INCEPTION REPORT

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Evaluation of Community Mobilization Volunteers (CMV) Network on Improving the Knowledge, Attitudes, Behaviors, and Practices (KABP) of the Rohingya Communities

Presented to:

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About IPA-Bangladesh

Innovations for Poverty Action (IPA) is a 501(c) (3) non-profit organization dedicated to building a world with more evidence and less poverty. To that end, IPA designs and evaluates potential solutions to global policy problems and supports decision-makers to use this evidence in policy creation. IPA specializes in conducting randomized controlled trials (RCTs), because this rigorous evaluation methodology makes it possible to determine to what extent changes in people's lives can be attributed to a given poverty intervention program. IPA has a proven history of conducting RCTs and other rigorous impact evaluations with a broad range of service providers in a variety of settings across the developing world. Since our founding in 2002, IPA has worked with over 600 leading academics to conduct over 900 such evaluations in more than 50 countries.

Innovations for Poverty Action Bangladesh (IPAB) has been conducting impact evaluations since 2010, and through this successful history of work, has developed a comprehensive, local research infrastructure for administering large-scale surveys and randomized evaluations. Our research teams seek to determine which development interventions work, why they work, and how to share results with relevant policymakers and practitioners. IPA- B has grown to a current staff of 56 full-time employees, overseen by Country Director Mohammad Ashraful Haque. Other staff include: one Research Manager, three Research Coordinators (RC), fourteen Research Associates (RA), twenty-six Research Analysts and Field Managers and seven administrative staff. Our Bangladesh staff have studied at reputed universities both within Bangladesh as well as internationally, and every member at the Research Associate-level and above possesses rigorous academic training in economics, public policy, statistics, and other relevant fields. Our research staff complete courses in impact evaluation design, randomized controlled trials, implementation, management of field experiments, Survey CTO, STATA programming and research ethics involving human subjects as part of their on-boarding in the organization.

Background

According to the Inter Sector Coordination Group (ISCG) Situation Report of August 2019, there are a total of 911,566 Forcibly Displaced Myanmar Nationals (FDMNs) in Cox's Bazar who fled Myanmar since 25 August 2017 due to extreme violence and atrocities. Among them 914,998 Rohingyas[1] have been identified in camps according to the Refugee Repatriation and Relief Commissioner (RRRC) UNHCR registration exercise (including

[1] Data as of 30 September 2019. A full verification exercise was undertaken, but the results have not been published.

34,172 registered before 31 Aug 2017). Of these, 54 per cent are children under 18 and 19 per cent are under 5 years. Fifty-two per cent of the Rohingya refugee population is female. No detailed data is available on disability, with UNHCR estimating that four per cent of the population faces some sort of impairment. In addition to that, 5,812 Rohingyas are estimated to be in host communities in Ukhia and Teknaf upazilas as per Needs and Population Monitoring (NPM) round 15.

A major area of concern among these displaced communities is health, particularly, a lack of knowledge about where and how to access healthcare services. These refugees also lack vital information on childcare and key life-saving behaviors. As such, the practice of such behaviors is very low among these communities. To address the issue, UNICEF and BRAC initiated a Community-Mobilization Volunteers (CMVs) network that employs evidence- based communication with communities (CwC) and social and behavioral change communication (SBCC) strategies to improve knowledge, attitude, practice and behavior (KAPB) related to childcare and healthcare access.

IPA lead data collection activities for the baseline (2018) and midline surveys (2019) on knowledge, attitude, practice and behavior (KAPB) regarding critical lifesaving issues from the Rohingya and host communities. We were scheduled to start the Endline survey for this Impact Evaluation in April 2020, however, given the COVID-19 pandemic and the resultant lockdown, the field data collection was put on hold.

Impact of COVID-19 on the Rohingya Refugee Camps

On 30th January 2020, COVID-19 was declared a Public Health Emergency of International Concern on the recommendation of the WHO's Emergency Committee. By 11th March 2020, WHO declared the virus a pandemic—the first coronavirus to be declared as such. Bangladesh recorded its first COVID-19 cases in early March 2020.

Currently, more than 900,000 Rohingya reside in the world's largest, most densely populated refugee camp in Cox's Bazar, Bangladesh. With a population density of 40,000 people/square kilometer, the risk of COVID-19 infection is high[2]. The risk of morbidity and mortality is compounded by a nexus of factors, including local transmission (within Bangladesh), limited health infrastructure, poor health-seeking behaviors, shared sanitary facilities and general unhygienic living conditions. Furthermore, towards the end of March 2020, humanitarian

2 https://www.wvi.org/publications/report/world-vision-rohingya-refugee-response/rohingya-refugee-response-covid-19

operations were restricted in the camps to only essential services and assistance, to minimize the risk within camps settings.

As of 30th September 2020, a total of 261 confirmed cases of COVID-19 had been identified in the Rohingya refugee camps (151 new cases in September) with 8 deaths, according to the Institute of Epidemiology Disease Control and Research (IEDCR). There was a significant increase seen in testing throughout the month, with the total number of tests reaching 10,988, an increase of almost 50 per cent from August. As per IEDCR, a total 4,506 confirmed COVID-19 cases and 65 deaths were reported in Cox's Bazar District.[3]

Purpose of Evaluation

The purpose of the evaluation is to generate evidence on what worked and what did not work and to document lessons from the implementation of Community Mobilization Volunteers (CMVs) network on the Knowledge, Attitudes, Behaviors, and Practices (KABP) of the Rohingya communities to inform future C4D interventions for UNICEF and its partners in humanitarian settings.

The primary users for the findings of this evaluation are the UNICEF C4D sector and other relevant sectors in UNICEF. Potential secondary users are UN agencies, Government of Bangladesh and CSO partners. Findings and recommendations from the evaluation are expected to become a reference document for the planning of evidence-based C4D interventions in humanitarian settings in the future.

Objective of the Assignment

The evaluation aims to assess the relevance, effectiveness, impact, efficiency, and sustainability of the CMV network. While the Midline survey set the foundation to monitor the impact on the KAPB of the Rohingya refugees, the evaluation will be an opportunity to conduct a broader assessment of the CMV network through the OECD-DAC criteria.

Specific objectives:

a. **Assess the extent to which the CMV network led to changes in knowledge, attitudes, behaviors and practices (KABP) of the Rohingya community including pregnant and lactating women and young children; and to the extent**

[3] https://reliefweb.int/sites/reliefweb.int/files/resources/final_iscg_sitrep_-_september_2020.pdf

possible, determine contribution to the changes among Rohingya to the program.

b. **Assess the extent to which the CMV network led to changes in capacities of CMVs, including personal/technical skills regarding key life-saving messages, interpersonal communication (IPC), community engagement, and leadership skills.**
c. **Assess the relevance, efficiency and sustainability of the program.**
d. **Assess the extent to which human rights approach, equity and gender equality were integrated and addressed in programme implementation.**
e. **Identify and validate lessons learned, good practices and examples and efforts that enhanced programme implementation and provide actionable recommendations**

Scope of the Evaluation

An original goal of the CMV program was a quantitative impact evaluation of the program. In light of the impacts of the coronavirus pandemic and response, this impact evaluation is no longer feasible in its original form. Given that it has been over ten months since the CMV intervention started to scale down, a main concern for the project at this stage is the ability of the refugee population to accurately provide survey responses. Furthermore, the profound changes that camps have experienced in the past ten months will complicate accurate recall.

