Australian Aid

Australian Humanitarian Partnership

Strength & Weakness

MEAL Framework, Gender Inclusion, Disability Inclusion, Localization

Evaluation of the Bangladesh Rohingya Response

Phase II

January 2021

AHP Australian Humanitarian Partnership

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List of Acronym

CBM	Christian Blind Mission
CBV	Community Based Volunteers
CDD	Centre for Disability in Development
CHV	Community Health Volunteers
CIC	Camp in Charge
COG	Community Outreach Group
DPO	Disabled Person Organization
DRR	Disaster Risk Reduction
DSK	Dushtha Shasthya Kendra
EiE	Education in Emergency
FIVDB	Friends In Village Development Bangladesh
GBV	Gender-Based Violence
GC	Girls Committee
GiE	Gender in Emergency
HI	Humanity & Inclusion
IASC	Inter-Agency Standing Committee
IPTT	Implementation Plan
JRP	Joint Response Plan
KII	Key Informant Interview
M&E	Monitoring & Evaluation
MEAL	Monitoring, Evaluation, Accountability, Learning
MHPSS	Mental Health and Psychosocial Support
OPD	Organization for Person with Disability
PC	Protection Committee
PDM	Post Distribution Monitoring
PIA	Plan International Australia
PSEA	Policy on Protection from Sexual Exploitation & Abuse
SADD	Sex, Age, Disability Disaggregated
SRH	Sexual Reproductive Health
TLC	Temporary Learning Center
WASH	Water, Sanitation and Hygiene
WC	Women Committee
WGSS	Women and Girls Safe Space
WGSSQ	Washington Group Short Set of Questions
WWC	Women Watch Committee

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Introduction

Background

As part of the AHP Phase II Response evaluation, the evaluation team has analyzed the Strengths and Weaknesses of AHP partner NGOs in terms of their MEAL Framework, Gender Inclusion, Disability Inclusion, and Localisation. This document summarizes and presents the early findings from the analysis. In addition to the strength and weakness analysis on the mentioned four key areas, the document also provides the emerging recommendations for the AHP Phase 3 response.

These early findings and emerging recommendations will provide useful background analysis and important lessons from the Phase II response to guide and inform the design, planning, and overall programming of the AHP Phase III response.

Methods

The Strength and Weakness analysis is a subset of the evaluation, and hence utilized some of the tools and methods from the overall evaluation methodology. Two major tools used for the analysis are –

A. Desk Review of Project Documents- Gap analysis against relevant international standards and good practice guides. The evaluation team's experience in similar evaluation assignments also informed the desk review findings.
B. Remote Key Informant Interviews with key personnel from the AHP Partner NGOs.

Desk Review of Project Documents

The documents reviewed as part of the analysis are listed below -

Project Documents	● Project Implementation Plan ● Proposal and other design documents ● MEAL Plan ● Monitoring trackers ● Progress reports ● Meeting minutes of workshops, reports on lessons learned. ● Final reports ● Baseline and Need Assessment reports ● Financial documents ● Documents related to the governance framework ● Risk Management documents ● Organization policies on Safeguarding, anti-harassment, PSEA, etc.

Relevant Standards	● DFAT Humanitarian Strategy ● DFAT Monitoring and Evaluation Standards ● DFAT Gender Equality in Investment Design Good Practice Note ● Seven Dimensions of Localisation

Remote Key Informant Interviews

AHP Partner NGOs – The evaluation team has conducted 15 formal remote interview sessions with key persons from five AHP Partner NGOs – Save the Children, Oxfam, World Vision, CARE, and Humanity & Inclusion and their technical/implementing partners. Each interview session was sufficiently long to gather comprehensive insights and typically ranged from 1.30 to 2 hours.

Time Period

Insights from the desk review and remote Key Interview sessions conducted up to the 28th of January 2020 have informed the early findings shared in this document.

Limitations of the Early Findings

The identified strengths and weaknesses will be further verified and triangulated with the findings from the remaining remote KIIs, and other qualitative and quantitative data collected from the field. Since data collection is still ongoing, some of the preliminary findings explained in this document may become irrelevant and consequently be eliminated from the draft report. The findings therefore should not be considered conclusive.

Furthermore, the evaluation team requests additional documents from the AHP partner NGOs from time to time as needs emerge. The evaluation team is also currently in the process of acquiring more documents. It is possible that such additional documents may bring about adjustments to the findings of the current preliminary analysis.

Structure of the Report

The report has two major parts - Strength and Weakness Analysis (Part A) and Emerging Recommendations from the evaluation study (Part B). Part A is further divided into four parts - **MEAL Framework, Gender Inclusion, Disability Inclusion, and Localisation**. For each of these sub-sections, the strengths and weaknesses of the AHP Partner NGOs are presented. These subsections begin with the analysis for the Inclusive Communities consortium (Save the Children, CARE, Oxfam, and HI), and then present that for World Vision and Plan International Australia.

Part A - Strength and Weakness Analysis

1.0 MEAL Framework

Inclusive Communities Consortium (Save the Children, CARE, Oxfam, and HI)

Criteria	Strength	Weakness and Scope for further improvement
The end-of-program outcomes are expressed in terms of performance outcomes where possible rather than capacity, or open-ended outcomes	The end-of-program results are clear and articulated in terms of quantitative changes that are expected to happen at the end of the program. When there are open-ended outcome statements, these are supported by quantitative and specific indicators. Gender equality and social inclusion outcomes are identified and incorporated into the design.	
MEAL plan includes a Summary of the investment goals, outcomes, investment size and length, and any other relevant information.	The consortium had a stand-alone MEAL plan that incorporates the program brief, logical framework, performance expectation and standards to be followed. The M&E Plan has a clear description of the investment including overview, goals, outcomes, duration, location, beneficiaries, etc.	The log frame did not disaggregate Rohingya and host community beneficiaries. Targets of different key indicators were not disaggregated by age, sex, and disability.
Consortium MEAL Coordination	The Consortium adopted a clear and structured approach to MEAL Coordination. The Consortium MEAL manager and MEAL focal from the consortium agencies were given clear responsibility to oversee the activities so that the outcomes are monitored at the consortium level. A MEAL working group was established who would regularly meet to discuss various issues faced by the consortium partners and share learning.	Although the MEAL plan clearly established a MEAL coordination mechanism, there were some communication gaps. According to several KIIs, the position of consortium MEAL manager was vacant for some time. During this period the consortium partners did not get sufficient support as they wanted.

	The consortium developed a uniform performance tracker, called the Indicator Performance Tracking Tool (IPTT). All the partner agencies used the same tracker. It is a simple tracker in excel which can continuously track progress against all indicators of all consortium members. The reporting structure included Monthly Project Reports based on the IPTT.	According to some of the Key Informant Interviews, the MEAL working group was effective in clarifying the issues related to IPTT, update sharing from individual partner agencies, and on common response areas. However, some Key Informant said the consortium should have also played a greater role in harmonizing individual agency MEAL plans, data validity checks, and MEAL capacity development.
Causal Linkages, Risks and Assumptions		The MEAL plan shows a basic log frame. It does not clearly express the causal linkages among activities, outputs, and outcomes, the contextual factors, or the key assumptions and risks. The log frame is not very strategic and does not address the intermediate or long-term results. Some of the broader goals of the response such as social cohesion, resilience, advocacy, and localisation were not incorporated in the result framework. Having a theory of change and/or a more rigorous strategic result framework would have incorporated these broader goals into the program. However since it was a one-year program, it would have been difficult to incorporate these goals, even if necessary.
Baselines are constructed where appropriate		There was no baseline study, a key imperative to establish a comprehensive result framework. While it is understandable that in a humanitarian crisis, it is not always feasible to have comprehensive baseline studies, the rationale and assumptions behind the targets need to be clearly explained. The rationale

