Asia Pacific Community Based Health workshop

Bangkok, 01 – 05 June 2015

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I. Executive Summary

Community-Based Health and First Aid (CBHFA) is the flagship approach of the International Federation of the Red Cross and Red Crescent Societies (IFRC) aimed at supporting communities so that individuals, households and the communities in general are empowered to take charge of their own health, including reducing risks and strengthening resilience to health threats. The approach is an effort to promote community participation and focus on behaviour change.

IFRC has been contributing to meeting the Millennium Development Goals 4, 5, 6 and 7, through community health programmes. As the international community is shaping the post-2015 agenda, through the Sustainable Development Goals (SDG), the IFRC is contributing to multi-stakeholder consultations and is also reflecting on ways, through which our community health programmes and approaches help in achieving the emerging global public health goals. To this effect, there is an on-going process of further developing the CBHFA approach and its tools.

In 2014 IFRC carried out a global mapping exercise to better understand how National Societies are utilizing CBHFA approach. The mapping showed that 109 National Societies implement CBHFA globally, and 22 in Asia Pacific (AP) reaching about 44% of the five million beneficiaries, globally. AP National Societies (NS) volunteers and master facilitators account for 69% and 36% of total global pool, respectively.

Keeping the above mandate, global situation and the work done by the national societies in Asia Pacific a workshop on the community based health and first aid (CBHFA) was organized by IFRC, at the Chatrium Residence Sathon, Bangkok with financial support from Finnish Red Cross between 01 and 05 June 2015. The workshop was attended by 36 participants from 18 national societies and IFRC offices across Asia Pacific and Geneva headquarters. The workshop was conducted under the tagline ‘towards evidence based, community led programming’ and the goal of the workshop was to facilitate knowledge sharing of good practices and lessons learned on evidence-based community health programming – which will ultimately contribute to the enhancement of capacity of NS health managers and coordinators to design, implement and manage these programmes. The specific objectives of the workshop are elaborated was to –

- Learn and discuss recent developments and future directions in CBHFA across the world, and how these relate to recently-adopted IFRC framework for community resilience and related declarations, as well as the post-2015 global development goals, agenda and priorities.
- Share recent experiences, lessons learnt, local tools and materials produced through the implementation of programmes using CBHFA approach, including efforts related to integrated programmes and harmonization of tools.
- Revise on the CBHFA PMER toolkit, with focus on M&E using experiences of NS
- Agree on the way forward and next steps for 2015 – 2016

The workshop was organized over a period of five days with two and a half days dedicated to updating the participants about the global, regional and cross country activities, new technical modules and changing face of work under community based health paradigm. The last two and a half days were dedicated to building knowledge and skills on practical application of Rapid Assessment using Mobile Phone (RAMP) and planning and carrying out field survey. The detail list of content is given below. Which are later elaborated in the day to day, session wise detail report. The content, presentations, posters and all relevant documents, including resource materials are shared with all the participants in soft copies. The major content covered, as per the agenda are given herewith –

- Global. AP and NS updates on the concept and practice of CBHFA, including the global agenda for the further development of the approach.
- Positioning of NS community health programmes in the light of IFRC framework for community resilience and related declarations, Universal Health Coverage (UHC), as well as the Hyogo Framework for Action on Disaster Risk Reduction (SFA), and Sustainable Development Goals (SDG).
- Further developments on Healthy Lifestyle (HL) to address NCD, including adaptation and roll-out of HL training module for communities, roll out of HL in the workplace, development of the HL on-line community.
- Scaling up of Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) in NS community health programmes.
- Improving evidence-based programming through application of mHealth tools – using rapid mobile phone-based (RAMP) assessments – and PMER tools and processes.
- Implementation of the CBHFA approach in different settings and contexts.

The workshop was carried out with full compliance of adult learning principles and thus there were more room for discussions, networking, poster presentation, medical conference and hands of practical learning alongside some PowerPoint presentations. The workshop was evaluated on a daily basis and at the end the workshop was evaluated for its effectiveness. Result of both the feedback and evaluations are given in the annexes.

In a nutshell, the workshop can be termed as a successful initiative, where the participants, shared and learned, enjoyed and relaxed, questioned and made commitments, learned new tools and techniques and carried home the newly acquired knowledge for further dissemination. The overall feedback suggest that the sessions, methodologies, logistical arrangements, methodologies and an open fun learning environment was liked by all.

The workshop also came up with issues and new directions that will also help IFRC and the secretariat in Geneva to think about the issues around paradigm shift in CBHFA towards making it smarter, evidence based and more cutting edge, community led approach.

To conclude, this workshop was more of an empowering tool for the national societies that they could understand the nuances of community led programming across different context and be able to collect evidences that the future course of actions are decided upon solid evidences and mot mere assumptions. It was also realized that the technical content and technical minimum standards can be offered across the secretariat but the implementation mechanisms may be contextualized and tailor made at the country level.

Day by day session

Day 1: Monday, 01 June 2015

Chair: Hannele Virtanen

The day's session was introduced and initiated by the Chair of the day; Ms Hannele Virtanen, who briefed the day's plan and invited the key note speakers to deliver the welcome note and formally open the workshop.

The structure of the workshop was a series of brief presentations designed to provide a technical foundation on agenda topics and spur discussion among participants with the great contributions from the representatives from each national society. Topics of Day 1 ranged from overview of CBHFA at global, regional and national levels, NS experience sharing 1, CBHFA and resilience, and NS experience sharing 2. This workshop summary provides a briefly summary of the short presentation dialogue, and is organized by workshop agenda topic. All of these resources will be publicly available on the IFRC website.

The Welcome and keynote address were delivered by Mr Sanjeev Kumar Kafley, representative from the SEARD and Dr Arvind Bhardwaj, Senior Technical Officer RMNCAH from the IFRC headquarters. Mr Kafley and Dr Bhardwaj delivered their speeches for opening ceremony and warmly welcomed all of the participants to the workshop. The links between CBHFA and community resilience were highlighted. It was emphasized that the progress and achievements of both the elements are dependent upon integration and complementarity of the ideas globally and locally, alike.

The expectations from each participant were listed and documented on the flip chart. A number of key issues were identified at the workshop. The participants have raised the important issues with aspiring and motivating to learn and share their success stories and challenge experiences from each national society. The technical key words about "CBHFA strategic direction, CBHFA plus, RAMP, and health in emergencies" were raised and needed more information from the participants. Additionally, Discussion sessions centered around issues involving the update on the CBHFA –community health and community resilience.

The welcome note was followed by Briefing the objective, going through the agenda, a quick round of introduction, expectation setting and practical information about the logistics & the interactive methodology of the workshop for next five days. This session was jointly led by Ms Meghan Kelly O'Hearn, Ms Nutchapang Khowinij and Mr Gopal Mukherjee. The Objective, Agenda and Arrangements were introduced to the participants. The expectations from each participant were listed and documented on the flip chart. Participants introduced themselves in the process of capturing the expectations. 44% of participants said that they wanted to learn from practices of other National Societies. Participants also hope that by attending this workshop, they can update their knowledge in CBHFA and learn what is community participation, enhance CBHFA in their own country and improve resilience, learn about the strategic direction of CBHFA+, how to apply RMNCH to do CBHFA intervention as well as to learn RAMP, how to adopt Violence Prevention tool, consolidate learning to field, and gain knowledge on adult based learning in programmes.

Information on basic logistical arrangements was delivered to all participants. The participants were divided into five small group with key thematic areas assigned to each group; the thematic group themes are as followings -

1. People – centered
2. Health system
3. Advocacy
4. Striking key partnership
5. Integration

It was reiterated that the thematic groups will remain till the end of the workshop and an indicator based – achievement centric gamification of the whole methodology was explained to the participants by Ms O'hearn.

CBHFA Global and AP Updates

Facilitators: Dr Arvind Bhardwaj, Mr Gopal Mukherjee, Dr Manish Pant and Ms Hong Chen

Objectives:

- Understanding on the Global trends and achievements in relation to CBHFA.
- Knowledge of the milestones achieved in the Asia pacific, in relation to CBHFA.
- Awareness of changing trends and programming challenges in the AP countries in implementation of community based programs.

CBHFA Global and AP update sessions were delivered by Dr Arvind Bhardwaj, Mr Gopal Mukherjee, Dr Manish Pant and Ms Hong Chen. The sessions extended part was presented between 13:30 and 13:45 by Mr Pornsak Khortwong, who presented the update from SEARD. The session highlights and the flow are captured below –

1. Global update
2. APZ update
3. SARD
4. EARD
5. SEARD

The updates on CBHFA at global and regional and national priorities and achievements, lessons learned and challenges were identified, synthesized, and shared to encourage and promote the implementation of CBHFA, globally with increased coverage to 109 countries across the world. The toolkits have been translated into 49 local languages. The conceptual idea of CBHFA plus was provided with the initial frame of RALDA (research& learning, development and action).

National Society experience sharing on different Community Based Health programmes

Objectives:

- Better knowledge of CBHFA practices and projects being implemented in other countries on the region.
- Ideas to seek mutual learning and sharing of experiences from each other.
- A fair understanding of contextual challenges and local solutions without diluting the technical paradigm

The next session was on NS experience sharing (supported by IFRC) on different CBH programs and representatives from different NS and PNS presented achievement and challenges in their respective settings. key learning process of this workshop is provided the five thematic key words for each small group which consisted of 4-5 participants to keep focusing and discussing on the thematic topic. At the end of each presentation, the facilitators provide a couple minutes to discuss & share and then prepare the recap for the following day. The key sessions and topics covered in this session between 11:15 and 12:30 and 13:45 and 14:00 are listed as below:

1. The Status of Community based Health & first Aid (CBHFA) Project in Cambodia, Cambodian Red Cross
2. Experience from Bangladesh Red Crescent Society

3. CBH Program , Cook Islands Red Cross
4. CBHFA Program in Vietnam, Vietnam Red Cross
5. Resilience in Nepal, American Red Cross
6. CBHFA in Action, Implementation in the Philippines, Philippines Red Cross

CBHFA and resilience

Facilitator: Ms Indira Kulenovic

Objectives:

- Better understanding of the updated framework and commitments to community resilience strengthening
- Exchanged ideas on how the community health approach/programme can play a critical role in supporting community resilience strengthening
- Identified/agreed on few key actions to operationalise FCR via a community health approach/programme

The next session was on CBHFA and Resilience and Ms Indira Kulenovic, the Resilience Coordinator from the IFRC South East Asia Delegation, Bangkok, presented the concept through an interactive manner. Ms Kulenovic provided a comprehensive concept of "Community Resilience" that linked to the integration of DM and Health and FCR. Examples were taken from the previous disasters and same was discussed in the backdrop of the concept of Resilience.