Most notably, the coronavirus pandemic was a shock for the population and a number of interventions/programs/safeguards were developed in response to the crisis. These changes affected the original RCT design, specifically, the control group for the RCT. It is highly probable that the control group received similar knowledge interventions as the CMV program through some other means. Additionally, data provided by BRAC also described significant inter branch/ camp movement since the Midline survey, distorting the original saturation design.

Given these two factors, conducting a standard endline survey may not fully measure the impacts of the CMV evaluation in this current period of time. We could understate the effects of the CMV program on the population because of significant time lag, statistical power concerns and the large exogenous shock of the pandemic.

Despite these changes, other opportunities for valuable learning still exist. UNICEF and IPA still want to derive useful learning from the implementation of the CMV program, and therefore we propose a survey of the CMV Volunteers + a small batch of treated households

in order to inform future programming. The survey will include a host of questions included in the previous Baseline and Midline surveys. For the evaluation, we will focus on questions relating to health behaviors and information access. Following the program's implementation and depending on the context of the evaluation (e.g. some indicators are quick to respond, others slow), refugee participants exposed to the program can be expected to have entrenched knowledge/ practices and behaviors at this stage. While we cannot directly attribute changes in survey responses to the CMV program, we can look at changes in survey responses over a period of time, from Baseline/Midline to the Endline Survey.

The evaluation approach and data collection and analysis methods will be human rights based, including child rights based and gender sensitive. All data will be disaggregated by sex, age and ability level. We will abide by the UNEG Guidance on Integrating Human Rights and Gender Equality in Evaluation, and the UN-SWAP Evaluation Performance Indicator.

The evaluation will cover the timeframe of the CMV network from the end of 2017 to end-December 2020 in seven Rohingya Refugee camps. The stakeholders to be covered by the evaluation will include a broad range of age groups in Rohingya refugees such as adults, pregnant and lactating women and young children.

Methodology for Endline Evaluation

Our overall approach to the evaluation will be consultative, participatory, inclusive, and will employ mixed forms of data collection from both primary and secondary sources. We will conduct a thorough secondary review covering the various programmatic documents from UNICEF and BRAC. This will be augmented through validating our findings with primary interactions with various stakeholders including UNICEF staff, BRAC staff and stakeholders within the camps. The information from secondary and primary research will be triangulated as per the evaluation matrix. The evaluation exercise will also address gender in dimensions relevant to the scope of this assignment i.e. Knowledge, Attitudes, Behaviors, and Practices of Rohingya Refugee women and the impact of the program on the female volunteers that implemented the program.

We will identify and assess cross-cutting and inter-related development themes that emerge as central to achieving equity and underpin progress in all programs and interventions, for both the short- and long-term. The priority cross-cutting themes will include, but not limited to, empowering women, capacity development for the CMVs, and embedding effective planning and monitoring.

Data Collection

The data collection process will be conducted remotely over phone, using phone-based survey tools and we will maintain quality assurance accordingly.

In principle, the same data collection tools as the Midline Survey will be used to ensure comparability, where possible slight modifications may be necessary given the change to remote data collection techniques and to explore any topics that raised concern at baseline and midline or to better understand the CMV network. As discussed previously with UNICEF, the endline survey will focus exclusively on the impact of the CMV program. We will not be surveying households from the host communities.

We will collect quantitative data on themes relating to WASH, childcare, services, nutrition and qualitative data on programme understanding, difficulties, relationship with CMVs and so on from households. On a similar vein, we will collect demographic data and qualitative feedback on the implementation of the CMV program and its usefulness from the CMVs themselves. Furthermore, we will collect feedback on the CMV programme including operations, challenges, modifications and outcomes from implementing partners, government agencies that were closely involved in the programme alongwith community leaders in the Rohingya camps. As stated above, this information will be triangulated with insights from our desk review.

One of the key challenges for the Endline survey is the considerable time lag between the end of the CMV intervention (starting end-Dec 2019 to a shutdown by March 2020), the COVID-19 pandemic and completing the survey purely through remote survey work. Specifically, we will limit the recall bias when discussing the CMV intervention in two ways:

-- We will use distinct before/after stories due to the nature of the pandemic and the lockdown. We will specifically ask for results before the lockdown came into effect, helping them to bifurcate between both time periods.

-- We will also ask survey questions on the situation during the lockdown (post March 2020) to track changes in the respondents' experience. We will report all these responses to UNICEF.

Draft tools are shared in a separate attachment.[5] The below table provides a summary of stakeholder categories and nature of tools to be employed.

[4] This decision was made on an Inception call with UNICEF. Two key drivers: a) CMV program was only implemented in the camps b) Noisy comparability with camp respondents.

[5] Please note that only QS1 was used in the previous Baseline and Midline Surveys. All the other surveys (QS2, QL1, and QL2) are new surveys to complement our efforts to produce a summative evaluation.

Table 1: Nature of tools to be employed with different stakeholders

Category	**Nature of Tool**	**Acronym**
Treated Households	Quantitative Survey, In-depth Interviews	QS1, QL1
CMVs	Quantitative Survey, In-depth Interviews	QS2, QL2
UNICEF Field office staff	Key Informant Interviews and Discussion	QI

Category	**Nature of Tool**
BRAC Field office staff	Key Informant Interviews and Discussion
Other stakeholders	In-depth Interview and Discussion

List of tools:

1) Quantitative survey for treated households (QS1)
2) Quantitative survey for CMVs (QS2)
3) Qualitative interview for treated households (QL1)
4) Qualitative interview for CMVs (QL2)
5) Qualitative Interviews (QI) with

--- BRAC implementation managers

--- UNICEF implementation managers

--- Other stakeholders from NGOs, government authorities

Evaluation Questions

The evaluation will be informed by the OECD-DAC criteria of relevance, effectiveness, efficiency, impact and sustainability. In addition, gender and human rights will also be addressed.

Given the necessary methodological changes, an evaluability assessment matrix (see Table 2 below) has been developed outlining how each of these evaluation questions will be addressed methodologically and to what degree the findings will be conclusive, based on the methods and data access and availability. “High” is associated with strong data collection mechanisms, sound evaluation methods and clear identification strategies to isolate responses for a particular evaluation question. “Medium” refers to a satisfactory level of data collection mechanism, evaluation methods and clear identification strategies. A “Low” level of evaluation criteria refers to considerable uncertainty with regard to data quality due to limited channels to record survey responses that are reliable.

Table 2

Obj	Evaluation Criteria	Evaluation Question	Source(s) of data	Methodology	Evaluability Criteria
1	Relevance/ Appropriateness	1. To what extent was the CMV network relevant and responsive to the needs and priorities of the Rohingyas, including those most vulnerable?	QS1, QS2, QL1, QL2, QI	Survey, IDIs, KIIs	High
		2. To what extent was the program aligned and responsive to relevant human rights (including child rights and gender) global, regional and national legal and policy frameworks?	Programme documents/ reports, staff from UNICEF & NGO partners, QS1, QS2, QL1, QL2, QI	Desk review, KIIs	High
2	Effectiveness	1.To what extent did the CMV network lead to changes in the knowledge, attitudes, behaviors and practices (KABP) of the Rohingya refugees? How has this been affected by COVID-19?	QS1, QS2, QL1, QL2, QI	Survey, IDIs, KIIs	Medium
		2. To what extent did the intervention contribute to equitable participation and benefits to various groups (adults, the elderly, and adolescents of both sexes, as well as pregnant and lactating women and young children)?	QS1, QS2, QL1, QL2, QI	Survey, IDIs, KIIs	Medium
		3.To what extent did the CMV network lead to changes in capacities of CMVs including personal/technical skills regarding key life-saving messages, interpersonal	QS1, QS2, QL1, QL2, QI	Survey, IDIs, KIIs	Medium

