ROHINGYA CRISIS APPEAL

Mid-Term Evaluation Report of Age International's Age-Inclusive Humanitarian Assistance

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BACKGROUND

Twenty-fifth August 2017 marked a significant date when the targeted violence against the Rohingya communities and their exodus was recognised as a crisis. This persecution drove 671,000 people – many women and children, young, old, the infirmed to flee for their lives, becoming one of the fastest growing refugee crisis in current history.

The Bangladeshi Government opened its border communities to the Rohingya refugees officially referred to the Rohingya refugees as "Forcibly Displaced Myanmar Nationals" (FDMN). It helped put up temporary shelters for the FDMNs in about 6,000 acres of land in its border towns, which to begin with, are already very densely populated areas in the Ukhia and Teknaf Upazilas of the Cox's Bazar District. Thus, with the steady influx of refugees concentrated in these congested Upazilas of about half a million Bangladeshis, the strain on the socio-economic, political, and environmental aspects is overwhelming and most urgent.[3]

Two months after August, the refugee population in Cox's Bazar has more than quadrupled, according to the Joint Response Plan (March to Dec 2018). Before the said targeted violence that commenced on August 2017, there were already Rohingya refugees staying in Cox Bazar numbering 303,070. From the latest Situation Report Data Summary on the Rohingya Refugee Crisis of the Inter-Sector Coordination Group (ISCG), November 15, 2018, this number has now ballooned to 1,300,000, to include refugees in host communities as well. Refugees had steadily arrived by foot and by boat. Many suffer extreme exhaustion, hunger, and a host of cruelties along the way like gender-based violence (GBV), "attacks on their cultural identity and legal nationality", "forced statelessness", death of family members, denial of access to basic human rights as education, health care, food, movement and other traumas.

The Bangladeshi people and the Government of Bangladesh have generously responded to address the needs and demands of this massive refugee influx, as well as take care of the needs of its own people in the border host communities. And they were assisted by local and global humanitarian institutions, which responded with dispatch with its scaled-up operations. These humanitarian actors, including the UN, refugee formations and host communities, with the GoB at the helm, jointly acted to save lives put in jeopardy by the persecution in the Rakhine State.

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[3] Joint Response Plan (JRP) for the Rohingya Humanitarian Crisis (March to December 2018)

The humanitarian response community, specifically spearheaded by the Inter-Sector Coordination Group in Cox's Bazar, the Strategic Executive Group in Dhaka, and the GoB drew-up a Joint Response Plan for 2018, to collectively roll-out in coordinated, complementary fashion the timely and relevant response to the numerous needs of the refugees and mitigate the impacts on affected host communities. Such serious threats include:

- Congested living conditions increasing risks as disease outbreaks and fires;
- The coming of the rain and monsoon season that often lead to flooding and landslides;
- Massive pressure on the infrastructure, health and water services;
- Environmental degradation, especially the 4,800 acres of undeveloped, fragile forest and land resources at the border areas, which have been allocated for then new camp by the GoB up in September 2017.

In November 2017, the Governments of Bangladesh and Myanmar formed the Rakhine Advisory Commission and sat down to sign an agreement or arrangement on the repatriation and reintegration of the FDMNs. Very importantly, such arrangement should be "voluntary, safe and dignified, and sustainable". This is supported by the global community. Details to operationalize this repatriation is still being discussed by both Governments. The UNHCR is also engaging the Myanmar Government for unhampered access to Rakhine to bring development and humanitarian assistance to all people in need.

Regardless of this development and the continued pouring of the necessary, urgent humanitarian response, much work remains to be done. The response cannot cope with the steady growth in the scale of the needs of both the refugees and heavy burden on the carrying capacity of the host communities.

One such need, at threat of "falling through the cracks" of humanitarian assistance has to do with the rights and welfare of older people.

Brief summary of HelpAge International Response

Age International (HelpAge International UK) is one of the members of the Disasters Emergency Committee (DEC) and the UK member of the HelpAge Global Network. Age International manages the contracts and relationship with the DEC for this project, which is then implemented by HelpAge International in Bangladesh (HAIB). HelpAge International is providing assistance to the displaced Rohingya population in six camps, three of which are funded by the DEC. This evaluation covers the DEC-funded assistance in Camps 11, 12, and 18.

The project is implemented jointly with the Young Power in Social Action (YPSA), a local NGO based in Cox's Bazar, and Resource Integration Centre (RIC), a national-level NGO and a long-time partner of HAIB in the advocacy and programming of inclusion of ageing in Bangladesh. YPSA and RIC are responsible for implementing direct delivery of the humanitarian programme that is the subject of this evaluation. They are also responsible for site or camp-level advocacy but are also involved in national advocacy. HAIB supports the partners and has presence in Cox's Bazar, providing technical assistance, mentoring and accompaniment, and facilitating programme accreditation by government. HAIB's contract management

role also covers leading in the planning, monitoring and evaluation of the response programme, including reporting to the donor and the government.

The nature of the working relationship among the three partners is tight-knit, both at institutional level as well as between and among the staff. One interviewee commented: “If our programme is one body, we, partners are the different parts of that body.” The roles are clearly delineated, largely because the direct implementation at site-level is fully managed by each partner, responsible for specific camps.

Each partner also brings in a distinct value to the partnership – HAIB for technical expertise and resources on ageing issues in humanitarian and development spheres; RIC with its historical capacity in mainstreaming ageing in its programmes, a microfinance fund, and networks of partners including from the private sector; and YPSA and its local advocacy reach and a different perspective coming from a youth-orientation.

Throughout this report, reference to HAIB subsumes the three partners, and the use of “partners” refer to the three institutions working together in this humanitarian response. “HelpAge” is used when the reference is specific to HelpAge International only.

The Rohingya crisis response funded by the DEC started in October 2017. Since the start of its response, HAIB maintained its focus on four outcomes (see Table 1). The second phase, with additional funding and modifications in the outputs under the same four outcomes, started on April 2018 running through December (extended from an initial end-period of September). The programme is currently in its third phase which started on October 2018 (overlapping with Phase 2). During Phase 1, the programme reached out to older people in refugee camps, while its Phase 2 expanded to cover older people in host communities as well.

The four outcomes of HAIB’s Rohingya crisis humanitarian response are:

1. Reduce morbidity and mortality rate amongst older men and women of the displaced population through increased access to integrated health services
2. Exposure of older people to communicable diseases is reduced by provision of access to safe, appropriate, dignified WASH services at Age Friendly Spaces (AFS)
3. Older men and women are provided with safe and dignified spaces and community outreach structures to access information, referral pathways and social/recreational activities
4. Humanitarian services are more inclusive of older people and humanitarian agencies have increased knowledge and capacity to ensure the inclusion of older people in project design, implementation and monitoring

A unique approach piloted in this response is the establishment of AFS, where older people can access:

- age-friendly WASH facilities with privacy ensured and are gender-sensitive
- protection services
- health services including diagnosis of chronic diseases, referrals for more specialized services, treatment, medication, general secondary and tertiary care screening, and psychosocial

services/facilities for older people facing mental trauma, special health camps, eye camps, diabetics awareness sessions, referrals
- assisted accompaniment support for mobility
- individual case management mechanisms, follow-up support, outreaches and home-based care facilities for older people with disability
- recreational facilities (board games, radio w/ speakers)
- cultural/traditional events like puthi path (traditional script reading), Er Ashor, traditional music.

Objectives of the Mid-Term Evaluation

The evaluation was commissioned by Age International with funding from DEC, to assess humanitarian response to the Rohingya crisis to inform future programming.

The key areas of analysis include:

1. Assess the delivery of Age Friendly Spaces as a model for age-inclusive humanitarian response in terms of:
   - Inclusiveness (responsiveness of the approach to older people's needs and voice)
   - Effectiveness (critical project strategies and approaches and how they may be improved)
   - Sustainability (long-term viability and financial feasibility of the approach)
   - Replicability (opportunities for scaling up)

2. Assess more broadly the inclusiveness of programme strategies in terms of:
   - Effectiveness and timeliness of response in relation to older people's needs
   - Decision-making by older people (by age, sex and disability)
   - Data collection, analysis and utilisation in programming (current and future opportunities and challenges)
   - Accountability using CHS and mechanisms for feedback

3. Examine how the programme influenced the wider humanitarian community Based on the TOR, the areas of influencing to be assessed are:
   - Extent to which the programme raised awareness on older people's concerns
   - Extent to which other humanitarian actors made efforts to be inclusive of older people's needs and concerns as a result of Age International's awareness raising
   - Insights on the evolution of older people's needs in view of further prolonged crisis and how programming strategies may need to evolve in parallel, in relation to strategies, partnerships, capabilities, and resources of responding organisations as well as participation and access to assistance of older persons.

Methods and Limitations

Secondary Data Review. The review of documents focused on understanding the specific humanitarian context, programme logic model, indicators, budget, intended specific strategies and approaches (such as AFS, standards), and assessments to-date.

Focus Group Discussions. Six focus group discussions (FGDs) were done in two camps (Camp 11 and 18). The FGDs ran for about 1 hour to an hour and a half and was held in the AFS (among older people) and the partners' office (for the staff). The older people who participated were already in the AFS and getting assistance at the time of the FGD, except for the AFS Management Committee and WASH Committee whose participants were targeted.

1. One FGD for older women in each camp
2. One FGD for older men in each camp
3. One FGD for mixed older women and men for AFS Management Committee in each camp
4. One FGD for mixed older women and men for WASH Committee
5. One FGD for staff of YPSA (mixed men and women)
6. One FGD for staff of RIC (mixed men and women)

Key Informant Interviews. There were only two KIIs outside of the programme implementing partners who were available for interview at the time of the fieldwork. Staff who assisted the evaluators also provided in-depth information through conversations throughout the fieldwork. The evaluation team also held another series of interviews with HelpAge, RIC and YPSA staff.

Field Observation. Direct observation in the camps particularly the AFS were also sources of information and insights on the situation and programme implementation.

Initial Feedback. The evaluators presented the initial insights based on the 3-day fieldwork to Age International staff and aspects that needed to be clarified or contextualised are noted in this report as feedback.