		and assumptions behind the targets were not made explicit. Hence, it is difficult to comprehend how targets of different indicators were set. Only through further probing through Key Informant Interviews, the evaluation team learned about a few informal processes through which the targets were set.
Methods are fully described for sampling, data collection, management, analysis, and processing	The MEAL planning matrix outlines the data collection and analysis methods including indicator definition, tool, and frequency of data collection. Reporting schedule and MEAL tasks schedule are also detailed in the Annex. The MEAL plan sets out guidelines for ethical consideration for data protection and informed consent. The guideline includes attention to anonymity, voluntary participation, comfort, verbal or written consent.	
A schedule of M&E activities is presented	The MEAL plan includes a full schedule including completion dates of M&E system design, data collection frequency, specific reporting dates, etc. Additionally, it includes schedules on major events such as capacity development, MEAL coordination, field visits, and interim and final evaluation.	
Strategy for sharing information gathered through M&E activities		The MEAL plan should include a strategy and schedules of how information gathered through the M&E system will be shared with a wider audience such as the beneficiaries, government stakeholders and other humanitarian organizations, local implementing partners, etc. Having such a strategy would have ensured increased

		transparency and could have opened a wider avenue to receive feedback from a broader stakeholder group.

Additional Analysis on Consortium Partners at Individual Level

Save the Children

- Outcomes are based on immediate results such as increased access. improved teachers' competency, improved engagement of parents with children's education. In addition to these immediate results, the response could have pursued intermediate results such as quality of education, improved skill levels of the students, and satisfaction of children and parents regarding teachers' competencies.

CARE

- For some programmatic activities, only immediate outcomes were included in the log frame.. For instance, outcome 1.2 ("# of GBV risks reported by community groups") can be categorized as short term or immediate outcomes. It is suggested that CARE pursue and monitor more intermediate and long-term outcomes. For instance, indicators on whether the risks are resolved and vulnerable women are safe from the risks would make the framework more result-oriented.

HI

- Outcome indicators on mainstreaming support to partner agencies (1.4.1, 1.4.2, 1.4.3) were all basically outputs. HI could have gone one step ahead and monitor what was the result and benefit of their mainstreaming support in the form of the changes that took place regarding the inclusion of persons with disabilities.

World Vision

Key Standards	Strength	Weakness and Scope for further improvement
The end-of-program outcomes are expressed in terms of performance outcomes where possible rather than capacity, or open-ended outcomes	Gender equality, the inclusion of marginalized communities like persons with disabilities are not treated as separate work programs. Outcomes related to equality and inclusion are identified and incorporated in the design and in the log frame.	The log frame in the Project Implementation Plan or the MEAL plan include the indicators of different outcomes and outputs, but do not show the targets to be achieved at the end of the program. These design documents should include targets so that anyone who was not involved in the design or implementation of the response can easily comprehend the desired results of the program. Also, some of the targets are not desegregated by age, sex, and gender. Finally, there are some mismatches between the PIP and MEAL plan in terms of the stated outcomes and outputs. For instance, the log frame in the PIP has 7 indicators for Outcome 1 ("Targeted Vulnerable populations (women, girls, and boys including those with disabilities) have improved access to safe water, environment and good sanitation and hygiene facilities and practices"). However, the MEAL plan only includes four of the indicators. Also, the outcome indicator 1.g (Reduced risk of water-borne related diseases in the targeted areas) stated in the PIP has been changed to an output indicator in the MEAL plan.
Summary of the investment goals, outcomes, investment size and length, and any other	The definitions of indicators are sufficiently clear. For percentage calculations, the numerators and denominators are clearly mentioned.	An ideal M&E Plan is one that is a stand-alone self-sufficient document that summarizes and gives information on the project, overview of the result, approaches followed,

relevant information in the M&E plan		intervention and delivery mechanism, specific M&E plan, and schedules, etc. The MEAL plan of the World Vision's AHP response only includes specifics about the indicators (definitions, frequency of data collection, tool, and responsible persons), it is not a sufficient stand-alone document.
Causal Linkages, Risks, and Assumptions	The Project Implementation Plan (Section - 3. Project Strategy) clearly describes what each of the major outcomes means, why these are necessary, and how different activities will contribute to these outcomes. In the absence of a theory of change, these descriptions do well in clarifying how different activities are related to the desired outcomes. For instance, for Outcome 2 (Women's participation, including the participation of women with disabilities, in decision making and protection in refugee camps is enhanced), the PIP describe set the context on important linkages between WASH and Gender, then it goes about describing the current situation of women participation in camp governance and decision making. Finally, it describes how it will adopt UNHCR's Protection Committee (PC) model, to respond to the male-dominated 'Majhi led' camp governance system. It also describes how community outreach activities including awareness sessions on the rights of women and persons with disabilities and inclusive participation in community decision-making through the Protection Committee will lead to the desired outcomes.	There is a project-level Risk Management Framework. However, the risks and assumptions for the causal linkages of the results chain are not sufficiently explicit. Having a shared theory of change and/or a more rigorous strategic result framework would not only make the assumptions and risks explicit but also allow for testing, evaluate and select the best-fit causal pathways for the desired outcomes. Also, many of the outcome indicators focus on immediate and direct results of program activities, rather than focusing on the actual benefits of these activities. This can be explained by the following outcome indicators - 2.a Proportion of women representatives in the protection committee and water management committees in the targeted areas. 2.b Proportion of women with disabilities in the protection committee and water management committees. Along with these immediate outcomes, the actual result or effect of having more women representatives in the protection and water management committees could have been included as outcomes. The short duration of the project has likely

		been a constraint in pursuing intermediate and long term results.
Methods are fully described for sampling, data collection, management, analysis, and processing		The M&E plan does not include the quantitative and qualitative methods and describes fully the sampling, data collection, management, analysis, and processing plans. The M&E plan does not have data validity or triangulation mechanism or the ethical considerations to be followed. An ideal M&E plan should also refer to what internationally accepted guidelines will be followed, which are also missing from the M&E plan. Finally, the Plan does now show specific dates of major MEAL tasks.
Baselines are constructed where appropriate	The baseline study was conducted to get the baseline figures of different outcome indicators. The study was done on a sufficiently large sample size using a mix of qualitative and quantitative approaches. The baseline study gathered baseline values of almost all of the key outcome indicators. Also, the study was conducted in all of the camps included in the program scope.	
Strategy for sharing information gathered through M&E activities		The MEAL plan should include a strategy and schedules of how information gathered through the M&E system will be shared with a wider audience such as the beneficiaries, government stakeholders and other humanitarian organizations, local implementing partners, etc. Having such a strategy would have ensured increased transparency and could have opened a wider avenue to receive feedback from a broader stakeholder group.

Plan International Australia

Key Standards	Strength	Weakness and Scope for further improvement
The end-of-program outcomes are expressed in terms of performance outcomes where possible rather than capacity, or open-ended outcomes		The end-of-program outcomes were expressed in terms of open-ended statements, without setting specific quantitative or qualitative targets. Outcome 1 has two indicators and both of these are open-ended. "1.1 Enhanced resilience through education in life skills development to promote social empowerment of young people, especially adolescent girls and boys & young women and men, including those with disabilities." "1.2 Increased access to safe, inclusive and quality non-formal learning opportunities (literacy, numeracy and life skills)." The log frame has only one open-ended output 1.1 which is the same as the outcome indicator 1.2. The result framework is more activity-oriented rather than being result-oriented. At the same time, targets were mostly determined in terms of the number of activities or people reached. Setting some of the indicators in percentage forms would allow the evaluation team to understand the actual coverage of the Plan's response in the camps they worked.
Summary of the investment goals, outcomes, investment size and length, and any other relevant information in the M&E plan	The overall objective and goals of the projects, working areas, overall strategy, implementing partners, etc are clearly explicit from the M&E Plan.	Targets of different key indicators were not disaggregated by age, sex, and disability.