National Society experience sharing on different Community Based Health programmes

The NS and PNS presentations continued after the Resilience session. The following sessions by respective national societies along with the title of the presentations are as followings –

1. CBHFA implementation and integration in Afghanistan, Afghanistan Red Crescent Society
2. CBHFA pilot and approach in ICBRR, CVTL
3. Community Health Education Project: 5 Stars Health 5 Stars Home, Hong Kong Red Cross
4. First Aid, Japanese Red Cross Society
5. CBHFA in Myanmar Red Cross
6. CBHFA Program, Pakistan Red Crescent Society

In conclusion, based on the presentations from each national society, the CBHFA implementation at the national level is moving forward with the achievements, best practices, lessons learned and challenges. The key highlights to promote and advocate this community health program is to extend and build up the network cooperation and partnerships with both internal and external organizations and all key stakeholders. The commitment and he support from government and MOH and international organizations in increasing the funding and technical assistance is needed to sustain this CBHFA implementation in the longer terms.

The day closed with a 'feedback form', circulated by Meghan who explained the next day's recapitulation proposition, once again and Hannele thanked all the participants for their proactive engagement in the sessions.

Day 2: Tuesday, 02 June 2015

Chair: Manish Pant

Day two started with Ms Meghan O'hearn providing the final result of previous day gamification and final voting of the group that had summarised the previous thematic areas. The group results ranged from 5 to 10 points. Group 1 won with 10 points.
The Thematic areas were covering NS presentations on CBHFA in their respective countries. The groups identified key elements that came out of the NS CBHFA presentations.

Group 1 – People Cantered Theme
They sighted key element of how CBHF in NS presentations demonstrated people centred activities which were

- Village communities in VCA
- The way Baseline surveys and the community were involved as participants and as stakeholders
- Philippines' as one example of the 143 strategy. One volunteer leader per 43 people in each community
- Beneficiary Feedback boxes
- Community Participation from the start of the program

Group 2 – Working with Health systems

- They summarised that some National societies indicated they work in system strengthening though others did not mention specific health Systems strengthening there was an indication that they do work with their Ministries of health.
- There were examples of MOU that have been signed.
- Systems were strengthened from village level through participation.
- PMI sighted mosquito nets distribution supported by MOH who impregnated the LLINS before distribution.
- Challenges experienced were mainly in weak coordination and collaboration with referral Health Centres.

Group 3 – Advocacy
Presented details of each NS CBHFA and advocacy. They pulled out the key elements of how CBHFA had been done through advocacy. Sighted various National Societies examples in health awareness activities.

Group 4 – Partnership

- The team sighted examples of CBHFA in partnerships through financial support from donors, IFRC PNS and Red Cross Red Crescent movement partners.
- Partnerships through Academia, University institutions for research and knowledge development.
- Technical support from the RCRC movement partners.
- Partnership with their respective governments.

Group 5 – Integration
Various integration activates were observed such as in
Evidence - based Multi-sectoral assessment strategies as in Myanmar in DM, OD, WASH and Climate Change.

After the Recap, Mr Mukherjee introduced Dr Manish who was the key facilitator for the day. Mr Mukherjee introduced the on-coming presentation on Violence prevention which was to be presented via Skype from Canada by Mr Gurvinder Singh.

Introduction on Violence Prevention

By Mr Gurvinder Singh, Violence Prevention Advisor, IFRC (from Vancouver, Canada via Skype)
Supported by Gopal Mukherjee, IFRC DPRK

Objectives:

- Participants have knowledge of the VP module, the implementation challenges and good practices from across Asian countries.
- Participants are able to identify and commit to specific, concrete actions in their respective NS/ countries in relation to rolling out VP modules and its various components.

The presentation started with definition of what is Interpersonal violence which was:

Interpersonal violence is when one person uses his or her own power, in any setting, to cause harm physically, sexually or psychologically to a person or group of people" - IFRC

A video was presented from Pakistan:

- Key elements of the video was emphasising how Pakistan Red Crescent has tackled Violence prevention
- in schools and in communities
- It was further deliberated that Violence comes in various forms of physical and psychological ways
- Violence used as umbrella over gender. Men or women having the power to treat others harshly because of their gender. Most violence is male against females.

Q: What types of violence do you see as a priority in your country/community?

A: Domestic Violence as

- Gender based violence, Child abuse – neglect, social media,, power bases, forced marriages, self-directed sexual abuse.
- Corporal Punishment

Q: What actions have you already taken as a NS? Or plan to take?

- NS child protection policies
    - Translated CPP in their local languages
- Sensitization of workshops with community leaders and stake holders
- Some Ns Thai RC has a hotline to call in and report VP
- and Some NS stand by citizen reporting on violence

Q: What questions would you like answered today?

- And how does one convince communities who are not aware that there is violence in the communities.
- A: The answer was to address the issue using the phases approach as per module slowly and not fast track the approach.
- Hannele asked how do we measure Impact on violence prevention using our baseline.
- Responses were suggested to include violence prevention at the design stage of any program. Assessment before the design.
- In the design to also include referral centres. That can measure impact if referrals are documented.
- Referral can be either informal – Family or Formal as to referrals to special centres or women refugee or child protection centres.
- Some issues identified were that some violence issues such as sexual are too sensitive in some cultures.
- Advocacy was required.
- Hannele also mentioned that some NS found it difficult to ask violence prevention questions in surveys. The response centred on conversations and discussions with key people in the community before a trail of the survey.

- Take Phased out approach as per module
- Framing the issue about how to "Talk about VP"
- All agree that children should be protected. Involve men to be part of the solution.

Key Summary Messages

- Everyone deserves to be safe from violence: physical, sexual, and emotional and through neglect.
- Hitting other people is harmful and unnecessary.
- Sexual violence is cruel and degrading.
- Crushing a person's self-esteem is damaging and unhealthy.
- Violence can be prevented; helping resources and laws exist.

Recommendations

- Recommendations were to replace violence with love and care
- Reduce corporal punishment.
- Encourage positive behaviour change
- Encourage Children to continue with school and attend class free of corporal punishment

(The Skype kept on dropping off. Technology was not favourable).

Lessons Learnt

- Include VP indicators in baselines
- Monitor the indicators, regularly
- Develop case studies as examples (Pakistan) video Streaming VP.
- Sensitize high ranking policy makers
- Include VP lens in existing programs as cross cutting area
- Translate and locally contextualize VP module
- Undertake continuous advocacy efforts for enhanced financial support.
- Have minimum standards for Violence prevention and weigh all programs through these.

After tea break

- Poster presentation by Cook Islands
    - Identified NCD strategies are Multi sectorial
    - Partnerships and collaboration with Government Ministry of health and Agriculture
    - Better use of skills and resources

Public Health in Emergency Management in communities

By Dr Bhanu Pratap, Dr Durgavasini Devanath and Ms Eka Wulan Cahyasari

- Review of PH in emergency management concept and approaches, highlighting importance of community capacities
- NS case presentation, followed by a summary of the ECV roll out review and next steps.
- Group work on how CBH can maximise support to building PHEM in communities through the CBHFA + process as well as ECV further development.

Objectives:

- Better understanding of the concept of PH in emergency in relation to CBH.
- Shared experience in rolling out the ECV toolkit as well as ideas for community level actions to enhance local preparedness and response capacity.

There was an overview of what Public health in emergency is about by Dr Bhanu Pratap.

- He gave the conceptual understanding of the PHIE.
- Systematic analysis and management of health risks posed by emergencies and disasters and Multi-sectorial approach

NS had examples of PHI responses

- Dengue awareness, preparedness
- Measles outbreak response
- Leptospirosis and typhoid outbreak response
- Cyclone and Typhoon response
- Pandemic preparedness

Ms Eka Wulan Cahyasari presented a case study from Indonesian Red Cross.

- The case study showed how ECV was rolled out with other sectors
- ECV was included in the strategic plan for 2014- 2019.
- As auxiliary to the Government PMI play a key role Nationally with MOH and other Sectors and RCRC movement partners
- Integration with other sectors such as Wash, DM.
- The ECV was rolled out at the same time as the simulation in Banten during a flood. Real time ECV application was done. The contingency plan was activated and utilised in diarrhoea, dengue prevention
- ECV in Papua funded by JRCS in prevention of Malaria through WASH
- Illustrations were adapted to local context pictures.
- ECV on the Phone application

Key Changes were in Translation's Diseases information and Action plans

- Bureaucracy
- No sense of urgency from PMI leadership to Institutionalise ECV

Questions:

- Q: How to compile questions for volunteers in ECV
    - A: the numbering system in tool kits make it easier to train volunteers in Q and A.
    - A: The basic knowledge helps in surveillance as well..
    - A: Rapid training and integrate ECV.
    - A: The design can support Intergradation.
    - A: Malaria prevention goes on as normal under CBHFA regardless of an epidemic or not.
    - A: Re activate ECV tools when necessary
    - A: CBHFA will continue as an approach.
    - A: Workplace Community Centred

Communities are first responders e.g. in Nepal. For a week, no outside assistance reached epicentre victims of the earth quake. The victims relied on each other before any outside help could arrive.

There was a question how do we measure resilience?

What are the indicators –

- Community capacity – Communities are first responders
- Focus on strengthening workforce /Community centred.
- SN have already responded to Epidemics

Tool Kit Review and Recommendations of the Review

Tool Kit Review was presented and shared the learnings from the Review.

- Relevance & Appropriateness
- Effectiveness
- Efficiency
- Impact
- Sustainability

The presentation showed thematic areas

- DM cycle.
- Using ECV tools to mitigate prevent and recover from emergencies.
- Whole of social approach Civil Societies
- Govern business sectors

Key findings

- ECV was easy to use
- Complimentary to CBHFA.
- Longer term

Q: How is BCC used in ECV?
A: Can be used as recommendation (or) a rapid response or crash training (or) ECV can be used in Long Term program and DM preparedness.

Group work

Objective:
To come out with recommendations to feed into the CBHFA+ process which has a specific component on health emergency management?

Discussion question:
How to further develop community health emergency preparedness and response, building on ECV tool kit roll out and other initiatives from your experience and working with communities.
We had to make it simpler to how to further strengthen the emergency health component in Community based health programming using CBHFA approach and tools**.**

1. ***Examples and good practices – discussions on PMI, Myanmar RC and Pakistan RC***

- Development of Contingency plans and SOPS, First Aid
- Networking. Prepositioning of Kits
- Deployment of Volunteers from DM and Health
- CBHFA assessment
- Sessions on HP

- Training as First Responders Refresher training
- Preposition of stocks Integration with sectors and DM

2. Challenges and needs –

- Integration of DM and Health departments
- Little understanding on how to integrate not only within NS but also partners Including IFRC and PNS health and DM departments
- Limited time of implementation
- Expired stocks and goods.
- Difficult to integrate. with other departments

3. Recommended priority actions to undertake by NS and IFRC secretariat to address those challenges and needs.

- Clear guidelines/ documents on how to integrate tools in DM and Health
- How to use ECV in preparedness planning and incorporating it into CP/ SOPs etc
- Refresher trainings
- Within IFRC country, regional offices to discuss and share tools within IFRC/ PNS different departments and teams so that everybody is on same platform
- Replenishment guidelines and preposition of kits with expiry of items and how to incorporate training to replenish/ manage and take care of kits
- Better guidelines on how to use ECV into CBHFA and different settings.
- Dissemination and Advocacy by IFRC Globally through Zone PNS and other stake holders.

