Photo: PWJ

FINAL REPORT

Third-party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh"

DM WATCH

JAPAN PLATFORM

Acknowledgment

The evaluation team acknowledges the persons who volunteered their time, expertise, experience, and viewpoints in accomplishing the assignment. The team would like to express its heartfelt gratitude to the project's donor agency, Japan Platform (JPF). We thank JPF, and Peace Wind Japan (PWJ) colleagues for guiding and assisting us during the assignment. Additionally, we would like to express our gratitude to the implementing partner Dhaka Community Hospital Trust (DCHT) for their tremendous cooperation throughout the data collection process.

We are indebted to the study participants for providing the necessary information and giving their valuable time. Additionally, we would like to thank the government officials and staff from I/NGO for participating in our study and giving critical information.

The team would like to express its gratitude to colleagues at DM WATCH LIMITED for their academic support. Additionally, we would like to thank our enumerators for their dedication and hard work.

Prepared for Japan Platform

Authors

Nowshin Monir
Saeed Sazzad Jeris
MD Khalid Ibne Kamal
Khadija Leena
Dr. Md Habibur Rahman Salman (Team Lead)

Cover Photo: PWJ

Report Layout and Design Adapted by: Shadman Al Arabi

Published by

DM WATCH LIMITED
Shatabdi Haque Tower (3rd Floor), 586/3, Begum Rokeya Sharoni, Dhaka 1216
Email: info@dmwatch.com
Website: www.dmwatch.com

Suggested Citation

Monir N,. Jeris, S. S., Kamal, M. K. I., Leena, K,. & Salman, M. H. R. (2023). *Third-Party Evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMN) and Host Communities (HC) in Cox's Bazar District of Bangladesh", Dhaka: DM WATCH LIMITED.*

Contents

Acknowledgment ii

Contents iv

List of Tables vi

List of Figures vii

List of Abbreviations viii

Glossary ix

Executive Summary 1

1 Introduction 7

1.1 Contextual Background 7

1.2 Interventional Background 9

1.3 Project Details 10

1.4 The Objectives of the Evaluation 12

2 Methodology 13

2.1 Study Area of the Evaluation 13

2.2 Evaluation Methodology 14

2.3 Evaluation Framework 14

2.4 Study Design for the Evaluation 16

2.5 Quantitative Sampling Technique and Sample Size 16

2.6 Qualitative Sample Size 17

2.7 Recruitment and Contracting 18

2.8 Training of the Field Team 18

2.9 Field Mobilization 18

2.10 Data Analysis Plan and Data Triangulation 19

2.10.1 Qualitative Data Analysis 19

2.10.2 Quantitative Data 19

2.11 Ethical Guideline and Risk Mitigation Measures 20

3 Findings 22
3.1 CHS 1: Humanitarian Response is Appropriate and Relevant 22
3.1.1 Relevance of JPF project-6 with other relevant projects in the camps 25
3.2 CHS 2: Humanitarian Response is Effective and Timely 26
3.3 CHS 3: Humanitarian Response Strengthens Local Capacities and Avoids Negative Effects 41
3.4 CHS 4: Humanitarian Response is Based on Communication Participation and Feedback ... 45
3.5 CHS 5: Complaints are Welcome and Addressed 51
3.6 CHS 6: Humanitarian Response is Coordinated and Complementary 55
3.7 CHS 7: Humanitarian Actors Continuously Learn and Improve 58
3.7.1 Programs Improvement 58
3.8 CHS 8: Staff are Supported to Do Their Job Effectively and are Treated Fairly and Equitably 62
3.8.1 Staff support from the organization 62
3.8.2 Beneficiaries' satisfaction regarding project staff 63
4 Success Stories 65
5 Lessons Learned 67
6 Recommendations 70
7 Conclusion 72
8 References 73
Annex 1: Study Design Matrix 74
Annex 2: Terms of Reference 94
Annex 3: Data Collection Tools 105
Quantitative Tool 105
Qualitative Checklists 118
Physical observation checklist for the clinic 133
Annex 4: Pictures from the Field 137

List of Tables

Table 1: Study area for the project-6 PWJ *13*

Table 2: Quantitative sample distribution *16*

Table 3: Qualitative Sample Distribution for Project 6 ..... *17*

Table 4: Ethical risk mitigation measures taken for conducting the study *20*

Table 5: Priority Targets of Emergency Response for People Fleeing Myanmar 2021 ..... *24*

Table 6: Beneficiary satisfaction on clinic service *30*

Table 7: Enough information provided on how to use the medicine *32*

Table 8: Whether the people getting all of the prescribed medicines from the clinic or not *33*

Table 9: Level of Beneficiaries' satisfaction with the clinic's service (based on location) *33*

Table 10: Level of Beneficiaries' satisfaction with the clinic's service (based on Sex) *34*

Table 11 :Brief resilience score of the beneficiaries *44*

Table 12: Access to information regarding health in time *47*

Table 13: Access to information about all the healthcare services from the clinic *47*

Table 14: Accessibility of making a complaint or giving feedback after getting service from the clinic *52*

Table 15: Comparison of satisfaction among Host and FDMN beneficiaries regarding project staff *64*

List of Figures

Figure 1: Study Area 13

Figure 2: Evaluation Framework by JPF Adapted from CHS Quality Criteria And OECD-DAC Criteria 15

Figure 3: Beneficiaries satisfaction with clinic staff's service 31

Figure 4: Informed about the side effects and adverse symptoms of the medicine 32

Figure 5: Level of satisfaction of beneficiaries with the skill of clinic staff 35

Figure 6: Whether people are getting enough services from the clinic to reduce the burden of ill health to the beneficiaries and community or not 36

Figure 7: Status of receiving primary health care 37

Figure 8: Whether responses meet beneficiaries need or not 38

Figure 9: Beneficiaries' perception of the appropriateness of the feedback mechanism 52

Figure 10: People's perception about safety ensured by the feedback mechanism at the clinic 53

Figure 11: Whether clinic staff are correcting their activity or not based on the feedback 54

Figure 12: Status of improvements to the assistance and protection over time 58

Figure 13: Satisfaction of Host and FDMN beneficiaries regarding project staff 63

List of Abbreviations

ANC	Antenatal Care
CHS	Core Humanitarian Standards
CiC	Camp in Charge
DCHT	Dhaka Community Hospital Trust
EPI	Expanded Programme on Immunization
FDMN	Forcibly Displaced Myanmar Nationals
FGD	Focus Group Discussion
GPS	Global Positioning System
FP	Family Planning
IDI	In-depth Interview
INGO	International Non-Governmental Organizations
JPF	Japan Platform
KII	Key Informant Interview
NCD	Non-Communicable Diseases
NGO	Non-Governmental Organizations
PWJ	Peace Winds Japan
PHCC	Primary Health Care Center
PNC	Postnatal Care
UHFPO	Upazila Health and Family Planning Officer
UNICEF	United Nations International Children's Emergency Fund
WHO	World Health Organization

Glossary

Core Humanitarian Standards (CHS)

The CHS describes the essential elements of principled, accountable, and high-quality humanitarian aid. It is a voluntary and measurable standard. The CHS is the result of a global consultation process**.** It draws together key elements of existing humanitarian standards and commitments.[1]

Communities and people affected by crisis

The totality of women, men, girls and boys with different needs, vulnerabilities and capacities who are affected by disasters, conflict, poverty or other crises at a specific location.

Clinic

A building, often part of a hospital, to which people can go for medical care or advice relating to a particular condition.[2]

Effectiveness

The extent to which an aid activity attains its objectives.[3]

Efficiency

The extent to which the outputs of humanitarian programmes, both qualitative and quantitative, are achieved as a result of inputs.[4]

Forcibly Displaced Myanmar Nationals

Forced displacement (also forced migration) is an involuntary or coerced movement of a person or people away from their home or home region. The UNHCR defines 'forced displacement' as follows: displaced "as a result of persecution, conflict, generalized violence, or human rights violations. Forcibly Displaced Myanmar Nationals are those Myanmar nationals who were displaced from their home because of conflict.[5]

1https://corehumanitarianstandard.org/the-standard#:~:text=As%20a%20core%20standard%2C%20the,existing%20humanitarian%20standards%20and%20commitments.

2 https://dictionary.cambridge.org/dictionary/english/clinic

3 https://corehumanitarianstandard.org/files/files/Core%20Humanitarian%20Standard%20-%20English.pdf

4 Ibid.

5 https://www.unhcr.org/556725e69.html

Health Care Workers

A healthcare worker is anyone who works in a healthcare or social care setting, including healthcare students on clinical placement, frontline healthcare workers, and other healthcare workers not in direct patient contact.[6]

Health promotion

Health promotion is the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behaviour towards a wide range of social and environmental interventions.[7]

Host Communities

A host community in this context refers to the local region of Bangladesh where FDMNs are living temporarily.[8]

Humanitarian Action

The aim of humanitarian action is to support people affected by conflict and natural disasters – to save lives, alleviate suffering and maintain human dignity during crisis.[9]

Infectious Disease

Infectious diseases are caused by pathogenic microorganisms, such as bacteria, viruses, parasites or fungi; the diseases can be spread, directly or indirectly, from one person to another.[10]

Primary Health Care

Primary Health Care (PHC) is a whole-of-society approach to health that aims at ensuring the highest possible level of health and well-being and their equitable distribution by focusing on people's needs and as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation, and palliative care, and as close as feasible to people's everyday environment.[11]

---

[6] https://www.hpsc.ie/notifiablediseases/casedefinitions/healthcareworkerdefinition/

[7] https://www.who.int/westernpacific/about/how-we-work/programmes/health-promotion

[8]https://www.unhcr.org/protection/resettlement/4cd7d1509/unhcr-ngo-toolkit-practical-cooperation-resettlement-community-outreach.html#:~:text=A%20host%20community%20in%20this,recognition%20by%20the%20host%20community.

[9] https://gsdrc.org/professional-dev/humanitarian-action/

[10] http://www.emro.who.int/health-topics/infectious-diseases/index.html

[11] https://www.who.int/news-room/fact-sheets/detail/primary-health-care

Staff

Any designated representative of an organization, including national, international, and permanent or short-term employees, as well as volunteers and consultants.[12]

Volunteer

A person who does something, especially helping other people, willingly and without being forced or paid to do it.[13]

ANC

Antenatal Care is a must in order to ensure good health for mother and their unborn children, according to UNICEF percentage of women aged 15-49 who are attended by any health care provider at least four times during their pregnancy period is ANC, also Antenatal care is routine health checks on pregnant women who are thought to be healthy and don't have any symptoms. This is called "screening," and it's done to find diseases or obstetric conditions that don't have symptoms and to give women information about their lifestyle, pregnancy, and delivery[14].

PNC

The first 6 to 8 weeks after birth are called the postnatal period. Postnatal care should be a continuation of the care the woman received during her pregnancy, labor, and birth. It should also take into account the woman's individual needs and preferences. It should try to make a safe place for families where professionals can show them how to take care of their baby and themselves, and where they can spot anything out of the ordinary and do something about it[15].

Health seeking behaviour

Health seeking behaviour (HSB) has been defined as, "any action or inaction undertaken by individuals who perceive themselves to have a health problem or to be ill for the purpose of finding an appropriate remedy"[16]

12 https://corehumanitarianstandard.org/files/files/Core%20Humanitarian%20Standard%20-%20English.pdf

13 Ibid.

14 https://data.unicef.org/topic/maternal-health/antenatal-care/

15 https://www.uclh.nhs.uk/our-services/find-service/womens-health-1/maternity-services/postnatal-care

16 Olenja J. Editorial Health seeking behaviour in context. 2004

Executive Summary

Introduction

The Rohingya crisis has resulted in the displacement of a significant number of Myanmar nationals seeking refuge in neighboring countries, with over 1,118,576 Forcibly Displaced Myanmar Nationals (FDMN) residing in Bangladesh as of 2022. Approximately 859,000 FDMNs reside in just 26 square kilometers of land in the FDMN camps of Cox's Bazar, leaving them vulnerable to a range of health issues, including communicable and non-communicable diseases, mental health disorders, and malnutrition. The Joint Response Plan (JRP) 2021 has called for health partners to improve access to preventive and curative health services to address these health concerns. It is crucial to ensure that all individuals, regardless of their race, gender, culture, religion, political beliefs, or socioeconomic status, have access to quality healthcare services. However, the COVID-19 pandemic has further complicated the situation, leading to heightened levels of anxiety and uncertainty. The Bangladesh government, United Nations agencies, and multiple humanitarian organizations are working tirelessly to improve healthcare services in the FDMN camps amidst the Rohingya crisis. Adequate healthcare services are essential to ensure that the displaced population receives the care they need to manage existing health issues and prevent the emergence of new ones.

Project background

The project "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMN) and Host Communities (HC) in Cox's Bazar District of Bangladesh" was implemented in FDMN Camp 14 and the Host Community of Telkhola and Gujogona village, Palong Khali Union, Ukhiya, Cox's Bazar by theDhaka Community Hospital Trust (DCHT) and Peace Wind Japan (PWJ) from Sept 2021 to July 2022. The project aimed to promote health and infectious disease prevention for FDMNs and the host community by providing primary health care services and establishing a community-based network for health promotion activities. The project had two main components: Provision of Primary Health Care services and Support the Establishment of Community-Based Health Activities. The project provided primary health care services, such as PNC, ANC, FP, EPI, normal deliveries, infectious diseases management, and general outpatient department services, and established a community-based network for health promotion activities. The project recruited four community volunteers from each of the communities (16 volunteers) and conducted several awareness-raising sessions on topics such as hygiene, handwash, skin diseases, NCD, menstrual hygiene, COVID-19, family planning, early marriage, and fire safety. The project also identified and prepared a vulnerable and high-risk

individual's list within the community and provided door-to-door information to the residents about the health services available in their area.

Methodology

The evaluation utilized a mixed-method approach that included both qualitative and quantitative methods for data collection. The study team conducted 6 Key Informant Interviews (KIIs), 3 Focus Group Discussions (FGDs), 14 In-depth Interviews (IDIs), and a physical observation to collect qualitative data, in addition to a structured questionnaire survey of 100 households. The evaluation focused on assessing the health and medical assistance provided to the FDMN and host community and used eight (out of nine) Core Humanitarian Standards (CHS) and six criteria from the OECD-DAC evaluation framework. The study team analyzed the data using SPSS version 23 and used descriptive statistical measures such as frequency counts, contingency tables/cross-tabs, percentage, min value, max value, and average to explain the indicators set by the study.

Findings

The evaluation team conducted an analysis based on Core Humanitarian Standards (CHS) and their related indicators, along with the OECD-DAC criteria. The findings showed that the project largely met the core humanitarian standards. However, the team also identified areas for improvement based on challenges and successes encountered during the project's implementation. These lessons learned can guide future project planning and implementation, with the aim of achieving even better outcomes.

CHS 1: Humanitarian response is appropriate and relevant

The Core Humanitarian Standard 1 emphasizes the importance of comprehending the context and requirements of stakeholders and recognizing their risks and vulnerabilities. The evaluation team scrutinized the appropriateness of the program's interventions, coverage, and relevance with respect to CHS 1. PWJ and DCHT developed the project for FDMNs and host community at the camps in Cox's Bazar, considering JPF's vision, mission, and priorities. The project's component was formulated in line with the minimum service essential package for primary health care and JPF's goals. Throughout the design and implementation phase, PWJ and DCHT implemented their activities by considering the strategic plan and development priorities of the Japan Platform. The clinic covered a significant number of FDMN and host populations, considering their cultural, religious needs, risks, and vulnerabilities. Overall, the project interventions were found to be relevant and appropriate by the study team, considering the current needs of the FDMN community, the international framework concerning refugees, and the government's intervention priorities regarding FDMN refugees.

CHS 2: Humanitarian response is effective and timely

The research findings related to CHS 2 indicate that the provision of primary health care services and support for community-based health activities are effective and timely. The project's success is attributed to the establishment of a referral system, awareness on various health-related issues, and the deployment of health volunteers who provide door-to-door visits, follow-up visits, and necessary information to beneficiaries regarding maternal and child healthcare, delivery services, and non-communicable diseases. The study team reviewed the Project Accomplishment Report and found that the majority of female FDMN beneficiaries visit the Hakimpara clinic to receive primary healthcare services. However, the clinic's location was less convenient for the host community people, who faced transportation difficulties during the rainy season, summer months, or emergency cases. Overall, the beneficiaries were satisfied with the clinic's services, including the treatment approach, the clinic's staff, the time spent with the doctor, and the information received. Nonetheless, some host community members expressed dissatisfaction with the clinic's privacy and transparency. Finally, the survey revealed that 98% of male and female beneficiaries had enough time to discuss their health concerns during their visit to clinic.

CHS 3: Humanitarian response strengthens local capacities and avoids the negative effect

The research findings related to CHS 3 highlight the importance of building resilience in individuals, communities, and health systems to adapt and respond to changes and challenges in health and healthcare delivery. The project implemented by PWJ in the Hakimpara camp has provided clinical services, including ANC, delivery, PNC, vaccination, NCD, and awareness sessions to the FDMN population. The project has helped the beneficiaries to withstand future shocks and stresses through knowledge about handwashing, prevention of NCDs, and awareness of common diseases. The project has also empowered the beneficiaries to confront future challenges by providing knowledge and awareness about diseases through the efforts of volunteers, nurses, and doctors. The study found that both the host and FDMN communities are well-informed about various diseases, where to seek medical assistance, and how to take preventive measures. The project has improved the overall health condition in the camp and changed the health-seeking behavior of the FDMN population. Due to the participation of FDMN volunteers in the project, conducting awareness sessions in the camp has become more convenient. This is because the FDMN individuals feel more at ease with each other and are not hindered by language barriers.The evaluation team utilized the Brief Resilience Scale to assess the level of resilience developed through this project.

CHS 4: Humanitarian response is based on communication, participation, and feedback

The research findings indicate that access to relevant information is essential for individuals to make informed decisions and take actions that can lead to positive outcomes. However, it can be challenging to provide the FDMN community with pertinent information because of their low levels of literacy, restricted access to technology, and language barriers. To address these challenges, the study community engagement and participation, and coordination with local community leaders should be increased more. The research findings also highlight the importance of door-to-door visits as an effective method to provide healthcare services and educate beneficiaries and more door-to-door visits will be helpful. The project team placed significant emphasis on capacity-building for the volunteers, and staff training was a critical component of the organization's service delivery. Active participation from the beneficiary communities is critical to the development of healthcare services and addressing health risks, and feedback mechanisms help ensure patient satisfaction throughout the project's implementation period.

CHS 5: Complaints are welcomed and addressed

It is found that that the project has followed a good complaint procedure, allowing beneficiaries to file concerns and actively engage in improving clinic services. A feedback box located in front of the clinic allows patients and their families to provide feedback, and clinic staff usually receive happy emojis. However, only 41% of the respondents mentioned that they could make a complaint or give feedback easily, with females being less interested due to socio-cultural barriers and low levels of literacy. The majority of the respondents (65%) remained neutral about the safety maintenance of the feedback mechanism, while 28% believed that the clinic maintained the secrecy of their identification. Over 80% of the respondents agree that the clinic staff considers complaints and takes corrective measures. The report suggests that future projects should explore and take evidence-based action to address the socio-cultural barriers for females in understanding the complaint mechanism.

CHS 6: Humanitarian response is coordinated and complementary

It is found that effective organizational coordination is crucial for efficient humanitarian response. To assess the success of organizational coordination, two key indicators should be considered: minimizing gaps and overlaps in aid and sharing relevant information among responding organizations. The research focused on the Hakimpara clinic in Camp 14, where different organizations, including MSF, DG Health, BRAC, and IOM, provide health-related services. The study team found that a reporting system had been developed, and a community health working group provided mapping for each health agency, ensuring that no overlapping was happening. The coordination mechanisms showed adequate participation and representation from local organizations. Effective communication was established through regular coordination with various stakeholders in monthly meetings, which were arranged by the Camp Health Focal Person. DCHT and PWJ had established satisfactory coordination among themselves, with the Camp in Charge

(CiC), Camp Health Focal Person, and other stakeholders. The CiC played a crucial role in maintaining overall coordination among different stakeholders, and the clinic followed the government strategy of referral. The research findings suggest that effective organizational coordination, with proper local engagement and representation, sharing of relevant information with other agencies, and adherence to the referral strategy, can lead to efficient humanitarian response.

CHS 7: Humanitarian actors continuously learn and improve

Feedback was obtained from respondents using a four-part questionnaire and a five-point Likert scale to measure the medical staff's progress, environment, and service quality. The results showed that respondents had moderately positive perceptions of the improvement in assistance and protection services they received over time, with the physical environment of the clinic showing the most improvement. The report also highlights the popularity of one of the primary health care centers and its structural development, which has elevated the satisfaction level among beneficiaries regarding the clinic's physical environment. The program incorporates various learning components, including training for doctors, medical coordinators, health volunteers, and the involvement of the FDMN community to raise patient awareness more effectively. According to the report, the project staff frequently exchange information on their experiences and obstacles. PWJ stays in regular contact with DCHT and weekly meetings are organized for all staff to provide mutual support, discuss their experiences and challenges. The medical officer attends monthly meetings hosted by the Camp Health Focal Person, where medical officers from other agencies also present and exchange their project's experiences and challenges. Additionally, community volunteers share their knowledge with volunteers from other organizations through community networking. The project staff listens to feedback and complaints from beneficiaries, and endeavors to improve the project based on their responses. The report concludes by discussing the valuable practices adopted by the program team to ensure the proper involvement of the community and reduce language barriers.

CHS 8: Staff are supported to do their job effectively and are treated fairly and equitably

This report focuses on the support and performance of staff in clinic and the satisfaction of beneficiaries in the FDMN and host communities in a humanitarian project. The staff receives technical, medical, and financial assistance, including trainings on various topics such as COVID-19 vaccination, immunization, and infection control. The beneficiaries perceive the doctors and nurses as knowledgeable and skilled in treating and addressing their healthcare concerns. Health volunteers play a critical role in educating beneficiaries on various illnesses and preventive measures.

Lessons learned

The project has several positive outcomes, including the engagement of local FDMN volunteers, door-to-door and follow-up services, involvement of clinic practitioners, awareness sessions, focus on preventive medicine, upgradation of tools, building self-reliance, a feedback mechanism, training of healthcare providers, and resource management. Both PWJ and DCHT have recognized the importance of local volunteer involvement in promoting health-seeking behaviors and delivering health education within both the host and FDMN communities. The provision of regular follow-up and door-to-door services was successful in reaching vulnerable and marginalized patients. Besides this, using emojis as a mechanism for receiving complaints, instead of written forms, has proven to be effective in the camp setting. This approach also includes illiterate beneficiaries who may have difficulty communicating through written forms. However, there are also some challenges, such as the distance and location of the clinic, less availability of medicines, lack of transportation, space limitation.In addition, some beneficiaries do not follow the advice of community volunteers and prefer to follow the doctor's instructions as well as don't participate in awareness sessions. The project team should consider these challenges and take appropriate steps to overcome them.

Recommendations

The project faces budget constraints and a reduction in medication availability, leading to decreased effectiveness and dissatisfaction among beneficiaries. To address these issues, it is recommended to increase the project budget and medicine supply. It is suggested to establish need-based additional health service components including but not limited to nutrition center, mental health and psychosocial services, and expanded care for children. Furthermore, it is advisable to set up extra laboratory facilities at the clinic to ensure that both the host and FDMN communities can receive essential testing services when required. Apart from this, it is also recommended to provide additional training for health volunteers to enhance their knowledge and prepare them for upcoming issues. Besides this some other suggestions include, ensure awareness sessions, inform more about complaint boxes, increase human power, and build a ramp at the entrance of the clinic. Additionally, it is important to ensure that marginalized individuals are included in awareness and feedback mechanisms.

1 Introduction

1.1 Contextual Background

The Rohingyas are one of the most persecuted minority groups in the world, as their mass exodus from Myanmar in 2017 prompted them to seek asylum in neighboring Bangladesh.[17] The Government of Bangladesh (GoB) recognizes the Rohingyas as "Forcibly Displaced Myanmar Nationals,"[18] despite their legal status as "de jure stateless."[19] Bangladesh has had a long history of hosting displaced Rohingyas. The majority of them returned to Myanmar as a result of the United Nations (UN) pressure on the Myanmar government to accept them back. From 1991–92, around 250,000 Rohingyas sought safety in Bangladesh.[20] With the assistance of international and national humanitarian organizations, the Bangladeshi government is striving to improve the health and WASH conditions in the camps.[21] This huge influx has created unbearable pressure on the prevailing health and medical services and infrastructure in Cox's Bazar, which caused a catastrophic humanitarian crisis in the sector of sanitation, health, safety, nutrition, and education.[22] In both the Forcibly Displaced Myanmar Nationals (FDMN) camps and the host community areas, there are insufficient high-quality health services. The Joint Responding Plan (JRP) 2021 asked health partners to keep working on enhancing access to preventative and curative health services, as well as response to public health crises such as COVID-19 prevention and infectious disease outbreaks, for the Rohingya Humanitarian Crisis.[23] The health-sector partners are under the leadership of the Civil Surgeon's Office of Cox's Bazar, the Directorate General Health Services Coordination Centre, and the World Health Organization (WHO), for better planning and implementation of a coordinated emergency response. The sector has adopted a three-tiered coordination structure at the district, sub-district (Upazila), and union levels to combat the current health issues[24].

More than 270 static and mobile health facilities were established in Ukhiya and Teknaf Rohingya camps in response to the needs identified by the 150 national and international health sector partners. The anticipated overall population in need that the health sector aims to serve is 1,3 million. Currently there are 140 registered health facilities in the camp. More than 87 of them are

[17] https://www.unhcr.org/5bbc6f014.pdf/

[18] Ibid.

[19] Ibid.

[20] See Note 1

[21] https://www.orfonline.org/research/the-rohingya-crisis-a-health-situation-analysis-of-refugee-camps-in-bangladesh-53011/#_edn12

[22] https://www.who.int/

[23] https://reporting.unhcr.org/sites/default/files/2021%20JRP.pdf

[24] Ibid.

health posts, 46 of them are primary health centers and 3 secondary health facilities[25] Under the guidance of the Civil Surgeon's Office of Cox's Bazar, the Directorate General Health Services Coordination Center, and the World Health Organization (WHO), the health sector partners are coordinated for improved disaster response planning and implementation. District, sub-district (Upazila), and union levels have been incorporated into the health sector's coordination system. At the District level, a strategic advisory group comprised of the primary health sector partners advises the health sector coordinator based on priority requirements. Since the start of 2019, the health coordination structure was formalized in the following working groups, which meet regularly: • Mental Health and Psychosocial Support (chaired by IOM and UNHCR) • Sexual and Reproductive Health (chaired by UNFPA) • Community Health (chaired by UNHCR and co-chaired by BRAC) • Epidemiology and Case Management (chaired by WHO)[26]

Among the Forcibly Displaced Myanmar Nationals (FDMN) in the camps, males account for 48% of the total population, while females account for 52%. Females and children together account for about 78% of the total refugee population living in the camps.[27] Although the precise number of children in Rohingya camps is unavailable, a UNICEF statement stated that there are 500,000 Rohingya children in Cox's Bazar. Many girls and women in the camps deliver their babies in unhygienic conditions. Around 75% of babies are born in unsafe and unsanitary bamboo shelters. The children are very worried about their future and are at risk of frustration and despair.[28] There are challenges with geographical access to health services as well as access to accurate health information. If any emergency occurs, there is no established transportation or communication infrastructure for referrals. In the event of an emergency, vulnerable people such as the elderly, person with disabilities, women-headed families, and those with particular health requirements are likely to be left out.[29]

Numerous health facilities are operating in Cox’s Bazar District camps availing health care to Forcibly Displaced Myanmar Nationals (FDMNs) as well as nearby host communities, many with varying levels of services and quality of care. Among the services, the Essential Minimal Health Care Package's goal is to define the minimal requirements and services provided by Primary Health Care (PHC) facilities. PHC is a society-wide approach to health that aims to ensure the

[25] https://www.humanitarianresponse.info/sites/www.humanitarianresponse.info/files/documents/files/who_cxb_hf_populationpartners_20222410_a3who.pdf

[26] https://www.humanitarianresponse.info/en/operations/bangladesh/health

[27] https://data.unhcr.org/en/situations/myanmar_refugees

[28] https://www.unicef.org/emergencies/rohingya-crisis

[29] https://www.who.int/bangladesh/news/detail/15-03-2021-who-joining-forces-to-strengthen-cox-s-bazar-referral-pathway-for-emergency-medical-and-obstetric-care-life-saving-interventions-for-rohingya-refugees

highest possible level of health and well-being and their equitable distribution by focusing on people's needs as early as possible along the continuum from health promotion and disease prevention to treatment, rehabilitation, and palliative care, and as close as possible to people's everyday environments. [30]This revised package is based on the earlier Essential Service Package that was developed in 2017 and revised in December 2018 and February 2020 by the Health Sector under the direction of MOHFW and RRRC. Health promotion, preventative care, curative services, and access to secondary/tertiary referrals will be provided by the primary health facilities. Community Health Workers affiliated with primary health centers are implementing health promotion and preventative services on a systemic basis at the community level. Curative services include IMNCI, SRHR, and MHPSS in addition to standard curative services for communicable and noncommunicable disorders. As per the Minimum Package of Essential Health Services for Primary Healthcare Facilities in the FDMN/Refugee camps, Cox Bazar, February 2020, it is recommended that one primary healthcare center should be available within a 30-minute distance from the patient's residence, catering to 25,000 to 30,000 individuals. addition to facilities that are open 24 hours per day and provide essential PHC services.[31]

1.2 Interventional Background

The Japan Platform (JPF) is an international emergency humanitarian aid organization that focuses on refugee and natural disaster issues and provides the most appropriate and comprehensive emergency relief in response to humanitarian needs. JPF has funded the aid activities of 44 member NGOs, each with its own set of diverse strengths. With a total financial commitment of 60 billion yen, it has provided humanitarian assistance to 55 countries and regions in the form of 1,500 projects.

