Independent Evaluation Report

End of Program Evaluation of DFAT's 'COVID-19 Response in Bangladesh' Investment

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Executive Summary

The following is the independent end of program evaluation of DFAT's 'COVID-19 Response in Bangladesh' Investment. In response to the rapidly evolving COVID-19 crisis, and Red Cross global appeal, 13 countries provide pledges, with Australia contributing A$5 million (16 percent) to Bangladesh's IFRC COVID-19 appeal. At the end of the program on 31st December 2022, the Australian contribution was fully utilised across three pillars of health, socio-economic and capacity building.

The objective of the investment was to support BDRCS's emergency response in anticipation of a COVID-19 surge similar to the Delta Wave experienced in India. The implementation period was initially one year (7 June 2021 to 30 June 2022), based on the expectation that COVID-19 response needs in that year would far exceed resources available to respond. As a result of the second wave being less severe than predicted and a slower than anticipated expenditure, the investment was extended by 6-months to end of December 2022.

The purpose of the end of program evaluation is to provide a systematic and objective assessment of effectiveness, efficiency and relevance of the 'COVID-19 Response in Bangladesh' investment, including the extent to which it delivered the intended outcomes and objectives. The evaluation also seeks to assess the effectiveness and efficiency of ARC, IFRC and BDRCS' delivery of the investment, including the implementation and management approach taken.

The pandemic significantly impacted the Bangladesh economy, especially affecting the poor. Particularly hard hit were workers laid off in the export garment sector which represent more than 80 percent of Bangladesh's exports. The lockdown also reduced domestic economic activity and the global pandemic slowed remittances from relatives in the Middle East. Improvements made in Bangladesh over the last decade in reducing poverty and improving health and education development indicators all suffered setbacks during the pandemic.

Effectiveness: Despite IFRC/BDRCS having some initial problems in collecting data and mobilisation, the grant was effective in contributing to a Bangladesh wide response to COVID-19 that coordinated and worked with government's response plans. Australia's contribution was effective in leveraging other resources. DFAT's pledge was one of 13 and BDRCS provided volunteers critical to the government's vaccination program and other COVID-19 related services. By March 2023, BDRCS had a total of 8,700 volunteers across its 68 branches and on average 1,660 volunteers were mobilised per day during BDRCS COVID-19 response.

Sustainability: The IFRC/BDRCS response to the COVID-19 pandemic contained both physical and functional elements of sustainability. On the physical side, the IFRC/BDRCS support provided for acquiring ambulances and the oxygen plant at the COVID-19 dedicated hospital and ensuring maintenance was incorporated into existing systems. A functional sustainable outcome from the IFRC/BDRCS response to COVID-19 was the development of it having deeper and more formalised relationships with the government in the delivery of services.

Relevance: IFRC/BDRCS close relationships through existing networks of formal and informal government relationships allowed it to remain relevant as the pandemic evolved. IFRC/BDRCS focus on the three pillars aligned with the government's strategy and with the WHO recommendations and global policy leadership. The different country pledges' conditions were complementary rather than creating "gap fillers" where more flexible financing was directed at those activities not able to be funded by more restricted pledges. Questions of whether Australia "over pledged", while difficult to judge prior to the pandemic, did not appear to be the case based on this evaluation's findings. The

priorities for IFRC/BDRCS and the government shifted as the pandemic developed, but the program of medical support, vaccination and hygiene continued to be important to manage the crises and prevent further outbreaks.

Efficiency: The funding of ARC to on-grant at no cost to IFRC and BDRCS was an efficient arrangement. The arrangement took advantage of DFAT's existing relationship with ARC and provided fiduciary, risk management and safeguard assurances which would otherwise have been difficult to put in place quickly. The contracting arrangements could have included better reporting requirements.

Recommendation: For future similar Humanitarian rapid funding, DFAT should include more detailed and specific reporting requirements.

Recommendation: Contractor's reporting requirements should as much as possible align with DFAT's fiduciary, risk management and safeguard reporting requirement and structure of reporting.

Value for Money was achieved by working though a multi-donor partnership under the umbrella of IFRC and working through BDRCS local network of branches and coordinated with government's efforts. IFRC/BDRCS provided ready access to 68 branches, 57 Mother and Child Centers, 9 Blood Banks and over 8,000 volunteers across Bangladesh 64 districts.

Gender Equality, Disability and Social Inclusion (GEDSI): ARC, IFRC and BDRCS, reporting is almost completely devoid of any gender data and no analysis of GEDSI. Gender data was collected, it just wasn't reported on. The reason given for not reporting GEDSI data was that humanitarian crises response organisation normally do not include GEDSI in reporting and there had been no explicit requirement by DFAT in its contract to provide such data.

Recommendation: At a minimum, future humanitarian emergency aid should require reporting on gender disaggregated data and consider including the cost, if any, in the contracting.

Managing Investment Financing: The management financing arrangement appeared to work well. There was a good flow of information between Australian High Commission, Dhaka and IFRC/BDRCS including several informal reports that were contractually not required. The informal reporting during the 18 months allowed Australian High Commission, Dhaka to report to Canberra on the investment's financial and outputs progress and more broadly on Bangladesh management of the pandemic.

Working Through Partnerships: DFAT's COVID-19 Response worked through existing partnerships and proved to be highly effective. Partnership in this case was closely tied to localisation and aligned with DFAT's localisation policy approach. The COVID-19 crisis has strengthened existing informal partnerships. There is now a closer working relationship between Australian High Commission, Dhaka and IFRC, and between BDRCS and Directorate General of Health Services (DGHS) at Ministry of Health and Family Welfare.

Recommendation: Partnership and localisation should be encouraged with considerations given to the feasibility of further or deeper partnerships and localisation in terms of counterpart's capacity and meeting fiduciary, risk management and safeguard assurances.

Introduction

The following is the end of program evaluation for DFAT's 'COVID-19 Response in Bangladesh' Investment. In response to the rapidly evolving COVID-19 crisis, the International Federation of Red Cross and Red Crescent Societies (IFRC) and the International Committee of the Red Cross (ICRC) launched a revised, coordinated appeals. Thirteen countries responded to Bangladesh IFRC appeal with a combined value of just over 20 million Swiss Franc (CHF), of this amount Australia was an early contributor with A$5 million, accounting for approximately 16 percent of the total. At the end of 2022 the Australian contribution was fully utilised across three pillars of health, socio-economic and capacity building. The following is the independent evaluation of DFAT's investment guided by DFAT's Statement of Requirement (see Annex A: Key Evaluation Questions and Scope).

Background

The 'COVID-19 Response in Bangladesh' project was funded by the Department of Foreign Affairs and Trade (DFAT) through an agreement with the Australian Red Cross (ARC). Activities were implemented by the International Federation of the Red Cross and Red Crescent Societies (IFRC) and the Bangladesh Red Crescent Society (BDRCS).

The objective of this investment was to support BDRCS's emergency response in anticipation of a COVID-19 surge similar to the Delta Wave experienced in India, sustain the ongoing COVID-19 response across the country (including the national vaccine rollout) and prepare and plan for potential future surges and/or concurrent disasters. It aimed to provide critical health and economic relief to those impacted by COVID-19 during a period of intense strain for Bangladesh's public health and social security systems.

The implementation period was initially one year (7 June 2021 to 30 June 2022), based on the expectation that COVID-19 response needs in that year would far exceed resources available to respond. By late 2021, COVID 19 cases had receded in Bangladesh and - while the country's caseload had been substantial - health systems had not been overwhelmed as expected. By December 2021, global pressure on vaccine stocks had reduced, allowing Bangladesh to vaccinate a large portion of its population, further reducing the likelihood of a COVID-19 health systems crisis. In light of this, IFRC/BDRCS sought a six month no-cost extension to ensure full expenditure with slightly amended project priorities (as approved by DFAT). The revised end date of the grant was 31 December 2022.

Objective

The purpose of the end of program evaluation is to provide a systematic and objective assessment of effectiveness, efficiency and relevance of the 'COVID-19 Response in Bangladesh' project, including the extent to which it delivered the intended outcomes and objectives.