Introduction to Reproductive, maternal and new born child's health (RMNCH) and Health System Strengthening

By Dr Arvind Bhardwaj and Ms Meghan O'hearn

Objectives:

- Global update and Case studies.
- The participants will know Essential interventions and HSS.

The post-Lunch session started with Presentation on RMNCAH by Dr Arvind Bhardwaj. The presentation shared information regarding the burden in terms of global Morbidity and Mortality with regards to RMNCAH – (a WHO Presentation) capturing the global figures showing the burden

A reference was also made by Dr Arvind to the IFRC's Framework on MNCH which was developed in 2012.

He also explained to the participants the change in the terminology from CBHFA to CBHFA+, till a new name, has been finalized. He also stressed the importance of keeping in mind and actually using the terminology of CBHFA as an Approach rather than a Program as it actually makes us think about CBHFA as a program which will not be correct – also he emphasized the importance of taking the CBHFA approach in a more integrated and more practical way in order to get the results.

During the discussion about the changing trends and scenarios at the global level he explained the switching from Millennium Development Goals to Sustainable Development Goals with new target especially the Maternal, Infant and Child Health Morbidity and Mortality with a focus on the reasons and causes contributing to the loss in terms of death and disease.

Case Studies (10) and Brochure on RMNCAH were shared with all the participants as they were requested to go through these in order to have a better understanding and insight into the issue and the possible solutions in terms of different interventions carried-out in different settings.

Girl-Effect video about the consequences of Early Marriages as the girls turns 12 – with education and proper RMNCAH services available to the adolescents the positive impact was also highlighted in order to draw comparisons between the two approaches

Group-Work – 5 Groups 5 Themes

30 minutes – all the 5 groups were given Case Study/Scenario and assigned an area/theme of RMNCAH to focus on – the groups were encouraged to brain-storm and discuss thoroughly the theme and come up with a minimum of 2 issues with possible practical solutions.

Tea Break – Poster Display by Cambodian Red Cross

Presentations of the groups (Group Work) – all the 5 groups presented their group-work in the form of short-presentations covering the theme in terms of issue/cause, impact/effect as well as supply and demand on part of the Health Facilities and the Communities.

Arvind shared a story from recent Ebola response reflecting the state of health system mentioning the lack of awareness on part of the communities as well as health staff – bad examples to learn from – a system development approach is needed for better results – how systems link-up within themselves –

Nutrition in RMNCAH

Dr Arvind Bhardwaj and Ms Megan O'hearn both facilitated the session on Nutrition.

An introduction to "Nutrition Guide" as will be needed by any National Society looking to initiate – haven't published yet – going through the last read – will be out soon – (World Vision) 1000 days – impact of malnutrition in the life of a child and how the cycle of stunting goes on was shared with the help of a video, showing the state of Nutrition, across the globe.

Group-work as assigned to all the groups with very interesting scenarios covering the different aspects of malnutrition – the groups were encouraged to go through the (Provided) Nutrition Guide and come up with strategies and interventions targeted at addressing the theme – after brain storming within the group and extensive discussions resulted in groups coming up with very interesting interventions and strategies – questions and answers and comments were taken during these group presentations. Different reasons for the bad-practices (with regards to Malnutrition), examples from many countries were quoted and many ideas and important information regarding the impact of malnutrition and strategies were shared. The importance of "provision of enabling environments in addition to the awareness" was also emphasized.

In the end the participants were asked to fill the daily feedback forms as well as "One Good Thing of the Day" and One "Thing that could be Improved'.

Day 3: Wednesday, 03 June 2015

Chair: Hong Chen

Day third started with the recap and key feedbacks points of last day sessions of the participants;

- Knowledge exchange is considered as a key important learning point….
- More time has to be allocated for discussions
- Time management has to considered properly

Non Communicable Diseases

The CBHFA – NCD topic was the morning session.

Objectives:

- To have better understanding on global updates
- To develop better understanding of the 4 key thematic areas (adults, youth, elderly and emergency) and 3 cross-cutting areas (advocacy, research and innovation, partnership)
- To identify the need for guidance on ageing
- To identify the priority areas for NCDs

The NCD is not a stand along, some of the component of NCD's Violence Perversion& ECV can also be included in CBHFA approach. Later the healthy life style movie was played. To contribute Global NCD target by 2025, NSs should strengthen their capacity to contribute in reduction in 25% of NCD morbidity and mortality globally.

In regard to roll out of NCD intervention by the NS, those have not yet started, the Federation is ready to provide technical support. The facilitator also touched base on the availability of IEC materials like online healthy lifestyle community and brochures.

The future of community based health at IFRC and the concept of CBHFA+

Objectives:

- Better understanding of the changing face of community based health work at IFRC.
- Complete understanding of and awareness of the concept of CBHFA + and the opportunities and challenges, it pose.
- Identified/agreed on key steps to maximise contribution of AP NS in the CBHFA+ process.

Later the CBHFA + update were presented. It was also made clear that CBHFA is not going through a mere procedural or structural change rather a it is just a paradigm shift to make it better, inclusive and more community led.

It is just to increase our scope based on the realty need. In regard to changing the name of CBHFA, roadmap is the way forward of the Federation Secretariat, the consultation has started and some PNs and NSs is already take part in the working groups, to see how CBHFA would look like. Since it is crucial and vital issue to all of us, so it is a very good opportunity to provide inputs through active participation in joining the working group.

Questions were raised - Is there need to change the name of CBHFA?

- Because a lot of departments want to change the name of CBHFA

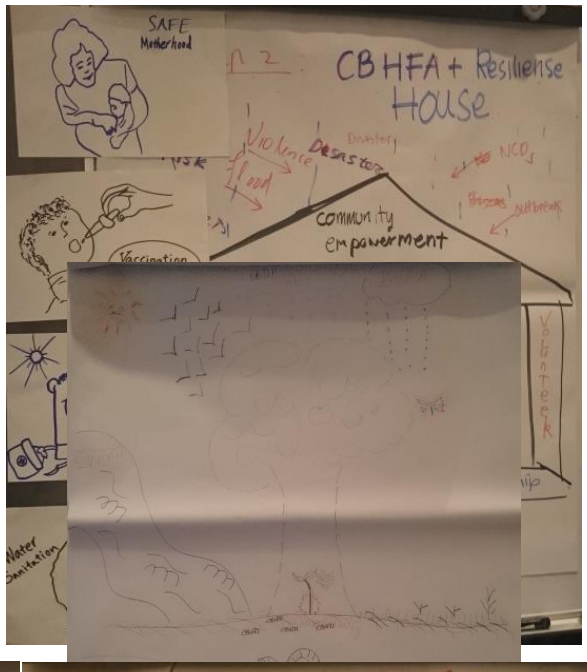
- The name can be adopted

<u>What is the logic beyond changing the name, even if it is not necessary. this point has to be considered by those who are or will be taking part in working group for reviewing of CBHFA</u>

Drawing on CBHFA + and Resilience:

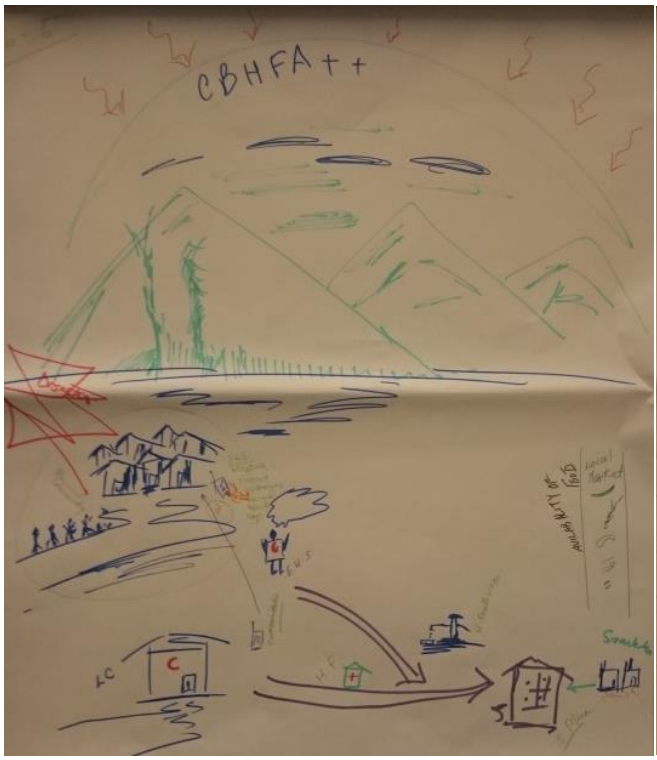
Group 1 – Saw the community already being well equipped and resilient to the problems due to CBHFA, and the enhancement to the approach was the links and partnerships with multiple stakeholders such as government, private sector etc.

Group 2- A conceptual diagram of components making up a house; the foundation, pillars, windows, a door and the roof is resilient to elements that danger. It and also noted was Mr. that Gulabuddin has great illustration skills and is a great asset to the organization.



Group 3 – Multiple factors that encourages the resilience of CBHFA captured in a diagram of a becoming a resilient tree. growth and seedling

Group 4 – Included multiple components such as health care, hygiene, WASH, education, IEC, first aid,



environmental factors in enhancing resilience

Group 5 – showcased CBHFA & resilience in disaster preparedness and response

Group work on CBHFA+ ---- open session

Questions	Feedback from each group/ Consolidations
1. What is the best part of your community based health programme?	1. First Aid 2. Community Engagement 3. Youth Involvement 4. Partnership and collaboration with stakeholders 5. Recognition from local health unit/workers 6. PMER 7. Community Action Plan 8. Increased in access to services 9. Community/Volunteer Mobilization in Emergencies 10. Entry point into communities that can be built on/adopted & adapted for other projects/ programmes
2. With what do you struggle with most in CNHFA implementation?	1. Integration 2. Staff /Volunteer Retention/ High turnover 3. Community Motivation 4. Methodology of skill building and training 5. Resource mobilization in a local context (Fund raising) 6. Overload of subject and topics for volunteers 7. No contribution from the community 8. Communication is used but literacy is low (making people understand)
3. Mention ONE thing you would like to change in CBHFA.	1. Assessment and baseline 2. Community and population specific (wide approach) 3. Scalability – simplified for easy duplication 4. Standard Memorandum of Understanding/ Advocacy Documents 5. Include Psychological Support System (PSP)
4. How should CBHFA be called in the future?	1. "SCBH" –sustainable community based health 2. "ICBHA"-Integrated community based health approach. Integrations of new modules (NCD, ECV, Violence Prevention). 3. Add + (or any sign) on to CBHFA to show change 4. CBHFA PLUS (people centred, linked, useful/universal, sustainable) 5. To include the word approach within the acronym / name Out of 24 participants 16 are not in favour of changing the name. 8 persons want to make little change.