In Cox's Bazar, there are three active projects for FDMN and host communities funded by JPF in the areas of health, medical support, and education. As the projects end, JPF hired DM WATCH LIMITED as a third-party consulting firm for conducting an end-line evaluation for the three projects. The current report deals with the project titled "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMN) and Host Communities (HC) in Cox's Bazar District of Bangladesh". The project was implemented by Dhaka Community Hospital Trust (DCHT) and Peace Winds Japan (PWJ).

[30] https://www.who.int/news-room/fact-sheets/detail/primary-health-care

[31] https://reliefweb.int/report/bangladesh/minimum-package-essential-health-services-primary-healthcare-facilities

1.3 Project Details

The "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMN) and Host Communities (HC) in Cox's Bazar District of Bangladesh" was executed in FDMN Camp 14 and the Host Community of Telkhola and Gujogona village, Palong Khali Union, Ukhiya Upazila. The project ran for 9 months from September 1st, 2021, to July 1st, 2022, with the primary goal of promoting health and preventing infectious diseases among FDMNs and the Host community by providing primary health care services and establishing a community-based network for health promotion activities in Ukhiya, Cox's Bazar.

The project consisted of two main components, with the first component focused on providing primary health care services to the target population. The second component involved establishing a community-based network to promote health and prevent infectious diseases through various health promotion activities.

Component 1: Provision of primary health care services

The DCHT and PWJ teams initiated a response in Ukhia, Cox's Bazar, which involved providing primary health care services at Hakimpara clinic. These services included Postnatal Care (PNC), Antenatal Care (ANC), Family Planning (FP), EPI (Expanded Program on Immunization), normal deliveries, infectious diseases management, and general outpatient department services. As a result of this project, more than 4,500 patients, including both FDMN camp residents and the host community, received primary health care services from Hakimpara clinic. According to Project Accomplishment Report , at the beginning of the project in September 2021, approximately 4,890 patients received services, while at the end of the project in June 2022, around 4,157 patients received services from Hakimpara Clinic. At the end of the project, approximately 41,134 FDMN and 4764 host received health services where around 18200 beneficiaries were male and more than 27500 were female. Additionally, emergency patients and pregnant women received 24-hour service as part of this project.

As per the Referral Pathway established by the Health Sector, patients with severe illnesses that could not be treated at the Hakimpara clinic were transferred to a secondary healthcare institution. Referral records were maintained at the clinic, and patients exhibiting COVID-19 symptoms were advised to use the testing facilities available at MSF in Camp 14. The DCHT and PWJ collaborated with the government and health sector to implement various projects, including OCV and COVID-19 immunization. Additionally, awareness sessions were conducted in the clinic by the DCHT and PWJ, which were attended by patients from both the FDMN and the host community once every two months, with additional sessions organized as required. These sessions covered several topics, including hygiene, handwashing, skin diseases, NCD, menstrual hygiene, COVID-19, family planning, early marriage, and fire safety. Fresh posters based on these topics were printed and

displayed inside the clinic's waiting and consulting rooms. Patients received daily counseling using these posters, allowing them to interact with clinic staff, receive advice and counseling, build mutual trust and understanding, and share their health concerns and solutions with other beneficiaries.

Under component 1 of the project, the implementing partners maintained a routine record of clinical data. The following records were kept:

- Daily clinic database
- Monthly medicine consumption record
- Weekly Early Warning, Alert and Response System (EWARS) report
- Monthly report
- Monthly Sexual and Reproductive Health (SRH) report

In addition to this, patient satisfaction was regularly measured within the clinic.

Component 2: Support the establishment of community-based health activities

As part of component 2, the implementing partners identified communities in both the camps and host communities with limited access to the Hakimapara clinic, and worked to improve their healthcare-seeking behavior.

The aim was to improve access for proper information and people's health seeking behavior and health promotion.

For this purpose, four target communities were selected - two from Camp 14 (blocks with poor access to health facilities, including Hakimpara clinic) and two from Palong Khali Union (villages that were accessible to the clinic but had fewer patients visiting). To promote health and infectious disease prevention for fdmns and Host community by providing primary health care services and Establishing a community-based network for health promotion Activities in ukhiya cox`s bazar.

FDMNs of Camp 14

- Block B4
- Block E4

Host community villages under Palongkhali Union

- Telkhola
- Gujogona

Under component 2, the project aimed to establish community-based health activities by recruiting four volunteers from each of the four targeted communities, totaling 16 volunteers. The

primary objective of this recruitment was to increase the knowledge and experience of the community volunteers regarding health and disease-related issues so that they could assist their respective community members during and after the project period.

The project began with Focus Group Discussion (FGD)s with both host and FDMN beneficiaries to identify knowledge gaps and potential areas for positive health-seeking behavior among the community members. Based on the FGD, topics for promoting awareness were selected, and awareness-raising sessions were conducted by community health workers and volunteers. Separate sessions were arranged for male and female members of the community, and various awareness materials were developed and distributed during these sessions. More than 880 participants attended the awareness-raising sessions conducted by volunteers during the project period.

Community volunteers, with the help of local leaders and participants from already-established community groups, identified and prepared a list of vulnerable and high-risk individuals within their respective communities. Volunteers visited households to inform residents about available health services in their area, how to access them, and whom to contact in case of an emergency. If necessary, volunteers acted as liaisons with various organizations or sectors. Volunteers used flipcharts and provided information during house visits. A phone directory with essential phone numbers from various sectors and organizations was created and distributed across the community at the end of the project. Community volunteers also made contact with medical facilities or other relevant facilities when necessary and sought advice.

1.4 The Objectives of the Evaluation

The objectives of the evaluation include:

1. To verify actual outputs and if possible, outcomes of the project with the available data.
2. To verify that the humanitarian principles and standards including Core Humanitarian Standards (CHS) are respected.
3. To understand the beneficiary satisfaction.
4. To assess the contributions of the project to Joint Response Plan 2021 and JPF's program goals.
5. To document and extract lessons learned and best practices and provide robust recommendations to improve the future projects and Programme.

2 Methodology

2.1 Study Area of the Evaluation

The evaluation study covered all of the project areas listed in Table 1 (for map, Figure 1).

Table 1: Study area for the project-6 PWJ

Community	Location
FDMN	Camp 14 of Ukhiya Upazila
Host	Telkhola, Gujogona village from Palong Khali Union , Ukhiya Upazila

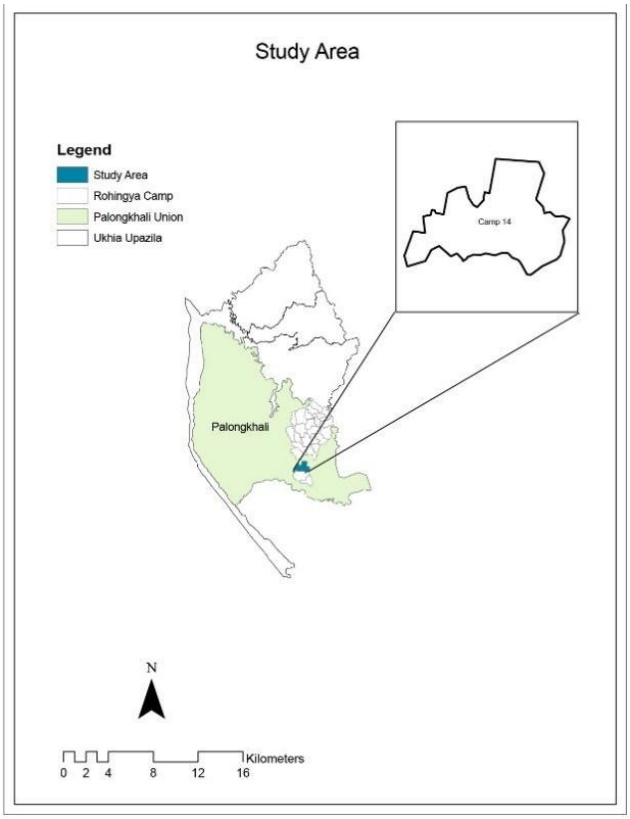


Figure 1: Study Area

2.2 Evaluation Methodology

This evaluation used a mixed-method, which consisted of both qualitative and quantitative methods. Along with a desk-based document review, Key Informant Interviews (KIIs), Focus Group Discussions (FGDs), In-depth Interviews (IDI), and Physical Observations were conducted for qualitative data collection. To collect quantitative data, a structured questionnaire survey was conducted using the digital platform "Kobo Toolbox."

2.3 Evaluation Framework

The primary focus of the evaluated program was on providing primary health care services for both FDMN and the host community. To evaluate the program, the study team used a combined framework of evaluation that integrated the 9 core Humanitarian Standards (CHS) and the 6 criteria from the OECD-DAC evaluation framework, as shown in Figure 2. Additionally, the study team evaluated the localization features of the program, including the Partnership, Capacity, and Participation components. These components emphasized the importance of partnership between member NGOs and local partners, as well as the overall improvement of project beneficiaries and their involvement in decision-making.

The evaluation also considered two out of the four health sector objectives from the Joint Response Plan 2021 for the Rohingya Humanitarian Crisis, as well as two out of the four strategic objectives of JPF, to determine how the program contributed to these objectives.

CHS QUALITY CRITERIA	OECD-DAC CRITERIA						
	RELEVANCE	EFFECTIVENESS	EFFICIENCY	IMPACT	SUSTAINABILITY	COVER	COHERENCE
1. Humanitarian response is appropriate and relevant	●	●	●	●	●	●	●
2. Humanitarian response is effective and timely	●	●	●	●	●	●	●
3. Humanitarian response strengthens local capacities and avoids negative effects	●	●	●	●	●	●	●

4. Humanitarian response is based on communication, participation, and feedback	●	●	●	●	●	●	●
5. Complaints are welcomed and addressed	●	●	●	●	●	●	●
6. Humanitarian response is coordinated and complementary	●	●	●	●	●	●	●
7. Humanitarian actors continuously learn and improve	●	●	●	●	●	●	●
8. Staff are supported to do their job effectively. and are treated fairly and equitably	●	●	●	●	●	●	●

Key

● Fully relevant to that particular OECD-DAC Criteria

● Partly relevant

● No specific relevance

Figure 2: Evaluation Framework by JPF Adapted from CHS Quality Criteria And OECD-DAC Criteria

2.4 Study Design for the Evaluation

The study design matrix was developed in line with objectives, target outcomes, and evaluation criteria indicators (Annex 1).

2.5 Quantitative Sampling Technique and Sample Size

The study team collected data from FDMN camp 14 and Palong Khali Union of Ukhiya Upazila. A simple random sampling was used to select the respondents according to the groups of respondents mentioned in the following Tables 2. If the beneficiary list was not available, then the evaluation team has taken the help of local facilitators provided by PWJ to locate the beneficiaries inside the camp.

To get a statistically significant sample size, the study team used Cochran's formula (Equation 1) and selected the parameters. Selected parameters produced a sample size of 100. The total sample is finally 100.

$$n = \frac{P(1-P)(Z)^2}{(P-p)^2} \quad \text{..... } \textbf{(Equation 1)}$$

Where,

P = Proportion to be estimated = 50%, which gives statistically significant sample size

P – p = Margin of error (8.2%)

Z= confidence level (90%)

n = Size of sample (100)

Table 2 represents the quantitative sample distribution for this project.

Table 2: Quantitative sample distribution

Study area	Community people		Total
	Male	Female	
Camp 14	25	25	50
Palong Khali Union (host community)	25	25	50
Total			100

2.6 Qualitative Sample Size

Purposive sampling technique was employed for the collection of qualitative data from the targeted respondents (Table 3). The majority of the qualitative interviews were conducted in-person, but for some of the KIIs, the evaluation team used online platform such as zoom and phone call to carry out the interviews.

Table 3: Qualitative Sample Distribution for Project 6

Method	Stakeholders	Host	FDMN	Numbers
Key-Informant Interview	Representative of PWJ			2
	Representative of DCHT			2
	Camp in Charge			1
	Representative from health sector coordinator			1
Total				**6**
In-Depth Interviews	FDMN and Host Community Member (Male)	1	1	2
	FDMN and Host Community Member (Female)	1	1	2
	Community Health Workers	1	1	2
	FDMN and Host Community Volunteers	2	2	4
	FDMN and Host Community leaders	1	1	2
	Doctor			1
	Nurse			1
Total				**14**
Focus Group Discussion	FDMN Community Member (Male & Female)			2
	Host Community Member (Female)			1
Total				**3**

Physical Observation	Hakimpara Clinic			1
Success Story	FDMN and Host Community Member			2
Total				**26**

For the success story, the data collection team identified interesting cases on-site. Each day of fieldwork, the team met in the evening to discuss the interesting issues that could be the potential cases. Following the identification of potential cases, researchers will gather comprehensive data on the cases.

2.7 Recruitment and Contracting

Three local enumerators (one male and two female) were recruited based on their knowledge and experience of working in FDMN related projects. In addition, their prior experience of collecting data in the similar domain was given higher consideration. Local enumerators (who can communicate properly with Rohingya and local people) were recruited so that the language barrier of the population in question can be removed. Each enumerator collected 9 household survey data each day.

2.8 Training of the Field Team

After finalizing the checklists and questionnaires, a comprehensive guideline was developed for enumerators for conducting (one-to-one) surveys. The guideline described important definitions, terminology, question objectives, data input instructions, skipping logic, etc. The study team (including recruited enumerators) received a day-long training on data collection and scripting. During the training sessions, each enumerator took part in the role-playing of respondents, which helped them prepare for the real scenario of the field. Enumerators also conducted a mock test with the Kobo app.

2.9 Field Mobilization

Before commencing the fieldwork, the study team prepared a sampling frame of beneficiaries from the list of beneficiaries provided by PWJ and DCHT team. Beneficiaries were reached randomly using the list and with the support from the volunteers provided by DCHT. Moreover, for collecting qualitative data, the stakeholders were contacted in advance for getting their consent and time for an interview. The study team started the fieldwork after receiving approval from the office of the Refugee Relief and Repatriation Commissioner (RRRC). A detailed schedule with the date, time, and venue was prepared and shared with the PWJ and DCHT staff before the field movement took place.

2.10 Data Analysis Plan and Data Triangulation

Primary and secondary data were investigated based on the objectives, evaluation questions, and specific indicators set out by the Japan Platform (JPF) team. All the results were found using different statistical tools and were analyzed objective and indicator-wise. As an analytical framework, the final evaluation was made through the lens of CHS and OECD-DAC criteria.

2.10.1 Qualitative Data Analysis

To assess qualitative information, the study team conducted content and narrative analysis. Qualitative data were coded based on both deductive and inducted themes. The evaluation process included several steps for analyzing the data collected through qualitative data collection methods. These steps are as follows:

1. The study team conducted a preliminary analysis of the findings with research associates involved in qualitative data collection during a separate session. This allowed the team to discuss initial observations and obtain feedback on the data collection process.
2. Thematic coding of the data was done according to content and specific categories. If the findings included reasons, causes, and consequences, they were categorized accordingly.
3. The data was compiled by themes to systematically analyze the qualitative data. This allowed the team to identify patterns and trends in the data.
4. Qualitative observations were compiled by themes, and issues were selected along with appropriate quotations. This allowed the team to present specific examples to support their findings and conclusions.

2.10.2 Quantitative Data

After collecting and cleaning the quantitative data, a final screening was conducted to ensure the usability, reliability, and validity of the data analysis. The data was transformed into a suitable code for computer-aided analysis.

To explain the indicators set by the study, some descriptive statistical values such as frequency counts, contingency tables/cross-tabs, percentage, minimum value, maximum value, and average were calculated using SPSS software version 23. These values were used to provide a better understanding of the quantitative data collected.

2.11 Ethical Guideline and Risk Mitigation Measures

The evaluation activities did not contradict ethical principles. DM WATCH LIMITED took all reasonable steps to ensure that the evaluation activities were designed and conducted within the "Do No Harm" principle to respect and protect the people's safety, rights, and welfare. Consents were taken from all participants in data collection activities, and all data gathered were kept confidential. Ownership of all data, information, and findings collected through different evaluation activities lies with JPF. Strategic mitigations were followed against potential ethical risks.

DM WATCH LIMITED also followed the below ethical guidelines (Table 4):

Table 4: Ethical risk mitigation measures taken for conducting the study

Potential Ethical Risk	Strategic ways to mitigate
Harms and benefit	The study team justified the research objectives, process, and consequence of the study.
Informed consent	The study team maintained different types of consent forms for respondents of structured survey, IDIs, and FGDs. The language of the consent form was Bengali. Simple sentences were used. The objective of the study was narrated in the form. If participants did not permit, the interviewer went to the next available participant.
Privacy and confidentiality	The study team ensured privacy and confidentiality by respecting human rights, securely storing data, and being aware of the safety concerns of person related to the evaluation.
Payment and compensation	The study team avoided providing any kind of payment and showing any unrealistic expectations.

DM WATCH LIMITED also followed the below ethical guidelines:

Participatory: Participatory approaches were followed to involve all the key stakeholders of the project.

Ethical: The evaluation was guided by the following ethical considerations:

- Sensitive— to human rights, gender, inclusion, and cultural contexts.
- Integrity— honest and truthful in communication and actions. Professional, credible, and trustworthy behavior.
- Accountability— transparent regarding evaluation, responsive, and responsible.

- Respect— access to the evaluation process and products by all relevant stakeholders, meaningful participation and equitable treatment, and fair representation of different voices and perspectives in evaluation products (reports, webinars, etc.).
- Beneficence— explicit and ongoing consideration of risks and benefits from evaluation processes. Maximum benefits at systemic (including environmental), organizational and programmatic levels.
- Confidentiality and data protection – measures were put in place to protect the identity of all participants and any other information that may put them or others at risk.

3 Findings

The findings section of this evaluation report was created by examining the 8 core Humanitarian Standards (CHS) and their associated indicators, as well as the 6 criteria from the OECD-DAC evaluation framework. In each section of the findings, the assessment team highlighted the significance of each indicator and the program activities designed to address them.

Each indicator was concluded with a fundamental lesson learned and advice, which helped to provide an understanding of the success and challenges of the program. By using this approach, the evaluation report was able to present a comprehensive and detailed analysis of the program's effectiveness in meeting the established standards and criteria.

3.1 CHS 1: Humanitarian Response is Appropriate and Relevant

The first Core Humanitarian Standard (CHS 1) emphasizes the importance of understanding the context and requirements of stakeholders, including the risks they face, vulnerabilities, and capacities of different groups. It also highlights the appropriateness and relevance of program interventions in emergency zones.

In humanitarian assistance, the concept of appropriateness refers to the acceptability and suitability of program interventions under specific circumstances, while relevance is the degree to which the project aligns with local needs and priorities, including the requirements of beneficiaries, policies, preferences, geographical features, and partner/institutional capacity, as well as changing circumstances. To establish a standard for judging appropriateness, most humanitarian actors agree that it should primarily be based on the needs of the impacted community.

During the evaluation process of CHS 1, the evaluation team carefully examined the appropriateness of the program's interventions, along with the program's relevance and coverage. The team assessed the need for the program intervention based on the needs of the crisis-affected community, looked at whether the interventions and program design addressed gaps in health services, and considered the community's cultural conditions and preferences.

The following section provides an analysis of the appropriateness and relevance of the program interventions by examining the project's priority targets, outputs, and outcomes. The evaluation also assesses the accessibility and coverage of the Primary Health Care Centre (PHCC) and explores the project's relevance with other projects in the FDMN camps situated in Ukhiya, Cox's Bazar.

The study team found that the project's interventions aligned with the current needs of the FDMN community, as well as international frameworks related to refugees and the government's intervention priorities concerning FDMN refugees. In the upcoming section, the study will further examine various indicators of CHS 1 and evaluate their relevance and appropriateness in the context of the project.

3.1.1 JPF's development priorities and strategic plan, and the current program's output and outcome

To assess the relevance of the evaluated program intervention, it is essential to consider the funding partner's development priorities, objectives, goals, values, and how the strategic and implementing partners designed their program interventions to achieve and meet those goals and objectives with anticipated outputs and outcomes.

In the following section, the evaluation team discussed JPF and its priorities, program components, and activities and examined how relevant they were considering JPF and Bangladesh's priorities and goals. This analysis provides a clearer understanding of the program's appropriateness and effectiveness in addressing the needs of the targeted communities.

The Japan Platform (JPF) is a novel framework for collaboration and synchronization established with the aim of delivering speedy and effective emergency assistance with participation from the Japanese government (namely the Ministry of Foreign Affairs), NGOs, and the business sector to contribute their respective skills and resources. By leveraging the skill sets and resources of both non-governmental organizations and commercial enterprises, the Japan Platform devises emergency response strategies and builds up stockpiles of relief supplies in preparation for potential refugee crises and major natural calamities.

The vision of JPF is to extend the reach of Japanese humanitarian aid globally and establish a world where every individual has access to a path towards the future. JPF adheres to three fundamental principles to fulfil its vision:

- Effective Assistance through Collaboration: Combining the expertise of NGOs, the Japanese government, business communities, and intellectuals to build a platform for efficient operation, providing recipients with the most sustainable and effective support possible.
- Empowerment of Affected Communities: Building a self-reliant community where people from diverse backgrounds can survive and prosper independently.
- Leadership for NGO activities in Humanitarian Assistance: Assuming a crucial role in securing aid and promoting the Japanese NGO aid paradigm both nationally and internationally.

Based on the vision, JPF has identified four priority targets for emergency response to assist people fleeing Myanmar (Table 5).

Table 5: Priority Targets of Emergency Response for People Fleeing Myanmar 2021

Strategic objectives	Ways to address
Promotion of equitable access to the necessary support services to ensure displaced persons have access to a quality and dignified standard of living.	Address the urgent humanitarian needs of displaced communities through assistance in various areas such as WASH (Water, Sanitation, and Hygiene), health, education, and protection. These needs are particularly critical in the context of the COVID-19 pandemic. Regardless of a displaced person's gender, age, or disability, everyone has equal access to a good quality of life is also encouraged.
Delivering aid that has a positive impact on both displaced people and host communities.	JPF will provide aid that directly or indirectly satisfies the humanitarian needs of the camps and host communities while take into account the socioeconomic conditions of the area, which is inherently vulnerable due to the ongoing hostility between the host communities and the displaced people in the Cox's Bazar camp.
Contribute to strengthening the resilience of humanitarian crisis affected people and communities.	Establishment of the foundation of the system for the displaced people and communities to continue and develop their activities despite the prolonged plight of displacement. With initiatives like education, skill development, promoting awareness, and human resource development, this aid will help communities become more capable.
Promote among people who have gender-related vulnerabilities about the understanding and awareness of their rights.	Women and children need protection now more than ever because to the postponed evacuation, increasing psychological stress brought on by COVID-19, and deteriorating security. While respecting the traditional values and cultures of the displaced people, JPF will actively involve them in the activities of each sector and carry out awareness-raising activities to promote understanding of the people around them. It also contributing to understanding and awareness of the rights of vulnerable groups from a gender perspective.

DCHT and PWJ implemented the project "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMN) and Host Communities (HC) in Cox's Bazar District of Bangladesh" in FDMN Camp 14 and in the Host Community of Telkhola and Gujogona village,

Palong Khali Union, Ukhiya Upazila based on JPF's vision, mission, and priorities. The main objective is to promote health and infectious disease prevention for FDMNs and the Host community by providing primary health care services and establishing a community-based network for health promotion activities in Ukhiya, Cox's Bazar.

3.1.1 Relevance of JPF project-6 with other relevant projects in the camps

3.1.1.1 Communities and people affected by crisis consider that the response takes account of their specific needs and culture

Humanitarian agencies needs to be consider the needs and cultural preferences of the affected people for their intended interventions to work appropriately in a particular context. The evaluation team assessed whether the clinic could meet the FDMN and host population's health needs, such as health information, vaccination, outpatient services, mother and child health, and medicine (Uddin et al., 2022). Also, the team assessed whether the program gave due attention to the culture and beliefs of FDMN's while designing the project.

The evaluation team found that PWJ and DCHT have considered the health needs of the FDMN and host community as they have discussed with CiC, health Focal Person, local authorities such as majhees and carried out need analysis. The Rohingya community uses the term "majhee" to describe a person who leads a group and provides them with support in every way possible. The PWJ and DCHT carried out FGDs for needs analysis with both host and FDMN people in the presence of Majhees and local leaders . The project staffs also ensured the community meetings. Majhee and other community members confirmed to the study team that they had several meetings before the project started and had a meeting as needed where they could share their feedback from the community people for better health care.

The Rohingya are Myanmar's largest Muslim group. Their ethnic background is complicated, with exposure to a long history of human rights violations such as torture, rape, assault, extrajudicial killings, and limited access to education and health care (UNHCR, 2018). Many cultural and religious preferences exist in the Rohingya community, such as older men growing beards and women typically wearing a hijab (head and chest veil). Women are barred from participating in certain aspects of public and civic life. Traditional houses are surrounded by bamboo fences, allowing for the practice of purdah (strict gender segregation), which prevents women from being seen by outsiders. Religious leaders (mullahs and imams) are the most respected, mainly making decisions in the community. Health volunteers reported that the Rohingya male doesn't want their wife to go to the clinic and see doctors, more than that they don't want any outsiders to meet the female members of their family.

3.1.1.2 The assistance and protection provided correspond with assessed risks, vulnerabilities, and needs

PWJ and DCHT conducted a gap analysis of clinic and Primary Health Care (PHC) in the respected camp and host area to identify the needs of the FDMN and host population. As a result, PWJ and DCHT established a clinic in Camp 14 in the prior phases of this project in 2018 and have continuously supported the clinic operation. Along with the clinic operation, PWJ and DCHT has trained health volunteers and healthcare service providers on existing health problems. The report also highlights the challenges faced by the FDMN and host population in terms of lack of knowledge about health, education, unhygienic living conditions, and reliance on incorrect medical practices. To combat these challenges, the project team heavily focused on raising awareness and educating FDMN and host populations on health-related topics. The clinic provides basic medical services, and for wider services such as delivery and vaccinations, a referral system is used. However, FDMN and host beneficiaries expect additional services in the clinic, such as caesarean section and a small surgical unit, which will help them to ensure child health care facilities in the long run. Nevertheless, the Hakimpara clinic is limited to providing primary healthcare services and cannot accommodate a caesarean section or surgery unit due to government regulations.

3.1.1.3 Access and coverage of the JPF project- 6 in the camps

Health care access refers to obtaining healthcare services, while coverage refers to the geographical location and type of population accessing the clinic. The clinic provides good service provision, but as it provides primary health care, some facilities such as x-ray and caesarean section are not available. Many beneficiaries learned about health services from others or clinic staff, and follow-up treatment is easy to obtain. The clinic has a safe and comforting environment for the female population. The project is set up to cover a large number of FDMN and host populations and from the survey, FGD and IDIs, the study team has found that all of the beneficiaries can easily accessed to the clinic.

3.2 CHS 2: Humanitarian Response is Effective and Timely

This is a very common scenario in the community that always the most vulnerable populations suffer the most whenever any crises or disaster both natural and man-made arises.If humanitarian organizations can address the problems in a timely and adequate manner, it strengthens the effectiveness of humanitarian response. Effective humanitarian response refers to aiding that meets the needs of affected individuals and communities in a relevant, appropriate, and sustainable manner by ensuring that the interventions have a positive impact and minimize negative consequences. Timely humanitarian response means aiding in a prompt and appropriate

manner to meet the needs of affected individuals and communities as quickly as possible. It also involves implementing interventions that are responsive to the changing needs of the affected population throughout the crisis or disaster.