		communication (IPC), community engagement, and leadership skills?			
		4. What enabled or hindered the achievement of outcomes?	NGO partners, QS1, QS2, QL1, QL2, QI	Survey, IDIs, KIIs	Medium
3	Impact	1. What was the perceived and measurable impact of the different CMV intervention approaches, as implemented in 2019, on KAPB among the Rohingya refugees living in the camps?	QS1, QS2, QL1, QL2, QI	Survey, IDIs, KIIs	Medium
		2. Did the programme lead to any positive or negative unintended results?	QS1, QS2, QL1, QL2, QI	Survey, IDIs, KIIs	Medium
		3. To what extent was gender and human rights (including child rights) advanced as a result of the CMV programme?	QS1, QS2, QL1, QL2, QI	Survey, IDIs, KIIs	Medium
		4. Was there any evidence of or perceived spillover effects of the programme into non- programme areas? If so, was there evidence of the main change factors being spilled over?	QS1, QS2, QL1, QL2, QI	Survey, IDIs, KIIs	Low
4	Efficiency	1. What was the cost-effectiveness of the programme in terms of inputs to outputs?	Partners report, progress report sourced from UNICEF, QI	Desk review	Medium
		2. What were the factors affecting the pace and quality of implementation (i.e., high CMV dropouts) and how could these have been better mitigated?	QS2, QL2, QI beneficiaries, NGO partners	Desk review, KIIs	Medium
		3. To what extent were the outputs (i.e., number of	QS2, QL2, QI progress	Desk review, Surveys, IDIs,	Medium

		households reached; number of consultations held) delivered in reference to quality standards and timeliness?	report	KIIs	
		4. To what extent was the allocation of resources in the program appropriate to the beneficiaries and the most vulnerable groups (mothers and their children, people with disabilities)?	QS1, QS2, QL1, QL2, QI	Survey, IDIs, KIIs	Medium
5	Sustainability	1. To what extent were sustainability considerations built into programme implementation, in terms of recruitment, training and retention of CMVs, among others?	QS2, QL2, QI NGO and government partners	Survey, IDIs, KIIs	Medium
		2. To what extent have the beneficiaries sustained the good behaviors and practices after the end of the intervention?	QS1, QS2, QL1, QL2, QI	Survey, IDIs, KIIs	Medium
		3. To what extent have or can the achieved results been/be replicated or integrated into policies, strategies, and programmes?	TBD	Desk Review	Low

A mapping of the Evaluation Criteria to the surveys can be found **here.**

Sampling Methodology and Sample Size

For the Endline data collection, we expect to re-interview a subset of respondents from the Midline survey conducted in 2019. We have access to encrypted identifiable information, and we will use this information to re-interview households from Midline who were visited by the CMVs as part of the program. Out of the total sample, 750 participants fulfilled our eligibility criteria: (a) Contact number provided during Midline survey and (b) from the camp blocks that received 100% and 50% treatment levels during the Midline survey. We have also collected names and contact information for 29 CMVs from BRAC to be surveyed as part of the Quantitative and Qualitative interviews.

Treated Households

Camp	Block (treatment level=.5)	No. of HHs	Block (treatment level=1)	No. of HHs
Camp 01W	13	18	32	182
Camp 02W	8	22	15	99
Camp 07	8	19	20	141
Camp 12	7	22	17	116
Camp 21	5	13	9	50
Camp 25	1	2	3	23
Camp 27	4	7	6	36
Total		**103**		**647**

The number of HHs contacted from each camp/block is dictated by a) contact numbers available from the Midline survey b) Households that could be connected to the BRAC document listing households treated by CMVs and were a part of 100% and 50% treatment blocks.

Towards the end of the survey we will ask the respondent if they recall the CMV program. If they remember the program, we will move to the qualitative interview (In depth Interview) with the participant. If the respondent does not recall the CMV program, we will end the survey there and we will not conduct the qualitative interview with them.

CMVs

Female	25
Male	4
Total	29

We will conduct both quantitative and qualitative (in depth interviews) surveys with all CMVs. Contact information for 29 CMVs was provided by BRAC and the additional CMV contact numbers will be derived through snowballing during the CMV interviews itself.

KIIs:

We will also conduct two Key Informant Interviews (KIIs) with BRAC field staff and UNICEF field staff who were associated with the implementation of the program. For the KII, we will reach out to participants from the list below and conduct individual interviews. We aim to conduct 3-4 KIIs with each Agency.

List of Agencies for KIIs
UNICEF
BRAC
Civil Surgeon Office
UH&FPO, Ukhiya & Teknaf
WHO Cox's Bazar
Coordinators
CiC/RRRC
RTM International
PHD
Save the Children
GUK
Concern Worldwide
IRC
NGO Forum
Friendship
CODEC
BITA
Mukti

Methodology for Phone Surveys

As a rule of thumb, interviews during mobile phone surveys are each restricted to about 15– 30 minutes, and a typical questionnaire contains around 20 questions. The suggested duration of an interview is based on common practice in recent IPA remote phone surveys.

A typical mobile phone round questionnaire has the following elements. First, respondent verification: after making contact, the call center interviewer uses baseline data on name, age, and sex to assess whether the person answering is the originally sampled respondent. After respondent identity confirmation, the enumerator introduces the questions. A final fixed part of the questionnaire allows for interviewer observations related to survey management: How many calls were used to reach this respondent? Was the respondent reached directly or through tracing, whereby contact with the respondent was attempted through a family member or another respondent?

This will be done using Computer Assisted Telephone Interviewing (CATI) for data collection and workflow management. This method is applicable for both quantitative and qualitative data collection for Treated Households, CMVs and KIIs.

CATI

Computer Assisted Telephone Interviewing (CATI) is an interviewing mode in which an electronic device (computer/tablet/mobile) displays questions on its screen, the interviewer reads them to a respondent over a phone call and enters the respondent’s answers directly into the electronic device. SurveyCTO's CATI system offers an automated and scalable approach to using SurveyCTO as a CATI solution on both mobile devices and web forms.

Requirements:

1) Phone Numbers: We will need a list of program participants, including phone numbers for remote survey work.

2) Data Capture Hardware: Data capture using SurveyCTO can be done using smartphones, tablets, or computers. At IPA Bangladesh, we use a single tablet that supports a SIM card to

both make calls and capture data. This feature also allows for automatic number dialing on Android.

3) Internet Services: Our team of enumerators need to connect to the internet to submit filled forms, the same as field-based CAPI questionnaires.

Quality Assurance Plan

Data Quality in phone surveys:

SurveyCTO has a built in CATI dashboard for maintaining oversight of survey progress and adherence to protocol. We will use these services along with IPA's principles for maintaining survey data quality measures during data collection. Most of these principles remain the same in phone surveys as compared to field data collection:

Data security: Because IPA often collects very sensitive information, data security is a high priority. As such, we maintain a detailed data and device security protocol throughout the project lifecycle. During the questionnaire design stage, we will ensure that personally identifiable information (PII) is easily separable from the main survey. During data collection, we will securely store PII using software encryption software. Throughout the data entry and analysis processes, we will store PII separately from the original data and ensure all data is securely backed up offsite, all transmissions of data are secured, and data is de-identified before analysis begins.