Limitations of the methods. As agreed with the HAIB team, on-site evaluation activities focused on two out of the three camps funded by the DEC. There are several limitations to the methods, aside from the limited number of FGDs and KII that could be done within the fieldwork timeframe:

1) The main limitation of the FGD is that programme implementation partners served as translators during the discussion so participant bias cannot be eliminated. In many occasions, the translation of the question and response were interpreted (not literal) so the exact words used in the question or the answers were contextualised – this has positive and negative aspects. The advantage is that it helps with clarity, context and sensitivity-awareness. Whereas the disadvantage is that the interpretation of the questions to the participants can be lengthy such that facilitators fear the questions/answers are interpreted or framed that could lead to bias or focus on certain aspects rather than being open-ended. For example, on the question, "what are the rights you are aware of?", there was a lengthy explanation when translating the question. And the response relayed to the facilitators was brief, "Assistance is our right. This is not mercy."

2) The absence of female translators is a major constraint despite a request to have both male and female translators. While it is obvious that there is rapport and respect between male staff and the female participants, there are still barriers between female participants and male facilitators who are also service providers.

3) The evaluators were not able to conduct FGDs with at least one host community because of the heavy traffic going to and from the camp on the day it was scheduled (which was also the day of the flight back to Dhaka).

4) The evaluators requested the HAIB team arrange interviews with other humanitarian actors, but this was not arranged prior to the fieldwork. The fieldwork also coincided with a holiday which made it difficult to arrange for interviews at the time.

FINDINGS, ANALYSIS AND SPECIFIC RECOMMENDATIONS

This section presents the findings and analysis and appropriate ways to address the current gaps or challenges in the response.

Evaluation objective 1: Assess the delivery of Age Friendly Spaces as a model for age-inclusive humanitarian response

Overall, the AFS is an effective approach to holistically address the immediate humanitarian needs of older people (men and women and those with disability). The aspects of analysis are on inclusiveness, effectiveness, sustainability, and replicability.

The AFS is a physical space that provides primary medical assistance (check-ups, medicines), psychosocial support (with dedicated formally trained practitioner), WASH facilities, information bulletins, and one-stop-shop for accessing services targeted at older people. The physical space is divided into two primary areas – for males and females. Each male/female area has six private rooms: 2 medical consultation rooms, 2 psychosocial consultation rooms, and 2 play areas (each for women and men). One enters the AFS and will find these rooms at the middle-centre of the entire space. The open corridors surrounding these private rooms provide access to all the rooms as well as queuing area, with a curtain separating the male and female areas at one end of the hall. In the corridor of the male section, there are seats for male older people waiting for their turn. In the game area for men, there is a local Bangladeshi version of a billiard pool table. In the female section, there are chairs and mats for women to sit on the floor. Most women prefer to sit on the floor according to one of the staff assisting in the AFS. The female play area also has mats where women mostly congregate to socialize and talk. The AFS also provide Rohingya traditional recreational games such as ludo and karam.

Older men and women have repeatedly called the AFS their “house of peace”. This is very important, considering the high levels of stress and trauma that the displaced Rohingya have experienced, historically and during this migration experience. There is a degree of ownership of the AFS by the older people in the sense that they recognise it is a place dedicated for them, as there are other sites

dedicated for children (child friendly spaces) and women (women-friendly spaces) being hosted by other humanitarian actors.

Inclusiveness

There were several evident indications of the inclusiveness of AFS:

1. Older people like to come to the AFS – this is where they receive medical screening, psychosocial support, receive items that are useful to them, use age-friendly and sex-segregated toilets, and to socialize.

   There is no evidence that any older person has been denied of assistance, whether as a factor of age, sex or disability, in the AFS or the Age International assistance.

   As expressed by respondents during interviews and FGDs, where AFS is not present, there is a high likelihood that older people are being excluded or neglected. They cited the absence of dedicated queues for older people (or people with disability or pregnant women) in getting assistance from other responding institutions. They reported during the FGD that there was a case that one older people passed out or collapsed while in queue to claim her relief goods. There was also a case where they were told to get out of the queue or being shouted at while queuing.

2. The coverage of FDMNs aged 50+ is a very inclusive model and goes far beyond the humanitarian inclusion standard. This acknowledged that the aged-to-be are already experiencing the same stressors and exclusion given the humanitarian context, and by including them in the services of the AFS, their specific needs were addressed. While the services provided catered to all older people aged 50 and above, the evaluation was unable to further segregate context and needs differences between 50-59 through 80+ age groups which could be a specific area of analysis in future reflection and evaluation. However, it is significant that while 3.6%[4] of the total refugee population are older people aged 60 and above, the inclusion of older people aged 50+ significantly increased the project's coverage of vulnerable older people to 10% of the total FDMNs where AFS is set-up, as the older people aged 50-59 years comprised 7% of total FDMN population.

3. To complement the service provision in the AFS, home-based care is provided by reaching out to older people in their homes, particularly those who have mobility issues. The number of home-based care visits were 638/480 and 401/1,500 (achieved over targets) for Phases 1 and 2, respectively. There is also a device used to carry older people who are unable to walk to help the person reach a facility.

4. Sex-segregated services ensure that women and men feel comfortable and are able to access appropriate care and assistance. Sex-segregated spaces for males and females are culturally appropriate in the Rohingya context.

[4] As of 31 Dec 2018, UNCHR, https://data2.unhcr.org/en/situations/myanmar_refugees

5. The identification of male and female older persons as representatives in the sub-blocks are also important channels of information and assistance where the older people get information about available services from HAIB and other agencies.

6. Through WASH and AFS management committees and volunteers, it is ensured that services are provided in culturally appropriate and timely manner. The WASH facility has handwashing facilities, water, and separate cubicles for males and females. In Camp 18, the water storage tank was built through the coordination of the AFS volunteers and staff with IFRC a proud accomplishment by the staff and volunteers.

7. Assistance for non-older persons brought to the attention of the AFS or programme team were also addressed through direct or facilitated service provision.

The assessment is unable to have a discussion with the protection cluster, so there are gaps in understanding of specific protection issues being handled through the AFS and its referral mechanism, although there were mention of a few of these protection issues in the FGD and channelled through the referral mechanism. Additional information gathered from the staff is that there has been 200 incident reports of protection issues in the three DEC -funded camp sites, a substantial number of which are various forms of physical abuse on older women, younger women and girls in older people's households, and other forms of exploitation on older people by their family members such as being driven to live alone (to qualify for assistance separately) or being denied of the assistance received.

Effectiveness of the AFS

The AFS is a pivotal strategy to the entire project response as it integrates all front-line services for the older people in one place. AFS strategy must be appreciated within the broader project context where a multiplicity of approaches is being carried out by HAIB – provision of integrated services in one-stop-shop location, home-based care, coordination for delivery of services, among others – that further enhance the effectiveness of the approach.

1. The one-stop-shop/integrated service provision through the AFS enables older people to access several services uniquely provided through the AFS – from medical care to psychosocial and peer support. This is further strengthened by the presence of professional medical and psychosocial services in the AFS. The participants noted very high satisfaction of these services. In all FGDs, when asked "Are you satisfied with the services you receive in the AFS?", their vocal "yes" was expressed together with a gesture where they lifted or patted their hand to their head or above their head that showed high approval.

   FGD participants noted, "Aside from preventing water-related diseases, we don't know where to get services. We learned these here." Other participants noted that "they are more vulnerable and in mental stress and have high blood pressure. After counselling, they are now stable," and that they experienced "trauma and mental stress. They are frustrated and their physical condition is not good. But now through AFS, they are better."

2. The provision of specialised medical services, particularly eye camps, provided appropriate and professional care, from eye screening to operation (via referrals), that older people have not been able to access through other service providers. The eye camps have also been highlighted by the older people as one of the most important services they accessed through the AFS. For example, medicines were not initially provided. As older people demanded medicines to be made available in the AFS, HAIB initially formed partnerships with local business and other providers that have provided medicines. Now, older people can get medicines in the AFS.

3. While the AFS is already a safe space, safe spaces within the AFS (medical consultation room, counselling room, play room, that are sex-segregated) further enhance the cultural and gender sensitivity of the service delivery for older men and women. One female FGD participant noted: "[In the AFS,] We share our problems with other older women. And needs and support are provided here. This is our house of peace."

4. Older people already accessing the services in the AFS as well as other humanitarian actors (including the Camp Manager in Camp 18) are recommending for additional AFS to be set-up in other camps. Underlying this request is their assessment that older people in other camps are not able to access appropriate assistance and that other agencies remain unable to address specific needs of older people, and that HAIB has the specialised capacity to deliver this.

5. The AFS provides individualised services – therefore humanising the response – through home visits as well as maintaining individual files of each older man/woman (with separate folders for protection and medical records). The FGD participants can name the staff that have been visiting them or they have been consulting in the AFS, signifying a strong relationship between staff, volunteers, and the older people.

6. The distinction in the approach for camp-based and host community-based AFS signals the ability of the project to respond appropriately based on cultural and local context. One main difference is the setting up two separate AFS facilities, one for male (funded by DEC) and another for female (funded by DFID) because in the local culture, male and females cannot socialize in the same place even if it is a shared community space. With less resources, the host community AFS only provide health and psychosocial services (with less staff). RIC and YPSA are utilising their networks and resources to provide additional services, like eye camps and medicines. The partners have also linked the host community AFS with local clinics or health service providers for referrals. The community-based approach is modelled from experience of RIC elsewhere whereby the community takes charge in managing a community service – in this case, the AFS. Through community-based approach older people (and later younger people) are involved in the planning, management, resources and networking to ensure the services are delivered. The community-based approach and planned inter-generational approach where younger people can help in managing the AFS together are strong foundations for building sustainability, with sufficient capacity development support.

Sustainability of the AFS as a Response Strategy

Evidence point to the high degree of sustainability of the AFS as an approach:

1. The recognition of older men and women at camp level, as representatives in the community – a role that prior to their displacement was a rare possibility – has developed a sense of empowerment that older men and women have internalised and will be an important capital however the situation evolves – whether the displaced population will be able to return, or the population stays for longer periods.

2. The AFS has built the foundation or strengthen the grounds for a community-managed service delivery – through this innovative facility, the older people as volunteers were responsible for some of the crucial services in the AFS like mapping of the service providers, assessing and referring cases, following-up cases and assisting in service delivery. With this capacity, there is potential to expand AFS in other sites, while the current AFS can be managed by trained staff and volunteers with oversight management support from the project team. One FGD participant said, "Every month, we have two WASH Committee meetings. Now we can conduct [these meetings] on our own."