Introduction to IFRC's mobile data collection methodology (RAMP) and experience sharing on its application

By Rania Alerksoussi, IFRC, Geneva

Objectives:

- Basic understanding of RAMP, its utility and scope
- Ideas to seek mutual learning and sharing of experiences from each other.
- A fair understanding of potential challenges and opportunities that could be encountered

Rania introduced RAMP, exploring its purpose and how it shortens the data collection cycle, to the workshop participants. Key features of RAMP was discussed, including the 2 technologies it takes advantages of. She also explained how RAMP works (including its mobile application & the web based server). The process was introduced:

Design Questionnaire – Share & Store on Phone – Collect Data in the Field – Data Sent to web based server – Data Monitoring & Analysis.

There was a discussion on the use of mobile phones to collect data, followed by exploring the benefits of multiple stakeholders (decision makers, programme managers, fieldworkers, evaluators and researchers). Then Ms Rania talked about the comprehensive training, content and materials, RAMP toolkit and other guidance available. The cost of RAMP, ethical considerations and challenges were taken into account.

RAMP Group Discussion

Q1. Would you use RAMP in your National Society?
Most, if not all said YES.

Q2. If yes, what potential uses you can identify?
- Health
- WASH/Watsan
- ICBDRR
- Cyclone preparedness
- Baseline & Endline / Monitoring & Evaluation
- Consolidating data
- Time management

Q3. What kind of support will you need?
- Training
- Data Management (analysis)
- Technical support
- Funding / financial support
- Partnerships (private companies – mobile phone / operators)

Some other issues discussed:
- Logistic needs – power-banks / batteries
- Loss of data (and the need to back up)

Day 4: Thursday, 04 June 2015

Chair: Jessie Kanhutu

The morning started with an interactive recap led by Ms. Ellen Grace G. Ledesma from the Philippine RC. Standing in a circle, one participant was called on to name all the other workshop participants. If they couldn't remember the other participants' names, they had a question to answer about yesterday's sessions. There were 5 questions total on topics including CBHFA+, NCDs, and RAMP.

RAMP / Magpi crash-course

By Rania Alerksoussi and Meghan O'hearn from IFRC, Geneva office

Objectives: (By the end of this session, the participants would)

- Create their own Magpi free account
- Create a form for mobile data collection with an understanding of different types of questions, skip logic, and ranges
- Install Magpi on a mobile phone
- Share form by email or SMS
- Fill a form on mobile device and uploaded record
- View data, map, basic analysis, and exported it to Excel for further analysis

To start learning how to use RAMP, everyone created a Magpi account on their computers and opened their account on their mobile phone or one provided by IFRC. The participants experienced first had the difficulties with poor internet connection. Once we got over internet difficulties, participants filled out a quick and easy survey about AP volunteer motivation. The AP staff volunteer motivation form had a variety of question types: radial button, one answer choice; drop-down menu; image capture.

Rania then explained how to design surveys on your computer. She also explained the different aspect of the Magpi internet dashboard and the various utilities including the 'data' tab, 'design' tab for designing surveys, the 'map' tab for displaying GPS coordinates, and the 'analysis' tab which shows basic analysis of each of the questions in bar chart form. For more elaborate analysis, information should be exported. Discussion moved more towards the practical aspects of collecting the survey and triangulation of surveys for accuracy (ie using GPS coordinates).

Poster presentation:

Mobile survey experiences of American Red Cross during Typhoon Haiyan Recovery in Philippines using ODK. They conducted a household profiling survey. Beyond the typical survey processes, ODK was used. This involved developing the survey form in excel, uploading the survey form on mobile devices, conducting a 4-day training in survey and interview processes, mobile technology, and practical community exercises. Enumerators were put in groups of 4 and had a leader in each group. The presenter discussed the advantages of using ODK including: ease of monitoring, clean data, reduction in transcription errors, and real-time data access. It is great for projects that need to collect data accurately, quickly, offline and at scale. Challenges included: lack of familiarity with mobile data entry and android software, some mobile batteries got worn out during survey, and some enumerators assigned wrong information, especially village code.

After the break, Rania went through how to design a survey form. Save frequently to avoid losses. She went through creating different types of questions such as multiple choice, radial, integer, drop down (village name),

image, GPS, etc. We also talked about different functionalities such as inserting, deleting, cutting, and copying questions and making questions required (only if there won't be problem with those questions) and exporting Word files and codebooks. We also discussed different ways to share surveys (mobile app, structured SMS for short surveys, and interactive SMS). Rania explained the GPS modality by showing a previous survey done in Ivory Coast. The GPS helps program managers trace where surveys are being conducted, ensure enumerators are actually going to the field to collect data, and is especially useful for doing endline surveys (linked with previous records).

The afternoon session started with questionnaire designing by group working. The facilitator assigned each groups to design a questionnaire to evaluate NCD risk factors at the workplace. The five groups drafted 10 questions by 3 different types on paper through participatory discussion. Follow up the questionnaires were designed on rampsurveyrcrc@gmail.com afterwards. Group members were requested to share the questionnaire among themselves.

The group discussions were conducted based on the experience of learning by completing this exercise. Feedback was collected with below key points:

- It takes time to design the questionnaires in whole RAMP process
- RAMP needs to have expertise for data analysis
- Questionnaire should be prepared for easy data analysis
- For those working in the field are expected to be familiar with and comfortable in mobile phone using for data collection

Plenary discussion went on by talking each questions of Group 1 as an example.
To sum up, the participants really appreciated the knowledge/skills learnt and experienced in a way of 'learning by doing' in this afternoon. Even it took time to share the questionnaire with other group members, the participants actively practiced each steps with high initiatives. They strongly believe this new technique will add value to RCRC work in the relevant working fields.

Day 5: Friday, 05 June 2015

Chair: Bhanu Pratap

Principles and practices of field surveying – planning phase, field work and post field work phases

By Gregory Rose, British Red Cross

Objectives: (by the end of this session, the participants will understand)

- Their role in planning a field survey.
- How to recruit a field team for undertaking the survey?
- Basics and the importance of sampling.
- How to select household and/ or individuals for the survey?
- How to organize a training of the surveyors?
- How to select household and/ or individuals for the survey?
- How to organize a training of the surveyors
- Data manipulation, cleaning and analysis.

Field Survey Planning

The facilitator asked everyone to, individually, identify their own future or present role in field surveys (in case the participants were not responsible, they were instructed to describe the role of those they manage)

Outcome of group work on personal responsibilities:

1 Recruiting consultants for surveys (describe responsibilities – e.g. developing TOR, job description, interviewing/assessing skills) **Roles:** Find multiple consultants (3). Interview – investigate background. Specific questions. Experience of technical area. Planning jointly with consultant, prepare TOR. **Negative experiences:** TOR developed by IFRC, scope of survey explained. Quality vs Cost. Chose the cheapest local according to delegation rules. Trust in field staff. Not well organised. Little supervision, information not exactly what desired. Data entry not good. Analysis poor. Report unclear. **Positive experience:** In beginning, highlight that consultant is not familiar with RC. They contacted indirect beneficiaries – leaders. Composition of team is important – consultant not on own. They may have only a survey background. Others	2 Assisting in survey planning (describe responsibilities e.g. sampling, survey design, logistics, security) **Roles:** Baselines in CBHFA. Developed questionnaire, sampling size and design (systematic); logistics. **Challenges:** Developing the integrated questionnaire (getting all sectors involved and covered in questions). Some consultants are not local and then you have to translate questions. It may be translated incorrectly. Cross-checking of translation. Check with others who know the languages and check it with the original. Designing in English and then using 3 local languages. After field testing you can end up with very different Qs. Theres are

may be broader. Cost is not the only consideration. We ask for references, experience of others. If a group, well chosen. Ask for an inception report. What is expected, a plan for how they will fulfil the TOR. You can see if their scope is too narrow. You can then interfere or halt. Ask for another report from previous survey. In IFRC building a roster of technical expertise – so ask Rania and others in Geneva for information on good consultants (knowing sampling methods, data analysis).	many methods of sample size. Causes confusion. Sample size in Sindh was larger than planned. Needs to be a simple design. People who design the survey are clear, but the field data collectors often miss parts of the question understanding. Pay attention to the questionnaire and train well.
3 Being a field survey team member (describe responsibilities – e.g. supervision, enumerator/ interviewer, analysis, report writing, etc.) **Roles:** baseline survey anaemia project in Bangladesh. Developing TOR, following IFRC guidelines and being advised. Identified number of families and women in families – pregnant/not. Enumerator work in VCA. **Challenges:** cultural barriers. Responses – not prepared to answer. Often could not locate address or house. Often unclear about questionnaire. As a supervisor for household profiling in Philippines. Team of 6 people, and 4 teams. Have to travel with all teams. Went as a foreigner. Most were volunteers with a small allowance. Harsh conditions. Uplifted their allowance. As a supervisor, need to think about a budget. Treats, incentives. In Mazar-i-sharif, Afghanistan. Colleagues going to Saripul province for flood survey. They had no tools, no preparation. Developed questionnaire for them. Poor preparation. Used experience from Pakistan and adapted to context. Conducted training and developed teams for house-to-house survey. Translation of tools. Problem is transferring written into spoken. They just read. This means community did not understand. In some languages written and spoken is very different. Enumerators are volunteers. People absent from community.	4 Coordinating the field survey from beginning to end (describe responsibilities – could be activities from the other 3 boxes) **Roles:** Conducted baseline endline surveys in Cambodia using CBHFA. Discussing the roles and responsibilities of each team member. Scope of survey among team members. Sampling, questionnaire design. How to select household to interview. Making plan of whole survey – timeline. Coordination with local authority, branch and sub-branch, community. Administration and logistics. **Challenges:** Communication problems. Data may be missing. Questionnaire may not be completed due to technical team skills. The whole planning process may take up to 6 months.