The effectiveness and timeliness of the program intervention regarding health need of both host and FDMN community, the satisfaction level of the FDMN community was measured by using a Likert Scale for each of the services the beneficiaries are receiving from the PHC. Apart from this, the quality and quantity of the program was also assessed. Overall, the beneficiaries both host and FDMN are satisfied with the PHC's service and the standard of the service quality and quantity of interventions in both camp and host area are found to be maintained by the implementing partners.

3.2.1 FDMN beneficiaries and their satisfaction with provided health services

3.2.1.1 FDMN benefited from using the PHC

The project focused on two components- provision of primary health care services and support for the establishment of community-based health activities. Previously, when DCHT and PWJ team started response to Ukhia, Cox's Bazaar, they provided only curative services and free medicine services. Later the team acknowledged the underprivileged host community who also need support and the necessity of sustainability and strengthening the knowledge of the community people. That's why the project has initiated awareness on various health related issues and establishing community networking. The health volunteers performed door-to-door visits and follow-up visits and provided all necessary information to the beneficiaries regarding maternal and child health care, delivery services and NCDs.

The study team reviewed Project Accomplishment Report and found that FDMN female visits the Hakimpara clinic most to receive primary health care services, where the numbers vary from 2300 to 3100 during the 10 months of project running. Around 3000 Community Health Worker (CHW) home visits were conducted during that period. However, there was a fluctuation in the frequencies of beneficiaries visiting the Hakimpara clinic and CHW home visits due to COVID-19 emergency.

> *The primary issue is related to distance, as we reside in a remote area that requires a 2-mile walk to reach the main road. In case of an emergency, it becomes an enormous challenge for us to transport the patient to the clinic."-*
>
> Female Beneficiary from the Host Community

The representative from DCHT informed the study team about the referral system of the clinic during the KII sessions. When the study team asked the DCHT representative about the referral system, she said they had followed government strategy of referral. If any complicated pregnancy case/ patient had come to the clinic, they referred the patient accompanied by a midwife/ nurse to other health care centers through the ambulance service. For pregnancy related case, they mostly referred to MSF-Maternal and Children Hospital having cesarean section and advance care for children. Other emergency patients are referred to Ukhiya Health Complex. The clinic provides service 24 hours and almost all the beneficiaries knew about the referral system of the clinic. One of the female beneficiaries from the community host said the services the clinic provides are very well and we are very satisfied with their services.

During the evaluation, the accessibility and coverage of the Primary Health Care Centre (PHCC) were assessed, and from the IDIs and FGDs the study team found that the clinic's location was convenient for the FDMN population but not for the host community people. The Minimum Package of Essential Health Services for Primary healthcare facilities in the FDMN/Refugee camps states that the clinic should be located within 30 minutes walking distance from patients' homes, which is not the case for the host community people. The study team also observed that there were transportation issues for the host community people to reach the clinic, especially during the rainy season or in case of emergencies. The evaluation team suggests that implementing partners should consider the location and accessibility of primary health care services in future, while designing interventions and strategies, especially for host communities living in remote areas. This will help to ensure that all community members have equitable access to essential health care services.

3.2.1.2 Treatment approach and adequacy of medicine prescriptions

During the visit to the health clinic, the evaluation team monitored how the beneficiaries were treated throughout the entire process, including their entry to the health clinic,, waiting for receiving consultations. This treatment approach was evaluated to determine the program's effectiveness for both host and FDMN beneficiaries.

Following the Minimum Package of Essential Health Services for Primary healthcare facilities in the FDMN/Refugee camps, Cox Bazar, February 2020, Hakimpara clinic also opens for 24/7 and is adopted for 25000-30000 population. The clinic's medical team and health volunteers work together to provide primary healthcare services, and awareness sessions among the beneficiaries. They collaborate with other NGOs and health facilities to establish a referral system and share information at camp-level health sector meetings. The health volunteers are tasked with visiting the homes of patients as well as follow-up visits. They conduct awareness sessions and promote health-related issues, such as COVID-19, hygiene maintenance, reproductive health, and healthy lifestyle habits. Moreover, they ensure that patients receive the appropriate vaccinations, especially for infants and pregnant women, and assess if there are any other special requirements. In addition, whenever they are informed, they also manage transportation for emergency patients.

The PWJ and DCHT team collected feedback data to ensure patients satisfaction as well as their any significant problems or difficulties relating to the home visits. Apart from this, the health volunteers also asked the beneficiaries about their health related problems, or complaints during their home visits.

During the physical observation, the evaluation team saw hand washing facility situated outside the clinic. Based on feedback gathered through beneficiary interviews and FGDs, it was found that, the patients wait in the waiting room until a doctor or nurse calls them for consultation following registration. Beneficiaries both host and FDMN seemed very happy with the health service providers such including doctor, nurse, and health workers and described them friendly, welcoming, and cooperative to the patients care and communications. From the household survey its found that regarding the amount of time beneficiaries spent with the doctor at the health clinic, more than 70% of hosts were satisfied, while the satisfaction level was over 90% in FDMN beneficiaries. However, around 28% of the host beneficiaries were very unsatisfied about doctors timing (Table 6). The host people travel a long way to visit the clinic. After reaching the clinic they have to stand in ques and wait in the waiting room. In this regard, the host beneficiary, perhaps, expect a little more time and availability of doctors.

Regarding access to information, both host and camp community received information from the health clinic regarding health care and well-being., Around 68% of the host community

participants in the survey were found to be satisfied and very satisfied with the information accessibility and the percentage was around 86% among FDMN beneficiaries. Nonetheless, 32% of the host seemed to be very unsatisfied regarding the health-related information they receive (Table 6). However, approximately 28% were very unsatisfied regarding the privacy and transparency of the health clinic. Almost all of the FDMN beneficiaries said the clinic had provided them privacy.

Table 6: Beneficiary satisfaction on clinic service

Statements	Very unsatisfied		Unsatisfied		Neutral		Satisfied		Very satisfied	
	Host	Camp	Host	Camp	Host	Camp	Host	Camp	Host	Camp
Level of satisfaction with the amount of time you get to spent with the doctor	28%	1.3%	0%	5.3%	0%	0%	56%	52%	16%	41%
Level of satisfaction with the information you received from the health clinic regarding your health and well being	32%	1.3%	0%	12%	0%	1.3%	56%	57.3%	12%	28%
Level of satisfaction with the privacy and transparency of the health clinic	28%	1.3%	0%	0%	0%	1.3%	40%	60.0%	32%	38.7%

From the survey, it's evident that 98% male and female are getting enough time to discuss health or medical problems with the doctor. Apart from this, around 82% male and 98% female responded positively, stating that the doctors had provided great assistance and explained the reason for their treatment in a comprehensible manner. Almost all the male (98%) and all female stated they were given enough privacy for the treatment (Figure 3).

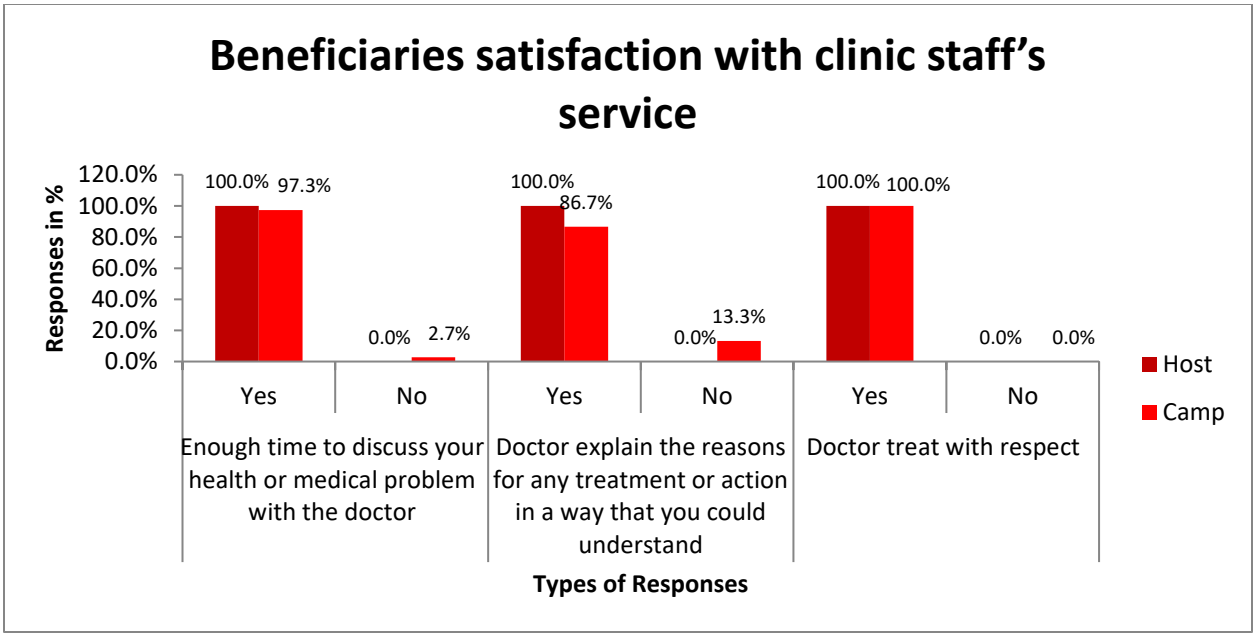


Figure 3: Beneficiaries satisfaction with clinic staff's service

During the evaluation, the study team observed that Hakimpara clinic had a waiting room for patients, as well as rooms for Outpatient Department (OPD), emergency services, Maternal and Child Health (MCH) services, midwifery services, breastfeeding areas, vaccination corners, generator services, laboratories, and pharmacies. The study team found that all the rooms were spacious, well-ventilated, and clean. However, the clinic lacks a ramp for disabled or wheelchair patients, which could pose a challenge for those with mobility impairments. The evaluation team suggests that implementing partners should consider making the clinic more accessible for people with disabilities by installing a ramp or other measures that would facilitate their access to the clinic.

The doctor at the clinic writes the prescription in the English language so that when a patient goes to other clinic or primary health care centers, doctors, and pharmacists, they can easily understand the prescription and give appropriate medicines. Around 76% male and 74% female participants in the survey acknowledged that, they were informed about the side effects and adverse symptoms of the medicine prescribed to them (Figure 4). According to Table 7, more than 90% of the host and FDMN reported that they had received adequate information on how to take their medication, while about 9% FDMN beneficiaries expressed a desire for additional information on this topic.

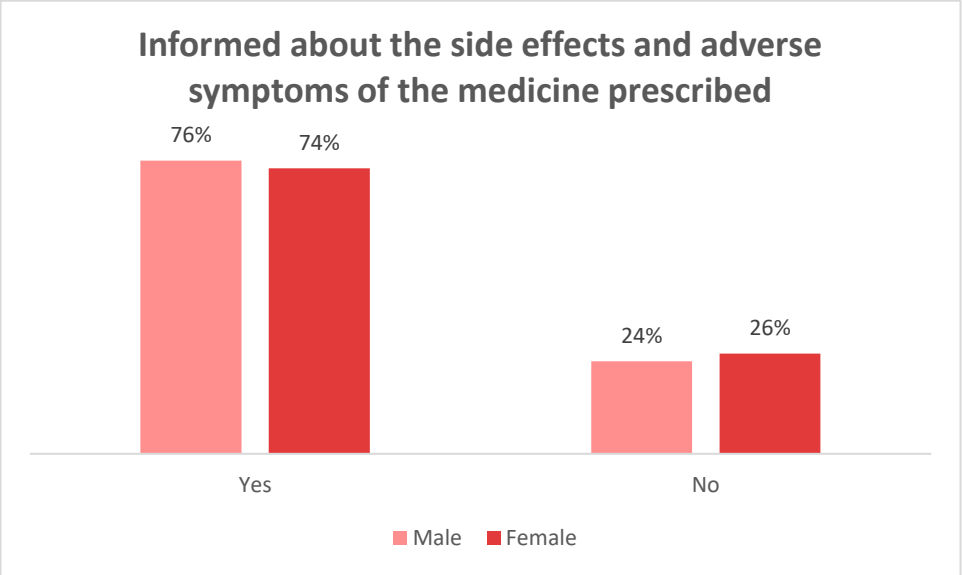


Figure 4: Informed about the side effects and adverse symptoms of the medicine

Theconsulting doctor at Hakimpara clinic provides a prescription to the patient on the clinic's pad. After receiving the prescription, the patient goes to the pharmacy where the pharmacist dispenses the medication. According to the survey, approximately 96% of the beneficiaries reported that they received all their prescribed medication from the clinic's pharmacy. However, it was observed that the amount of medication dispensed by the pharmacy has decreased over time, as indicated in Table 8.

The DCHT representative acknowledged during the evaluation that the clinic's available medicine stock has reduced compared to before due to budget constraints. In addition, to prevent illegal sale of prescription drugs by some FDMN beneficiaries who collect medications from multiple centers, the clinic now provides a maximum of three to five days of medication. However, both PWJ and DCHT are making efforts to increase the supply of medicine.

Table 7: Enough information provided on how to use the medicine

Responses	Host	Camp 14
Yes, enough information	96%	91%
Some, but I would have liked more	4%	9.3%

The beneficiaries, including both FDMN and host community members, have expressed their need for surgical and caesarean services to be provided at the Hakimpara clinic. The addition of these services would be beneficial for pregnant women and individuals requiring surgical interventions.

Table 8: Whether the people getting all of the prescribed medicines from the clinic or not

Responses	Percentages
Yes	96%
No	3%
Can not remember	1%

The patients who participated in the evaluation generally reported being satisfied with the treatment and medication services provided at the clinic. However, some respondents expressed concerns over the quantity of medication they received, and requested an increase in the amount provided. Additionally, there was a suggestion for more awareness sessions on disease prevention, rather than simply relying on curative medication. Counselling by clinical staff could also help to reduce dependency on medication.

3.2.1.3 Beneficiaries' satisfaction with the clinic's service

The evaluation team conducted a thorough analysis of the clinic's operational aspects and project activities by gathering feedback from both the host and FDMN beneficiaries. The primary objective was to assess their satisfaction with the services provided and gain insights from their perspective. During the assessment, the beneficiaries were asked to provide their feedback on the clinic's doctor, nurse, and equipment to gauge their opinions and overall experience with the services provided.

In general, the majority of the beneficiaries expressed that the clinic's services were satisfactory. According to the survey results, over 90% of both the host and FDMN beneficiaries reported that the clinic had sufficient nursing staff and medical equipment. As for the availability of doctors, approximately 84% of host beneficiaries responded affirmatively, whereas all FDMN beneficiaries responded positively, as shown in Table 9.

Table 9: Level of Beneficiaries' satisfaction with the clinic's service (based on location)

Statements	Response	Host (n=25)	FDMN (n=75)	Total (n=100)
Clinic has adequate number of nurses	Yes	92%	100%	98%
	No	8%	0%	2%
Health clinic has adequate medical equipment	Yes	96%	89%	98%

	No	4%	11%	9%
Clinic has adequate number of doctors	Yes	84%	100%	96%
	No	16%	0%	4%
One health clinic is enough for the community	Yes	88%	73%	77%
	No	12%	27%	23%

Table 10: Level of Beneficiaries' satisfaction with the clinic's service (based on Sex)

Statement	Response	Male (n=50)	Female (n=50)	Total (n=100)
Clinic has adequate number of nurses	Yes	98%	98%	98%
	No	2%	2%	2%
health clinic has adequate medical equipment	Yes	88%	88%	88%
	No	12%	12%	12%
Clinic has adequate number of doctors	Yes	98%	94%	96%
	No	2%	6%	4%
One health clinic is enough for the community	Yes	86%	68%	77%
	No	14%	32%	23%

According to Figure 5, the majority of the beneficiaries expressed satisfaction with the staff's skills, with a significant proportion being very satisfied. Specifically, around 65% and 24% of the beneficiaries reported being satisfied and very satisfied, respectively, with the doctor's competency. Furthermore, approximately 67% of the beneficiaries were satisfied with the nursing staff's skills, with 21% being very satisfied. In addition, 58% of the beneficiaries reported being

satisfied with the community health workers, and 32% were very satisfied with their services.

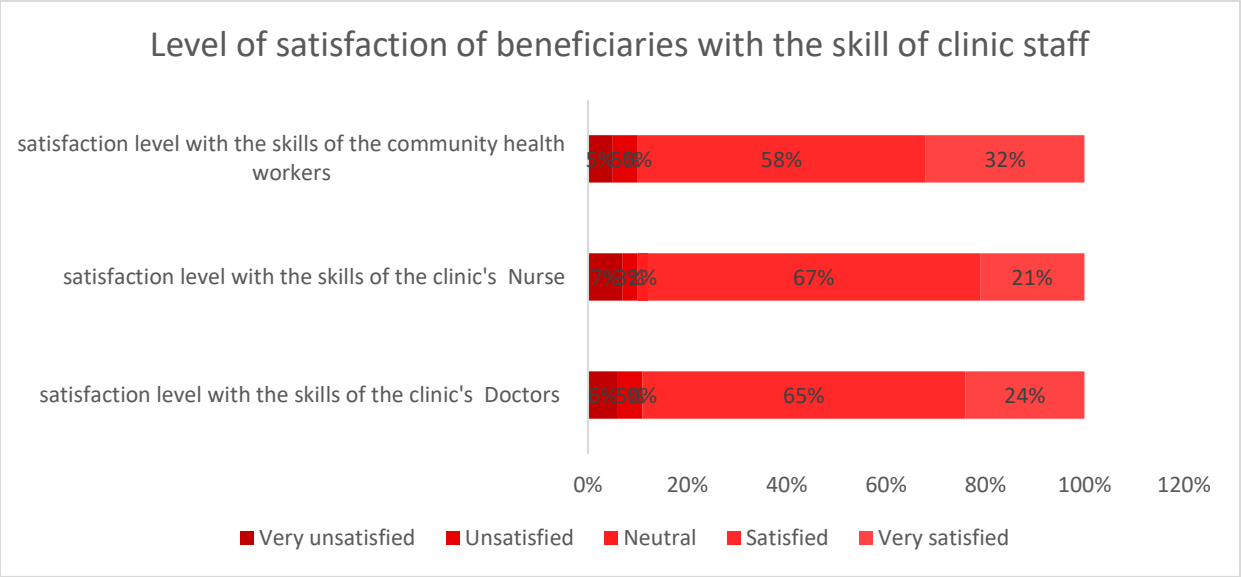


Figure 5: Level of satisfaction of beneficiaries with the skill of clinic staff

DCHT and PWJ have enlisted the support of local volunteers to cater to the language requirements of the beneficiaries. These volunteers maintain an affable rapport with the beneficiaries and communicate with them in their native tongue. During the IDI and FGD sessions, both the host and FDMN beneficiaries expressed their satisfaction with the health volunteers. The volunteers provide information to the beneficiaries on a range of topics. In addition, they also arrange transportation for emergency patients upon receiving notification.

> *The community volunteer who assists us is compassionate and exhibits great patience. She imparts valuable insights on various topics such as hygiene, childcare, antenatal care, postnatal care, diarrhoea, non-communicable diseases, and dengue. Her proficiency in our language and respectful demeanor is greatly appreciated.*
>
> *-Female Beneficiary from Host Community*

Most of the beneficiaries expressed high levels of satisfaction with the clinic's services. Nonetheless, a few beneficiaries have reported having to endure long queues to wait for a doctor's consultation, causing inconvenience. As a result, the authorities must take necessary steps to address this issue.

3.2.2 Adequate and timely response

The project "Primary health care service support project for forcibly displaced Myanmar Nations (FDMNs) and host community (HC) in Cox`s Bazar district of Bangladesh" was initiated in September, 2021 and ran for 10 months. A PWJ representative highlighted that, during the project's development in mid-2021, the COVID-19 pandemic was still ongoing, prompting the project's emphasis on promoting health-seeking behavior. Accordingly, the project was designed to improve such behavior among the beneficiaries. Another representative from PWJ mentioned that the project provides a diverse range of services. However, with the increasing number of FDMN beneficiaries, more interventions are required to cater to their needs.

Based on the results of the household survey conducted with the beneficiaries, it was observed that the majority of both the host (96%) and FDMN (83%) beneficiaries reported that the clinic provides adequate services, thus reducing the burden of illness on themselves and the community, as shown in Figure 6.

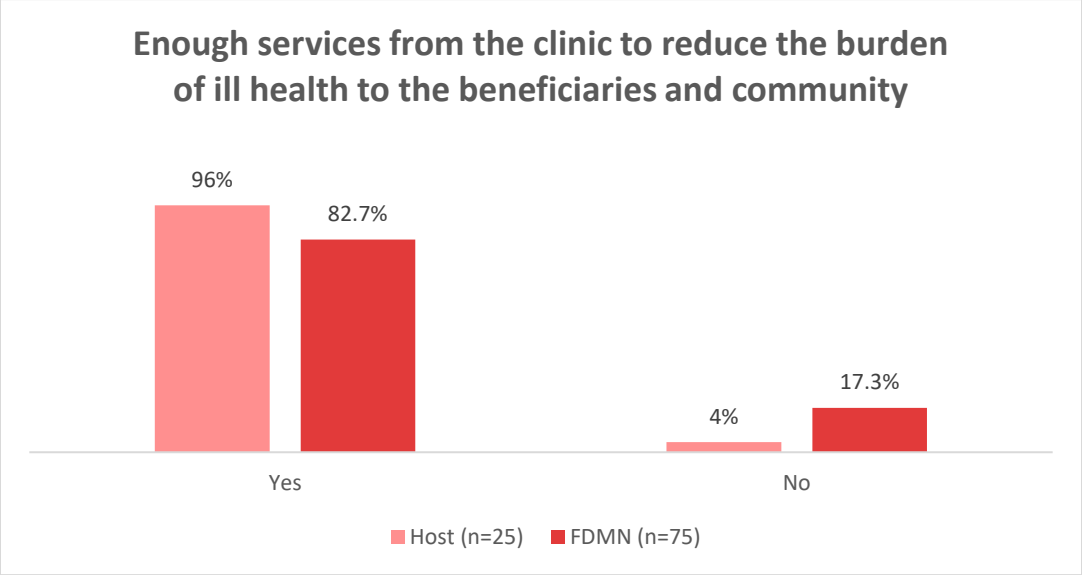


Figure 6: Whether people are getting enough services from the clinic to reduce the burden of ill health to the beneficiaries and community or not

3.2.3 Health needs of the beneficiaries

Within camp 14, seven health agencies are operating, with two providing Primary Health Care and the others functioning as Health posts. The results of the household survey indicate that approximately 70% of beneficiaries receive primary health care services. Nearly all beneficiaries (97%) have participated in health awareness sessions provided by the Hakimpara clinic. However, some beneficiaries (25%) reported feeling that they were treated differently by the clinic staff due to their nationality. This information is illustrated in Figure 8.

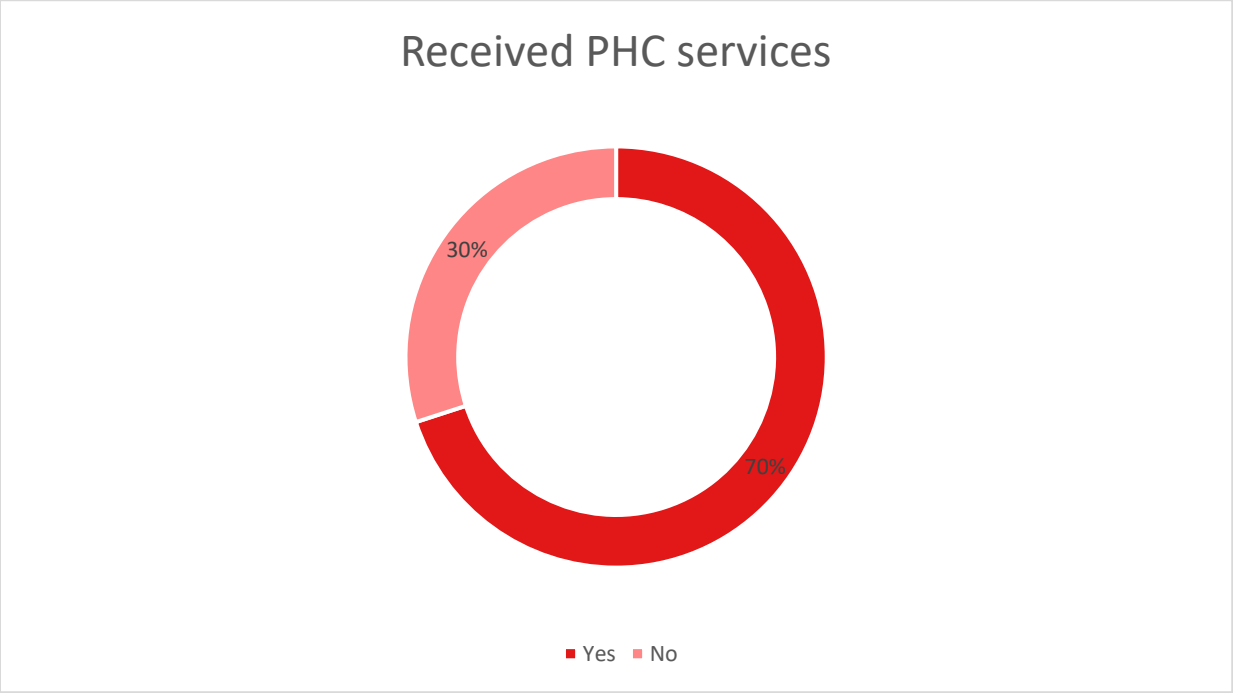


Figure 7: Status of receiving primary health care

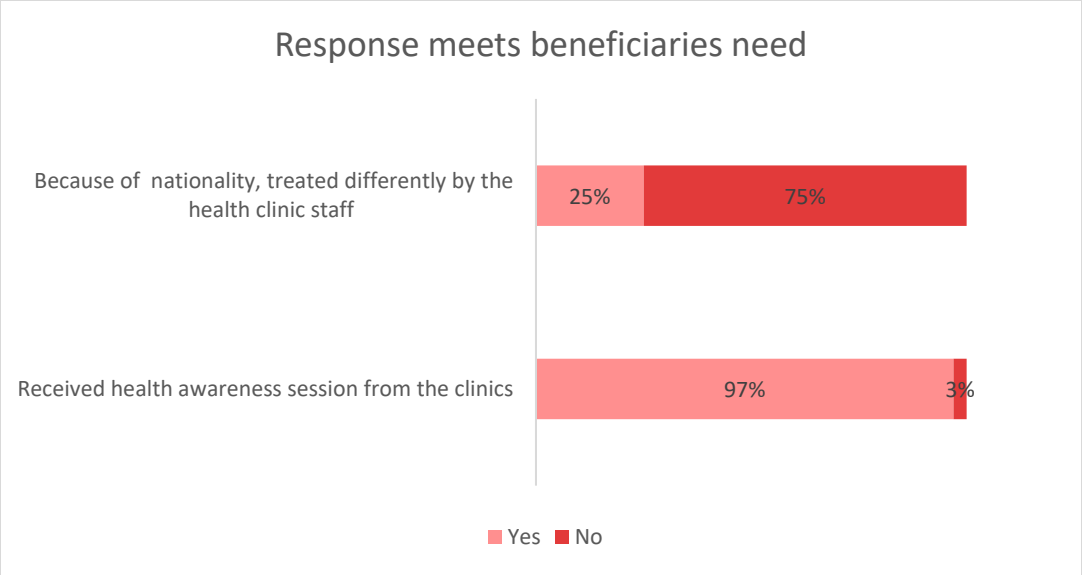


Figure 8: Whether responses meet beneficiaries need or not

According to a health worker, the FDMN community typically experiences seasonal illnesses. Recently, the community was hit by an outbreak of conjunctivitis, but currently, skin diseases are more prevalent. Additionally, the community occasionally experiences outbreaks of diarrhea. Furthermore, NCDs and gastric ailments are also common among the beneficiaries. Within the camp area, skin diseases affect individuals of all ages as they are communicable. The elderly and children are particularly vulnerable to such illnesses.

The volunteers organize awareness sessions in both the host and FDMN communities. During IDI, a female volunteer from the host community reported that she conducts house visits within a span of 2 to 3 days, during which she listens to the beneficiaries' problems and provides them with feedback. She also ensures that the beneficiaries are taking their medications as prescribed by the doctor. If she encounters a NCD patient during her visit, she invites them to attend the relevant awareness sessions. Similarly, during hygiene-related awareness sessions, women between the ages of 18 and 48 are invited to participate. In her sessions, she highlights the importance of COVID-19, skin disease, hygiene, menstrual hygiene, communicable disease (CD), and non-communicable disease (NCD). For example, during an NCD awareness session, she educates the beneficiaries on what they should and should not do, what foods to eat and avoid, and encourages them to share this information with others.