Standard quality control procedures: What distinguishes IPA is its ability to consistently produce high-quality data. IPA employs a number of methods in maintaining data quality, including:

a. Random recording of surveyors: Randomly selected parts of the survey will be recorded and audited by an audio-auditor.

b. Consistency checks: Consistency of data across all interrelated questions will be ensured by adding different constraints in the SurveyCTO CATI form.

c. Monitoring feedback: The enumerators, supervisors, and the Operations Manager will have a bi-weekly to discuss all monitoring feedback and improve their data collection efforts.

d. High Frequency checks: The Research Analyst will conduct a number of checks on the data at the end of every day to record inconsistencies in survey data, record outliers and track enumerator performance.

Quality control measures for phone surveys:

SurveyCTO CATI Coding and Case Management

• SurveyCTO's latest CATI feature allows us to call phone numbers directly through the tablet. The CAPI can be filled up while the call is ongoing.

• SurveyCTO's Case Management allows us record keeping of each attempt of each ID. And we can filter in a manner that an enumerator can only see IDs assigned to him/her only (thus, no heavy loaded prefill).

• Each enumerator will be assigned a unique User ID and password. The "Manage Cases" feature will be activated on the SurveyCTO Collect app on their devices. Enumerators will enter their User ID and password in order to download forms. After downloading the form through "Get Blank Forms" tab, they will enter the "Manage Cases" tab. All IDs assigned to them will be listed there. They can start a survey by clicking a particular ID. All forms filled up under that ID will be listed with timestamps.

• Once a form is complete and "finalized", enumerators will submit it to the server immediately.

IPA Bangladesh protocols for calling a RESPONDENT/Respondent

1. Each household will be attempted twice in total over two days, with a gap of one day in between. Thus, if the Attempt 1 takes place on Day 1 and no success is availed, the final attempt, Attempt 2, will take place on Day 3.

2. If on Day 1 attempt is made in morning hours, and phone call to a respondent needs to be continued to Day 3, Day 3 phone calls would be made in the afternoon hours. This will maximize the variation of the phone call attempts over different times of a day.

3. Each attempt will comprise of trying all numbers available for that respondent. The first number will be tried first (Attempt 1 of Day 1). If calling the first number of Attempt 1 is successful (call is picked up, correct respondent is found and there is consent for survey; or call is picked up, correct respondent is found and call is rescheduled), then interview will continue at this number. If the first number is found to be unsuccessful (e.g. Wrong number,

Switched off, Inactive/SIM not in use, Ringing but no one responding etc.), then the CAPI prompt will move onto the next number.

4. In this manner, all the numbers will keep getting tried till the first "success". By "success", we mean either – (a) Call is picked up, correct respondent is found and he/she is willing to survey now; or (b) Call is picked up, correct respondent is found and he/she agrees to survey but requests a reschedule. If there is success in Day 1 Attempt 1, then enumerators complete the survey, finalizes the form and submits it. If calling all the numbers in Attempt 1 becomes unsuccessful (all numbers are either Switched off, Rings but nobody receives, Wrong number etc.), then the enumerator will stop trying that household for the day and schedule Attempt 2 after a gap of one day.

5. Similar protocol to Attempt 1 will be followed for Attempt 2 in Day 2. Definition of "success" and "unsuccessful" remains the same. However, if a number is found to be the wrong number in Attempt 1 then that number will not appear for Attempt 2. After Attempt 2, enumerators must submit a form to the server, regardless of the result.

Replacement protocol

• [Proposed] we will have a main sample pool and a replacement pool, and replacements will be assigned when a main sample is unsuccessful through all attempts.

• The following steps will be followed to consider a replacement:

  o If in any of the attempts, there is non-consent/refusal from the respondent, then that respondent will be replaced.

  o If after all attempts, a respondent is unreachable (e.g. Switched off or Rings but nobody picks up), then that respondent will be replaced after Day 2.

  o If in one of/all of the attempts, all phone numbers are found to be wrong numbers, then that respondent will be replaced.

  o Each enumerator will be assigned a set of main samples. Based on requirement, replacement samples will be assigned and updated for the cases (samples) for that enumerator

The replacement sample will be sorted into bins so that the pool first comes from the same camp, same gender and similar age group [wherever possible].

Tracking and Quality Control Measures

• Tracking on IDs will be maintained as part of HFCs. Assigned sample IDs will be compared against number of attempts and attempt results of those IDs. If any ID is attempted more/less than expected, then that will be identified and communicated accordingly.

• SurveyCTO form will have codes to store information on number and timestamps of daily attempts to check if enumerators are calling the required number of times a day with appropriate time gap.

• Non PII data will be published on Google Sheet real time to have almost-live update on number of submissions made (by enumerators, and by results).

• HFCs will be run and daily reports will be generated. Problematic issues will be communicated with enumerators every alternate day.

• Audio recordings will be kept through SurveyCTO's audio audit. Audio auditor(s) will listen to sample audios (by enumerators) to assess quality of interview. Audio auditor will prepare reports every alternate day.

The Research Associate (RA) will perform various checks—such as consistency checks and high frequency checks—on the data on a regular basis. This will help identify any issues with the data, such as completion rates or accuracy, and take prompt action to correct the issues. Since the data will be collected on tablets and uploaded to the cloud daily, the RA will be able to access the uploaded data in near real-time.

Quality control for tabulation/data analysis

Based on the study design and the expected program outputs, we will first develop a pre- analysis plan for the project. This will ensure that our analysis serves the intended purpose. Then the Research Coordinator (RC) and RA will find the appropriate techniques for performing the intended analysis; in doing so, they will use their experience as well as support from IPA's vast institutional resources developed over the years.

IPA Bangladesh has a team of highly qualified RCs and RAs, who are familiar with using advanced data analysis methods and techniques. They have gained this expertise through their work with the top academics in the fields of economics and public health. We use STATA (if necessary, R) for data management and analysis, and we use ArcGIS to work with geo- spatial data. We will follow strict guidelines for labeling the variables and preparing the do- files in such a way that the entire analysis is perfectly replicable.

Data Analysis

The primary statistical methods will be estimation of sample and population means, followed by comparison across subgroups[6]. Each such result will also present standard deviations and make transparent whether subgroup differences are statistically significant. We do not have the final response rate for the phone surveys conducted with treated households and CMVs at this juncture so we will revisit this plan once we begin data collection.

Subgroup Analysis & Disaggregation

The most important dimensions for subgroup analysis will be at the camp level, gender and age, and vulnerability levels.

1. Subnational Region: To ensure credible disaggregation, we will focus our attention on camp level differences.[7] This will ensure that we still have sufficiently large sample sizes in each area to credibly report averages. Any geographic data sufficiently granular to compromise anonymity will be stripped from the data before publication.

2. Vulnerability Status: We will use responses from the questionnaire as markers for poverty and vulnerability. The Baseline and Midline dataset was built before the recent crisis, allowing us to estimate "baseline" household welfare before the (potentially large) increase in poverty rates currently unfolding.

3. Gender and age: We will identify key demographic characteristics that have policy relevance, such as the respondent's gender as well as household members that are employed, school-aged, elderly, pregnant women, and/or children. For analysis purposes, knowing the gender of the respondent will allow for disaggregation on individual-level questions. This disaggregation will be done for treated households as well as CMV volunteers.

Gender, Equity & Human Rights

The impact evaluation will be guided by the principles of human rights, gender equality and leaving no one behind. As a part of endline reporting, the evaluation will incorporate a

[6] To weight the results to a target population, we will apply a weighting-based approach, which weights the sample to resemble the target populations and is similar to inverse probability weighting for non-experimental studies.

[7] Based on data collection, we do not think camp level disaggregation is justified.

gender sensitive methodology including identifying recommendations, lessons learned and best practices in relation to human rights and gender.

