFID	Department for International Development
ESD	Essential Services Delivery
FDMN	Forcibly Displaced Myanmar Nationals
FGD	Focus Group Discussion
GUK	Gana Unnayan Kendra
HCTT	Humanitarian Coordination Task Team
ICCO Cooperation	Interchurch Organization for Development Cooperation
IEHR	Integrated Emergency Humanitarian Response
IOM	International Organization for Migration
IYCF- E	Infant and Young Child Feeding Practices in Emergencies
KIIs	Key Informant Interviews
MEAL	Monitoring Evaluation and Learning
MIS	Management Information System
NFI	Non Food Items
NGO	Non-Governmental Organization
OECD - DAC	Organization for Economic Co-operation Development's Development Assistance Committee
PLWs	Pregnant and Lactating Mothers
PNC	Post Natal Care
PWSN	Persons with Specific Needs
RRRC	Refugee Relief and Repatriation Commission
SAM	Severe Acute Malnutrition
SHPR	Strengthening Humanitarian Preparedness and Response
SRH	Sexual Reproductive Health
ToR -	Terms of Reference
UN	United Nations
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNOPS	United Nations Office for Project Services
WASH	Water Sanitation and Hygiene
WVI	World Vision International

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EXECUTIVE SUMMARY

This report was commissioned to evaluate the impact and measure project achievements against the baseline of the project interventions which were focused on improving access to and utilization of quality WaSH, health, nutrition and protection services in selected six Rohingya camps.
The report draws attention to the evaluation findings on four thematic areas of intervention – Health, WASH, Nutrition and Protection. Below findings of the evaluation are listed according to the themes.

Health

1. The findings suggest that majority of the community accesses the health services through the community clinics (44 %) and static health clinic (31 %) in the camps as compared to just 16 % and 6 % respectively in the baseline. Also, the number of people using health services through pharmacy, quacks, traditional healer and Kabiraj has also reduced considerably. The health centres were easily and frequently accessed by the community on the need-basis and the need for healthcare services pertinent especially for the rainy season was expressed.
2. The pattern of vaccination of children has changed with more number (35 %) of the community members now referring to the Static Medical Centre for vaccination. It implies that the Static Medical Centre is preferred more for vaccination and it could be linked to the awareness generated by the health workers and better accessibility of the community health centres.
3. There has been an increase (53% increase) in the number of respondents receiving pregnancy/maternal care needs in the medical centres in the camp areas. The ANC and PNC services are effective and pregnant women are taken care of. During ANC the pregnant women were provided counselling on diet and other precautions and during the PNC, lactating women were counselled on importance and need of breastfeeding.
4. There has been an improvement in the availability of doctors in the medical centres with the number of regular availability of doctors increasing from 10 % to almost 35 % and irregularity reducing from 83 %to 51 %.
5. The health information provided either through the door to door or at the health clinic has been effective as almost there was an increase (from 66% in baseline to 93 % in end line) of the respondents reported receiving health information from the trained health workers.
6. There was an increase (From 72% in baseline to 87 % in end line) in community members receiving information about the SRH and Family Planning from health workers.
7. The need prioritization shifted from more regular doctors (who stays for longer duration) to need for more medicines from baseline to end line respectively. It indicates an increase in the awareness level of the community members.
8. The community satisfaction with on health care services been adequately provided increased to 79% in the end line from 22% in the baseline. It also implies that requirements for essential services such as health services are much more than the available resources.

WASH

1. It was found that majority of the people across the six camps have been using the constructed toilets. In the camp number 15 and 19, 98% of the households reported of using the constructed toilets and for other camps, it was found that almost 2/3rd of the total households were using toilets for defecation. These findings imply the relevance of toilets constructed for the beneficiaries under the project.
2. There has been an increase in the appropriate usage of handwashing points and it can be attributed to the adoption of the hygiene promotion messages and activities conducted with the community. Almost 79% of the respondents informed that handwashing points installed under the project were utilized for the purpose of hygiene maintenance.
3. The deep tube-wells and gravity water structures constructed under the project have been able to enhance the water accessibility to the community, specifically for PWSN. The water point accessibility for PWD, pregnant women, adolescent girls and aged people have been enhanced. The increase in ease of accessibility for pregnant women rose from 6 % in baseline to 48% in the end line, similarly, for adolescent girls, it changed from 24% to 83%. The difficulty for PWD in accessing water points was reduced from 95% in baseline to 49% in the end line.
4. The gravity water structures constructed under the project have ensured water availability and also enabled people in the community to save time spent in fetching water. It was found that 55% of the respondents informed that it took less than 15 minutes for fetching drinking water and 38% of the total respondents informed that it took them 15-30 minutes for fetching water. So as per the sphere guidelines on the queuing time which is less than 30 minutes, a total of 93% of the households reported that the queuing time was less than 30 minutes.
5. The selection of the location of water-points was done in consultation with the community. It ensured that the maximum of the participants had easy (distance-wise) accessibility of the water-points. It was found that the distance of drinking water point was less than 100 metres for 94% of the households, which is within the sphere guideline which marks it at a distance of fewer than 500 metres.
6. There was a change in general hygiene behaviour of the community but in case of open defecation, it was found that there was an increase from 39% in baseline to 53% in the end line of the households which practised open defecation. Sphere standards prescribe a minimum of 1 toilet per 20 people, but it was found during the evaluation that 10-20 households were using the single toilet, which makes it difficult for all the members to access and make use of the toilet
7. One of the key indicators under excreta management standard (Sphere Standards) is - ***There are no human faeces present in the environment in which people live, learn and work.*** It was found that post the implementation of the project "***sometimes"*** visibility of faeces near households decreased from 85% in the baseline to 52% in the end line. It implies that the beneficiaries understand the value of hygiene maintenance and its impact on their health and general well-being as a result of persistent hygiene promotion training sessions.
8. The satisfaction of the respondents on solid waste management in their area increased 9% in baseline to 74% in the end line. It suggests that solid waste management had been handled properly in the camps under the project.

Nutrition

1. The community members are satisfied with the services and the women groups were appreciative of the training and the door to door services.
2. The OTP centre for the treatment of MAM and SAM children were found appropriate given the high percentage of malnourished children in the camps.

3. It was found that the mothers' group regularly meets (weekly) at IYCF centres and they learn about the importance of a balanced diet through the sessions which were conducted on proper nutrition. Through these MSGs, women members of the community have formed space to discuss and to mingle. In the community kitchen women (of MSGs) cook and feed their children.
4. There has been an improvement in the nutrition services in the camp especially with the nutritional services for adolescent girls with improving from 47 % in baseline to 76 % in the end line. As part of the nutritional programmes for mothers, the IYCF centres work as a counselling and training centre for the mothers' group.
5. It was found that most of the respondents felt that the IYCF centre provide a welcoming environment for women and children with 37 %responding positively in end line in comparison with baseline, where only 18 % of the respondent positively felt about the environment is welcoming.
6. It was found that the respondents were more positive about receiving sessions on safe breastfeeding practices and optimal childcare practices for women with 40 % being affirmative in the end line. It is worth noting that the number of respondents sharing about receiving no sessions on safe breastfeeding and childcare practices have reduced from 40 % in baseline to 16 % in the end line.

Protection

1. The women experiencing physical and sexual violence either in the community or their home to some extent reduced from 63% in baseline to 30% in the end line. Though there was a reduction in percentage but this finding suggests that there is still a need for such a programme in the camps.
2. It was found that the awareness level of the protection mechanism was higher amongst the respondents during the baseline i.e. as compared to 74% at the end line.
3. It is observed that the effectiveness of the protection mechanism needs to be monitored as 23 % of the people mentioned that it is not effective at the end line whereas none felt the same at the baseline.
4. It was found that the complaint mechanism is functioning well only in camp 12 (84%) and camp 18 (49%) however in the rest of the camps (camps 13, 14, 15 and 19), majority of the respondents mentioned that it is effective only to some extent (end line).
5. In the end line it was found that in camp 14, 19 and 15, majority of the respondents felt that the complaint box was installed far from where the community habitation is located. In the camp 18, 14 % of the respondent mentioned that they are afraid to provide a complaint or feedback and 14% also felt they are pressured while 17% of the respondents felt that nothing will change. Hence there is a need to address these issues in order to improve the effectiveness of the complaint mechanism.
6. It was found that majority of the respondents have received training on protection/Child protection /GBV, as 95% of the respondents from camps 14 and 13, 94% from camp 12, 98% from camp 15 and 80% from camp 18 informed about having received it.

Recommendations

Health

- The IEC materials used in the programme for Hygiene Promotion, SRH awareness at the centres currently should be translated in the local language (Arakan script) for better outreach of messages.

- A separate programme for FP and SRH of women should be designed for men in the community.

- The health centres and pop-up centres should have at least one female doctor at each health centre and at the pop-centre in order to provide obstetrical/gynaecological services to the female members of the community.

- In a camp situation, it becomes essential that the community are aware of HIV and other sexually transmitted diseases. Due to its consideration as a taboo, people also do not come out for testing and treatment hence, there is a need for addressing it discretely and sensitizing the community on the same.

WASH

1. The number of users per toilet should be targeted more along the lines of Sphere Standards prescription - a minimum of 1 toilet per 20 people.

2. It is suggested that prior to a decision on construction of separate toilets, the members of the community (in this case females) be consulted for the feasibility and operability of such ideas in order to ensure ownership and achievement of the desired objective.

Nutrition

- The services provisioned under Health and Nutrition are required to be provided in a continuum, so contingency planning for provisioning of these services in the event of exhaustion of project funds needs to be charted out beforehand.

- In order to provide services efficiently, a growth monitoring system for tracking of MAM and SAM categorized children should be developed with growth monitoring taking place on a fortnightly or monthly basis.
- The kitchen garden as an activity for ensuring dietary diversity can further be explored for developing it as a holistic model involving poultry and other livestock cultivation along with vegetable cultivation (similar to PRADAN model)[1].

[1] https://unevoc.unesco.org/print.php?q=Promising+Practices+List&id=10

Protection

- The current protection mechanisms and systems appeared to be limited to information awareness wherein participants have become aware of issues (Trafficking, child marriages etcetera) but the enabling systems and mechanisms for reporting (without threat/fear to one's life) the instances are limited to reporting these issues largely to Majhi. Further evolved and practical systems and mechanisms under the protection component need to be developed.
- The distribution of dignity kits needs to be done on the basis of the women groups rather than a blanket approach. The SADDD will provide necessary information on the camp wise/block-wise population which can be used to identify the required target groups for the distribution of the dignity kits.
- It needs to be ensured that there are women group present in the working group formed for Protection Groups and there is a record of their meetings and programme.

Cross-cutting recommendations

- The community needs to have more awareness about the complaint mechanism as an accountability system for the project activities. The current project system has a written as well as recorded format for registering a complaint however most of the community member depends upon the Majhis to address their complaint and many of them are not even aware of the complaint boxes being installed. There is a need for awareness and clearer understanding amongst the beneficiaries on the purpose of complaint boxes. The complaints which are registered also needs to be documented so as to have the challenges (implementation) and resolution (strategies) recorded to have learnings and understanding of the trends from the project implementation.
- There is a need for having proper synergies and collaboration between different programme activities. Many of the collaboration is limited to human resource and space allocation. One good example of synergy within the project was providing street lights in the toilets areas. Such cross functionality needs to be further explored especially with Nutrition and WaSH sector. The cross-sectionality amongst the beneficiaries of the different project components (Health, Nutrition, Protection and WASH) should be considered in the next phase. Although it is fairly understood that there can't be a total overlap of beneficiaries of different components, but to whatever level this cross-sectionality is possible, it should be explored.
- Under the project component, many of the activities involve awareness and behaviour change activities. These activities, for any visible outcome, require a longer duration than most of the other activities implemented as part of emergency response. So long term plan (at least one year) with a breakdown of the achievement of milestones should be categorized prior to the implementation of these activities.

SECTION A - INTRODUCTION

Background of the Project

Starting 25th August 2017, following the crisis in Myanmar, there has been a large scale massive inflow of the Rohingya population who have been forcibly displaced from their homes in the Rakhine State of Myanmar to Cox's Bazaar in Bangladesh. The United Nations (UN) estimates that as of February 2018, almost 1 million Rohingya refugees have fled Burma and moved into refugee settlements in Cox's Bazar, Bangladesh. 903,788 refugees identified in camps according to the RRRC-UNHCR Family Counting exercise (including 34,172 registered before 31 Aug 2017)[2]

The massive inflow of refugees has not only led to desperately cramped conditions in camps resulting in heightened issues of health, food security and nutrition and protection but also caused severe strain on the host country, humanitarian agencies and other actors in many ways.

From the very beginning, these severely traumatized, Forcibly Displaced Myanmar Nationals (FDMN) are dependent on humanitarian aid for food, water, WASH, health care, and other basic services. Risk of disease is still high due to the speed and size of the influx complicating planning, especially of latrines and tube wells. A range of national, international and UN agencies are providing multiple services to the communities. However, ensuring minimum standards and appropriateness of humanitarian services are major challenges.

Continued and sustained scale-up is required to save lives, ensure overall protection of vulnerable refugees and preserve social cohesion within the refugee community and with host communities. There is an urgent need for robust interventions - across all sectors - in refugee camps and settlements as well as affected host communities. Humanitarian agencies are still not operating to scale. A gender-sensitive, protective, environmentally sustainable, and comprehensive response must take into account all refugees in Cox's Bazar and their host communities. Such a response is key to saving lives and mitigating tensions both within the Rohingya communities as well as between refugees and host communities.

Since then many of the National and International organization has been responding to meet the basic needs of the communities in the camp.

Project Overview

The "*Integrated Emergency Humanitarian Response to the Rohingya population in Cox's Bazar*" project is a joint collaboration of 5 agencies i.e. Christian Aid Bangladesh(CAID), World Vision International (WVI), Concern World Wide (CWW), Dhaka Ahsania Mission (DAM) and Gana Unnayan Kendra (GUK) through a consortium partnership with CAID as the lead to provide basic services and address the needs of the Rohingya community in selected camps. It was a 6-months project funded under the DFID SHPR programmes in 2018.

The project focused on providing:

- Basic Water, Sanitation and Hygiene (WASH) with a focus on provisioning groundwater, safe and inclusive latrines and the distribution of hygiene materials supported by promotion and behaviour change awareness activities through an integrated approach;
- Access to comprehensive and inclusive primary healthcare services to save lives of the affected population through static clinics as well as pop-up medical centres in hard to reach blocks in the camps;

[2] https://reliefweb.int/sites/reliefweb.int/files/resources/ISCG-Situation-Report-January-2019.pdf

- Nutrition services to prevent micronutrient deficiencies and malnutrition-related mortality and morbidity along with the promotion of appropriate infant and young child feeding practices through malnutrition prevention interventions;
- Prevention, mitigation and address of protection risks and assuring safe and dignified living conditions through direct and indirect assistance to survivors of abuse and Persons with Specific Needs (PWSN); awareness enhancement through community mobilization, capacity building and social cohesion activities at WCFS.

This project was in line with the Humanitarian Response Plan and followed a coordinated, integrated and inclusive intervention to fill critical gaps in existing humanitarian assistance in WASH, Health, Nutrition and Protection at the camp number - 12, 13, 14, 15, 18 and 19.

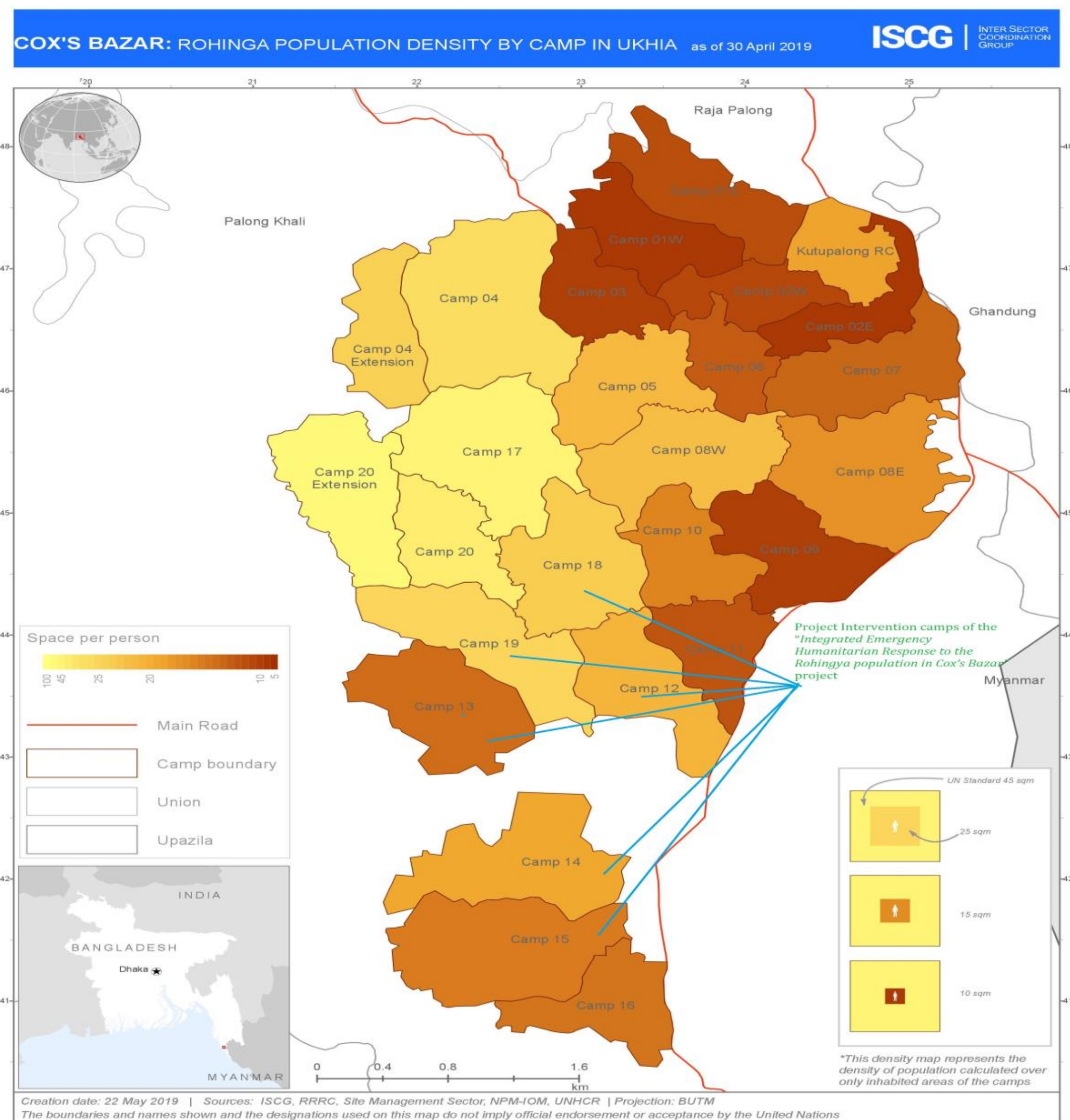


Image 1 Rohingya population density in camps at Cox Bazar (Source: ISCG)

Purpose of Evaluation

The main purpose of the assignment was to evaluate the impact and measure its achievements against the baseline of the project interventions which were focused on improving access to and utilization of quality WaSH, health, nutrition and protection services in selected six Rohingya camps. The overall objectives of this end line evaluation were to understand whether the objectives of this project have been achieved by comparing the end line findings with the baseline findings.

As mentioned in the ToR the specific objectives of end line evaluation were;

1. To measure improvement in access to Safe, clean, inclusive and dignified water and sanitation facilities in the targeted community along with increase in knowledge and practice among people.
2. To understand the contribution of the project on comprehensive and inclusive primary health provisions and surveillance for FDMN.
3. To assess the provisions of preventing malnutrition interventions among affected communities (girls, boys, adolescents' girls and PLWs) and level of awareness.
4. To measure the functionality of the protection support systems strengthening and social cohesion among FDMN.
5. To evaluate the project using OECD-DAC (Relevance, Effectiveness, Efficiency, Impact and Sustainability) criteria

Methodology

The methodology used for this project evaluation was based on the OECD-DAC criteria for evaluating development assistance. The interventions are undertaken by the consortium under the project across Health, Nutrition, Protection and WaSH were evaluated on five criteria - relevance, effectiveness, efficiency, impact and sustainability.

Research Method

The study was conducted using mix-method (quantitative and qualitative) and involved desk review of secondary data (project documents, project data plan), Key Informant Interviews (KIIs) with the staff of partner organizations and key stakeholders in the project area, semi-structured focus group discussions (FGDs), case study and household survey. The aforementioned tools for primary data collection were finalized in consultation with CAID Bangladesh Project staff for the relevance and appropriateness.

The process of finalization of data collection tool involved initial discussion on the broad plan of action, checklist of activities and timeline. After the finalization of a broad plan, a desk review of the project documents, which included a baseline study of the project and other secondary literature, was conducted.

The household survey tool for the end line evaluation was developed and executed by CAID Bangladesh and RedR India team focused on the qualitative aspect of the end line evaluation.

The qualitative data for the evaluation was collected through FGDs and KII with key project staffs and primary stakeholders. The table below provides details of the stakeholders and the corresponding data collection tool used.

Enquiry Level	Stakeholders	Tools used
DFID consortium partners	**Consortium Manager, Project Lead, MEAL Officer, The project team (partners and consortium lead)**	**Participatory project analysis using a mix of: 1) Group discussions 2) Secondary Literature 3) KIIs**
Community	**Beneficiary community members from the project intervention camps (Camp 12, Camp 13, Camp 15, Camp 18, Camp 19, Camp 14)**	**Participatory project analysis using a mix of: 1) Focused Group discussions 2) Site visits, observation and physical verification**
Government	**Assistant CIC**	**Semi-structured interview**
Overall	**Project document review, quantitative data from the Baseline and End line assessment**	

Table 1 Details of Stakeholders and data collection tool

Sampling Strategy

For the qualitative study, purposive sampling was used to select the sample. The respondents selected included program personnel from thematic (Health, Nutrition, Protection and WaSH) areas, the government official in charge of managing the camp and groups of beneficiaries across the five camps (Camp 12, Camp 13, Camp 15, Camp 18 and Camp 19). The participants for FGD were from displaced Rohingya community and representative of the cross-sectional group (age, literacy, sex, profession before entering Bangladesh). In each discussion, the number of participants was between 8-12. During the FGD every participant's basic information with signature was taken along with the photograph of conducted FGD. Similarly, participants for the KII included project staff and government staff, who were involved in the aspects of project implementation directly or indirectly. The table below provides broader categories of participants and respondents. The details of respondents and participants from whom primary data was collected are listed in the Annexure 2.