Methods are fully described for sampling, data collection, management, analysis, and processing	The M&E plan describes major components of the MEAL system, major steps in the monitoring process (On-site visit, PDM, monthly output monitoring, Annual Outcome monitoring, etc.), sources and means of verification, and assumptions on different indicators.	The method of data validation, quality assurance, and triangulation is not clear from the M&E Plan. It is also not clear what safeguarding and ethical measures will be taken during data collection for monitoring activities.
Baselines are constructed where appropriate	There was a need assessment and situational analysis on protection, education, and youth's conditions in Cox's Bazar. The urgent need to support adolescents and youths, particularly girls by providing access to education, like skills, etc. were identified.	No baseline data were constructed. Therefore, it can not be tracked how much progress has been made in terms of different outcome indicators.
A schedule of M&E activities is presented	The MEAL plan includes a section on reporting structure that presents the frequency of major monitoring reports.	Specific dates of the M&E activities are not provided.
Strategy for sharing information gathered through M&E activities		The M&E Plan has a section on documentation and dissemination. The section vaguely states that project information will be shared with proper authority. The plan does not have specific activities or schedules on what will be done to share the information gathered through M&E activities with a broader group of stakeholders.

2.0 Gender Inclusion

Inclusive Communities Consortium

Save the Children

Strength

- **Gender Analysis:** Along with JRP and their previous experience, the consortium had a detailed need assessment conducted by CARE, by which they have identified the needs with regards to different gender and age.
- **SADD:** Save the Children has collected disaggregated data by age and sex for each of the indicators; the disaggregated can be utilized for future response as well.
- **Equal access to benefit:** Save the Children attempted to ensure that women got equal benefits from their response, as evident from the IPTT that they engaged women significantly. For example, they targeted both male and female in providing SRH services (Output 2.3), trained SC staff on SRH service provision where 67 members were female out of 112 (Output 2.4), ensured significant female participation in awareness sessions on MHPSS (Output 2.5)
- **Protection and GBV:** Save the Children has a number policy to ensure protection of women and children, such as Child Safeguarding Policy, Anti-harassment, and Policy on Protection from Sexual Exploitation & Abuse (PSEA), focusing on the following issues:
    - To safeguard the children throughout their work
    - To reinforce key messages and expectations related to ensuring a safe working environment for all their people, with a particular emphasis on sexual harassment
    - To protect from Sexual Exploitation and Abuse (PSEA) of adults including direct or indirect beneficiaries of their programming and adults in the wider communities in which they work
- **Capacity Development of Women:** Capacity development of women on different thematic priorities such as
    - adolescent boys and girls reached through family planning
    - SC staff trained on SRH service provision
    - volunteers recruited to conduct awareness sessions on MHPSS and SRH service
    - teachers/facilitators provided with training, monitoring, supportive supervision, weekly learning circles, and monthly Peer Learning Meetings
    - monthly parenting sessions and Community Education Committee meetings conducted to support parental and community engagement in children's engagement

  The majority of the participants of these events were women

- **Gender Expertise:** Save the Children utilized CARE's expertise to ensure gender mainstreaming in a different phase of the response
    - CARE took an active role in Gender & GBV mainstreaming within the consortium.CARE has shared key messages on MHM, gender, GBV & SRH and conducted a 2-days training on Gender in Emergencies (GiE), GBV, PSEA & Referral with the widen group
- **Gender-based Outcomes:** Gender-based outcomes were identified and included in their response, while other outcomes are also gender-inclusive. For instances, Save the Children have the following outcome indicators in their log frame:
    - % of women aged 15-49 who make own informed decisions regarding sexual relations, contraceptive use and reproductive health care
    - % demand satisfied for modern contraceptives among women aged 15-49

      Moreover, all the outcomes and outputs are gender-inclusive with substantial participation of women and girls.

Weakness

- **Women's economic empowerment and access to livelihood:** Women's access to livelihood seems less of a priority in their response as no indicator shows the engagement of women and girls participating in life-skills
- **SADD in Target:** During the planning phase, Save the Children didn't specify the number of beneficiaries on a gender basis in the log frame.
- **IASC Gender marker**: No reporting incorporating IASC gender marker is found, which is a good practice in accordance with DFAT Humanitarian Strategy to ensure that all members of affected populations have equal access to services and that targeted action to advance gender equality is based on a gender and age analysis.
- **Gender Issue in Risk Matrix:** Gender-related issue is mentioned in the risk matrix; however, no evidence is found whether the risk matrix is updated regularly during implementation.

CARE

Strength

- **Gender Analysis:** Along with JRP and their previous experience, the consortium have detailed need assessment conducted by CARE, by which they have identified the needs with regards to different gender and age. For instance,
    - COVID-19 Bangladesh Rapid Gender Analysis
    - CARE RGA of Myanmar refugee crisis
- **SADD:** CARE has collected disaggregated data by age and sex for each of the indicator; the disaggregated can be utilized for future response as well.
- **Prioritized Focus on Women Needs:** CARE attempted to ensure that women got equal benefits from their response, as evident from the IPTT that they engaged women significantly. For instance
    - provided support and counseling for women aged 15-49 on psychosocial support
    - provided support for women and girls on life-skills and recreational activities
    - launched community awareness and engagement initiatives on GBV prevention with the participating of community members

  Moreover, CARE principally focus on gender-based support through their GBV and SRHR interventions in the selected camps, where around 70% of the beneficiaries were female.

- **Protection and GBV:** CARE has provided Gender-Based services through 4 Women & Girls' Safe Space (WGSS) in camps 11, 12 and 13. A total of 5,404 individuals accessed WGSS including 2,107 girls and 3,297 women, where 123 girls and 155 women were people with disabilities. Prior to these, they conducted gender safety audits, from which they identified four recommendations and implemented those. They also established 12 community groups and trained them on GBV prevention activities.
- **Gender Expertise:** CARE has substantial gender expertise, by which they also ensured gender mainstreaming across the consortium by providing support to the consortium members.
- **Gender-based Outcomes:** Gender-based outcomes were identified and included in their response. For instance, they focused on providing GBV prevention and SRH services, where they identified the following outcome indicators:
    - # of women with and without disability with access to safe space
    - # of GBV risks reported by community groups
    - % of men and boys who report rejecting intimate partner violence and domestic violence
    - % of people (m/f) trained who have increased knowledge on GBV prevention and protection
    - % of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use, and reproductive health care
    - % demand satisfied for modern contraceptives among women aged 15-49
- **Women's economic empowerment and access to livelihood:** 1,048 women and girls have received life skills such as numeracy and literacy sessions, decision making, Sewing activities, problem solving, and negotiation skills training

- **Participation of Women in Providing Support:** As evident from the document CARE organized a meeting with Community Outreach Group (COG), Girls Committee (GC) & Women Committee (WC) at the early stage of their response to discuss the responsibilities of these groups.
- **Gender Safety Audits:** Besides Gender Needs Assessment, CARE conducted 4 gender safety audits to mitigate GBV in the community by identifying present situations on women & girls focused available services, risk zone and need assessment for women & girls in camp 11, 12, and 16.
- **Capacity Development of Women:** CARE provided capacity strengthening support on GBV and SRH to the women. For instance,
    - 577 women aged 15-49 receiving psychosocial support and counseling (group and individual)
    - 1048 women and girls participating in life-skills and recreational activities
    - Around 20 thousand women including women with disabilities aged 15-49 and men reached with SRH service information

Weakness

- **IASC gender marker**: No reporting incorporating IASC gender marker is found, which is a good practice in accordance with DFAT Humanitarian Strategy to ensure that all members of affected populations have equal access to services and that targeted action to advance gender equality is based on a gender and age analysis.
- **SADD in Target:** During the planning phase, CARE didn't specify the number of beneficiaries on gender basis in the log frame.