The desk review and primary research undertaken during the Endline will be used to answer the following questions:

a) The extent of gender equality/gender mainstreaming in the design and implementation of the CMV programme; and, b) get a common understanding on what a gender-responsive programme entails and share good practices.
b) How gender is reflected (or not) in the design (results framework, indicators, activities, etc.). - How gender is reflected (or not) in the progress reports and monitoring data (Is disaggregated data available?

The CMV programme did not specifically identify "gender-transformative" ideas to address in the camps. We plan to generate themes from what information comes forth from the various data collection methods.

Sections directly Identified as gender-focused areas	
1	Childbirth and Child health care (Delivery, ante/ post- natal care, new born health)
2	Child learning activities and Education
3	Breast feeding and nutrition
4	Vaccination
5	Water, Sanitation and Hygiene (Hand wash, water treatment, waste disposal)
6	Birth registration
7	Child safety
8	Menstruation health and practices
9	Gender based violence
10	Diarrhea prevention in children and treatment (ORS preparation)
11	Emergency /cyclone preparedness

In the Endline report, we will present information on the program contributions to the empowerment of women including how stakeholders (both women and men) have participated in the various stages and activities of the project/program.

The evaluation will also analyze information in a disaggregated manner when possible. For example, when analyzing survey responses, we will see if men and women give us different information. We will also make sure that you include gender-related findings under most of the evaluation criteria following the evaluation matrix. Depending on our findings, we may also cluster all this information under a separate chapter titled the "Gender Equality and Human Rights Chapter".

The gender-related findings and conclusions will be accompanied by an appropriate gender-related recommendation. Additionally, the evaluation will provide sex-disaggregated list of stakeholders and respondents of the evaluation while ensuring confidentiality and anonymity. Finally, the Endline report will strictly adhere to IPA standards of non-sexist language, avoiding stereotypes, and inclusive writing.

Human Rights and Equity

During the evaluation, we will examine the human rights analysis done at the design phase and look at the participation of different stakeholders in the various steps of implementation. During the surveys, we will attempt to select a sample that reflects the diversity of stakeholders in the intervention, including gender diversity, pregnant women and disabled persons. We will seek disaggregation by gender, age and disability. We will present evidence of how human Rights issues were addressed by the intervention and what results were achieved in this area.

Note on Qualitative Interviews

Qualitative responses will be recorded and analyzed in a similar format to the interview notes, through a thematically arranged searchable compendium. The questionnaire for type of respondent/survey method will cover core themes such as relevance and appropriateness of the program, views on the services provided, effectiveness and quality of the activities, any contributions toward building longer term resilience and COVID-19 impacts and recommendations for future work.

Detailed codes for content and thematic analysis will be used to analyze and interpret the findings of the qualitative interviews. The thematic analysis would require IPA to be fully aware of the areas, positions, places and organizations involved in the interview to allow for the understanding of the full story. Thematic analysis includes the summarization and debriefing as the essential steps in rapid analysis. The entire data collection team should be able to freely communicate their findings and experiences and refer to each other during the data collection process. For these reasons, the raw files would clearly be identified according to location and type of respondent and may contain other personally identifiable information. After the full analysis has been completed, anonymization process will be done.

Strategy

The enumerators, hired locally from the Chittagong and Cox’s Bazar district, will interview the Rohingya community using the Rohingya language, which is very similar to the local Chittagong and Cox’s Bazar dialect of the Bengali language.

We will record all the interviews on password-protected tablets. We will administer interviews using CATI devices (similar to the quantitative surveys). Most of the questions will be open-ended and entered using “Note” type questions on Survey CTO.

Data Cleaning Methodology

1) We will first transcribe interviews from audio to text. To ensure quality, we will re-transcribed 10% of all interviews. We will compare both documents and check for consistency before moving forward.
2) We will then translate the documents from Bangla to English. To ensure quality, we will re-translate 10% of all interviews.
3) We will not clean or edit translations for the purpose of analysis.

Interview transcripts will be deconstructed, segmented and divided into recurring headline themes that emerge from the transcripts themselves. Weaker, ‘emergent’ sub-themes will also be identified. Each will be aligned to the most relevant evaluation question, with ‘connectors’ to other secondary evaluation questions where these could be justified by repetition in the transcripts and resonance with the known research evidence around the Refugee camps. Quantitative data and secondary sources will be sought to triangulate conclusions.

Measuring Outcomes for CMVs

We want to understand why the program did or not improve outcomes, process and mechanisms for CMVs, impact on refugee households: including whether it worked better for certain types of people (heterogeneity).

The following individual indicators will form the family of outcomes for CMVs:

- Taught new technical skills (new skills mechanism)
- Certified skills they already had (signaling mechanism)
- Made them more aware of job opportunities (job matching improvement)
- Made them more confident to undertake new roles (empowerment)

All the above outcomes will be disaggregated by gender for both the respondent (CMVs) and the people the CMV interacted with due to the program (female/males in treated households).

Measuring Outcomes from Stakeholder Interviews:

Stakeholder Consultations (UNICEF)

Group discussions will be employed for internal stakeholder interactions. Interviews will enable the evaluation team to gain complete knowledge and perspective of the stakeholder towards their areas of accountability. These interviews will be used to gather opinions and perspectives about strengths, weaknesses, opportunities and experiences of implementing the CMV programme.

- To understand and document views of UNICEF's staff on critical aspects pertaining to programme management with specific focus on lifecycle approach and formulation of headline results.
- To understand alignment of new programming areas, specifically gender, in setting up and implementing the CMV program.
- To understand how planning and review mechanisms been institutionalised within the CMV program implementation process, and how will learnings from the evaluation feed into development of the next program.

Stakeholder Consultations (BRAC)

Group Discussions will be employed for the external stakeholder interactions. This will enable the evaluation team to gain complete knowledge and perspective of the stakeholder towards UNICEF's areas of work, areas of collaboration and convergence, strengths and challenges in the collaboration etc.

- To understand the views of the stakeholder(s) on capacity building and technical assistance provided by UNICEF and/or understand the views of the stakeholder(s) on the assistance received by UNICEF
- To explore the visible strengths and challenges faced while implementing the CMV program and how this has supported the stakeholder in achieving planned results
- To draw insights and feedback to formulate strategic inputs for planning way forward for similar programs in the camps.

Measuring Outcomes from Desk Reviews

Desk review activities include scanning the literature, analyzing secondary data, and creating a reference list so that all documents are organized and easily accessible to all team members.

We have received the following documents from UNICEF on the CMV program:

1. **Copy of September progress report format** - Phase 2 (UNICEF-BRAC) *Dated: September 2019*
   The file (excel sheet) tracks the progress, that is, no of HH/people reached by CMVs in terms of information dissemination and through advocacy meetings on various indicators across different camps.

2. **Copy of October progress report format** - Phase 2 (UNICEF-BRAC) *Dated: October 2019*
   The file (excel sheet) tracks the progress, that is, no of HH/people reached by CMVs in terms of information dissemination and through advocacy meetings on various indicators across different camps.

3. **Final Partnership Review Form**
   Date: 19 November 2018 - 31 March 2020
   The PDF file illustrates the key achievement against planned results of the programme over a period of time (19 November 2018 - 31 March 2020) along with final status of planned outputs. In addition to this, the document also accounts for key issues, challenges and constraints during the implementation and way forward in order to sustain or expand the achieved results of the programme. The document also outlines the logical/results framework for the programme.

4. **Programme progress report - completed by CSO as a part of reporting FACE** The document outlines a general programme and CSO overview followed by the cumulative progress made across different indicators over a period of time (November 2018 - March 2020), and a narrative assessment/summary of progress made across these indicators in January 2020 - 31 March 2020. The document also illustrates the bottlenecks faced in the reporting period along with the proposed way forward.