S. No.	Location	Organization/Individual
1.	CAMP -12	Beneficiaries of WVI
2.	CAMP -13	Beneficiaries of CWW and DAM
3.	CAMP – 18	Beneficiaries of GUK and CWW
4.	CAMP – 19	Beneficiaries of WVI and CWW

5.	CAMP - 15	Beneficiaries of DAM and GUK
6.	CAMP – 15	Assistant CIC
7.	CAID Office	Program Development & Funding Manager, Protection (Theme) Specialist
8.	Remote/Telephone Skype	Consortium Manager, MEAL Officer (Consortium), WASH (Theme) Specialist, Senior Emergency Response Manager (CAID)
9.	CAID Guest House	Program Officer (WVI), MEAL Coordinator (CWW), MIS Officer (DAM), with Project Coordinator, MEAL Officer and Project Manager, GUK

Table 2 Details of Respondents and Participants

Sampling strategy for the survey

Simple random sampling was followed for designing the sample size. Considering the homogeneity of the Rohingya community. Proportionate sample distribution approach was applied to identify sample size for each camp block.

A total of 385 households were taken as a sample from the total 47,157 households considering as the population size (confidence level of 95% and Confident interval 5). The formula used for the sample calculation was:

$$SS = \frac{\frac{Z^2 * p * (1-p)}{e^2}}{(1 + \frac{Z^2 * p * (1-p)}{e^2 N})}$$

$$SS = \frac{\frac{1.96^2 * .5 * (1-.5)}{.05^2}}{(1 + \frac{1.96^2 * .5 * (1-.5)}{.05^2 * 47157})}$$

$$SS = 385$$

Where:

SS = Sample size

Z = 1.96 (Z value for 95% confidence level)

p =0.5 (percentage picking a choice, expressed as a decimal)

e= 0.05 (±5= confidence interval)

N= 47,157 population size

Total households in camp 12,13,14,15,18,19 are (47,157) and Rohingya community status more or less is in the same dimension.

- Confidence level – 95%
- Margin of Error- 5%
- Sample calculation: 385

The data was collected using a structured questionnaire through **kobo toolbox** in digital devices. The data was gathered by 18 volunteers and data collation was done by M&E Officer.

Data Analysis

Quantitative data of the household survey was analyzed over MS excel and thematic analysis was done for the qualitative data. For the data quality check, a two-step approach was adopted. Before the submission of data, enumerators checked whether sections were filled properly with valid information, which was then uploaded on the M&E system. After data collation and import into MS Excel, random basis quality was check was done.

The quantitative and qualitative data was segregated and analyzed with the OECD-DAC framework (discussed in detail above). The findings and analysis are presented in the below sections.

Limitations of the evaluation study

1. **Limited accessibility to beneficiaries**: The timeline for the collection of field data and duration of time spent with the beneficiaries was limited due to the prevailing time-related (daily) restrictions in the camp. The time required to delve deeper into sensitive issues related to protection (trafficking, sexual abuse, early marriage, other threats) was limited as a result the effectiveness and impact of interventions taken under protection were evaluated based on limited information shared by the participants and from KII with consortium partners engaged in the field.

2. **Lost information in translation:** The FGD sessions conducted in the five camps were facilitated through translators who knew the local language (Arakanese[3]). Translation in any qualitative research is challenging and translation between languages involves interpretation and the message communicated in the source language has to be interpreted by the translator and transferred into the target language, and usually challenges in the interpretation and representation of meaning are experienced in any communicative action[4]. The translation along with the difference in cultural context during the conduct of FGDs might have resulted in a loss of some aspects shared and discussed by the participants.
3. **Limited time and access due to Ramadan:** Besides the time related mobility limitation and restriction in the camps, there was also challenge for the team in fixing interview timings and availability of the project staff because of the holy month of Ramadan, when most of the followers of Islam undergo rigorous regime of fasting (no solid and liquid intake) from dawn to dusk (usually more than 12 hours out of 24 hours of a day). People had to leave the office earlier than the normal timing and even within the camps the team had to be mindful of the prayer timing and some of the FGDs had to be wrapped up earlier than planned. However, wherever possible the project staff (working and the ones who have left CAID) tried to give sufficient time despite being in fasting. For similar reasons, the Govt. officials were also not easily available.

[3] Arakanese is a Burmese language spoken in Rakhine state (ရခိုင်ပြည်နယ်), a region in the south west of Burma/Myanmar formerly known as Arakan, by about 2 million people, half of whom are native speakers
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2995873/

4. **Limited mobility due to the weather:** On the last day of the field visit the team could not visit Camp 14 due to heavy rainfall. The participants who were to attend FGDs could not come out of their houses due to strong winds and heavy rain. Camp 14 is topographically challenging (mounds) as compared to the rest of the camps visited hence the team could not visit the sites in the camp 14 as per the plan.

5. **Difficulty in accessing the CiCs of the camps:** As mentioned earlier due to the holy month of the Ramadan and training deployment of CiCs in Dhaka, it was difficult to get CiC members' time for the KII. During the evaluation, only one of the CiC members in the camp 15 could be interviewed, but owing to the fact that he was newly appointed, not many strategic inputs and challenges on the project activities could be gathered. The CiC member prior to the current one has been sent for training, hence, inputs from the Govt. officials were limited.

Framework of Analysis

The Evaluation has been conducted using the OECD-DAC criteria of Relevance, Effectiveness, Efficiency, Impact and Sustainability. The detailed framework of analysis is attached in Annexure 1

Relevance

- Whether the project design was appropriate and addressing the felt needs of the affected community?
- What processes/measures informed the project design?
- What was the nature and extent of participation of key stakeholders' viz. affected community, implementing team, local government officials, and supporting organizations in the project design?
- To what extent was the project pertinent to the local context and initiatives by other organizations in the project area?

Effectiveness

- To what extent were the planned results for the project achieved?
- What is the nature of intended and unintended outcomes emanating from the project?
- What extent of the affected population in the project area was benefitted because of this project?

Efficiency

- Were available resources optimally used in this project?
- What was the extent of affected community's participation in project implementation? How beneficial was this for the project?
- Were the project management systems appropriate and useful for this project?

Impact and Sustainability

- What were the immediate and medium-term intended and unintended as well as positive and negative impacts of this project?
- What measures have been taken to ensure the sustainability of project achievements?
- How were the user group and other committees formed during the project period keeping their sustainability and functionality post the project period?
- How will the gains achieved through establishment of systems, mechanisms and processes be kept intact and further enhanced after the project completion? (Capacity building of the community with empowerment approach)

Structure of the Evaluation Report

The first section of the report outlines the background of the report including the background of the project, the context, methodology, sampling strategy, limitations and the framework of analysis.

In the second section, there is finding and analysis where demographic data of the respondents are detailed out. The section of Findings includes sector wise findings with each section covering the programme wise intervention of Health, WaSH, Nutrition and Protection. The analysis for each of the sector has been done through the five DAC OECD criteria of Appropriateness/Relevance, Effectiveness, Efficiencies, Impact and Sustainability. The quantitative data of baseline and end line findings have also been incorporated in logical places to substantiate the quality findings or vice-versa. The section also covers ranking the overall performance of the project through the Linkert scale on 5 values ((Excellent=5; Very Good=4; Good=3; Satisfactory=2; Poor=1) for all the thematic sectors.

The last section of the report focuses on Recommendations and Conclusions with recommendations for sector-wise findings namely Health, WaSH, Nutrition and Protection. The cross-cutting recommendations across the themes have been clubbed together and put under the theme "Cross-Cutting Recommendations". The last section on Recommendations and Conclusions also covers the learning and recommendation from the Coordination of the consortium Model

SECTION B - FINDING AND ANALYSIS

The findings presented below along with the analysis of the project have been done across the project themes and Consortium Coordination. In the first section findings and analysis on Health, Nutrition, Protection and WASH themes are provided theme-wise. The findings are analyzed on the relevance, efficiency, effectiveness, impact and sustainability of the project activities conducted across each theme.

Demographic Details and Evaluation sites

This section provides an overview of the demographic details of the respondents and the surveyed population. The below details provide the spread of respondents across the six camps where project intervention was conducted.

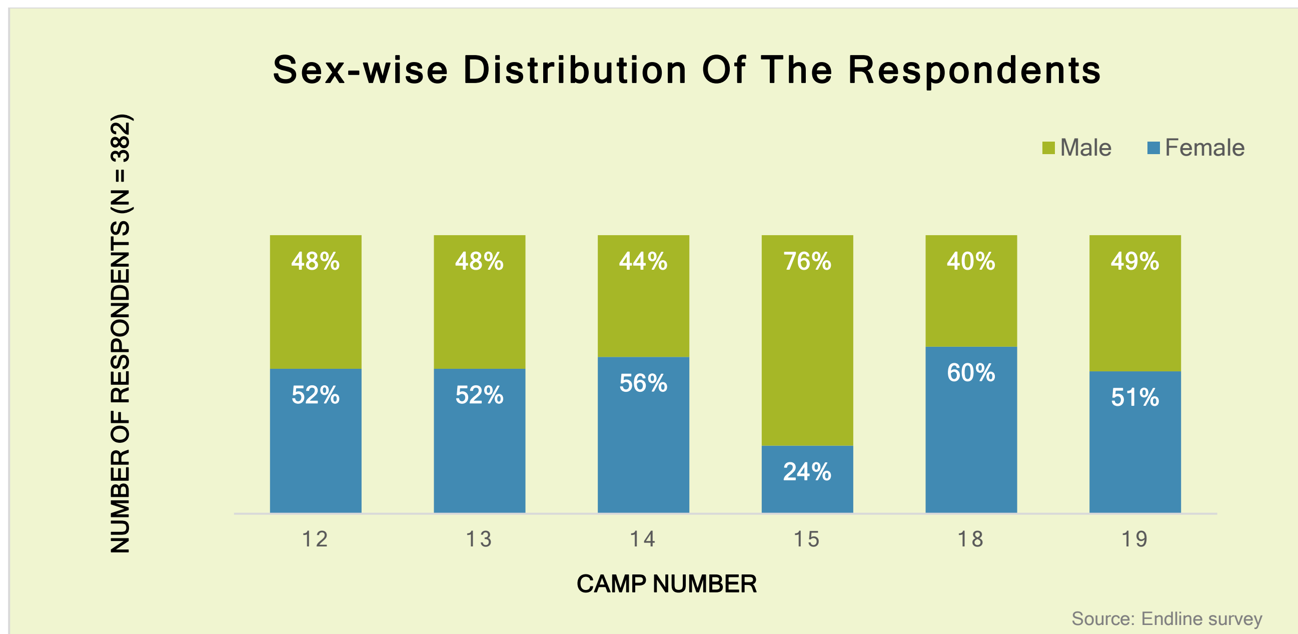


Figure 1 Sex-wise distribution of the respondents

The above chart shows the sex-wise distribution of the respondents across the six camps. It can be seen that there was appropriate gender balance across the camps except the camp number 15, where the percentage of female respondents stood at 24%.

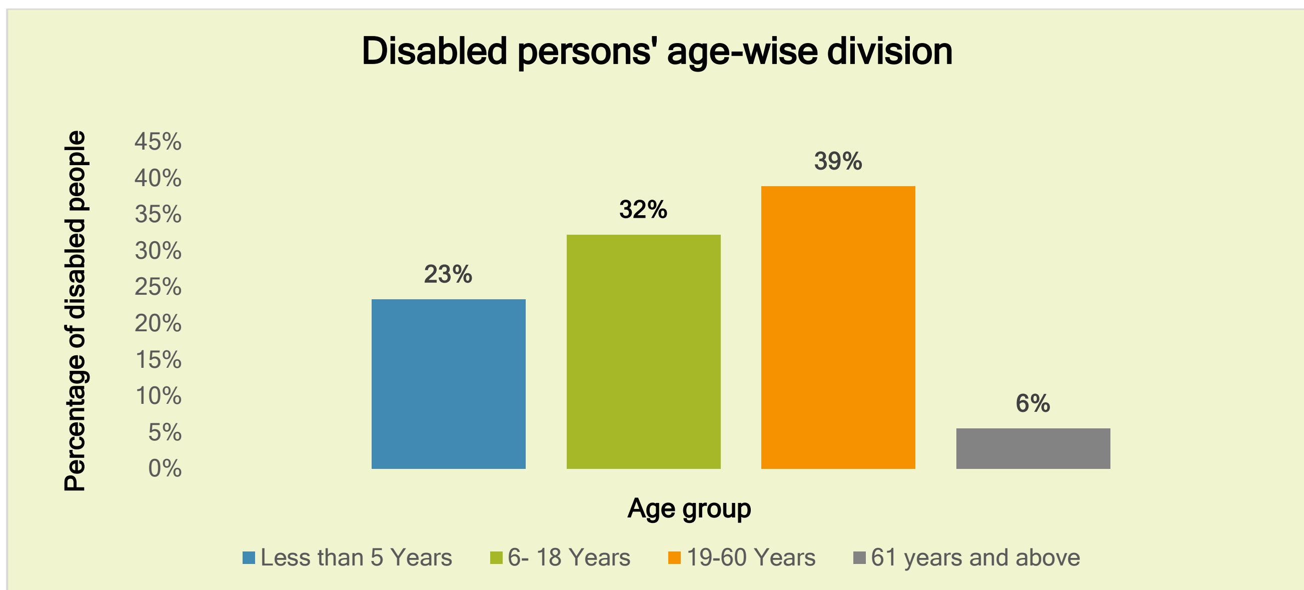


Figure 2 Disabled persons' age-wise division

The above chart shows the spread of age group of disabled persons across the six camps. It can be seen from the above chart that majority of disabled persons, 39%, fall in the age group of 19-60 years, and 32% of the respondents fall in the age group of 6-18 years. A very small percentage of people, 6% fall in the age group of 61 years and above.

Project Themes (Health, Nutrition, Protection and WASH)

Health

Program Activity

The consortium in this project employed twin approach in the health sector by setting up Static Health centres and Pop up medical centres to increase the primary healthcare coverage in the camps.

Under the project period, a total of four Static Health Centers, including three that were set up during phase-1 and three pop-up centres in camp 15, 13 and 18 are operational. The centres were expected to handle 49,400 medical cases (caseload) during this phase. Besides the healthcare services, the project also included targeted outreach-based surveillance activities conducted by trained Health Volunteers. For these activities, the most vulnerable and persons with specific needs (PWSN) like the elderly, chronically ill with limited mobility and pregnant and lactating women (PLW) were trained in the door to door surveillance. These Health Volunteers provided door-to-door awareness on Sexual Reproductive Health (SRH), maternal and infant health and family planning. It is targeted to reach out to 12000 young couples to promote family planning.

Relevance / Appropriateness

The evaluation measured the appropriateness and relevance to the end users of the services provided under this project. This assessment involved documents' review, discussions with field staff and project managers, and field visits to the camps and discussions with the service providers and community. It was apparent during the discussions with respondents that all healthcare services provisioned have been very welcome and well received by them. The services for ante-natal and post-natal care has also been appreciated by the respondents. It was found from interaction with the doctor at the health centre in Camp 15, that a minimum of 25-30 patients per day was being attended to at the health centre. The health centres

were easily and frequently accessed by the community on the need-basis and the need for healthcare services pertinent especially for the rainy season was expressed. Although the project does not have scope for the community to decide on the site of the infrastructure as the CIC office and the site management pre-decides the location beforehand, the community members have shared easy access to the site selected for health services hence it is appropriately located in the camps.

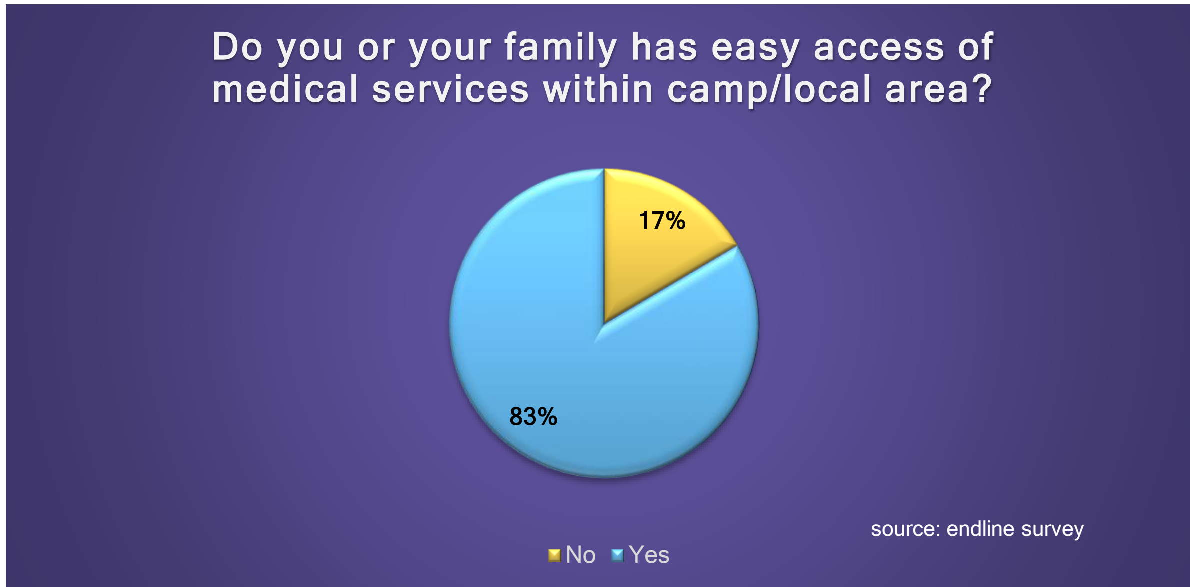


Figure 3 Easy access of medical services within camp/local area

As the graphs suggest, 83 % of the respondents shared that there is easy access to the medical services in the camp and they are accessing those regularly. Most of the static health centre is located at space which is accessible to the majority of the people in the camps and pops up centres are placed at the interior of the camps. Hence as the end line and baseline survey graph suggest the majority of the community access the health services through the community clinics (44 %) and static health clinic (31 %) in the camps as compared to just 16 %and 6 %respectively in the baseline. The number of people using health services through pharmacy, quacks, traditional healer and Kabiraj has also reduced considerably from the baseline. This also could be a result of the community health awareness and accessibility of the medical services in the camps.

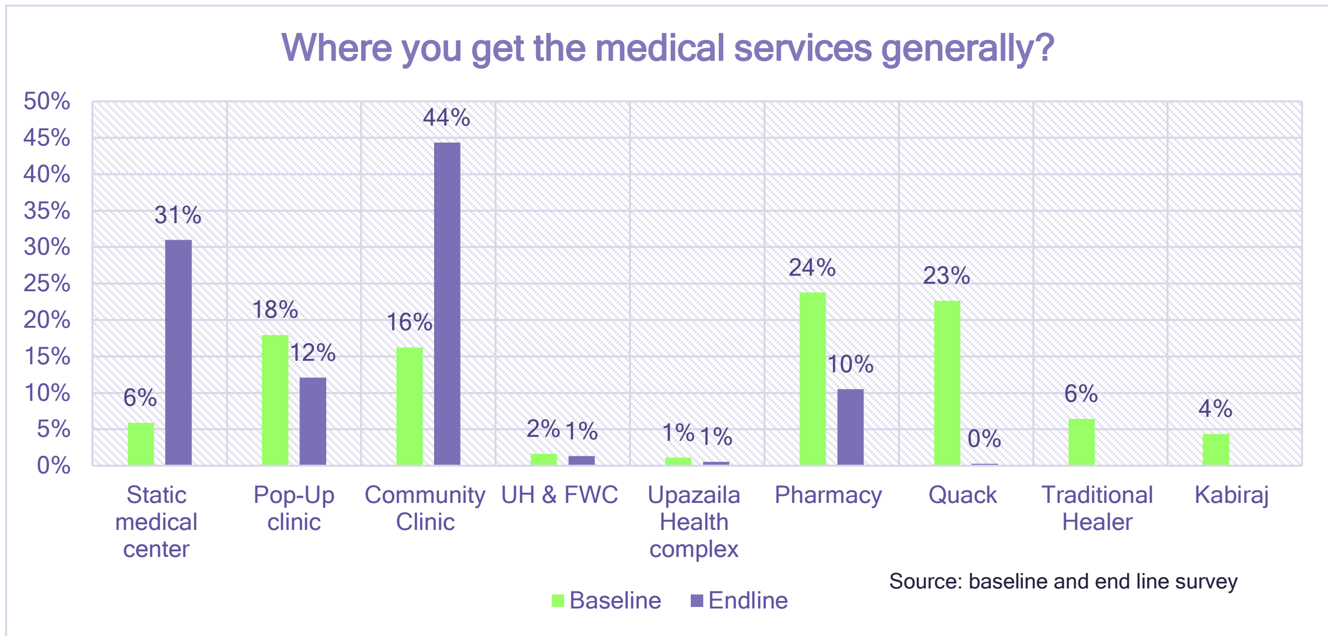


Figure 4 Where you get the medical services generally?

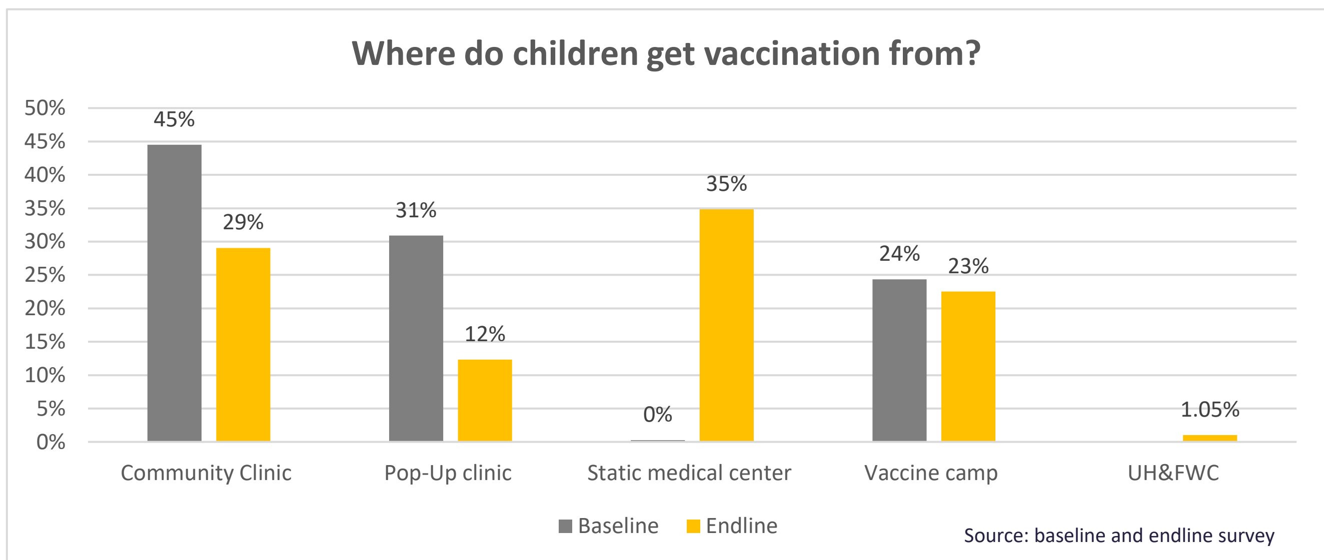


Figure 5 Where do children get vaccination from?