Outcome of small group work on Team and skills required to undertake a survey –	
1 Planning phase • Manager/Coordinator &/or Consultant • M&E • Finance / administration / HR • Community leaders • Technical skills area from each relevant sector • Statistician • IT / technology person (phones, sim cards, data plan for phones) – may not have a job description of IT • When to do, how to do, where to do, why to do are important questions • Security / police / military actors • Trainers • Independent back translation	Skills • Know scope of program, experience of surveys, leadership, • Not reporting, real M&E • Sample size understanding, survey design, methods. • Application of technology to the problems • Facilitation, coaching, probing skills, Communication • Labour intensive, should not know the original English/Portuguese.
2 Field work phase • Enumerators (appropriate gender balance) • Interviewers for in-depth interviews • Someone to introduce and lead enumerators in the field (e.g. volunteers) • Supervisors / someone to ensure household selection (holder of methods) • Driver / logistics • Community leaders • Local government for permission and security • Interpreters / dialectic experience • Field editing / data managers for mobile technology – looking at data as it comes it to ensure quality and to correct errors	Skills • Verbal communication, read/write, numerate, relevant language, honest, respectful, organised, clear accurate typing/writing, adaptability, trust/confidence, able to recognise and troubleshooting problems / solutions oriented, (if volunteers, from the community so familiar which is good and bad, bias!) • Supervisors from enumerator training – the best, leadership • Knowledge of subject and independence. Can interpret cultural / non-verbal aspects which give an indication of honesty
3 Post field work phase • HMIS person • Translator (translation/data validation) • Data entry person • Project management people • IT / mobile technology person • Consultant (involved throughout from planning to analysis) • Analyst/Data cleaners / manipulators • Report writer	Skills • Knowledge of subject and independence. Can interpret cultural / non-verbal aspects which give an indication of honesty • Accuracy and care in data entry/mobile use • Depends on the data system. • Cleaning requires someone who understands the possible contradictions of data • Literate, concise
(*) Should at least consider (these are not individual people, some may have multiple roles)	

The following outcomes were recorded as part of the open session that happened as part of small groups discussions and the identified roles and skills for different phases of the a field survey are encompassed, below –

Planning phase:

Coordinator (someone responsible for the overall survey) (skills: management, coordination, communication, planning)

Question development (This is a role for the whole team, including those involved in the intervention)

Sampling / design person (skills: numeracy, statistical, spatial)

Data entry – who designs the Magpi or other data entry template? (skills: numeracy, IT, software knowledge)

Logistics (Skills: transport, routes, communication)

Administration / finance

Security (skills: awareness, knowledge of risks, personal protection, planning communication and teams)

Field work trainer (skills: survey knowledge, training ability, communication, can be overall coordinator)

Field work phase:

Enumerators / interviewers (skills: numeracy, literacy listening, recording accuracy, INDEPENDENCE)

Supervisors (Magpi does not mean unmanaged!) (skills: numeracy, literacy listening, recording accuracy – can be drawn from the best of the enumerators)

Post field work phase

Data cleaning, manipulation/formatting (especially free text) (skills: numeracy, IT, software knowledge)

Analysis / interpretation (skills: statistics, numeracy, interpretation, analysis, INDEPENDENCE)

Report writing (skills: literacy, interpretation, analysis, can be overall coordinator, INDEPENDENCE)

Random game

This was followed by a game with an objective to understand random sampling and role of clustering as a tool to reduce bias in any survey –

The Simple or stratified random sample game took 20 minutes including analysis. The participants were asked to select from all 45 sites – choosing 3 sites only in the beginning, then 2 more and at the end 30 additional sites (compare prevalence using 10 beans from each).

Cluster Sample game took 30 minutes including analysis where selection from 30 sites – choosing 5 sites only and then from 30 (compare prevalence using 10 beans from each)

The result are given in the below table –

Sampled villages	Black-eyed peas (open defecation)	Cow peas (VIP latrines)	% open defecation
3 clusters (sample 30)	10x3=30	10x0=0	100%
5 clusters (sample 50)	36	14	72%
25 clusters (sample 250)	99	151	39.5%
30 clusters (sample 300)	135	165	45%

The cluster selection was made understood with reference from GPS maps and it was envisaged that taking large sample from one are may not be representative of the universe, rather sample should be drawn from across the universe, in a random or/ and in a clustered manner.

The Principles were also highlighted, which are:

- The larger sample size improves precision
- Stratifying improves precision
- Cluster sampling increases bias and reduces precision
- Higher number of clusters reduces bias, increases precision
- Increasing the number within clusters does not improve this and can even make it worse

The later sessions also encompassed points like –

- **How to select households / individuals (50 minutes including practical)**
    - From lists
        - Random sample (ask for ideas on how to do – caution on Excel) – Name lits game
        - Random sample using online software without replacement http://stattrek.com/statistics/random-number-generator.aspx
    - Systematic sample with random start
        - The simplest way
        - In most cases we don't have up-to-date lists
        - Principle – every house has a chance of selection and creates an even spatial spread
        - Demonstrate with volunteers using chairs counting to left
- GIS positioning – only for the expert (don't try this at home)

A session on the **training methodologies and practical do and don'ts**, followed. It was envisaged that the training is best done with enumerators and supervisors together and it is imperative to keep it lively, with practical sessions and formal education.

This was followed by a session on **Fieldwork Planning and group work on the critical pathway** (60 minutes: 30 minutes group work, 20 minutes discussion) was introduced to the participants. Group 1 was given to plan the fieldwork for a survey of 40 sites (from 10 minutes to 1 hour apart) and 450 households. They were asked to answer –

- How many people will you need?
- How many days?
- What can be done simultaneously?

Group 2 was given to plan the fieldwork for survey 5 sites (2-3 hours apart) and 300 households. They were asked –

- How many people will you need?
- How many days?
- What can be done simultaneously?

The outcomes of the group work are as follows –

Group 1: Planning the fieldwork for a survey of 40 sites (from 10 minutes to 1 hour apart) and 450 households.

1 How many people do you need? (all roles) Why? Group1 32 people. Enumerators 20; supervisors 10 people (1 for every 2). 5 days: 1 day training, 4 days field data collection. Divide 20 into 5 groups. Each has 4 members. Each member to interview 6 households/day. In 1 day, each group can go to a different site – so, 120 interviews in a day. In 4 days, 480 interviews. Group2 20 enumerators, 4 supervisors, 4 drivers, divided into 4 groups of 5 people, driver and supervisor. 1 household 30 minutes for consent and interview. Group3 Tried to separate into 2 teams so they go to different sites (20 sites each to reduce travel time based on proximity). Supervisor will be enumerator and all based in town. Including training, 7-8 days. You need to build in to the sample, sample loss to ensure you get the full size. Also, plan time for revisit. Give some flexibility in the schedule. Plan for when the target interviewees will be in place.	2 What is the average sample in each site? 11-12 households per site.
3 How will you organise time among the sites? Why?	3a If this is not using Magpi (paper questionnaires) how do you organise the data entry? (when to do) If Magpi, what do you have in place to ensure quality control?

4 Logistics & living conditions (what needs to be arranged?)	5 Communication & security (what needs to be in place for your teams) – think about a base for collection of data, troubleshooting

Group 2: Planning the fieldwork for a survey 5 site (2-3 hours apart) and 300 households

1 How many people do you need? (all roles) Why? Group3 Some sites will have higher or lower sizes. 6 groups of mixed sex groups. They will go to the site and return to branches – no overnight stays. Start 8am-6pm. Each will take 6 hours – 15 minutes interview. 100 in one day. 4h in another village. Another smaller, 3h, etc. 5 days of collecting data, 3days prior training, 1 day in case of problems. 3 supervisors for 6 teams with an agreed place for meeting supervisors using mobiles if possible. Group4 Train 3 groups of 1 supervisor, driver, 5 enumerators, 1 translator, 1 guide in community. 3 days including training. Site 1-3 day 2 and remaining in day 3. Mobilised simultaneously to sites 1, 2 and 3. **Training should be at least 3 days including practical**	2 What is the average sample in each site? Averages sample each site 66. 4.5h per site for RAMP. 33 households in morning.
3 How will you organise time among the sites? Why?	3a If this is not using Magpi (paper questionnaires) how do you organise the data entry? (when to do) If Magpi, what do you have in place to ensure quality control?
4 Logistics & living conditions (what needs to be arranged?)	5 Communication & security (what needs to be in place for your teams) – think about a base for collection of data, troubleshooting

It was followed by a discussion on post field work phase data cleaning and analysis. The facilitator provided practical definition of the same, as following –

Cleaning: Depending on the complexity of your data entry or mobile collection software, this can be a short or long process. Software like Access can be used to introduce predictive text which means free-text is clean.

Manipulation: Grouping data or reclassifying it can aid analysis. E.g. all those with tube wells, protected springs, protected hand-dug wells, protected rainwater can be classed as improved sources. Certain types of treatment of surface water can be classed as acceptable treatment.

Principles of analysis:

Cluster samples should be analysed using complex samples analysis software (Epi Info is free). This adjusts for cluster bias.

Analysis should include confidence intervals (measures of precision). Many consultant-led surveys show no error bars in the report yet claim to have used statistical software.

Important if you want to know if you've seen a real change

Even if a consultant coordinates the survey you should retain the raw data in a usable format.

Analysis should be 2 dimensional and meaningful. Tallies of who had hand-dug wells aren't helpful. Percentages of those who had improved sources or treated surface water are meaningful.

The session ended with a post mortem of the day and reiterating the major principles and by the facilitators. The participants explained how the same can be adjusted to National Society needs and discussed and came up with practical needs to undertake planning for field surveys using Magpi or traditional methods.

National Society experience sharing on different Community Based Health programmes

Indonesian Red Cross (poster presentation)
CBHFA in Mongolia (PowerPoint presentation)

Summary and closing

The concluding session started with a request and directions for filling up the evaluation of the sessions sand submitting the same, back to the facilitators and also filling in the survey monkey questionnaire for highlighting the achievements and areas of improvement for the workshop. The comments and the analysis of both the exercise are given in the annexes.

Ms Anne E. Leclerc and Ms. Hannele Virtanen motivated the participants by their presence and encouraging words about the power of Red Cross as a movement. They reiterated the concept of resilience building and RC as movement's mandate to make it happen. Ms Anne also highlighted the role of health in driving the concept of resilience towards achieving the overall organizational goal. Ms Hannele highlighted the role of CBHFA in positioning RC as a movement, a community led and evidence based organization, in future.

The result of the 05 day long gamified methodology was consolidated and Ms Meghan announced the ranking, however all the groups were conferred upon some token gift as appreciation of participation. This was followed by a group photograph session.

The participants were encouraged to enrol for different working groups for sharpening the 'concept of CBHFA in future'; a list of the preferred group for participating in the evolution process are captured below –

Developing core areas in CBHFA+

1. **Defining CBHFA+ platform**
    a. Dr Fawad Iqbal (Pakistan Red Crescent)
    b. Dr Sultanmohammad Hamayoun (IFRC Afghanistan)
2. **Health system strengthening**
    a. Dr Durgavasini Devanath (IFRC APZ)
3. **Health emergency risk management**
    a. Mr Hang Chan Sana (Cambodian Red Cross)
    b. Dr Durgavasini Devanath (IFRC APZ)
    c. Dr Sayed Zalmai Abdullah (Afghanistan Red Crescent)

   d. Mr Muhammad Akhtar Ayoub (Pakistan Red Crescent)
   e. Ms Ellen Grace G. Ledesma (Philippine Red Cross)
   f. Dr Davaajargal Baasansuren (Mongolian Red Cross)
4. **Data system and mHealth**
   a. Dr Naing Naing (Myanmar Red Cross)
5. **First aid in CBHFA**
   a. Dr. Davaajargal Baasansuren (Mongolian Red Cross)
   b. Mr Marcelino Albuquerque (CVTL)
6. **Volunteer capacity building**
   a. Ms Ellen Grace G. Ledesma (Philippine Red Cross)
   b. Mr Golabodin Miri (Afghanistan Red Crescent)

Reviews

1. **Review of CBHFA Global Mapping**
   a. Dr Durgavasini Devanath (IFRC APZ)

The day closed with a summary of the workshop by Gopal Mukherjee, who reviewed attainment of meeting objectives and expected outcomes, and put forward recommendations for future meetings. He also conveyed his heartfelt gratitude and profound reverence to SEARD for their support, enthusiasm and proactive involvement in the entire process.