3. Particularly in host communities, the engagement of community volunteers from older people and younger generation has the potential to sustain the management of AFS. Currently, it is the partners who are directly engaging local authorities and service providers in host communities. The programme can provide opportunities for training, mentoring, and exposure of older people to directly engage local governance structures (ward, Upazilla, Union disaster management structures and other local authorities) and services providers (such as local health facilities) to be able to sustain the management of AFS (and advocacy of ageing concerns more broadly).

There is potential to build from the capacities developed to train more volunteers among the youth (both among refugees and host communities) to assist in service provision, possibly towards 24/7 accessibility of services on primary health care and counselling or even just facilitation of emergency referrals during night time. This is imperative as sharing from the FGDs revealed that there are emergency medical cases outside of the AFS operational hours and days. Alternatively, the partners can study how emergency cases outside of AFS operational hours can be facilitated by older people representatives who can seek assistance from other service providers in the camps for such urgent cases.

Replicability of the AFS

With its simple and functional design, the potential replicability of the AFS is high, considering the capacities as well already developed among volunteers, youth and the older people. Other stakeholders have also expressed the value of the AFS as a facility uniquely addressing older people's needs – which are critical to ensuring there is dignity of assistance to the older people. Other reasons to replicate the AFS in the current Rohingya response include the fact that older people's needs in camps where no HelpAge intervention is available has not been addressed and there are signs of systematically excluding or doing harm to older people by ignoring their specific needs. One example is that older people have said that when claiming their food assistance, they have been forced to sell several kilos of their rice

ration to porters to carry their items back to their homes. There is an unconfirmed anecdote that the porter ran away leaving the elderly empty-handed.

There is high demand and obvious rationale to replicate the AFS. First, there is urgency to address needs of older people in the other 20 camps currently not covered by HelpAge to ensure dignified assistance and doing no further harm. There is ample basis to assume that practical needs of the older people such as age-friendly WASH facilities, medical and geriatric services, psychosocial support are not being addressed by other agencies or that older people's needs are not met appropriately. While the task of influencing other humanitarian actors to consider older people's specific needs and context in their response strategies remains a critical complementary strategy, the need for AFS (or its variant) to be accessible for older people remains important for the entire Rohingya crisis response to be inclusive and ensure no one is left is behind. At the moment, only HAIB is focused on older people as a stakeholder group in this area and the AFS as a mechanism to ensure older people' needs are attended to in a comprehensive manner.

There are several options for HAIB to consider towards replication of the AFS, outlined below. While it is ideal for the AFS to be replicated in all camps, given that HelpAge and its partners are the only agencies currently responding focused on older people, the resource and human capacity requirement will be high. As such, following are other strategic approaches for replication recommended for consideration.

Replication options:

1. **Compact AFS**. A more compact version of the AFS can be established to cover more camps by identifying available spaces that can be used where limited but specialised services can be made available on a rotating basis. This is also premised on developing a core team of staff and volunteers to operate the compact AFS with oversight supervision from HelpAge and implementing partners. Current volunteers who have experience may be assigned to manage the operations, therefore building their capacities further.

2. **Strategic Location in Larger Catchment Area**. The comprehensive AFS design can be located in a fewer number of strategic sites servicing a cluster of camps, managed with a larger corps of medical and volunteer staff to service a wider catchment area.

3. **Co-Located AFS or Shared Use**. Age-Friendly Services may be advocated to be provided in existing child and women friendly spaces and other similar facilities. Age-focused services may be provided in selected days or hours every week in co-shared facilities and a rotating corps of staff provides services across several camps.

Integral to all three options is conduct of learning sessions on AFS and inclusion. This can be done by HelpAge and its local partners or in partnership with other humanitarian organizations with the aim to multiply the knowledge and skills on establishment, operation and management of AFS and mainstreaming of older people concerns and issues in the programming of other humanitarian organizations/agencies.

There are several ways to generate support and resources for the replication of AFS in other camps. One way is by securing sponsors from the private sector/business sector where company's interest or corporate social responsibilities are related to AFS services. A simple brochure or reference material about AFS should be prepared, incorporating the costs of the physical facility and the operational costs in running the facility.

Evaluation objective 2: Assess more broadly the inclusiveness of programme strategies

The aspects of inquiry are effectiveness and timeliness of response in relation to older people's needs; decision-making by older people (by age, sex and disability); data collection, analysis and utilisation in programming (current and future opportunities and challenges); and accountability using CHS and mechanisms for feedback. This section begins with a summative statement of the level of achievement of the programme targets based on plan and reports for Phases 1 and 2.

Programme Accomplishment

This section discusses the Evaluators' observations and insights based on the programme objectives and performance reports for Phase 1 and Phase 2 provided by HAIB. Overall, the programme is able to adapt based on programme implementation, as demonstrated by changes in formation of outputs and adjustment of targets. The Evaluators also generally note that the differences in the figures between older male and females are not very significant and is relative to the sex ratio of the overall population of older people 1.7% and 1.9%[5] for male and female respectively.

1. **Outcome 1: Reduce morbidity and mortality rate amongst older men and women of the displaced population through increased access to integrated health services**

The reduction of morbidity and mortality is expected to be achieved by provision of basic health screening, referral, follow-up services, home-based care, and provision of psychosocial support. The number of patients were referred to a specialist doctor is reduced from 183 (Phase 1) to 176 (Phase 3). This could indicate that primary health care provided through the AFS is preventing serious medical conditions to advance.

Data on disability are not available in the reports. There is a target of 960 older men and women people with disability screened by medical staff under Output A3 in Phase 1, but it is not found in Phase 2. It could be presumed this target refers to older people with mobility difficulties. It will therefore be useful to record and monitor patients or cases by type disability[6].

One indicator – number of patients followed up by doctor is a fixed number whereas it could also be a percentage of the number of cases that needed urgent or regular follow-up (first indicator under Output B1). This means also "triaging" cases for follow up and flagging (using four coloured sticky notes: cases that are for (a) urgent follow-up in AFS, (b) urgent follow-up by home visit, (c) regular follow-up in AFS,

[5] UNCHR, December 2018
[6] Using Washington Group Short Set

and (d) regular follow-up by home visit. There are also several staff responsible for home-based care (doctors, paramedics and psychotherapists), but largely triggered by information from field facilitators who regularly do house visits for monitoring not only of health but also WASH and other concerns. The data on home-based care visits appear to be low and it is not clear whether such mentioned under Output A3 (Phase 1)/B2 (Phase 2) are older people with severe mobility constraints. Therefore, the target for home-based care should be clarified and classified according to severity or urgency of medical/mobility conditions or some other typology that is useful for programming and advocacy.

Paramedics are also outperforming their targets but the burden of follow up is also heavy responsibility upon them. This must be considered as a staff welfare concern while also looking at positive reinforcement in several ways: sanctioned leaves or rest-and-recreation, transport support, to name a few.

Psychosocial support is also a major accomplishment, minimally short of targets, considering it requires one to three hours for a psychosocial counsellor therapist to attend to one patient. Options that can be entertained to support psychosocial support providers include working with local universities for internships (with capacity in the Rohingya language), fellowships for other university students who can make sense of data and support the counsellors in other ways (such as documentation), use of group therapy, even involving artists to facilitate art workshops as a form of expression and release.

Care for care-givers must be given due management attention. About 70-100 patients are attended by medical staff (doctors and paramedics) on any given day in the AFS. Each field facilitator has a caseload between 600-700 (overall) looking also at WASH, health and psychosocial care. Staff do not have vehicle support to go around the camps and commute to and from the camp site, which could be a security issue. To address this, more volunteers both older people and younger population from households with older people can be trained to enable the rotation of tasks in the management of the AFS and other project components. HelpAge can also request donors and other agencies for vehicle or transport assistance (ideally 1 vehicle for every 2-3 camps).

Overall, the daily average caseload (based on project monitoring documents and FGDs) show that Partners and Age International are over-performing in their efforts to ensure that needs of older people are addressed appropriately (refer to succeeding section for comparison of targets and accomplishments).

With a staffing of 3 doctors, 6 paramedics, and 6 psychosocial counsellors, 4 field facilitators and 24 volunteers, the estimated caseloads are (based on (a) interviews and (b) reports for Phase 2):

- Average number of medical patients per day: 70 (screened by paramedics) (a)
- Average number of medical patients per day: 10-15 (seen by doctors) (a)
- Average number of psychosocial support patients per day: 10-15 (a)
- Medical screening (first and follow-up, total: 7,694): 1 paramedic : 1,282 patients (b)
- Medical screening (first visit and follow-up visit, total: 4,593): 1 doctor : 1,531 patients (b)
- Psychosocial support (total 3,596 patients): 1 counsellor : 600 patients (b)
- Average number of older people per Field Facilitator (targeted to be visited): 700 (a)

Phase 1 Outputs	Phase 2 Outputs
Output A 1: Basic health screening, assessment, referral, education and follow up services are available for older people at centralized locations A1.1.1 **2,402/4260** No. of older men and women screened, started treatment, referred and followed up by doctor A1.2.1 **13/ND** No. of medical staff trained on patient flow chart, data protection and monthly report format A1.3.1 **183/ND** No. of patients referred to specialised services by doctor	**Output B1: Basic Health screening, assessment, referral, education and follow up services are available for older people at centralized locations.** B.1.1.1 **2,854/3,000** No. of older men and women screened and started treatment by Doctor B.1.2.1 **14/15** No. of medical staff trained on patient flow chart, data protection and monthly report format B1.3.1 **176/500** No. of patients referred to specialised services by Doctor B1.4.1 **1,739/2,000** No. of patients followed up by doctor
Output A2: Referral mechanisms for older people (including disabled older people) to emergency, secondary and tertiary care are in place. A2.1.1 **13/ND** No. of medical staff trained on patient flow chart, data protection and monthly report format A2.2.1 **13/5** No. of MD and paramedics trained on data protection and monthly report format	
Output A3: Community based Healthcare support is available through a Community Health Volunteer structure for screening, referral to AFS Doctor, health education and a Home-Based Care service for older people with mobility and access constraints. A3.1.1 **6,534/3750** No. of people outreached by paramedics, followed up by paramedic after discharge/treatment A3.2.1 **1,993/2000** No. of older men and women followed up by paramedic after discharge/treatment A3.3.1 **69/960** No. of older men and women people with disability screened by medical staff A3.4.1 **24/24** No. of CHV trained to provide protection focused health services for older men and women in the community, including home-based care A3.5.1 **638/480** No. of Home-based care visits	**Output B2: Community based Healthcare support is available through a Community Health Volunteer structure for screening, referral to AFSs, health education and a Home-Based Care service for older people with mobility and access constraints.** B2.1.1 **4,135/4,000** No. of older people screened and started treatment by paramedics at AFS B2.2.1 **3,164/2,000** No. of older people outreached by paramedics B2.3.1 **3,559/3,000** No. of older people followed up by paramedic after treatment B2.4.1 **12/12** No. of CHV trained to provide protection focused health services for older men and women in the community, including home-based care B2.5.1 **401/1,500** No. of Home-based care visits