The pattern of vaccination of children has changed with more number (35 %) of the community members now referring to the static medical Centre for vaccination. This also implies that the static medical centre is preferred more for vaccination. This could be linked to the awareness generation of the health workers and better accessibility of the community health centres. During the FGDs many of the respondents shared that the static health centre was at a favourable location and was easily accessible to the community.

The community members were aware of the complaint box (feedback mechanism for accountability), but it was found that most of the messages received in the complaint box were more of a wish-list and demands for the extension of the health centre which implies the necessity of health clinics in the camps.

The availability of female doctors in the health centres in the first phase of the project was appropriate for the female members of the community, given the ease and comfort they have in discussing their gynaecological issues with the female doctor. However, in the second phase, only one female doctor was available at the health centres running in the six camps. It was informed that there was one more female doctor who left in the month of April (2019) and hence it has been challenging for the female members of the community to avail gynaecological/obstetrical consultations at the health centre. Despite the mentioned challenges, and given the scenario at the Rohingya camps, the healthcare services provided under the project are relevant in the situational context of the camps.

Efficiency

The delay in disbursal of funds, approvals and staff recruitments delayed planned implementation timeline of the project activities. The assessment of documents and discussions with the project team and the beneficiaries revealed that the project implementation was to begin from September 2019 but it could only be initiated from December 2019.

Despite these challenges, the DAM staff from the previous phase continued providing their services and continuum in the provisioning of services was kept. However, due to fund exhaustion, DAM had to reduce their activities conducted under the Health component of the project.

Effectiveness

The participants from the FGDs shared that the ANC and PNC services are effective and pregnant women are taken care of. During ANC the pregnant women were provided counselling on diet and other precautions and during the PNC, lactating women were counselled on importance and need of breastfeeding and it was ensured that they complete their PNC visits.

As it is also evident from the baseline and end line survey data, there is an increase in the number of respondents receiving pregnancy /maternal care needs in the medical centres in the camp areas with 81 % in the end line as compared to only 28 % during the baseline.

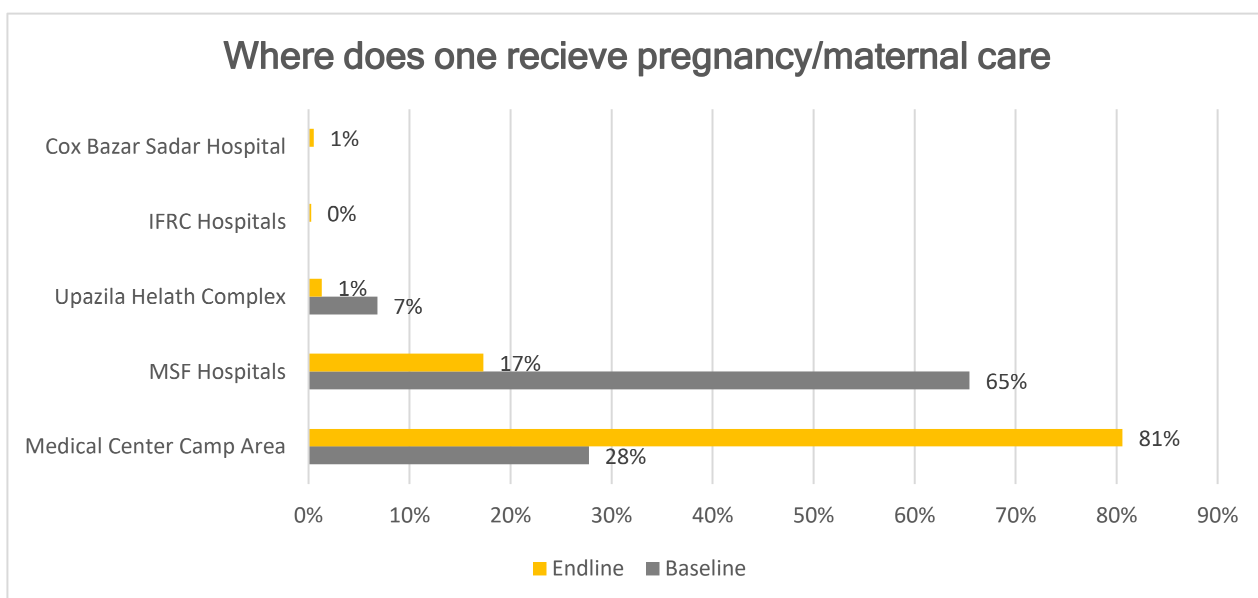


Figure 6 Pregnancy/maternal care

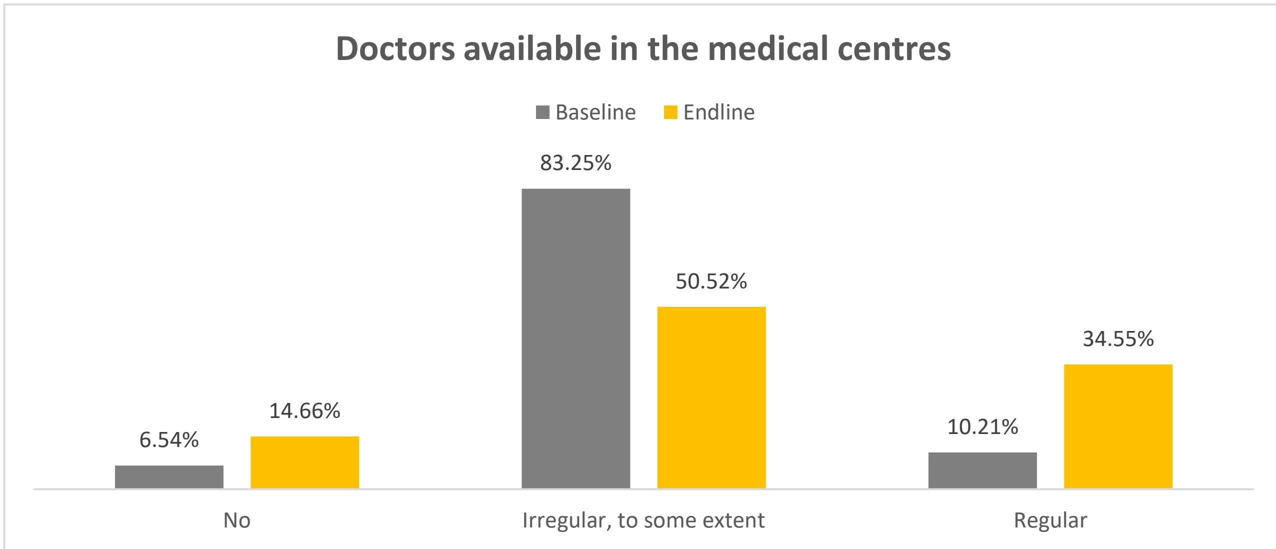
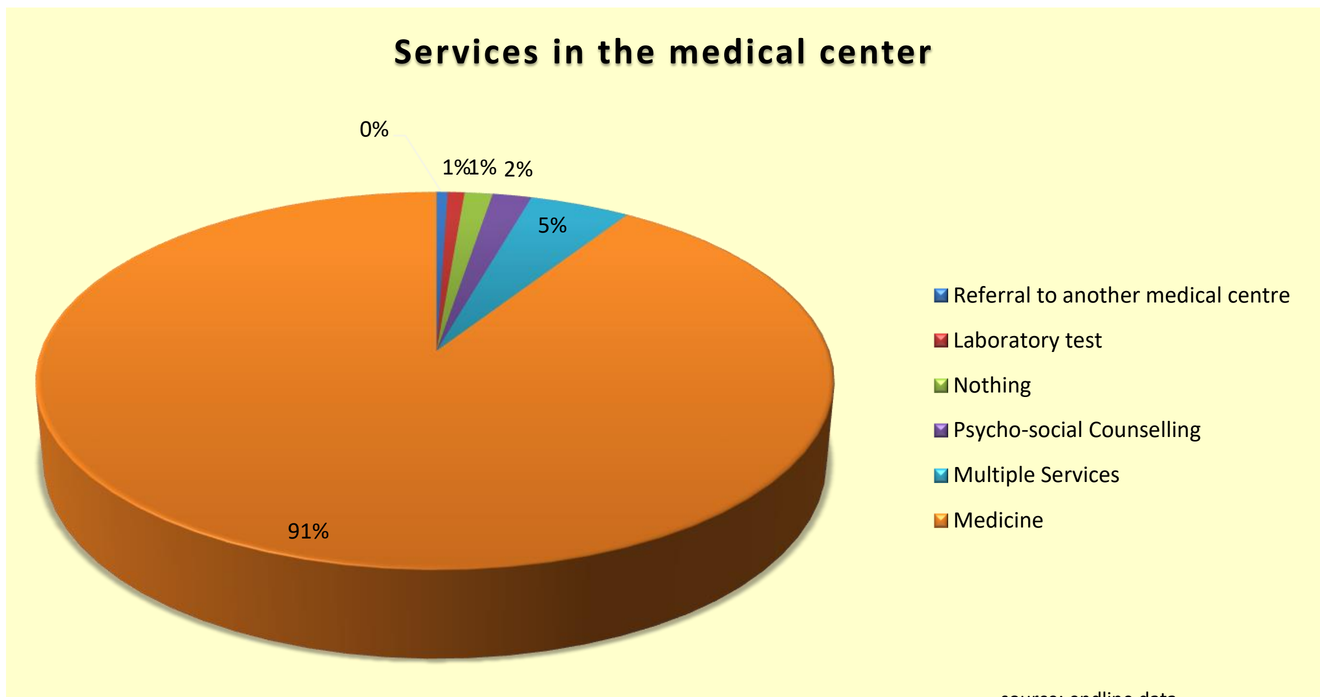


Figure 7 Doctors available in the medical centres

The baseline and the end line surveys also show that during there has been an improvement in the availability of doctors in the medical centres with the number of regular availability of doctors increasing from 10 % to almost 35 % and irregularity reducing from 83 %to 51 %. However, there still is a scope for improvement for the availability of doctors. This could also mean that there are more requirements of doctors in the health centres, especially in the pop-up centres. As shared by one of the doctors working in Camp 15 static health centre, the demands are much higher in the health centres and currently, only two doctors are managing the health centre. There is a scope for having one more doctor.



source: endline data

Figure 8 Services in the medical center

However, it is interesting to note that, the majority (91%) of the respondents shared that they refer to the health centres for medicines, a small proportion also uses the health centres for pyschosocial counselling and other services.

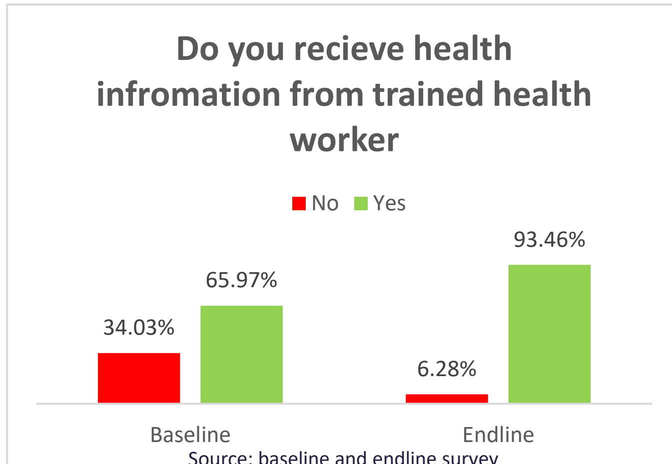


Figure 10 Do you receive health information from trained health worker

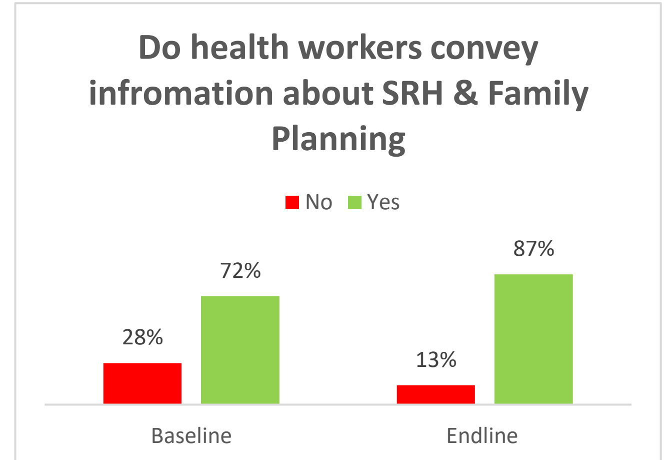


Figure 9 Do health workers convey information about SRH & Family Planning

From the baseline and end line data, it is evident that the health information provided either door to door or in the health clinic has been effective as almost 93 % of the respondents responded in receiving health information from the trained health workers which are also a significant increase from the baseline data of 66 %. There is also increased in the respondent mentioning that the health workers are providing information about the SRH and Family Planning. In the end line survey data, there is an increase with 87 % of the respondents sharing that they receive information about SRH and Family planning from the health workers as compared to 72 % who responded the same during the baseline. This shows that there is awareness among community members.

The effectiveness of the door to door services and the health information can also be seen in the increase in the number of people referring to health centres instead of local quacks, Kabiraj and local healers and pharmacies as mentioned earlier.

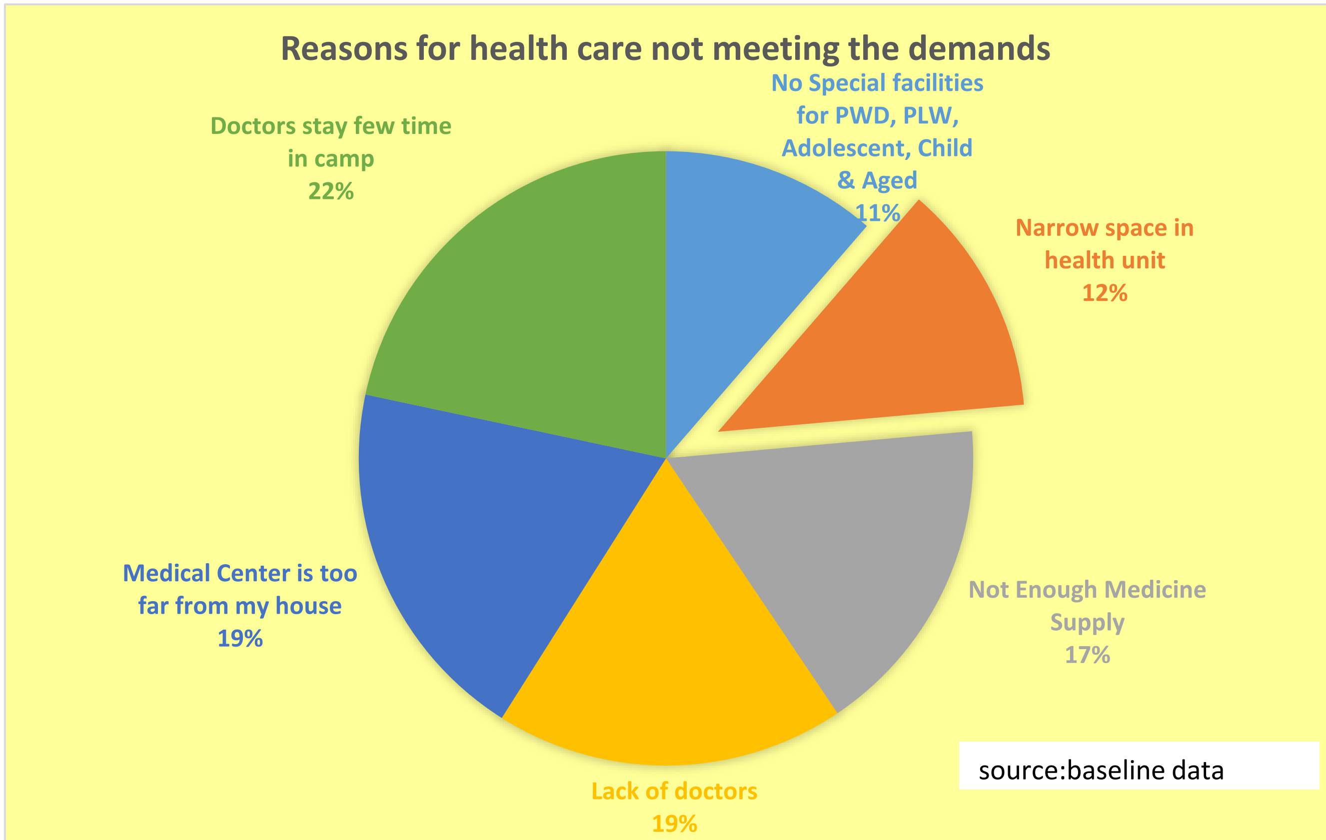


Figure 11 Reasons for health care not meeting the demands

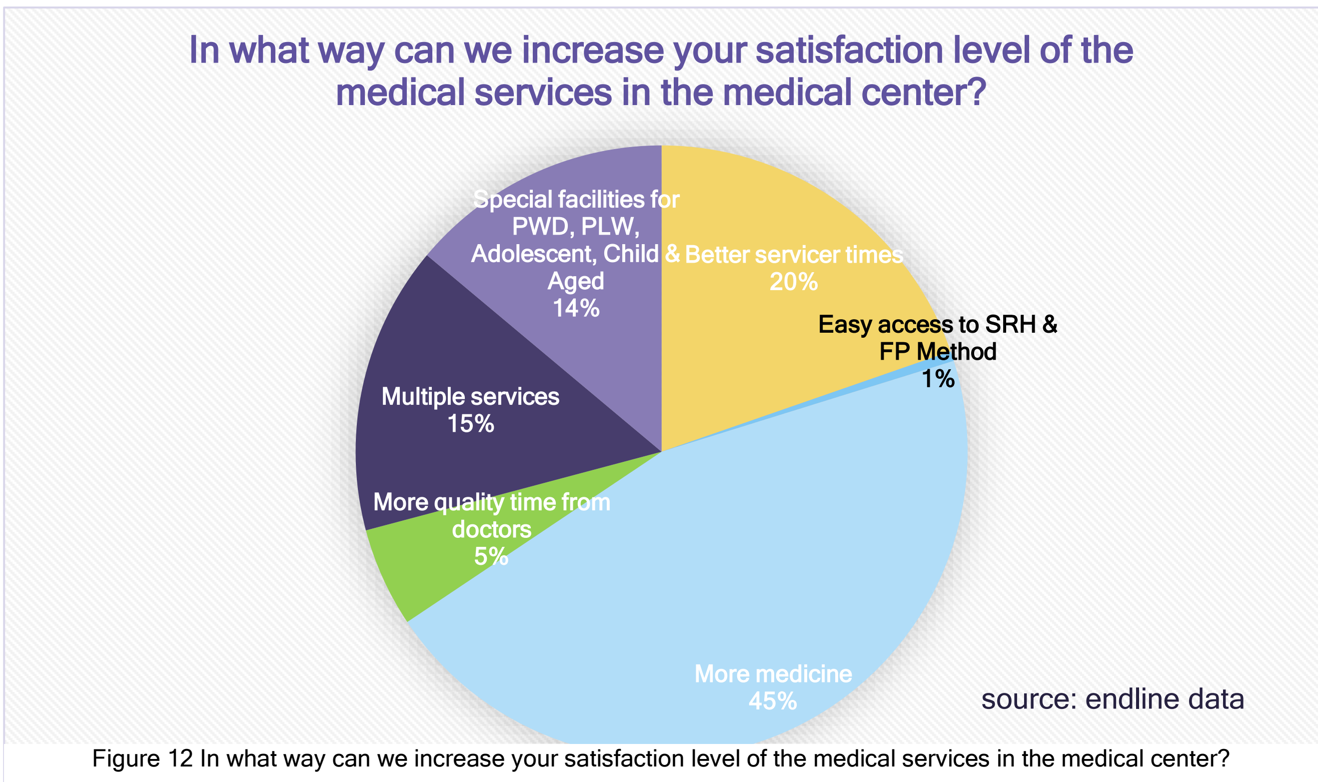


Figure 12 In what way can we increase your satisfaction level of the medical services in the medical center?

During the baseline survey, majority of the respondents mentioned that the present health care system needed more regular doctors who stay for a longer duration with 22 %mentioning that the doctors stay for a fewer duration and 19 %sharing that there is a need for more doctors. The respondents also shared issues of accessibility such as the distance of the health centres (19 %), special facilities for PWD, children and elderly (11 %), narrow space (12%) while 17 % felt that there are not enough medicines.

While in the end line, majority of the respondents (45 %) mentioned that there is a need for more medicines, accessibility in relation to elderly, PWD and children (14 %) and Multiple services (15 %). There has been an increase in the demand for medicines as compared to the baseline, this could also indicate an increase in the awareness level. Although, it is not mentioned what type of medicines are more in demand, as shared by the FP counsellor more and more women are demanding contraceptive pills as it is a more convenient way of family planning. There is also more demand for injection as it is a onetime procedure and does not require remembering to take the pills. Hence, this could also link to an increase in demand for medicines.

Comparatively only 5 % of the respondent mentioned more quality time from the doctors as compared to 31 % in the baseline.   Access due to distance has also been reduced with the availability of pop up centres.

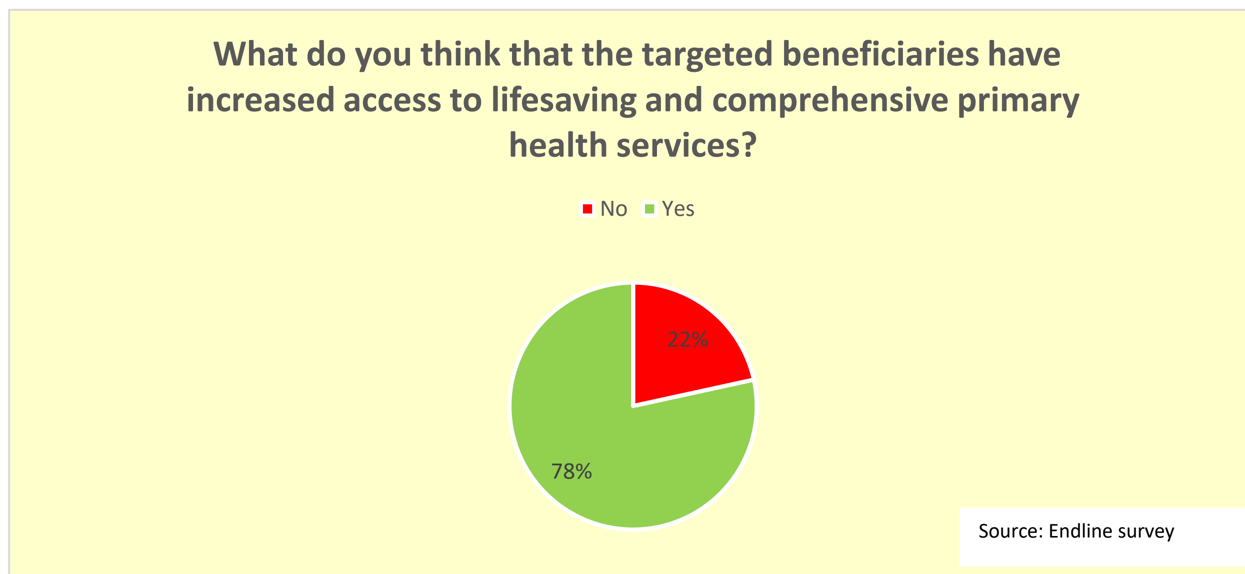


Figure 13 Increased access to lifesaving and comprehensive primary health services

Overall a total of 78 % of the respondents mentioned that access to health services has increased in the camps which is a positive impact and shows the project activity has been effective for the community.