Annex 1: Workshop Agenda

	Day 1, Mon- 01 June CBHFA updates and Resilience	Day 2,Tue-02 June VP, PHiE and RMNCH	Day 3, Wed- 03 June NCD, CBHFA + and RAMP	Day 4,Thu-04 June RAMP	Day 5, Fri-05 June Field Survey
8:45-10:30	Registration, Opening welcome, and introduction. Welcome and keynote. Objective, Agenda and Arrangements CBHFA Global and AP update.	Housekeeping Recap from Day 1 Violence Preventions.	Recap from Day 2 Non Communicable Disease	Recap from Day 3 Crash course on RAMP	Recap from Day 4. Principle and practices of field survey – planning
10:30-11:00	Break	Break	Break	Break	Break
11:00-12:30	NS experience sharing (supported by IFRC) on different CBH programs.	Public Health in Emergencies Management in communities.	The future of community based health at IFRC and the concept of CBHFA +	Crash course on RAMP	Principle and practices of field survey – planning
12:30-14:00	Lunch	Lunch	Lunch	Lunch	Lunch
14:00-15:30	CBHFA and resilience .	Reproductive, Maternal and New born Child Health.	The future of community based health at IFRC and the concept of CBHFA + (continues)	Crash course on RAMP	Principle and practices of field survey – field work and post field work
15:30-16:00	Break	Break	Break	Break	Break
16:00-17:30	NS experience sharing (supported by IFRC) on different CBH programs.	Reproductive, Maternal and New born Child Health.	Introduction to RAMP and importance of RAMP in M&E	Crash course on RAMP	Evaluation of the meeting. Next steps, group photo and closing.

Annex 2: Participants list

No.	Name	Position	Country NS/ Secretariat/ Country PNS	Country (office)	Email
1	Mr. Golabodin Miri	CBHFA Supervisor in Western Region	Afghanistan RC	Afghanistan	Gulabuddin.arcs@gmail.com
2	Dr. Sayed Zalmai Abdullah	CBHFA Manager	Afghanistan RC	Afghanistan	drzalmaiabdullah91@gmail.com
3	Dr. Sultan Mohammad Hamayoun	Senior Health Programme Manager	IFRC, CD	Afghanistan	Sultanmohammad.hamayoun@ifrc.org
4	Mr. Ranjan Mohnot	Senior Delegate Regional Quality and Learning	American RC	Thailand	ranjan.mohnot@redcross.org
5	Ms. Rattanaporn Poungpattana	Snr. Knowledge Management, Monitoring & Evaluation Asst.	American RC	Thailand	rattanaporn.poungpattana@ifrc.org
6	Dr. Shahana Zafor	Deputy Director (Health)	Bangladesh RC	Bangladesh	shahana.zafor@bdrcs.org
7	Ms. Vantha Dim	CBHFA Project Officer	Cambodian RC	Cambodia	dim.vantha@redcross.org.kh
8	Mr. Hang Chan Sana	CBHFA Project Manager	Cambodian RC	Cambodia	hangchansana2011@gmail.com
9	Mr. Hong Chen	Regional Health Manager	IFRC EARD	China	hong.chen@ifrc.org
10	Ms. Cynda Baker	Health Coordinator	Cook Island RC	Cook Islands	bcynda@redcross.org.ck
11	Ms. Tsz Ning Fong	International & Relief Service Officer (Health)	Hong Kong RC	Hong Kong	elaine.fong@redcross.org.hk
12	Ms. Eka Wulan Cahyasari	Head of Public Health subdivision	PMI	Indonesia	eka_wulan@pmi.or.id
13	Mr. Toshiharu Shinozaki	Officer, Development Cooperation Division, International Department	Japanese RC	Japan	t-shinozaki@jrc.or.jp
14	Ms. Miki Takahara	Nurse	Japanese RC	Japan	miki-takahara@himeji.jrc.or.jp
15	Mr. Baasansuren Davaajargal	CBHFA Project Manager	Mongolian	Mongolia	davaajargalb@redcross.mn

No.	Name	Position	Country NS/ Secretariat/ Country PNS	Country (office)	Email
			RC		
16	Dr. Naing Naing	Health Department	Myanmar RC	Myanmar	nnaing82@gmail.com
17	Dr. Jessie Kanhutu	Health Delegate	IFRC, CD	Myanmar	jessie.kanhutu@ifrc.org
18	Mr. Muhammad Akhtar Ayoub	PRCS Program Manager AJK	Pakistan RC	Pakistan	akhtar.ayoub@gmail.com
19	Dr. Fawad Iqbal	Senior technical officer (Health)	IFRC, CD	Pakistan	fawad.iqbal@ifrc.org
20	Dr. Bhanu Pratap Maurya		IFRC, CD	Philippines	Bhanu.PRATAP@ifrc.org
21	Ms. Ellen Grace G. Ledesma	National Project Coordinator, Health Services	PRC	Philippines	ellengrace.ledesma@redcross.org.ph
22	Dr. Manish Pant	Health Coordinator	SARD	India	manish.pant@ifrc.org
23	Ms. Thunwarut Worrmongkolchai	In Emergency Department	Thai RC	Thailand	mean_thunder@hotmail.com
24	Mr. Pornsak Khortwong	Regional Health Officer-SEARD	SEARD	Thailand	pornsak.khortwong@ifrc.org
25	Mr. Marcelino Albuquerque	CBHFA Manager	CVTL	Timor Leste	Marcelino_cvtl@redcross.tl
26	Mr. Tuyen Vu Huu	Program Officer	Vietnam RC	Vietnam	vuhuutuyen@gmail.com vuhuutuyen@hotmail.com
27	Mr. Gopal Mukherjee	Health Delegate	IFRC, CD	DPRK	gopal.mukherjee@ifrc.org
28	Ms. Hannele Virtanen	Healthcare Advisor	Finnish RC	Finland	Hannele.Virtanen@redcross.fi
29	Ms. Rania Alerksoussi	Officer, Coordination & Planning Support	IFRC, HQ	Geneva	rania.alerksoussi@ifrc.org
30	Dr. Arvind Bhardwaj	Senior Officer, RMNCH & Immunisation	IFRC, HQ	Geneva	Arvind.Bhardwaj@ifrc.org

No.	Name	Position	Country NS/ Secretariat/ Country PNS	Country (office)	Email
31	Mr. Gregory Rose	Health Advisor EURASIA	British RC	United Kingdom	GRose@redcross.org.uk
32	Ms. Jessie Lucien	Programme Officer, Health & NSD	IFRC, APZO	Malaysia	jessie.lucien@ifrc.org
33	Dr. Durgavasini Devanath	Senior Emergency Health Officer	IFRC APZO	Malaysia	Durgavasini.DEVANATH@ifrc.org
34	Ms. Meghan Kelly O'Hearn	Nutrition Consultant, Health Dept.	IFRC, HQ	Geneva	meghan.ohearn@ifrc.org
35	Ms. Nutchapang Khowinij (Tum)	Regional CSRU Assistant	IFRC, SEARD	Thailand	nutchapang.khowinij@ifrc.org

Annex 3: List of posters presented

Day 1, 1 June 2015:	Afghanistan Red Crescent
Day 2, 2 June 2015:	Cook Islands Red Cross (PowerPoint presentation)
	Cambodian Red Cross
Day 3, 3 June 2015:	Pakistan Red Crescent
	Hong Kong Red Cross
Day 4, 4 June 2015:	American Red Cross (PowerPoint presentation)
	Philippine Red Cross
Day 5, 5 June 2015:	Indonesian Red Crescent
	Mongolian Red Cross (PowerPoint presentation)

Annex 4: List of Presentations by different National Societies

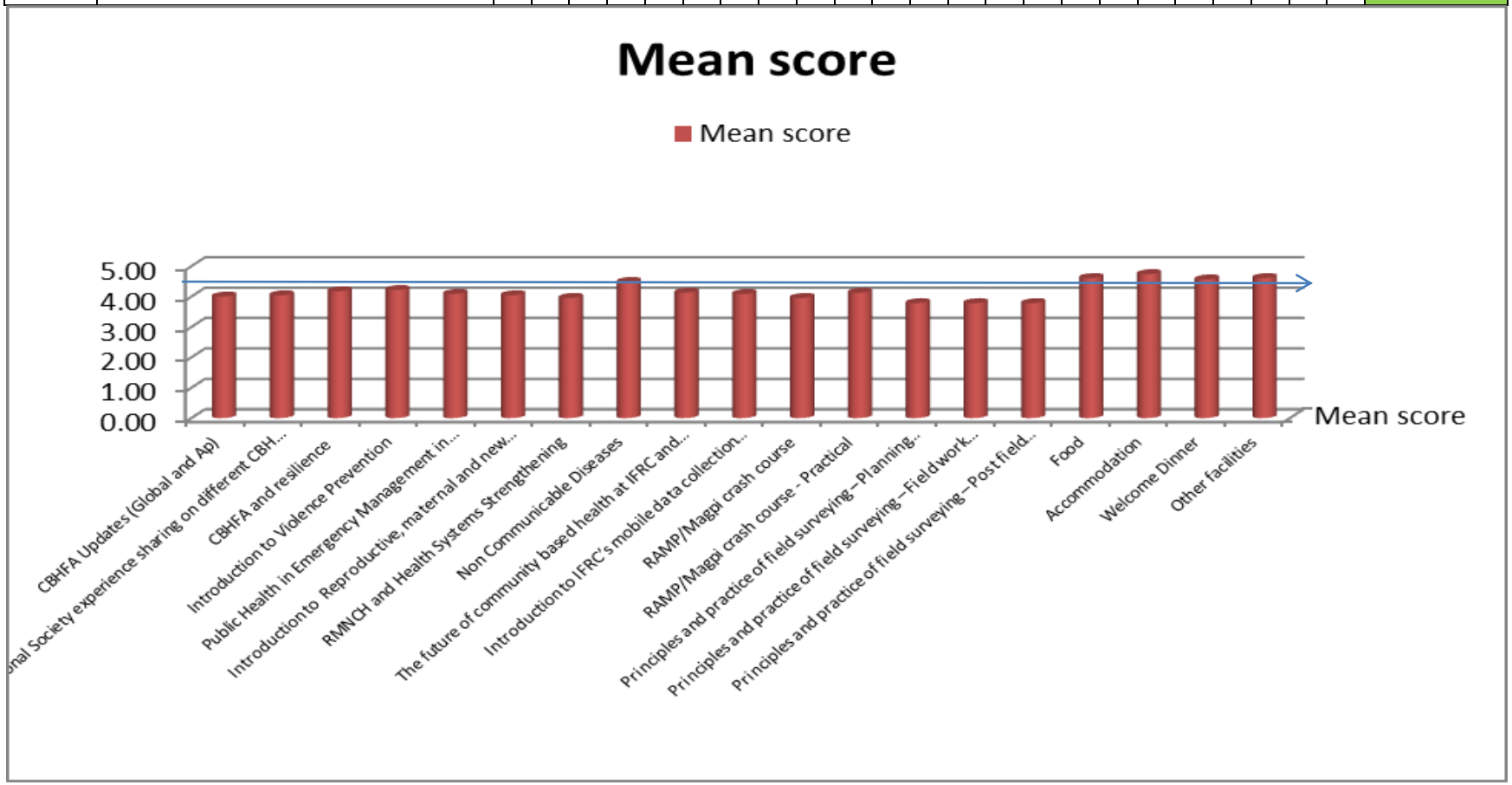
Day 1: June 01, 2015	
Time	**Presenting National Society**
11:15 – 12:30 (Pre Lunch session)	
11:15 – 11:30	Cambodia RCS
11:30 – 11:45	Bangladesh RCS
11:45 – 12:00	Cook Islands
12:00 – 12:15	Vietnam RCS
12:15 – 12:30	American RC
13:30 – 13:45	SEARD
13:45 – 14:00	Philippines RCS
16:00 – 17:30 (Post afternoon coffee break session)	
16:00 – 16:15	Japanese RCS
16:15 – 16:30	CVTL
16:30 – 16:45	Afghan RCS
16:45 – 17:00	Myanmar RCS
17:00 – 17:15	Pakistan RCS
17:15 – 17:30	Hong Kong RCS