	Output B3: Host community older people have access to specialised health care services. B3.1.1 **331/900** No. of older people from host community receiving specialized health and eye care services
Output A4: older people have access to well trained staff providing psychosocial support. A4.1.1 **6/4** No. of counsellors recruited and trained on needs of older people A4.2.1 **694/2000** No. of counsellors recruited and trained on needs of older people A4.3.1 **3,564/16,500** No. of older people and their family members referred to specialised PSS support A4.3.2 **ND/ND** No. of older people receiving PSS support.	**Output B4: Older people have access to well trained staff providing psychosocial support.** B4.1.1 **6/6** No. of counsellors recruited and trained on needs of older people B4.2.1 **3,596/4,000** No. of people receiving PSS support B4.3.1 **1,118/500** No. of older people and their family members referred to specialised PSS support

2. Outcome 2: Exposure of older people to communicable diseases is reduced by provision of access to safe, appropriate, dignified WASH services at Age Friendly Spaces (AFS)

The AFS, specialized health services (medical screening, eye camps, diabetes awareness), Home-Based Care services, referrals to other service providers like hospital-based care/treatments, follow-up services and coordination of support were all instrumental in achieving the effectiveness of the project. Capacitating older people volunteers and younger Rohingya volunteers as mobilizers and facilitators also contributed significantly in the overall delivery of the services and its effectiveness. Volunteers generally support operations in the AFS, managing queues, filing of documents, security.

One of the strengths of the response is the change in hygiene practices through its various WASH components. Its age-friendly WASH facilities have been used as a model or example by camp managers who know of the design; monitoring and documenting how other agencies have adopted the model will advance advocacy and integration in other humanitarian actors' response programmes. Other agencies have been tapped (such as IFRC) for the provision of water connection pipes from the AFS to older people and people with disabilities' households.

The AFS is where older people learn about good WASH practices. As described by the FGD participants:

- "Before, we experience diarrhoea, dysentery, food poising, worm [infestation]. By using sandals, we are prevented from contacting disease."
- "We use sandals in the toilet."
- "We have no hygiene practices like handwashing in Myanmar. We learned it here."

In terms of timeliness, the presence of the AFS ensured that older people were given the treatment or assistance they needed at the time they needed it. The referral system also enables the provision of urgent emergency assistance, although the problem of lacking in dedicated ambulance services has

been raised. While arrangements have been done to request for use of ambulance services from other agencies, it still requires an amount of time and coordination to secure one vehicle since these may not be available for use by HelpAge when requested. This can be addressed by having a priority list of ambulance services available for each camp, with pre-agreed arrangements to speed up the request process with respective institutions. Having a priority list will also ensure that that when the first ambulance is not available, then there will be a second or third service that staff can call. At a more strategic level, this is about HAIB working out a solution for improved sharing or pooling of common ambulance services for the entire response. Should resources be available, there should be at least one ambulance for the response, which in turn can be a shared resource for other agencies as well.

Another gap raised by the staff is the absence of a pharmacist[7]. The role of dispensing medicines is also being done by the paramedics. Similarly, one pharmacist can be recruited to service all the camps, providing training to staff or volunteers as pharmacy aide, and coordinating with other partners to make medicines available for older people.

Phase 1 Outputs	Phase 2 Outputs
Output B1: Older people are accessing appropriately adapted and dignified toilet facilities via Age Friendly Spaces. B1.1.1 **10,247/6,000** No. of older people with access to an appropriately adapted toilet B1.2.1 **30/ND** No. of older people involved in designing and maintaining latrines **Output B2: Older people can access appropriately adapted handwashing facilities via Age Friendly spaces.** B2.1.1 **ND/ND** No. of Hand-Washing Points functioning at AFS **Output B3: Older people are provided with targeted Hygiene Promotion messages and items.** B3.1.1 **14,461/1,170** No. of individuals receiving direct hygiene promotion messages (excluding mass media campaigns) B3.3.1 **ND/ND** No. of WASH committees established	**Output A1: Older people can access appropriately adapted and dignified handwashing and toilet facilities via Age Friendly Spaces.** A1.1.1 **ND/0** No. of latrines desludged A1.2.1 **7,100/4,000** No. of older people using latrines and Handwashing Points at AFSs in the camps A1.3.1 **8/0** Construction/maintenance of older people latrines and Handwashing Point in Host Community including cleaning materials **Output A2: Older people are provided with targeted Hygiene Promotion messages and items.** A2.1.1 **8,078/6,000** No. of individuals receiving direct hygiene promotion messages (excluding mass media campaigns) A2.2.1 **5/0** No. of WASH committees established A2.3.1 **2,630/900** No. of older people from Host Community receives cleaning materials

3. Outcome 3: Older men and women are provided with safe and dignified spaces and community outreach structures to access information, referral pathways and social/recreational activities.

[7] There is are pharmacists for DFID funded sites, but not DEC-funded response (according to interview)

Outputs under Outcome 3 changed in terms of nature and quantity of outputs, which shows how the response is evolving with implementation. For Phase 2, the key outputs are the documentation of how older people's protection and health needs are met, engagement of older people and volunteers in AFS management and protection groups, and access of older people to safe and recreational spaces.

AFS management committees and protection groups were not targeted but accomplished through this programme. These structures proved to be significant platforms for providing opportunities for older people's and volunteers' to be engaged in community affairs, an opportunity they do not necessarily have back home. This is even particularly significant for older women and young women volunteers (discussed further below). The AFS is also highly regarded by older people as their safe place and a "house of peace", and a place to enjoy, socialize with other older people and enjoy recreational facilities. The number of older people coming to the AFS and using its recreational facilities exceeds the target significantly. One reason is that older people from other camps come to the AFS to avail of its services (also denoting that the absence of the AFS in other camps).

The programme has been able to establish 24 protection groups, designate 54 older peoples' representatives, and 24 community volunteers. All these structures are composed of older people aged 50 and above. Community volunteers serve full time (earn casual labour wage of BDT 400/day) providing needed support in information collection, needs assessment, home-based service, accompaniment services to older people in accessing humanitarian services, support to field facilitators and other project staff, and overall support in in operation of AFS including linkaging and networking with other service providers.

Older people's representatives serve mainly as information resource for older people about services that can be tapped from other providers. They also accompany fellow older people in accessing such services. They also represent the older people in community discussions and meetings of the inter-agency protection group meetings. Older People Representatives receive an honorarium of BDT 1000/month as honorarium.

The older peoples' protection group is the primary platform of community empowerment and mobilisation in the camp. They meet fortnightly, discuss older people's issues (challenge, opportunity, threat concern). They raise their concern to respective platforms at site or camp level. They are also involved in Community Case Response Mechanism and also provide information and support to other older people within their area or cluster.

The specific skills and knowledge expected from older people's representatives, AFS management committees and protection groups can also be spelt out more definitively, from a strategic standpoint – that is, what are their expected roles in the next year/midterm 3 years or during the transition phase towards repatriation. This means providing them skills development in planning, scenario building, environmental analysis (such as using Strengths, Weaknesses, Opportunities and Threats analysis), to name a few.

In terms of protection, the response has in place the following: referral mechanisms for protection issues; separate filing system to ensure confidentiality; establishment of protection committees; psychosocial services; and staff aware of protection issues. Staff has raised the concern that families either neglect or abuse their older family members either by forcing them to live separately, denying them of their items received as assistance, and physical or psychological abuse as examples. Older people on the other hand have raised concerns about security of women and girls in the camps. The extent to which the project addresses these concerns was not sufficiently explored in this evaluation and is recommended as a full study to be undertaken by HAIB.

Phase 1 Outputs	Phase 2 Outputs
Output C1: Age Friendly Spaces (AFS) are functioning and staffed. C1.1.1 **ND/4,000** No. of AFS functioning [error in original target noted in report]	**Output C1: Older people protection and health needs are documented.** C1.1.1 **8,040/7,000** No. of Older People received relevant humanitarian services through AFSs and referrals C1.2.1 **4,887/8,000** No. of Older People receiving Age Friendly Kits/Winter cloths
Output C2: Older people focused community mobilisation structures are established. C2.1.1 **11,093/5,000** No. of older people receiving a visit in a home setting from field teams	**Output C2: Older people focused community engagement and empowerment structures are strengthened.** C2.1.1 **16/14** Recruited and trained Field Facilitators and Field Supervisors for community engagement and mobilization C2.2.1 **66/66** Recruited Protection Volunteers for Age Friendly Spaces and engage Older People Representation C2.3.1 **5/0** Established AFS Management Committees for community mobilization, coordination and management of AFSs C2.4.1 **24/0** Established Community based Protection Group
Output C3: older people have meaningful access to essential humanitarian services via centralized referral and assistance mechanisms. C3.1.1 **ND/860** No. of older men and women referred to relevant humanitarian services.	
Output C4: older people can access information on humanitarian services at a centralised point. C4.1.1 **17,478/1,600** No. of awareness sessions promoting inclusion of older men and women in mainstream humanitarian activities	**Output C3: Older people have access to safe and dignified recreational and social spaces.** C3.1.1 **4,986/2,500** No. of older people availing recreational activities and basic refreshments from AFSs

4. **Output 4: Humanitarian services are more inclusive of older people and humanitarian agencies have increased knowledge and capacity to ensure the inclusion of older people in project design, implementation and monitoring.**

Based on interviews, there are indications that there is an increase in awareness among strategic individuals (RRRC, camp managers and key staff of agencies designated as site managers) about the importance of inclusion of older people in the Rohingya crisis response. However, there is little evidence this awareness translates to programmatic changes at institutional level. In the area of advocacy, changes happen when direct engagement by the partners are done – as described in the case of WFP overlooking older people in food distribution.