Impact

Overall, the team felt that the Health Services and the Counselling services that are being provided were appreciated by the community and there seems to be an immediate impact in terms of community members being able to access medicines for short term illness and getting referral immediately for serious illnesses.

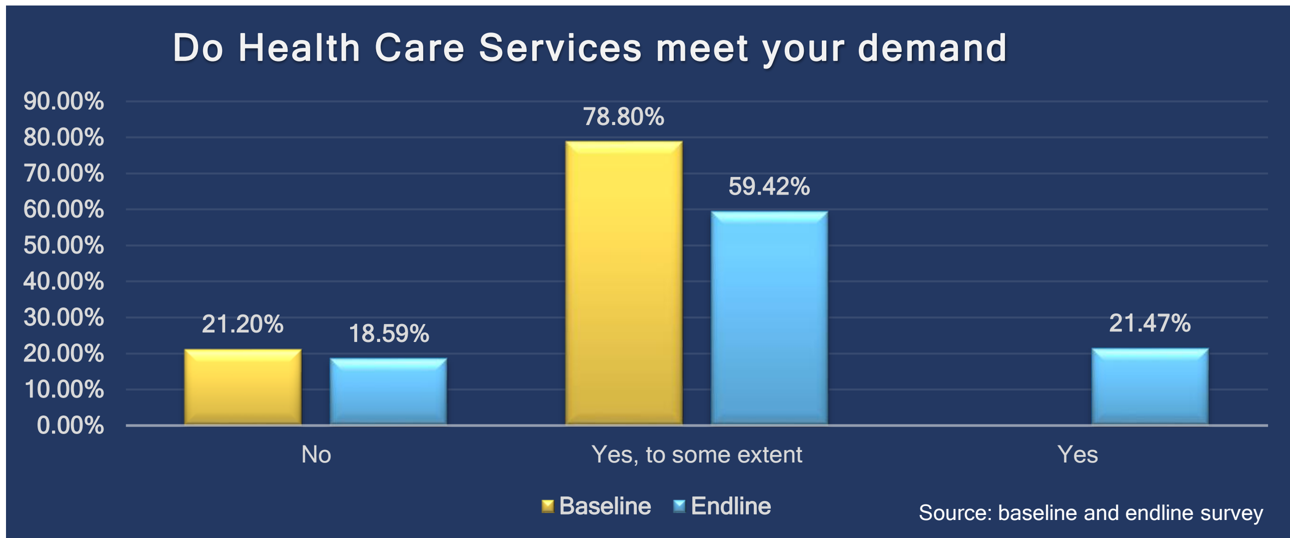


Figure 14 Do Health Care Services meet your demand

As compared to the baseline and end line survey, it shows that the community are more satisfied with almost 22 % of the participants mentioning that it meets the demands and 79 % responding that the demand for health care services has been met to some extent. This could also mean that requirements for essential services such as health services are much more than the available resources.

The counselling services and FP services provided under the project would require time for any visible impact on the community. Although it was found that there was general awareness amongst the community members about birth control pills and where to get them. However, the long term impact in terms of the application of this information and the resulting impact would be difficult to measure given the duration of the project. In the community, there is a reservation against family planning and birth control methods such as condoms. However, to understand and measure the impact in terms of perceptional change and usage (application) due to the project, it will require a minimum of a one-year timeline.

Sustainability

Given the nature of the response, the team understand that sustainability is a challenge since the provisioning of services primarily depends upon the permission grant from the office of the CIC. However, for provisioning of essential services such as health, contingency planning needs to be done beforehand.
Currently (during the period of team's visit) the staff from DAM were volunteering and providing their services in the hope that project will continue and they will receive payments once the bridge funding or project extension is done. However, such services cannot be stopped immediately, hence a different arrangement/contingency planning is needed. It was found by the team that there is no alternative plan with the implementing partner or with the consortium in case the bridge funding for continuing the project activities is not received.

WaSH

Programme Activity

Under the project, a total of 20 activities were implemented by WVI and GUK for provisioning "**Safe, clean, inclusive and dignified water and sanitation facilities**" to the FDMN (beneficiaries) across the six camps. The 20 activities which were implemented in the project period are: a) Faecal Sludge Management (FSM); b) Maintenance of phase 1 FSM; c) Improvement of existing latrines (lighting and privacy); d) Decommissioning of dysfunctional latrines; e) Construction of new inclusive and safe latrines; f) Distribution of portable toilets for elderly and PWD; g) Improvement of existing bathing cubicles (lighting and privacy); h) Construction of bathing cubicles; i) Maintenance of existing handwashing points; j) Installation of new handwashing points; k) Maintenance of new handwashing points; l) Distribution of replenishment hygiene kits; m) Distribution of latrine cleaning kits to WASH committees; n) Door-to-door health awareness; o) hygiene and nutrition promotion awareness sessions; p) Community-level health; q) hygiene and nutrition promotion awareness sessions; r) Construction of deep tube-wells and gravity water structures; s) Solid waste management; and t) Cash for work for solid waste collection and dumping. In the following section, the outcome of these activities is discussed vis-à-vis relevance, efficiency, effectiveness, impact and sustainability.

Relevance

Under the programme intervention the toilets, Gravity Water Points and Bathing Cubicles were expressed as the most important infrastructures built, given the daily need and utilization of the same by the community. For dignified and safe living conditions it becomes essential that these services are functioning properly.

The quality of toilets constructed was good (6 ringed better than 3 rings constructed by previous NGO) and in line with the WASH sector guidelines. The two pit toilets constructed provide better usability and maintenance (FSM) without any disruption in usage by the community. Overall it was found the design and structures constructed were spacious and considered good by the community for use.

The chart below shows the percentage of households using toilets for defecation. It is visibly clear that in camp number 15 and 19, 98% of the households have been using the constructed toilets. Similarly, for other camps, it can be seen that almost 2/3rd of the households are using toilets for defecation. These findings imply the relevance of toilets constructed for the beneficiaries under the project.

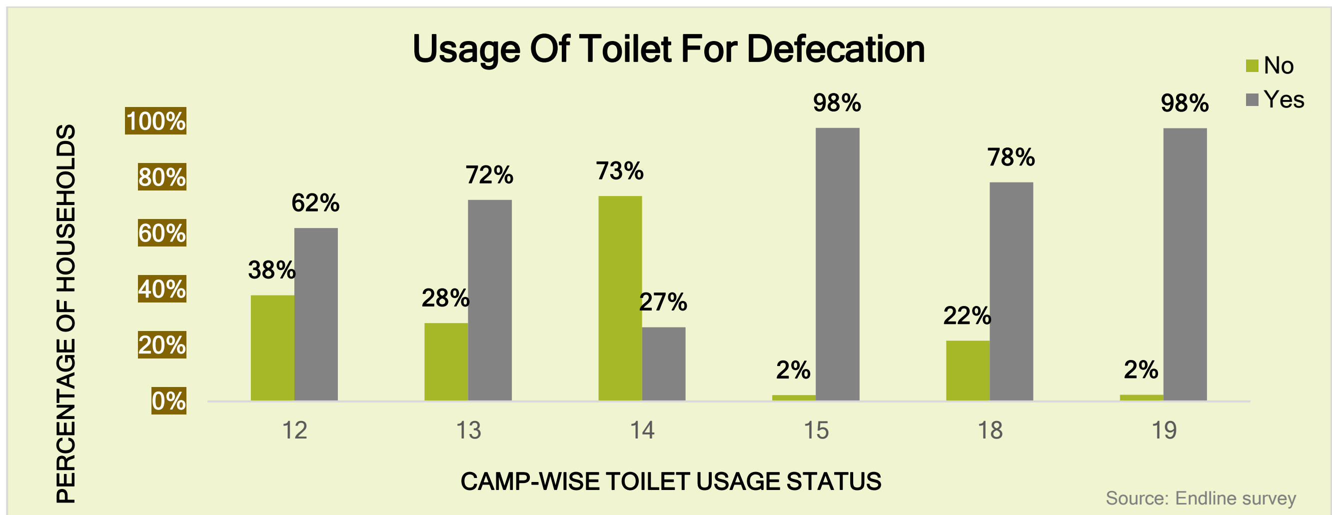


Figure 15 Usage Of Toilet For Defecation

Similarly, it was found that bathing cubicles which were constructed have been relevant and utilized by the users appropriately. The following chart provides camp-wise usage of bathing cubicles by the households. The usage of bathing cubicle across the six camps highlights the need and importance of structure amongst the beneficiaries.

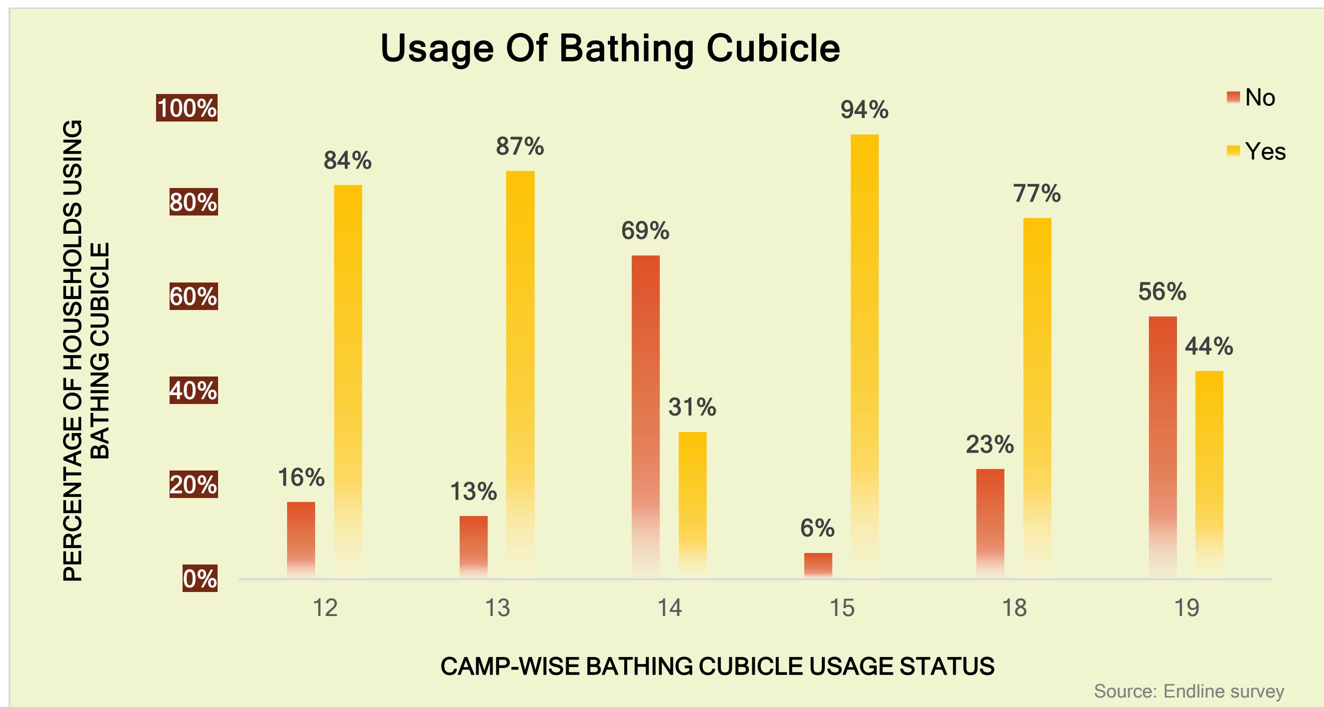


Figure 16 Usage Of Bathing Cubicle

In the project period, there was a provision of elderly and disabled friendly toilet support such as a handle to assist in balancing while sitting and getting up. This service was also useful for pregnant women and was being used by them. In addition to that portable toilets were also distributed to elderly people. The following pie-chart shows that portable toilets distributed have been of utility to the elderly and PWD and have been used by them. Nearly 81% of the respondents shared that portable toilets are used by the elderly and PWD.

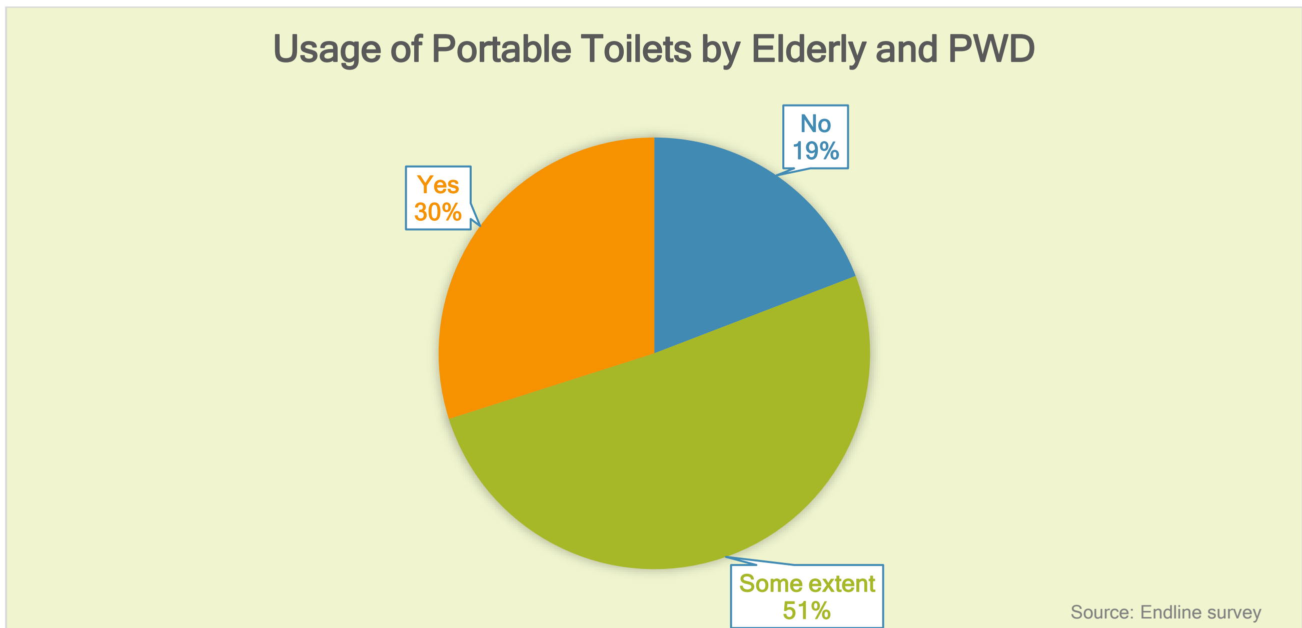


Figure 17 USAGE OF Portable Toilets By Elderly And PWD

Efficiency and Effectiveness

The consortium under this project applied the consultative and methodical approach for the positive behaviour change for hygiene promotion through regular hygiene promotion training sessions. These sessions conducted by the project staff have been effective in bringing positive change in the awareness and attitude towards hygiene.

Adjacent to the toilets are handwashing points, and it was found that handwashing points are well maintained and used by the community members. Handwashing points comprise of a water drum, metallic structure to hold the drum and small space in the structure to keep the soap. This can be attributed to the adoption of the hygiene promotion messages and activities conducted with the community. The pie-chart below provides usage of handwashing points across the six camps where the project was implemented. Almost 79% of the respondents informed that handwashing points installed under the project are utilized for the purpose of hygiene maintenance.

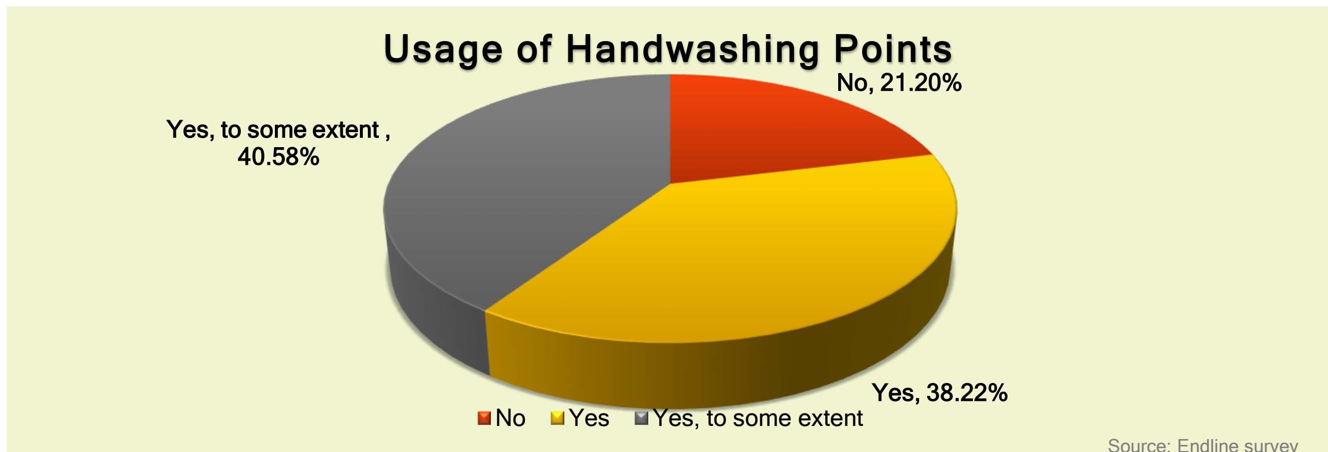


Figure 18 Usage Of Handwashing Points

The deep tube-wells and gravity water structures constructed under the project have been able to enhance the water accessibility to the community, specifically for PWSN. From the chart below it can be seen that the water point accessibility for PWD, pregnant women, adolescent girls and aged people have been enhanced. The increase in ease of accessibility for pregnant women rose from 6 % in baseline to 48% in the end line, similarly, for adolescent girls, it changed from 24% to 83%. The difficulty for PWD in accessing water points was reduced from 95% in baseline to 49% in the end line. The ease in access to water points has ensured water availability and also enabled people in the community to save time spent in fetching water.

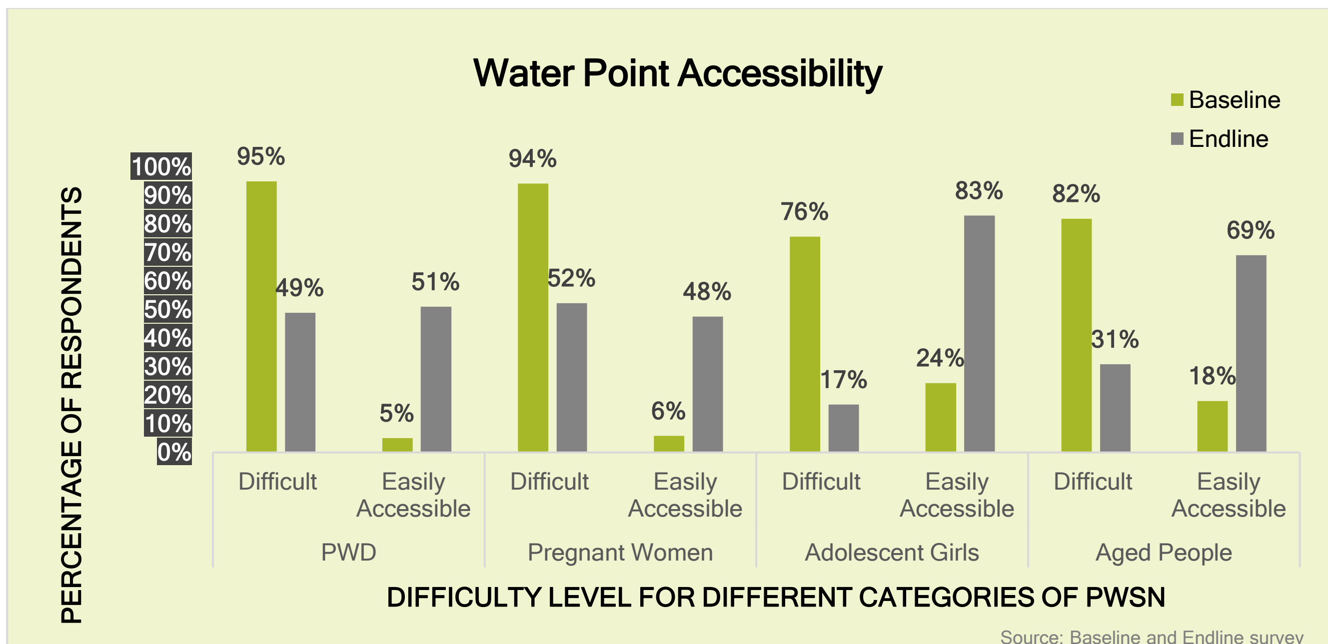


Figure 19 Water Point Accessibility

The behaviour change in the community is systematically adopted and sustained through the formation of user groups which has ensured ownership and hygienic upkeep of the constructed toilet. The user group comprises of the members of the community who use that particular toilet, and user group members are rotated weekly/fortnightly to ensure collective ownership over the hygienic maintenance of the toilet. The behaviour change and ownership over the constructed infrastructure are visible from the following chart which provides the satisfaction level of the respondents on access to the toilet. From the below table it can be seen that the number of respondents who are satisfied with access to toilet rose from 11% in baseline

to 69% in the endline. Though some of the respondents stated their satisfaction on access to the toilet as unsatisfied and very unsatisfied, their respective percentages were reduced in the end line as compared with the baseline. Although not in all the sites, it was reported in Camp 12 (G-8 block) that the location of toilet constructed under the project is slightly away from the habitation which results into difficulty in accessing for pregnant and lactating women and elderly members of the community. Another aspect which came forth was the usage of toilets by male members, which are exclusively marked for females. This issue has been reported earlier by UNICEF too in its case studies[5].