The evaluation also seeks to assess the effectiveness and efficiency of ARC, IFRC and BDRCS' delivery of the investment, including the implementation and management approach taken. In light of the IFRC/BDRC's request for a no-cost extension to complete investment activities, the evaluation explores the extent to which partners utilized funding effectively and efficiently to achieve timely and relevant results and identify the factors that may have contributed to a delay in program implementation. The evaluation also examines the timeliness, relevance and efficacy of adjustments made throughout the program period in response to:

- Changes in the COVID-19 caseload in Bangladesh
- internal organisational factors (relevant to ARC or its downstream partners)
- experiences gained during the implementation process and / or

- changes in the risks and/or assumptions relevant to the project.

Methodology

The methodology is based around the collection of quantitative and qualitative data to address each of the key evaluation questions and cross-cutting themes identified in the evaluation plan (see Annex A: Key Evaluation Questions and Scope). The methodology was flexible to address changing circumstances and respond to information collected during the fieldwork. The methodology was also informed by DFAT's refreshed Design and Monitoring & Evaluation Standards, December 2022, which in turn, are based on the OECD DAC criteria of relevance, coherence, effectiveness, efficiency, impact, and sustainability. The key evaluation questions and methodology were informed by a review of the literature on measuring the impact of humanitarian aid.[1] The methodology included the following:

1. Inception meeting with ARC investment manager and Australian High Commission, Dhaka Humanitarian Team.
2. A desktop review of documents provided by DFAT and a secondary search for relevant documents (Annex B). This includes but not limited to:
    a. Rapid Funding Proposal for DFAT to support the BDRCS COVID-19 response by ARC and IFRC.
    b. Informal Update Reports from IFRC/BDRCS
    c. IFRC interim and final financial reports
    d. IFRC interim and final narrative reports
    e. 2021 Humanitarian Investment Monitoring Report (HIMR) for IFRC (prepared by DFAT) – interim reporting covering programs in the 2021 calendar year.
    f. IFRC Final narrative and financial reports (due to ARC by 10 April 2023).
    g. Secondary material covering Bangladesh response to COVID-19, Humanitarian best practice, and lessons learned from other country's response to COVID-19.
3. Discussion with the Australian High Commission, Dhaka to finalise the Evaluation Plan and refine the key questions and cross cutting themes.
4. Regular check-in meetings with the Australian High Commission, Dhaka and Australian Red Cross partnership manager (Canberra).
5. Virtual interviews in Australia with key stakeholders.
6. Field visit to Bangladesh to meet with key stakeholders, Including IFRC, BDRCS, Ministry of Health and Family Welfare and Hospital staff.
7. Initial validation workshop to highlight key findings for DFAT staff, answer questions regarding the draft evaluation report and adjust findings as needed.
8. Virtual validation workshop and discussion of draft report with wider set of stakeholders.

Interviews with stakeholders, whether in person or virtual, were open ended and explored key questions and cross cutting themes without necessarily asking key questions directly to interviewees. The interviews and the reading of secondary documents together sought to develop a narrative that was validated by triangulation of various forms of data, and in doing so strengthening the confidence in the findings.

[1] See for example: Hofmann, Charles-Antoine, Roberts, Les, Shoham, Jeremy and Harvey, Paul, 2004. Measuring the Impact of Humanitarian Aid: A Review of Current Practice. Humanitarian Policy Group, ODI.

Key Stakeholders

The list of key stakeholders was developed in conjunction with the Australian High Commission, Dhaka. It includes stakeholders in Australia and Bangladesh and consists of virtual and in person meetings. Additional interviews were added during the evaluation as evidence suggests further sources of information. Annex C provides the list of stakeholders interviewed.

All meetings whether virtual or in person followed a similar pattern. it included presenting an overview and purpose of the meeting, a confirmation of the confidentiality of evidence provided and/or confirmation to quote from the interview, an open-ended discussion around the key questions and cross cutting themes and finish with providing contact information for further follow up if needed.

Analysis and Findings

In March 2020 the first cases of COVID-19 were confirmed in Bangladesh, and in the same month the first deaths from the virus were recorded. From there the pandemic spread rapidly across the country with Bangladesh the second most affected country in South Asia, after India.[2] By March 2023, the World Health Organization (WHO) had recorded in Bangladesh just over 2 million COVID-19 cases and just under 30 thousand deaths. Figure 1 provides a summary of weekly and cumulative COVID-19 cases and deaths recorded by the WHO. Figure 1 also shows (blue vertical lines) the timing of Australia's grant, with the start date, one year end date and the 6-month extension shown.

Once established COVID-19 spread quite rapidly in Bangladesh. Initially COVID-19 infections remained low but by April rates of infections had started to rapidly increase. As a result, from 23 March to 30 May 2020 the Bangladesh government declared a national "lockdown". By early April, new cases were growing at a rate of 1,155 percent, and by early May, COVID-19 was confirmed in all 64 districts. In contrast to other countries, the rate of infections was comparatively high. By April 2020, Indonesia, the second highest rate of COVID-19 in Asia had only one-sixth the rate of infection compared to Bangladesh. By mid-June 2020 the number of cases in Bangladesh exceeded the number of cases in China.

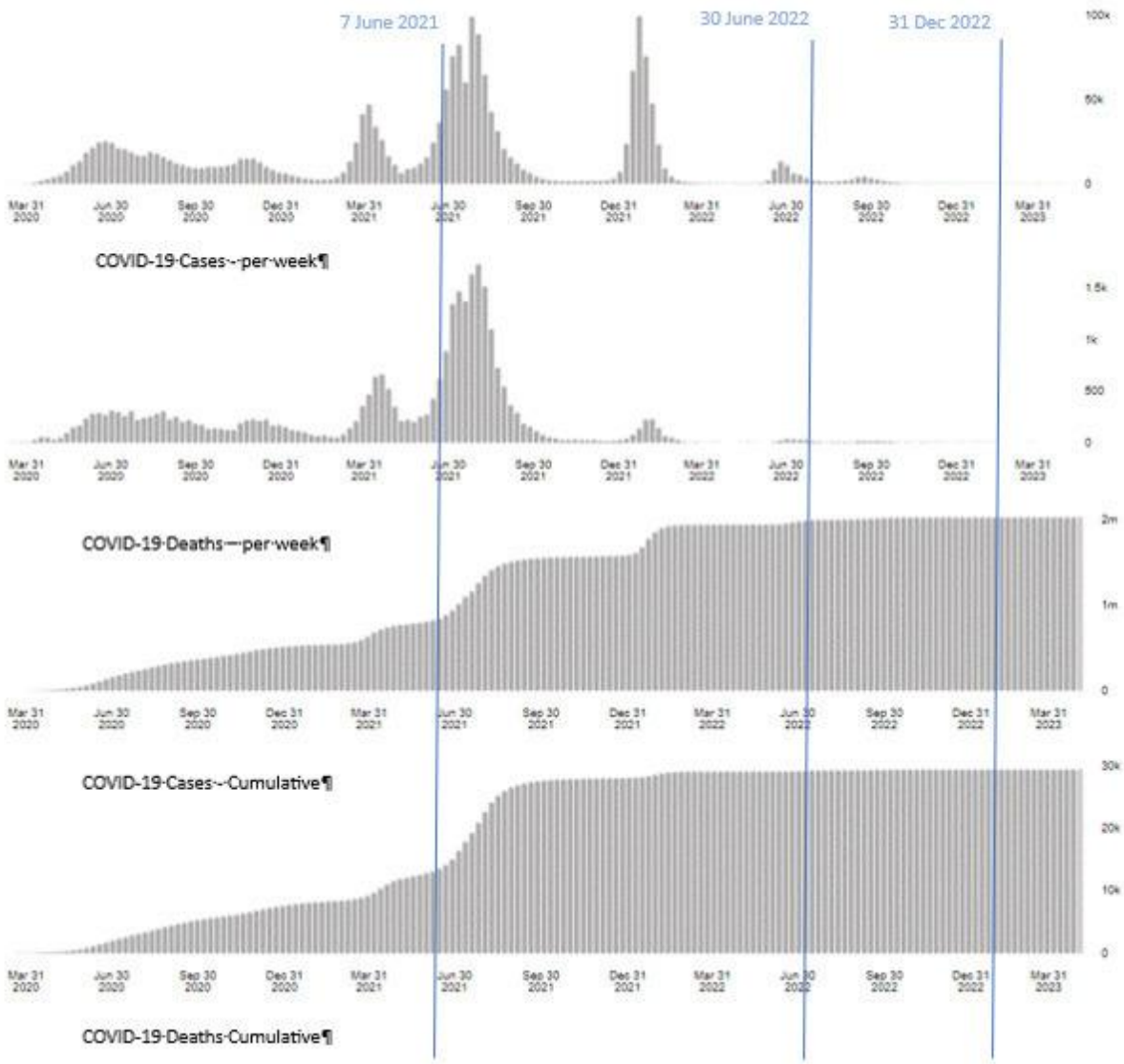
As was the case with most if not all countries, Bangladesh was ill prepared for the COVID-19 pandemic. Initial testing was centralised and only done by the Institute of Epidemiology, Disease Control and Research (IEDCR) in Dhaka. Throughout 2020 and the first half of 2021, routine testing was not adopted in Bangladesh. Testing was one of the lowest rates per capita in the world.[3] At the same time, at the start of the pandemic, Bangladesh has only 1,169 ICU beds, of these 432 beds were in government hospitals and 737 in private hospitals.[4] The country also had only 550 ventilators.[5] There was concern that Medical-grade Oxygen was low compared to the demand being created by the pandemic.[6]