5. **Report Final Liquidation BRAC CMV**
   *Reporting period***:** January 2020 - 31 March 2020
   The document outlines a general programme and CSO overview followed by the cumulative progress made across different indicators in January 2020- 31 March 2020, and
   a narrative assessment/summary of progress made across these indicators during that period. The document also illustrates the bottlenecks faced in the reporting period.

6. **Theory of change (CMVn)** - The document illustrates the theory of change for the community mobilization volunteers network program aimed at improving life saving behaviors in humanitarian crisis in Cox's Bazar.

Along with these documents, IPA will identify documents and reports that are relevant to the impact evaluation such as assessment reports on camp status, health and behavior surveys and COVID-19 rapid surveys conducted by key organizations. These documents will be examined and used to substantiate information collected through our primary research. We will provide a comprehensive list of documents used for the Desk review in our final report.

IRB Ethical Clearance

IPA is committed to conducting high quality, ethical research. This project, like all IPA projects, has been reviewed by IPA's Institutional Review Board (IRB) prior to implementation (See attached approval letter).

In adherence to IRB protocols and to the principles outlined by UNICEF's standards for ethics, the research team possesses a valid and updated certification to conduct human subjects' research from a reputable source (the CITI program). Furthermore, all potential participants will be asked for their consent to participate voluntarily in the study.

Ensuring informed consent of participants: In all IPA studies, participants are asked to consent to voluntarily participate in the survey, either in writing or verbally. Since this survey will be implemented over the phone, consent must be requested and given verbally. Enumerators will discuss this information with participants and are trained to respect participants' right to refusal, for the entire survey or for any question they may not want to answer.

The project will adhere to the UNEG Code of Conduct for Evaluation in the UN system and UNEG norms and standards for Evaluation[8].The team engaged on the evaluation will familiarize themselves with the guidelines and ensure that at all times that we act with independence, impartiality, credibility, independent of conflicts of interest, honesty and integrity, and accountability.

The team will ensure that the evaluation is conducted with the standards of integrity and respect for the beliefs, manners and customs of the social and cultural environment; for human rights and gender equality; and for the 'do no harm' principle for humanitarian assistance. Evaluators will respect the rights of institutions and individuals to provide information in confidence and ensure that sensitive data is protected, and that it cannot be traced to its source and must validate statements made in the report with those who provided the relevant information. All information will be obtained with informed consent for the use of private information from those who provide it. The evaluation study will adhere to utilization of evaluation competences and recognition of knowledge, skills and experience of all internal and external stakeholders.

Final Report

After the data collection process, evaluators will analyze the data and prepare the evaluation report. The Final Report will follow the UNEG standards for UNICEF Global Evaluation Quality Oversight System.

The Report Structure:

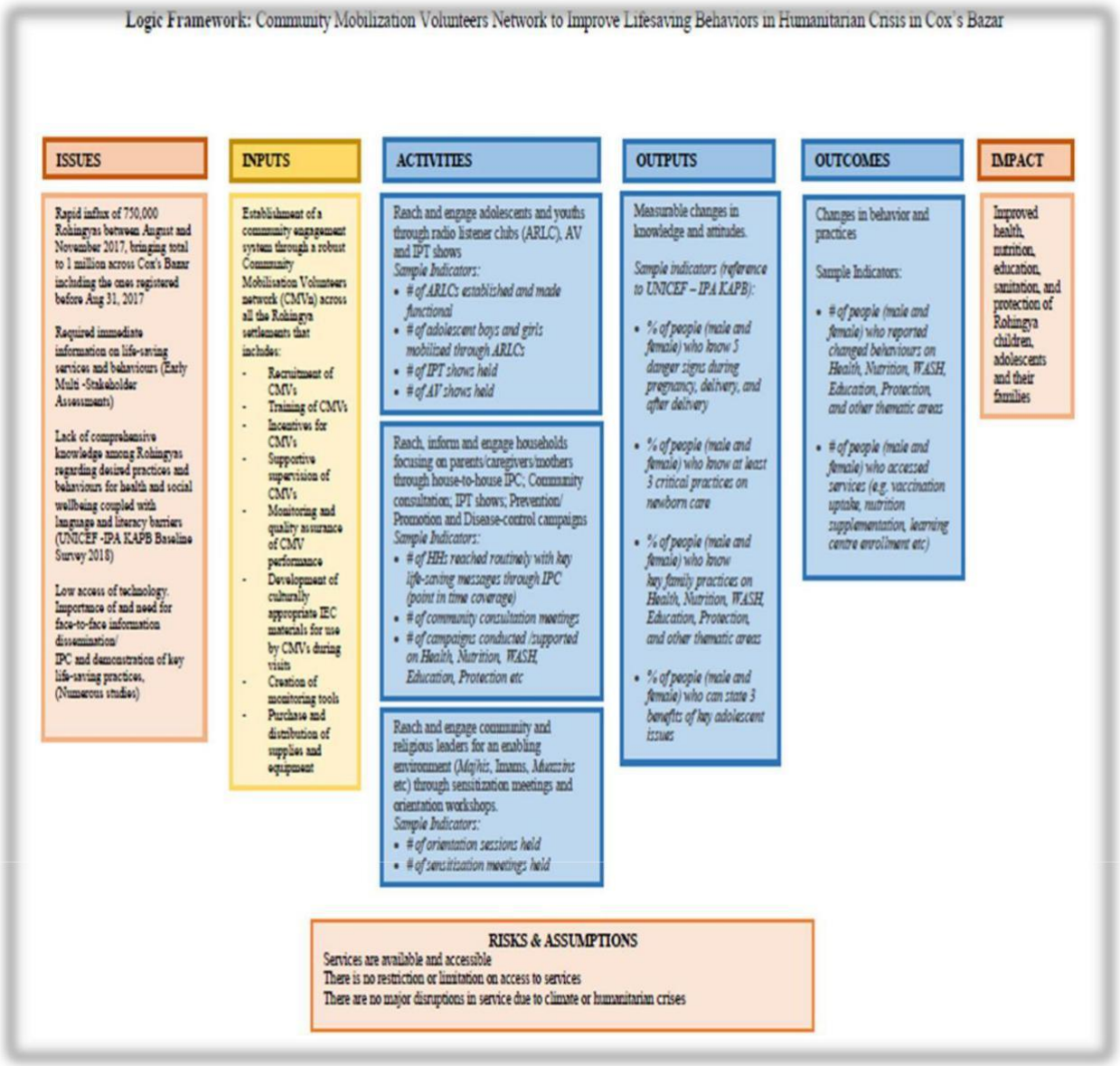
1. Map: Camps and Villages Surveyed
2. Acknowledgement
3. List of Tables
4. List of Figures
5. Glossary of Terms
6. Abbreviations
7. Executive Summary
8. Introduction
9. Background and Literature Review
10. Objectives of the Evaluation
11. Data Collection
12. 1Methodology
    - *Quantitative Method*
    - *Qualitative Method*
13. Evaluation limitations and challenges 14.Analysis and Results
    - *Households*
    - *CMVs*
    - *Gender Equality and Human Rights*
15. Conclusions
    - *Analysis by sub group*
    - *Analysis by evaluation criteria*
16. Recommendations
17. Annex