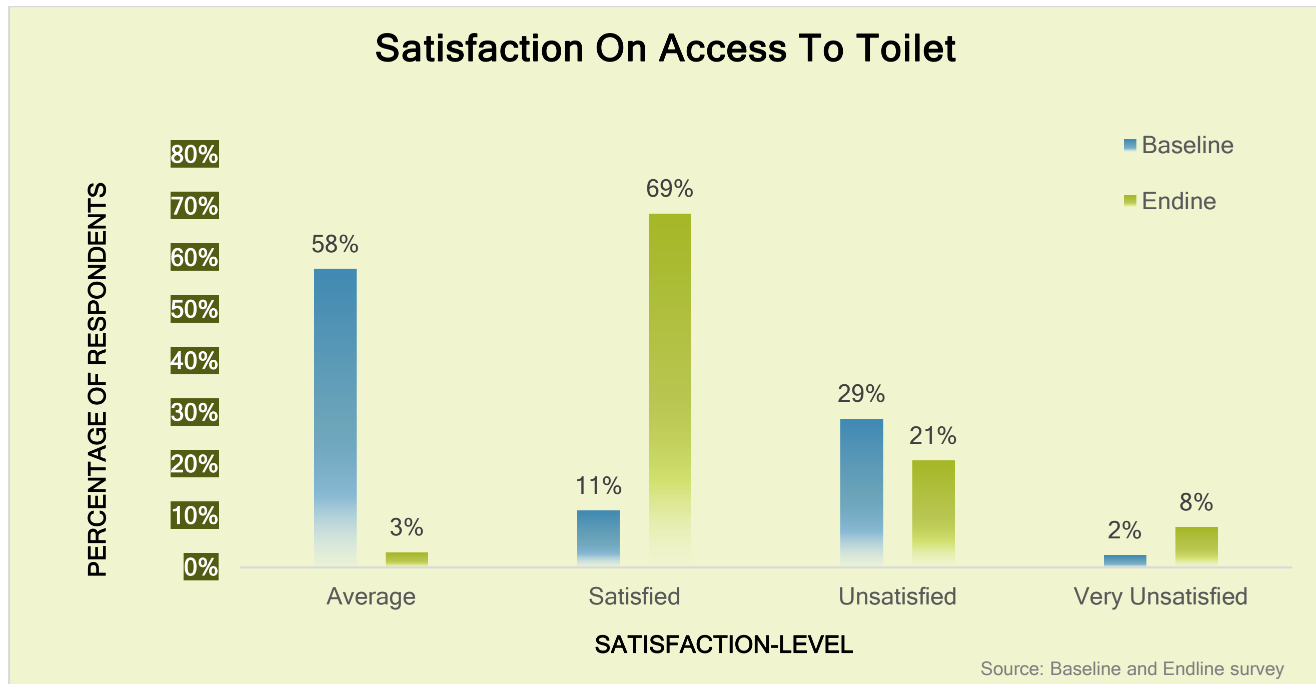


Figure 20 Satisfaction On Access To Toilet

The maintenance of cleanliness in the toilets as a behaviour change is not similar across the camps, but generally, it was found that there is a changing trend (positive) towards the desired scenario. Another factor which affected the cleanliness of the toilets, aside from the behaviour of users, was the water availability in the particular block.

Impact

The gravity water structures constructed under the project have ensured water availability and also enabled people in the community to save time spent in fetching water. From the below chart it can be seen that 55% of the respondents informed that it took less than 15 minutes for fetching drinking water and 38% of the total respondents informed that it took them 15-30 minutes for fetching water. So as per the sphere guidelines on the queuing time which is less than 30 minutes, a total of 93% of the households reported that the queuing time was less than 30 minutes. Though there were a minuscule 3% respondents who informed that it took them 45-60 minutes in the queue.

[5] https://www.unicef.org/rosa/stories/when-going-bathroom-takes-courage

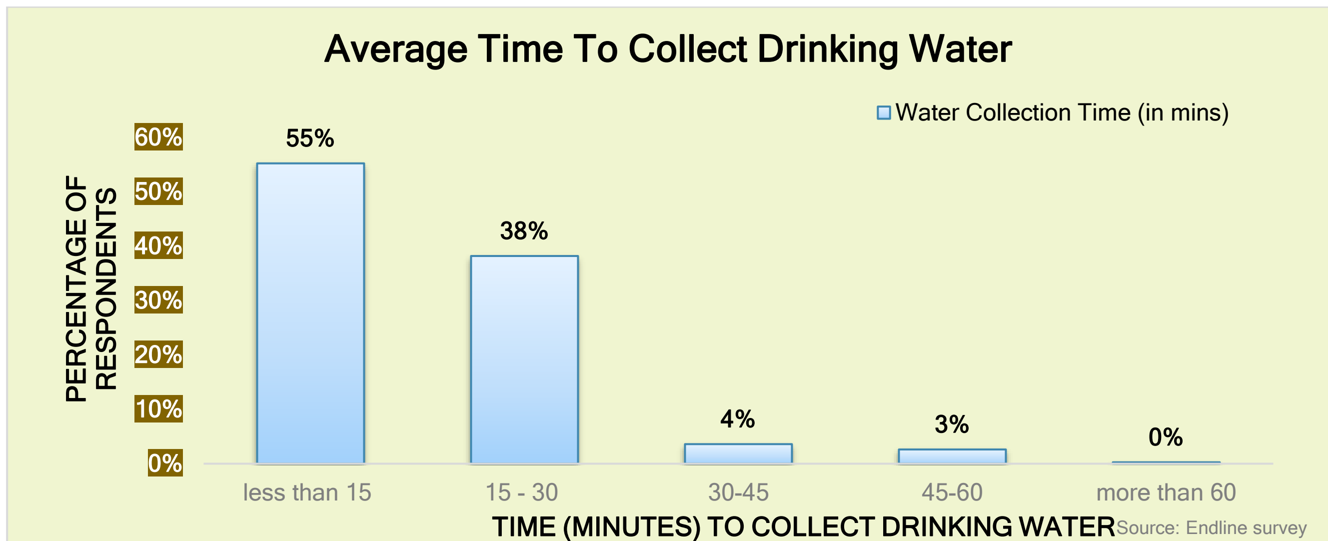


Figure 21 Average Time To Collect Drinking Water

The selection of the location of water-points was done in consultation with the community. It ensured that the maximum of the participants had easy (distance-wise) accessibility of the water-points. From the below chart it can be seen that the distance of drinking water point was less than 100 metres for 94% of the households, which is within the sphere guideline which marks it at a distance of fewer than 500 metres.

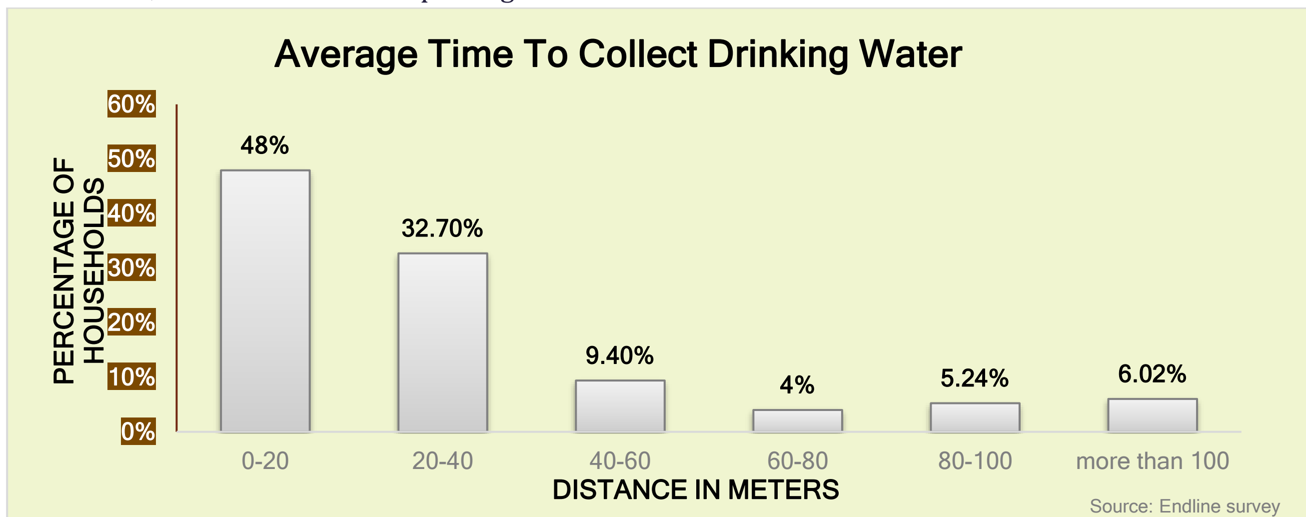


Figure 22 Average Time To Collect Drinking Water

As a result of water availability, hygiene maintenance has enhanced within the community across four camps. From the below chart it can be seen that regular bathing was practised by the majority of households in camps number 12, 13, 15 and 18. In the camps number 14 and 19, the practice of regular bathing was practised by less than half of the total households surveyed. This can be attributed to a sufficient supply of the water and hygiene behaviour of the community. The bathing cubicles constructed have been beneficial specifically to the female members of the community and have ensured privacy for their daily cleansing activities. Bathing cubicles constructed are sturdy, spacious and have a functional door locking system to ensure the privacy of the user.

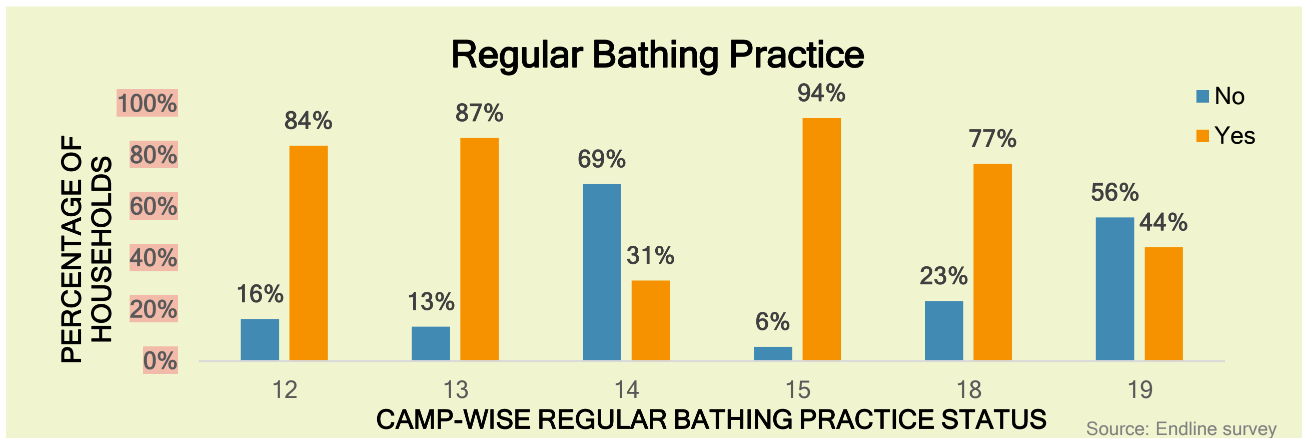


Figure 23 Regular Bathing Practice

Although there was a change in general hygiene behaviour of the community in case of open defecation it was found that there was an increase from 39% in baseline to 53% in the end line of the households which practised open defecation. Sphere standards guideline prescribes a minimum of 1 toilet per 20 people, and it was found during the evaluation that 10-20 households were using the single toilet, which makes it difficult for all the members to access and make use of the toilet. During the discussion with the community, it was informed that there might be still members of the community who would be practising open defecation owing to the challenge of a large number of users per toilet.

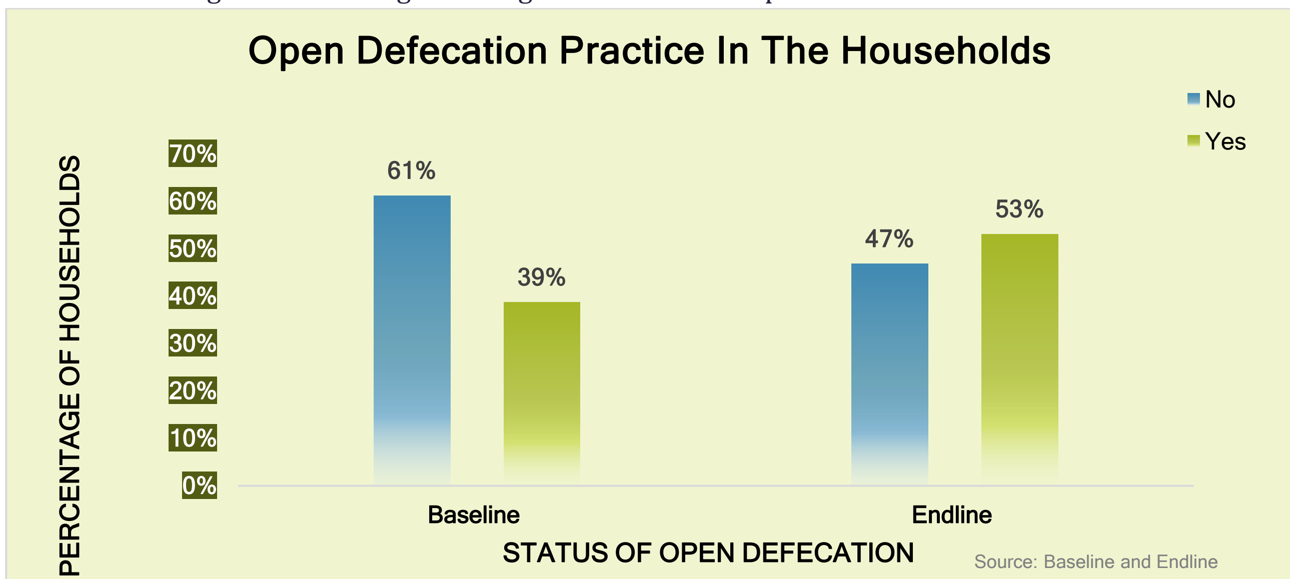


Figure 24 Open Defecation Practice In The Households

The availability of water in the toilets was ensured under the project, hence there was an increase in the number of households from 25% in baseline to 52% in the end line, who reported sufficient availability of water for toilet cleaning.

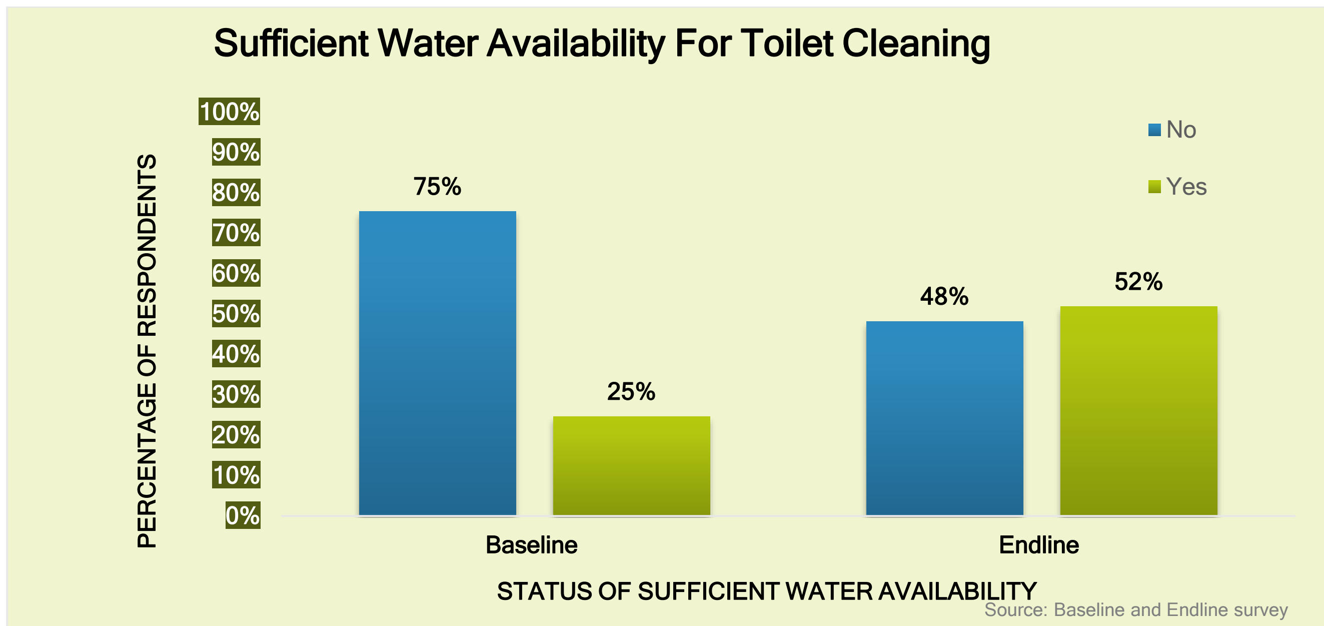


Figure 25 Sufficient Water Availability For Toilet Cleaning

The status of functional lights in the toilet improved from the baseline to endline. A total of 79% of the respondents reported unavailability of functional lights in the baseline, whereas by the endline only 45% of the respondents reported unavailability of functional lights in the toilet. Functional lights are important for women to access the toilet at all hours of the day. It was found during the evaluation that access to a toilet at all the hours of the day have improved for women and functional lights in the toilet are one of the major factors.

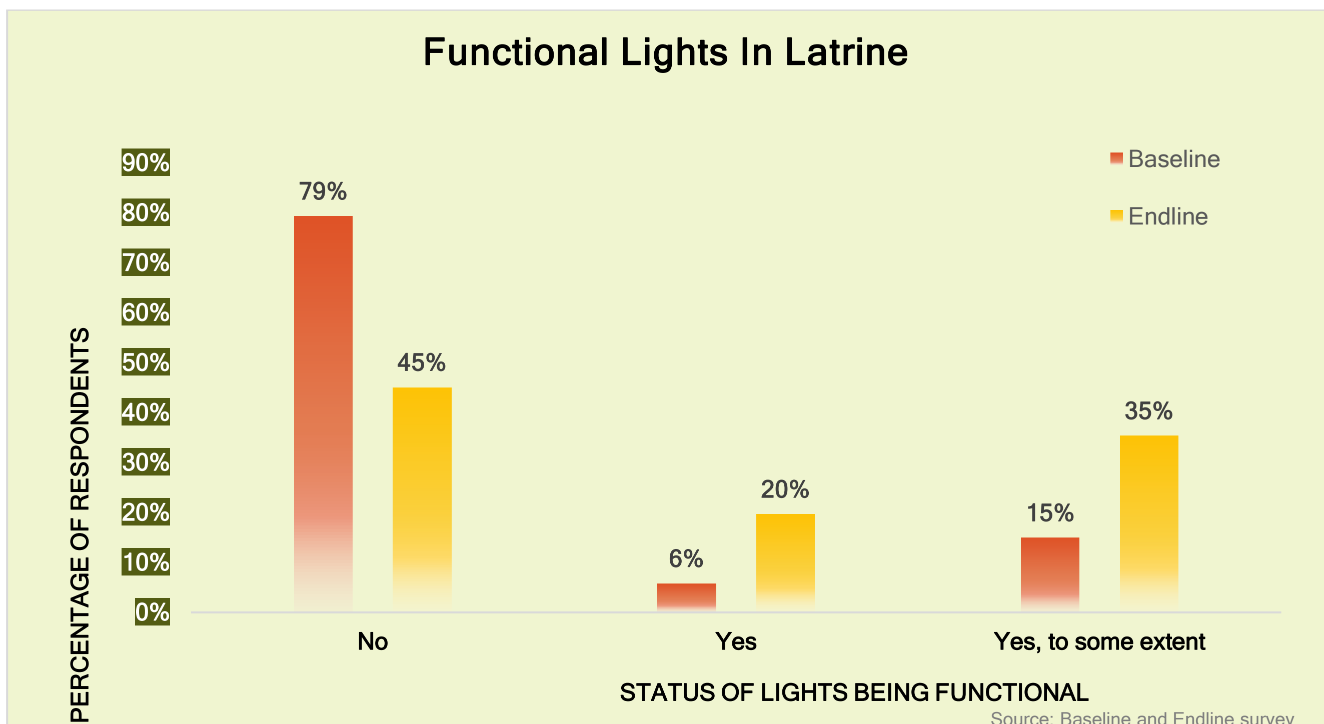


Figure 26 Functional Lights In Latrine

One of the key indicators under excreta management standard (Sphere Standards) is - ***There are no human faeces present in the environment in which people live, learn and work.*** It can be seen from the chart

below that post the implementation of the project "***sometimes"*** visibility of faeces near households decreased from 85% in the baseline to 52% in the endline. This finding suggests the adoption of appropriate hygiene behaviour by the community in the short duration of time. The beneficiaries understand the value of hygiene maintenance and its impact on their health and general well-being as a result of persistent hygiene promotion training sessions. The community members have become aware of the fecal-oral cycle and have been making conscious efforts in applying learnings in their life from the hygiene promotion sessions which have been conducted under the program intervention.

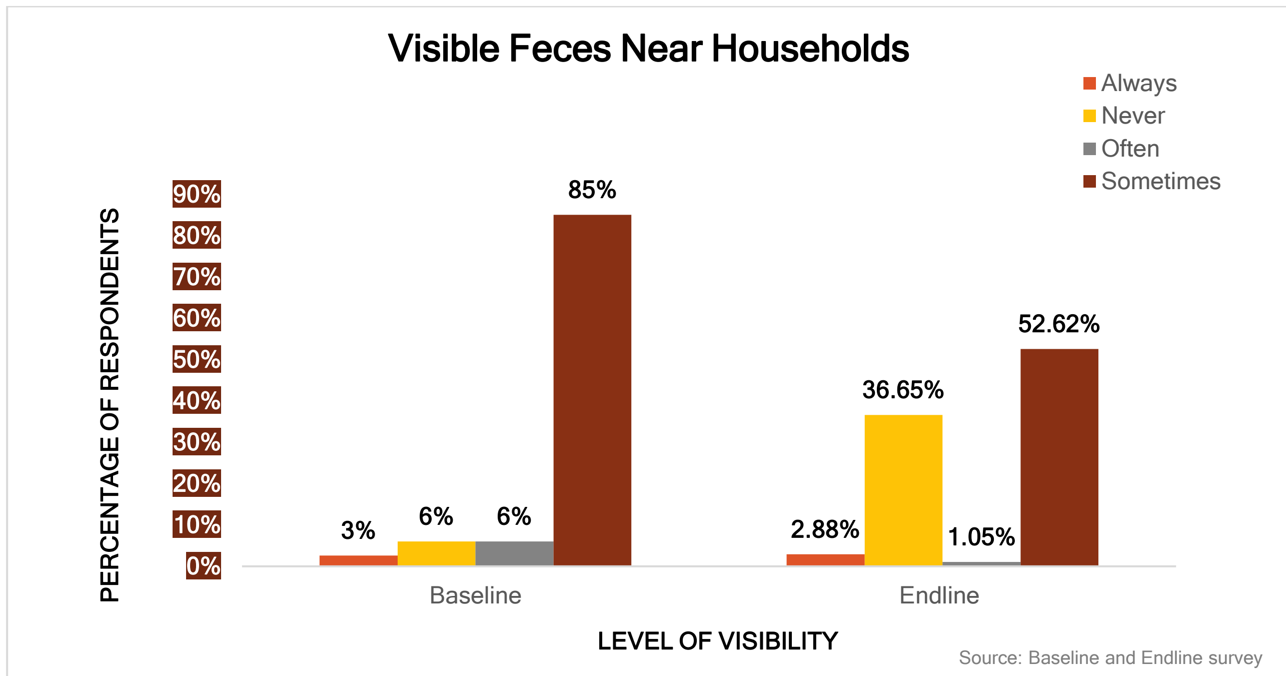


Figure 27 Visible Feces Near Households

Dustbins have been constructed for solid waste management in the community and solid waste management is handled by one of the community members, who collects solid wastes from the locality (of his work-area) and also clears the waste from these dustbins. The person who collects solid waste is paid (Cash for work) and has been effective in providing livelihood option for a few members of the community and also ensuring the cleanliness in the community. The satisfaction of the respondents on solid waste management in their area increased 9% in baseline to 74% in the end line. It suggests that solid waste management had been handled properly in the camps under the project.