Oxfam

Strength

- **Gender Analysis:** Along with JRP and experience, the consortium has detailed need assessment, by which they have identified the needs with regards to different gender. Oxfam completed several detailed needs assessments on the different needs of men, women, boys and girls in relation to WASH.
- **SADD:** Oxfam has collected disaggregated the data by age and sex for each of the indicator; the disaggregated data can be utilized for future response as well.
- **Equal access to benefit:** Oxfam attempted to ensure that women got equal benefits from their response. According to their final report, 52% of the total beneficiaries of Oxfam's response were women.
- **Protection and GBV:** Gender considerations were integrated in the whole project cycle for all of Oxfam's activities including Protection Monitoring, focus group discussions, one to one interactions with communities, to ensure sensitive issues such as GBV issues are managed appropriately and with strict confidentiality.
- **Participation of Women in Providing Support:** Oxfam formed two youth groups in Camp 12 & Camp 19 with 24 youth members to engage them in protection issues in those camps, where around 50% of the members were female. Besides, they formed protection committees in the two camps with significant participation of women.

Weakness

- **Women's economic empowerment and access to livelihood:** Women's access to livelihood seems less of a priority in their response as no indicator shows the engagement of women and girls participating in life-skills
- **IASC Gender marker**: No reporting incorporating IASC gender marker is found, which is a good practice in accordance with DFAT Humanitarian Strategy to ensure that all members of affected populations have equal access to services and that targeted action to advance gender equality is based on a gender and age analysis.

World Vision

Strength

- **Gender Analysis:** As per the final report of World Vision, the NGO conducted needs assessments to identify beneficiaries' interest in skill-building activities through focus group discussions and current response plans, ensuring interventions were focused to defend their needs and rights in coordination with like-minded organizations, site management, protection partners and local government bodies for greater impact.
- **Equal access to benefit:** World Vision attempted to ensure that women got equal benefits from their response. They formed 55 Women Watch Committee and Protection Committee with significant participation of women. Around 48% of their total beneficiaries were women.
- **Protection and GBV:** To ensure proper protection and GBV support, World Vision took a number of measures. The project brought a significant comprehensive approach to prevention, response, women's empowerment and skill-building in emergency response within the GBV sector. Notable activities undertaken by World Vision is provided below:
    - The project formed 55 Women Watch Committees (WWC) and Protection Committees (PCs), and provided training on effective representation and decision making for the committee members in Camp 13 and 15.
    - The project delivered awareness sessions and non-specialized psychosocial support to women and adolescent girls, including persons with disabilities, in Safe Spaces for Women & Girls (SSWG), including those attending skill-building activities.
    - Safe and accessible environments at Happy Corners and WGSS created avenues for social networking, information and resource exchange, enhancing dignity, protection and inclusion.
    - Women Watch Committee and Protection Committee teams conducted HH level visits and sensitized communities to prevent domestic violence. They also referred 110 individuals for psychosocial services especially those who have faced serious challenges.
    - All project staff were oriented in PSEA to response-wide protection from sexual exploitation and abuse networks.
    - Managers received 183 cases of feedback /complaints (mainly of generic nature) and the accountability team addressed 100% of them.
- **Capacity Development of Women:** World Vision initiated capacity development of women on different thematic priorities such as
    - The project formed 55 Women Watch Committees (WWC) and Protection Committees (PCs), and provided training on effective representation and decision making for the committee members.
    - The project delivered awareness sessions and non-specialized psychosocial support to women and adolescent girls, including persons with disabilities, in Safe Spaces for Women & Girls (SSWG)
    - The project initiated empowerment and skill-building activities among 350 women to ensure women's participation in decision making and self-empowerment
- **Gender Expertise:** All of the World Vision's activities were mostly directed to girls and women, and to address gender-based issues including GBV. For this, they had a number of people

assigned for gender-specific issues including GBV coordinator, GBV Sector Lead, Inclusion Officer, and Protection Focal.

- **Gender-based Outcomes:** Gender-based outcomes were identified and included in their response, where all the outcomes were also gender inclusive. For instance, outcome 2 of the programme works for the enhancement of women's participation in decision making and protection in refugee camps.
- **Women's economic empowerment and access to livelihood:** The project initiated empowerment and skill-building activities (handicraft, tailoring) among 350 women to ensure women's participation in decision making and self-empowerment, and 81.67% of participants reported that they were satisfied with skill-building training and ability to graduate from the program acquiring a transferable skill.

Weakness

- **SADD:** World Vision's data is not disaggregated in terms of sex, age, and disability, During the planning phase, World Vision didn't specify the number of beneficiaries on gender basis in the log frame. As evident from their final report, they mentioned only their achievement against the target; however, the number of male, female, and person with disability beneficiaries are not mentioned.
- **IASC Gender marker**: No reporting incorporating IASC gender marker is found, which is a good practice in accordance with DFAT Humanitarian Strategy to ensure that all members of affected populations have equal access to services and that targeted action to advance gender equality is based on a gender and age analysis.

Plan International Australia

Strength

- **Gender Analysis:** As per the PIP of Plan International, their proposal is largely structured around comprehensive analysis conducted as part of the Plan International Bangladesh Cox's Bazar Program Framework 2019-20 – based on several different needs assessments including Rapid Needs Assessment (Dec'18) for EiE; gender, etc.
- **Equal access to benefit:** Plan International attempted to ensure that women got equal benefits from their response. Around 52% of their total beneficiaries were women.
- **Protection and GBV:** As per implementation plan, to ensure proper protection and GBV support, Plan with local partners would provide input on how SGBV could be integrated into the project. Possible interventions were: capacity development for potential victims, community awareness-raising, case management, referral systems, and a livelihoods program to help beneficiaries become more economically resilient.
- **Gender Expertise:** As mentioned in the programme proposal, Plan has a gender and inclusion specialist, a child protection in emergencies specialist, and MEL specialist who will provide technical support as and when necessary to the project e.g. design/appraisal, detailed work planning, MEL, etc.
- **Gender-based Outcomes:** Gender-based outcomes were identified and included in their response, where all the outcomes were also gender-inclusive. For instance, Outcome 2: Girls, adolescents, young women, and their families are able to secure their rights to dignity, protection, and education through timely humanitarian assistance.

Weakness

- **SADD:** No evidence that Plan International didn't collect disaggregated data with regards to sex, age, and disability
- **IASC Gender marker**: No reporting incorporating IASC gender marker is found, which is a good practice in accordance with DFAT Humanitarian Strategy to ensure that all members of affected populations have equal access to services and that targeted action to advance gender equality is based on a gender and age analysis.
- **Engagement with women's organizations:** Evidence on consultation with Women's organizations is poor. There's no indication in their documents regarding the consultation with women's organizations. These organizations might assist the NGOs in identifying needs.
- **SADD in Target:** During the planning phase, Plan International didn't specify the number of beneficiaries on a gender basis in log frame.