Work Plan

Sl	Activity	Tentative Schedule
1. Development of Quantitative & Qualitative Questionnaire		
1.1	Refining the existing midline questionnaires	Done
1.2	Sharing the questionnaires with UNICEF (both qualitative & quantitative)	Done
1.3	Finalizing the qualitative and quantitative questionnaire with feedback from UNICEF	Done
1.4	Produce an inception report outlining the background, issue to be reviewed, methodological approach, including types of data and information to be reviewed	4/19/2021
1.5	Finalizing study sample	Done
2. Develop Digital Data Collection Forms		
2.1	Set up the CATI tool (phone survey requirements)	Done
2.2	Bench test, refine and finalize the digital data collection tools	Done
2.3	Set up HFCs and data cleaning framework	Done
3. Logistical Arrangements		
3.1	Recruitment of field team including enumerators, supervisors.	Done
3.2	Design field plan	Done
3.3	Distribute devices and materials to enumerators	Done
3.4	Apply for permits from all required parties (RRRC, Camp CIC and site management)	Done
3.5	Finalize training materials	Done

4. Training Survey Team (enumerators)		
4.1	Organize and conduct trainings with the enumerators	Done
4.2	Conduct debriefing sessions with the enumerators and finalize the team	Done
4.3	Field work qualitative & quantitative begins HFC report Daily field logs	Done
4.4	Conduct stakeholder consultations and Desk reviews	3/22/2021- Ongoing
5. Data Analysis and Report Writing		
5.1	Clean and organize the datasets	4/10/2021
5.2	Conduct preliminary data analysis	4/30/2021
5.3	Prepare draft review report with key findings from desk and key informant interviews and recommendations to address issues	5/10/2021
5.4	Final report/ Presentation[9]	5/20/2021

Appendix A


Logic Framework: Community Mobilization Volunteers Network to Improve Lifesaving Behaviors in Humanitarian Crisis in Cox's Bazar
ISSUES
Rapid influx of 750,000 Rohingyas between August and November 2017, bringing total to 1 million across Cox's Bazar including the ones registered before Aug 31, 2017
Required immediate information on life-saving services and behaviours (Early Multi -Stakeholder Assessment)
Lack of comprehensive knowledge among Rohingyas regarding desired practices and behaviours for health and social wellbeing coupled with language and literacy barriers (UNICEF -IPA KAPB Baseline Survey 2018)
Low access of technology. Importance of and need for face-to-face information dissemination/
IPC and demonstration of key life-saving practices, (Numerous studies)
INPUTS
Establishment of a community engagement system through a robust Community Mobilisation Volunteers network (CMVn) across all the Rohingya settlements that includes:
- Recruitment of CMVs
- Training of CMVs
- Incentives for CMVs
- Supportive supervision of CMVs
- Monitoring and quality assurance of CMV performance
- Development of culturally appropriate IEC materials for use by CMVs during visits
- Creation of monitoring tools
- Purchase and distribution of supplies and equipment
ACTIVITIES
Reach and engage adolescents and youths through radio listener clubs (ARLC), AV and IPT shows
Sample Indicators:
• # of ARLCs established and made functional
• # of adolescent boys and girls mobilized through ARLCs
• # of IPT shows held
• # of AV shows held
Reach, inform and engage households focusing on parents/caregivers/mothers through house-to-house IPC; Community consultation; IPT shows; Prevention/ Promotion and Disease-control campaigns
Sample Indicators:
• # of HHs reached routinely with key life-saving messages through IPC (point in time coverage)
• # of community consultation meetings
• # of campaigns conducted /supported on Health, Nutrition, WASH, Education, Protection etc
Reach and engage community and religious leaders for an enabling environment (Majhis, Imams, Muezzins etc) through sensitization meetings and orientation workshops.
Sample Indicators:
• # of orientation sessions held
• # of sensitization meetings held
OUTPUTS
Measurable changes in knowledge and attitudes.
Sample indicators (reference to UNICEF – IPA KAPB):
• % of people (male and female) who know 3 danger signs during pregnancy, delivery, and after delivery
• % of people (male and female) who know at least 3 critical practices on newborn care
• % of people (male and female) who know key family practices on Health, Nutrition, WASH, Education, Protection, and other thematic areas
• % of people (male and female) who can state 3 benefits of key adolescent issues
OUTCOMES
Changes in behavior and practices
Sample Indicators:
• # of people (male and female) who reported changed behaviours on Health, Nutrition, WASH, Education, Protection, and other thematic areas
• # of people (male and female) who accessed services (e.g. vaccination uptake, nutrition supplementation, learning centre enrollment etc)
IMPACT
Improved health, nutrition, education, sanitation, and protection of Rohingya children, adolescents and their families
RISKS & ASSUMPTIONS
Services are available and accessible
There is no restriction or limitation on access to services
There are no major disruptions in service due to climate or humanitarian crises

Questionnaire Mapping:

	Evaluation Criteria	**Evaluation Question**	**Source(s) of data**	**Methodology**	**Evaluability y Criteria (Low-Med-High)**	**Questions that address the criteria**
1	Relevance /Appropriateness	1. To what extent was the CMV network relevant and responsive to the needs and priorities of the Rohingyas communities, including those most vulnerable (adults, the elderly, and adolescents of both sexes, as well as pregnant and lactating women and young children)?	Survey respondent s (Qualitative and Quantitative surveys)	Survey, IDIs, KIIs	High	**QL2-*useful_topics:*** Please think about the time before the CMVn program started relaying information to the Rohingya households. Which of these topics from the program do you feel were most useful/ necessary for the Rohingya community to know about? **QL2 - *extent*:** For all topics (listed in1), according to you, to what extent were refugee households visited by CMVs generally able apply the information shared from {topic} section into their daily lives or when needed? [consider the time before March 2020, that is, before lockdown] **QL1- *topic_useful:*** Which of the topics discussed you found were more useful for you? **QL1 - *topic_apply:*** Which of the topics do you feel you have been able to apply in practice in your daily lives?

						QS2- *topic_delivered*: What was the kind of information you delivered?
		2.To what extent was the program aligned and responsive to relevant human rights (including child rights and gender) global, regional and national legal and policy frameworks?	Programme documents/ reports, staff from UNICEF & NGO partners, Survey respondents	Desk review, KIIs	High	**QI** - Do you feel that this program was designed and implemented as gender equitable? Please provide some examples. **QS2: *topic_focus:*** Which of these topics do you feel were more emphasized in the training?
2	Effectiveness	1.To what extent did the CMV network lead to changes in the knowledge, attitudes, behaviors and practices (KABP) of the Rohingya refugees communities ? How has this been affected by COVID-19?	Survey respondents	Survey, IDIs, KIIs	Medium	**QL2 - *apply_behav:*** What were the key behaviors you observed or heard of to validate that households could fully/ partially apply information shared into their regular practice? **QL1- *topic_apply_how:*** What were the key messages conveyed to you that you were able to apply fully/ partially into practice? **QS1- *Anc:*** Did you/your wife receive antenatal care before birth during your last pregnancy? **QS1- *pnc_assist_whom*:** If your wife received post-natal care at home, who assisted?