In response to COVID-19, Bangladesh rapidly increased the rate of vaccination. Initially the rate of vaccination was constrained by shortage of supplies. In response to the emerging pandemic, Bangladesh began COVID-19 vaccination on 27 January 2021, with mass vaccination starting on 7 February 2021. A large number of COVID-19 vaccines were ordered from India but due to supply

[2] Research (IEDCR), Institute of Epidemiology, Disease Control, Bangladesh.
[3] "Coronavirus Outbreak: Low test rate may be belying reality". The Daily Star. 1 April 2020.
[4] "Number of ICU beds insufficient to combat COVID-19 pandemic". Dhaka Tribune, 21 March 2020.
[5] "Bangladesh may suffer setback in its fight against coronavirus for shortage of life-saving ventilators". United News of Bangladesh, 10 April 2020.
[6] Latifee, Enamul Hafiz; Latifi, Tanzia Islam (3 May 2021). "What Bangladesh should learn from the recent C-19 spike in India?". The Daily Observer (Op-Ed).

constraints only half of the initial doses were made available. In response, Bangladesh approved the use of vaccines from Russia and China. Eventually vaccines were received from the international community, including China, United States, Japan and under the COVAX programme. By early 2023, 88 percent (150 million) of the population had received a first dose, 82 percent (139 million) a second dose and 48 percent (67 million) a third dose of COVID-19 vaccine.[7]

Figure 1: Bangladesh COVID-19 Cases and Dates for DFAT's Grant and Extension



Source: WHO Health Emergency Dashboard. https://covid19.who.int/region/searo/country/bd

The COVID-19 pandemic significantly impacted the Bangladesh economy, especially affecting the poor. Estimated unemployment in mid-2020 reached 22 percent with the incident of poverty significantly increasing.[8] Economic growth declined from close to 7 percent pre-pandemic to 2 percent

[7] COVID-19 Vaccination Dashboard for Bangladesh. http://dashboard.dghs.gov.bd/webportal/pages/covid19-vaccination-update.php.
[8] https://www.adb.org/results/adb-helps-bangladesh-road-recovery-covid-19.

in 2020.[9] Particularly hard hit were workers laid off in the export garment sector which represent more than 80 percent of Bangladesh's exports. The lockdown also reduced domestic economic activity and the global pandemic slowed remittances from relatives in the Middle East.[10] Improvements Bangladesh had made over the last decade in reducing poverty and improving health and education development indicators all suffered setbacks during the pandemic.

In response to the health, humanitarian and economic crises created by the COVID-19 pandemic, Australia and 12 other donors responded to the International Federation of Red Cross and Red Crescent Societies (IFRC) appeal for Bangladesh.[11] Australia's response was informed by a deep concern that Bangladesh might be affected in the same way India had been, pre-vaccination. The response was intended to help Bangladesh avoid a health systems failure as was seen in India during April-June 2021. The anticipation of such failure was the primary reason for Australia's assistance to Bangladesh. In June 2021, Australia provided A$5 million pledge in Humanitarian aid to the Australia Red Cross (ARC), to on-grant to IFRC/BDRCS to bolster Bangladesh's preparedness for an acute COVID-19 crisis. Australia's contribution made up 16 percent of the overall IFRC/BDRCS pledges made to Bangladesh. Australia's pledge was the second largest with the largest being from USAID.

Figure 2: Oxygen Plant Supported by DFAT Pledge at the Holy Family Red Crescent Medical College Hospital

Funds were provided under a head agreement between DFAT and the ARC, which allowed ARC to direct the contribution quickly toward IFRC Bangladesh's COVID-19 appeal. IFRC and BDRCS then delivered assistance. Under the agreement and in line with IFRC/BDRCS international strategy, the grant was provided to support three pillars of:

[9] https://www.imf.org/en/News/Articles/2020/06/11/na-06122020-helping-bangladesh-recover-from-covid-19.
[10] Ibid.
[11] As of April 2023, total support for IFRC COVID-19 global appeal stood at 670 million Swiss Franc (A$ 1,112 million): https://go.ifrc.org/emergencies/3972. Of this amount a little over A$33 million (or 20 million Swiss Franc) was dedicated to Bangladesh.

1. **Curb the Pandemic – Sustaining Health and WASH.** Its objective was to support National Society contributions to reducing illness and loss of life, while protecting the health, safety and wellbeing of the most vulnerable people, by supporting efforts to contain, slow or suppress transmission of the virus, treating cases, and helping affected communities maintain access to essential health and social services.
2. **Tackling Socio-Economic Impacts.** Its objective was to support National Society contributions to protecting the livelihoods and wellbeing of the most vulnerable people, by addressing the socio-economic impact of COVID-19.
3. **Strengthening National Society.** Its objective was to provide National Society with programmatic support for preparedness and institutional readiness to respond to COVID-19, as well as other disasters and crises, through sound preparedness and contingency planning.

Key Finding: COVID-19 was unlike any crises experienced in recent history. At the beginning no one anticipated the full impact of the pandemic. It evolved from a health crisis to a humanitarian crisis to an economic crisis. Most countries were ill prepared to manage the response needed.

Effectiveness

The following provides an assessment of how effective Australia's humanitarian grant was in achieving the objectives and outcomes as outlined in the Rapid Funding Proposal, submitted by the ARC and summarised in the above analysis. As with most humanitarian aid, the focus of the evaluation is less on attributing results to Australia's investment and more on assessing the effectiveness of Australia contribution.

In terms of outputs related to Australia's grant BDRCS and IFRC provided several reports, including the overview infographic summaries presented in Annex D and E respectively. Annex D provides a summary of BDRCS outputs from June 2021 (the start of the grant) to December 2022 (the end of the 6-month extension). Annex E provides IFRC list of outputs and dates from February 2020 to December 2022. The differences in the outputs listed in Annexes D and E are a result of the different dates and BDRCS reporting against the Australian grant and the IFRC reporting against the IFRC/BDRCS 13 pledges made, of which Australia represents 16 percent.

In measuring whether the outputs listed in Annex D and E were effective in delivering the outcomes and objectives as was envisaged under DFAT's humanitarian grant and IFRC/BDRCS three pillars, it needs to be recognised that the pandemic was a unique global event that very few countries or disaster organisations were prepared for. In most Asia countries the response evolved and changed as the pandemic transformed from a health crisis to a humanitarian to a socio-economic crisis.

Key Finding: Despite some initial problems in collecting data and mobilisation, the grant to IFRC/BDRCS was effective in contributing to a Bangladesh wide response to COVID-19, coordinated and worked with government's response plans and provided access to BDRCS nationwide network of branches and volunteers.

IFRC/BDRCS are uniquely qualified and setup to deal with natural disasters. In this respect BDRCS has a large network of branches or societies across all 64 Bangladesh districts.[12] Moreover, it has an extensive network of volunteers that were mobilised during the pandemic and a range of protocols in

[12] BDRCS has 68 branches/societies across the country.

place to manage resources and address natural disasters. During the height of the pandemic, IFRC/BDRCS were also managing two natural disasters (an earth quack and flood) at the same time.