The level of influence and the challenges in mainstreaming ageing within the broader humanitarian community is discussed in more detail under the section, Evaluation objective 3 below. What is significant to note here is that the nature of the outputs (awareness raising, training and participation in meetings) targeted will require follow-through and monitoring to ensure that they are translated into changes in policy or programmes or modes of delivery sensitive to the context of older people.

Phase 1 Outputs	Phase 2 Outputs
Output D1: Project Team advocate for the inclusion of older people needs in all Humanitarian sector activities. D1.1.1 **ND/ND** No. of coordination forums in which the needs of older people are represented and actioned **Output D2: Three older committees are established and participating in community leadership mechanisms.** D2.1.1 **ND/450** No. of older people facilitated to advocate on the rights and inclusion of older people	**Output D1: Humanitarian Organizations are provided with technical support on older people inclusion and mainstreaming.** D1.1.1 **5/0** No. of Humanitarian Organizations trained on older people's inclusion and mainstreaming- ADCAP **Output D2: Project Team advocate for the inclusion of older people needs in all Humanitarian sector activities.** D2.1.1 **155/0** No. of humanitarian meetings attended by project team **Output D3: Conduct Minimum Inclusions Standards training for local/national government bodies.** D3.1.1 **ND/15** No. of Government Officials attended training **Output D4: Conduct Minimum Inclusions Standards training and follow up support for local/national NGOs.** D4.1.1 **ND/150** No. of staffs local/national NGOs trained. **Output 5D: Basic Health screening, assessment, referral, education and follow up services are**

	available for older people at centralized locations D5.1.1 **8/9** No. of medical staff trained on patient flow chart, data protection and monthly report format **Output D6: Advocacy Campaign with Government, INGO and Local NGOs on Age & Disability Inclusive programming** D6.1.1. **ND/0** No. of organization attended in the advocacy campaign **Output D7: Advocacy Campaign with Government, INGO and Local NGOs on Age & Disability Inclusive programming** D7.1.1. **ND/40** No. of person attended in the advocacy campaign

A significant gap overall in the programme components is livelihood. This is a sensitive area of intervention because the government of Bangladesh prohibits any livelihood assistance to be undertaken. At a strategic level, this needs collective advocacy by the humanitarian community. This crisis has been ongoing more than a year now and may be prolonged for months or even years. With this scenario, it is expected that food insecurity and other negative coping mechanisms will intensify and so are the threats on protection particularly among women, older people, young girls and children. The more that the Refugee Protection Framework should be pushed collectively by DEC partners and other humanitarian organizations with the Government of Bangladesh in order to open the options for livelihoods and food security and protection of the FDMNs. Accordingly, monitoring of protection issues should also be intensified. HelpAge and partners' inputs on the framework and operational strategies by being engaged in the process will ensure that older people's concerns are integrated and addressed. However the situation evolves, livelihoods skills from new production activities, marketing, simple accounting and arithmetic literacy will be useful life skills for the older people and their family.

At a practical, project level, there are different ways to meet non-income-based livelihood needs. Other humanitarian organisations have already succeeded in using non-cash variations of livelihood assistance and increase choices in the food bowls of refugees through voucher system. HelpAge and its partners could already explore this modality especially among older people whose physiological and social needs are distinct from other population groups.

Older people have also raised concerns about the limited food choices provided by other assisting agencies – rice, oil, lentil and dal. This is a challenge for most older people who are already suffering from arthritis and other medical conditions and should be raised with the WFP. They have also raised the problem of fuelwood as a daily practical problem. HelpAge can introduce alternative fuel technologies (such as biogas production and coal briquettes) as a group-based activity that older people can "supply" (produce and/or sell) in the camps.

Additionally, environmental management (forest, water and waste management) are critical gaps that are not being addressed because of the political context of the response. Livelihoods assistance is not allowed on the presumption that the situation is temporary. However, there is no telling when the situation will change or end. But Bangladesh's fragile forests are being denuded on a daily basis. Forest management can be advocated as a the Rohingya community's responsibility and gratefulness by restoring the forest through reforestation (and can be designed with alternative to cash for work mechanism – for example, a voucher can be issued to purchase medicines and other items in the camp). For water supply, rain harvesting facilities can be introduced to collect and store water for other domestic purposes.

Response Effectiveness

HelpAge and partners are the only organisation delivering ageing-focused assistance in the Rohingya crisis. Other agencies (such as those focused on health) may be providing assistance to older people. But HAIB's response is the only comprehensive intervention that is informed by the specific context and needs of older people.

On the aspects of effectiveness, the response has been able to deliver quality programming, ensuring that the response is:

1. **Appropriate to older people's contexts** – Facilities (AFS, WASH) have been designed with older peoples' needs at the core. Mobility and access constraints have been addressed through home visits by both staff, volunteers and doctors. The older people appreciate the Age Friendly Kits consisting of umbrella, walking stick, torch light, hot water bag, medicine bag, urine pot, portable commode; leaders (older people representatives) were identified from traditional leaders as well as new ones creating a balance of transforming power structures and gender equality opportunities.

2. **Gender-responsive** – In addition to the design of the AFS and WASH facilities that take into consideration gender contexts, capacities of older women and men have both been developed through participation in committees and as representatives in their sub-blocks, including in site-based conflict management mechanisms headed by the Mazis (Bangladesh government representatives).

   According to the staff, women enjoy more freedom of movement in the camps that in their Rakhine life. Being able to go to the AFS and have time to interact with other women, and the ability to take key positions such as older people representatives and to participate in community affairs (through AFS activities) will certainly have created a significant change in perspectives about women's roles – not only by the women but also by men.

   Women FGD participants noted the following:

   - "We have learned lots of things here. We feel safe here. We learned how to cope and with new knowledge, we are ready to face any kind of situation."
   - "We know this is not mercy. This is my right. In Myanmar, we don't know we have rights."

However, overall, the programme can still be developed to be better targeted for gender inclusion, in several areas:

- Monitoring of types of gender-based violence based according to types of violence (physical, emotional/psychological, economic), as experienced differently by older men and women – for its value in terms of advocacy (for example, to say that majority of older women N% reported being physically abused; N% of older male are unable to sleep well because of security-related fear; or N% of older people are being denied assistance by their family member). Making concrete the types of violence experienced by older people will help prompt specific approaches (whether policy or programming) to address them and to call attention to other agencies that might be overlooking these specific issues of older people.

- Documenting and communicating examples of gender issues (including GBV) of older men and women in different sectoral concerns (WASH, protection, food, livelihood, etc.)

- Documenting and disseminating concrete examples of how older women and men's capacities have been developed through gender-responsive programming to promote good practices.

- Identifying strategic areas of gender-based intervention for older women in view of the volatile situation – should the displacement continue for a longer period, how would older women's food, health, livelihood needs be addressed? Should there be an abrupt change in Myanmar's repatriation policy, how would older women and men be able to return with dignity, cope positively, or influence the recovery process? What attitudes and behaviour among older people as perpetrators or allies in transforming gender relations need to change? Working with key partners or inter-agency structures, to specifically address protection and prevention of gender-based violence working on gender issues and inclusion of older women and men in transforming gender relations will be important as a strategy to also influence how gender-aware agencies address gender issues of older people. By saying the programme needs to be better targeted means identifying realistic targets as there is a broad range of interventions, and by being selective of the change that need to happen, then the programme can be focused in devising strategies to realise that change.

3. **Disability-inclusive** – There are several ways the programme is addressing disability among older people: holding Eye Camps, provision of eye glasses, walking sticks, and use of a contraption for carrying older people, as examples. Homebased care visit was primarily designed to ensure that the services reach older people with mobility constraints and counts as one of the stronger areas of the programme. The partners are also working directly with agencies such as Handicap International, CBM, and Centre for Disability in Development for advocacy, raising awareness, and delivery of disability-inclusive services or items (such as toilet commode).

   The advocacy and functional relationships of the partners particularly at camp level have significantly resulted in better awareness about disability within this response context. In particular,

the settlement locations are rolling hills that put people with mobility issues at a significant disadvantage in accessing assistance. One example of how through this response, food distribution by WFP considered porter services for the older people. In another occasion, older people complained at the AFS that they did not receive food voucher. Upon investigation, it was revealed the identification process overlooked households further out from the main road, and those older people who were bypassed where then given food vouchers. In retrospect, had disability been a first-order consideration, shelter location of households with members who have mobility constraints and other disabilities could have been located in more accessible areas in the camps.

An area that can be improved is communicating the situation of older people with disability. Around 40-45% of older Rohingya displaced in Cox's Bazar have disability (taken from an interview). This information is nowhere found in situation reports. The programme can also improve on documenting and monitoring the different types of disabilities of older people, also for purposes of advocacy. During an interview, it was mentioned that a study using the Washington Group Questionnaire was done by HAIB, which is a good start.

While disability inclusion is very much a core strength of the programme, influencing more broadly the humanitarian community can still be improved. At present, coordination of service delivery is the main reason for engaging other actors more directly. While training and advocacy are being done, particularly through the Age and Disability Task Force, training and sensitizing other actors both government and non-government humanitarian response agencies, monitoring of the progress in terms of changes in programming and policy is not strong. In particular, there appears to be no attempt at utilising the opportunity of the RRRC's call for ageing inclusive humanitarian programming either through monitoring, looking at new practices in service delivery by other service providers, or engaging specific agencies or inter-agency structures to target change in their humanitarian programmes.