Annex 5: AP CBH workshop Final Evaluation

Feedback based on sessions and technical content:

SL	Topic/ Issues	Score of 18 participants (scale 0 - 5)																						Mean score
1.	CBHFA Updates (Global and Ap)	4	4	4	3	4	4	3	5	4	4	3	5	5	5	4	4	4	4	5	3	3	4	4	4.00
2.	National Society experience sharing on different CBH programs.	3	4	5	3	4	4	3	5	5	4	4	5	5	4	4	4	4	4	4	4	3	4	4	4.04
3.	CBHFA and resilience		4	4	5	5	5	4	4	3	4	4	5	5	5	4	5	4	4	5	4	5	4	4	4.17
4.	Introduction to Violence Prevention	5	4	4	4	5	4	4	4	3	4	3	4	5	5	5	4	3	4	5	4	5	5	4	4.22
5.	Public Health in Emergency Management in communities	5	4	5	3	3	4	4	4	3	4	4	5	5	5	4	4	4	4	5	4	3	4	4	4.09
6.	Introduction to Reproductive, maternal and new born child's health (RMNCH)	4	4	4	4	4	2	4	4	3	4	4	5	5	5	4	4	4	4	5	4	4	4	4	4.04
7.	RMNCH and Health Systems Strengthening	4	4	4	4	4	3	4	4	3	4	3	5	5	5	3	4	4	4	5	3	4	4	4	3.96
8.	Non Communicable Diseases	4	3	5	5	5	3	4	5	4	4	5	5	5	5	5	5	4	4	5	5	5	4	4	4.48
9.	The future of community based health at IFRC and the concept of CBHFA +	4	4	5	5	4	4	5	4	3	4	3	5	5	4	4	4	4	4	4	3	5	4	4	4.13
10.	Introduction to IFRC's mobile data collection methodology (RAMP) and experience sharing on its application	4	4	5	4	5	5	5	5	4	4	4	4	5	1	4	4	5	4	1	4	4	5	4	4.09
11.	RAMP/Magpi crash course	5	4	5	3	5	5	5	4	4	4	3	4	5	1	4	5	5	4	1	3	3	5	4	3.96
12.	RAMP/Magpi crash course - Practical	5	4	5	3	5	5	5	4	4	5	4	5	5	1	4	5	5	4	1	4	3	5	4	4.13
13.	Principles and practice of field surveying – Planning phase	5	4	4	3	4	4	4	4	4	4	4	4	5	2	5	4	3	4	2	4	3	3	4	3.78
14.	Principles and practice of field surveying – Field work phase	5	4	4	3	4	3	5	4	4	4	4	4	5	2	5	4	3	4	2	4	3	3	4	3.78

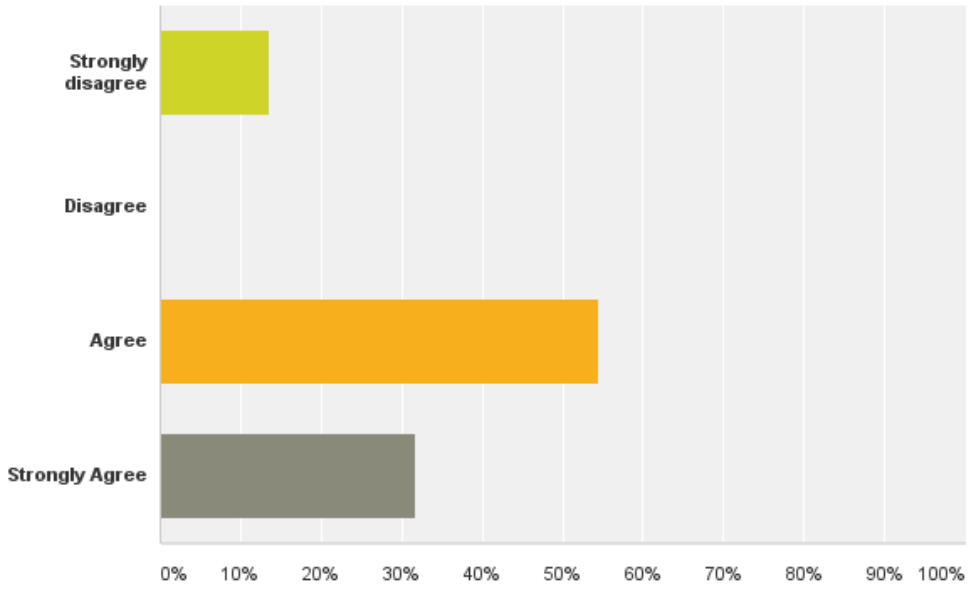
SL	Topic/ Issues	Score of 18 participants (scale 0 - 5)																							Mean score
15.	Principles and practice of field surveying – Post field work phase	5	4	4	3	4	3	5	4	4	4	4	4	5	2	5	4	3	4	2	4	3	3	4	3.78
16.	Food	5	4	3	5	5	5	3	5	5	4	5	5	5	5	5	4	5	4	5	5	5	5	4	4.61
17.	Accommodation	5	4	4	5	5	5	5	5	5	4	5	4	5	5	5	5	5	4	5	5	5	5	4	4.74
18.	Welcome Dinner	5	4	4	5	5	4	5	5	4	4	5	4	5	5	5	5	4	4	5	5	5	4	4	4.57
19.	Other facilities	5	4	4	5	5	5	5	5	5	4	5	4	5	5	5	4	4	4	5	5	5	4	4	4.61



Feedback based on questionnaire on the Survey Monkey:

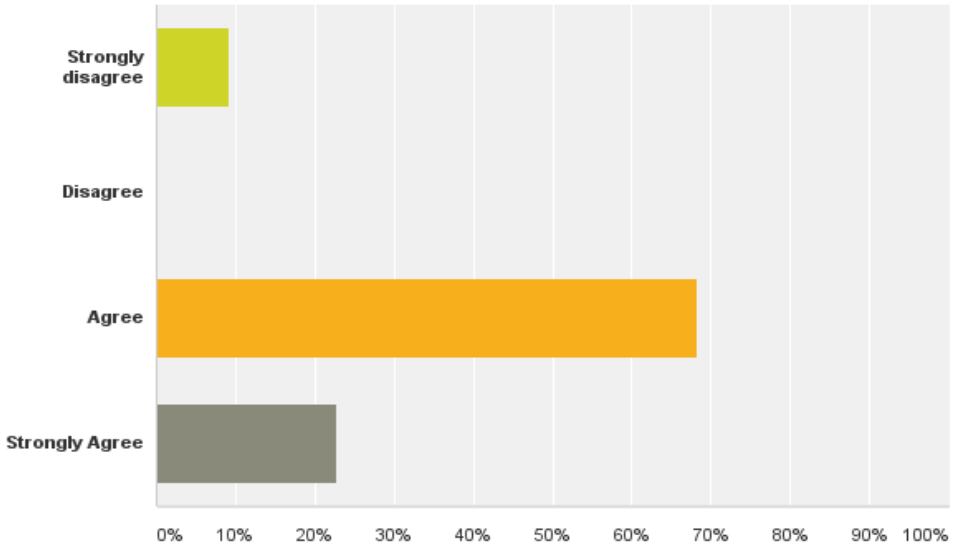
Q1 Overall, I found the workshop helpful for my daily program management

Answered: 22 Skipped: 1



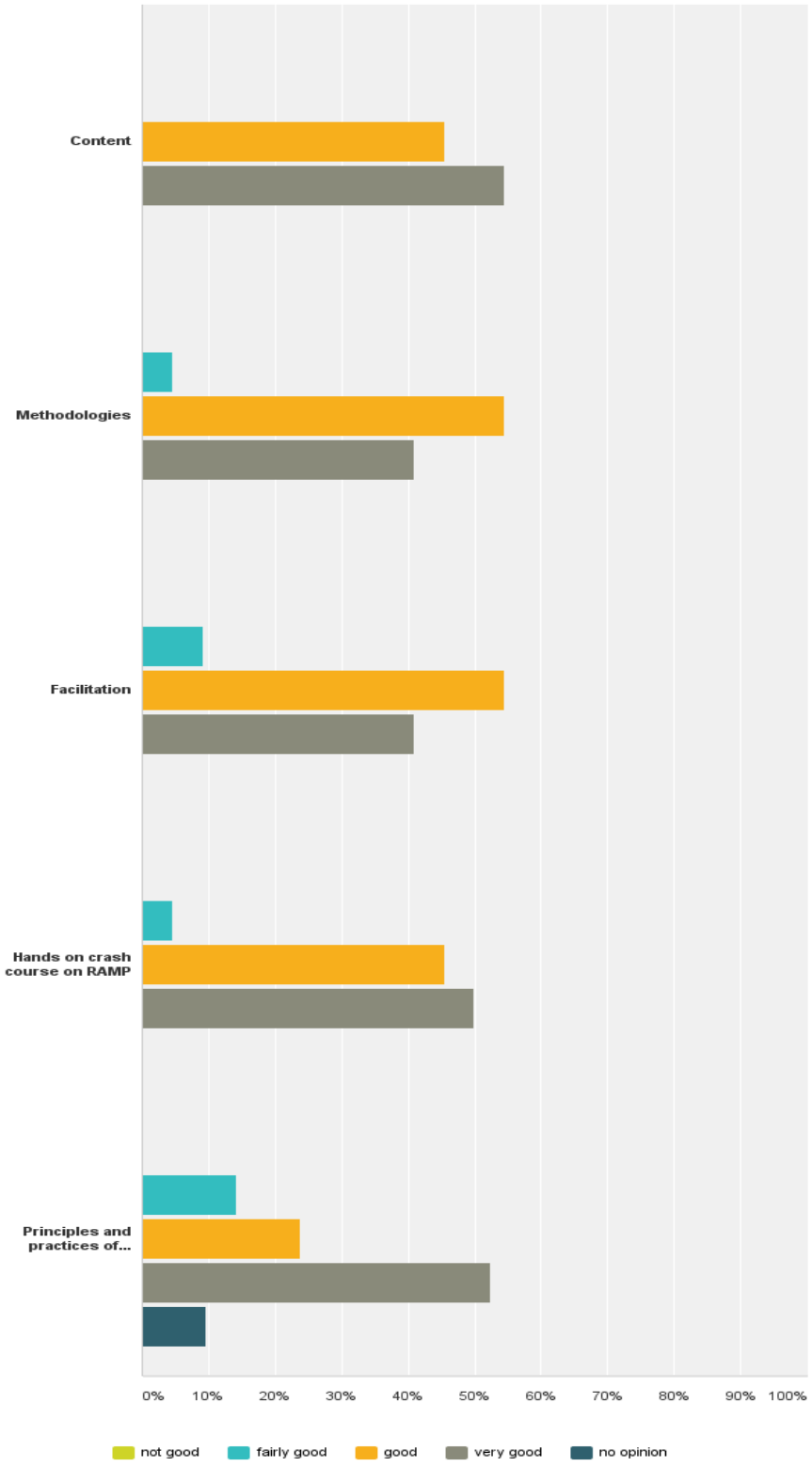
Q2 Overall, my expectations of the workshop were reached