The three pillars strategy adopted by IFRC/BDRCS is similar to many, if not most, country approach to the COVID-19 pandemic. In this respect it reflected an effective approach to addressing the pandemic. The approach complemented the government's strategy and worked closely with the government's working group to build a partnership that was responsive to addressing the pandemic and coordinated with and complemented the government's strategy.

Australia's contribution to the IFRC/BDRCS was effective in leveraging other resources. The services enabled by Australia's contribution and delivered by IFRC/BDRCS, whether ambulance services, oxygen, vaccination centre volunteers, cash grants or meals, were part of a larger effort than Australia could have proportionately delivered from a standalone grant. The global fund through the 13 pledges allowed economies of scale and leveraging off pooled resources. The investment also benefited from IFRC/BDRCS working closely with other actors and non-government organisations, including coordinating delivery through the government's working group. Finally, the choice of IFRC/BDRCS, to deliver Australia's aid, despite some initial difficulties in collecting data and mobilisation, provided access to a nation-wide network of BRDCS branches.

BDRCS volunteers were a critical component of the government's vaccination program. By March 2023, BDRCS has a total of 8,700 volunteers across its 68 branches and on average 1,660 volunteers were mobilised per day during BDRCS COVID-19 response. While the volunteers did not deliver the vaccine injections, they provided the logistical and support necessary for managing the vaccine centres around the country. Across its 68 branches BDRCS covered all the country's 64 districts and enabled it to provide support to the vaccination centres. The vaccination program's success and reach were a combined effort through the government program and the support provided by BDRCS and the large number of volunteers it mobilised. Supporting BDRCS highlights the importance of working with local partners that have an established service delivery infrastructure and networks.

The funding provided through the global appeal enabled IFRC/BDRCS to effectively support the government efforts. The funding of Australia and the other donors supported BDRCS efforts to mobilise volunteers in large number and provide them with training and logistics to effectively support the government's vaccination centres, unconditional cash transfers, cooked meals, ambulances, and oxygen services and much more (see Annex D and E).

Key Lesson: In a pandemic such as COVID-19 effectiveness requires being able to work through local actors at the district level, having access to a wide network of volunteers and being able to supplement, coordinate and support government's nationwide efforts.

A key measure of "success" is the speed at which IFRC/BDRCS were able to adjust to meeting the health, humanitarian and economic challenges created by COVID-19. The effectiveness of the IFRC/BDRCS efforts were initially hampered by a lack of available data and protocols in place to help it respond to the pandemic. The lockdown also hampered mobility. As mentioned earlier, IFRC/BDRCS did not initially have specific protocols in place to manage a national pandemic such as COVID-19. The initial lack of data collected by the government and at BRDCS branch level slowed the implementation of an effective response. In IFRC/BDRCS defence, the organisational structures were flexible enough to overcome these early setbacks and to adapt and develop effective ways to respond and manage

the pandemic. Moreover, the initial slow response was not unlike that experienced in other countries. For example, IFRC own internal review noted India had the same early difficulty in responding.[13]

What was clear from interviews and discussions with IFRC/BDRCS, and stakeholders was the existing IFRC/BDRCS protocols were not setup or intended to handle a pandemic of the size and nature of COVID-19. A large number of interviewees mentioned this was a new experience and that they needed to learn from it and develop better systems to be able to respond in future. IFRC/BDRCS protocols are traditionally more designed to manage natural disasters such as floods and earth quacks and man-made disasters such as the refugee situation in the world's largest refugee camp at Cox's Bazar in Bangladesh.

A theme that came through a number of interviews was the need for IFRC/BDRCS to be better prepared for a future pandemic. Specifically, interviewees identified a number of improvements that could be made, that were also identified in IFRC internal review. In addition to those already mentioned, it included strengthening management through additional training, ongoing training for volunteers at the local level, and importantly, developing greater local organisational capacity. The lock down brought home the importance of having to rely on and work through the 68 BDRCS branches. Additional improvements identified included having an emergency fund and the ability to better collect data at the local level and ability to mobilise quicker.

Sustainability

While responses to humanitarian crises do not always prioritise sustainability, in the IFRC/BDRCS case it is worth a brief mention. The IFRC/BDRCS response to the COVID-19 pandemic contained both physical and functional elements of sustainability. On the physical side, the IFRC/BDRCS support provided for acquiring ambulances and the oxygen plant at the COVID-19 dedicated hospital at the Holy Family Red Crescent Medical College Hospital (Figure 2). These and other purchased equipment are likely to be available for use long after the immediate crises.[14]

The equipment is likely to be maintained through incorporation into existing hospital maintenance budgets. Too often equipment from donor projects is lost at the end of a project through provisions not being made for maintenance. The Holy Family Red Crescent Medical College Hospital was asked whether provisions had been made for maintenance of the IFRC funded equipment. The hospital management responded that maintenance for the equipment was being integrated into existing systems. IFRC indicated maintenance for ambulances would also be included in the various hospital budgets.

A functional sustainable outcome from the IFRC/BDRCS response to COVID-19 has been the development of deeper and more formalised relationships with the government in the delivery of services. An MOU is being finalised between BDRCS and Director General of Health Services (DGHS) with the support of IFRC setting out how the two entities would work together during a crisis. A further MOU between BDRCS, DGHS and IFRC is being finalised for Cox Bazar for the delivery of Primary health Care. IFRC/BDRCS identified this as an important sustainable outcome evolving out of the close cooperation during the COVID-19 crises and for managing future pandemics. From Australian High Commission, Dhaka perspective and supported by conversations with the head of IFRC in Bangladesh,

[13] Key Aid Consulting, March 2023. Internal Review of COVID-19 Operations in Bangladesh and India. Final Report.
[14] For a more complete list of outputs than mentioned in Annex D and E see ARC final narrative report to DFAT dated April 2023.

the working relationship with IFRC during the crises has also strengthened and is likely to be important for responding to future natural disasters.

Relevance

Australia's pledge, as with all 13 pledges made for Bangladesh's Red Cross global appeal, remained relevant throughout the crises. The funding allowed IFRC/BDRCS to mobilise resources otherwise not available to the government. Furthermore, without the 13 pledges IFRC/BDRCS would not have had the resources to mobilise and implement the program it did.

IFRC/BDRCS focus on the three pillars remained relevant over the period of the investment. The three pillars, as were put forward in the ARC-IFRC proposal to DFAT dated June 1st 2021, continued to be the foundation for IFRC/BDRCS program over the 18 months. Despite the pandemic not developing in Bangladesh as had been expected following the pattern in India, the IFRC/BDRCS continued to deliver activities relevant to all three pillars. The three pillars and the government program aligned with the WHO recommendations and policy leadership. During the latter part of the 18 months, activities shifted more to delivering against pillar two and three as might be expected during an evolving crisis.

IFRC/BDRCS close relationships through existing networks of formal and informal government relationships allowed it to remain relevant as the pandemic evolved. IFRC/BDRCS focus on the three pillars aligned with the government's strategy and worked closely with the government's working group to deliver what was needed as identified by the government's health and humanitarian program. Monthly meetings attended by IFRC/BDRCS and convened by the Ministry of Health and Family Welfare coordinated government and non-government actors. These meetings were supplemented by IFRC/BDRCS informal sharing of information and responding to request for assistance. IFRC/BDRCS networks on the ground and within government were built over many years in managing natural disasters and through retired and previously senior government officials holding positions in IFRC/BDRCS. Such networks of trust are important in time of crises to allow coordination and delivery services without protracted negotiations or formal agreements.

The issue was raised of Australia untied pledge's relevance compared to those pledges that were more directed. The concern was that within a multi-donor pool of funds, pledges that were unconditional may be used to "fill gaps" by the executing agency rather than address key areas of concern.[15] The ARC acknowledged this can happen and identified countries where this is likely to have happened. However, the ARC and IFRC/BDRCS maintained this was not the case in Bangladesh.