3.0 Disability Inclusion

Inclusive Communities Consortium

Save the Children

Strength

- **Technical Expertise on Disability Inclusion**: Save the Children ensured that the disability inclusion partner, HI, was actively involved in coordination mechanisms, needs assessments, and the development of humanitarian needs. HI chaired the Technical Inclusion Working Group - mainly responsible for organizing monthly meetings, following up on sectorial (thematic) progress on MEAL, gender, CSG, MHPSS and Protection to cross engage on disability issues (TIWG Document). HI identified needs for education support for persons with disabilities, which were discussed with SCI Education Team, YPSA, and other education partners. To ensure the Technical Support Plans are executed smoothly, Save the Children assigned dedicated focal points to facilitate uninterrupted communication and to regularly conduct a bi-lateral meeting with HI (HI Final Report).
- **Consider Various forms of Disability:** In the education service of Save the Children, HI considered various forms of disability and tailored their services accordingly. To empower and support the targeted 150 children with disabilities HI carried out initial screenings and identification of children with functional difficulties, followed up by technical and medical assessments to provide accurate diagnoses, providing individual aids, and setting up individual rehabilitation and learning goals. HI identified the actual individual physical and functional rehabilitation needs of each child and to create a combined rehabilitation intervention plan of all three services (Physiotherapy, Occupational Therapy, Speech and Language Therapy) if needed for a child. All of the 150 children received individual aids (HI Final Report).
- I**dentify Barriers:** For education service of Save the Children, HI identified inclusion barriers through "Barriers and Facilitators Assessments''. These assessments were conducted in 18 Temporary Learning Centers (TLCs) and accessibility audits in 8 TLCs and the findings are discussed with SCI and Partner/ YPSA to improve the overall accessibility standards of the 60 TLCs with an agreed technical support plan (TIWG Document).
- **Qual/Quant Information to Identify Person with Disability:** Save the Children's inclusion partner, HI, resort to appropriate standards for the identification of children with disability for education response. The three major selection criteria used were the following:
    - Children with disabilities flagged as having difficulties using Washington Group Child Functioning Module (CFM) Set of Questions;
    - Children from 6-18 years of age;
    - and children with moderate to severe disabilities receiving either home-based (community) or learning center based education services (HI Final Report)

  For such identification in other sectors, HI conducted a capacity development programme for the internal staff of the consortium members to align them with the Washington set of questionnaires to identify persons with disability.

- **Capacity development for Internal Staff:** HI initiated a capacity development programme on disability inclusion for the internal staff of Save Consortium. HI conducted 24 of various trainings, total participants from Save the Children were 127. (TIWG Document)
- **Persons with Disability Status on Periodic Meeting:** Save consortium partners provided updates and discussed key issues on disability inclusion in their periodic meetings. (Meeting Notes)
- **SADD in Implementation:** Save the Children had collected desaggregated beneficiary data in terms of Sex, Age, Disability during the implementation period
- **Twin-track approach:** Save the Children's inclusion partner, HI, implemented the 'Twin-track' approach to inclusive education where children were empowered and supported to gain skills at individual level according to their specific needs on one track, and the education system and services were improved to be inclusive on the second track.

Weakness

- **Person with Disability, OPD in Coordination, Planning**: Save the Children didn't involve or consult with any DPOs for their response. When asked about this, the NGO mentioned the limited presence of DPOs in Rohingya camps.
- **Capacity Building Initiatives of OPD:** There is no evidence of capacity development programmes directed to OPD in the Save the Children's programme.
- **SADD in Targets:** Save consortium targeted to reach around 14,000 people with disability in the planning stage. However, the log frame didn't specify the target of providing services to persons with disabilities for each of the indicators.
- **Findings from HI (taken from HI Final Report):**
    - There are no specific policy, SOPs around Disability Inclusion in the assessed organization;
    - There is a need of one focal person in each organization to lead and facilitate overall inclusion mainstreaming process;
    - Organizations do not have Disability Inclusive policy as people with disabilities have limited access to the recruitment process;
    - No specific training on Disability Inclusion and universal design/ accessibility within the standard package of training of each organization assessed.

Oxfam

Strength

- **Technical Expertise on Disability Inclusion**: Oxfam has conducted a series of FGD at the community level to tackle the needs of people with disability, which essentially ensured the participation of persons with disability in coordination and planning, As a result of such consultation, f.i., Oxfam has developed a latrine design which is user friendly for people living with disabilities (PIP). Oxfam also participated in monthly meetings chaired by HI (TIWG Doc, Meeting Notes). [However, since the Oxfam programme started late in January, the initially planned inclusion assessment work recommended by HI to Oxfam couldn't be implemented which was informed during the Consortium monthly meetings (HI Final Report)]
- **Qual/Quant Information to Identify Person with Disability:** Oxfam has integrated the Washington Group of Questions (6 criteria on disability) in its operations to identify persons living with disability. Oxfam also developed a beneficiary selection process guideline to ensure inclusive participation of people with disabilities (PIP).
- **Persons with Disability Status on Periodic Meeting:** Save consortium partners provided updates and discussed key issues on disability inclusion in their periodic meetings. (Meeting Notes)
- **SADD in Implementation:** Oxfam had collected disaggregated beneficiary data in terms of Sex, Age, Disability during the implementation period

Weakness

- **OPD in Coordination, Planning**: Oxfam didn't involve or consulted with any OPDs for their response. When asked about this, the NGO mentioned the limited presence of OPDs in Rohingya camps.
- **Identify Barriers:** No evidence of barrier assessment for Oxfam is found. Moreover, since the Oxfam programme started late in January, the initially planned inclusion assessment work recommended by HI to Oxfam couldn't be implemented which was informed during the Consortium monthly meetings (HI Final Report)
- **Capacity Building Initiatives of OPD:** There is no evidence of involvement of OPD in capacity development programmes directed to persons with disabilities in Oxfam's WASH programme.
- **Capacity Development for Internal Staff:** Although HI initiated a capacity development programme on disability inclusion for the internal staff of Save Consortium members, Oxfam's engagement in such programmes was considerably low. HI conducted 24 of various training; however, the total number of participants from Oxfam was only 20, whereas the number of participants from Save the Children and CARE were more than 100 each (TIWG Document). Moreover, only 2 KIIs were conducted with Oxfam for inclusion assessment (HI Final Report).
- **SADD in Targets:** Save consortium targeted to reach around 14,000 people with disability in the planning stage. However, the log frame didn't specify the target of providing services to persons with disabilities for each of the indicators.

CARE

Strength

- **Technical Expertise on Disability Inclusion:** Consortium's disability inclusion partner, HI, was actively involved in coordination mechanisms, needs assessments, and the development of humanitarian needs. HI chaired the Technical Inclusion Working Group - mainly responsible for organizing monthly meetings, following up on sectorial (thematic) progress on MEAL, gender, CSG, MHPSS, and Protection to cross engage on disability issues (TIWG Document). For CARE's GBV and SRHR programme, HI conducted FGD, accessibility audit, field visit, and awareness session with the participation of persons with disabilities (Inclusion Assessment). To ensure the Technical Support Plans are executed smoothly, CARE assigned dedicated focal points to facilitate uninterrupted communication and to regularly conduct a bi-lateral meeting with HI (HI Final Report).
- **Identify Barriers:** For GBV and SRHR services of CARE, HI identified inclusion barriers through "Barriers and Facilitators Assessments' '. These assessments were conducted in health posts, WGSS, Camp-13,and 16 with the participation of persons with disability and relevant actors. Two focused group discussions, two key interviews, two observation visits, and two accessibility audits have been carried out to identify the barriers, as the factors that prevent persons with disabilities from having full and equal access and participation in the activities (Inclusion Assessment).
- **Qual/Quant Information to Identify Person with Disability:** In order to increase skills and capacity CARE has provided disability inclusion training to its frontline health service providers with the support of Handicap International (HI), where frontline staff are able to access clients through Washington group of question and to date 65 adults and children living with disabilities have received services (CARE Final Report)
- **Capacity development for Internal Staff:** HI initiated a capacity development programme on disability inclusion for the internal staff of Save Consortium. HI conducted 24 of various training, total participants from CARE were 111. (TIWG Document)
- **Persons with Disability Status on Periodic Meeting:** Save consortium partners provided updates and discussed key issues on disability inclusion in their periodic meetings. (Meeting Notes)
- **SADD in Implementation:** CARE had collected disaggregated beneficiary data in terms of Sex, Age, Disability during the implementation period.