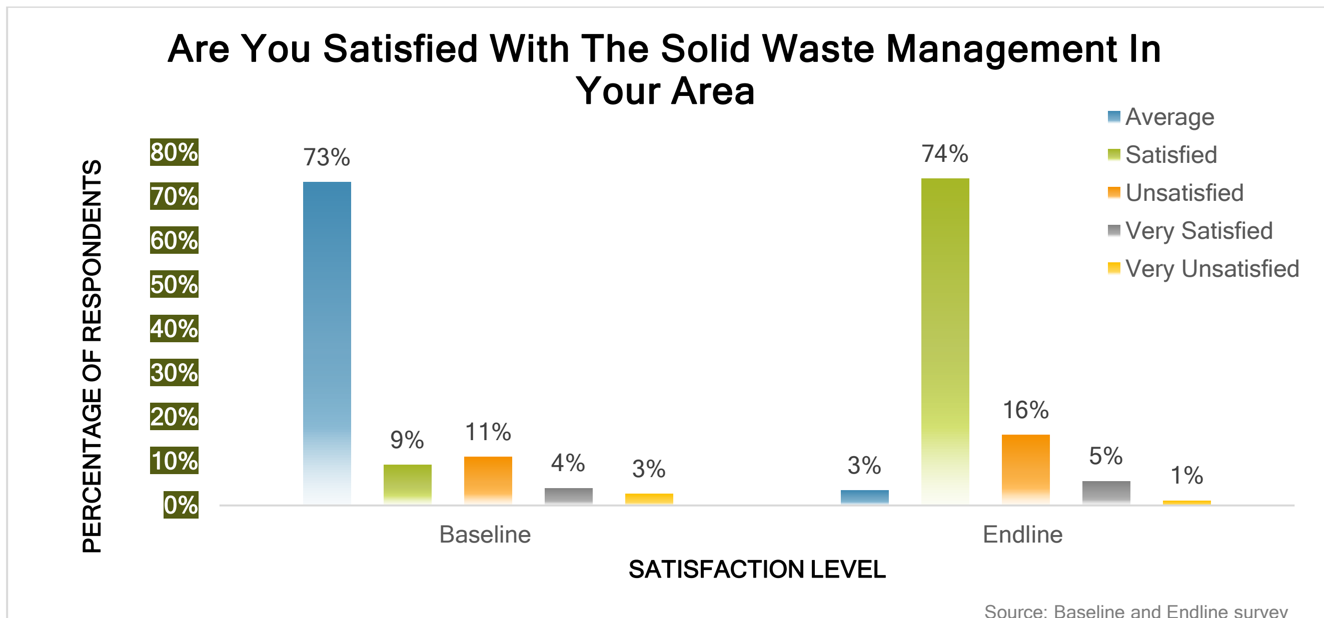


Figure 28 Are you satisfied with the solid waste management in your area

It was found that the community members consider hygiene promotion and WASH activities (including the construction of structures) have resulted in a contraction in a number of visible diarrhoea cases (community observation). This observation was further substantiated from the site management data (camp 15) on the health sector, which suggested that diarrheal cases have decreased in the existing hospital setting post the initiation of activities under the WASH intervention. Although no clear correlation between WASH activities and contraction in diarrheal cases can be established within the scope of this study, a further study in future can be conducted on it.

Sustainability

The toilets and gravity water points are essential and day to day utility structures, as a result, ownership amongst users have been developed successfully for proper upkeep of the structures. The user groups have been provided toilet cleaning kits and they use these kits for proper and hygienic upkeep of the toilets. Further rotation in the user group members is practised which ensures ownership is developed by all the users of that particular toilet. The community members expressed that the upkeep and maintenance of the toilet structure will be continued by them even after the completion of the project support stops, as it is their daily utility and they are the primary users. Although the user groups have developed ownership, this ownership trend is sporadic and it needs to replicate across the sites with localized strategies specific to the particular location and community members.

Nutrition

Program Activity

The nutrition project intervention targets the treatment of identified SAM and MAM children through Outpatient Therapeutic Programmes (OTP) centres set up at every camp. Under the project activity, there are 9 OTP centres to treat children with SAM as well as 16 infant & young child feeding (IYCF) centres to promote optimal feeding for children under the age of two.

Key interventions and activities include:

- Expansion of community mobilisation and engagement activities with the beneficiaries through community kitchens, provided with cooking demonstrations as well as referred to IYCF centres for targeted support
- Existing IYCF centres providing a proper environment for women and their children in which they can safely breastfeed and learn about optimal childcare practices.
- IYCF centres connecting women with other available services in the camps and provide a daycare space for women.
- Formation of Mother to Mother Support Groups (MtMSGs) in the camps providing a safe place for mothers to talk about the challenges they are experiencing, learn about optimal child care practices and gain support in caring for their children.
- Providing training to health workers, extension workers and WASH volunteers to understand the critical and lifesaving importance of nutrition interventions and how to identify children who may be malnourished.

Relevance / Appropriateness

Given the fact that the food distributed in the camps only consists of rice, pulses and oil from the WFP food aid, the community members require dietary diversity in their food intake. Within the limited option, the community kitchen for the nutritional purpose was found to be appropriate and relevant. The community members are satisfied with the services and the women groups have appreciated the training and the door to door services. The OTP centre for the treatment of MAM and SAM children is also appropriate given the high percentage of malnourished children in the camps.

According to ISCG Joint Response Plan report (Jan- December) to the overall malnutrition rate is below the WHO emergency threshold of >15%, but within the serious category according to the SMART nutrition surveys conducted in April/May 2018. Lack of proper nutrition amongst the Rohingya community demands further scale up and improvement in the quality of nutrition services. Hence the team found that activities conducted under the nutrition component of the project was highly appropriate and needs to be continued.

Efficiency

The delay in the project initiation impacted the program efficiency. Since there was a delay in implementation of the project on the field, so it also delayed the process of getting seeds for the kitchen garden activity. As most of the vegetables are seasonal so this directly impacted the quality of the production achieved in the kitchen gardens of the community members (beneficiaries) from the distributed seeds.

Effectiveness

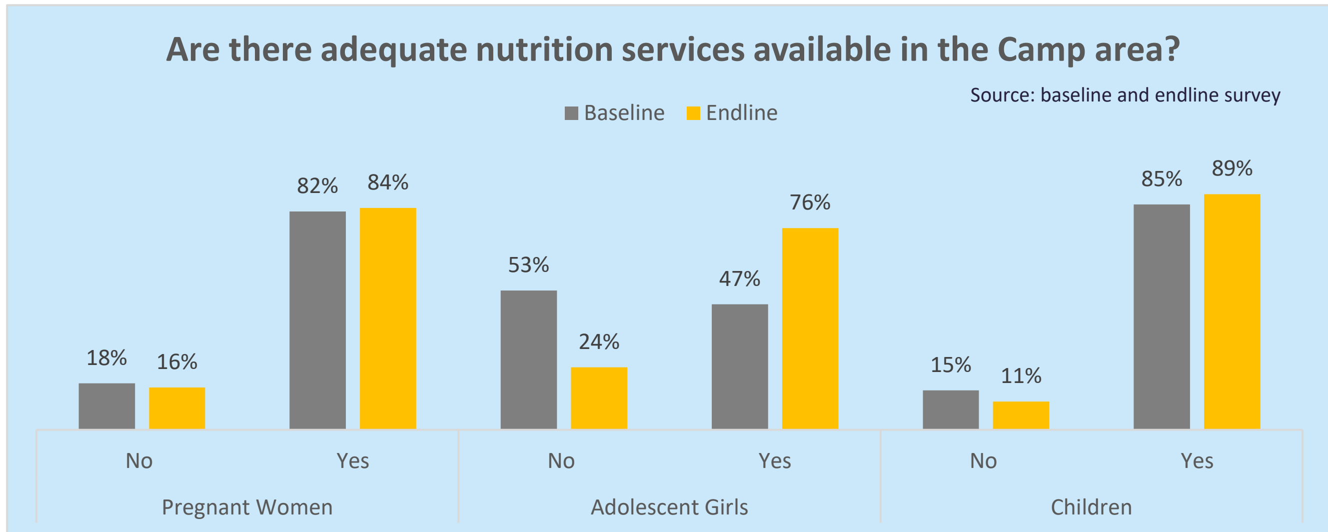


Figure 29 Adequate nutrition services available in the Camp

The baseline and the end line data shows that there has been an improvement in the nutrition services in the camp especially with the nutritional services for adolescent girls with improving from 47 % to 76%.
As part of the nutritional programmes for mothers, the IYCF centres work as a counselling and training centre for the mothers' group. They also cook and provide food at the centre and while the mothers are having sessions, the safe space for children to play. As the graph below shows that about 38 % of the respondent was aware of the mother's support group while 34 % expressed that it is there to some extent. However, it also shows that there needs to be more awareness generation of having more members in the mother's group. A longer duration programme will be able to determine more impact.

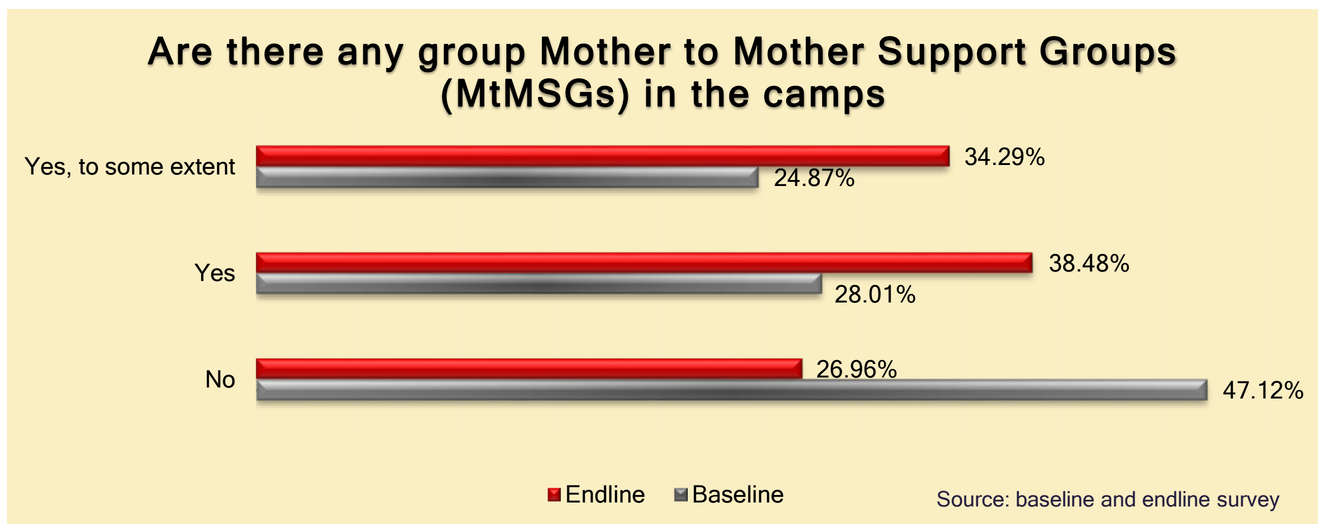


Figure 30 Mother to Mother Support Groups (MtMSGs) in the camps

During the FGD most of the responded shared that the mother's support group was effective and functional.

It was found that the mothers' group regularly meets (weekly) at IYCF centres and they learn about the importance of a balanced diet through the sessions which were conducted on proper nutrition. Through these MSGs, women members of the community have formed space to discuss and to mingle. In the community kitchen women (of MSGs) cook and feed their children. The IYCF Centre usually have a shelter to sit and basic facilities such as fan and the women of the MSGs look forward to the meetings.

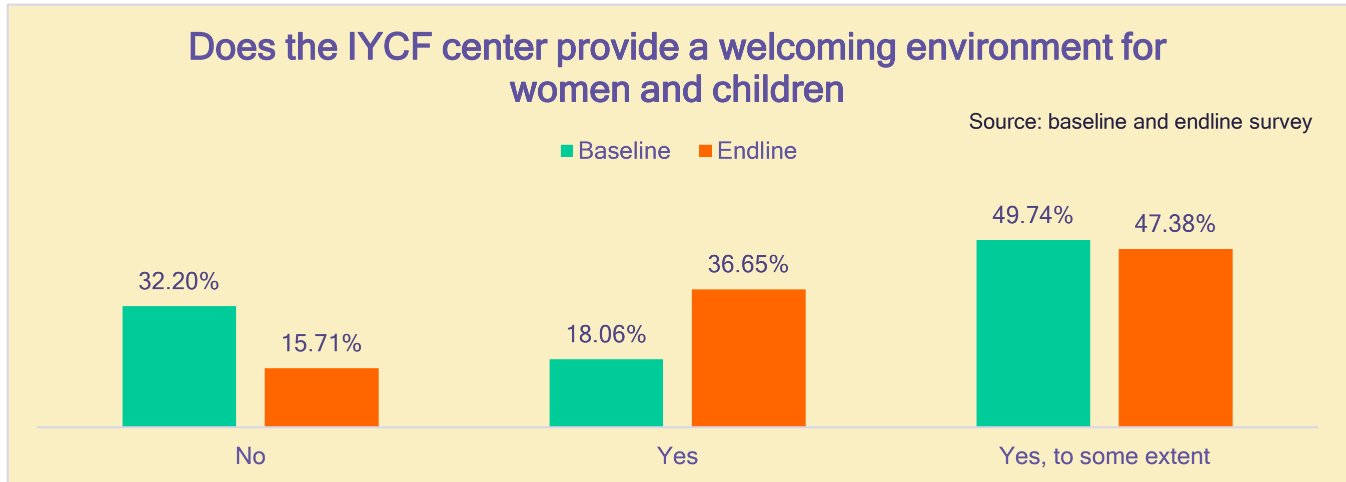


Figure 31 Does the IYCF center provide a welcoming environment for women and children

The survey data also shows that most of the respondent felt that the IYCF centre provide a welcoming environment for women and children with 37 %responding positively and around 47 %agreeing to some extent. This is also an improvement from the baseline where only 18 %of the respondent positively felt there was a welcoming environment.

The members of mothers' support groups shared that they have learnt a various aspect of child care, nutrition and how to take care of the pregnant women, risk positions for the pregnant women, safe food preparation and breastfeeding. It is through these sessions that they have learnt on the importance of colostrum for the nutrition of the newborn. Mothers of the MSGs shared that when they were in Burma, they use to throw away the first breast milk because they thought that it was unhealthy, however, now after attending the training sessions, they know the health benefit of colostrum and why it should be given to the newborn children. The team found that most of the participants knew about the importance of the nutrition centre and the programme was running effectively.

As the graphs below also suggest that during the end line the respondents were more positive about receiving sessions on safe breastfeeding practices and optimal childcare practices for women with 40 % being affirmative and 43 %sharing that they have sessions to some extent. The number of respondents sharing about receiving no sessions on safe breastfeeding and childcare practices have reduced from 40 % to 16 %.

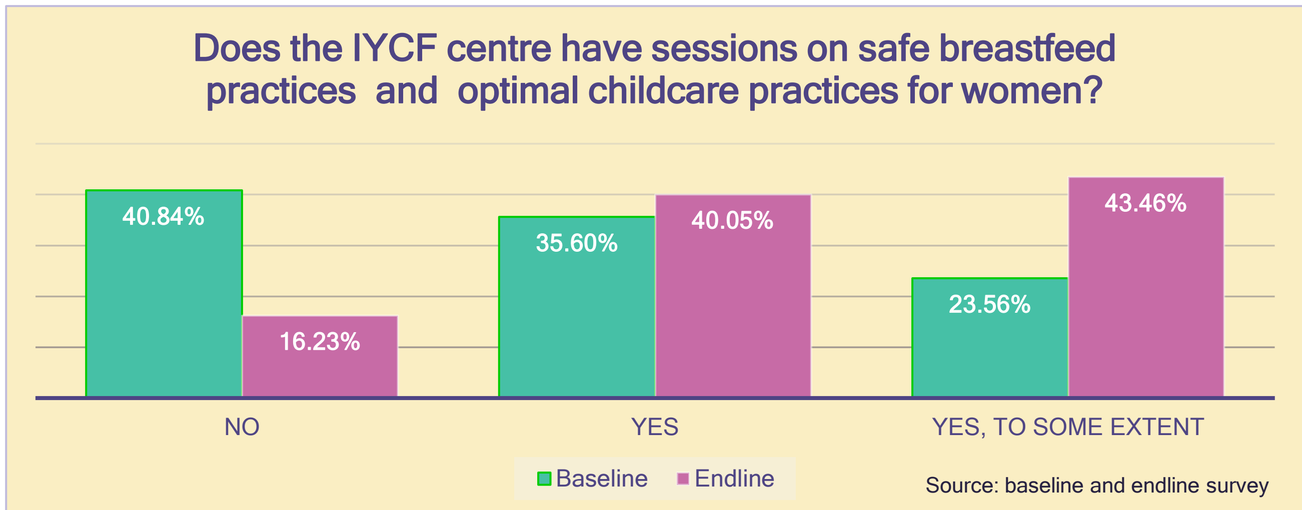


Figure 32 Does the IYCF centre have sessions on safe breastfeed practices and optimal childcare practices for women?

Distribution of seeds under the program activities has proved to be efficient as it served the family as well as help in getting extra income in case of surplus to the sustenance harvest.

The door to door visit by the volunteers has been very effective. However, the team found that the activities conducted with adolescent girls are not clear and the community members did not share any information on the same. Similarly, the activities (inclusion) for the vulnerable population (PWSN) are also not clear. In the OTP centre, MAM and SAM children are sent for testing. They are weights and then checked by a

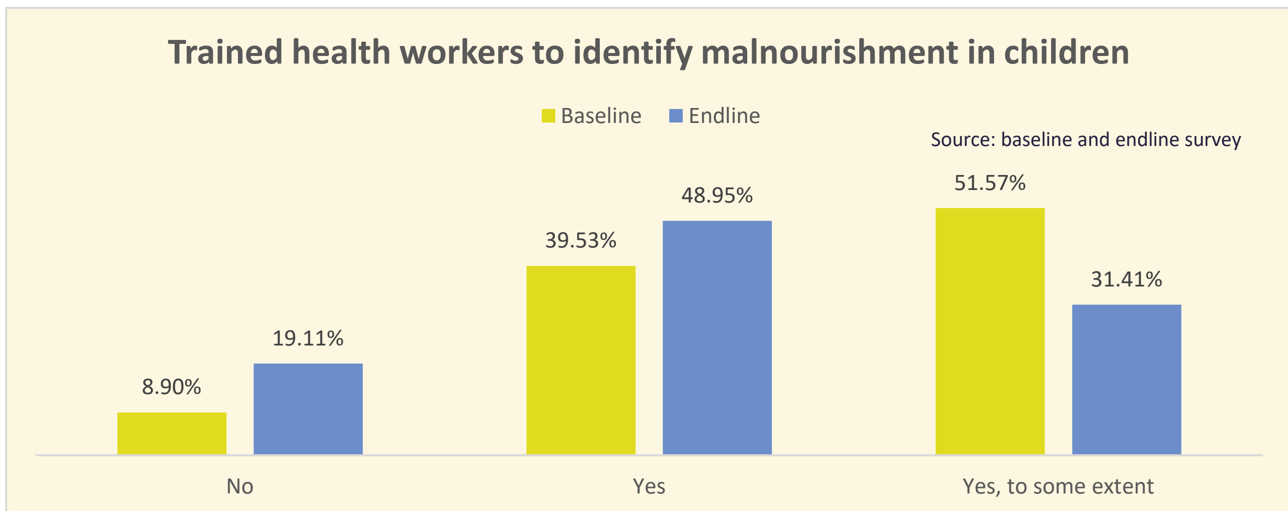


Figure 33: Trained health workers to identify malnourishment in children

nutrition's specialist. Severe cases are sent to Stabilisation centre which is in camp 18. A nutritionist work along with other health workers in the OTP centre. The volunteers shared that they were trained during the initial phase of the project implementation. In the graph above it can be seen that there is a slight increase (49 %) in the availability of trained health workers to identify malnourished children as compared to the baseline (39%). During the FGD it is shared that the health workers also identify the cases in their door to door visits.

Impact and Sustainability

Despite the short duration of the programme, the substantial impact was visible with different mothers' support groups functioning well and the dietary requirements of children under 5 being monitored.
Groups were aware of essential topics on nutrition such as balanced diet, care required by young babies, care needed by lactating mother and pregnant women etc.
SAM and MAM children are being identified and referred to OTP centres. These data are all recorded in the centres in a register however, for long term impact assessment, an alternative method on data recording could be maintained which is in a soft copy form.

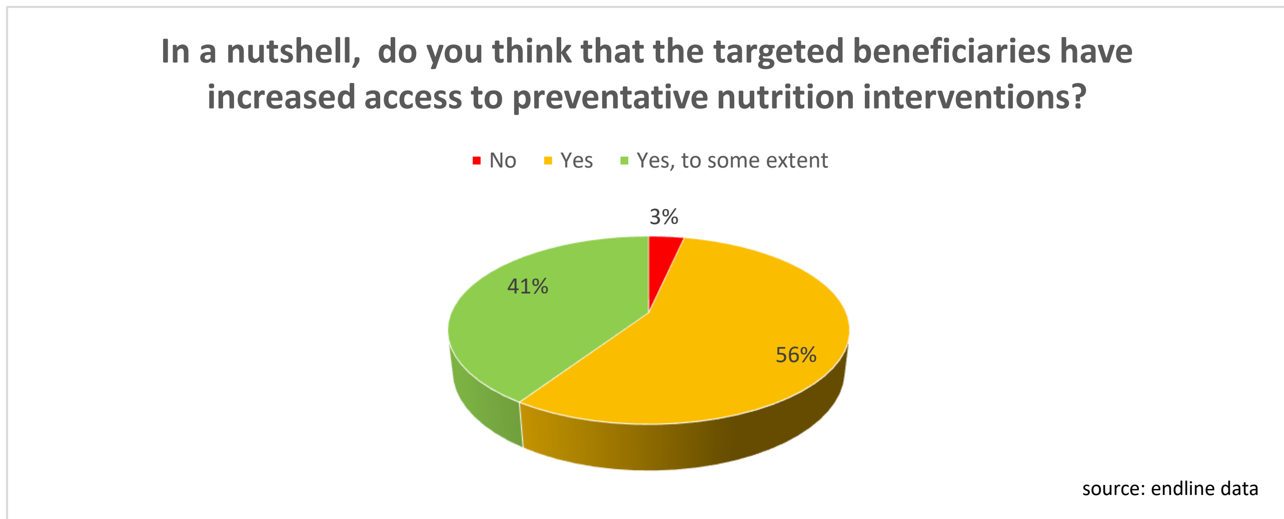


Figure 34 Increased access to preventative nutrition interventions

The above pie chart shows the impact of the nutritional programme with 56 % of the respondent sharing that the targeted beneficiaries now have access to preventive nutrition interventions while 41 % sharing that this has been achieved to some extent.
Nutrition is an essential service needs to be sustained in the next phase for further building on the gains achieved till now. Also, there is a need to ascertain whether people understand - how to identify MAM and SAM children and in the absence of OTP centre in the camp whether they can take them to different health centres or not.