Moving forward, HAIB can consider the following next steps to strengthen its gender and disability inclusive work in the response:

a) A more defined strategy on influencing around gender, including a vision of what gender equality changes can be achieved both with the perspective that the displacement can take a longer period but also bearing in mind how they will sustain their achieved sense of freedom and right to participate in community affairs when they are repatriated. This could cover targets around how many response agencies are implementing changes in their delivery of response to address needs of older women within their scope or mandates (WASH, health, GBV and protection, livelihoods, etc.).

b) Stronger messaging on older women's views, experiences through case studies or dossiers about older women in the context of Rohingya displacement, emphasizing on significant change at individual level, camp level, including specific examples of how a response can be sensitive to older Rohingya women (building in an analysis of culture and what changes can or have taken place) that are breaking down the gender barriers for women.

c) Strengthening women's skills in articulating their rights (both older women and young women), exposing them in networking and advocacy activities and enabling them to demand specific changes in policy or practice in the delivery of response (such as appropriate NFI and food kits)

d) Having a clearer messaging about gender-based violence in relation to older women's experiences (as victims and survivors) and building upon older women's roles through group or collective action by older women (the question is, how can older women contribute to eliminating gender-based violence, in the context of displacement in the short term and as a community in the long term). A cultural study of the intersection of culture, Islam, sex, age, disability and how the experience of violence is perpetrated or overcome through rights-based approach. The issue can also be tackled from an inter-generational approach – experiences of violence against women and men across life stages and from their perspective, what needs to change and how that change can happen.

e) Production of easy-to-use information resources on how to integrate age, sex and disability-inclusive programming

f) Influencing by monitoring or tracking the extent to which older people (by sex, age, disability) were reached by the overall humanitarian response, by sector – in effect ensuring that all humanitarian agencies track and account for older people in their own humanitarian programmes.

4. **Responsive** – Addressing recommendations by older people such as having medicines available and implementing eye camps (from screening to provision of eyeglasses and referral of cases needing operations). The AFS committees provide the opportunity to regularly discuss plans and get feedback from the older people, which is then considered for plan adjustment. Other examples have been mentioned above about how the partners are finding ways to address specific demands or complaints of older people through referrals, direct engagement, or resource pooling. For example, eye camps were done by RIC using their own resources from their microfinance funds. RIC also tapped into local pharmaceuticals to provide the medicines.

5. **Empowering** – The programme has built capacities of older people (and volunteers) about their rights through training provided by HAIB that included Humanitarian Inclusion Standards. The co-management of the AFS, whereby the older persons' committees and implementing partners collectively plan and manage the AFS have resulted in new sets of skills and knowledge. A significant skill mentioned is older people representatives have become an information resource for other older people within their area of jurisdiction, able to identify agencies other than HelpAge who can assist in specific issues being referred to them.

6. **Connected** – Partnerships and coordination have been established to implement the referral system and provide a comprehensive menu of services to older people. Often mentioned as partners or direct links in the response are the Camp in Charge, IOM and Action Aid. These agencies are also the agencies designated by government for site management. This means that the partners are working

directly and effectively with camp-level management to coordinate the delivery of services for older people, particularly where it is beyond the capacity of the AFS or the larger programme to address. The programme is also able to refer to cases, medical or otherwise, to specific service providers in the camps, such as field hospitals as well as in local hospitals.

7. **Inclusive of other age groups** – Besides meeting older people's needs, medical and psychosocial cases by other age groups brought to its attention are either addressed directly or referred to other responding agencies.

Enabling Decision-Making by older people

Decision-making is a complex human activity that entails identification and analysis of a problem, identifying causes and effects, scanning potential solutions, prioritising and selecting from the options, and taking action. For the purpose of this evaluation, we focused on ability of the older people to increase their coping capacity by making sound choices or providing alternatives, assist others in this regard, and highlight changes on their ability to take control of their lives through decision-making. The co-management approach through committees and protection groups increase the abilities of the older people to take ownership of the AFS and its management and has been a crucial space for the older people to internalise their empowerment.

Older men and women have expressed ability in the following aspects:

- Contribute to organised and orderly operations of the AFS – older people who are engaged in the operations and management of the AFS through the committees and site-based management mechanisms while the beneficiaries have also maintained order and cleanliness in the AFS by queuing and avoiding discord
- Inform those seeking assistance about the referral mechanism by providing information about whom to approach or directly linking them to service delivery partners
- Participate in site-based conflict management mechanisms and helping to resolve discord between families
- Mobilise older people to participate in project activities
- Articulate their rights and socialising other actors about the needs as well as capacities of older people to contribute their own recovery within the constrained context of the response

We also consider the ability to process and make sense of unfamiliar situations as an aspect of decision-making. At the end of each FGD, we have a space for the older people to ask us any question, and during this period, there will be a few seconds of silence, and then one will start to speak and afterwards we will receive a round of questions. We were strongly advised by the staff to avoid asking questions about their options for going back or staying. It was thus interesting that in all the FGDs, this subject has come up from the older people themselves either during the main FGD process or at the end when we open the floor for questions. In various FGDs, the older people expressed that they intend to return but only when their full rights are protected or else, they would rather "die in this place". This is significant in that they are able to articulate the conditions for their return.

There were issues where the older people feel they do not have control over. One significant example is being able to marry their daughters. This came up in several FGDs. When we probed why this is important to them, men and women have different responses. For the men, they expressed concern about the security of their daughters. For the women, they were concerned that they are unable to observe their norm to wed their daughters at a certain age (and this is a cause for their worry), which is aggravated by the fact that they do not have resources for dowry. HAIB may consider doing a study on the impact of the displacement on marriage practices and investigate how significant this is for older people as well as younger generation. Ordinarily, marriage decisions are outside of any development programme intervention, except in cases where it is forced on young children especially girls. In this instance, it may be considered a social "problem" not only because it is a concern for many older people, but more importantly, on the related issues that development interventions may be able to directly or indirectly respond to. On one hand, the problem of security of women should be recognised and be looked into more closely in coordination with other agencies. For HelpAge and partners, it is important to recognise that this concern increases the stress or lack of sleep among older people who are afraid about the security of their daughters. Dowry as a socio-economic arrangement also brings up the issue of livelihood security and a potential threat for utilising negative coping mechanisms in the absence of livelihood options. Finally, it may be related to lack of social support system for older people and their family in the absence of a male head (and the cultural expectations of income and other social support provided by a husband). This relates to understanding the older people's context at a household level and the resources and capacities available within the family to support the older people (discussed in the next section).

Data Collection, Analysis and Utilisation in Programming

The applied system of data collection and information exchange is simple and participatory. Each older people that come to the AFS have a file that can be easily retrieved and updated every time they come to the AFS. There is also a separate filing system for protection and medical records.

Older people as sub-block representatives are sources of information and updates not only for their families but also for their relatives and neighbours. The different organized older people committees and protection groups were also sources of information and feedback about the response. All these data and feedback were utilised in designing, re-designing and decision-making around the project, bearing in mind the limits and volatility of the crisis situation. The AFS also serves as data repository and information hub for the older people apart from other services that can be accessed from the facility.

HAIB reports reviewed show assistance received by age cohorts (18-59, 60-79, and 80+) and by male/female. HAIB targeted older people aged 50 and above. So, the age cluster of 18-59 is inconsistent and can distort data, particularly as HAIB will move into an intergenerational approach for some of its components. The value of having data by age cohorts has not yet been explored because services are not targeted specific to age – both for programmatic or advocacy purposes. Collecting and consolidating such data could then be a misuse of valuable time unless used for a purpose. It is relevant to note here that disaggregating data by age cohorts would be useful to analyse and forecast the types of services needed as the crisis will evolve – every year, there will be new entrants to the younger old population, while the older age groups will also evolve in their needs, capacities and contexts.

HAI can also reflect further on the dimensions of data disaggregation for programme management and advocacy. As already pointed out here and in the earlier section, systematising data around the following may be considered for its programmatic and advocacy value:

- Age groups (male/female): 18-49, 50-59, 60-79, 80+
- Disability prevalence by age groups and by sex: 50-59, 60-79, 80+
- Disability prevalence by type of disability, age groups and sex: 50-59, 60-79, 80+
- Number and proportion of older people living alone; living with/caring for children (household head); living with family (family size of 4*); living with family (family size greater than 4) [*4 represents the WFP standard family size; may need to be corrected based on official figure]
- Number of older persons (by sex) in the community structures established (AFS management and WASH committees, protection groups, representatives)

For the disaggregation of disability prevalence by type of disability, it will be helpful to use the Washington Group Short Question in identifying older men and women with difficulties in sight, hearing, speech, mobility, and cognition.

Automating data management can also be done through a PC-enabled database (in the absence of electricity, solar power facilities can be installed in the AFS to run the PCs). This will also help to easily track each older people's frequency of visits and progress in their health condition. When files are stored in a database, it is also easier to filter and consolidate data by age groups, gender, housing arrangement (living alone or with family), and other characteristics. When an older people come to visit, her/his file is retrieved from the database and updated in-situ, thus enabling the staff to maintain the personalised service, being able to see previous consultations, what medicines were prescribed, etc. The database can be as comprehensive or can contain only limited information such as personal information and dates of visit (other manual records can be maintained for other data). In both cases, it still facilitates ability to track what problems the older people sought assistance for in the AFS and ensures accurate data that can be used for project monitoring and advocacy. HelpAge can partner with a local university to design a simple database for this purpose at no cost.

Currently, the response is designed based on ability to access AFS (those who cannot are reached through Home-Based Care approach). It will be then useful to disaggregate assistance in terms of what percent of the older people are able to access AFS and those reached through home-based care and use this as basis for projecting future needs and support services required (for example, will more mobile staff be needed for home-based care or to be based at the AFS).

Another dimension of data analysis is recognition of the household context. In terms of protection, HAI staff raised on-going problems that some older people have been forced to live alone so that they will be entitled separately to housing, food and other assistance. Understanding household context will also help HAIB design other interventions in complementation with other humanitarian agencies. For example, have an agreement with other agencies to prioritise training and recruitment of volunteers among households taking care of an older person.

What the evaluation team also observed is the limited influence the programme has in the overall humanitarian communication products (such as those produced by UNOCHA and UNCHR). Information on older people are limited (total population) and their issues are not discussed substantively. HelpAge should engage appropriate agencies or working groups producing this report to include data and analysis on older people, providing them with data from HelpAge's response, initially. The strategic objective is that data collected should be disaggregated including sectoral data where relevant. Here, HelpAge should propose data indices that should be monitored and reported to the public, for example:

- Number of older people living alone, or as household heads (caring with minors), by sex
- Number of older people with disabilities (by type of disability, by sex)
- Number of WASH facilities (total vs age-friendly, gaps)

To generate sex, age, and disability disaggregated data for the entire response is a huge challenge and this will require stronger advocacy and partnerships with other humanitarian agencies. Beyond data disaggregation, analysis of ageing should be advocated as standard area of analysis in major humanitarian reports and documents (such as JRP and factsheets).