Weakness

- **OPD in Coordination, Planning:** CARE didn't involve or consult with any OPDs for their response. When asked about this, the NGO mentioned the limited presence of OPDs in Rohingya camps.
- **Capacity Building Initiatives for OPD:** There was no evidence of capacity development programmes directed to OPDs in CARE's health and protection programme.
- **SADD in Targets:** Save consortium targeted to reach around 14,000 people with disabilities in the planning stage. However, the log frame didn't specify the target on providing services to persons with disabilities for each of the indicators.

World Vision

Strength

- **Technical Expertise on Disability Inclusion:** World Vision had two disability inclusion partners, CBM and CDD, who were mainly responsible for the inclusion of persons with disabilities across the thematic sectors of World Vision. World Vision formed Women Watch Committees and Protection Committees where total 47 persons with disability were members of these groups. World Vision provided training on effective representation and decision making for them. In addition to that, World Vision included 10 persons with disabilities in the steering Water Management Committee. These committees also focused on the needs of persons with disabilities. For example, 27 toilets (out of 100) had custom made changes in line with proposed persons with disability needs.
- **Identification and Addressing Barriers:** With the participation of community forums and local partners, World Vision identified barriers for persons with disabilities. CBM with the support of its implementing partner CDD, conducted accessibility audits, supported the baseline assessment and conducted capacity building events as well as provided hands-on support and sensitization at different levels to create inclusive service for all including persons with disability. Local partners addressed the needs of vulnerable communities based on focus group discussions and experience with the consultation of local Govt for WASH, GBV facilities to women, men, adolescents, and especially persons with disabilities. In accordance with the barriers identified for accessing services of persons with disabilities, World Vision undertook the following activities:
    - the project prioritized common and significant disabled-friendly toilets in coordination with all consortium partners in Camp 13 & 19
    - distribution of home hygiene products and assistive devices to older people and persons with disabilities
- **Qual/Quant Information to Identify Person with Disability:** World Vision's disability inclusion partners, CDD & CBM, conducted a one-day training on “Disability Specific Data Collection” for BGS Hygiene Promoters, Field Facilitators, Technical Officer, and WASH Engineer. Contents of the training were: Disability Terminology, Inclusive Home Hygiene Solution, Disability Etiquette, Orientation on WGSSQ, and Adapted Survey Form. Based on the training, BGS identified 161 perosns with disability.
- **Capacity Development for Internal Staff:** To ensure persons with disability inclusion in their programme, World Vision initiated capacity development activities, For instance,
    - CBM and CDD provided technical support in making the existing WASH and protection modules inclusive and helped trainers/facilitators at different field levels to practice inclusive facilitation techniques.
    - CDD-CBM conducted a training on “Disability Specific Data Collection” for BGS Hygiene Promoters, Field Facilitators, Technical Officer and WASH Engineer

  Moreover, World Vision involved a DPO consultant, who helped in providing on-site support and sensitization to staff, organizing persons with disabilities, and improving their voice in the program delivery.

- **Twin-track approach:** There is some evidence of twin-track approach being followed by World Vision. Besides mainstreaming of persons with disabilities by including them in World Vision's support, World Vision addressed specific needs of persons with disabilities. For instance, World Vision provided home hygiene/assistive devices (e.g. walking aid, special seats, urinary pots and others) to 215 persons with disabilities.

Weakness

- **SADD in Targets:** World Vision targeted to reach around 4,000 persons with disability in the planning stage. However, the log frame didn't specify the target on providing services to persons with disabilities for each of the indicators.

Plan International Australia

Strength

- **Technical Expertise on Disability Inclusion:** As mentioned in the PIP, Plan International would take input from CBM, a member of the Plan consortium under AHP, throughout the implementation phase as necessary. Moreover, Plan would strengthen their inclusion specialist capacity by taking support from CBM.

  [Note: it was mentioned in the Proposal / PIP; however, the evaluation assessment team didn't receive any further evidence on the involvement of CBM.]

- **Identification and Addressing Barriers:** According to design documents of Plan International, they would engage with local disabled peoples' organizations to participate in any 'course-correct' exercises throughout the project, with the support from Plan's partner CBM.

Weakness

- **Capacity Building Initiatives for OPD:** There was no evidence of capacity development programmes directed to OPDs in Plan's programme.
- **SADD:** Plan reached around 100 persons with disability in the implementation stage. However, the log frame didn't specify the target on providing services to persons with disabilities for each of the indicators, neither the collected data was Sex, Age, and Disability disaggregated.
- **Capacity Development for Internal Staff:** The evaluation team didn't find any evidence on capacity development initiatives for Plan's internal staff with regards to providing disability inclusive support for the persons with disability.

4.0 Localisation

Inclusive Communities Consortium

Save the Children

Strength

- **Relational/ Coordination with Local Authorities:** As mentioned in the PIP, Save the Children has built strong functional relationships with local authorities. They coordinate regularly with the offices of the District Commissioner, Civil Surgeon, CIC, and RRRC.
- **Coordination of Education Local Partner:** Save the Children has been maintaining close coordination with local EiE organization, YPSA, in the Rohingya humanitarian context. They partner up with YPSA in EiE interventions and have worked on a number of projects. This actually opens up the scope of skill transfer to YPSA, and builds trust between the two NGOs. Eventually, this leads to the empowerment of YPSA, which will help the local partner to formulate coherent strategy as well as provide effective response to the affected communities.
- **Capacity Development of Local Partner:** To ensure inclusion in Save the Children's education programme, HI conducted accessibility audits in 8 TLCs and the findings were discussed with local partner, YPSA, to improve the overall accessibility standards of the 60 TLCs. Such initiatives can assist the local partner in mainstreaming education services for children with disabilities.
- **Capacity Development of Community Stakeholders:** Save the Children initiated capacity development programmes for CBV and local teachers on providing education services and awareness sessions. Besides, Save the Children made compulsory training on protection, such as
    - Child Safeguarding
    - Child Protection

Weakness

- **Outcome/ Output Indicators:** No apparent outcome/output indicators supporting localisation.
- **Support through Local Organization:** Save the Children worked with only one local organization for their education response. They didn't have any local partners for Health activities.
- **Budget Allocation:** Budget for the local partner isn't provided. As per the Grand Bargain agreement, 25% of annual fund is to be allocated to the local partners as directly as possible.
- **Local Partner Involvement in Planning Phase:** Save the Children worked with local NGO, YPSA, to provide support in EiE during the implementation phase of their project. However, there was no evidence of Save the Children involving the local partner during the planning phase of the project. From localisation facet, this approach might hinder effective needs identification as well formulating coherent strategy in their response. In health intervention, the AHP partner NGO didn't have any local partner.
- **Presence of Local Partners in Periodic Meeting:** Save the Children maintained a number of working groups, such as - Communication and Advocacy Working Group, Operation Working Group, Technical and Inclusion Working Group. With the participation of the working groups, the consortium regularly arranged meetings to take key decisions and ensure coordination. However, local partners' participation is not clearly mentioned in the meeting notes provided by Save the Children.