According to the survey results, both communities expressed a need for an additional clinic, albeit to varying degrees. The majority of FDMN beneficiaries (73%) believed that one clinic was sufficient for their community, but about 32% of female FDMN beneficiaries expressed a desire for another clinic. On the other hand, around 88% of host beneficiaries believed that one clinic

was enough for them. However, a health volunteer for the host community noted that many people in remote areas found it challenging to manage transport and reach the clinic during emergencies. Moreover, some women were hesitant to go to the clinic due to its far-flung location and secluded road. Therefore, having a village hospital in their area would be more beneficial for the host community. (See Table 10 and 11 for details).

> *I am content with the medical attention I received, but I think there should be an increase in the amount of medication provided. Furthermore, it would be beneficial if a clinic were to be set up in the central area of the camp.*
>
> *-Male Beneficiary from FDMN Community*

3.2.4 Programs quality and quantity

Based on physical observations and qualitative interviews, it has been determined that the implementing partners have been delivering satisfactory healthcare services since the beginning of the project. Furthermore, the project has had a significant impact on the beneficiaries as it successfully established an effective referral system for the host and FDMN community and conducted awareness sessions. The project has notable achievement on increasing delivery in health care facility. The continuous awareness sessions on ANC, PNC and safe delivery have motivated women to come to the clinic.clinic. The DCHT representative stated during KII that the project has mainly focused on improving self-reliance by creating a community network, which has been one of its major impacts. Additionally, the project has helped beneficiaries identify whom to consult in case of any problems and whom to call in the event of fire break incidents, which is another significant achievement.

> *Although we have put in a significant amount of effort, our delivery rate has not increased to the extent it was expected to. One of the main reason behind this is the religious beliefs of the FDMN community members. They come to the clinic for checkups and supplements, but when it comes to delivery, they prefer to call their traditional birth attendants (Dhai).*
>
> *- Representative from DCHT*
>
> -

The lack of basic health education and family planning knowledge are the main reasons why some areas of the project have been less successful. The representative from DCHT reported that although there are many individuals seeking ANC services, the number of deliveries is not as high. One of the reasons for this may be the changing government rules and policies due to COVID-19 wave.. Additionally, the project may have tried to reach too many households instead of focusing on a smaller number of households and providing them with more in-depth counseling.

> *One of the project's areas of limited success is family planning. Despite conducting awareness sessions and offering counselling services by doctors and nurses, there has been no significant decrease in the birth rate. While the efforts have increased women's awareness of family planning, men are not receptive to advice, and women lack the courage to challenge their husbands' decisions.*
>
> *- Representative from DCHT*

After conducting the study, it was discovered that the project was successful in implementing all of its strategies, which effectively addressed the majority of the health needs of both host and FDMN population. Despite a setback at the beginning of the project caused by the COVID-19 pandemic, the DCHT and PWJ team and clinic staff persisted in their efforts to achieve their objectives, working under difficult conditions. As a result, the project met the CHS 2 quality criterion by maintaining both its quality and quantity of service provision.

3.3 CHS 3: Humanitarian Response Strengthens Local Capacities and Avoids Negative Effects

The third standard of the Core Humanitarian Standard (CHS) provides a framework for ensuring the quality and accountability of humanitarian responses. This standard emphasizes the importance of empowering and collaborating with local communities and organizations, as well as promoting their participation in decision-making processes. By adopting CHS 3, humanitarian actors can better engage with communities affected by crises, strengthen their resilience, and ensure that their needs are effectively addressed. This standard also encourages a focus on sustainability and impact, with the goal of achieving lasting positive outcomes for communities in crisis.

3.3.1 Resilience built through the health program

Resilience refers to the ability of individuals, communities, or systems to withstand and adapt to stress, adversity, and change and involves the capacity to bounce back from difficult circumstances and to recover quickly from setbacks. It also refers to the ability to learn from and even grow stronger because of these experiences. Resilience can be physical, mental, emotional, or social in nature, and can be built through a variety of strategies and interventions that promote well-being, preparedness, and adaptability. Following the term resilience, health resilience defines the ability of individuals, communities, and health systems to adapt and respond to changes and challenges in health and healthcare delivery. This includes the ability to withstand and recover from natural disasters, disease outbreaks, and other health emergencies, as well as the ability to adapt to changing health needs and priorities over time. In the context of humanitarian crises and disasters, by building health resilience, individuals and communities can better cope with health challenges, minimize the impact of health crises, and maintain their overall health and well-being.

One of the representatives from PWJ acknowledged that the project has benefited some individuals, particularly in terms of clinical services. Several beneficiaries have shared their positive experiences with the services they received, and the Hakimpara clinic is the only one in the camp that offers normal delivery, making it a safer option for pregnant women. The project has also introduced new community activities that allow beneficiaries to discuss health issues and raise awareness. Although the impact may not be immediate, it has contributed to a better life for both the FDMN and host communities. The health focal person from Camp 14 believes that the project's various services and awareness sessions, along with support from other health agencies, have brought about significant change to the lives of the FDMN population in the camp 14. In the past, particularly women used to feel hesitant to visit healthcare facilities, but now they are attending them regularly, and their health knowledge has also improved. One of the PWJ

representatives is confident that the project has equipped the beneficiaries with adequate knowledge on topics like handwashing and prevention of non-communicable diseases, which will enable them to cope with future shocks and stresses. Another representative believes that their project provides practical tips, ideas, and solutions to improve the health of the beneficiaries, and whenever they face any health issues, they can visit the clinic without hesitation. This can reduce their stress since they know they can receive assistance at the facility.

> *The project has aimed to enhance the self-reliance of beneficiaries, which has enabled them to access more information. For example, previously, the FDMN community lacked awareness regarding mental health services, but now they are well-informed about where they can access such services. With this improved knowledge and self-reliance, I believe they can withstand future shocks and stresses.*
>
> *- Representative of DCHT*

While conducting the IDI and FGD sessions, it became evident that both of the host and FDMN communities are well-informed about various diseases, where to seek medical assistance, and how to take preventive measures. A male beneficiary from FDMN shared that he gained a lot of health-related knowledge from the health volunteers, making him more conscious and informed about the availability of health services. Overall, the clinic is empowering the beneficiaries to confront future challenges by providing them with knowledge and awareness about common diseases through the efforts of volunteers, nurses, and doctors. This has led to an increased understanding of the entire healthcare process, including how to manage and seek treatment for a disease if they experience any symptoms. As a result, both the host and FDMN community are better equipped to face potential health difficulties in the future.

The health focal person stated that, when the FDMN community first arrived in Bangladesh, they lacked health education. With support from organizations, they received various services such as vaccination and continuous awareness sessions. The collective efforts of all agencies have significantly improved the overall health condition of the camp. However, two things must be ensured for the project's long-term positive outcomes. Firstly, there should be improvement in their living standards, and secondly, improvement in their health-seeking behavior. Until their health-seeking behavior changes, their health status will not improve. To improve this situation,

regular awareness sessions, counseling, and a growing consciousness of health must be provided. These activities should continue until they achieve success. In case health volunteers encounter challenges, they can seek support and guidance from DCHT and PWJ personnel to manage the situation effectively. Through this process of teaching and learning, they can develop the necessary skills and knowledge to assist their community during future periods of hardship or stress.

> *"I have learned about skin disease, dengue, diarrhea, vaccination, hygiene, ANC, delivery and PNC. These awareness sessions makes me conscious and informed about the availability of health services." –*
>
> Male Beneficiary from FDMN Community

According to a PWJ representative, the involvement of FDMN volunteers in this project was a first-time occurrence, which greatly facilitated the awareness sessions in the camp. As a result, the FDMN people feel more connected to their fellow volunteers. For community-based activities, PWJ has developed some user-friendly IEC materials, such as posters and banners, with plenty of pictures. Moreover, they have utilized existing audiovisual materials in the Rohingya language, which have proven to be highly effective.

To assess the level of resilience developed through this project, the evaluation team utilized the Brief Resilience Scale in their household survey. This scale was specifically designed to measure an individual's perceived ability to recover and adapt to stressful situations. The scale was structured to assess a singular construct of resilience by incorporating items with both positive and negative wording. The resulting Brief Resilience Score (BRS) can range from 1 (indicating poor resilience) to 5 (indicating great resilience). By evaluating how strongly survey respondents agree or disagree with the provided statements, the evaluation team was able to gain insight into the resilience score of the beneficiaries.

Statements are:

1. I tend to bounce back quickly after hard times.
2. I have a hard time making it through stressful events.

3. It does not take me long to recover from a stressful event.
4. It is hard for me to snap back when something bad happens.
5. I usually come through difficult times with little trouble.
6. I tend to take a long time to get over setbacks in my life.

In the Brief Resilience Scale used in the household survey, statements 1, 3, and 5 are phrased in a positive manner, while statements 2, 4, and 6 are phrased negatively. To determine the BRS score, the evaluation team reversed the scores for statements 2, 4, and 6 and calculated the average of all six items. A BRS score falling between 1.00 and 2.99 indicates low resilience among the respondents, a score of 3.00 to 4.30 indicates normal resilience, and a score between 4.31 and 5.00 indicates high resilience.

Table 11 :Brief resilience score of the beneficiaries

Host		Camp 14		Overall		
Male	Female	Male	Female	Male	Female	Total
3.52	3.3	3.57	3.64	3.54	3.47	3.50

This paragraph discusses the findings from the household survey regarding the Brief Resilience Scale (BRS) scores of both host and FMDN beneficiaries. The evaluation team calculated an average BRS score of 3.50 for the beneficiaries, which indicates a normal level of resilience. According to Table 11 mentioned earlier, male participants from both the host and FDMN communities had slightly higher BRS scores compared to female participants. However, the female FDMN beneficiaries are more resilient than male This result could be attributed to a number of factors including the social, cultural, and environmental factors that impact the way health volunteers interact with beneficiaries. Additionally, since males are often away from home for work and have more social interactions, this could contribute to their increased resilience. Overall, the project has been effective in targeting and building resilience among vulnerable populations.

3.3.2 Local capacity developed for a sustainable approach

Both PWJ and DCHT has involved local stakeholders at the inception phase of the project and continued with their considered plan. According to a representative from PWJ, for the local parts, they have tried to implement the activities in the community which had received less support. That was based on analyzing available health related services. The community with less connections was placed on their priority list. Before starting to implement the project, they have talked to the community leader to make sure the project aligns with the host community's activities. The representative from DCHT stated that, before implementing the project, they have

done an assessment on the local people's capacity and their education level to determine what awareness sessions will be beneficiary for them. They conducted FGDs in every two months to identify the topics of awareness sessions. They have also conducted local resource analysis to detect local resources.

> *The participation of both the FDMN and host communities is considered to be the most noteworthy accomplishment of the project, as both communities must be able to stand on their own after the project's conclusion. Therefore, it was critical to engage local people, which is why volunteers from both the host and FDMN communities were included in the project for the first time.*
>
> *- Representative of PWJ*

3.3.3 The negative effect of the program

After engaging with the host and FDMN population, project staff, relevant authorities, and conducting a household survey, it was determined that there have been no adverse effects on the population as a result of the project activities since its inception.

3.4 CHS 4: Humanitarian Response is Based on Communication Participation and Feedback

The importance of effective communication, participation, and feedback cannot be overstated in times of crisis and disaster. Humanitarian response is often based on these three key elements, as they are essential to ensuring that aid is delivered to those who need it most and that the affected communities are engaged and empowered throughout the process. Communication helps to establish trust and understanding between aid organizations and affected communities, while participation ensures that the voices and perspectives of these communities are heard and incorporated into response efforts. Finally, feedback enables aid organizations to learn from their experiences and make improvements to their response efforts, ultimately leading to more effective and impactful humanitarian interventions. This combination of communication, participation, and feedback is therefore critical to ensuring that humanitarian response is both responsive to the needs of affected communities and accountable to the people it seeks to serve.

According to the study team's assessment, the project successfully adhered to the standard by prioritizing effective communication, participation, and feedback. The project placed particular importance on information sharing and staff training, which were key elements in engaging beneficiaries in their activities. Relevant information on health services, maternal and childcare, hygiene, COVID-19, NCD, gender-based violence (GBV) and health rights was disseminated to actively involve beneficiaries in the project. The following sections will delve into how the project emphasized communication, participation, and feedback by examining the beneficiaries' access to pertinent information, the participation of FDMN in the program, and the staff training.

3.4.1 Access to relevant information

Access to relevant information is essential for individuals to make informed decisions and take actions that can lead to positive outcomes. Access to proper information can help beneficiaries better understand the resources and services available to them, the goals, and objectives of this project, and how they can participate and contribute to these efforts. Additionally, they can be aware of what they can expect from DCHT and PWJ team in terms of information, participation, respect, and how to file a complaint with the organization. It is the right of stakeholders, beneficiaries, and partner organizations to have access to this information. However, ensuring access to relevant information can be a challenge in communities with low literacy rates, limited access to technology, and language barriers.

Addressing these challenges requires innovative approaches, including the use of accessible formats and technologies such as limited text on images, community engagement and participation, and partnerships with local organizations and community leaders. To assess the beneficiaries' awareness of the healthcare services offered by the clinic, the study team conducted an inquiry since this information can assist them in better understanding their own and their families' health.

According to the data presented in Table 12, it can be observed that the majority of host beneficiaries, approximately 96%, have access to health-related information in a timely manner. In contrast, only about 79% of FDMN beneficiaries have reported the same. The data also revealed that more than 90% of male beneficiaries can access health-related information in a timely manner, whereas the percentage was lower, around 74%, for female beneficiaries. Regarding the timely access to health information, approximately 92% of male host beneficiaries have responded positively while the figure was around 75% for female FDMN beneficiaries.

Table 12: Access to information regarding health in time

Statements	Response	Host (n=25)	FDMN (n=75)	Male (n=50)	Female (n=50)	Total (n=100)
Access to information regarding health in time	Yes	96%	78.7%	92%	74%	83%
	No	4%	21.3%	8%	26%	17%
Access to timely health care information	Yes	100%	78.7%	92%	76%	84%
	No	0%	21.3%	8%	24%	16%

Table 13 shows that the majority of male host beneficiaries (over 90%) have convenient access to health care services. Around 84% of FDMN beneficiaries also reported that they can easily access health care services, and this percentage was around 75% for female FDMN beneficiaries.

Table 13: Access to information about all the healthcare services from the clinic

Statements	Response	Host (n=25)	FDMN (n=75)	Male (n=50)	Female (n=50)	Total (n=100)
Easy access to health care services	Yes, easy	96%	84%	92%	74%	83%
	No, it's difficult	4%	16%	8%	26%	17%
Access to information about all the healthcare services from the Hakimpara Clinic	I was told about all of them without asking	80%	70.7%	66%	80%	73%
	I was told after I asked for them	8%	26.7%	28%	16%	22%
	I was not told about them	12%	2.7%	6%	4%	5%

According to the evaluation team's findings from FGD sessions and IDI, health volunteers were identified as the primary source of information for both the host and FDMN communities. A health worker reported keeping registers of their beneficiaries and visiting their homes in a serial order. If anyone reports a problem or a sick person is found, they make sure to follow up with visits. Depending on the severity of the illness, they decide whether to visit the patient daily or not. They also ensure that patients are visiting doctors, taking their medication on time, and monitoring whether their condition is improving.

From the FGDs and IDIs door-to-door visits by volunteers have been found to be highly effective as they create a comfortable and welcoming environment for beneficiaries who may be too shy to ask questions during group awareness sessions. This approach has led to increased awareness and consciousness among the beneficiaries, resulting in an increased likelihood of seeking healthcare services. Volunteers visiting beneficiaries' homes encourages people to schedule

check-ups, visit doctors and hospitals, and receive vaccinations. During home visits, some beneficiaries even requested volunteers to confirm their vaccine schedules. This approach demonstrates the project's strong commitment to reaching vulnerable individuals in need of healthcare services. By providing assistance directly to beneficiaries at their doorstep, volunteers educate them about their rights and benefits while also informing them about other available health service centres. Moreover, in the host community, NGO workers also inform local people about available services and their locations.

> *During the regular door-to-door visits by volunteers, my community and I have the opportunity to access information about health and related matters. We have been informed about where to go in the camp to receive health services, and we are confident in our ability to access such services when needed.*
>
> *- Female Beneficiary from Host Community*

3.4.2 FDMNs participation in the program

The involvement of both host and FDMN communities is crucial for the improvement of healthcare services and tackling health risks. The project organizers, PWJ and DCHT, ensured that the beneficiary communities were actively engaged in the project from the beginning and throughout its implementation. They conducted need assessments, including FGDs, to identify gaps and understand the preferences and opinions of the people. Additionally, they collected feedback from beneficiaries on a weekly basis to gauge patient satisfaction and ensure that their services were meeting their needs. According to a DCHT representative, this feedback mechanism resulted in a high level of satisfaction, with around 95% of beneficiaries reporting satisfaction with the services provided. In case of any negative complaints, the authority conducts an inquiry to investigate the matterThrough this approach, the community was given a chance to have a say in the design and implementation of clinic services.

3.4.3 Staff training

Staff training is a critical component of any organization, especially those involved in service delivery. Staff training is a process of providing employees with the necessary knowledge, skills, and tools to perform their jobs effectively Effective training ensures that staff members are equipped with the necessary skills and knowledge to provide quality services to the beneficiaries.

It also enhances the staff's confidence and job satisfaction, leading to improved job performance and staff retention. In this project, volunteers played a vital role in delivering services to the beneficiaries. Therefore, the project placed significant emphasis on capacity-building for the volunteers. Additionally, other staff members received sufficient training that they found to be satisfactory.

Every week, health volunteers were trained in a specific location at the Hakimpara clinic, from morning. The training werefacilitated by doctors, nurses, and DCHT program officers who encouraged trainee participation by asking questions. Training manuals and other written materials were used to deliver the instruction, and FGDs were conducted every two months to determine training topics based on community needs. When there were specific concerns or incidents, such as a fire in camp 14, additional training sessions wre conducted on relevant issues. During training sessions, volunteers shared their experiences, and trainers offered guidance on how to overcome any obstacles. Facilitators discussed the training topics until trainees had a clear understanding and were confident enough to deliver them in awareness sessions. The trainees received training on a variety of topics, including door-to-door visits, Antenatal Care (ANC), Delivery, Postnatal Care (PNC), Expanded Program on Immunization (EPI), Family Planning (FP), Non-Communicable Diseases (NCD), skin diseases, Dengue, Gender-Based Violence (GBV), mental health, as well as community networking.

The training has provided me with valuable knowledge that I will always cherish. I have gained a better understanding on how to conduct awareness sessions, including how to effectively initiate and lead them. With this improved training now, I know about GBV, ANC, and NCD which has improved my skills.

- Health Volunteer from Host Community

After volunteers were trained on various topics related to diseases, their knowledge and understanding were evaluated by the facilitators. During the project period, the volunteers and health workers were tested three times (beginning, mid- term and end)wereto assess the volunteers' understanding of the training content. Besides this, the project staff continuously assessed their understanding through monitoring their activities as well as through weekly meetings, The volunteers were encouraged to demonstrate their understanding of the material,

and any concerns or questions about the material are addressed by the facilitators. If any concepts were not understood by the volunteers, the facilitators revisited them to ensure complete understanding. The training provided volunteers with the skills to recognize and comprehend various types of illnesses.

The staff members, including both doctors and nurses, also underwent frequent training sessions, which were conducted both internally and externally. The doctor at the clinic reported during IDI that he received training from renowned physicians on various topics, including the Infection Control Program (ICP), Vaccine Preventable Disease (VPD), Non-Communicable Disease (NCD), and chest pain. Similarly, the nurse reveled during IDI that she has received training on Covid-19 vaccination , Expanded Program on Immunization (EPI), Inactivated poliovirus vaccine (IPV), Gender-Based Violence (GBV), and Cardiovascular Magnetic Resonance Imaging (CMRI), which she found very useful for her daily work. The facilitators who conducted the training sessions were highly skilled and knowledgeable in the relevant diseases, and were physicians from foreign countries arranged by the World Health Organization (WHO). The contents of the training and tips provided by the facilitators were also deemed essential and relevant by the staff members.

All of the clinic's staffs including doctor, nurse, health workers and volunteers stated that,the trainers delivering the training have had a positive and straightforward approach,approach, and were open to questions from trainees, responding courteously and succinctly to help clarify any information covered. The training environment was conducive to learning. Nonetheless, in order to achieve better results, it may be necessary to increase the duration of certain training sessions.

To sum up, although the staff at the Hakimpara clinic are currently receiving sufficient training, it might be necessary to prolong some of the training sessions in order to achieve improved outcomes. Furthermore, performing evaluations of both the trainers and trainees can aid in guaranteeing that the training is valuable and advantageous for all stakeholders.

> *Everything in the training sessions- from the training content to delivery was perfect and effective. All the training sessions had enough time except the training on chest pain. The training on chest pain was a day long training, I wish it was a three-day long training.*
>
> *- Medical Officer*

3.5 CHS 5: Complaints are Welcome and Addressed

A complaint mechanism refers to a system or process established by an organization or entity to receive, handle, and resolve complaints from community people or relevant stakeholders. According to CHS Alliance (2015), every organization or entity is vulnerable to fraud or abuse of power, and a complaints system can assist in recognizing and responding to malpractice, manipulation, and exploitation.

PWJ has introduced a complaint mechanism to ensure the healthcare services provided by the Hakimpara clinic are of high quality and meet the needs of people. This mechanism enables patients and their families to provide feedback, suggestions, and complaints regarding the healthcare services they receive at the clinic. The below section reports the assessment of the complaint mechanism of Hakimpara clinics well as the community people's awareness surrounding the complaint mechanism.

The study team attempted at figuring out the condition of the complaint mechanism by asking about the procedure for filing a complaint and the challenges faced during the complaint process. Overall, the team explained that the project followed a good complaint procedure, which ensures that beneficiaries can file concerns, allowing them to appreciate their active engagement in the improvement of clinic services.

To understand whether communities and people are aware of complaint mechanisms established in the clinic, the study team asked communities and people who are affected by crises, including vulnerable and marginalized groups, about complaint mechanisms. It was found that if people have any complaints/issues/challenges regarding the services available at the clinic, they can submit a complaint in writing. A complaint box is available in front of the clinic for submitting complaints (confirmed from observation).

The figure below depicts the community feedback box located at the beginning of the clinic. People use emojis to provide feedback on the service they receive from the clinic.. This feedback box is opened every week to count the number of responses from people. From the KII and IDI with the clinic employees and PWJ representatives, it was determined that they had gotten happy emojis usually. If the clinic staff discovers any sad emojis, they will bring the matter up at the weekly community meeting to determine the root reason for discontent and attempt to rectify it.

The study team asked the respondents whether they consider complaints response mechanisms accessible, effective, confidential, and safe. It is found that less than half of the respondents (41%) mentioned that after getting the service from the clinic, they could make a complaint or give feedback or to some extent (Table 14). More specifically, majority of the female respondents (82%)

think they cannot make complaints easily (a phenomenon such as the level of familiarity with the complaint mechanism). With high levels of illiteracy and even higher levels of mistrust of such formal systems among people culturally unaccustomed to providing feedback or making complaints, females are less interested in this mechanism. The coordinator of the clinic stated that as many of the FDMN community people are not able to read or write, females do not appear interested to inform their issues directly or verbally.

Table 14: Accessibility of making a complaint or giving feedback after getting service from the clinic

Responses	Male (n = 50)	Female (n = 50)	Total (N = 100)
Yes	68%	18%	41%
No	32%	82%	59%

When asked about the appropriateness and effectiveness of the method of complaints, it is found that half of the respondents believe that the feedback mechanism worked well for them (Figure 9). However, 26% of the female respondents think that the method does not work well. The socio-cultural barrier for females in understanding the complaint mechanism requires further exploration and evidence-based action by future projects. Also, the female respondents may have cultural beliefs or norms that discourage them from speaking out or providing feedback, particularly to authority figures such as medical staff.

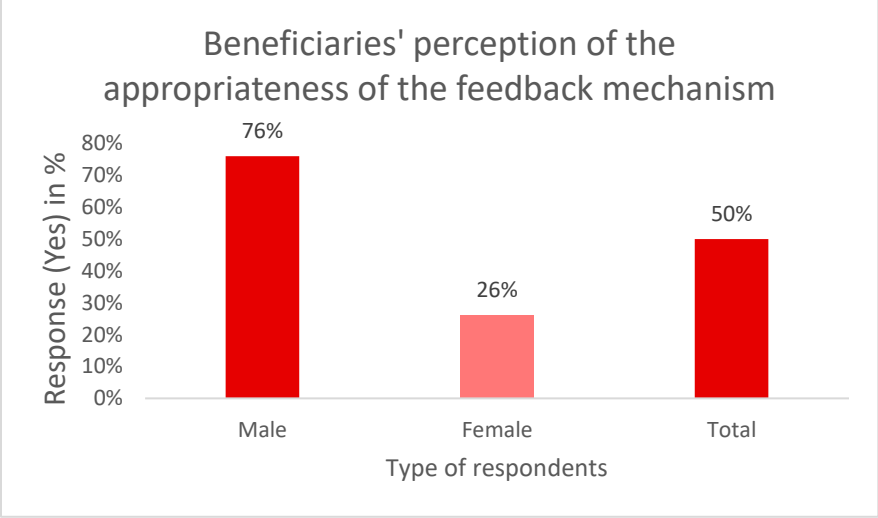


Figure 9: Beneficiaries' perception of the appropriateness of the feedback mechanism

When people complain by mentioning their personal information, keeping their identity safe and protected is a standard that a project must comply with. The study team asked the respondents

about the safety maintenance of feedback mechanism at the clinic. A majority of the respondents (65%) remained neutral about the safety maintenance of the feedback mechanism at the clinic (Figure 10). One of the health volunteers said that when people have a complaint or feedback to submit, they keep the name and personal information of the people confidential and safe. When they take the necessary steps to consider the complaint of a person, they just focus on the complaint and inform the related authorities.

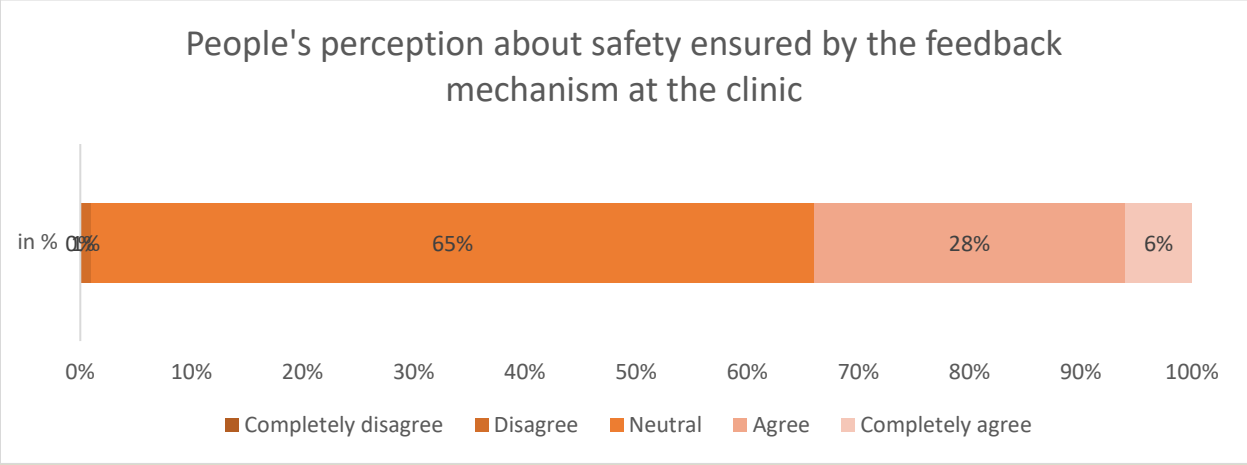


Figure 10: People's perception about safety ensured by the feedback mechanism at the clinic

When a complaint is submitted, it is also necessary to understand whether it is being investigated, solved, and returned with a solution within the stated time frame. Respondents were also asked about this issue to know their perspectives, opinions, and expectations after the submission of a complaint or feedback.