Core Humanitarian Standards

We conducted an FGD with mixed male and female members of two committees (WASH committee in Camp 11 and AFS management committee in Camp 18), specifically asking questions using the CHS quality criterion. Our findings for each standard are in the table below.

Table 1 | Performance against CHS			
CHS Standard/ Quality Criterion (QC)	**Summary**	**Evidence/Examples**	**Remarks**
1. Communities and people affected by crisis receive assistance appropriate and relevant to their needs. QC: **Humanitarian response is appropriate and relevant.**	Evident	older people repeatedly expressed their satisfaction on the array of assistance and services they have received from medical, psycho-social, WASH, Age-friendly kits, and to the other services in the AFS. The quality, dignity and care in extending these assistance and services were likewise appreciated by the older people.	Strong area of response
2. Communities and people affected by crisis have access to the humanitarian assistance they need at the right time. QC: **Humanitarian response is effective and timely.**	Evident	By international standards, the response came in a bit late already but due to the enormous needs of hundreds of thousands FDMNs, the assistance and services extended by HAI and its partners remain valued and regarded as effective by the older people and government counterparts. The AFS provides a go-to place to seek assistance when needed. As expressed in the FGDs with older people and KII with CIC, HelpAge and partners' assistance and services contributed distinctly in saving lives and prevented further risks among the older people, PWDs and other persons in need.	HAI and partners need to consider extending assistance on age-friendly food items. This is one of the main limitations of food rations by other humanitarian organizations that older people get and forced to sell portions of it in order to buy fish or vegetables and other needs. HelpAge and partners may also consider extending non-cash vouchers for the older people to procure these items if cash transfer is still restricted. Facilitating home-based or small group vegetable production (like vegetable planting in empty containers or so-called urban vegetable gardening) for older people may also be explored to increase food availability and choices for the

Table 1 | Performance against CHS			
CHS Standard/ Quality Criterion (QC)	**Summary**	**Evidence/Examples**	**Remarks**
			older people, lactating mothers and the children.
3. Communities and people affected by crisis are not negatively affected and are more prepared, resilient and less at-risk as a result of humanitarian action. QC: **Humanitarian response strengthens local capacities and avoids negative effects.**	Evident	The accompanying awareness raising activities in different forms done by HAI and its local partners in the response activities were highly appreciated by the older people leaders and volunteers. older people have expressed confidence about their newly learned knowledge and skills include older people's rights, WASH, health and well-being, participating in consultations and discussions, sharing of information on what and how older people can access various services. The co-management approach/ highlighting older people partner-beneficiaries' roles through committees and volunteer groups were also an instrumental response strategy in empowering and strengthening the partner-beneficiaries. Older people feel empowered as a result of the interventions; shared their confidence that they can already run the simple operations and management of the AFS.	Strong area of response Outside of DEC and HAIB covered camps, this is likely a huge gap on provision of age-friendly services.
4. Communities and people affected by crisis know their rights and entitlements, have access to information and participate in decisions that affect them. QC: **Humanitarian response is based on communication, participation and feedback.**	Evident	During the FGDs, some of the men older people strongly expressed that if repatriation will be forced and the government of Myanmar will not guarantee their rights, they will rather stay in the camps and die there. HAI and its local partners seriously considered the partner-beneficiaries participation and feedback in this response initiative and have addressed some of those concerns already.	Strong Area of Response
5. Communities and people affected by crisis have access to	Evident	HAI and partners have installed an accessible and safe mechanism for complaints. It appears that the complaint	Complaints raised during the FGD about how other

Table 1 | Performance against CHS			
CHS Standard/ Quality Criterion (QC)	**Summary**	**Evidence/Examples**	**Remarks**
safe and responsive mechanisms to handle complaints. QC: **Complaints are welcomed and addressed.**		mechanisms work and other "complaints" (request for services) beyond the scope or capacity of the teams are referred to the site-based conflict management mechanism and other service providers/ humanitarian organizations. For example, most of older people prevailing concerns are the very limited food choices from the rations and the lack of firewood	humanitarian organisations are treating older people should be discussed by HAIB, investigated, and addressed through advocacy
6. Communities and people affected by crisis receive coordinated, complementary assistance. QC: **Humanitarian response is coordinated and complementary**	Somewhat evident	HAI and partners significantly exerted time, attention and effort to ensure that coordination with other relevant humanitarian actors including the private sector to deliver its integrated services. Some improvement can be done in ensuring ambulance services are quickly available. With HAIB as the single agency focused on older people, there is huge gap in understanding how other older people in camps not covered by HAIB programming are not being excluded, and this is a huge area for advocacy as well as to develop complementary assistance. For example, other agencies focused on WASH could be compelled to install age-friendly/disability friendly facilities. Sharing of data and analysis is also an area of collaboration and complementation that is not yet being done. For example, other agencies collect data at household level – accounting for the number of older people in all projects should be advocated as a standard practice. HAIB can then use that data for advocacy in improving services for older people.	There is still an expressed issue on exclusion or non-prioritization of older people by other service providers/ humanitarian organizations which signals the need for HAI and partners to intensify its coordination and key campaign on inclusion and participation of older people in humanitarian activities of the different organizations.
7. Communities and people affected by crisis can expect delivery of improved assistance	Somewhat evident	The project demonstrated responsiveness to older people's recommendations to improve its services. There will always be gaps but critical needs have thus far been	The ability of the staff to reflect on their experience, to analyse effectivity of current

Table 1 | Performance against CHS			
CHS Standard/ Quality Criterion (QC)	**Summary**	**Evidence/Examples**	**Remarks**
as organisations learn from experience and reflection. QC: **Humanitarian actors continuously learn and improve**.		addressed through its integrated service framework. The presence of older people' committees is a significant approach to continued learning and reflection. There is a need however, to raise more awareness about learnings on approaches that are responsive to the needs and context of older people to the wider humanitarian community.	approaches, and to continually think creatively or innovatively may be hampered by the high caseloads and limited staff care support.
8. Communities and people affected by crisis receive the assistance they require from competent and well-managed staff and volunteers. QC: **Staff are supported to do their job effectively and are treated fairly and equitably.**	Evident	HAIB and partners are striving to provide sufficient support for its staff and field personnel by hiring competent staff, increased its numbers including volunteers and providing training.	HAI and partners need to explore options for staff support including social/accident insurance, transportation support and "care for the caregivers" activities.
9. Communities and people affected by crisis can expect that the organisations assisting them are managing resources effectively, efficiently and ethically. QC: **Resources are managed and used responsibly for their intended purpose.**	Evident	Current resources are being optimised to the fullest particularly the staff being able to deliver effectively despite high caseload ratio to staff. Other services have been provided by partnering with local hospitals for operative cases, and the private sector for medicines and other needs. As such, the total cost of delivering the services exceed that of what is directly funded by DEC. A straightforward cost-to-benefit analysis (total project fund USD 240140 ÷ number of beneficiaries 10,050) reveals a USD 24 cost per older people beneficiary for a period of 6 months, or USD 4 per older people per month. This already delivers the comprehensive integrated package.	

Evaluation objective 3: **Examine how the programme influenced the wider humanitarian community**

Given that HAIB is the singular agency focused on older people, the implications for advocacy become even more significant to influence how the whole humanitarian response is able to appropriately address the needs of older people.

Extent to which the programme raised awareness on older people's concerns

This evaluation is constrained to assess the extent of raising awareness about older people's concerns because of the limited interaction outside of the HAIB implementation network. However, HAIB's presence and its services, the presence of AFS, and the active engagement of the older people, have raised awareness in the camps about older people's capacities and that they have specific needs and situations that require special attention. This is evidenced by anecdotes from older people that other people (non-older people) have sought their help about information and services that can be accessed. older people are now being seen as a resource in the community.

Extent to which other humanitarian actors made efforts to be inclusive of older people's needs and concerns as a result of Age International's awareness raising

In terms of service provision, HAIB was able to affect modifications and inclusion by some humanitarian agencies of older people friendly services. For example, WFP modified its mode of delivery of relief items; the site management coordination mechanisms included older people representatives including in conflict management structures, and infrastructural development like accessibility to roads, facilities and other services. Sensitisation about age-friendly service provision also included local hospitals that HAI partners with in its referral mechanism. Still, there is space to improve awareness and in translating awareness about older people into changes in programming of humanitarian agencies.

HAIB can target specific organisations on improving their services to be inclusive of older people, for example, accessibility in WASH facilities, separate queues for older people together with people disabilities, and women who are pregnant or with very young children and expanding the menu of items to include needs of older people. Complementation can be achieved by, as an example, other agencies identifying aspects they can support within their programme and HAIB providing the specialised items.

The biggest success has been the issuance of a memorandum from the RRRC to prioritise older people in all humanitarian actions. Currently, the impact of this statement is not yet being assessed, for example, tracking how many agencies have started to adjust their programmes to be inclusive of older people, based on interviews. Therefore, the challenge now for HAIB is to utilise this opportunity to promote specific outcomes by the humanitarian community as a whole. HAIB's advocacy and communication strategies must be targeted, in such a way that other humanitarian actors understand the specific outputs or outcomes expected of them for an inclusive response and how HAIB can complement in this regard. One challenge is to breakdown the perception that working with older people is a specialised

service which other organisations do not have capacity. The following table proposes to identify which actions can be taken by other agencies and those that will be a specialised complementary support by HAIB.

A dedicated age inclusion adviser or similar post can be designated at the Refugee Relief And Repatriation Commission (RRRC) level to provide technical advice, data consolidation and analysis, and other coordination roles. For agencies that are willing to take on a broader integration approach for inclusion of older people, HAIB may designate a resource to provide accompaniment and technical support to the team/ staff.

The table is an initial list only to demonstrate the point that complementation is a key strategy to ensure that older people are not excluded in other humanitarian actors' response. The integrated services column shows examples of actions that any agency can do simply by integrating (adding) these activities/interventions in their existing programmes. The specialist services are services that may be provided by HAIB. The third column recognises that some interventions require the collective action of the humanitarian community working together. The Humanitarian Inclusion Standards for Older People and People with Disabilities and other resources provide a more comprehensive reference about intervention options.