Different pledges' conditions were complementary rather than creating "gap fillers". USAID provided the largest pledge of 67% to the global Red Cross appeal and required funds to be spend through the Ministry of Health and Family Welfare. Figure 3 shows the DGHS trucks funded by USAID for carrying vaccines to centres spread throughout the country's 64 districts. The vaccine centres were supported by BDRCS and its volunteers. The activities of IFRC/BDRCS were coordinated through the government's working group and subgroups rather than determined by the conditions tied to pledges. In this respect the use of funds was determined by needs, coordinated by government planning, and supported by minimal conditions placed on funds.

[15] The term "fill gaps" refers to the most flexible funding sometimes being used for funding activities that remain after more conditional financing have been used and implies less "newsworthy" if no less necessary funding.

Key Lesson: In a rapidly changing large scale pandemic, remaining relevant requires flexibility to respond to changing circumstances; an ability to have local reach and capacity to deliver services; and trust to work closely in a government-and non-government coordination effort.

Several elements of Australia's pledge to the Red Cross appeal were relevant. DFAT's early pledge was influential in bringing on board other pledges. Both ARC and IFRC independently and without prompting said that Australia's early pledge helped encourage other pledges. While it is quite likely that USAID and others would have pledged support regardless of Australia's support, it is also recognised that a significant pledge by a respected partner such as DFAT had a catalytic effect on other donors' view of fund-raising efforts.

Figure 2: Directorate General of Health Services Refrigerated Vaccine Transport Trucks Supported by USAID Pledge

The question can be asked whether Australia "over pledged" given the 6-month extension required for disbursing the funds and the second wave of COVID-19 was less severe than anticipated? The question goes to the relevance of Australia's investment. At the time of the pledge, it was not possible to accurately predict how the pandemic would develop in Bangladesh, other than by looking at India and assume a similar scenario would play out. While the nature of the crises changed, the humanitarian crises and social dishevel and poverty created continued, and Australia's investment remained relevant. As evident from other countries and the WHO policy guidelines, the program of medical support, vaccination and hygiene continued to be important to manage the crises and prevent further outbreaks. Had Australia pledged a smaller amount with the promise of a second tranche if the crises worsened or continued, it would have had several consequences. A series of tranches would have impacted how IFRC/BDRC could plan, mobilise and support the government, it would likely have affected Australia's reputation and could have influenced other pledges to structure the same, with significant consequences.

The early commitment by Australia, the size of the commitment and the flexibility in the funding arrangement enhanced Australia reputation as a partner of choice. Other pledges contained some of

the same elements and IFRC/BDRCS appreciated all pledges and without doubt the large USAID pledge was particularly welcome. Australia's reputation as a donor of choice has not been built on one investment, but in this case DFAT's pledge to the Red Cross appeal and how it was structured and managed added to Australia's reputation as a partner of choice.

Efficiency

The efficiency analysis are primarily limited to considerations of how Australia's investment performed. The efficiency approach considers the working relationship between Australian High Commission, Dhaka, IFRC, BDRCS and government counterparts. A more detailed internal review of IFRC/BDRCS COVID-19 operations in Bangladesh and India was carried out on behalf of IFRC/BDRCS, and a report was prepared for management.[16] The internal review focused very much on the operational efficiency at the delivery end. In this respect DFAT's independent evaluation is different in that it focuses on the efficiency of Australia's investment. IFRC/BDRCS internal review, overlaps in part with this evaluation, while the language used is somewhat different. Given the overlap, it is worth briefly mentioning the findings of the internal review (which covered both Bangladesh and India) without making any judgement, the following lists selective key findings from IFRC/BDRCS internal review that are related to Bangladesh:

1. Receiving large allowances over a short period of time has been a challenge. In June 2022, 6 months before the end of the appeal, spending rates were low with 41 per cent for Bangladesh.[17]
2. BDRCS was quick to play an auxiliary role and support the government and affected populations with small-scale disinfection activities and food distributions, as requested. These activities were very popular and helped the BDRCS gain the trust of the population.
3. BDRCS has been able to forge a much closer relationship with the GoB, especially with the Directorate General of Health Services (DGHS).
4. Across the country, the 68 local branches of the BDRCS actively supported the national vaccination campaign against COVID-19.
5. With this programme, for the first time in its history, the BDRCS covered all geographical areas of Bangladesh simultaneously.
6. The contraction of the global economy and the problems caused by the subsequent waves in the international market also led to partial deliveries and unavoidable long delays.
7. Limited epidemic preparedness plan/preparatory action activities were carried out. Roles and responsibilities were not defined within the organizations, as they are for other types of rapid-onset emergencies.
8. Initially IFRC conducted limited situation analysis, due to the area to be covered by the assessments was very large and restrictions on movement prevented field visits.
9. At the beginning of the crises a joint-planning tool relevant for the pandemic did not seem to exist at the level of the IFRC.[18]

[16] Key Aid Consulting, March 2023. Internal Review of COVID-19 Operations in Bangladesh and India. Final Report.

[17] The IFRC/BDRCS internal review primarily explains the low spending rate due to "lack of a sufficiently detailed response analysis at the country level"; "limited epidemic preparedness"; and "emergency staffing mechanisms were not fit for purpose in such a context". See IFRC/BDRCS internal review's conclusion (page 27-28).

[18] Since Australia's initial funding of IFRC/BDRCS response to the pandemic and in response to the IFRC/BDRCS internal review, IFRC/BDRCS has updated and revised its systems and tools to be better prepared in future, this includes the development of an MOU with DGHS.

In regard to Australia's contribution to the global Red Cross appeal for Bangladesh, the funding to ARC to on-grant at no cost to IFRC and fund BDRCS was an efficient arrangement. On first appearance it might seem convoluted to fund ARC to on-grant to IFRC and finance BDRCS efforts. However, the process was efficient as measured by speed in responding to the global appeal and simplicity in meeting fiduciary, risk management and safeguard conditions. The global appeal from the International Red Cross was of some urgency and was relayed to DFAT through ARC with whom DFAT has an ongoing relationship. The global appeal was for funding IFRC in Bangladesh (and a number of other countries) and to work with IFRC Bangladesh and BDRCS. The arrangement was efficient in that it:[19]

1. Took advantage of DFAT's existing relationship with ARC and could respond quickly to IFRC international appeal.
2. ARC provided fiduciary, risk management and safeguard assurances which would be difficult to manage by DFAT and take time if it was done directly with IFRC Bangladesh or BDRCS.
3. ARC provided value added in terms of supporting IFRC.
4. There was no cost to DFAT in the on-granting process.

The alternative would have been to fund IFRC Bangladesh or BDRCS directly. Funding IFRC Bangladesh directly would have been inefficient in terms of supporting a global effort, contracting and putting in place DFAT specific fiduciary, risk management and safeguard conditions. ARC acknowledged that IFRC had in place good baseline understanding of DFAT requirements, founded on a history of working with a range of donors. What ARC provided, therefore, was information and input to help IFRC align with DFAT's requirement and assurance for DFAT that IFRC was meeting its conditions.

Funding BDRCS directly was not possible and would have been inefficient for the same reason as funding IFRC Bangladesh. Furthermore, it would have created tensions between IFRC Bangladesh and BDRCS existing relationship and undermine IFRC's global effort. DFAT's own contracting requirements, including the need to establish a due diligence assessments before entering into a contracting arrangement, meant establishing a direct arrangement would have taken much longer to establish. This would have delayed provision of time-sensitive financial assistance at a time when Bangladesh was expected to experience an India-like health-systems crisis.

Key Lesson: Australian High Commission, Dhaka relationship with local on the ground actors is critical for being able to assess needs and respond to an emergency quickly.

As previously mentioned, funding IFRC/BDRCS was effective and efficient in respect to being able to deliver services through an existing on the ground network across all Bangladesh's 64 districts, noting the earlier comment from IFRC/BDRCS internal review, that this was the first time such an endeavour had been undertaken by BDRCS.