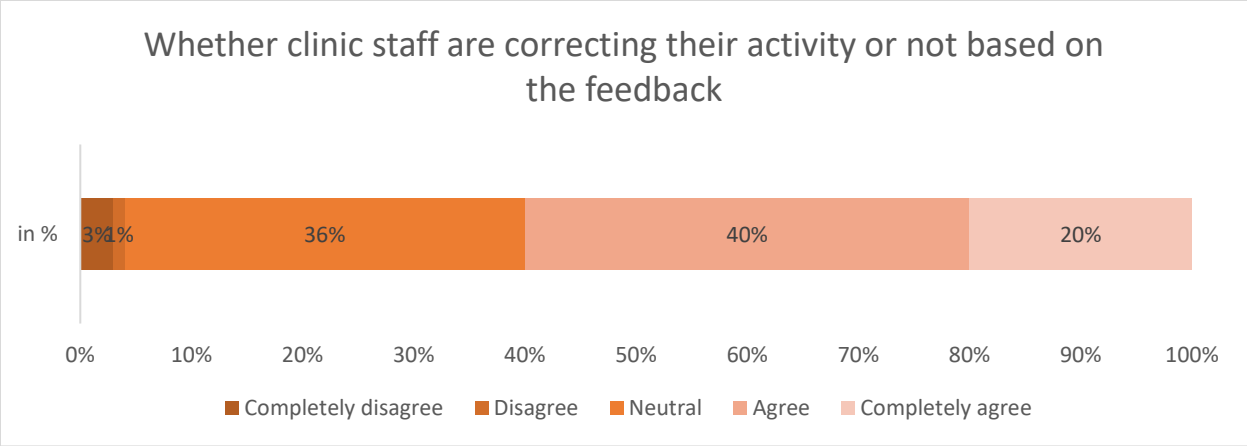


Figure 11: Whether clinic staff are correcting their activity or not based on the feedback

Well over half of the respondents (60%) agree that staff of clinic consider the complaints or feedback submitted by the FDMNs community and take corrective measures (Figure 11). In-depth interviews also confirmed such agreement. For example, a male beneficiary stated that he had submitted a complaint regarding the availability of medicine at the clinic. After some days, the complaint was considered, and he got the desired or required services.

Overall, the feedback mechanism received good acceptance among the community. However, a free hotline number might be useful to gather feedback and complaints confidentially in addition to the feedback mechanism. Also, the recording system of feedback and complaints should be introduced which will be helpful in solving the complaints.

3.6 CHS 6: Humanitarian Response is Coordinated and Complementary

Humanitarian response is an essential component of emergency management and disaster relief efforts. It involves the coordination and provision of aid to those affected by disasters, conflicts, and other crises, with the aim of alleviating suffering and meeting basic needs. Effective humanitarian response requires coordination and complementarily among various actors, including governments, non-governmental organizations, and international organizations. This is because no single organization can respond to all the needs of those affected by a crisis, and working together can ensure a more efficient and effective response. Moreover, it is important to avoid duplication of work and wasteful expenditure of funds. In this context, the principle of humanitarian response being coordinated and complementary is crucial for ensuring that aid efforts are effective, efficient, and reach those in need in a timely manner.

During the project evaluation, the evaluation team examined the organizational coordination and participation in the program. This involved investigating who was involved in decision-making, how internal and external communication was managed in the camps, and how information was shared among the organizations. In this section, the findings related to coordination of health services among the organizations are presented in two sub-sections: organization coordination and organizational participation. The analysis of the findings was conducted based on the criteria of coverage and coherence, which are part of the OECD-DAC framework.

3.6.1 Organization coordination

Organizational coordination is essential for effective humanitarian response. In emergency situations, multiple organizations may be involved in providing aid to those in need, including governments, non-governmental organizations, and international organizations. The effectiveness of organization coordination can be evaluated using two key indicators. The first indicator is the extent to which organizational coordination has helped to minimize gaps and overlaps in humanitarian assistance, as identified by both communities and partner organizations. The second indicator relates to the sharing of relevant information among responding organizations, including local organizations, through formal and informal coordination mechanisms. These indicators can help to assess the success of organizational coordination in a specific humanitarian response program.

According to the qualitative investigation, the Hakimpara clinic in camp 14 has a system of regular coordination with various government agencies, NGOs, and health officials to identify gaps and overlaps in the provision of humanitarian assistance. The Camp-in-Charge (CiC) reported that, the health agencies hold monthly meetings to discuss their current activities and any support they

need. The community health working team works under the community health working group and provides a mapping for each health agency to ensure door-to-door services without overlapping. The Camp Health Focal confirmed that no other projects are working on a similar thematic area in the camp, and there is a well-defined structure to prevent overlapping.

Several organizations, such as MSF, DG Health, BRAC, and IOM, are delivering health services in Camp 14. In addition, PHD has trained community health workers (CHWs) who are conducting awareness sessions. Both DCHT and PWJ maintain regular communication with the CHW working group and report on vulnerable individuals, sharing their database with the Camp Health Focal. A reporting system has been established to provide government updates on the health situation of a specific zone. At the end of each day, all healthcare facilities are required to report patient details using reporting systems such as EWARS (Early Warning, Alert and Response System), a weekly base reporting system to detect outbreaks of patients with infectious diseases; DHIS2, daily data on patients including patient type, mortality, and morbidity; and 4W, which mandates that all health facilities report to the government through the health sector.

3.6.2 Organizational participation

Organizational participation refers to the involvement of individuals and groups in decision-making processes, planning, and implementation of activities within an organization. It is an essential aspect of effective organizational management as it promotes the inclusion of diverse perspectives, ideas, and experiences in the decision-making process. The study team examined how local organizations report sufficient engagement and representation in coordination mechanisms concerning the Hakimpara clinic services when working together towards a shared goal. A diverse range of participations and representations can be observed in these mechanisms, which are critical to ensure effective coordination. The evaluation team discussed various ways that local organizations can demonstrate adequate participation and representation in coordination mechanisms in this sub- section.

To ensure effective coordination and collaboration in providing humanitarian aid, both PWJ and DCHT coordinate regularly with various stakeholders such as site management, local and national government, Camp-in-Charge (CiC), Refugee Relief and Repatriation Commission, and UN agencies. The DCHT field manager attends Camp coordination meetings led by CiC, where progress and updates are shared. Additionally, the clinic's medical representative attends monthly meetings arranged by Camp Health Focal. The CiC recommends that partner organizations share assessment findings when handing over projects to new partners, as this is crucial for identifying critical issues at the clinic and avoiding problems among different stakeholders. Without sharing assessment findings, new partners may need to conduct further assessments, which can be time-

consuming and costly. Thus, sharing assessment findings is essential for the overall success of humanitarian aid in the camp setting.

The Hakimpara clinic operates under the guidance of the Camp in Charge (CiC), who holds a vital role in coordinating various stakeholders involved in providing humanitarian aid. The clinic seeks CiC's permission and consultation with the Camp Health Focal before implementing any new decisions or initiatives. This approach ensures that the clinic's efforts are consistent with the broader objectives of the humanitarian aid efforts and avoid any potential conflicts or overlap of services. The involvement of CiC and other stakeholders in the decision-making process helps in maintaining overall coordination and effective implementation of the clinic's initiatives.

At the Hakimpara clinic, patients with complicated pregnancy cases are referred to other healthcare centers through their ambulance service, accompanied by a midwife/nurse, in accordance with the government's referral strategy. MSF clinic in camp 15 is the preferred center for pregnancy-related cases since they perform cesarean sections, while Ukhiya Health Complex is the preferred center for other emergency patients. In the case of emergency FDMN beneficiaries, they are referred to the Field Hospital, which is the secondary healthcare facility for the FDMN community, established in a suitable location for easy access. If the treating doctor determines that the beneficiary requires better treatment, they consult with the CiC, Camp Health Focal, and other doctors to decide whether to refer the beneficiary to another healthcare center. The clinic provides patients with a referral form containing all their details when referring them to another healthcare center.

PWJ sends monthly monitoring reports to JPF which is based on DCHT's regular reporting to PWJ as well as from field monitoring to update them on their field activities. The medical officer also sends a report on the clinic's Infection Control program. Moreover, the clinic shares reports on EWARS, DHIS2, and 4W with the Camp Health Focal Office. PWJ also maintains regular communication with DCHT and arranges weekly meetings with all staff to provide support to each other.

To sum up, the overall coordination of DCHT and PWJ with external and internal partners was well-coordinated. They also maintained strong connection with the CiC office and Camp Health Focal, showed up to all meetings, and shared information about their program with them. In context of internal coordination, both DCHT and PWJ staff members maintained regular communication with each other and sent monthly reports to JPF.

3.7 CHS 7: Humanitarian Actors Continuously Learn and Improve

In the field of humanitarian aid, it is essential for organizations and individuals to constantly learn and improve their practices to better serve the needs of affected populations. By continuously assessing and improving their strategies and approaches, humanitarian actors can ensure that their interventions are effective, efficient, and responsive to the evolving needs of crisis-affected communities. Humanitarian actors should also emphasize the need for accountability and transparency in learning and improvement processes, as well as the importance of sharing lessons learned across the humanitarian community and all stakeholders to facilitate collective progress towards better outcomes for those in need.

3.7.1 Programs Improvement

The study team requested feedback from the respondents to assess the progress of the program and determine if the medical staffs, environment, and service quality had provided better assistance and protection over time. The respondents provide feedback on four separated questions related to doctors, nurses, clinic's physical environment, and health service quality. By using the five-point Likert scale, the results were calculated.

Figure 13 presents the results of the questionnaire survey section that focused on improvements in assistance and protection services. The respondents generally had a slightly positive perception of the improvements in services they received over time. Using a five-point Likert scale, the average score was 3.625 out of 5.00 for the four questions related to doctors, nurses, clinic's physical environment, and health service quality. The respondents noted that the physical environment of the clinic had improved the most over time, with a score of 3.83. Additionally, they perceived relatively better improvement in the nursing services (score= 3.62) than the overall

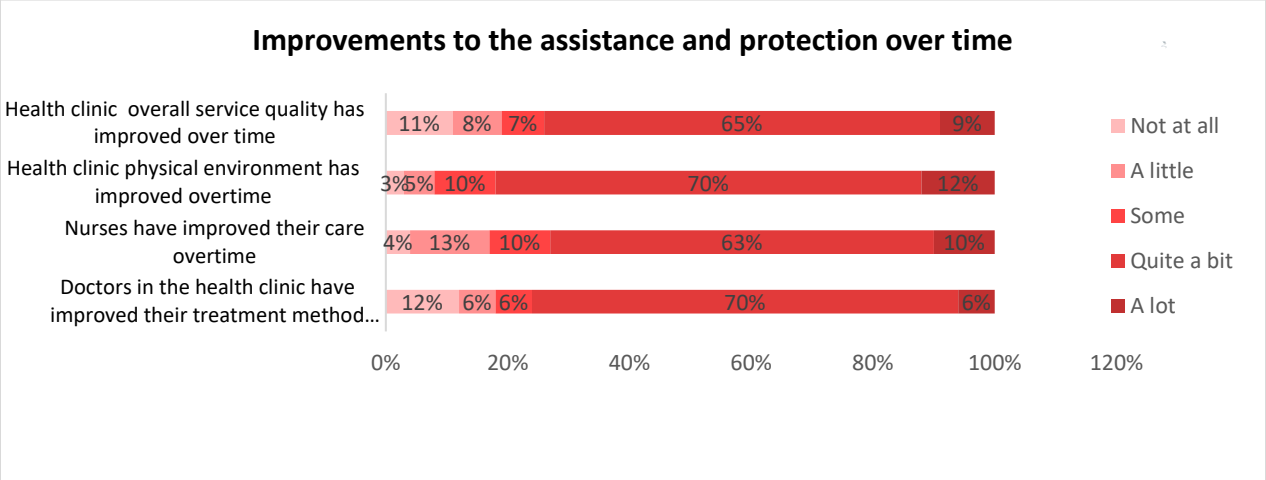


Figure 12: Status of improvements to the assistance and protection over time

service quality (score= 3.53) and the doctors (score= 3.52). However, it is important to interpret these results with caution as the scores may not accurately reflect the respondents' satisfaction level or the program's effectiveness.

$$\text{Overall Score: } \frac{3.52+3.62+3.83+3.53}{4} = 3.625$$

In Camp 14, where there is a large population, only two primary health care centers are available, one of which is Hakimpara Clinic, also known as "Japan Hospital" by its beneficiaries, which was established in 2018. The clinic provides mainly pregnancy and child-related services but also offers primary care for other age groups among both the FDMN and host beneficiaries. The clinic is particularly popular among the FDMN community due to its delivery services and provides easy access to treatment and medication for various common ailments such as fever, cough, colds, flu, headaches, skin diseases, diarrhoea, etc. The physical environment of the clinic was improved based on recommendations and suggestions from the Health Focal and CiC, which resulted in an increase in beneficiary satisfaction levels.

The clinic offers blood and urine testing through its laboratory, but patients in need of X-rays or caesarean procedures are referred to other healthcare institutions managed by organizations like MSF, and Upzila Health Complex. However, during FGDs and IDIs the study team found that the beneficiaries acknowledge these referrals to be inconvenient, especially in critical health situations. Therefore, they suggest that introducing X-ray and caesarean facilities at the Hakimpara clinic would be advantageous for complex health treatments. Although the doctors and nurses have been rated positively by most beneficiaries from the survey for their attitude, behavior, and skill, the scarcity of medicines and unavailability of some services and instruments limit their ability to provide adequate treatment. Given the nature and scope of PHCs, providing the necessary services and instruments for treating seriously ill patients poses a challenge. Nevertheless, future projects could conduct needs assessments and expand the range of services provided by the clinic to upgrade the services accordingly.

> *The clinic currently offers women ANC, PNC, and ultrasound services. When a child needs medical attention, the doctor examines them and prescribes medication. However, the lack of caesarean section and x-ray facilities is a significant limitation, and it would be beneficial if the clinic could provide these services.*

3.7.2 Program Learning

The program incorporates various learning components that can be viewed from different angles. With the training provided by doctors and medical coordinators, health volunteers have gained better knowledge about these diseases. This has enabled them to raise patient awareness more effectively through door-to-door services. Apart from this, involving FDMN volunteers for the first time also have uplifted the project performance and helped to make people more conscious regarding health-related issues as FDMN beneficiaries feel comfortable around their community people. Regular training, monitoring and evaluation by doctors, nurse and project staffs has made the health volunteers more efficient and work more systematically. The staff responsible for implementing the project have gained knowledge on the importance of involving health practitioners in health promotion to help beneficiaries understand ways to improve their health, manage resources, and adopt technology. As a result, the FDMN community has received education on basic health practices and available services. A female FDMN beneficiary reported learning about topics such as ANC, maternal danger signs, hygiene, proper nutrition during pregnancy, and childcare. She has also gained knowledge on where to access available health services.

> *A key takeaway is that practitioners should actively engage in promoting health to help beneficiaries comprehend the various actions they can take to enhance their well-being.*
>
> *- Project Coordinator of PWJ*

During FGDs, the host community beneficiaries stated that theirawareness of basic health education has increased due to the door-to-door visits of volunteers, resulting in more frequent visits to Hakimpara clinic. The clinical staff has learned new health-related topics from doctors and other staff, and the doctors and nurses have received training on various subjects, including ICP, NCD, VPD, and chest pain. The health focal person expressed appreciation for the positive and effective communication between the project staff and beneficiaries, which was a valuable lesson learned from the project. The health focal person also recognized the project staff's remarkable teamwork and dedication in providing optimal services despite resource limitations as another valuable lesson.

The DCHT and PWJ team have adopted effective practices by studying established PHCs, including consulting with community leaders, conducting weekly feedback surveys, and taking appropriate actions based on the feedback received. To ensure proper community involvement and to overcome language barriers, they have engaged FDMN community members and local volunteers. To address the issue of insufficient lighting, they have installed transparent tin sheds in the clinic's ceilings and have a generator on standby for emergency electricity supply. Additionally, an emoji-based feedback mechanism has proven to be a useful tool for gathering patient feedback, especially for those who cannot write or write in Rohingya language.

3.8 CHS 8: Staff are Supported to Do Their Job Effectively and are Treated Fairly and Equitably

CHS Alliance, 2015 emphasize on fair and equitable recruitment process and available support for staff to ensure that all staff members are treated equally. Equitably means that things are divided or distributed fairly and justly, considering any relevant differences or needs among the parties involved. When the staff and volunteers are supported by an organization, it can lead to increased effectiveness and efficiency, better job performance, and improved job satisfaction.

Both PWJ and DCHT assured to support their staff whom they consider critical for organizations to achieve their goals and make a positive impact in crisis-affected communities. By investing in staff, both organizations have ensured that they are providing the best possible service to their beneficiaries. The following section is divided into two sub-sections: staff support from the organization and FDMN beneficiaries' satisfaction regarding project staff.

3.8.1 Staff support from the organization

Typically, staff members in organizations receive two types of support: technical and financial assistance. In terms of technical support, staff are trained on various topics to enhance their knowledge and skills. For instance, the nurse underwent training on COVID-19 vaccination, Expanded Program on Immunization (EPI), Inactivated Poliovirus Vaccine (IPV), Gender-Based Violence (GBV), and Cardiovascular Magnetic Resonance Imaging (CMRI). Similarly, the doctor regularly receives training on Infection Control Protection (ICP) as he is the ICP focal point of the Primary Health Care (PHC) facility, as well as Non-Communicable Diseases (NCDs), Vaccine Preventable Diseases (VPDs), and chest pain. The training sessions were led by renowned physicians and foreigners, and some of them were organized by the World Health Organization (WHO).

The staff also receives medical support and are taken for refreshments once a month by the District Community Health Team (DCHT). The project coordinators of both DCHT and Peace Winds Japan (PWJ) stated that DCHT provides accommodation facilities for the clinic staff, which fosters good communication among the staff, as well as transportation facilities. Both organizations acknowledged that their staff members receive regular remuneration.

According to the senior management, including the project coordinators of PWJ and DCHT, as well as the project officer, the staff's performance was deemed satisfactory. The representative from DCHT emphasized that they recruit community volunteers and health workers based on a rigorous testing process, and they also conduct tests after staff members have received training. These tests aid in evaluating the staff's performance, which is why they have implemented a system of conducting tests three times (beginning, mid-term, ending) to assess their progress.

3.8.2 Beneficiaries' satisfaction regarding project staff

The satisfaction of beneficiaries regarding the service provided by the staff of the PHC is a critical component of evaluating the effectiveness of any humanitarian project. To determine the satisfaction levels of FDMN beneficiaries, they were asked to rate the knowledge, skills, behaviors, and attitudes of PHC staff. The staff, in this context, referred to doctors, and nurses. The study team asked the beneficiaries to evaluate the effectiveness of these two groups based on four statements, providing valuable insights into their perception of the quality of healthcare services provided in the camps.

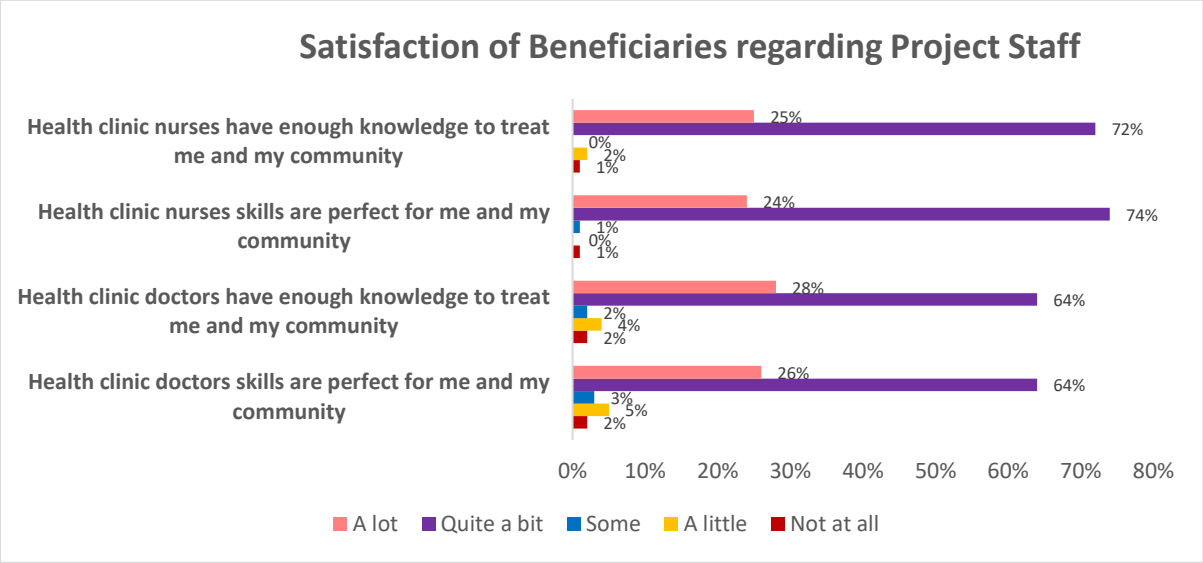


Figure 13: Satisfaction of Host and FDMN beneficiaries regarding project staff

Based on the data presented in Figure 14 and Table 15, it is clear that a majority of beneficiaries (more than 60%) feel that doctors and nurses have the necessary knowledge and skills to provide effective healthcare services to them and their community. Specifically, around 92% of FDMN community members agreed that the doctors are skilled and knowledgeable, while more than 90% of host community members also agreed that the doctors have enough knowledge and skills. Additionally, almost all of the host and FDMN beneficiaries agreed that the nurses have the appropriate skills and knowledge.

Table 15: Comparison of satisfaction among Host and FDMN beneficiaries regarding project staff

Statements	Community	Completely Disagree	Disagree	Neutral	Agree	Completely Agree
Health clinic doctors' skills are perfect for me and my community	Host	4.0%	0.0%	4.0%	52.0%	40.0%
	FDMN	1.3%	6.7%	2.7%	68.0%	21.3%
Health clinic doctors have enough knowledge to treat me and my community	Host	8.0%	0.0%	0.0%	48.0%	44.0%
	FDMN	0.0%	5.3%	2.7%	69.3%	22.7%
Health clinic nurses' skills are perfect for me and my community	Host	0.0%	0.0%	0.0%	60.0%	40.0%
	FDMN	1.3%	0.0%	1.3%	78.7%	18.7%
Health clinic nurses have enough knowledge to treat me and my community	Host	0.0%	0.0%	0.0%	64.0%	36.0%
	FDMN	1.3%	2.7%	0.0%	74.7%	21.3%

According to a female FDMN beneficiary, when they encounter any health-related issue, they visit the clinic where they can share their concerns with a doctor who listens attentively and performs a medical examination using a stethoscope before providing the necessary treatment. The doctor also offers guidance on medication usage and ensures privacy, allowing patients to discuss their problems openly. After the consultation, patients obtain prescribed medication from the pharmacy. In cases where patients have difficulty understanding the prescribed medication or instructions, they can consult with the doctor again or seek assistance from nurses or healthcare workers. Health volunteers play a crucial role in providing essential information to the beneficiaries. They offer door-to-door or follow-up services, visiting patients' residences to educate them on various illnesses such as pregnancy-related complications, ANC, PNC, NCDs, and more, while also advising them on preventive measures. According to a health volunteer, the most common communicable disease among FDMN people is skin disease, likely due to their crowded living conditions. As a result, the health volunteer stressed the importance of maintaining cleanliness in homes, hands, and the surrounding environment to the local community.

4 Success Stories

"Quick Thinking and Community Outreach: A Tale of Safe Delivery in Telkhola Village"

Mr. Monotosh Chakma, a 55-year-old resident of Telkhola village, demonstrated exceptional presence of mind and quick thinking in a critical situation that could have resulted in a tragic outcome.

About a year ago, his neighbor, Mrs. Uma Rani Chakma, was experiencing labor pains and her husband was not present. The local traditional birth attendant (TBA) was called, but due to the baby's breech position, she was unable to perform the delivery. Mrs. Chakma's condition was rapidly deteriorating, and there were no nearby healthcare facilities or available transportation options.

Fortunately, Mr. Chakma recalled a conversation he had with a Peace Winds Japan (PWJ) volunteer during one of their home visits. The volunteer had informed him about the safe delivery services offered at the "Japan Hospital." Mr. Chakma immediately contacted the volunteer using the provided contact number, and the volunteer promptly responded by arranging for transportation to take the mother to the nearby Hakimpara clinic.

Mr. Chakma, along with Mrs. Chakma's mother, accompanied the volunteer, and thanks to their quick thinking and timely intervention, the mother was able to reach the clinic safely and deliver a healthy baby.

This incident highlights the vital role of community outreach and education in promoting safe maternal and newborn health practices. It also underscores the importance of having responsive and well-equipped healthcare systems that can address emergencies promptly and effectively.

"Timely Intervention and Community Trust: A Success Story in Childhood Illness Management"

Mrs. Ayesha Siddiqua, a 22-year-old mother of four children residing in Camp 14, demonstrated the importance of timely and effective healthcare services in managing childhood illnesses.

Approximately five months ago, her 7-month-old son suddenly fell ill with diarrhoea, causing great concern for the family. Without hesitation, Ayesha reached out to the DCHT/PWJ volunteer whom she had met during previous home visits. The volunteer responded quickly, assessing the child's condition and providing guidance and support to the worried mother.

Recognizing the urgency of the situation, the volunteer arranged for Ayesha and her son to be transported to the clinic for immediate medical attention. Once there, the doctor assessed the child and began treatment promptly. Within two days of receiving medical care, the infant had made a full recovery, providing much-needed relief to the entire family.

This case highlights the critical role that frontline health workers and community outreach programs play in identifying and addressing health concerns in marginalized and vulnerable populations. It also underscores the importance of building trust and rapport with local communities to promote timely access to healthcare services and improve health outcomes.

5 Lessons Learned

Positive lessons:

Engagement of local volunteers: PWJ and DCHT have considered involving local FDMN volunteers which bridge the gap between the health system and the community, serving as a crucial link in promoting health-seeking behaviors and delivering health education. This also reduced the language barrier and brought effective results.

Door-to-door and follow-up services: Regular follow-up visits and door-to-door services by the volunteers have been identified as highly effective in reaching vulnerable and marginalized patients within the camp. Typically, health volunteers conduct home visits and provide education on various diseases and how to manage them during different seasons, as many illnesses are seasonal.

Involving clinic's practitioner: PWJ and DCHT team have involved doctors and nurses for health promotion at the clinic which brought positive and effective results. Beneficiaries are more convinced by the advice from the practitioner The doctors and nurses counsel them and conducted some sessions on safe delivery and maternal and childcare.

Awareness sessions: Health volunteers have been actively conducting awareness sessions on various topics, with a special emphasis on maternal health care, safe delivery practices, and hygiene. These sessions have been crucial in increasing community awareness and knowledge. As a result of the awareness sessions conducted by health volunteers, pregnant mothers in the community have become more conscious about the importance of antenatal care (ANC) visits and delivering their babies in a clinic setting. This has resulted in an increase in the number of pregnant women seeking ANC services and delivering their babies at clinics. Furthermore, community members have become more aware of danger signs related to maternal and child health, proper nutrition, and maintaining good hygiene practices, including environmental hygiene. This increased awareness has contributed to improved health outcomes for mothers and children within the community.

Focusing on preventive medicine: The evaluation team observed that there is a tendency among patients, especially those from the camps, to expect a large quantity of medication when they visit the clinic. However, it is important to note that not all health conditions require medication. As a result, Hakimpara clinic aims to provide patients with the necessary medications for their conditions, rather than simply fulfilling their expectations. The project has also emphasized the importance of shifting the focus of FDMN beneficiaries from curative medicine to preventive medicine through proper education and counseling. By raising awareness about disease

prevention and encouraging healthier lifestyles, the clinic hopes to reduce patients' dependency on medication and promote overall well-being.

Upgradation of tools: The project relied on paper-based documentation, which often led to spelling mistakes and other challenges. The project has learned positive lesson from these issues and now implementing a digital tool like Kobo Toolbox. This tool serve as a checklist for voluneers, reminding them of important points and helping to reduce errors in documentation. The use of this digital tool is expected to improve the accuracy and efficiency of data collection and documentation, ultimately leading to better healthcare outcomes for the FDMN and host community populations.

Building self-reliance: To build resilience among both host and FDMN beneficiaries, the doctors and medical staff trained the health volunteers on building community networks and increasing awareness and knowledge. Community members now know who to turn to for help and support, whether they have a health problem or need assistance with other issues such as fire safety. By increasing self-reliance and building community networks, the project has created a more resilient and empowered community that is better equipped to meet the challenges they face.

Feedback mechanism: The clinic feedback mechanism was well thought out and inclusive of both literate and illiterate beneficiaries. Using emojis as a feedback mechanism is an innovative way to ensure that everyone's voice is heard and valued, regardless of their literacy level.

Training of the health care providers: The training provided to the health care providers by experts in NCD care was a valuable intervention that resulted in improved access to high-quality care for both the host community and FDMN beneficiaries. By equipping local healthcare providers with the knowledge and skills they need, we can ensure that NCD care is delivered in a way that is effective, up-to-date, and culturally appropriate. This approach can help to build long-term capacity and support sustainable healthcare solutions in the community.

Resource management: The clinic provided health care services to a large population with limited manpower and restricted budget.