Table 2 | Examples of Complementation for Age-Inclusive Response

Aspects/Sectors	**Integrated Services older people** (Other humanitarian agencies)	**Specialist Services** (HelpAge and partners)	**Collaborative Opportunities** (Humanitarian community)
Data management	Documenting number of older people in current beneficiary list (at household level) and relaying to HAI any concern outside the capacity of the agency to address	Detailed disability study in collaboration with disability-focused agencies using Washington Group questionnaire	Data sharing protocol (access to raw data)
Food	Alternative food/ food supplement for older people	List of alternative food supplement for older people	Identification of plots of land for vegetable and root crop farming
Health	Referral system/protocols for medical emergencies of older people	Referral system in place with logistics/transport	Referral system network, shared resources (e.g. ambulance) and priority handling for urgent emergency cases
WASH	Installation of age-assistive accessibility tools Age-disaggregated monitoring of WASH-related diseases and prompting HAIB on severe/	Provision of portable commode to households/ common WASH facilities Consolidation of age-disaggregated WASH-related diseases and recommendations	Standardising accessibility-friendly WASH facilities in all camps

Table 2 | Examples of Complementation for Age-Inclusive Response			
Aspects/Sectors	**Integrated Services older people** (Other humanitarian agencies)	**Specialist Services** (HelpAge and partners)	**Collaborative Opportunities** (Humanitarian community)
	widespread cases affecting older people		
Protection	Inclusion of older people women in protection committees (taking note that older women are both victims or perpetrators)	Training on protection for older people, information resources (e.g. warning signs of abuse on older people)	Case referral system and information management (particularly on trafficking, GBV, etc)

Insights on the evolution of older people's needs in a volatile crisis

The Rohingya crisis remains volatile. Possibilities of how the situation will evolve include short-term (immediate repatriation) or prolonged refuge in the camps. However, the situation evolves, there are critical aspects of work that would be critical to be in place so that both the staff and older people are able to quickly adjust to the changing conditions to maximise opportunities. Essentially, there is a need for increased programme adaptiveness in the face of the Rohingya crisis' volatile context. The four areas to maintain in programme strategy will enable HAIB and the older people to quickly adapt to changing conditions.

These four strategies are critical to adaptive programming:

1. **Increased preparedness and capacity of older people** – no matter how the situation evolves, the knowledge about their rights and the development of leadership, management in committee roles, participation in community decision-making are important life skills that older people will utilise to improve their situation in the camps or rebuild the communities after repatriation.

2. **Data readiness** – data and information should be managed bearing in mind that at any time, the FDMNs may be repatriated (what critical information will staff need to ensure the return happens smoothly). At any given point in time, data and analysis should be used to enhance advocacy messages as well as track programme implementation whether the situation changes or the crisis stays on for a longer period.

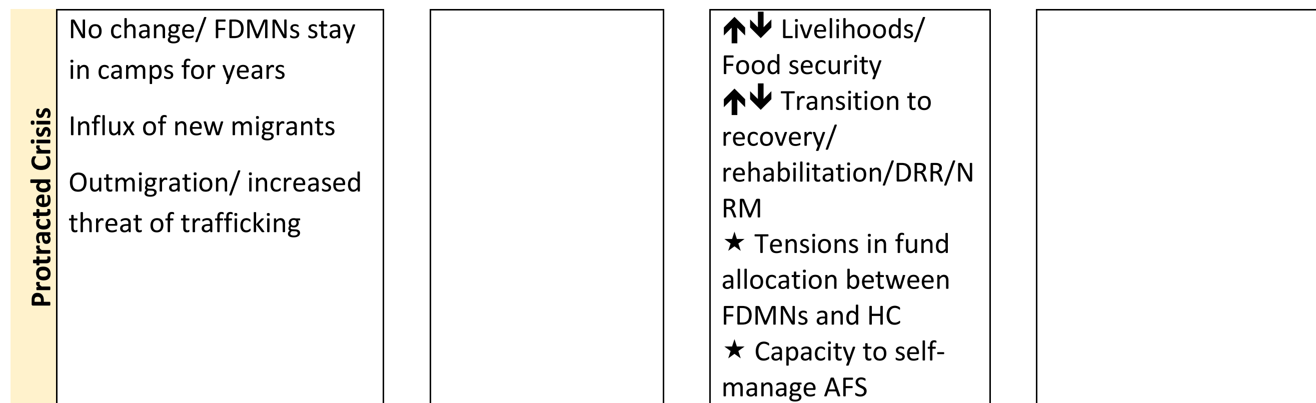
3. **Capacity for situational analysis and programme flexibility** – HAIB should be strategically placed at strategic decision-making levels to ground level to gather information about the changing situation and any emerging issues on the ground. HAIB can then provide its perspective to further the interests of the older people. Staff should be always ready to adjust based on emerging information, so a continuing situational analysis must be available for HAIB and partners to make sense of the changing situations. HAIB and staff can regularly do an exercise of "what should be do if tomorrow….", repeatedly rehearsing and thinking through how they will react when the situation changes.

4. **Coverage expansion** – there remains a huge gap in addressing the needs and conditions of older people in other campsites. Expanding coverage does not always mean locating offices and programmes in all camps. This can be addressed through coordination, complementation, advocacy, training and accompaniment. The challenge for HAIB is to reflect how every older person will be provided with the dignity of assistance and that their perspectives are raised and paid attention to so that no one is left behind.

The illustration below shows what surfaced as possibilities of how the crisis will evolve and the implications for programming (that would change with every different scenario).

Table 3 | Scenarios and implications for adaptive response (schema)

	Scenarios	*Other factors*	*Implications*	*Flexible programming*
Short-Term (immediate repatriation)	Myanmar agrees to repatriation with no guarantee or rights Myanmar agrees to repatriation with respect for rights GoB issues an ultimatum for repatriation	Bangladesh Election Increasing international pressure on Myanmar government More countries accept Rohingya refugees ASEAN takes action to put pressure on Myanmar	***FDMN*** ↑↓ Elderly population ↑↓ WASH management ↑↓ Livelihoods/ Food security ↑↓ Protection issues ↑↓ International funding ★ Capacity to self-manage AFS ★ Ability of natural resources to sustain communities ***Host Community*** ↑↓ Elderly population ↑↓ WASH facility needs and management capacity	**Increased preparedness and capacity of older people** on their rights and in recovery (rebuilding livelihoods, participation in decision-making)
Volatile (varying signals)	GoB enforces transfer of refugees to Vasan Char (100,000 people) Influx of new migrants			



Protracted Crisis	No change/ FDMNs stay in camps for years Influx of new migrants Outmigration/ increased threat of trafficking		🡅🡇 Livelihoods/ Food security 🡅🡇 Transition to recovery/ rehabilitation/DRR/NRM ★ Tensions in fund allocation between FDMNs and HC ★ Capacity to self-manage AFS	

SUMMARY AND OVERALL RECOMMENDATIONS

Overall, the HAIB response has been highly effective, ensuring that its integrated services appropriately meet the needs and contexts of older people (both men and women). Significant achievements have been that older people had in fact better opportunities at building their capacities and understanding of their rights, compared to their situation before the displacement. Respect for culture is a basis for gender-responsive interventions, while at the same time, new opportunities for older women to occupy leadership roles have also been provided, therefore, contributing to transformation of gender roles.

The AFS is a critical strategy that integrates services, makes visible the unique conditions of older people in this crisis, and provides the older people with a safe spaces and professional medical and psychosocial support. The AFS's simple design is replicable and sustainable, having also built the capacities of older people and volunteers to co-manage this place of refuge. Options for replicating the AFS proposed include a compact/minimalist design with rotating corps of specialists (medical and psychosocial) to provide support; building new AFS in strategic locations covering several camps, requiring a larger corps of specialists, staff and volunteers; and co-locating the AFS as a shared space within other agencies' facilities with a corps of rotating specialists, staff and volunteers.

The inclusiveness of the programme is enhanced by many factors, most significant of which is the inclusion of affected population aged 50-59 years. However, more reflection is needed (as well as data consolidation and analysis) on how age cohorts significantly affects the demand for services as much as physical ability (to access AFS, for example). HAIB can further utilise such data and analysis to inform the wider humanitarian community of significant issues as well as lessons learned that can be modelled or replicated within their own response initiatives.

A key management concern is the support to staff from logistics (transport) and "care for caregiver" initiatives so that the staff can maintain their high quality of service as well as provide them space to think, reflect, and utilise their creativity and innovation to further improve the services and ensure dignified assistance.

Programmatically, there need to think about livelihood strategies, where given that some older people will have limited ability to do livelihood activities, more creative ways to ensure that at the household level, livelihood interventions also positively bring about improved welfare of older people is as much a concern for HAIB as other agencies focused on the productive age group. Still, HAIB can explore livelihood interventions such as vouchers so that older people can procure their needs without having to sell their "unwanted" items and enable them to make their own choices. Related to this, environmental management is an area that can be advocated as a sustainability measure as well as an expression of gratitude to the Bangladesh community. This could be an opportunity as a form of cash for work (or voucher for work).

A significant gap is how older people's concerns are being addressed by the entire humanitarian community. More work on the part of HAIB is needed to produce targeted communication strategies, per sector (health, WASH, protection, etc) and expected advocacy change outcomes. This means tailor-fitting recommendations and complementation activities per organisation based on the capacities of the other agencies to integrate an age-inclusive response. It would be a mutual benefit for HAIB to designate an age inclusion advisor who can also serve as advocacy coordinator and information focal point linking the strategic decision-making structures and the operational structures in the camps.

With the Rohingya crisis situation continuing to be volatile, HAIB's response will need to be adaptive and agile to respond to changing conditions, requiring staff to be continually flexible and creative, with the ability to collect, process, analyse and act upon emerging information and changing response contexts. The critical result that needs to be achieved is that older people's capacities are enhanced to articulate and demand for their rights and that the coverage of the HAIB's influence expands to the entire Rohingya response, beyond the current coverage, which could be addressed through advocacy, collaboration, alongside increasing its response footprint through direct programming.