The contracting arrangement was efficient but could have included better reporting arrangements. The contract between DFAT and ARC endorsed IFRC/Bangladesh three pillar proposal as the objective with a six month and an end of investment report required. In reality, Australian High Commission,

[19] BDRCS own reporting (Annex D) can be used to calculate a simple "cost-per-beneficiary" output for Australia's A$5 million investment. BDRCS Annex D reports a total of 1,239,794 beneficiaries across the various services proved (hot meals, vaccinations, ambulances etc), divided by Australia's A$5 million investment equals a cost of A$4.03 per head of beneficiary. However, such a calculation does not measure the ongoing tangible benefits (from ongoing capital investments such as the oxygen equipment) or the intangible benefits of being part of a larger effort or the improved response mechanisms and relationships it has fostered.

Dhaka received a number of ARC-IFRC Narrative Reports and BDRCS COVID-19 Updates. It also received ARC-IFRC Interim Financial Reports and ARC-IFRC Expenditure Forecasts. These were provided approximately every 6 months. The format of these were primarily determined by ARC-IFRC and BDRCS and based on the objectives of the three pillars. The reports provided were informative as was the ARC-IFRC Final Narrative Report as required under the contract. The practice of providing these reports was based on IFRC/BDRCS good practice, existing relationship with Australian High Commission, Dhaka and DFAT's Grand Bargain commitments to use partner-led reporting.

A more formal contractual arrangement in terms of reporting may have helped with meeting Canberra requirements without overburdening any of the recipient organisations. At all stages ARC, IFRC and BDRCS were compliant and provided information as requested. However, the sharing of information relied on the good relationship that existed between Australian High Commission, Dhaka and IFRC and between ARC and DFAT Canberra. As IFRC/BDRCS were already collecting regular data (including disaggregated data) for their own management and reporting, DFAT could have maintained its Grand Bargain commitment to using partner-led reporting, while still requesting more frequent and detailed reports that better complied with its own internal reporting needs. This would have led to about the same amount of work for the recipient organisations and provided Canberra with more structured reporting while maintaining the close working relationship between Australian High Commission, Dhaka and IFRC/BDRCS.

Recommendation: For future similar Humanitarian rapid funding, DFAT should include more detailed and specific reporting requirements.

Recommendation: Contractor's reporting requirements should as much as possible align with DFAT's fiduciary, risk management and safeguard reporting requirement and structure of

The slower than expected expenditure and implementation by IFRC and BDRCS of Australia's investment had little to do with inefficiencies. The slow expenditure had more to do with unforeseen consequences from the global pandemic. The 12-month time frame was always seen (at least by ARC) as ambitious for disbursing the funds. The expenditure was slower than Australian High Commission, Dhaka had initially expected. However, this was more an issue for Australian High Commission, Dhaka and Canberra in managing the contract than ARC, IFRC or BDRCS contractual considerations. In part the delay in expenditure was caused by procurement being held up because of disruption to global supply lines and the second wave of COVID-19 being less severe than anticipated. The reality is that natural and humanitarian disasters, especially on the scale and type as presented by COVID-19 are hard to predict.

In terms of managing the contractual arrangements, several solutions can be suggested. This could include an inbuild option in the initial contract for a 6-month no-cost extension or including a longer contract period than initially anticipated. None of these are perfect solutions. Given what was known at the time of contracting, while the period of 12 months might have seemed ambitious, it was probably the right decision.

Key Finding: Value for Money was achieved by working though a multi-donor partnership under the umbrella of IFRC and working through BDRCS local network of branches and coordinated with government's efforts.

When efficiency is measured in terms of Value of Money, the administrative and delivery arrangement demonstrated value for money. First, regarding administrative value for money, the arrangement of funding ARC to on-grant IFRC to finance BDRCS meant that the cost of administration and ensuring compliance was minimal. It required no new arrangements since ARC had existing processes and safeguards in place previously approved by DFAT. The on-granting was at no cost and ARC provided additional value by supporting IFRC in Bangladesh. In terms of delivery, as has been previously highlighted in this report, by working through IFRC/BDRCS, it provided ready access to 68 branches, 57 Mother and Child Centres, 9 Blood Banks and over 8,000 volunteers across Bangladesh 64 districts. It provided further value for money by IFRC/BDRCS plans closely complementing and aligning with government plans. The funding arrangement worked through a global coalition of 13 pledges and support, providing greater benefits than Australia could achieve if it went alone.

Cross Cutting Themes

The following covers four specific thematic cross cutting themes that were identified from discussion with Australian High Commission, Dhaka, background reading and initial discussions with stakeholders. The cross-cutting themes are important considerations for DFAT and future similar investments. An analysis of the reporting provided by ARC, IFRC and BDRCS, although extensive, is almost completely devoid of any gender data and no analysis of gender or Gender Equality, Disability and Social Inclusion (GEDSI). Given the importance of GEDSI and the requirement for DFAT to report on GEDSI this was of concern. The issue of GEDSI data and analysis was raised with ARC, IFRC and BDRCS. Every person from the three Red Cross organisations that was asked about gender data mentioned that gender disaggregated data was collected, it just wasn't reported on. The only data reported on in ARC Final Narrative Report was a breakdown by gender of volunteers trained. Data on people with disabilities was in most cases not collected. Although for vaccination, food distribution and unconditional cash grants, data was collected by gender, age and disability and used in decision making. The reason for not reporting on the data was not because it wasn't important but because as a humanitarian crises response organisation this data was not normally included in reporting and there had been no explicit requirement by DFAT in its contract to provide such data.

Recommendation: At a minimum, future humanitarian emergency aid should require reporting on gender disaggregated data and consider including the cost, if any, in the contracting.

In discussion with ARC, it was clear that the issue was perhaps more complex than making sure existing GEDSI data collected was reported on. ARC indicated that for appropriate reporting and analysis of GEDSI data, not only would it need to be included in the contracting arrangement, but capacity for GEDSI reporting and analysis would need to be developed prior to the crisis unfolding. The reporting of gender disaggregated data could be done relatively quickly in future similar circumstances by including the requirement in the contracting. But for additional disability and social inclusion data collection and analysis that was not already being done, this would likely increase costs and require additional capacity development as the skillset didn't exist among most existing staff requiring either additional training and/or additional staff. Such capacity development needs to be developed before the start of a humanitarian emergency.

Humanitarian Crises

Within the evaluation's scope, the question was asked what lessons can be learned from providing funding in anticipation of a humanitarian crisis. How can future similar investments in Bangladesh ensure that it adequately addresses an emerging humanitarian crisis?

It should be noted that humanitarian policy and responses are a specialist area that this evaluation is not designed to cover. DFAT has produced a policy paper titled Partnerships for recovery: Australia's COVID-19 Development Response, which sets out how Australia intends to respond to the COVID 19 crises in its region. With these limitations in mind, the following are some brief observations drawn from DFAT's 'COVID-19 Response in Bangladesh' Investment:

1. Early and relatively flexible support, that includes appropriate checks and balances is an appropriate response.
2. For humanitarian aid delivery, working through existing and trusted local networks provide an important ability to reach those affected.
3. For meeting DFAT's fiduciary, risk management and safeguard conditions, working through existing DFAT relationships, improves the ability to respond quickly.
4. Good existing working relationships between Australian High Commission, Dhaka and the humanitarian delivery agency are important for effective and efficient partnerships and delivery.
5. Supporting national and local humanitarian agencies in terms of developing adequate response mechanisms and protocols helps preparedness for being able to respond to future humanitarian crises.

Managing Investment Financing

In reviewing the management of Australia's, A$5 million investment it was noted that the close relationship between Australian High Commission, Dhaka and IFRC/BDRCS provided a good flow of information, including several informal reports that were contractually not required, as well as other informal contact between Australian High Commission, Dhaka and IFRC/BDRCS. All three organisations, ARC, IFRC and BDRCS provided progress reports. IFRC also provided three interim financial reports and ARC provided at the end of April 2023 a final financial report as an attachment to their Final Narrative Report. The informal reporting during the 18 months allowed Australian High Commission, Dhaka to report to Canberra on the investment's financial progress and outputs, and more broadly on Bangladesh management of the pandemic. Australian High Commission, Dhaka relationship with a range of local actors was important for it to perform its function.