Challenges:

Distance and location: FDMN beneficiaries living on block 18 along with host beneficiaries find the distance to and location of the clinic inconvenient. The host beneficiary area is a hilly area. Access to healthcare services is essential, and it's important to consider the needs and challenges of all beneficiaries, especially those living in more remote areas.

Unavailability of caesarean section: The clinic offers only basic delivery services, which means that not all delivery-related facilities are available. Therefore, patients are often referred to other healthcare centers for better services. For instance, obstetric care is provided at Friendship Hospital (Camp 4) and neonatal patients are referred to the MSF Mother and Children Hospital, which has a pediatrician and advanced care for children.

Availability of the medicine: Low-cost medicines are typically available at the health clinic, while expensive medications are not as readily accessible. Additionally, limited budgetary resources contribute to the scarcity of medication at the clinic.

Lack of transportation: The host beneficiaries and FDMN beneficiaries of block 18 do not have available access to transport. If any emergency arises, it becomes very difficult for the patients at these locations to reach the clinic.

Space limitation: The clinic requires an expanded infrastructure to cater to the needs of the large population it serves.

Unsupportive beneficiaries: Some beneficiaries have been observed to not follow the recommendations of the community volunteers and instead choose to follow only the doctor's prescriptions. Additionally, some beneficiaries may show reluctance in participating in community awareness sessions.

6 Recommendations

Increase in the project budget: The project involves a wide range of activities, but the available funding may not be sufficient to sustain all the activities within the budgetary constraints. To ensure the effectiveness of the health services provided, it is recommended that JPF consider increasing the overall budget allocated to Hakimpara clinic.

Inclusion of more service components: The evaluation team recommends the inclusion of additional health service components, such as a nutrition center, mental health and psychosocial services, and expanded care for children, , to ensure the primary healthcare centre provides round-the-clock service delivery with all the necessary health components.

Escalation of medication provision: It has been observed that the availability of medication at the clinic has decreased compared to before due to limited funds, which has led to dissatisfaction among beneficiaries and affected the clinic's effectiveness negatively. Therefore, it is recommended to increase the supply of medicines to address these concerns.

Continuation of the project: Given that the clinic in the refugee camps is only a temporary structure, it is crucial to ensure that the project has a lasting impact on beneficiaries. To achieve this, it is recommended that the project's duration be extended, and continuous funding be secured to sustain its activities. JPF can allocate additional funding to extend the project for several more years, thereby ensuring a sustainable impact on the communities served.

Arranging training on new topics: The volunteers should be provided with additional training and education to broaden their knowledge and introduce them to additional topics that are relevant to the needs of both FDMN and host communities. This will enable the volunteers to better support their communities and enhance the effectiveness of the health services provided.

Ensuring awareness sessions: To sustain the impact of the program, it is recommended to conduct additional sensitization sessions for both the host and FDMN beneficiaries. This can be accomplished through increased community consultations and door-to-door visits, which will improve beneficiaries' awareness of their health needs and available health services. Furthermore, special attention should be given to marginalized individuals to ensure their inclusion in these efforts.

Extension of the Clinic's structure: To effectively cater to the healthcare needs of the large population served by the clinic, it is recommended that the clinic's physical structure is expanded. This expansion should be done in consultation with relevant authorities to ensure compliance with regulations and requirements. The clinic should also consider adding new service components to its existing structure, such as a laboratory, nutrition center, mental health and psychosocial services, and expanded care for children.

Inform the community more about compliant box: To improve the effectiveness of the complaint or feedback mechanism, it is crucial to consider the literacy level and cultural context of the population. One potential solution is to provide alternative methods for providing feedback, such as voice recorders in safe zones, that allow individuals to provide anonymous feedback without requiring literacy skills. By incorporating feedback mechanisms that are accessible and culturally appropriate, the project can receive more comprehensive feedback from a wider range of beneficiaries, ultimately leading to better program outcomes.

Increase humanpower: It is recommended to recruit additional humanpower, including volunteers, to ensure the smooth operation of the clinic's activities. This will not only help in managing the increasing patient load but also in improving the quality of services provided by the clinic. The recruitment of additional volunteers could help the clinic conduct community awareness sessions and educate beneficiaries on the importance of preventive healthcare measures. Additionally, the recruitment of more healthcare professionals, such as doctors and nurses, can help in expanding the clinic's services.

Building a ramp: Based on the evaluation team's physical observation, it was noted that the Hakimpara clinic lacks a ramp at its entrance. This poses a challenge for pregnant mothers, elderly individuals, persons with disabilities (PWD), and emergency patients who visit the clinic. It is recommended that the clinic authorities construct a ramp at the entrance to provide easy access for all patients, regardless of their physical abilities. This improvement can enhance the clinic's inclusivity and ensure that all patients receive the necessary care they require.

7 Conclusion

The provision of primary healthcare is critical for ensuring the well-being of refugees during times of humanitarian crisis. It is a fundamental human need that must be met to enable individuals to maintain a healthy life despite the crisis they are experiencing. In this regard, humanitarian organizations play a vital role in providing essential support during emergencies. The Rohingya humanitarian crisis is no exception, and clinics have been established to meet the primary healthcare needs of the displaced people in Cox's Bazar.

One such clinic, built by PWJ and DCHT at camp 14, provides primary medical services to both FDMN and host populations. The clinic has successfully met all the requirements of the CHS and delivered its services effectively and efficiently. PWJ and DCHT's bottom-up approach to delivering primary healthcare and their continued development of existing services have contributed to the organization's success in the challenging emergency environment. The clinic has set a benchmark for other organizations to emulate within the framework of the FDMN camp.

However, health care services in the Rohingya camps are shrinking due to the curtailment of funds by donors. Therefore, it is crucial for donor communities, including JPF, to continue funding to sustain the community's health needs and build resilience. It is essential to recognize the critical role that primary healthcare plays in ensuring the well-being of refugees during times of humanitarian crisis and to prioritize funding for these essential services.

Primary healthcare is a vital aspect of ensuring the well-being of refugees and host communities affected by the refugee influx, and it is necessary to provide sustainable and effective services to the displaced people during times of crisis. PWJ and DCHT have demonstrated their effectiveness in delivering primary healthcare services, and their success should be replicated across other humanitarian organizations working in the health sector.

8 References

CHS Alliance. (2015). *CHS Guidance Notes and Indicators*.

Core Humanitarian Standards. (2018). *Core Humanitarian Standard on Quality and Accountability*. 40–41. https://doi.org/10.18356/4a4b59ce-en

Darcy, J., & Hofmann, C. (2003). *According to need? Needs assessment and decision_making in the humanitarian sector. Overseas Development Institute - Humanitarian Policy Group*.

Health Sector CXB. (2020). *Minimum Package of Essential Health Services for Primary healthcare facilities in the FDMN/ Refugee camps, Cox Bazar, February 2020* (Issue Vidette). https://reliefweb.int/report/bangladesh/minimum-package-essential-health-services-primary-healthcare-facilities

Health Sector CXB. (2022). *Quarter 1/2022 Health Sector*. *March*.

Netuveli, G., Wiggins, R., Montgomery, S. ., Hildon, Z., & Blane, D. (2008). Mental health and resilience at older ages: bouncing back after adversity in the British Household Panel Survey. *Journal of Epidemiology & Community Health.*, *62*(11), 987–91.

OECD. (2017). Localising the response. World Humanitarian Summit: Putting Policy into Practice, The Commitments into Action Series. I. *OECD Development Co-Operation Directorate, Paris*. www. oecd. org/development/humanitarian-donors/docs/Localisingtheresponse. pdf

Turner, P., & Turner, S. (2009). Triangulation in practice. *Virtual Reality*, *13*(3), 171–181. https://doi.org/https://doi.org/10.1007/s10055-009-0117-2

Uddin, A. M. S., Hussain, M. F., Adnan, A. B. M., Hasan, R., Helal, A., Amin, U. S., & Faiz, M. A. (2022). Common Health Problems of 'Forcibly Displaced Myanmar Nationals' "(FDMNs)" of Bangladesh. *Journal of Medicine (Bangladesh)*, *23*(1), 13–19. https://doi.org/10.3329/jom.v23i1.57931

UNHCR. (2015). *Accountability to affected populations (AAP).* https://emergency.unhcr.org/entry/42554/%0Aaccountability-to-affected-populations-aap

UNHCR. (2018). Culture , Context and Mental Health of Rohingya Refugees. In *The UN Refugee Agency*.

WHO. (2020). *Examples from the WHO Small Countries Initiative*.

Wulff, K., Donato, D., & Lurie, N. (2015). What is health resilience and how can we build it? *Annual Review of Public Health*, *36*, 361–374. https://doi.org/10.1146/annurev-publhealth-031914-122829

Annex 1: Study Design Matrix

The study design matrix has been developed in line with objectives, target outcomes, and evaluation criteria indicators (Table 2).

Table 2: Study design matrix

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
To verify actual outputs and if possible, outcomes of the project with the available data	✓ Access to primary health care services improves for FDMNs and host community	CHS 1: Humanitarian response is appropriate and relevant (Relevance)	✓ Communities and people affected by crisis consider that the response takes account of their specific needs, culture, and preferences ✓ The assistance and protection provided correspond with assessed risk, vulnerabilities and need	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				FGD	FDMN and host community beneficiaries
				Questionnaire Survey	FDMN and Host beneficiaries

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
		CHS 2: Humanitarian response is effective and timely (Effectiveness)	✓ Increase in clinic patients from both FDMN and host community compared to the previous year ✓ Number of patients: FDMNs/ HC ✓ Number patient per: e.g., ANC/PNC, delivery, EPI, NCD ✓ Humanitarian response meets its objective in terms of timing, quality and quantity	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers,, Nurse, Doctor
				FGD	FDMN and host community beneficiaries
				Questionnaire Survey	FDMN and Host Community beneficiaries
	Primary health care service are provided at the clinic 24/7	CHS 2: Humanitarian response is effective and timely (Effectiveness)	✓ Days of clinic operation: Every day ✓ Communities and people affected by crisis including the most vulnerable groups, consider that the timing of the assistance and	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
			protection they receive is adequate	IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				Questionnaire Survey	FDMN and Host community beneficiaries
	Health awareness sessions are provided at the clinic bi-monthly for FDMNs and host community	CHS 3: Humanitarian response strengthens local capacities and avoid negative effect (impact and sustainability)	✓ Health awareness sessions at clinic: Bi monthly ✓ Communities and people affected by crisis consider themselves better able to withstand future shocks and stresses, as a result of humanitarian action. ✓ Local authorities, leaders and organizations with responsibilities for responding to crises consider that their	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				FGD	FDMN and host community beneficiaries

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
			capacities have been increased. ✓ Communities and people affected by crisis, including vulnerable and marginalized individuals, do not identify negative effects resulting from humanitarian action.	Questionnaire Survey	FDMN and Host community beneficiaries
	Quality of health care services are maintained and assured	CHS 2: Humanitarian response is effective and timely (Effectiveness)	✓ Clinic database, medicine consumption are recorded and regularly monitored ✓ Communities and people affected by crisis consider that the response meet their need	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers,, Nurse, Doctor
				FGD	FDMN and host community beneficiaries
				Questionnaire Survey	FDMN and Host Community beneficiaries

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
	Clinic database and medicine consumption are monitored for quality control and regularly reported to the health sector	CHS 2: Humanitarian response is effective and timely (Effectiveness)	✓ Monthly report: monthly Medicine consumption report: monthly ✓ EWARS: weekly ✓ 4W: monthly ✓ SRH report: monthly	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
	Establish the basis to support community-based health promotion and improve health-seeking behaviour for FDMNs and host community.	CHS 4: Humanitarian response is based on communication, participation and feedback (Relevance and Coherence)	✓ Improvement in community volunteers' knowledge on basic health information and available health services in their community ✓ Share learning and innovation internally, with communities and people affected by crisis, and with other stakeholders. ✓ Communities and people affected by crisis consider that they have timely access to clear and relevant information, including about issues that may put them at further risk.	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				Questionnaire Survey	FDMN and Host Community beneficiaries

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
	FGD on health and hygiene are held at the four target communities	CHS 4: Humanitarian response is based on communication, participation and feedback (Relevance and Coherence)	✓ Number of FGD sessions ✓ Communities and people affected by crisis are satisfied with the opportunities they have to influence the response. ✓ Number of FGD participants	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				Questionnaire Survey	FDMN and Host Community beneficiaries
	Community volunteers are able to hold health awareness sessions at the four target communities	CHS 8: Staff are supported to do their job effectively, and are treated fairly and equitably. (Effectiveness, coherence)	✓ Number of Health awareness sessions at the community ✓ Number of Health awareness session participants ✓ All staff are trained and provided with guidance on the rights of the affected population.	Secondary Document Review	Relevant project and policy documents
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				KII	Representative of PWJ, JPF, CiC, ISCG,

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
			✓ All staff feel supported by their organiation to do their work ✓ Staff satisfactory meet their performance objectives ✓ Communities and people affected by crisis assess staff to be effective in terms of their knowledge, skill, behaviour and attitudes		SAG (Health), UHFPO, USSO
				FGD	FDMN and host community beneficiaries
				Questionnaire Survey	FDMN and Host community beneficiaries
	Establish an emergency network at the four target communities.	CHS 1: Humanitarian response is appropriate and relevant (Relevance)	Community people are given advice about available health services by community volunteers	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				FGD	FDMN and Host community Beneficiaries,

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
				Questionnaire Survey	FDMN and Host Community beneficiaries
		CHS 3: Humanitarian response strengthens local capacities and avoids negative effects (Impact & Sustainability)	Community people with higher health risks are identified and listed per community	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				FGD	FDMN and Host Community Beneficiaries,
				Questionnaire Survey	FDMN and Host Community beneficiaries
To verify that the humanitarian principles and	CHS principles are respected in	CHS 5: Complaints are welcomed and	✓ Communities and people affected by crisis, including	Secondary Document Review	Relevant project and policy documents

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
standards including Core Humanitarian Standards (CHS) are respected (already CHS1, CHS2, CHS 3, CHS4 and CHS7 are shown in objective 1)	project intervention	addressed (Coherence)	vulnerable and marginalized groups, are aware of complaints mechanisms established for their use. ✓ Communities and people affected by crisis consider the complaints response mechanisms accessible, effective, confidential and safe. ✓ Complaints are investigated, resolved and results fed back to the complainant within the stated time frame.	KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				FGD	FDMN Band Hsot community beneficiaries,
				Questionnaire Survey	FDMN and Host Community beneficiaries
		CHS 6: Humanitarian response is coordinated and complementary (cover, coherence)	✓ Organizations minimize gaps and overlaps identified by affected communities and partners through coordinated action. ✓ Responding organizations – including local organizations – share relevant information through formal and informal coordination mechanisms.	KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers Nurse, Doctor

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
			✓ Organizations coordinate needs assessments, delivery of humanitarian aid, and monitoring of aid implementation. ✓ Local organizations report adequate participation and representation in coordination mechanisms.		
		CHS 7: Humanitarian actors continuously learn and improve (Impact and Coherence)	✓ Communities and people affected by crisis identify improvements to the assistance and protection they receive over time. ✓ Improvements are made to assistance and protection interventions as a result of the learning generated in the current response. ✓ The assistance and protection provided reflects learning from other responses.	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers Nurse, Doctor
				FGD	FDMN and Host community Beneficiaries

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
			✓ Evaluation and learning policies are in place, and means are available to learn ✓ from experiences and improve practices. ✓ Mechanisms exist to record knowledge and experience, and make it accessible ✓ throughout the organisation. ✓ The organisation contributes to learning and innovation in humanitarian response ✓ amongst peers and within the sector	Questionnaire Survey	FDMN and host community beneficiaries
		CHS 8: Staff are supported to do their job effectively, and are treated fairly and equitably. (Effectiveness, coherence)	✓ All staff feel supported by their organization to do their work. ✓ Staff satisfactorily meet their performance objectives. ✓ Communities and people affected by crisis assess staff to	KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers Nurse, Doctor

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
			be effective in terms of their knowledge, skills, behaviours and attitudes. ✓ Communities and people effected by crisis are aware of humanitarian codes of conduct and how to raise concerns about violations	FGD	FDMN and Host community Beneficiaries
		CHS 9: Resource are managed and used responsibly for their intended purpose (efficiency)	✓ The resource obtained for the response are used and monitored according to agreed plans, targets, budget and time frame ✓ Humanitarian response is delivered in way that is cost effective	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
To understand the beneficiary satisfaction	Patients are satisfied with clinic service	CHS 2: Humanitarian response is effective and timely (Effectiveness)	✓ % of the patient answer that they are satisfied with the clinic service ✓ Communities and people affected by crisis, including the most vulnerable groups, consider that the timing of the	IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers Nurse, Doctor
				FGD	FDMN and host community Beneficiaries

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
			assistance and protection they receive is adequate ✓ Communities and people affected by crisis consider that the response meets their needs.	Questionnaire Survey	FDMN and host community Beneficiaries Community volunteer survey
		CHS 3: Humanitarian response strengthens local capacities and avoids negative effects (Impact & Sustainability)	✓ Communities and people affected by crisis, including vulnerable and marginalized individuals, do not identify negative effects resulting from humanitarian action.	IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers Nurse, Doctor
				FGD	FDMN and Host community Beneficiaries
				Questionnaire Survey	FDMN and Host community beneficiaries
		CHS 4: Humanitarian response is based on communication, participation and feedback (Relevance and Coherence)	✓ Communities and people affected by crisis are satisfied with the opportunities they have to influence the response	IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				FGD	FDMN and host community Beneficiaries

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
				Questionnaire Survey	FDMN and Host community beneficiaries
		CHS 8: Staff are supported to do their job effectively, and are treated fairly and equitably. (Effectiveness, coherence)	✓ Communities and people affected by crisis assess staff to be effective in terms of their knowledge, skills, behaviours and attitudes	IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers Nurse, Doctor
				FGD	FDMN and host community Beneficiaries
				Questionnaire Survey	FDMN and host community beneficiaries
To assess the contributions of the project to Joint Response Plan 2021 and JPF's program goals	Improve equitable access to and utilization of life-saving and comprehensive primary and secondary health services for all crisis-affected populations (JRP,2021)	CHS 7: Humanitarian actors continuously learn and improve (Impact and Coherence)	✓ Communities and people affected by crisis identify improvements to the assistance and protection they receive over time. ✓ Improvements are made to assistance and protection interventions as a result of the learning	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
			generated in the current response. ✓ The assistance and protection provided reflects learning from other responses.		health volunteers ,Nurse, Doctor
				FGD	FDMN and host community Beneficiaries
				Questionnaire Survey	FDMN and Host community beneficiaries
	Ensure robust Health Sector coordination, partner collaboration, information management and monitoring, and technical leadership with the aim of achieving rational, standardized and accountable health service delivery (JRP, 2021)	CHS 6: Humanitarian response is coordinated and complementary (cover, coherence)	✓ Organizations minimize gaps and overlaps identified by affected communities and partners through coordinated action. ✓ Responding organizations – including local organizations – share relevant information through formal and informal coordination mechanisms. ✓ Organizations coordinate needs assessments, delivery of humanitarian aid and monitoring of aid implementation.	KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
			✓ Local organizations report adequate participation and representation in coordination mechanisms		
	Providing assistance that benefits both displaced persons and host communities (JPF Goal)	CHS 1: Humanitarian response is appropriate and relevant (Relevance)	✓ Communities and people affected by crisis consider that the response takes account of their specific needs, culture, and preferences. ✓ The assistance and protection provided correspond with assessed risks, vulnerabilities and needs. ✓ The response takes account of the capacities, skills and knowledge of people requiring assistance and protection.	KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				FGD	FDMN and Host community beneficiaries
				Success Stories	FDMN beneficiaries or program components (physical or abstract)
				Questionnaire Survey	FDMN and Host community beneficiaries
	Contribute to strengthening the	CHS 3: Humanitarian	✓ Communities and people affected by	KII	Representative of PWJ, JPF, CiC, ISCG,

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
	resilience of people and communities affected by humanitarian crises	response strengthens local capacities and avoids negative effects (Impact & Sustainability)	crisis consider themselves better able to withstand future shocks and stresses, as a result of humanitarian action. ✓ Local authorities, leaders and organizations with responsibilities for responding to crises consider that their capacities have been increased. ✓ Communities and people affected by crisis, including vulnerable and marginalized individuals, do not identify negative effects resulting from humanitarian action		SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				FGD	FDMN and Host community beneficiaries
				Success Stories	FDMN beneficiaries or program components (physical or abstract)
				Questionnaire Survey	FDMN and host community beneficiaries
To document and extract lessons learned and best practices and provide robust recommendations to improve the	Lesson learned, best practice and robust recommendation		✓ lessons that the projects have had learned so far ✓ Good practices identified in the project life cycle, including project designing,	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
future projects and programme			monitoring and implementation ✓ Good practices or successful experiences or transferable examples were identified ✓ Programmatic recommendations based on the achievements	IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				FGD	FDMN and host Community beneficiaries
				Success Stories	FDMN beneficiaries or program components (physical or abstract)
				Physical Observation	Hakimpara Clinic
Assess the JPF localization performance	Equitable and complementary partnership between member NGOs and local partners are established	CHS 6: Humanitarian response is coordinated and complementary (cover, coherence)	✓ Local Partners are involved in critical aspects of project implementation ✓ Full participation of local partner in decision making ✓ Existing local system, capacity and resources are analyzed and fully utilized	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
	Member NGOs Local actors are mutually strengthening organizational capacities	CHS 6: Humanitarian response is coordinated and complementary (cover, coherence)	✓ Understanding of humanitarian standards are improved ✓ Priority capacity building need of each actor are identified and to what extend their needs are addressed ✓ Each actor has an opportunity to share and exchange its knowledge, expertise and capacity	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
	Local actors are empowered, more prepared and less vulnerable as a result of humanitarian action so that they can be more self-resilient	CHS 7: Humanitarian actors continuously learn and improve (Impact and Coherence)	✓ Knowledge and skills are developed through trainings, awareness rising or project implementation ✓ Community solidarity is strengthened with fostering leadership to facilitate self-support effort ✓ A sense of ownership, and systems among key local actors are	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor

Objective	Target Outcome/Output	Evaluation Criteria	Indicators	Methods	Stakeholder/Data Source
			strengthened through interventions		
	Fuller and more influential involvement of local actors in what relief is provided to them, and how, to provide more effective and contextualized humanitarian aid	CHS 5: Complaints are welcomed and addressed (Coherence) CHS 7: Humanitarian actors continuously learn and improve (Impact and Coherence)	✓ Beneficiaries' views are incorporate into project design through Bottom-up consultation-based needs assessment ✓ Formal and informal communication, feedback and response mechanisms are set up with participation from the community and are regularly reviewed ✓ All stakeholders are well informed about the assistance provided ✓ Vulnerable groups are paid particular attention	Secondary Document Review	Relevant project and policy documents
				KII	Representative of PWJ, JPF, CiC, ISCG, SAG (Health), UHFPO, USSO
				IDI	FDMN and host community Beneficiaries, Camp and host community health volunteers, Nurse, Doctor
				FGD	FDMN and Host community beneficiaries

Annex 2: Terms of Reference

TENDER DOSSIER

Request for Proposals for Third-party Evaluation of JPF Funded Projects in Bangladesh

Tender Reference:
JPF-BGD-21-002

December 2021

A – INSTRUCTIONS TO BIDDERS

In submitting a tender, the bidder accepts in full and without restriction the special and general conditions governing this contract as the sole basis of this tendering procedure, whatever his own conditions of sale may be, which hereby waives.

Bidders are expected to examine carefully and comply with all instructions, forms, provisions and specifications contained in this tender dossier. Failure to submit a tender containing all the required information and documentation within the deadline specified will lead to the rejection of the tender.

No account can be taken of any reservation in the tender as regards the tender dossier; any reservation will result in the immediate rejection of the tender without further evaluation.

Tender procedures will be conducted by authorized Japan Platform personnel and the decision will be given by the tender committee. If requested, representatives from the back donor or partner organizations can attend to the tender committee as an observer.

1. Preamble:

The Japan Platform (hereinafter referred to as "JPF") is an international emergency humanitarian aid organization which offers the most effective and prompt emergency aid in response to humanitarian needs, focusing on issues of refugees and natural disasters. JPF conducts such aid through a tripartite cooperation system where NGOs, business communities, and the government of Japan work in close cooperation, based on equal partnership, and making the most of the respective sectors' characteristics and resources.

JPF serves as an intermediary support organization providing various types of assistance to member NGOs in Japan to deliver quick and comprehensive aid on their own. JPF has supported aid activities of 44 member NGOs, each with its own set of diverse strengths. It has delivered humanitarian assistance to 55 nations and regions about 1,500 project, with a total financial contribution of 60 billion yen. JPF has built a strong reputation based on trust by promoting cooperation among private sectors and NGOs and by accurately reporting all of its activities. Please find attached JPF Information Leaflet as Annex 1. More information on JPF can be found at http://www.japanplatform.org/E/.

2. Purpose of the Request for Proposals

The purpose of this request for proposals (RFP) is to solicit competitive offers for the provision of Third-party project evaluation services for ongoing 3 JPF projects which are being funded by JPF and implemented by member NGOs in Cox's Bazar, Bangladesh.

JPF seeks to contract a TPM entity to accurately capture information, verify activities and analyse data on these project activities. JPF will use the outcome of this evaluation to improve the current and future projects and programme. The evaluation reports will be made available to public as a part of JPF's activity to ensure accountability to the donor and public.

The main objectives of evaluation are;

- To verify actual outputs and if possible outcomes of the project with the available data
- To verify that the humanitarian principles and standards including Core Humanitarian Standards (CHS) are respected
- To understand the beneficiary satisfaction

- To assess the contributions of the project to Joint Response Plan 2021 and JPF's program goals (JPF program objectives are attached as Annex 3)
- To document and extract lessons learned and best practices and provide robust recommendations to improve the future projects and programme.

In addition to above, JPF is keen to explore how it may advance the localization agenda called for since the 2016 World Humanitarian Summit. Although JPF has not consciously taken the localization agenda into account in developing the program strategy, its portfolio or financing modalities, it hopes to revisit the current ways of working vis-à-vis the localization agenda and explore how it delivers on the localization agenda in moving forward.

3. Scope of Services

This RFP encompasses the evaluation of ongoing three (3) projects as part of JPF accountability and learning initiatives for quality improvement. Prior to the start of data collection for evaluation activities, the selected contractor will closely collaborate with JPF and member NGO headquarters in Japan to develop data collection tools, field visit protocols and reporting formats. JPF will provide the contractor with relevant documentation, including approved projects proposals and other relevant information. The contractor is expected to conduct a review of project documentation prior to undertaking field visits. All documentation shared with the contractor is considered confidential and a data protection protocol will be signed as part of the agreement.

The projects brief information for each project can be found as an Annex 2 – Project Summary Document for Evaluation to this document. The field activities for three projects are expected to be conducted during the month of February, June and July 2022 respectively. (Subject to change depending on the progress of each project)

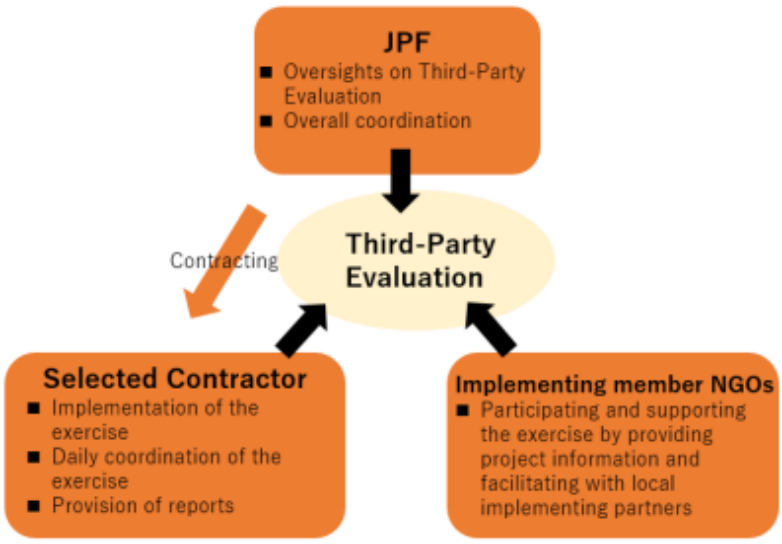
The TPE entity should have access to the project locations and should process all required permissions from the authorities prior to the implementation of the field work.