						QS1- *garbage_disposal:* How do you dispose of garbage or other material waste? **QS1- *covid_serv_hind*** Which of the following services that are usually provided in the camps, faced hindrance during the COVID- 19 pandemic and the following lockdown? **QS1: *covid_ser_hind_how:*** How were the services you mentioned impeded? **QS1- *covid_serv_imp*** Which of the following services that are usually provided in the camps, were upgraded/ received more focus during the COVID- 19 pandemic and the following lockdown? **QS1: *deliver_where:*** For your (or your wife's) last completed pregnancy, where did you (or your wife) deliver? **QI -** We understand that the pandemic and followed by lockdown post March 2020 may have hampered access to a lot of services, do you think refugee HHs still practiced the information that was relayed to them as a part of the CMV program? How did you observe, please

						provide some examples/instances?
		2. To what extent did the intervention contribute to equitable participation and benefits to various groups (adults, the elderly, and adolescents of both sexes, as well as pregnant and lactating women and young children)?	Survey respondents	Survey, IDIs, KIIs	Medium	**QS1- *deliver_where*:** For your (or your wife's) last completed pregnancy, where did you (or your wife) deliver?
		3.To what extent did the CMV network lead to changes in capacities of CMVs including personal/technical skills regarding key life- saving messages, interpersonal communication (IPC), community engagement, and	Survey respondents	Survey, IDIs, KIIs	Medium	**QL2 - *benefit_cmv:*** Were you able to benefit from the mass networking you achieved through visiting households and community leaders for the CMVn program? **QS2: *skill_dev*:** Do you feel the CMVn program has increased your capacity and provided you certain skillset in any way as an individual and a member of the community? **QS2: *skill_dev_which*:** Do you feel the CMVn program has increased your capacity and provided you with a certain skill set in any way as an individual

		leadership skills?				and a member of the community? **QS2- *skill_dev_apply*:** In which of the following areas of life were you able to apply these skills? **QI -** Did you feel that apart from benefiting the beneficiaries and most vulnerable, the program also helped the CMV volunteers in any way? What made you feel this way?
		4. What enabled or hindered the achievement of outcomes?	Survey findings, beneficiaries, NGO partners	Survey, IDIs, KIIs	Medium	**QL2 - *challenging_area***: Which areas did you feel were a challenge in explaining or communicating to households? **QL2- *challenge:*** What challenge did you feel? **QL2- *chal_gen***: Do you feel being male/ female (prefilled) has caused a challenge for you in disseminating this information? **QL2- *felt_why***: Why do you feel this way? **QL1 - *topic_apply_chall:*** What were the challenges you faced in putting this information into practice? **QS1- *covid_serv_hind*** Which of the following services that are usually provided in the camps,

						faced hindrance during the COVID- 19 pandemic and the following lockdown? **QS1: *reason_no_edu*:** If children are not getting an education, then "why not"? **QI** - Did you think there were any roadblocks during the implementation of the program from inception to recruitment and operations on the field? If yes, what kind, can you give us some examples? *(Note for the interviewer: Ask about each stage of the program separately with examples)*
3	Impact	1. What was the perceived and measurable impact of the different CMV intervention approaches, as implemented in 2019, on KAPB among the Rohingya refugees living in the camps?	Survey respondents	Survey, IDIs, KIIs	Medium	**QS1- *anc_where:*** If yes, where? **QS1- *vaccine_times:*** Can you please tell us How many times does a child need to get vaccines before the age of 15 months?
		2. Did the programme lead to	Survey respondents	Survey, IDIs, KIIs	Medium	**QS1- *current_participant:*** Are any of the children in your household currently participating in learning

		any positive or negative unintended results?				activities in an institution outside of the home? **QS1-** ***water_notreat_why***: Why do you not treat drinking water? **QI** - Did you observe any unintended consequences of the program within the refugee community/ households? If yes, what kind, could you please provide any examples?
		3. To what extent was gender and human rights (including child rights) advanced as a result of the CMV programme?	Survey respondents	Survey, IDIs, KIIs	Medium	**QS1-** ***current_participant***: Are any of the children in your household currently participating in learning activities in an institution outside of the home? **QL1 -** ***prog_group***: Do you feel any of the certain group of people in your household mentioned below were more benefitted by the information service program run by the BRAC CMVs? **QL1:** ***prog_group_how***: How were these groups benefited more?
		4. Was there any evidence of or perceived spillover effects of the programme into non-programme areas? If so,	Survey respondents	Survey, IDIs, KIIs	Low	**QL2 -** ***info_share_novist:*** Do you think the households visited by CMVs have communicated the information shared with them to households not visited? **QL2-** ***topic_share:*** Which topics were mainly shared by the households?

		was there evidence of the main change factors being spilled over?				**QL2-** ***topic_share_2:*** What helped you understand this? **QS1-** ***Info_share:*** Do you share information you have received about health care (Hygiene, vaccine, nutrition, childcare, health services) with your friends, family, neighbors or anyone else you know? **QS2-** ***skill_dev_apply:*** In which of the following areas of life were you able to apply these skills?
4	Efficiency	1. What was the cost-effectiveness of the programme in terms of inputs to outputs?	Partners report, progress report sourced from UNICEF and surveys	Desk review, KIIs	Medium	**QS2-** ***topic_focus:*** Which of these topics do you feel were more emphasized in the training?
		2. What were the factors affecting the pace and quality of implement ation (i.e., high CMV dropouts) and how could these have been better mitigated?	Survey findings, beneficiarie s, NGO partners	Desk review, KIIs	Medium	**QL2 -** ***way_imprv***: Are there any other ways this program could be improved to ensure better and more efficient reach, CMV retainment, logistic arrangements? **QL2 -** ***dropout_reason*****:** We observed massive dropouts among the CMVs during the program. According to you, what was the primary reason behind this and What do you think could be done to avoid this situation? **QL1 -** ***visit_inconvenience*****:** Did these visits create any

						inconvenience for you or your household members? **QL1 - *visit_convenience_why:*** What kind of inconvenience or difficulties did you or your household members face? **QL1- *prog_improve:*** Are there any ways you would like to improve these visits- in terms of types of information received, behaviour of person visiting, time of visit, etc. Please specify: **QS2- *hh_achiev_not:*** Why were you not able to do so?
		3.To what extent were the outputs (i.e., number of households reached; number of consultations held) delivered in reference to quality standards and timeliness?	Survey respondents, progress report	Desk review, Surveys, IDIs, KIIs	Medium	**QS2- *hh_target:*** What was the target number of households assigned per day to each CMV? **QS2- *hh_achievd:*** Were you generally able to achieve your targets per day? **QS2- *skill_dev_which*:** What skills do you feel you have achieved/ How do you feel your capacity has improved? This will also be addressed from Desk review (progress reports)
		4. To what extent was the	Survey respondents	Survey, IDIs, KIIs	Medium	**QI** - To what extent do you feel the allocation of resources in the program

		allocation of resources in the program appropriat e to the beneficiarie s and the most vulnerable groups (mothers and their children, people with disabilities) ?				was appropriate to the beneficiaries and most vulnerable groups (mothers and their children, people with disability)?
5	Sustainabi lity	1. To what extent were sustainabil ity considerati ons built into programm e implement ation, in terms of recruitmen t, training and retention of CMVs, among others?	Survey findings, beneficiarie s, NGO and government partners	Survey, IDIs, KIIs	Medium	**QI** - Did you feel that the program had a sustainable impact on the refugee HHs that received the intervention? What behaviors did you observe still being practiced, please provide some examples?
		2. To what extent have the beneficiarie s sustained the good behaviors and	Survey respondent s	Survey, IDIs, KIIs	Medium	**QS1** ***water_treat:*** How do you treat drinking water? **QS1-** ***child_feces:*** How do you usually handle or dispose of your (or your household's) youngest child's feces?

		practices after the end of the interventio n?				**QS1-** ***garbage_disposal*****:** How do you dispose of garbage or other material waste? **QS1-** ***menstruation_use*****:** What do you (or women in your HH if you do not menstruate) use to manage blood flow during menstruation?
		3. To what extent have or can the achieved results be replicated or integrated into policies, strategies, and programme s?	Field Document s	Desk Reviews	Low	This will be addressed from the Desk reviews.