For emergency humanitarian grants, flexibility that allows a local partner to drive priorities while keeping DFAT informed (via ARC and via direct updates to the Australian High Commission, Dhaka) is an appropriate financial management approach. The investment expenditure by IFRC/BDRCS went differently than Australian High Commission, Dhaka or Canberra had initially expected. It was slower and IFRC/BDRCS's priorities changed when the second wave was less severe than anticipated. Despite the limited reporting requirement, the investment was well management through informal information flow between the contractor (ARC and IFRC/BDRCS) and Australian High Commission, Dhaka, who in turn kept Canberra informed.

As previously noted, more detailed and specific reporting requirements in the contract that aligned with DFAT's own reporting conditions would have led to information flows that would have better suited Canberra meeting its reporting requirements. Such a requirement would not necessarily have increased the burden on ARC or IFRC/BDRCS given the amount of informal reporting that took place, but it would have provided information flows more suitable for DFAT's internal reporting requirements and improve Australian High Commission, Dhaka's reporting and Canberra's management as well as improved coordination between Australian High Commission, Dhaka and Canberra.

Working Through Partnerships

In the case of DFAT's COVID-19 Response in Bangladesh, working through existing partnerships proved to be highly effective. Partnership in this case was closely tied to localisation and aligned with DFAT's localisation policy approach. As previously mentioned, by working with and through IFRC/BDRCS it provided access to 68 BDRCS branches, 57 Mother and Child Centres, 9 Blood Banks and over 8,000 volunteers across Bangladesh 64 districts. IFRC/BDRCS close relationship with government also meant BDRCS efforts were closely coordinated with those of the governments. This included formal coordination with the government's working group and informally sharing information and responding to government requests for support.

Recommendation: Partnership and localisation should be encouraged with considerations given to the feasibility of further or deeper partnerships and localisation in terms of counterpart's capacity and meeting fiduciary, risk management and safeguard assurances.

The COVID-19 crisis has strengthened existing informal partnerships. As mentioned earlier, there is now a closer working relationship between Australian High Commission, Dhaka and IFRC, and BDRCS is in the process of finalising an MOU with the DGHS outlining how the two will cooperate in responding to future crises. A further MOU is being finalised between BDRCS, DGHS and IFRC for Cox Bazar to operationalize delivery of Primary health Care for host communities. The development of the closer working relationships is a positive outcome from the crisis and may increase Australia's responsiveness to future crises.

Strengthening partnerships and localisation are best developed prior to a crisis. Existing partnerships should be encouraged as it will improve local delivery of essential services and improve Australian High Commission, Dhaka ability to respond in future. However, working through government systems and local partners can carry with it fiduciary, management and safeguard risks. In this regard, considerations should be given to reviewing what is needed to promote working further through partnerships in terms of counterpart's capacity and meeting fiduciary, risk management and safeguard assurances.

Lessons Learned and Recommendations

As a way of concluding, the evaluation provides a summary of the key findings, key lessons learned, and recommendations identified in this report. Additional key lessons not previously highlighted in the evaluations are also listed here.

1. **Key Lessons from the Evaluation not Previously Highlighted:**
    a. The evaluation recognises the importance of joining a global effort and being flexible to address an evolving humanitarian crisis.
    b. In designing and implementing humanitarian investments it is important to keep lines of management simple and clear in reporting and defining who is responsible for what.
    c. Working through government systems and local partners, where possible, is important for effective and efficient delivery.
    d. When working through government systems and local partners it is important to have adequate safety measures - checks and balances - in place.

The following are key findings, lessons learned, and recommendations highlighted throughout the evaluation report:

2. **Key Findings Highlighted in the Evaluation:**

    a. COVID-19 was unlike any crises experienced in recent history. At the beginning no one anticipated the full impact of the pandemic. It evolved from a health crisis to a humanitarian crisis to an economic crisis. Most countries were ill prepared to manage the response needed.

    b. Despite some initial problems in collecting data and mobilisation, the grant to IFRC/BDRCS was effective in contributing to a Bangladesh wide response to COVID-19, coordinated and worked with government's response plans and provided access to BDRCS nationwide network of branches and volunteers.

    c. Value for money was achieved by working though a multi-donor partnership under the umbrella of IFRC and working through BDRCS local network of branches and coordinated with government's efforts.

3. **Key Lessons Highlighted in the Evaluation:**

    a. In a pandemic such as COVID-19 effectiveness requires being able to work through local actors at the district level, having access to a wide network of volunteers and being able to supplement, coordinate and support government's nationwide efforts.

    b. In a rapidly changing large scale pandemic, remaining relevant requires flexibility to respond to changing circumstances; an ability to have local reach and capacity to deliver services; and trust to work closely in a government-and non-government coordination effort.

    c. Australian High Commission, Dhaka relationship with local on the ground actors is critical for being able to assess needs and respond to an emergency quickly.

4. **Recommendations Highlighted in the Evaluation:**

    1. For future similar Humanitarian rapid funding, DFAT should include more detailed and specific reporting requirements.

    2. Contractor's reporting requirements should align as much as possible with DFAT's fiduciary, risk management and safeguard reporting requirement and structure of reporting.

    3. At a minimum, future humanitarian emergency aid should require reporting on gender disaggregated data and consider including the cost, if any, in the contracting .

    4. Partnership and localisation should be encouraged with considerations given to the feasibility of further or deeper partnerships and localisation in terms of counterpart's capacity and meeting fiduciary, risk management and safeguard assurances.

Annex A: Key Evaluation Questions and Scope

The key evaluation questions are kept to a minimum with a number of sub-questions identified under each key question. Key questions are structured around DFAT's refreshed Design and Monitoring & Evaluation Standards, December 2022, which in turn, are based on the OECD DAC criteria of relevance, coherence, effectiveness, efficiency, impact, and sustainability. The key evaluation questions and methodology was also informed by a review of the literature on measuring the impact of humanitarian aid.[20] Some overlap occurs across the various sub-questions, but this is not uncommon. The following are the evaluation questions and sub-questions:

Key Evaluation Questions

Effectiveness: to what extend did the investment achieve its objectives and outcomes as outlined in the Rapid Funding Proposal, submitted by the Australian Red Cross (ARC)? Sub-questions include:

9. To what extent did partners utilized funding effectively to achieve timely and relevant results?
10. How effective was the investment in achieving ARC, IFRC and BDRCS' stated outcomes?
11. How effective was the ARC, IFRC and BDRCS' implementation and management approach?
12. To what extend did the investment reach its targeted population?
13. Were there any unintended outcomes?
14. Were the outcomes sustainable?

Relevance: how relevant was the investment in meeting COVID-19 related humanitarian and protection needs in Bangladesh? Sub-questions include:

1. How relevant was ARC, IFRC and BDRCS' method of implementation and management?
2. To what extend did the implementation and management approach remain relevant throughout the implementation period?
3. Was the spending in line with the original intent of the submitted proposal?
4. Were adjustments to the investment made in a timely manner?

Efficiency: to what extend was the approach taken by IFRC/BDRCS an efficient approach to achieving the COVID-19 related humanitarian and protection needs in Bangladesh? Sub-questions include:

1. How efficient was the ARC, IFRC and BDRCS' implementation and management approach?
2. What factors delayed IFRC and BDRCS' program implementation?
3. Was DFAT's contractual and financial arrangements efficient (I.e.: DFAT funds ARC, who funds IFRC, who funds BDRCS)?
4. Where implementing partners' planning and management systems efficient for supporting accurate financial projections, and timely implementation and reporting?
5. Was the DFAT Canberra - Australian High Commission, Dhaka arrangement in managing the investment efficient?

Cross Cutting Thematic Topics

As with most end of program evaluations, the emphasis is on evaluating how the investment performed and what lessons can be learned for future investments. In this regard there are four

[20] See references in Annex C: List of Documents Consulted.

specific cross cutting thematic topics that the evaluation will emphasise while seeking to answer the effectiveness, efficiency, and relevance questions. The thematic topics are:

GEDSI: The evaluation will seek to explore to what extend GEDSI data was collected, how feasible it was to do more, and importantly, how the date contributed to decision making.

Humanitarian Crises: how can future similar investments in Bangladesh ensure that it adequately address an emerging humanitarian crisis?

Managing Investment Financing: How can changing priorities and financing needs, especially once funds have been committed, be best managed?

Working through partnerships: What can we learn from working with and through government and partner systems to deliver investment outcomes?