The criteria of value used for this evaluation is CHS and therefore it is essential that the selected contractor possesses a good understanding of this standard and past experience in conducting evaluation using CHS (See Annex4: JPF Evaluation Framework). Moreover, the selected contractor, and in particular the assigned team, is typically expected to be competent and have proven experience in the following;

- Desk review of the implementing partner's project documents; including but not limited to approved project proposal, project log frame, needs assessments, beneficiary selection criteria, latest project progress report and any other relevant document.
- Sample selection methodologies
- Beneficiary surveys to verify that;
  - HHs received the proposed service or input;
  - Measure project outcomes;
- Key indicators as defined in the proposal and relevant clusters
- Project Site visits and verification of project activities
- In depth interviews with beneficiaries to collect success stories
- Key Informant Interview with stakeholders
- Focus Group Discussions
- Country and sector context analysis

In order to assess the competency and consideration of the individuals and institutions submitting proposals with regards to COVID-19 preventive measures, this RFP is requiring a submission of one to two-page plan of free format stating organization policy toward preventive measure against COVID-19 together with other required documents. The plan should inform the approach to the data collection and any other information deemed necessary to demonstrate the ability to conduct data collection with much consideration on COVID-19 outbreak in general.

JPF has a unique system, acts as an intermediary support organization providing various types of assistance to its member NGOs in Japan. In such third party monitoring implementation, JPF follows the TPE implementation structure as below;



4. Expected Activities and Deliverables

The contractor will report directly to JPF but will work closely with the member NGOs and project implementing partners. During the course of the field level data collection, the contractor is expected to provide JPF with timely feedback, notably in instances where immediate attention or action is warranted. For all tasks specific tools and templates will be developed and agreed to between JPF and the contractor following signing of the contract. It is expected that the reports provided by the contractor will adhere to the agreed upon templates. For all remaining tasks, general approaches will be developed and agreed to between JPF and the contractor, upon signing of the contract.

It is expected from the TPE entity to undertake below mentioned activities and deliverables are underlined;

- To organize a pre-inception meeting/call with JPF and review documents from the member NGOs to gather required information for the inception report.
- To provide three inception reports specific per project with a detailed work plan and methodology and data collection tools, proposed schedule of site visits and sample beneficiary and key informant selection strategy and list of data to be collected.
- To organize three separate inception meetings with JPF and project implementing NGOs to discuss the details of the evaluation objectives, scope, targets, data processing and analysing, allocated team and reporting.

- To implement the work plan including scheduled visits, capturing and analyzing data in a timely and accurate manner and some qualitative assessment of select sample of sites.
- To produce two success stories per project.
- To submit final evaluation reports separate for each project as per the agreed format. It is expected TPE entity to submit a draft report and after two rounds of feedback to submit a final report. The reports must be accompanied by raw-data and visuals collected during the contract period.
- To organise 3 separate debriefing meetings and present details, findings and recommendations of the exercise to JPF, member NGOs and project implementation NGOs.

In the face of outbreak of COVID-19 worldwide, all discussions will be undertaken on line.

5. Call for Tenders Schedule

	DATE	TIME*
Tender publication date	17th December 2021	
Deadline for request for any clarifications from JPF	24th December 2021	17:00
Last date on which clarifications are issued by JPF	30st December 2021	17:00
Deadline for submission of tenders (receiving date, not sending date)	10th January 2022	17:00
Tender Committee Meetings by JPF	11-14 January 2022	
Notification of award to the successful tenderer	14th January 2022	
Signature of the contract	21st January 2022	

* All times are in the local time of Tokyo, Japan.

6. Questions and Clarifications

If JPF, either on its own initiative or in response to a request from a prospective bidder, provides additional information on the tender dossier, such information will be communicated simultaneously in writing to all the bidders.

Bidders may submit questions in writing to the following address by email before the deadline for request for any clarifications, specifying the tender reference number JPF-BGD-21-002.

Contact Person:

Name / Surname	Title	E-Mail Address
Procurement Department	-	procurement@japanplatform.org

Any explanation or amendment to be made regarding the tender dossier shall also be shared with all applicants simultaneously. Bilateral negotiations will not be held with the institutions applying during the tender.

7. Meeting with the Institutions / Company Visits

No clarification or bilateral meeting will be held with the entities applying during the tender. Company visits will not be conducted. However, a meeting will be held with the winning entity prior to the signing of the agreement.

8. Eligibility Documents Required for the Bidders

Participation in tendering is open on equal terms to all natural and legal entities that can provide the required documents by this tender. If the required document is in another language than English then an English translated copy should be provided along with the original.

8.1. Organizational Profile Document providing detailed information on the capacity of the organization and services provided (such as previous and ongoing works, relevant experiences, registration details, establishment year, number of offices, number of full/part time staff, experts, surveyors and etc.)

8.2. Valid company registration documents including licences obtained from the relevant governmental institution.

8.3. Submission of the most recent original and valid tax documents

8.4. Providing address declaration for notifications (phone and e-mail address information). Please indicate if you have an office in Bangladesh.

8.5. Signature declaration or list of authorized signatures indicating that they are authorized to submit bids;

8.6. Please provide detaild list of any ongoing or past activities of your organization in Bangladesh, especially in Cox's Bazar along with organization and contact person for reference check. Demonstrating past experience in conducting evaluation using CHS is strong assert.

8.7. Written commitment to not carry any of the "reasons for exclusion from the tender" under clause 21 of the tender dossier

8.8. Techincal Proposals should include;

8.8.1. Evaluation desing and methodology

8.8.2. Evaluation targets for field visits, household surveys, focus group discussions and key informant interviews should be indicated separately for each project with due consideration on Covid-19 prevention and Do No Harm principle

8.8.3. Evaluation Implementation Work and Time Plan

8.8.4. Provide information on your network and access to the target locations

8.8.5. Safety, Security and Covid19 related policy and procedures that will be applied

8.8.6. Confidentiality and Data Protection Policy and Procedures that will be applied

8.8.7. Information on the data collection tool and methodology of how the data analyzed

8.8.8. Provide the list of personnel who will be assigned to contract, detailing the tasks of each and provide CVs for listed key personnel. At least 50 percent of field monitors must be female and in the evaluation of bids gender equality in the project team will be recognized.

8.8.9.Sample questionnaire and report (please remove all related information to make it anonymous)

8.8.10. Indicating the delivarables

8.8.11. Provide an alternative methodology and activities if the proposed activities cannot be conducted due to COVID-19 limitations and restrictions.

8.10. Financial Proposal should include;

8.10.1. All the tax and costs

8.10.2. The cost of each project and the final total of 3 projects

8.10.3. Payment conditions

9. Bidding format and content

Bid proposal should consist of separate sub-folders as administrative documents, technical and financial proposals.

Bidding Documents should be in the same sequence as listed in clause 8. All the documents should be scanned and submitted via e-mail or a link should be provided to be downloaded. The bidder must be aware of the followings;

- Indicating that the tender dossier is fully read and accepted,
- The price quoted must be clearly written in accordance with the numbers and the written text,
- There shall not be any scratches, erosion or correction on the documents
- If the bidder is a real person, the name and surname of the bidder, if a legal entity, then the trade name must be fully written and shall be signed by the authorized persons.

The tender reference number ***JPF-BGD-21-002*** must be specified on the e-mail and on the file names.

Bidders who bid as a joint venture must sign bids by all partners or by persons authorized to bid.

In the tender letters who will bid as a consortium, the price that the consortium partners offer for the parts of the business that require their expertise will be written separately. The sum of the prices that the consortium partners offer shall constitute the consortium's total bid price.

All the bid letters submitted by the joint venture must be signed by all partners or by the representatives of the partners.

Proposals which are not in conformity with any of them or which have scrapes, erosions or corrections on them shall be rejected and shall not be considered as submitted at all.

10. Submission of Proposals

Interested Consultants/Companies/Organizations shall provide a proposal along with the information and documents listed under Clause 8, until ***17:00 (pm),10th of January 2022***. The documents shall be in PDF format and signed by the authorized person. All the documents shall be in a zipped file and shall be send to the following e-mail address;

	Name / Surname	Title	E-Mail Address
1.	Procurement Department	-	procurement@japanplatform.org

11. Period of validity

The validity period of the tenders shall be at least 60 calendar days from the date of procurement. The bids which has shorter period of validity will not be taken into account.

In case of need, the Contracting Authority will make a request for extension of the validity period of the bid for a maximum of 30 days. The tenderer may accept or reject this request of the Contracting Authority. Requests and answers in this regard shall be made in writing.

Successful bidder must ensure the validity of the bid for the following 60 days from being notified of the entitlement to the contract. Regardless of the date of notification, 60 days are added to the first 60 days.

12. Currency of tenders

The amounts quoted in the offers given by the companies are required to be written in American Dollar – USD or Japanese Yen (JPY).

13. Language of offers and procedure

The proposals and all other related documents and scanned version of the original document shall be written in English. If the original document language is other than English then the translation of the document will be accepted along with the original.

14. Alteration or withdrawal of tenders

Bidders may not alter or withdraw their tenders after submission.

15. Costs of preparing tenders

Tender dossier is free. All costs incurred during the preparation and submission of the tender offer shall be borne by the bidder. No reimbursement will be made for any charges regardless of the result.

16. Evaluation - Location, Date and Hour of the Tender Opening and Examination:

JPF will evaluate incoming bids on the following conditions.

- The conformity of the required documents
- Quality of technical proposal – weights 70%
- Financial Offer –weighs 30%

17. Notification award and contract signature

The successful bidder is informed in writing and the contract is signed within 10 (ten) calendar days. A meeting will be conducted prior to the signing of the contract. Firms that are not selected as the result of the evaluation are informed in writing within 15 (fifteen) working days. If the successful bidder does not sign the contract, the second best bidder is informed in writing by the tender committee and a contract is signed within 10 (ten) calendar days.

18. Ownership of tenders

JPF is obliged to keep the procurement proposals collected as a result of this tender for future audits.

19. Type of Contract

The contract will be drafted to include bid proposal specifications and tender requirements.

20. Cancellation of the tender procedure

In the event of a tender procedure's cancellation, bidders will be notified by JPF.

Cancellation may occur where:

1. The tender procedure has been unsuccessful, namely where no qualitatively or financially worthwhile tender has been received or there has been no response at all;
2. The economic or technical parameters of the project have been fundamentally altered;
3. Exceptional circumstances or force majeure render normal performance of the TPM impossible;
4. All technically compliant tenders exceed the financial resources available;
5. There have been irregularities in the procedure, in particular where these have prevented fair competition.

Under no circumstances JPF will be liable for damages, whatever their nature (in particular damages for loss of profits) or relation with the cancellation of a tender. The publication of a procurement notice does not commit JPF to implement the announced programme or project.

21. Reasons for disqualification from the tender

Tenderers in the following cases shall be excluded from the tender if they are found to be:

21.1. Those who are bankrupt, in liquidation, whose work is carried out by the court, declare concordat, suspend their business or are in a similar situation according to the legislative provisions in their home country,

21.2. Proven by the employer that there were activities in violation of business or professional ethics during the course of business with the organizations within five (5) years prior to the date of procurement.

21.3. As of the date of the procurement, if the bidder's membership/licence is cancelled from the chamber which the bidder had to registered in accordance with the legislation.

21.4. Bidders that has failed to provide the documents, or gives incomplete or misleading information and/or falsified documents that are requested by this tender dossier.

22. Prohibited Acts or Behaviours

The following acts or actions are prohibited during the tender;

22.1. To commit or attempt to commit mischief, fraud, promises, threats, to influence, to exploit for one's interest, to make deal, extortion, bribery or other means of breach

22.2. Acts to influence other bidder's willingness to attend tender, prevent their participation to tender, make or offer deals to other bidders and to engage in acts to influence fair competition or tender decision.

22.3. To arrange, use or attempt to falsify documents or fraudulent collateral.

22.4. To give more than one proposal, either directly or indirectly, in person or by proxy, on behalf of himself or other

23. Ethical Considerations

23.1. The monitoring and evaluation activities should not contradict ethical principles. The selected TPM entity should take all reasonable steps to ensure that the M&E activities are designed and conducted within the framework of Do No Harm principle to respect and protect the safety, rights and welfare of the people.

23.2. Consent should be taken from all participants of M&E data collection activities and all data gathered should be kept confidential. Ownership of all data, information, and

findings gathered through different M&E activities lies with the contracting authority (JPF).

23.3. The TPM entity should adhere to principles and policies of the member NGOs, a special attention should be given to Child Protection principles, gender policy and Preventing Sexual Exploitation, Abuse and Harassment (PSEAH) policy.

24. List Annexes

- Annex 1_JPF_Info_Sheet
- Annex_2 Project Summary Document for Evaluation

Annex 3: Data Collection Tools

Quantitative Tool

Third party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMN) and Host Communities in Cox's Bazar District of Bangladesh"

Structured Survey Questionnaire for FDMN and Host community beneficiaries

My name is _____ and I am working with DM WATCH. We are currently conducting a third-party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMN) and Host Communities in Cox's Bazar District of Bangladesh" implemented by PWJ and DCHT. I invite you to participate in the survey. Taking part in this study is voluntary. You may skip any questions that you do not want to answer. If you decide not to take part, or to skip some of the questions, it will not affect your current or future relationship with us. If you decide to take part, you are free to withdraw at any time. The study is conducted by DM WATCH. Please ask any questions you have now.

Statement of Consent: I understand the aforementioned information and I have received answers to any questions I asked. I consent to take part in the study.

Interviewer's Name	Code	Interviewer's Mobile Number
	|__|__|	|__|__|__|__|__|__|__|__|__|__|__|
Date of the Interview	Starting Time (24 hour)	End Time (24 hour)
|__|__|.|__|__|.|__|__|__|__| DD MM YYYY	|__|__|: |__|__| HH MM	|__|__|: |__|__| HH MM
District Name	Ukhiya Teknaf	
Camp No.		
Block		
GPS Location		

Basic Information			
Q. N	**Questions**	**Response**	**Code**
1	Respondent's Name		
2	Respondent's Mobile Number	|__|__|__|__|__|__|__|__|__|__|__|	
3	Sex of the respondent	Male	1
		Female	2
		Transgender	3
		Not interested to share	4
4	Age of the respondent		
5	Highest Educational status of the respondent	Did not enroll in any school/ learning center	1
		Can only sign	2
		Did not complete primary education	3
		Completed primary education	4
		Up to JSC/equivalent	5
		SSC/equivalent	6
6	Religion of the respondent	Muslim	1
		Hindu	2
		Buddhist	3
		Christianity	4
		Other (Please specify)	5
7	Marital status of the respondent	Unmarried	1
		Married	2
		Divorced/separated	3
		Widowed	4
		Other (Please specify)	5
8	Occupation of the respondent	Volunteer worker	1
		Livestock	2
		Merchant	3

		Skilled worker	4
		Day laborer	5
		Agricultural laborer	6
		Unskilled workers	7
		Driver	8
		Rickshaw puller / van driver	9
		Housewife	10
		Private employee	11
		Physician	12
		Teacher	13
		Student	14
		Unemployed	15
		Handy craft	16
		Other (Please specify)	17
		Not applicable	18

Objective 3: To understand beneficiary satisfaction				
Expected outcome: Patients are satisfied with clinic service				
Indicator: • **Number of patients who are satisfied with the Hakimpara clinic service** • **Communities and people affected by crisis assess staff to be effective in terms of their knowledge. skills, behaviour and attitudes**				
Q. N	**Questions**	**Response**	**Code**	**E.C**
1	Have you visited the health clinic at camp 14	Yes	1	CS:2 Effectiveness CHS 8: Effectiveness and
		No	2	
2	Is the health clinic at camp 14 is the one you usually visit in case of health problem	Yes	1	
		No	2	
3	Was the main reason you went to the health clinic dealt with up to your satisfaction	Yes, completely	1	
		Yes, to some extent	2	
		No	3	
4		Very unsatisfied	1	

	What is the level of satisfaction with your doctor's diagnosis/ treatment from the Hakimpara clinic	Unsatisfied	2	coherence
		Neutral	3	
		Satisfied	4	
		Very satisfied	5	
5	Was the treatment effective and helped you and your family recover from the disease/ health issues	Yes, definitely	1	
		No	2	
6	What is your level of satisfaction with the prescribed medicine for your treatment from the health clinic	Very unsatisfied	1	
		Unsatisfied	2	
		Neutral	3	
		Satisfied	4	
		Very satisfied	5	
7	To what extent are you satisfied with the behavior of the doctor at the health clinic	Very unsatisfied	1	
		Unsatisfied	2	
		Neutral	3	
		Satisfied	4	
		Very satisfied	5	
8	To what extent are you satisfied with the behavior of the health clinic nurses	Very unsatisfied	1	
		Unsatisfied	2	
		Neutral	3	
		Satisfied	4	
		Very satisfied	5	
9	To what extent are you satisfied with the cleanliness of the health clinic	Very unsatisfied	1	
		Unsatisfied	2	
		Neutral	3	
		Satisfied	4	
		Very satisfied	5	
10	To what extent are you satisfied with the amount of time you get to spent with the doctor at the health clinic?	Very unsatisfied	1	
		Unsatisfied	2	
		Neutral	3	
		Satisfied	4	
		Very satisfied	5	
11	To what extent are you satisfied with the privacy and transparency of the health clinic	Very unsatisfied	1	
		Unsatisfied	2	
		Neutral	3	
		Satisfied	4	
		Very satisfied	5	
12	Did the information you received from the health clinic help you to	Yes	1	

	understand the condition of you or your family's health	No	2	
13	To what extent are you satisfied with the information you received from the health clinic regarding your health and well being	Very unsatisfied	1	
		Unsatisfied	2	
		Neutral	3	
		Satisfied	4	
		Very satisfied	5	
14	How satisfied are you with the skills of the health clinic Doctors	Very unsatisfied	1	
		Unsatisfied	2	
		Neutral	3	
		Satisfied	4	
		Very satisfied	5	
15	How satisfied are you with the skills of the health clinic nurse	Very unsatisfied	1	
		Unsatisfied	2	
		Neutral	3	
		Satisfied	4	
		Very satisfied	5	
16	How satisfied are you with the skills of the community health workers	Very unsatisfied	1	
		Unsatisfied	2	
		Neutral	3	
		Satisfied	4	
		Very satisfied	5	
• Communities and people affected by crisis consider that the response meets their needs				
17	Have you received primary health care service such as antenatal care, post-natal care, Delivery, non-communicable diseases service from the health clinic	Yes	1	
		No	2	
18	Have you received health awareness session from the clinics	Yes	1	
		No	2	
CHS 3: Communities and people affected by crisis, including vulnerable and marginalized individuals do not identify negative effects resulting from humanitarian action				
19	Do you think, because of your nationality, you are treated differently by the health clinic staff	Yes	1	
		No	2	
CHS4: Communities and people affected by crisis are satisfied with the opportunities they have to influence the response				

20	Does health workers listen to your feedback	Yes	1	
		No	2	
21	Have you seen any changes on their activity because of your feedback	Yes	1	
		No	2	
22	Do you think you are able to influence the activities of health clinic doctor and nurse with your feedback	Yes	1	
		No	2	
23	Are you satisfied with the opportunity to make a difference in their activity	Yes	1	
		No	2	

Objective 1: To verify actual outputs and if possible, outcomes of the project with the available data.				
Target outcome: Access to primary health care services improved for FDMNs and host communities				
CHS 1: Communities and people affected by crisis consider that the response takes account of their specific needs, culture and preference				
Q. N	**Questions**	**Response**	**Code**	**E.C**
24	Are you able to communicate with your own language with health clinic staffs	Yes	1	
		no	2	
25	Is there any interpreter at the health clinic to help you with communication	Yes	1	
		No	2	
26	Do doctors ask about your cultural and dietary preferences before prescribing you any medicine or treatment	Yes	1	
		No	2	
27	Do you think the doctors, health clinic staff consider your need and cultural preferences	Yes	1	
		No	2	
28	Have you seen a doctor from the health clinic in the last 6 months	Yes	1	
		No	2	
29	Were you given enough time to discuss your health or medical problem with the doctor	Yes	1	
		No	2	
30		Yes	1	

	Did the doctor explain the reasons for any treatment or action in a way that you could understand	No	2	
31	Were you given enough privacy when treated and advised?	Yes	1	
		No	2	
32	Did your doctor treat you with respect	Yes	1	
		No	2	
33	Have you had any medicine prescribed for you by a doctor from the health clinic	Yes	1	
		No	2	
		Can not remember	3	
34	Were you given information about the purpose of the medicine?	Yes, enough information	1	
		Some, but I would have liked more	2	
		I got no information, but I want some	3	
		I did not need any information	4	
		Don't know	5	
35	Were you informed about the side effects and adverse symptoms of the medicine prescribed to you?	Yes	1	
		No	2	
36	Were you given enough information about how to use the medicine	Yes, enough information	1	
		Some, but I would have liked more	2	
		I got no information, but I want some	3	
		I did not need any information	4	
		Don't know	5	
37	Is it easy for you to access medical care service when you need it?	Yes, easy	1	
		No, it is difficult	2	
38	Do you know about all the healthcare services the health clinic offers?	I was told about all of them without asking	1	
		I was told after I asked for them	2	
		I was not told about them	3	
39	Did you conduct any laboratory test in the health clinic	Yes	1	
		No	2	
40		0-2 days	1	

	After the laboratory test, how many days did it take for you to receive your test results?	3-5 days	2	
		6-7 days	3	
		More than 7 days	4	
41	Did you get all of your prescribed medicines from the health clinic?	Yes	1	
		No	2	
42	How long do you have to wait to see the doctor in the health clinic	0-30 minutes	1	
		30-60 minutes	2	
		More than an hour	3	
43	In the past year, how frequently did you visit the health clinic?	1	1	
		2	2	
		3	3	
		4	4	
		More than 4 times	5	
44	How easy is it for you to navigate your way in the health clinic, to your destination with ease?	Very difficult	1	
		difficult	2	
		Neutral	3	
		Easy	4	
		Very easy	5	
45	How convenient is the location of the health clinic for you?	Inconvenient	1	
		Somewhat inconvenient	2	
		Neutral	3	
		Convenient	4	
		Somewhat convenient	5	
46	Do you think this health clinic has everything to provide you with proper care?	Yes	1	
		No	2	
47	Do you feel comfortable when you visit the health clinic at camp 14	Yes	1	
		No	2	
48	Based on your need, do you get follow- treatment from the health clinic?	Yes	1	
		No	2	
49	Were you able to communicate properly with the doctor?	Yes	1	
		No	2	
50	If no, what was the reason behind this	I didn't understand him	1	
		He didn't understand me	2	
		He didn't give me more time	3	
		He was not paying attention to me	4	

		Language problem	5	
Target outcome : Primary Health care service are provided at the clinic 24/7				
CHS 2: Communities and people affected by crisis including the most vulnerable groups, consider that the timing of the assistance and protection they receive is adequate				
51	Do you think the services that you get from the health clinic is enough to reduce the burden of ill health for you and your community	Yes	1	
		no	2	
52	Is there enough nurse at the health clinic, in your opinion	Yes	1	
		No	2	
53	In your opinion, the health clinic at camp 14 has adequate medical equipment to serve your community people	Yes	1	
		No	2	
54	In your opinion, the health clinic at camp 14 has adequate number of doctor to serve your community	Yes	1	
		No	2	
55	Is one health clinic enough/effective for your community	Yes	1	
		No	2	
Target outcome: Establish the basis to support community-based health promotion and improve health seeking behavior for FDMNs and host community				
CHS 4: Communities and people affected by crisis consider that they have timely access to clear and relevant information, including about the issues that may put them at further risk				
56	Are you able to access information regarding your health in time?	Yes	1	
		No	2	
57	Are you able to access information regarding health services in time?	Yes	1	
		No	2	
58	Are you able to access information regarding COVID-19 when you want?	Yes	1	
		No	2	
59	Where do you go when you have fever, headache, dysentery or diarrhea for health service and medicine	Health clinic	1	
		Pharmacy	3	
		Kobiraj	4	
		Local healer	5	
60	Where do you go when you have diseases such as skin diseases or any other communicable diseases	Health clinic	1	
			2	
		Pharmacy	3	
		Kobiraj	4	
		Local healer	5	

61	For childbirth where do your community people take pregnant mother for delivery?	Health clinic	1	
		Pharmacy	3	
		Kobiraj	4	
		Traditional birth attendedants	5	
62	How many times should a mother visit the health clinic before child birth	Once	1	
		Twice	2	
		Four time	3	
		Six time	4	
63	How many times should a mother visit the health clinic after child birth	Once	1	
		Twice	2	
		Thrice	3	
		Four time	4	
64	For COVID-19 vaccine and any other vaccine where should you go to take the service	Health clinic	1	
		c		
		Pharmacy	3	
		Others	4	
65	Where should a mother take her child for vaccination	Health clinic	1	
		Pharmacy	3	
		Others	4	
Target outcome: Community volunteers are able to hold health awareness sessions at the four target community				
CHS 8: Communities and people affected by crisis assess staff to be effective in terms of their knowledge, skill, behavior and attitudes				
66	Health clinic doctors' skills are perfect for me and my community	Completely disagree	1	
		Disagree	2	
		Neutral	3	
		Agree	4	
		Completely agree	5	
67	Health clinic doctors have enough knowledge to treat me and my community	Completely disagree	1	
		Disagree	2	
		Neutral	3	
		Agree	4	
		Completely agree	5	
68	Health clinic nurses skills are perfect for me and my community	Completely disagree	1	
		Disagree	2	
		Neutral	3	
		Agree	4	
		Completely agree	5	
69		Completely disagree	1	

	Health clinic nurses have enough knowledge to treat me and my community	Disagree	2	
		Neutral	3	
		Agree	4	
		Completely agree	5	
Health awareness sessions are provided at the clinic by monthly for FDMNs and host communities				
CHS3: Communities and people affected by crisis consider themselves better be able to withstand future shocks and stresses as a result of humanitarian actions				
70	In future shock or stress, I will be able to bounce back from health problems easily	Completely disagree	1	
		Disagree	2	
		Neutral	3	
		Agree	4	
		Completely agree	5	
71	In the future stressful event, I will have a hard time making it through	Completely disagree	1	
		Disagree	2	
		Neutral	3	
		Agree	4	
		Completely agree	5	
72	Because of the current health program, it will not take me long to recover from a stressful event	Completely disagree	1	
		Disagree	2	
		Neutral	3	
		Agree	4	
		Completely agree	5	
73	It will be hard for me to snap back when something bad happens	Completely disagree	1	
		Disagree	2	
		Neutral	3	
		Agree	4	
		Completely agree	5	
74	Because of the health program in this camp, I will usually come through difficult times with little trouble	Completely disagree	1	
		Disagree	2	
		Neutral	3	
		Agree	4	
		Completely agree	5	
75	It will take a long time for me to get over the stress and harm done by the shock	Completely disagree	1	
		Disagree	2	
		Neutral	3	
		Agree	4	
		Completely agree	5	

Objective 2: To verify that the humanitarian principles and standards including CHS are respected				
CHS 5: Communities and people affected by crisis, including vulnerable and marginalized groups, are aware of complaints mechanisms established for their use.				
Q. N	**Questions**	**Response**	**Code**	**E.C**
76	Have you used any feedback mechanism in the health clinic	Yes	1	
		No	2	
77	If yes, from where did you hear about the feedback			
		Health clinic staff told me	2	
		Doctor told me	3	
		I have seen it in the poster at the health clinic	4	
		I have heard about it from my neighbors	5	
		From other patients	6	
CHS5 :Communities and people affected by crisis consider the complaints response mechanisms accessible, effective, confidential and safe.				
78	Are you able to make a complaint or give feedback after getting service from the health clinic easily?	Yes	1	
		No	2	
79	Do you think the method they have set for feedback and complaint is appropriate for you and your community?	Yes	1	
		No	2	
80	Are children able to access this feedback mechanism?	Yes	1	
		No	2	
81	Are people with a disability able to access this mechanism?	Yes	1	
		No	2	
82	Health clinic staff are correcting their activity according to your feedback?	Completely disagree	1	
		Disagree	2	
		Neutral	3	
		Agree	4	
		Completely agree	5	
83	This feedback mechanism at the health clinic is ensuring our safety by protecting our identity	Completely disagree	1	
		Disagree	2	
		Neutral	3	
		Agree	4	
		Completely agree	5	

CHS7: Communities and people affected by crisis identify improvements to the assistance and protection				
84	Doctors in the health clinic have improved their treatment method overtime	Not at all	1	
		A little	2	
		Some	3	
		Quite a bit	4	
		A lot	5	
85	Nurses have improved their care overtime	Not at all	1	
		A little	2	
		Some	3	
		Quite a bit	4	
		A lot	5	
86	Health clinic physical environment has improved overtime	Not at all	1	
		A little	2	
		Some	3	
		Quite a bit	4	
		A lot	5	
87	Health clinic overall service quality has improved over time	Not at all	1	
		A little	2	
		Some	3	
		Quite a bit	4	
		A lot	5	

Qualitative Checklists

Focus Group Discussion (FGD and IDI) checklist for FDMN beneficiaries (male and female)

Third-party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh"

FGD and IDI Checklist for Male and Female FDMN and Host community Beneficiaries

My name is _____ and I am working with DM WATCH. We are currently conducting an third-party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh" implemented by PWJ and DCHT. I invite you to participate in the survey. Taking part in this study is voluntary. You may skip any questions that you do not want to answer. If you decide not to take part, or to skip some of the questions, it will not affect your current or future relationship with us. If you decide to take part, you are free to withdraw at any time. The study is conducted by DM WATCH. Please ask any questions you have now.