Protection

Programme Activity

In order to achieve the project output for protection which is to provide protection support system strengthened and social cohesion promoted with FDMN and host communities, the consortium has worked on activating the protection mechanism through operationalizing the Women and Child-Friendly Spaces, with the focus on mainstreaming protection and accountability concerns across all the interventions.
The project includes
-Sensitizing Majhis and other male community leaders on protection and gender-based concerns, identifying and referring protection cases requiring further support, connecting survivors to appropriate multi-sectoral GBV prevention and response services and building up of community-based protection and safety units to enhance community-based protection will be the key focus areas of this intervention.
- Training of the projects staff of all partners in basic services, i.e. GBV prevention, Psychosocial Support (PSS) and Psychological First Aid (PFA) to make sure that they can ensure the protection following the sector standards. The component for host communities was dropped during the project period due to time constraint and feasibility issues.

Relevance / Appropriateness

This was an important sector as many of the participants during the FGDs shared their need to have mechanism and awareness regarding protection issues. The members shared that there have been many trafficking cases in the camps and there is a need to raise the awareness level of the people. Hence addressing protection issues seems like an apt response. As the graph below suggests during the baseline survey a large proportion of the respondents mentioned that there are threats for women regarding physical and sexual violence either in the community or in their homes with 23% mentioning 'yes' and 63% responding to some extent. This shows that there is a need for such a programme in the camps.

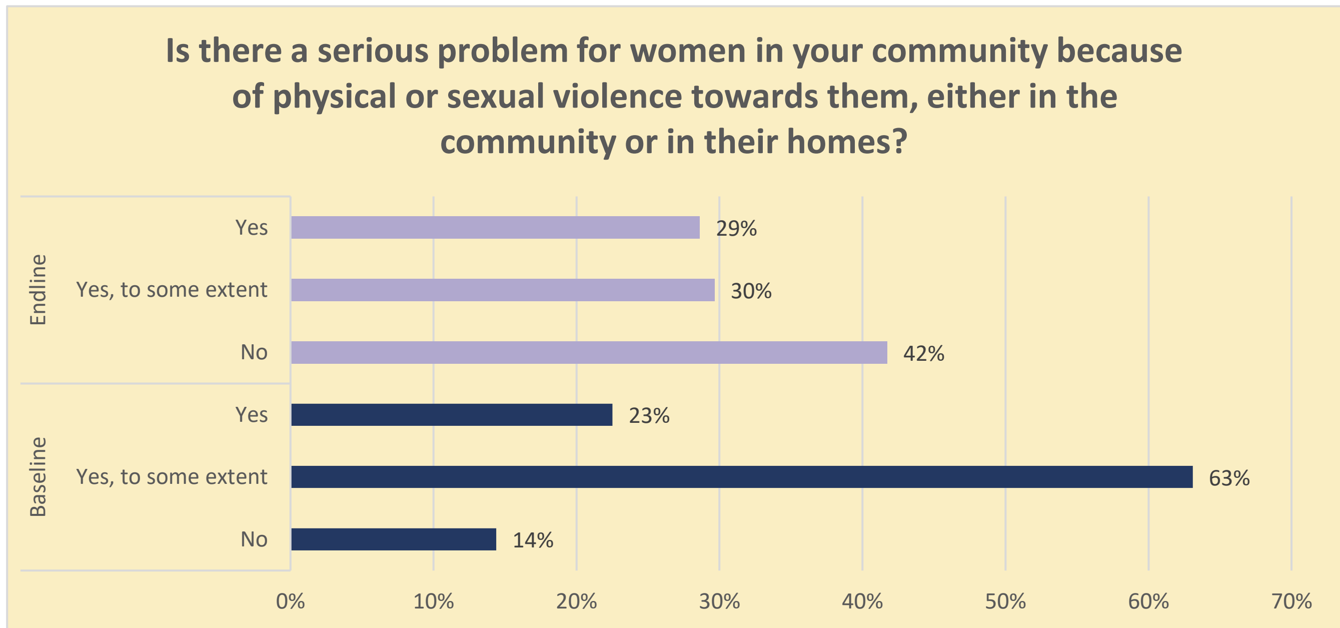


Figure 35 Physical or sexual violence towards women

During the end line, the figure has reduced to some extent with 42% responding that they do have serious threat regarding sexual and physical violence in the camp which is an improvement from 14 % in the baseline. This shows that the project has been effective in a certain section.

The female members of the community were highly satisfied with the dignity kits and felt it was much-needed item for them.

Efficiency and Effectiveness

During the FGDs the team felt that the training and awareness generation provided under the protection activity has been somewhat effective as the community members shared that they have a better awareness regarding issues of child marriages and GBV as and now they try their best to reduce the child marriage cases although the practice is still prevalent in the camp.

The protection mechanism in the camps needs to be more effective. Most of the community members depend solely on Majhis for resolution of their problems and many do not consider raising it to the level of NGOs. Women in the FGD groups were not aware of the protection groups hence efforts are needed to strengthen this aspect. The involvement of male community members is needed for more effective programming and impact.

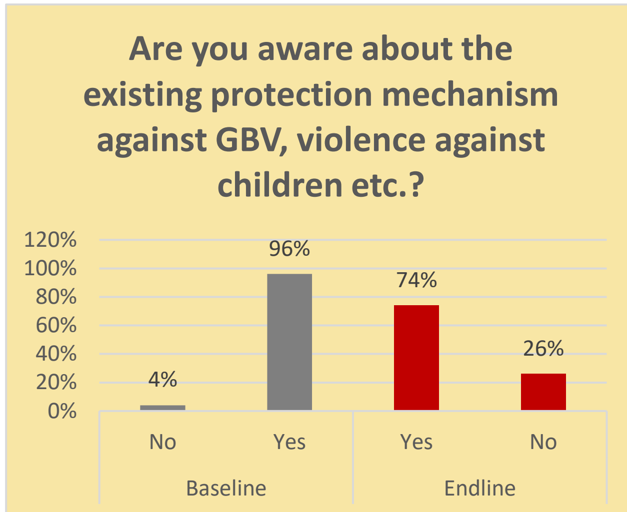


Figure 36 Awareness about the existing protection mechanism against GBV, violence against children

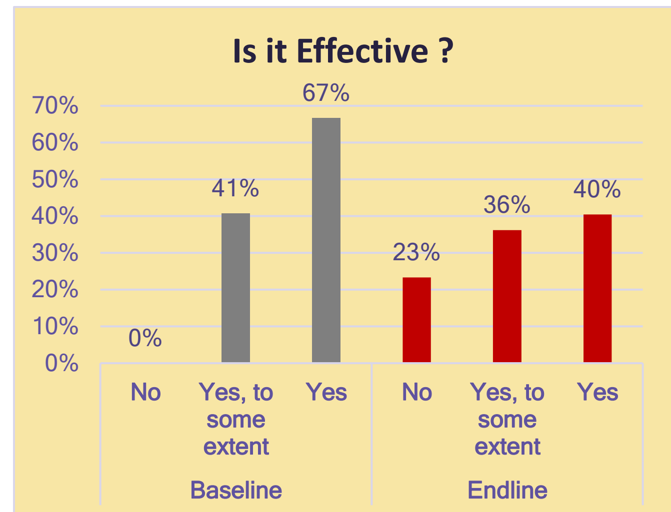


Figure 37 Effectiveness

From the quantitative data of the baseline and the end line survey, we can see that there is a general level of awareness about the existing protection mechanism and violence against children even during the baseline. The graphs above show that the awareness level of the protection mechanism was higher during the baseline survey with 96% mentioning their awareness on the protection mechanism as compared to 74% respondent during the end line albeit it still is a good percentage of people. We, however, need to understand whether the mechanism they are aware of is referring to the one set up by the NGOs and INGOs or just complaining to the Majhis as mentioned in the FGDs. However, it is evident that they know who to approach if they face any problem in the camps.

It is observed that the effectiveness of the protection mechanism needs to be monitored as depicted in the graph about 23 % of the people mentioned that it is not effective and only 40% of the respondent felt that the protection mechanism is effective while 36% mentions that it is somewhat effective.

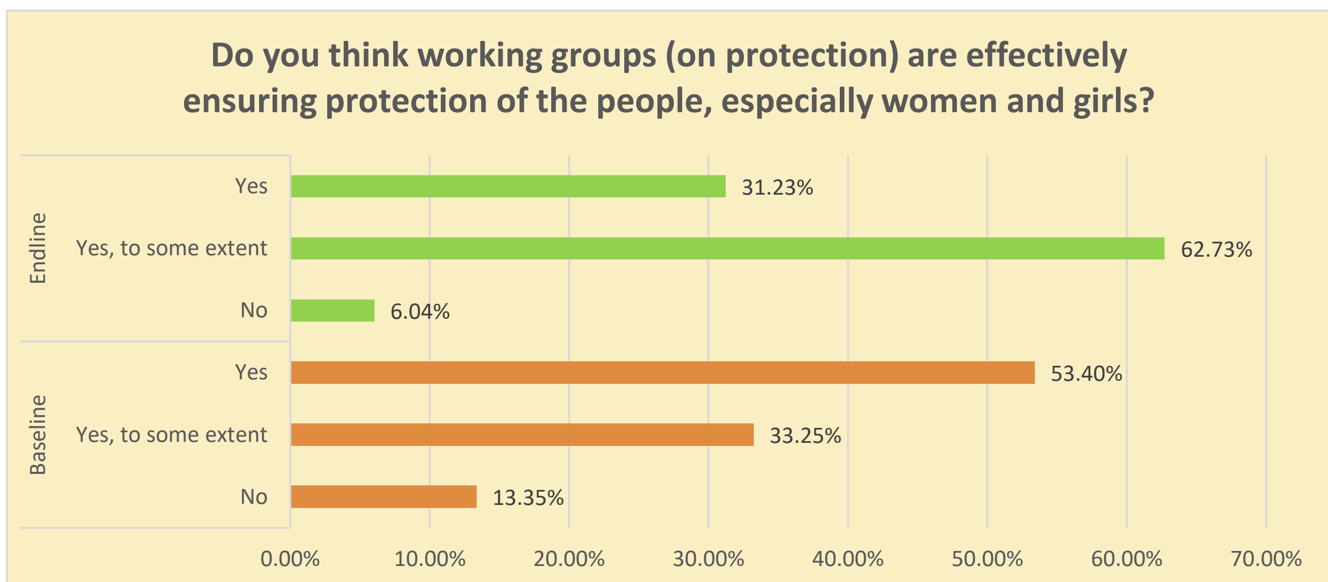


Figure 38 Effective protection of the people, especially women and girls

The above graph on the working groups for protection shows that the number of respondents feeling that it is working has reduced from 53 % to 31%. Majority of the respondents in the end line shared that it is effective to some extent with almost 63% of the respondent sharing the same. This is also evident during the FGDs as many of the women members were not aware of the protection group in the camp. This could also indicate the representation of a few female members in the working group for Protection.

The community members shared that the dignity kit was useful and appropriate however there was a blanket approach to the distribution of the dignity kits, hence the effectiveness has been affected in case of more than one users in a single household; as supplies exhaust much before the supply of next dignity kit.

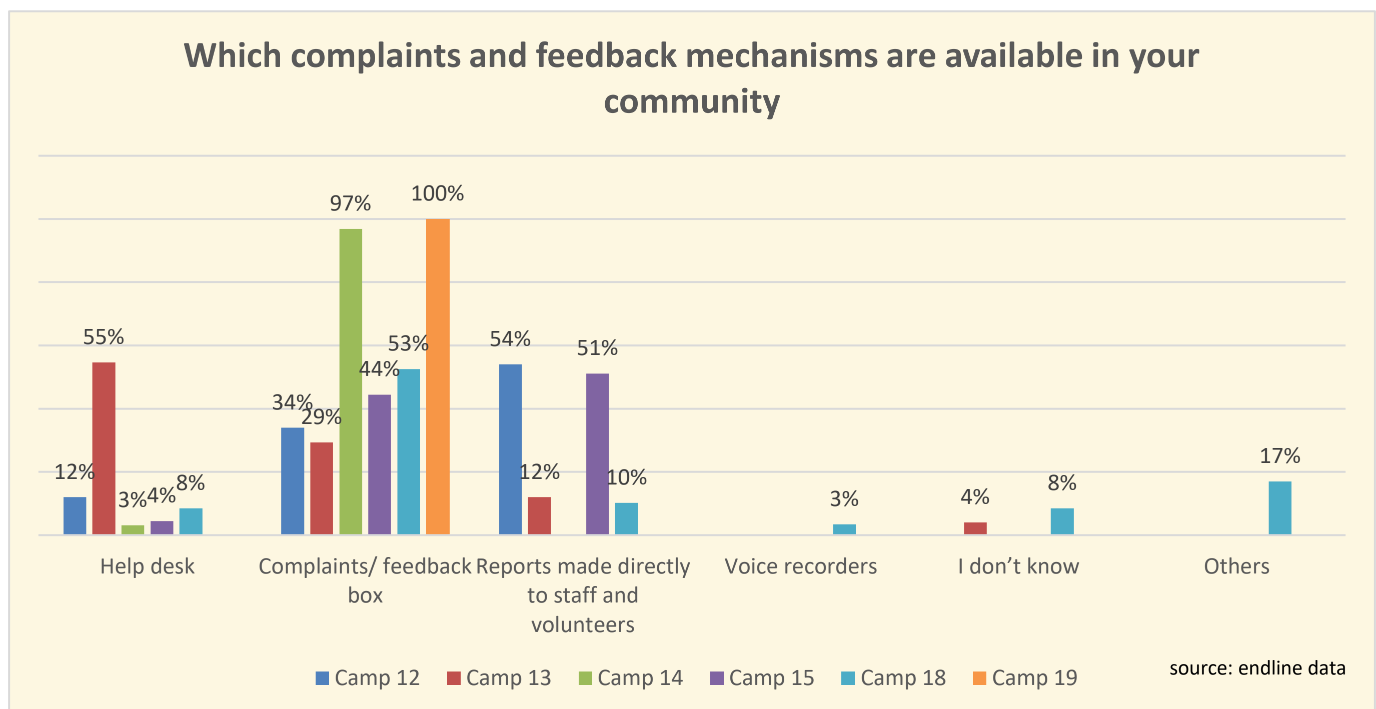


Figure 39 Complaints and feedback mechanisms

The graph above suggests that majority of the respondents are aware of the feedback/complaints box installed in the camps 97% and 100 % of respondents from camps 14 and 19 respectively sharing awareness about this form of mechanism while in camp 13 majorities of the respondent recorded using help desk with 55% of the respondent. However, in camp 12 and 15, the respondents' mentions reporting directly to staff or volunteers with 54% and 51% of the respondents from camp 12 and Camp 15 recording the same. The graph shows that the majority of the people are aware of the complaint mechanism in one form or the other with very less percentage of the respondents mentioning not knowing any form reporting a complaint.

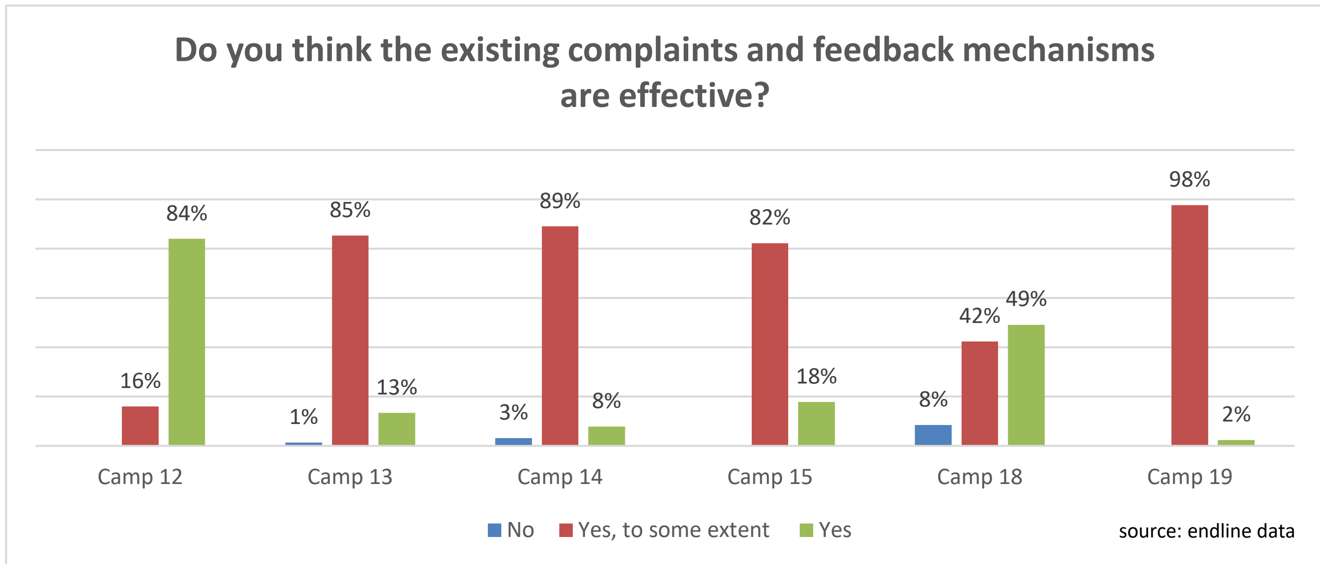


Figure 40 Effectiveness of existing complaints and feedback mechanisms

Although the majority of the respondents are aware of the existing mechanism for registering or recording a complaint, the effectiveness of the mechanism needs to be ensured. From the end line data, the graph above shows that the mechanism is functioning well only in camp 12 (84%) and camp 18 (49%) however in the rest of the camps (camps 13, 14, 15 and 19), majority of the respondents mentioned that it is effective only to some extent.

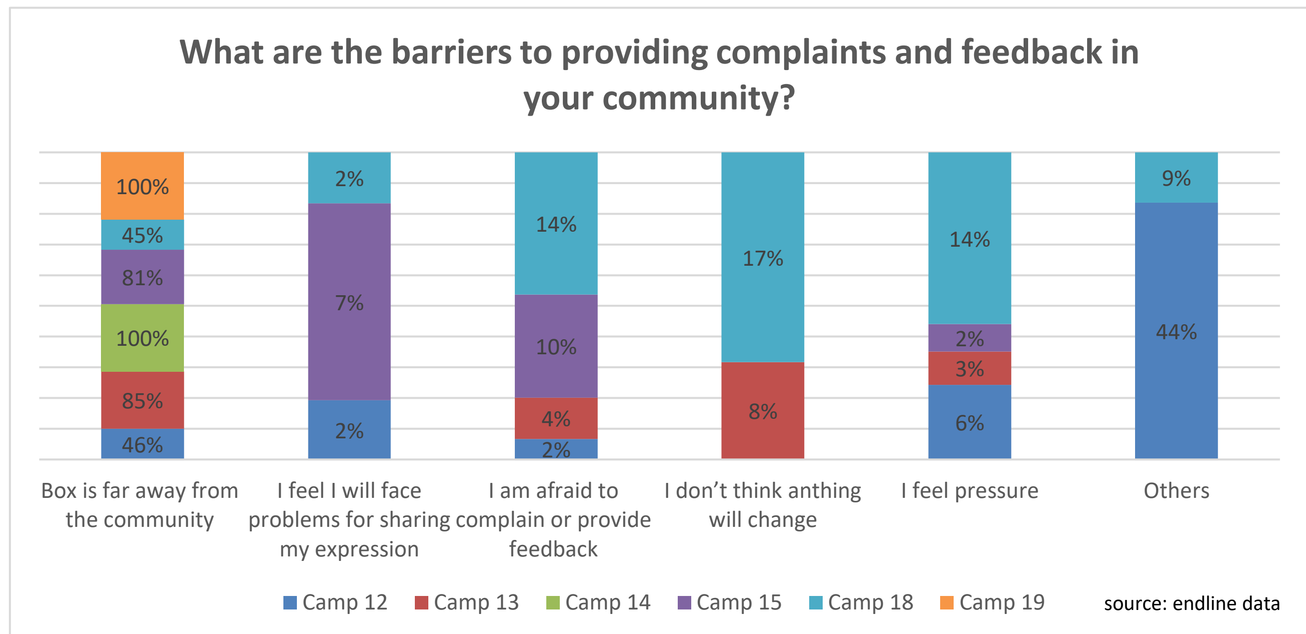


Figure 41 Barriers to providing complaints and feedback

The effectiveness of the complaint mechanism also depends on the number of people recording the complains hence, it is important to understand the barrier to register a complaint. In the end line data, it shows that in camp 14, 19 and 15 majorities of the respondents felt that the complaint box was installed far from where the community. In camp 18, 14 % of the respondent mentioned that they are afraid to provide a complaint or feedback and 14% also felt they are pressured while 17% of the respondents felt

that nothing will change. Hence there is a need to address these issues in order to improve the effectiveness of the complaint mechanism.

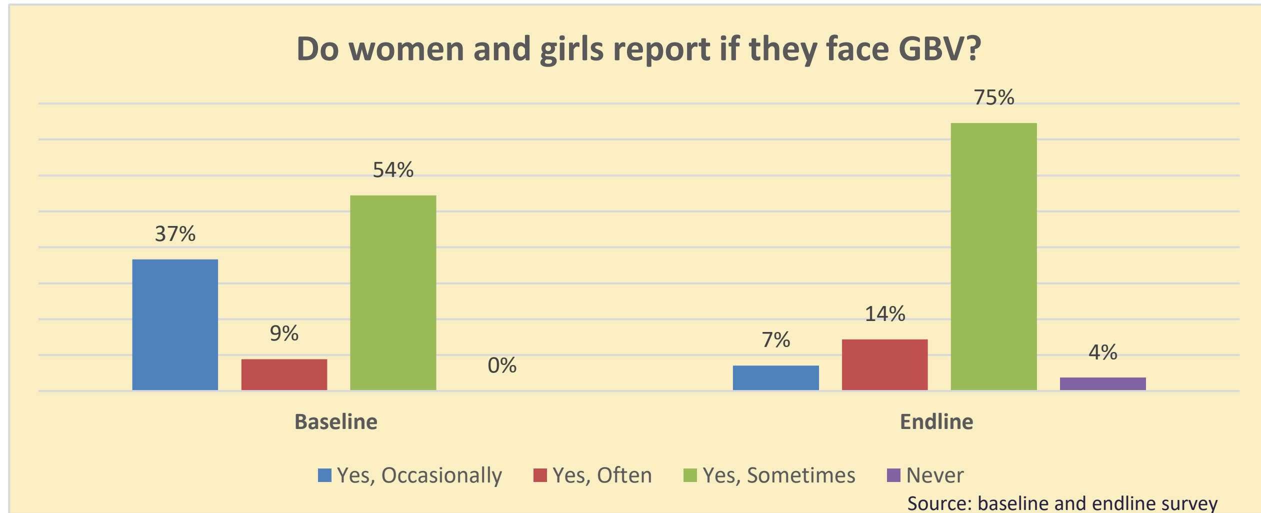


Figure 42 :Women and girls reporting GBV cases

From the baseline and end line survey data, as shown in the graph above the number of women and girls reporting cases of GBV has improved with 14% responding positively while 75 % mentioning they report to some extent. This is also evident during the FGDs where the women groups share that they often report such issues to the Majhis and if the Majhis are not able to solve the matter then they report to the CiCs.