Scope

The scope of the proposed independent evaluation is set out in the Statement of Requirement (SoR). The Evaluation Plan has not made any change to the scope as set out in the SoR. The scope aligns with the key question and the cross-cutting themes as described in the previous section. The SoR scope requires an evaluation and assessment of:

- **Any lessons that can be learnt from providing funding in anticipation of a crisis** noting that DFAT provided funding to ARC on the very reasonable assessment that the Delta Wave in India in the second quarter of 2021 would be mirrored in Bangladesh.
- **The effectiveness of the project** in achieving its objectives and outcomes as outlined in the Rapid Funding Proposal, submitted by the Australian Red Cross (ARC). This includes examination of the impact (intended, unintended, positive and negative) of the program on the target population, and the sustainability of those impacts.
- **The relevance of the project** and its implementation methods in meeting COVID-19 related humanitarian and protection needs in Bangladesh throughout the implementation period, including the extent to which funding was spent in line with the original intent of the submitted proposal.
- **The efficiency of the project** including factors impacting delayed expenditure of project funds (i.e. did the project demonstrate value-for-money?) and the efficiency of contractual and financial arrangements (I.e.: DFAT funds ARC, who funds IFRC, who funds BDRCS)
- **The effectiveness** of partners' planning and management systems in supporting accurate financial projections, and timely implementation and reporting.
- **Any unintended outcomes or consequences** of the project (positive and negative).

It will also explore and assess the extent to which:

- Gender, disability inclusion and protection were considered in project design, implementation, and reporting.
- Partners appropriately considered and implemented safeguarding policies, including on child protection, prevention of sexual exploitation and abuse and harassment (PSEAH), fraud, and environmental safeguards.
- Risks to project success were identified and managed by implementing partners, and the timeliness and appropriateness of how those risks (and relevant management strategies) were communicated to DFAT (via ARC or other channels).

- DFAT's management and administrative arrangements supported or hindered downstream partners' understanding of and implementation of project requirements.

While the evaluation focuses on evaluating the efficacy, efficiency and relevant of the completed investment, the final report will make recommendations, if any, that would improve DFAT, ARC or IFRC/BDRCs' approach to similar programs in the future.

Annex B: List of Documents Consulted

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Annex C: List of Stakeholders Interviewed

The following is a list of stakeholders that were interviewed during fieldwork in Dhaka and from remotely home base by video conference calls.

Australia Based

First name		Last name	Organization	Role
Emma		Brittain	a/g Assistant Director, Humanitarian & Development Deployments Section, DFAT	Canberra based Investment manager
Adrian		Prouse	Australian Red Cross	Head of International Humanitarian Programs
Semin		Qasmi	Australian Red Cross	Response Advisor

Bangladesh Based

First name	Last name	Organization	Role
Mr. Kazi Shofiqul	Azam	BDRCS	Secretary General
Sultan	Ahmed	BDRCS	Deputy Secretary General
Md. Mijanur	Rahman	BDRCS	Director, Disaster Response and Youth and Volunteer
Brigadier General (Dr.) S.M Humayun	Kabir (Retd)	BDRCS	Director-Health
A.H.M Mainul	Islam	BDRCS	Director, Finance
Mohammad Lutfor	Rahman	BDRCS	Director, HR & logistics
Mr. Imam Zafor	Sikder	BDRCS	Director-Youth & Volunteers
Md. Jahangir	Alam	BDRCS	Manager, COVID-19 operation
Sanjeev	Kafley	IFRC CD	Head of Country Delegation
Ali	Akgul	IFRC CD	Operation Manager, COVID 19
Dr. Amany	Ayub	IFRC CD	Health Manager
Raqibul	Alam	IFRC CD	Senior Manager, Programme Support
Dr. Abhishek	Rimal	IFRC CD	Manager, Country Support Platform
Mr. Arifur	Rahman	IFRC CD	Manager, Logistics and Procurement
Mr. Motiar	Rahman	IFRC CD	Senior Manager, Finance & Administration

Mr. Hasibul Bari	Razib	IFRC CD	Senior Manager, Disaster Preparedness, Response & Shelter
Mr. Mehedi Hasan	Shishir	IFRC CD	Manager, Livelihood & Cash
Maliha	Ferdous	IFRC CD	Sr. Manager-Resilience & PRD
Prof. (Dr.) S.M. Humayun	Kabir	Holy Family Red Crescent Medical College Hospital	Director
Dr. Md. Shamsul	Haque	Maternal, Neonatal, Child & Adolescent Health. Director General of Health Services	Director & Line Director
Sabeth	Ahmed	Australian High Commission, Dhaka	Humanitarian Program Manager
Emily	Macdonald	Australian High Commission, Dhaka	First Secretary (Humanitarian),

Annex D: BDRCS Infographic

BANGLADESH RED CRESCENT SOCIETY (BDRCS)

Covid-19 Operation

Supported by IFRC, Australian Red Cross (ARC), and Department of Foreign Affairs and Trade (DFAT)

June 2021 - December 2022

Cash Grant Support

Unconditional cash grant support was provided in 27 districts in coordination with the Bangladesh Post Office. 15,300 households received BDT 4,500 each (approx USD 52) whose income was disrupted due to the COVID-19 restrictions and overall pandemic situation.

POPULATION

76,500

Cooked Food

In coordination with the local branches, BDRCS provided cooked food support in **20** most affected districts. **176,850** food packets distributed.

POPULATION

176,850

Ambulance

BDRCS provided free 24/7 ambulance services to COVID-19 patients to transport them to the hospital in **21** districts.

POPULATION

2,344

PSS

BDRCS Volunteers provided Psychological First Aid (PFA) and Psychosocial Support (PSS) to the families of the COVID affected. **254** people reached the PFA and PSS services.

POPULATION

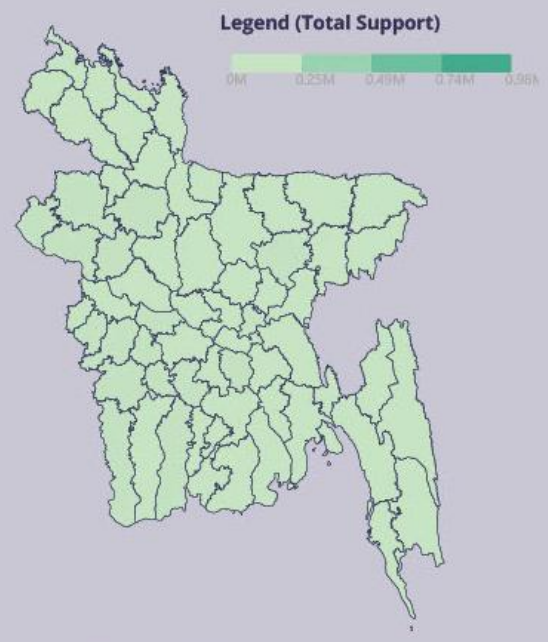
254

Govt. Support

- **100 BDRCS volunteers** assisted **360,000** individuals in the Outpatient Department (OPD) at Dhaka Medical College Hospital and Bangabandhu Sheikh Mujib Medical University Hospital.
- 24/7 support was offered at the Dhaka International Airport and **621,200** COVID-19 RT-PCR test reports were authenticated by volunteers.

POPULATION

981,200



Oxygen Support

- Installation of an oxygen generator plant with a filling system and gas pipelining was completed at Holy Family Hospital.
- BDRCS provided 24/7 free life-saving oxygen support to the **4,924** COVID-19-affected people who faced breathing problems. BDRCS branches in all districts and through its countrywide network of 56 Mother and Child Health (MCH) care centres opened hotline numbers.

POPULATION

4,924

National Society Development

- **66 (Female-20, Male-46) staff and volunteers** were trained in Protection, Gender, and Inclusion (PGI).
- BDRCS blood bank **renovation** in Dhaka and its necessary consumables and equipment were successfully purchased.
- The current power infrastructure which is not functioning properly renewed and IFRC CD has assisted BDRCS in procuring a new brand **200 kVA** generator with all fittings.
- **1,500 kVA** Power Substation in Holy Family Hospital was renewed to enhance its capacity.
- **Magura MCH centre** was built to enhance the BDRCS health infrastructure.

Annex E: IFRC Infographic