CARE

Strength

- **Engagement of Local Actors:** CARE engaged local actors. For instance,
    - Capacity development of 100 camp actors and stakeholders on GBV principles
    - 27 community awareness and engagement initiatives undertaken by stakeholders and actors for GBV prevention and mitigation
    - A COVID-19 awareness, prevention and response orientation were conducted for Rohingya community leaders, religious leaders, and community outreach group members
- **Participation of Affected Communities:** CARE undertook activities to ensure the participation of affected communities. Such as,
    - Capacity development of Rohingya communities on SRH service outreach, where SRH information is shared through door-to-door visits, reaching 18265 people
    - 1,048 women and girls have received life skills such as numeracy and literacy sessions, decision making, Sewing activities, problem solving and negotiation skills training and recreational activities such as drawing sessions, henna wearing on hand, paper crafting, indoor game (Ludu, Caram Bagaduli etc.)
    - Under GBV prevention activities, CARE provided gender-based violence related awareness sessions, Community Outreach group formation and training (64 GBV risks (potential cases) reported by community outreach groups)
    - To increase men's awareness and interest in SRH, CARE is engaging with males at the community level through 'courtyard sessions' specifically tailored for males.

Weakness

- **Outcome/ Output Indicators:** No apparent outcome/output indicators supporting localisation.
- **Support through Local Organizations:** CARE don't have any local partner for their GBV response
- **Engagement of Host Community:** no engagement of host communities, which is a must to develop social cohesion

Oxfam

Strength

- **Capacity Development of Local Youth:** Oxfam formed two youth groups in Camp 12 & Camp 19 with 24 youth members to engage them in protection issues in those camps. Afterwards, Oxfam linked them with community based structure (such as community leaders, religious leaders, Majhis) to ensure their involvement and expedite capacity, so that they can actively contribute to community-based protection issues. As a result, Youth are now actively participating in COVID-19 awareness programs with the support of community-based volunteers (CBV) and protection committee members including distributing leaflets, displaying posters and participating in Tom-Tom campaigns.
- **Participation of Affected Community:** Oxfam positively encouraged the participation of affected communities. Prior to the construction and installation of WASH hardware components, Oxfam undertook a series of community consultations for site selection and to form User Groups. In addition to this, Oxfam and national partner organizations engaged 125 community health volunteers (CHVs) from Rohingya communities. As a result, they are now well trained on preventing COVID-19 transmission and serve as a key point of information in their communities to disseminate messaging on COVID-19 and AWD prevention.
- **Support through Local Organizations:** Oxfam actively engaged two of their local partners in the implementation of the response. DSK worked in camp 12 and Shushilan in Camp 19. Oxfam provided support to build the capacity of the partners on WASH technical issues, COVID-19, and use of personal protective equipment and transferred the use of innovative technologies such as locally made hand washing devices and inclusive latrine design. The local partners executed, directed, monitored, and followed up the technical, organizational, and training activities to ensure the achievement of the project targets.
- **Budget Allocation:** Oxfam allocated 40% of the funding for local partners.
- **Participation of Local Actors:** All WASH interventions were implemented with the participation of local authorities.
- **Capacity Development of Local Partners:** Oxfam had two local partners, namely DSK & Shushilan. Oxfam has a long term strategic relationship with DSK. The AHP agency developed Shushilan's technical capacity to an extent that eventually led Shushilan to work without any direct technical support from Oxfam.

Weakness

- **Outcome/ Output Indicators:** No apparent outcome/output indicators supporting localisation
- **Detail Plan of Capacity Development for Local Partner:** It's not clear whether systematic process, plan, and schedule were undertaken to enhance capacity of local partners, like DSK and Shushilan.

World Vision

Strength

- **Relational/ Coordination with Local Authorities:** As mentioned in the final report, World Vision's project was run with the coordination of Sector Leads, local Government, and Site Management.
- **Coordination with Local Partner:** World Vision implemented all activities with the coordination from all consortium partners (CBM/CDD, BGS, FR and WVI) in two sectors (WASH and GBV); BGS to implement WASH activities, and CBM-CDD to address protection issues in the selected camps. This approach assisted World Vision to identify grassroots challenges as well. World Vision's also allocated 42% of the total funding to local partners to enable them to work with autonomy with the relevant stakeholders.
- **Capacity Development of Local Partner:** World Vision empowered local organizations with training and essential monitoring from the perspective of accountability to aid recipients and donors. Notable examples are given below:
    - CDD-CBM conducted a one-day training on “Disability Specific Data Collection” for BGS Hygiene Promoters, Field Facilitators, Technical Officer and WASH Engineer. Contents of the training were: Disability Terminology, Inclusive Home Hygiene Solution, Disability Etiquette, Orientation on WGSSQ and Adapted Survey Form.
    - As mentioned in the final report, the project developed capacity of local partners (BGS and CDD) and their project management, financial control, resource mobilization, national fund raising, ownership, build up strategy to sustain the project after World Vision's potential exit. WV conducted the training throughout the project duration.
- **Support through Local Organization:** World Vision provided their support through local organizations, namely Bangla-German Sampreeti, Christian Blind Mission, Centre for Disability in Development, and Field Ready. BGS planned and implemented accessible WASH services in the selected camps, CBM and CDD mainly focused on protection related issues including GBV, and Field Ready brought innovation in World Vision's WASH activities.
- **Participation of Affected Communities:** World Vision enabled the affected communities to participate in implementing their response significantly. Their project formed 55 Women Watch Committees (WWC) and Protection Committees (PCs) and provided training on effective representation and decision making for the committee members in Camp 13 and 15. They also established a Water Networks System at Camp-19 under the supervision of the Water Management Committee (WMC). These community forums (WWC, WMC) were formed and capacitated with hands-on support so that they can continue some of their essential activities even after the project period.
- **Engagement of Local Actors:** The project trained 200 community and faith leaders in different sessions on gender-inclusive COVID response, including inclusive COVID referral pathways and effective preventive measures, symptoms, cultural behaviors to avoid, and social distancing. Their role in the community now includes responsibility for mobilizing the Rohingya community to stay safe and prevent the possible transmission of COVID-19 and responsiveness on gender inclusive COVID response.
- **Budget Allocation:** Around 42% of the total fund was allocated for the local partners.

Weakness

- **Outcome/ Output Indicators:** No apparent outcome/output indicators supporting localisation
- **Local Partner Involvement in Planning Phase:** Although World Vision had a good number of local partners in the implementation of the project, participation and influence of the local partners in decision making of these partners were not clearly mentioned. There was no evidence of World Vision involving the local partner during the planning phase of the project.