Statement of Consent: I understand the aforementioned information and I have received answers to any questions I asked. I consent to take part in the study.

Interviewer's Name	Code	Interviewer's Mobile Number
Date of the Interview	Starting Time (24 hour)	End Time (24 hour)
|__|__|.|__|__|.|__|__|__|__| DD MM YYYY	|__|__|: |__|__| HH MM	|__|__|: |__|__| HH MM
Upazila Name	1. Ukhiya 2. Teknaf	
Type of interview area	1. Camp 2. Host community	
Camp/Union		
Block No		

Participant list:

SL.	Participant Name	Gender	Age	Occupation	Mobile Number

For component 1 and 2:

- Can you all please tell us about yourself one by one? (Your name, job, education, etc.)
- Can you tell us the reason for visiting the Hakimpara clinic? how was the service there? Are you satisfied with the service?
- Are women, children and elderly able to access the clinic properly? What can be done so that they can easily access the clinic?
- What are the Challenges faced by women, pregnant women, elderly people and children while going to the clinic?
- What type of facilities are available for women, pregnant women, elderly people and children at the clinic? please elaborate.
- Do women/pregnant women/ children feel safe at the health clinic, if yes, why? If no, why?
- what other service do you need?
- Because of the Hakimpara clinic and its service, what change did you see in yourself or in the community? How these services helped you or your community?
- Tell us about the feedback and complaint mechanism at the health clinic.
- Did you see any change after giving any feedback? What are these? Give examples.
- Can you tell us about the improvement you have seen in the service from health clinic and health volunteers?
- Any ideas or recommendations you want to share which will make health service for accessible and friendly towards you and your community?

Component 1:

- Have you attended any awareness session at the clinic? what topic they discussed? What you have learned from the awareness sessions?
- What are the services you get from the clinic, are you satisfied with the service? Please elaborate about the services you avail from the clinic, if you are satisfied can you explain why you are satisfied and if not, reasons for your dissatisfaction
- Please tell us about the clinic you visit, about the doctors and nurses, how are they, how do they behave with you?
- Did the doctor and nurse listen and explain to you carefully and give you enough time? Were you able to understand them properly? (Doctors behaviour, attitude, nurses' behaviour attitude, language barrier, hospital location)
  Are you satisfied with the treatment and medicine you get from the clinic? if yes, can you explain why? If not, can you explain why not?
- Please answer
  - What do you prefer more or less medicine?
  - Traditional birth attendants or doctor for delivery?
  - When do you wash your hand?

- What type of skin diseases available in your community? Where do you go for the treatment?
- Is early marriage harmful for women? Do explain
- What do you know about family planning
- Ask women about their menstrual hygiene
- How you receive prescription and medicine?

Component 2:

- Have you attended any awareness session held at your community? What did you learn from the session? Was the sessions helpful to you or your community?
- Did the project staff discussed or have a meeting with your community before giving you support from the clinic? If yes, what did they discuss with you??
- Do you know where to get health service in this camp or from any other place? Where do you go when you don't get proper care from this clinic? From whom did you learned about the health services available in your community?
- Tell us about the community volunteers? What type of information/service do they provide? Your satisfaction level with the community volunteers (community volunteer behavior, attitude, service, language barrier)
- Did you relay the information you learn from the session to your family member? How did you do that and why?
- Tell us about what you have learned so far from the health volunteers?
  Can you tell us from where you can access information about health and other related matters?

In-Depth Interview (IDI) checklist for Camp health workers and volunteers

Third party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh"

IDI Checklist for Camp volunteers and health workers

My name is _____ and I am working with DM WATCH. We are currently conducting an third party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh" implemented by PWJ and DCHT. I invite you to participate in the survey. Taking part in this study is voluntary. You may skip any questions that you do not want to answer. If you decide not to take part, or to skip some of the questions, it will not affect your current or future relationship with us. If you decide to take part, you are free to withdraw at any time. The study is conducted by DM WATCH. Please ask any questions you have now.

Statement of Consent: I understand the aforementioned information and I have received answers to any questions I asked. I consent to take part in the study.

Interviewer's Name	Code	Interviewer's Mobile Number
Date of the Interview	**Starting Time (24 hour)**	**End Time (24 hour)**
|__|__|.|__|__|.|__|__|__|__| DD MM YYYY	|__|__|: |__|__| HH MM	|__|__|: |__|__| HH MM
Upazila name	1. Ukhiya 2. Teknaf	
Type of interview area	1. Camp 2. Host community	
Camp/Union:		
Block No		
Respondent's Name		
Designation:		
Mobile No:		

1. Can you please tell us about yourself? Your educational background? Your past experience as a health volunteer/worker?
2. After the recruitment, what type of training did you receive from this project? Kindly tell us about the overall contents of the training (themes).
3. Kindly tell us about the facilitators who trained you in regards to their knowledge, skill, behavior and delivery of content.
4. How effective was the training in building your skill and knowledge on the related matters? Training time, was it enough? Is there any future plan for training?
5. Tell us about the health and medical need of the FDMN community? Which disease prevails the most and which part of the population is the most vulnerable.
6. What type of health service is available for the FDMN community from the clinic? Are the FDMN community able to access these health services easily?
7. From your point of view is the Hakimpara clinic is enough to meet the need of the FDMN community?
8. What kind of awareness information do you disseminate in the FDMN community? How did you arrange the awareness session, what topics did you discuss during the awareness session?
9. How did you identify the vulnerable individuals in your community? What did you do after identifying the vulnerable individuals?
10. What is the medicine preference and doctor preference of the FDMN beneficiaries in your camp?
11. How did you disseminate information regarding health services, what kind of tools you used for this?
12. What is the follow-up or door-to-door visit process of the health clinic? how does it work? Do you think this process is effective?
13. What type of health services are you giving to the FDMN community? What type of challenge you face when you go to the community to give the service? Please elaborate.
14. What do you do to overcome these challenges?
15. What do you or the health clinic staff do when they are unable to provide the required medical service to an FDMN patient? Can you please explain this matter?
16. As you are giving information on several health issues, do you think your service is making the FDMN community strong to face future difficulties?
17. Tell us about the difficulties you have faced during the door-to-door health service? Please elaborate on this matter.
18. Please provide your valuable recommendation to JPF on this matter?
19. Share your lesson learned with us? What you have learned and what can be done to make the door-to-door visit more effective?

In-Depth Interview (IDI) checklist for Hakimpara clinic doctors and nurses

Third party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh"

IDI Checklist for Hakimpara clinic doctor and nurse

My name is _____ and I am working with DM WATCH. We are currently conducting an third party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh" implemented by PWJ and DCHT. I invite you to participate in the survey. Taking part in this study is voluntary. You may skip any questions that you do not want to answer. If you decide not to take part, or to skip some of the questions, it will not affect your current or future relationship with us. If you decide to take part, you are free to withdraw at any time. The study is conducted by DM WATCH. Please ask any questions you have now.

Statement of Consent: I understand the aforementioned information and I have received answers to any questions I asked. I consent to take part in the study.

Interviewer's Name	Code	Interviewer's Mobile Number
Date of the Interview	**Starting Time (24 hour)**	**End Time (24 hour)**
|__|__|.|__|__|.|__|__|__|__| DD MM YYYY	|__|__|: |__|__| HH MM	|__|__|: |__|__| HH MM
Upazila Name	1. Ukhiya 2. Teknaf	
Type of interview area	1. Camp 2. Host community	
Camp/Union		
Respondent's Name		
Designation:		
Mobile No:		

1. Can you please provide an overview of what your department/ office does?
2. What are your main responsibilities in the department you are working?
3. What do you know about JPF project "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh" implemented by PWJ and DCHT?
4. How have you and your department worked with JPF, PWJ an DCHT?
5. tell us about the health care seeking behaviour of the FDMN community? What do they prefer in case of services?
6. What kind of service do you provide as a part of this project? Did you face any challenges while providing the services?
7. Tell us about the overall health situation of the camp? Which diseases occurs the most? What type of patient you get all the time and how you serve them?
8. What type of service do you have for children and mothers? Are they able to avail the service easily?
9. Have you receive any training from the project? What was the training about? Why did you attend the training?
10. Did you find the training useful? How?
11. Please tell us about the contents of the training? How important were the contents?
12. Kindly tell us about the facilitator of training session. (Their behaviour, knowledge, skill, attitude, delivery of the training contents)
13. Kindly tell us about the training environment and schedule, how friendly and effective it was?
14. Kindly tell us about the training time and was it enough?
15. Is there anything else about the JPF project that you would like to talk about?
16. Do you have any recommendations for further improvement of the Programme?
17. Share your lesson learned with us? What you have learned and what can be done to make the PHCmore effective?

Key Informant Interview (KII) check list for Camp-in-Charge

Third party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh"

KII Checklist for KII of Camp in Charge

My name is _____ and I am working with DM WATCH. We are currently conducting an third party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh" implemented by PWJ and DCHT. I invite you to participate in the survey. Taking part in this study is voluntary. You may skip any questions that you do not want to answer. If you decide not to take part, or to skip some of the questions, it will not affect your current or future relationship with us. If you decide to take part, you are free to withdraw at any time. The study is conducted by DM WATCH. Please ask any questions you have now.

Statement of Consent: I understand the aforementioned information and I have received answers to any questions I asked. I consent to take part in the study.

Interviewer's Name	Code	Interviewer's Mobile Number
Date of the Interview	**Starting Time (24 hour)**	**End Time (24 hour)**
|__|__|.|__|__|.|__|__|__|__| DD MM YYYY	|__|__|: |__|__| HH MM	|__|__|: |__|__| HH MM
Upazila Name	1. Ukhiya 2. Teknaf	
Type of interview area	1. Camp 2. Host community	
Camp/Union		
Block no		
Respondent's Name		
Designation:		
Mobile No:		

1. Discuss the overall health situation in the camp. Discuss the current community-based health sector mechanisms that are actively identifying, reporting, and referring health cases and how efficient and effective are they?
2. What are the differences in health structures between host and camp communities? And how?
3. Are the humanitarian projects meeting the local needs and addressing the issues concerning health? What extent do they meet the needs? Do you think the host community is overlooked in the existing projects?
4. Could you please say about the activities of DCHTand their contribution to the Rohingya situation?
5. Inclusivity of the projects undergoing in the camps. Any overlapping in-between collaboration? Are there any overlapping health care services?
6. Have you noticed any change in the health sector? How do you explain the changes that have been made in health issues compared to 2017?
7. How do you explain the health-related challenges, roam for improvement, type of interventions needed?
8. In your personal opinion what changes in policies (health related) need immediate attention, which humanitarian organizations should strictly follow? (Policy change and reforms)
9. How these project interventions could provide more support in this area? Please describe a bit.
10. Did PWJ maintain regular communication with you? Did they inform you about their ongoing activity and request your participation in their decision making process?
11. What is your recommendation for PWJ in their Hakimpara clinic activity?
12. Regarding the health sector and operation of a health clinic in the camp, what is your lesson learn? And what is the best practice from your perspectives.

Key Informant Interview (KII) check list for representative from JPF, Camp Health Focal

Third party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh"

KII Checklist for representatives of JPF/ SAG (health), Local Government and other INGOs

My name is _____ and I am working with DM WATCH. We are currently conducting an third party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh" implemented by PWJ and DCHT. I invite you to participate in the survey. Taking part in this study is voluntary. You may skip any questions that you do not want to answer. If you decide not to take part, or to skip some of the questions, it will not affect your current or future relationship with us. If you decide to take part, you are free to withdraw at any time. The study is conducted by DM WATCH. Please ask any questions you have now.

Statement of Consent: I understand the aforementioned information and I have received answers to any questions I asked. I consent to take part in the study.

Interviewer's Name	Code	Interviewer's Mobile Number
Date of the Interview	**Starting Time (24 hour)**	**End Time (24 hour)**
|__|__|.|__|__|.|__|__|__|__| DD MM YYYY	|__|__|: |__|__| HH MM	|__|__|: |__|__| HH MM
UpazilaName	1. Ukhiya 2. Teknaf	
Type of interview area	1. Camp 2. Host community	
Camp/Union		
Respondent's Name		
Designation:		
Organization's name		
Mobile No:		

Introduction:

1. Can you please provide an overview of what your department/ office does/?
2. What are your main responsibilities in the department?
3. What do you know about JPF project -"Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh" implemented by PWJ and DCHT ?
4. How have you and your department worked with JPF, PWJ and DCHT ?

CHS1: Humanitarian response is appropriate and relevant (Relevance)

5. Did PWJ talk with your organization about how the programme should be designed, either before or during the programme?
6. How does this project align with relevant national policy/ guidelines/ strategies?
7. Was the project able to contributes to Joint response plan 2021 goals, outcomes, and outputs and also to national development priorities? Please elaborate.
8. Do you think that the project was designed according to the needs of the targeted beneficiaries? Did the project reach most marginalized segments of the population including youth, minorities, persons with disabilities (PWD), and other vulnerable groups? Was the project able to address the needs of the targeted beneficiaries?
9. Did the project interventions were aligned with the minimum package of essential services of FDMNS?

CHS 2: Humanitarian response is effective and timely (Effectiveness)

10. Do you think that JPF project 6 was implemented timely and adequate interventions were in place for the FDMN?
11. Was the project able to ensure proper access of the FDMN at the health clinic and was it able to provide primary health care?
12. Did the project bring any change to the lives of the FDMN population in the camp 14?

CHS 3: Humanitarian response strengthens local capacities and avoids negative effects (Impact and sustainability)

(Impact:)

13. Have there been any changes in national/local policy/strategies/guidelines and practice in support of health and medical assistance because of your department's engagement with JPF and PWJ?
14. Do you think that the project has helped your department in strengthening capacity and skill on primary health care and medical assistance for the FDMN? If yes, how?
15. Have you noticed any shifts in institutional policy and practice (for instance, modality of providing services, institutional setup, etc.)? because of project interventions (sub-national, national, regional, or international levels) since the project started?
16. How will the intervention contribute to changing the FDMN community for the better?

(Sustainability:)

17. Do you think the positive outcomes of the project will sustain in long-term? Please elaborate.

CHS 4: Humanitarian response is based on communication, participation, and feedback? (Relevance and coherence)

18. What are the other projects working on a similar thematic area in the camps? Do you think that JPF project is complementing other projects programmatically? Please elaborate.
19. How does PWJ engage in joint efforts with your and other agencies?
20. What coordination mechanisms exist in the FDMN for donors, INGOs, and national civil society organizations working on health and medical assistance to come together.

CHS 6: humanitarian response is coordinated and complementary (cover and coherence)

21. Did the project coordinate and worked with other organizations/institutions? If so, what have been the results of this joint work? Did you see any gaps in the response of the program?

Recommendation:

22. Is there anything else about the JPF project that you would like to talk about?
23. Do you have any recommendations for the Programme?

Key Informant Interview (KII) check list for representative from PWJ, DCHT

Third party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh"

KII Checklist for representatives of PWJ and DCHT

My name is _____ and I am working with DM WATCH. We are currently conducting an third party evaluation of "Primary Health Care Service Support Project for Forcibly Displaced Myanmar Nationals (FDMNs) and Host Community (HC) in Cox's Bazar District of Bangladesh" implemented by PWJ and DCHT. I invite you to participate in the survey. Taking part in this study is voluntary. You may skip any questions that you do not want to answer. If you decide not to take part, or to skip some of the questions, it will not affect your current or future relationship with us. If you decide to take part, you are free to withdraw at any time. The study is conducted by DM WATCH. Please ask any questions you have now.

Statement of Consent: I understand the aforementioned information and I have received answers to any questions I asked. I agree to take part in the study.

Interviewer's Name	Code	Interviewer's Mobile Number
Date of the Interview	Starting Time (24 hour)	End Time (24 hour)
|__|__|.|__|__|.|__|__|__|__| DD MM YYYY	|__|__|: |__|__| HH MM	|__|__|: |__|__| HH MM
Upazila Name	1. Ukhiya 2. Teknaf	
Type of interview area	1. Camp 2. Host community	
Camp/Union	Camp/Union No.	
Respondent's Name		
Designation:		
Mobile No:		

Introduction:

1. Can you please tell me about your role in JPF project?

CHS1: Humanitarian response is appropriate and relevant (Relevance)

2. How does the project align with relevant national policy/ guidelines/ strategies regarding FDMN response?
3. To what extent, and how does the project contribute to Joint response plan 2021 goals and JPF's country goals, outcomes, and outputs and also to national development priorities?
4. What mechanisms were placed in project planning, designing, and implementation to address the needs and cultural preferences of the FDMNs? What approaches were taken to reach and address the needs of most marginalized segments of the population including youth, minorities, persons with disabilities (PWD), and other vulnerable groups?
5. To what extent the project took account of the capacities, skills, and knowledge of the FDMN while designing and implementing the project activities?
6. What mechanisms were placed to capture complaints/feedback from the project beneficiaries, target groups, and other stakeholders?
7. How were the project interventions aligned with the minimum package of essential services of FDMNS?
8. Till now how many FDMN patient did the project served?
9. How did the project ensure quality health services? What monitoring and reporting mechanism was in place?
10. What services are provided by the project to FDMN population? Specially for pregnant and children?
11. Did the project conduct any gap analysis before implementing the intervention? How did they do it and what were the findings from the gap analysis?
12. Who conducted the health awareness session at the hospital? What was the reason behind this session? Were the objective of this session achieved and how was it achieved?

CHS 2: Humanitarian response is effective and timely (Effectiveness)

13. Do you think that JPF project was implemented timely and adequate interventions were in place for the FDMN?
14. In your view, what are the main impacts of the project? To what extent has it achieved its objectives and results? What is the evidence for this?
15. What are the most significant achievements of the project? Why and what factors have contributed to these achievements?
16. In which areas does the project have the fewest achievements? What have been the constraining factors and why? How can they be overcome?
17. What are the gaps in the achievement of objectives and results and what are the reasons some were met while others were not? To what extent have outside factors affected results?
18. How did the project ensured that the community volunteers and health workers gained enough knowledge to ensure household visit and conduct awareness sessions?
19. How did the project identified vulnerable community and what type of services were given to the vulnerable community?
20. Was the project able to ensure safe and secure access to health service from the clinic? And how? was the project able to provide 24 hours service to pregnant women and how?
21. How did you ensure that the awareness session messages were relayed perfectly to the community people and community people were able to understand the messages?

22. Was the project able to ensure patients satisfaction throughout its implementing period? How did the project maintain this and how did you know that the patients were satisfied with the service?
23. Was the project able to change the health seeking behaviour of the community people? How and why?

CHS 3: Humanitarian response strengthens local capacities and avoids negative effects (Impact and sustainability)

(Impact:)

24. Because of the project intervention, do you think the FDMNs will be able to withstand future shocks and stresses?
25. How has the project brought changes in the lives of the people and their communities in line with the resulting framework of project . How will the intervention contribute to changing the FDMN community for the better?
26. To what extent, and how does the project address vulnerabilities regarding health and medical assistance?

(Sustainability:)

27. What measures were taken to ensure the sustainability of the project activities and impact? What was the strategy to ensure that the impact from the program is long-term and sustainable?
28. Do the existing legal frameworks, policies, governance structures, and processes within which the project operates pose risks that may jeopardize the sustainability of project benefits?

CHS 4: Humanitarian response is based on communication, participation, and feedback? (Relevance and coherence)

29. Do you consider that the capacity of local authorities and leaders and organizations (who are responsible for responding to crises)has been increased? Did the project analyze local systems, capacity, and resources before implementing the project?
30. How does this project provide information regarding health and medical awareness to the FDMN community? How can FDMN access this information easily?
31. When you train the community volunteers and medical staff, did you train them on the rights of the FDMN and how they can uphold those rights during their activities?
32. What are the other projects working on a similar thematic area in the camps? Do you think that JPF project is complementing other projects programmatically? Please elaborate.
33. Do you engage in joint efforts with other agencies? How do you engage them?

CHS 5: Complaints are welcomed and addressed (Coherence)

34. Did you consider the feedback of the beneficiaries to improve your interventions further down the project timeline? Are FDMN community people aware of the feedback mechanism? Is it accessible to all FDMNs (old, young, and other marginalized groups)?
35. How are complaints investigated, resolved within the time frame? What type of complaints do you usually get from the health clinic? How does the feedback mechanism work?

CHS 6: humanitarian response is coordinated and complementary (cover and coherence)

36. How has the project coordinated and worked with other organizations/institutions? If so, what have been the results of this joint work? Did you see any gaps in the response of the program?
37. To what extent local partners are involved in critical aspects of project implementation? How do they participate in the decision-making process? Did the project consult with local authorities, leaders before implementing the project?
38. Tell us about the coordination mechanism for this project. How do agencies share information with each other?

39. Can you explain the referral mechanism of the clinic?

CHS 7: Humanitarian actors continuously learn and improve (Impact and coherence)

40. To what extent have the assistance and protection given from the project improved over time? In which area did the improvement come?

41. How did the project know that improvement was needed? (through learnings from other projects or beneficiaries' views)? Do you incorporate the FDMN beneficiaries' view to improving your response?

42. As a part of coordination, are all the stakeholders related to this project informed about the type of health and medical assistance you are providing? Please elaborate on this matter.

CHS 8: Staff are supported to do their job effectively, and are treated fairly and equitably (effectiveness and coherence)

43. How do JPF and PWJ support their project staff? What type of facilities and remunerations are available? Did all the staffs satisfactorily meet their performance objectives?

(How many health workers attended the training, number of trainees whose understanding improved due to training)

CHS 9: Resources are managed and used responsibly for their interceded purposes (Efficiency)

44. What monitoring and evaluation mechanisms were placed to monitor the quality of implemented activities? Were realistic and clear milestones and targets set for this project?

45. What were the learnings from monitoring in implementation? Were the learnings captured systematically and reflected upon?

Recommendation and lesson learned

46. What are the lessons and learning from the implementation of the project/s? are the lessons learned documented and disseminated to relevant stakeholders? How?

47. Is there anything else about the JPF project that you would like to talk about?

Do you have any recommendations for future programming in these areas?

Physical observation checklist for the clinic

Standard	Requirements	Score (tick appropriate box)	Remarks
The health clinic shall be planned, managed, and comply with the applicable guidelines, policies, gazette notices and regulations.	The design of the facility is approved by the relevant authorities.	Yes No	
	The design of the facility complies with the infrastructure norms and standards.	Yes No	
Physical facilities and Environmental conditions			
The health clinic layout shall provide adequate space for quality health service delivery, while ensuring safety of personnel, patients and visitors.	The facility layout is appropriate for delivering health services.	Yes No	
	The service delivery rooms are well ventilated.	Yes No	
	The service delivery rooms are well lit.	Yes No	
	The service delivery rooms have the required equipment	Yes No	
	The service delivery rooms have hand hygiene facilities	Yes No	
	The facility has an accessibility ramp for disabled/wheelchair patients	Yes No	
Environment monitoring shall be done in all relevant areas.	Environmental monitoring done in all relevant areas for the following (MOV-Monitoring log sheets, observation)		
	Humidity	Yes No	
	Light	Yes No	
	Electrical supply	Yes No	
	Temperature	Yes No	
	Sound	Yes No	
	Vibrations	Yes No	
Sanitation and Hygiene			
The health facility infrastructure is designed, constructed and maintained to facilitate proper cleaning and drainage, infection prevention	The facility maintains smooth surfaces throughout to facilitate cleaning	Yes No	
	Design, construction and maintenance of the health facility allows fast drainage of	Yes No	

and control and pest, rodents and scavenger control	water in sinks, wash basins, ablution and laundry area		
	Maintenance of the health facility aids control of pests, rodents and scavengers	Yes No	
Facility shall ensure there is adequate safe running water at all times	Reliable sources of safe running water	Yes No	
Management of waste and hazardous materials			
The health facility shall implement measures on use, handling, storage and disposal of hazardous materials and waste.	Safe location for hazardous materials and wastes	Yes No	
	Labelling of hazardous materials and wastes	Yes No	
	Access to certified incinerator (MOV-Interview with staff)	Yes No	
	Disposal protocols in place (MOV- disposal protocols)	Yes No	
	Facility reports incidents to allow corrective actions (MOV- periodic reports)	Yes No	
	The facility has competent personnel responsible for waste disposal (MOV-designated officer with terms of reference or contract in case of outsourced services)	Yes No	
Lightning and security			
The health facility shall have a reliable and stable power supply.	The facility has a reliable and stable power supply	Yes No	
	The facility has a power back-up (MOV-evidence of functional and serviceable power back-up equipment)	Yes No	
The health facility shall have adequate precautions to ensure the security of its premises, staff, patients and visitors	The facility has a documented security plan (MOV-Documented security plan)	Yes No	
	Facility implements the security plan (MOV- fencing, security guards, metallic grills in relevant areas, secure locks)	Yes No	
Disaster Management, emergency preparedness and risk reduction			
The health facility shall have in place measures to facilitate emergency preparedness, disaster management and risk reduction.	Training programs on emergency preparedness, disaster management and risk reduction	Yes No	
	Standard operating procedures on emergency preparedness, disaster management and risk reduction	Yes No	

	Fire, safety and security drills	Yes No	
	Emergency exits and fire assembly points	Yes No	
	Firefighting equipment	Yes No	
	First aid kits	Yes No	
	The facility has personnel responsible for emergency preparedness, disaster management and risk reduction	Yes No	
Health clinic maintenance			
The healthcare facility infrastructure shall be maintained in a functional condition.	The facility has a maintenance unit with trained staff/ access to maintenance services (MOV-HR records)	Yes No	
	The facility has a costed routine and periodic maintenance plan (MOV-Maintenance plan)	Yes No	
	The facility implements the routine and periodic maintenance plans (MOV-Reports of corrective actions, up to date service or service contracts for outsourced services)	Yes No	
Planning for procurement			
Approved plans for procurement of goods and services are available and incorporated in the facility budget.	The facility has an approved procurement plan (MOV-Documented plan for current financial/calendar year, minutes)	Yes No	
	The procurement plan is incorporated in the facility budget. (MOV-Approved budget)	Yes No	
Equipment management			
The health facility shall have adequate equipment as per scope of service.	The facility has a defined list of equipment and quantities required to provide each of the services offered (MOV-File with list of equipment)	Yes No	
	The facility has adequate number of functional equipment as per the scope of service (MOV-Sample three service delivery areas one for routine outpatient care, support services and inpatient care)	Yes No	

	The facility verifies that upon installation and before use, equipment is capable of achieving the necessary performance and complies with relevant requirements. (MOV- Records of installation, records of validation and verification)	Yes No	
All equipment shall be operated by trained and authorized personnel.	The facility equipment is operated by trained and authorized personnel (MOV-HR records)	Yes No	
Operation manuals on the use, safety and maintenance of equipment are available.	All equipment has operation manuals/SOPs for use, safety and maintenance. (MOV – manuals available on site)	Yes No	
	Equipment operation manuals are in a language that is understood by users (MOV – observation of manuals)	Yes No	
	There is a preventive and periodic maintenance plan for all equipment in the facility (MOV-Maintenance plan)	Yes No	
Referral system			
The facility shall ensure that referral guidelines and SOPs are available and communicated to the relevant staff	National Referral Guidelines are available and accessible to relevant staff (MOV- confirm availability/accessibility to the guidelines)	Yes No	
	There is evidence that patients are referred to the appropriate health facility/specialist (MOV- referral register)	Yes No	
Health records			
The health facility shall have a system for data management	The health facility has data collection tools (MOV-Observe at the records unit and one service delivery area)	Yes No	
	The health facility has periodic data analysis reports (MOV-Filed reports)	Yes No	
	Results of analysis are disseminated to facility staff for decision-making (MOV-Filed reports)	Yes No	

Annex 4: Pictures from the Field

Picture 1: Monthly Infection Prevention Control Score Card at Hakimpara Clinic

Picture 2: Toilet cleaning Checklist at Hakimpara Clinic

Picture 3: Health worker advising a patient at Hakimpara Clinic

Picture 4: Medical waste incinerator at Hakimpara Clinic

Picture 5: Hakimpara Clinic

DM WATCH LIMITED

Shatabdi Haque Tower (3rd Floor)
586/3, Begum Rokeya Sharani
West Shewrapara, Mirpur
Dhaka-1216, Bangladesh
Hotline: +88028090617 | +88 01328964266
Email: info@dmwatch.com
Website: www.dmwatch.com