Figure 43 : Action after reporting GBV cases

There is an increase in awareness and knowledge about registering a complaint. However as shown in the graph above, the during the end line survey, only 44 % of the respondents felt that actions are taken by the authority while 34% of the respondents felt that very rarely any actions are taken. This, however, is an improvement from the baseline data where about 69% of the respondents felt that very rarely actions were taken. Hence, people are using the redressal mechanism and there is some change in perception about the

action taken by the authorities regarding their complaints. Hence there is an impact of the awareness session and activity within the protection project activity.

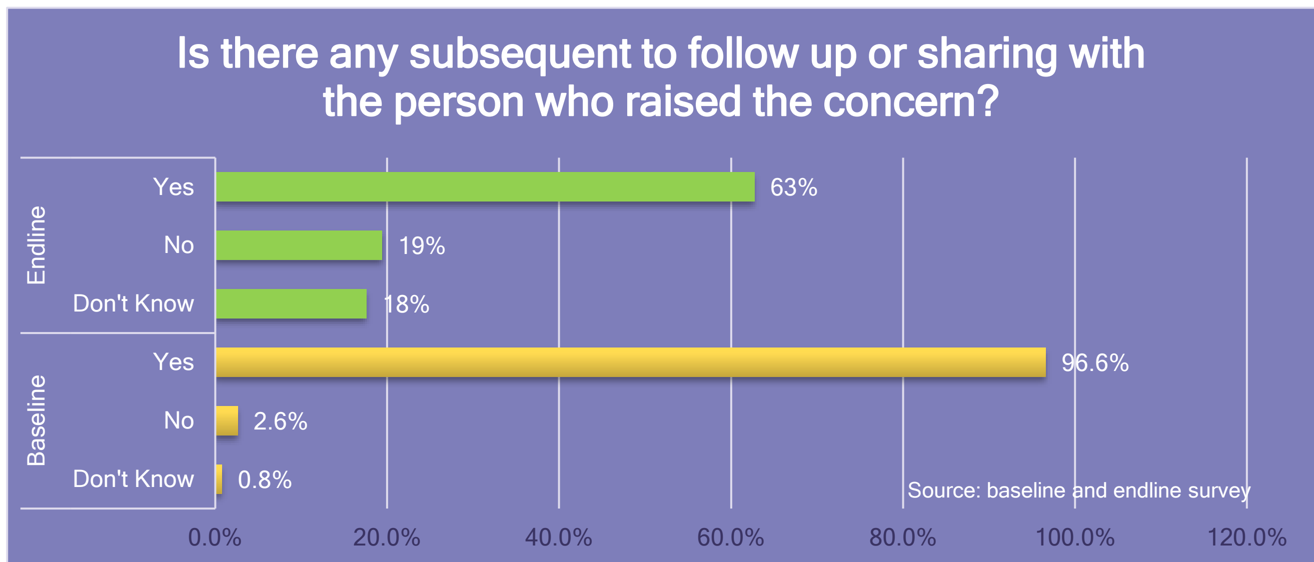


Figure 44 : Subsequent follow up with the concern person

From the graph of the end line and baseline survey it shows that there is follow up after the complaints have been filed, however, during the end line, the number of respondent sharing that there is a follow up has reduced to some extent although, it is still a good percentage with 63% of the respondent mentioning that there is a follow up mechanism. Hence, even though the number of people reporting/registering complaints has increased there is still less follow up and many of the respondents feel that no actions are taken.

Impact and Sustainability

Although it was a short project, the team felt that in terms of awareness level of the people, there has been an increase in awareness on issues such as trafficking, early marriage and Gender-based violence (GBV).

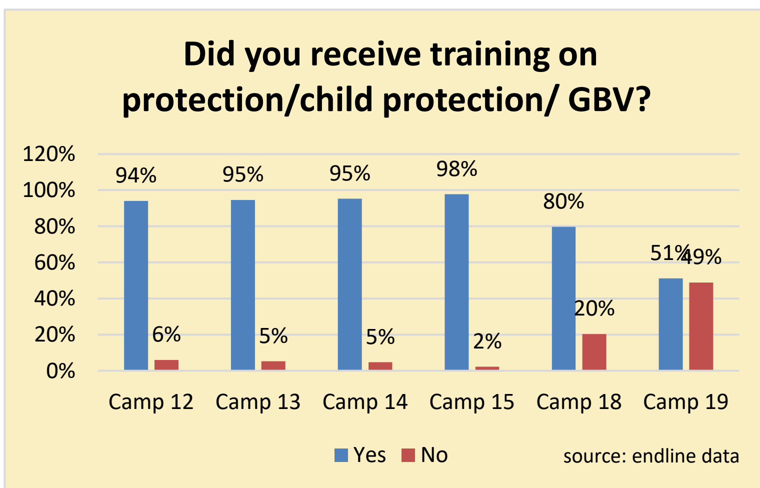


Figure 46 :Training received on protection

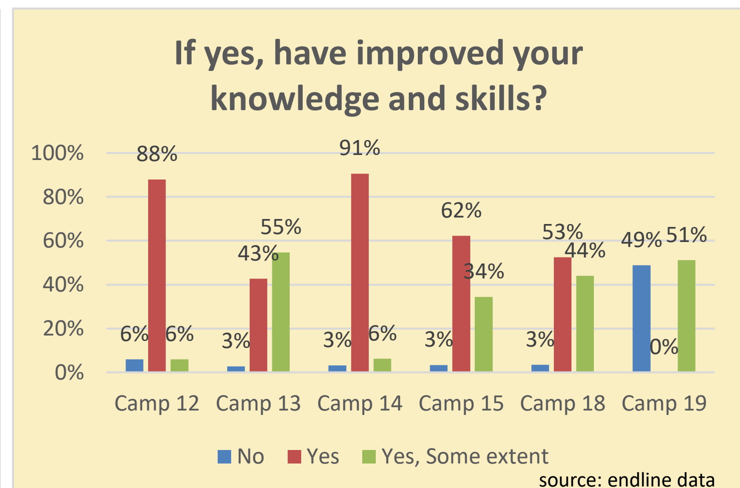


Figure 45 : Improved knowledge and skills

As the graph above shows that, majority of the respondent mentioned that they have received training on protection/Child protection /GBV with 95% of the respondents from camps 14 and 13, 94% from camp 12, 98% from camp 15 and 80% from camp 18. Only camp 19 shows 51% of the respondents receiving such training. Majority of the respondents have also shared that the training has helped in improving their knowledge and skills with almost all the camps responding more than 90% positively to some extent. As the participants during the FGDs also mentioned that they were learning and gaining more knowledge on issues related to early marriage issues, human trafficking and GBV related cases. It is interesting to note that many of the respondents also shared that they have been applying this knowledge and skills positively as shown in the graph below. About 86% in camp 12, 67% in camp 13, 89% in camp 14, 70% in camp 15, 53% in camp 18 have responded shared that they are applying this knowledge and skills. Only in camp 19, 2% of the respondent shared positively however 86% also mentions that they are applying these skills to some extent. Hence, there has been a positive impact of the training and awareness generation on the protection issues.

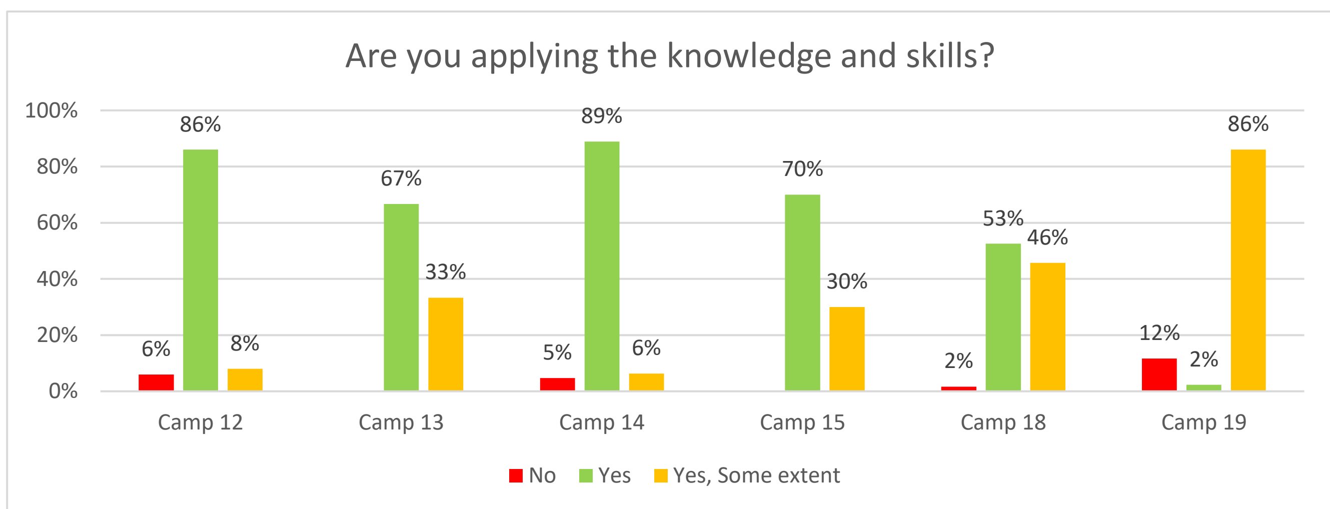


Figure 47: Application of Knowledge and skills

However, to understand the substantial impact of this project activity in terms of change in the behavioural pattern of the community could be measured if there was sufficient time for rolling out the project. Most of the protection activities involve training and awareness generation, which is time taking for results to appear. Also change from prevalent traditional practices will take time and community groups need to be strengthened for sustainability. There is a need for both the male and female members of the community to be involved in the protection issues in the camps and at this point of time, many of the women respondents were not aware of the protection groups.

Overall performance the project

Overall performance of the project is derived from the qualitative data collected during the evaluation of the project. The following chart provides overall ranking on the Likert scale[6] of 5 (Excellent=5; Very Good=4; Good=3; Satisfactory=2; Poor=1) for four thematic areas – Health, WASH, Nutrition and Protection – in which project intervention was done.

Criteria	Health	WASH	Nutrition	Protection	Overall
Relevance/ Appropriateness	Excellent	Excellent	Excellent	Very Good	Very good
Effectiveness	Very Good	Very Good	Good	Satisfactory	Good
Efficiency	Good	Satisfactory	Good	Satisfactory	Good
Impact	Very Good	Excellent	Very Good	Good	Very Good
Sustainability	Satisfactory	Good	Good	Satisfactory	Good
Overall	Very Good	Very Good	Very Good	Satisfactory	Good

Table 3 Overall ranking of the project interventions

From the above table it can be seen that the overall ranking on five criteria has been **Very good** in case of Health, WASH and Nutrition, whereas for Protection, it has been only satisfactory. Similarly, if intervention across the four sectors is considered, then it can be seen that only Relevance and Impact have been categorized as **Very Good.**

[6] https://www.surveymonkey.com/mp/likert-scale/

SECTION C - LEARNING, RECOMMENDATIONS AND CONCLUSION

Sector-specific Learning and Recommendations

Health

- **IEC Materials**: The IEC materials used in the programme for Hygiene Promotion, SRH awareness at the centres currently are mostly in Bangla language and hence for better outreach, these messages need to be translated in the local language (Arakan script).

- **Activity with men for SRH and FP:** Currently the FP programmes are targeted mostly at women, the men are reluctant to discuss the details of it due to cultural barriers and the pressure of family planning falls on women, hence it is important to design a separate programme targeting men in the community.

- **Appointment of female doctors at the Health and Pop-up centres:** The health centres and pop-up centres should have at least one female doctor at each health centre and at the pop-centre. Given the financial and operational viability, female doctors can be appointed and their presence in the health and pop-up centres can be arranged on alternate days, in order to provide obstetrical/gynaecological services to the female members of the community.

- **Awareness programme on HIV/AIDS and treatment:** The current health programme does not have any awareness of generation activity around HIV /AIDS and its treatment. In a camp situation, it becomes essential that the community are aware of such diseases along with other sexually transmitted diseases. Because of the taboo around the illness people also do not come out for testing and treatment hence, there is a need for addressing it discretely and sensitisation of the community on the same.

WASH

3. Under the project, there has been allocation of one toilet/latrine for a group of 10-20 households, which is a challenge for the users and it especially becomes difficult for the elderly, disabled, pregnant and lactating women (PWSN) to use the toilet given the number of users of a single latrine. Although the number of users per toilet is well within the prescribed ***WASH Sector Standards for Rohingya Response***[7], realistically it becomes difficult, hence the number of users per toilet should be targeted more along the lines of Sphere Standards prescription - a minimum of 1 toilet per 20 people.

4. Under the project construction of separate toilets for male and females was done, but it has not been effective. Sphere standards prescribe - ***Segregation of all communal or shared toilets by sex***

[7] https://www.humanitarianresponse.info/en/operations/bangladesh/document/wash-sector-standards-rohingya-response-summary-document

and by age where appropriate. The division of toilets in the community is much needed to ensure privacy and hygiene (MHM), needed by the female members of the community. But operationally it appears to be non-existent. It is suggested that prior to such decisions the members of the community (in this case females) be consulted for the feasibility and operability of such ideas in order to ensure ownership and achievement of the desired objective.

5. Prior to the construction of WASH infrastructure, the process of site selection for the structures involved CIC, Majhi (Headman/local representative) and men of the community at various stages. It was found that there has been limited involvement of the women in the process of site selection and it can be attributed to cultural practice (amongst Rohingya community) of non-involvement of women in the public decision-making processes. It was also found that though there was involvement of Majhi and men of the community, ultimately the final call on the selected site for the infrastructure is taken by the CIC, hence community's involvement is limited to participation in terms of the distribution of the toilets within the families.

- **A number of toilet users per toilet:** The number of toilet users per toilet should be reduced, though it is appropriate according to the sectoral guidelines, it becomes difficult for women, elderly and disabled to use due to the overcrowding. A number of toilet users per toilet should be reduced and accordingly the construction of toilets should be undertaken.

Nutrition

- **Contingency planning (funds) for essential components:** Health and Nutrition component of the project are the most essential. The services provisioned under these components are required to be provided in a continuum, so contingency planning for provisioning of these services in the event of exhaustion of project funds needs to be charted out beforehand.

- **Tracking of MAM and SAM categorized children:** Under the nutrition component, currently, the mechanism for tracking children coming out of MAM and SAM category after the intervention is not strong. In order to provide services efficiently, a growth monitoring system for tracking of MAM and SAM categorized children should be developed with growth monitoring taking place on a fortnightly or monthly basis.
- **Kitchen gardens as livelihood intervention:** The kitchen garden as an activity for ensuring dietary diversity can further be explored for developing it as a holistic model involving poultry and other livestock cultivation along with vegetable cultivation (similar to PRADAN model)[8].

[8] https://unevoc.unesco.org/print.php?q=Promising+Practices+List&id=10

Protection

- **Strengthening of protection mechanisms and systems:** The current protection mechanisms and systems appeared to be limited to information awareness wherein participants have become aware of issues (Trafficking, child marriages etcetera) but the enabling systems and mechanisms for reporting (without threat/fear to one's life) the instances are limited to reporting these issues largely to Majhi. Further evolved and practical systems and mechanisms under the protection component need to be developed.
- **Dignity Kit Distribution:** The distribution of dignity kits needs to be done on the basis of the women groups rather than a blanket approach. The SADDD will provide necessary information on the camp wise/block-wise population which can be used to identify the required target groups for the distribution of the dignity kits.
- **Women members in the protection groups:** It needs to be ensured that there are women group present in the working group formed for Protection Groups and there is a record of their meetings and programme.

Cross-cutting recommendations

- **Complaint Mechanism**: The community needs to have more awareness about the complaint mechanism as an accountability system for the project activities. The current project system has a written as well as recorded format for registering a complaint however most of the community member depends upon the Majhis to address their complaint and many of them are not even aware of the complaint boxes being installed. There is a need for awareness and clearer understanding amongst the beneficiaries on the purpose of complaint boxes. The complaints which are registered also needs to be documented so as to have the challenges (implementation) and resolution (strategies) recorded to have learnings and understanding of the trends from the project implementation.
- **Duration of the project**: A 6 months' project is a fairly short time for assessing the impact of project activities especially when many of the activities involve awareness, sensitization and behaviour change as a major component. Many of the Hygiene promotion activity, nutritional awareness programmes and protection activities require a minimum of one year to gauge any impact or progress. Hence, the team would recommend planning of such activities for a longer duration.
- **Synergies between project activities:** There is a need for having proper synergies and collaboration between different programme activities. Many of the collaboration is limited to human resource and space allocation. One good example of synergy within the project was providing street lights in the toilets areas. Such cross functionality needs to be further explored especially with Nutrition and WaSH sector. The cross-sectionality amongst the beneficiaries of the different project components (Health, Nutrition, Protection and WASH) should be considered in the next phase. Although it is fairly understood that there can't be a total overlap of beneficiaries of different components, but to whatever level this cross-sectionality is possible, it should be explored.
- **Long-term perspective for Awareness and Behaviour change activities:** Under the project component many of the activities involve awareness and behaviour change activities. These

activities, for any visible outcome, require a longer duration than most of the other activities implemented as part of emergency response. So long term plan (at least one year) with a breakdown of the achievement of milestones should be categorized prior to the implementation of these activities.

Coordination Consortium Model

To lead a coordinated, integrated and inclusive intervention response (in line with the Humanitarian Response Plan Strategic Objectives) for assistance in WASH, Health, Nutrition and Protection and Health the project was implemented as a consortium for better efficiency and effectiveness. The consortium partners – CAID, GUK, DAM, WVI and CWW – brought their individual strengths and accordingly led thematic area under the project. CAID led the consortium, providing strategic direction and sectoral expertise for thematic areas (WASH, Health, Nutrition and Protection) and program monitoring systems for tracking the project progress. Similarly, WVI and GUK implemented WASH and protection activities, DAM implemented Health activities and CWW implemented Nutrition activities. Some of the learnings from the consortium are discussed below:

1. The consortium model was able to achieve the leverage from the individual thematic area expertise of the partners in their respective implementation areas. Significant efforts were made for achieving the intersectionality of the program activities under the project by different partners, however, it was limited to cross-usage of human resources (trainers for conducting sessions) and materials (IEC). Other than that the intersectionality of different partners in the consortium was strengthened through collective decision making, Joint Monitoring mechanism and Joint Procurement. Although the joint procurement could not take off due to compliance which each partner had to adhere to at their organization level.
2. The consortium model has been useful and effective with different organizations bringing their individual strengths on-board and working together for reaching the maximum number of people. The joint monitoring method was effective in flagging important activity shortcomings and ensure more accountability with partner organization monitoring the work.
3. There was a delay in timely initiation of the project activities and reasons cited for this were majorly bureaucratic (at the level of the government) and beyond the control of the consortium. Specific reasons for the delay was **Approval under FD 7.** The approval under FD 7 was time taking which caused a delay in initiating the project activities.
4. The selection of consortium partners was done only after conducting POCRA (due diligence) of potential partners. POCRA was done for National and local NGOs, but it was not conducted for INGOs as they are mostly registered with charity commissioner in the UK, so they were considered compliant. The due diligence and previous experience (thematic strengths) were the major factors taken into consideration while selecting partners of the consortium. During the course of implementation, the challenges in coordination with the partners appeared in terms of understanding on the clarity of roles and responsibilities in the consortium vis-à-vis project progress monitoring and flow of funds for the implementation. It is recommended that SOPs or official instruments clearly defining roles and responsibilities and mechanisms for the resolution of any ambiguities arising in the course of association in the consortium be developed for the next phase of the project.
5. Though being an experienced development professional, the consortium manager did not have substantial experience of working in the humanitarian response, which led to avoidable issues

between the consortium lead and the partners. It is recommended that the consortium lead and staff engaged in the coordination be selected with due consideration to their experience in humanitarian response, and communication and liaisoning skills.

6. The joint procurement process was a good initiative and would have ensured quality and efficiency in the procurement process, however, the difference in the unit cost in the budget of the partners caused difficulty for the partners who have quoted less for the unit. It is recommended that specification (brand and quality standard) be kept in consideration of each partner while proceeding with the joint procurement in future.
7. The consortium has enhanced the capacity of the local consortium partners by enabling opportunities for cross-learning from practices of consortium lead and other partners with the global experience. Other than that the consortium model has come out as a remarkable platform for cross learning and sharing for future response activity.
8. The disruption of funding for short period (few weeks to months) may result in loss of infrastructure (Static Health Centre/Pop-up centre) possession which may impact the service delivery continuum and thus leading to loss of impacts achieved (long term/sustainable).

Coordination and Programme Implementation

- **Consortium Management**: The roles and responsibilities of each of the consortium partners need to be charted out in the inception phase itself. There also needs to be a clear indication of the reporting line. If possible, a written agreement/MoU will help in ensuring more accountability.

- **Government Permits:** There was a significant delay in the project implementation due to delays in acquiring permission. This has significantly impacted the efficiency and the process of the project. In the next phase, it is recommended that the time requirement is considered beforehand and there is a lobby at the coordination level /NGO forum for hastening the process.

- **Human Resource**: Timely recruitment of staff needs to be ensured for the effective and efficient execution of the project activity. There needs to be a gender-balance in the recruitment of staff especially in the Health component of the project. For continuity, staff retention needs to be prioritised. The relevant experience of the staff in the sector (Emergency response work) should also be considered while recruiting especially for the post of consortium manager who is responsible for leading the programme and coordinating with the partners.

- **Data Management**: Most of the project data in the field are recorded on papers and considering the amount of data in the project it is recommended to have a proper data management system which is accessible in the soft copy.

- **Monitoring and Reporting system:** The formats for monitoring need to be finalised during the inception meeting and ensured that all the partners are using similar formats for reporting. Timely dissemination of information of the reporting system needs to be ensured by the consortium lead. Similarly, a duration for submission of all the reports from the partners needs to be fixed beforehand to avoid delays. As requested by all the partners, the team also recommend that the final reports such as assessment reports, final reports, KAPS reports etc. which are submitted to the donors are also shared with all the partner organisation for better transparency.

- **Joint Procurement System:** The joint procurement system can be further improved in the next phase by setting the same unit cost across all the organisation and identifying a list of vendors. An MoU can also be formed with the identified vendors to avoid delays in the procurement process.

- **Lesson Learn Workshop:** It is recommended that at the end of the project, the consortium consider organising a lesson learnt workshop to capture the challenges and learning from the project. It should be ensured that the learning from the project is well documented and is shared for future programming.

LIST OF ANNEXURES

Annexure 1: Qualitative tools for Evaluation

Annexure 2: Evaluation Framework

Annexure 3: FGD participant’s list

Annexure 4: Baseline and Endline Questions

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