Plan International Australia

Strength

- **Relational/ Coordination with Local Authorities:** Maintained a good relationship with CiC, DRR and Site Management, and RRRC to pass the implementation plans and work permit inside the camps. Besides, the progress reports are regularly submitted and presented to CiC.
- **Coordination with Local Education Partner:** The project was designed and is implemented by PIAs local partners, namely, Plan International Bangladesh and FIVDB (in Cox's Bazar). This approach ensures the project remains relevant and appropriate for any context changes. CODEC was originally signed on as the preferred local NGO partner in Cox's Bazar. However, due to CODEC's competing priorities with other INGOs projects, CODEC and Plan amicably agreed to discontinue working together on the AHP activation project. In December, FIVDB was signed on as the replacement local NGO partner in Cox's Bazar. FIVDB is in place and has started working on the project activities. The replacement and resource transferring of local partners took place smoothly during the program implementation phase. FIVDB acted as a partner for Education in Emergencies (EiE) who identified the locations for home based learning centers, frequency of potential beneficiaries in blocks, trained teachers, provided learning facilities for rohingya beneficiaries as well as signed MOU with 10 schools of host communities, and distributed student kits.
- **Support through Local Organization:** FIVDB supported Plan to implement education program (blend with protection issues) for adolescent and youth, for instance, establishing home-based learning centers, training teachers and CBVs, distributing students kits, providing uniform to students, observing students, documenting and reporting changing needs and feedback, etc.
- **Capacity Development of Local Actors:** Organized training programs for teachers (selected from the community) on teaching materials, methods, feedback reporting, etc. Community Based Volunteers were also trained on community consultation, message sharing, community awareness session, feedback reporting, etc.
- **Engagement of Host Community:** Signed MOU with 10 schools of host communities in Teknaf sub-districts where education kits like- bag and as such were distributed. Besides, unconditional cash programming, message transmission through radio, cable TV network and SMS were carried out during COVID 19 period focusing on related protocols.
- **Participation of Affected Communities:** Several rounds of Community Consultations took place with participation of youth leaders, Imam, Hafeez, teachers, etc. to ensure the representation of the community. Teachers and CBVs were mostly recruited from the Rohingya communities.

Weakness

- **Relational/ Coordination with Local Authorities:** There is no linkage of FIVDB with the sector focal (current-CODEC) which affects transferring resources in the transition phase
- **Coordination with Local Partner for Disability Inclusion:** "PIA will manage a sub-grant order with AHP consortium partner CBM, who will provide access to disability inclusion inputs to the project e.g. technical input to the design, planning and implementation at relevant entry

points." This statement is mentioned in PIP but no activity of CBM has been found for disability inclusion.

- **Support through Local Person with Disability focused Organization:** There was no local organization/OPDs to support on disability inclusion
- **Capacity Development of Local Actors:** The number of training sessions for teachers and CBVs is inadequate. COVID 19 outbreak was an issue because all the training and education programming activities got stopped for around three months.
- **Engagement of Host Community:** No such community groups were created in host communities. If some groups could be created with the representation of all sorts of members, the capacity of local people could be enriched through self participation.
- **Participation of Affected Communities:** The Plan Child Friendly Feedback Mechanism was committed to be established in Cox's Bazar target locations but no evidence has been found which could ensure the viewpoints of children, adolescents, people with disabilities, and community leaders & religious leaders will be captured.
- **Budget Allocation:** Budget for local partners was not mentioned clearly. The standard practice according to the Grand Bargain, 25% of annual fund is to be allocated to the local partners as directly as possible.
- **Local Partner Involvement in Planning Phase:** No evidence of engaging local partners in planning phase. The current partner FIVDB started from December 2019.

Part B - Emerging Recommendations

A. The result framework should be strategic and focus more on outcomes.

As evidenced in the Strength and weakness analysis, the result framework was highly activity oriented. A multi-year program should pay greater attention to intermediate and long-term outcomes and incorporate strategic issues such as resilience, localization, social cohesion and accountability to affected communities.

The result framework should go beyond the basic log frame and individual agencies should clearly describe the causal linkages, available evidence of the linkages, assumptions, and risks. Greater focus should be given on determining and achieving outcomes, along with the outputs.

In addition to activity monitoring, an adequate system of outcome monitoring at a certain interval will be useful. A regular 6-monthly outcome progress monitoring can be explored. Baseline studies are highly recommended for all of the outcome indicators and if these cannot be done, clear justification and assumptions behind different targets need to be clearly established.

There should be shared understanding and ownership of the program logic at all layers starting from the management to senior program staff to field level staff. Hence, the program objectives, outcomes, rationale behind different activities should be clearly communicated in a systematic manner to field staff.

B. Social Cohesion should be a priority agenda

As evidenced from the recent demonstrations by host community youths against NGOs, rumors on COVID-19 spread, and the rising tensions between host communities and Rohingya communities during the COVID-19, social cohesion is of utmost importance. The AHP Phase 2 response did not identify and incorporate activities for maintaining social cohesion between the two communities. A key part of social cohesion is identifying the factors leading to tensions and the differential needs of host communities and incorporating those in programmatic activities. In the AHP Phase three response, this should be one of the strategic objectives.

C. Monitoring satisfaction on Consortium Governance

Along with regular monitoring and evaluation of programmatic activities, the effectiveness and efficiency of the consortium governance should be monitored as well. In a multi-year program, a feedback mechanism can be established where the consortium agencies can provide feedback on consortium governance.

D. Consortium role on MEAL data quality assurance, harmonization, and capacity development should be enhanced

As indicated in the Strength and Weakness analysis, the consortium should have increased roles and responsibilities on MEAL coordination in the following manners –

- **Data quality assurance** – The MEAL committee at the consortium level should play a greater role in ensuring data quality assurance. Spot checks, reviewing individual agency data quality assurance processes should be a key core responsibility of consortium MEAL management.

- **Harmonizing Individual Agency MEAL plan and system** – It was understood that each agency has their own MEAL plan and system and the MEAL committee meetings do not always focus on scrutinizing individual agency MEAL plan and systems and harmonizing them to achieve greater effectiveness. In the multi-year program, the consortium MEAL committee can ensure more in-depth review of individual plans and processes and greater collaboration and harmonization.

- **Capacity Development** – The AHP phase 2 MEAL capacity development activities were at a very basic level such as understanding the common reporting formats, explanation and clarification on the reporting processes etc. In the multi-year response, the consortium should identify the MEAL capacity gaps of individual agencies and plan on addressing those in a systematic manner. This can happen as a separate activity or part of regular MEAL harmonization meetings where agencies get to see the MEAL process, strengths, and weaknesses of the MEAL system of one another. Based on these reviews, the consortium should set the MEAL system benchmarks and analyze the position of each agency against those benchmarks and plan comprehensive capacity development plans.

E. Empowering Persons with Disabilities to engage in them decision making and governance

It was understood by the evaluation team that it is challenging to engage persons with disabilities in program design and implementation or in other decision-making processes. At the same time, there is a very limited presence of effective Disabled Persons Organizations that represent the interest and voice of persons with disabilities in the camps or in the host communities. Therefore, Phase 3 should focus on alternative means of empowering persons with disabilities by forming and facilitating committees and forums of persons with disabilities. Supporting these committees, enhancing their capacity, leadership and connecting them with the camp governance could lay the foundation of meaningful engagement with persons with disabilities.

F. Transition Strategy needs to be more robust

The evaluation team has understood that the transition strategies for the Inclusive Communities Consortium has not been adequately robust. While Save the Children, CARE and Oxfam would transition to AHP Phase III from the phase II response, HI will be excluded. Since HI is not a part of Phase III, it does not have the funds to continue to provide support to the beneficiaries that it did in the Phase II response. It was identified both from the remote interview and field observation that children with

disabilities who received inclusive education support from HI in Phase 2 are not receiving any support at this moment. The field interviews revealed that these children have either forgotten their learnings or are not able to practise their learning anymore. It was also identified that the support being technical, these services could not be handed over to another local NGO. There should have been adequate transition strategies so that beneficiaries continue to get support even if any partner is discontinued from the programme. Therefore, for the Phase III response, adequate attention should be given on transition strategies.

G. Risk Management Needs to be more systematic

All of the AHP Partner NGOs prepared Risk Matrix, identified project risks, categorized these risk ratings in terms of likelihood and potential impact and prepared mitigation plans. For most AHP Partners, however, the Risk Matrix was made only as part of planning documents. Risk Matrix was not systematically maintained by regularly reviewing the risks, changes in their likelihood or impact, and adjusting mitigation plans as necessary. In the multi-year response, risk management should be done more systematically by having a Risk Management tracker.