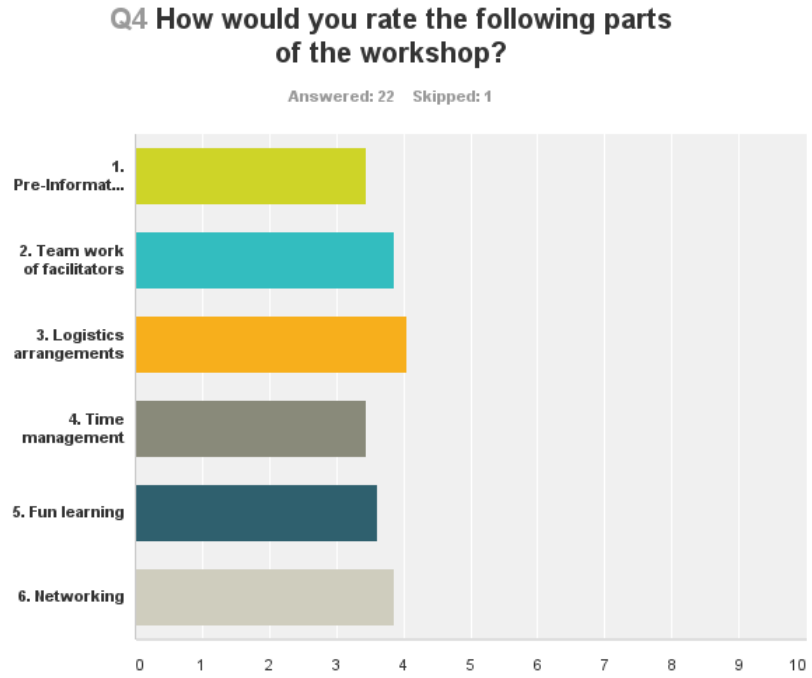
Answered: 22 Skipped: 1



Q3 What do you think about the content, methodologies used and facilitation during the workshop?

Answered: 22 Skipped: 1





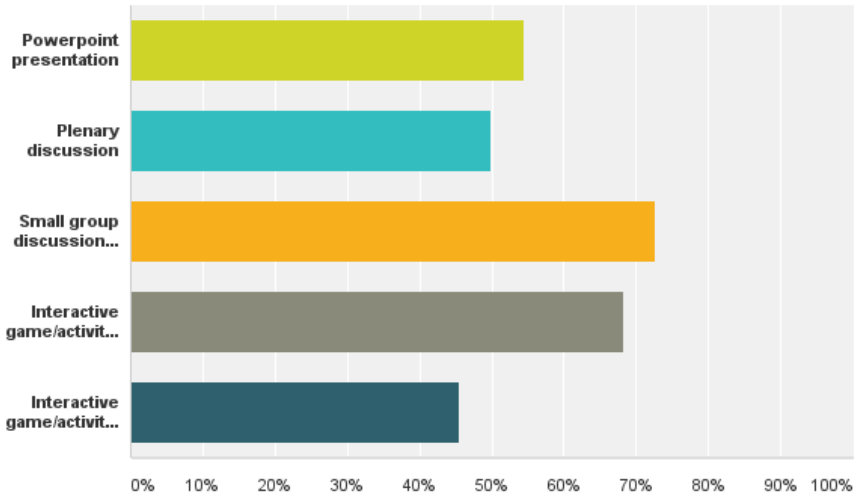
Q5 Which session or activity was most useful for you?	
Respondents	Response Text
1	CBHFA+ resilience drawing
2	RAMP and principles and practices of field survey
3	RAMP
4	CBHFA, NCD, ECV, Violence prevention , RMNCAH
5	RAMP survey, NCD, Planing of Survey and RH
6	Resilience, RMNCAH, NCDs, CBHFA+
7	Crash course on RAMP
8	RMAP and surevy plan
9	Experience sharing among different countries, CBHFA+ and RAMP
10	NCD and field survey
11	RAMP and Golbal and regional updates, NS presentations
12	all content
13	RAMP
14	RAMP
15	RAMP, RMNCH, NCDs
16	RAMP
17	Sharing of updates of other NS, poster presentation, and RAMP
18	RAMP
19	RAMP session
20	RAMP, VP
21	RAMP
22	Magpi exercise
23	CBHFA+ and RAMP

Q6 Why was this session/activity most useful?	
Respondent	Response Text
1	It is easy to understand about CBHFA
2	because survey is very important to measure our daily work and help us to improve our
3	Because I can use it for conducting survey (Baseline/ End-line) more accuracy , easy to
4	I can apply all this in my NS
5	Because in the developing countries the incidence of Mortality rate due NCD,and RD health are to high,also We need the RAMP and Planing and survey for our program,
6	Need to change our way of work to more needs and community based.
7	using RAMP in M&E
8	Because it was really new topics and ithese will make the programme qualitywise very good
9	Because they connect to my current project activities
10	I am familiar and applying NCD for our programming. Also I involve into survey regularly.
11	for apply to the local and country context
12	relevant and practical to work
13	practical
14	It is easy and practical. And also cause effective and less time consumption.
15	New knowledge and updates were introduced. Practicals were also included e.g. using
16	More practical and useful.
17	I learned different implementation strategy from other NS.
18	Because I leant something new. And more interactive.
19	Because It will help me to conduct baseline/endline faster than before
20	it was new for me actually
21	new learning
22	practical and very much needed
23	These were new and we will be needed to adapt to and adopt these in the coming days.

Q7 How are you going to use that useful things in your implementation?	
Respondents	Response Text
1	I will send the datas to the department which work likely CBHFA in my NS.
2	I will share it with my team and apply it in my project.
3	First, I will try to pilot it to our baseline survey first, If my team feel comfort to use it we will extent to our monitoring system.
4	I can integrate all in other program as a cross cutting issue.
5	By practicing all learnt topics during this training
6	Report. Have a meeting with the relevant teams.
7	for survey through volunteers
8	of course..
9	Apply in my current project implementation and share with my leaders/colleagues at all levels.
10	Also I involve into survey regularly. Macpi was also applicable to use for base and endline.
11	going to discuss and deliver the info for them , develop the concept notes and proposal for request the grants
12	apply knowledge to work
13	adopt using RAMP
14	CBHFA Baseline and endline survey
15	Try to explore potential new programmes and adopting techonology in future programmes
16	Sharing and practicise step by step. Avdvocacy is strongly necessary.
17	Suggest to NS Top Management revisions of our existing IEC Materias since a lot of new topics and updates had happened to CBHFA. I will also suggest revision of the training modules of our CBHFA trainings since NCD and VP had been added to CBHFA.
18	Surveys and M&E
19	I think I will use RAMP in Dengue Prevention project in June 2015
20	i will be more eager to use this technology in my NS in CBHFA even outside the box in other Programming
21	in baselines survey
22	base- and endlines as well as develop monitoring systems
23	Through advocacy and convincing my team that these are more useful.

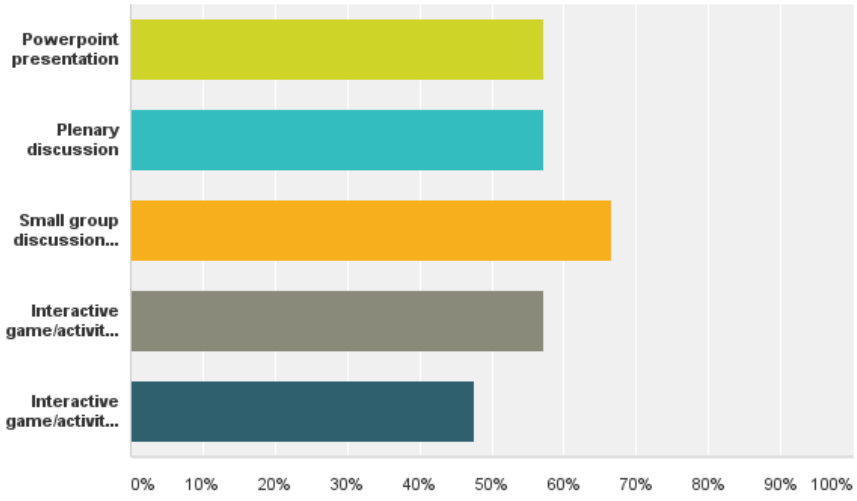
Q8 Which training methodology is best to help you with you BECOMING FAMILIAR WITH NEW MATERIAL (ie RAMP, RMNCAH)?

Answered: 22 Skipped: 1



Q9 Which training methodology is best to help you with UNDERSTANDING DIFFICULT/COMPLEX CONCEPTS (Resilience, CBHFA+)?

Answered: 21 Skipped: 2

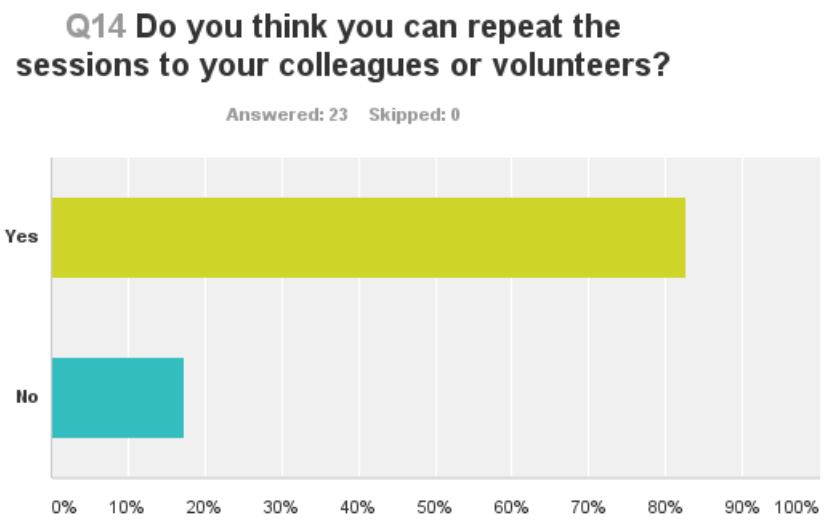


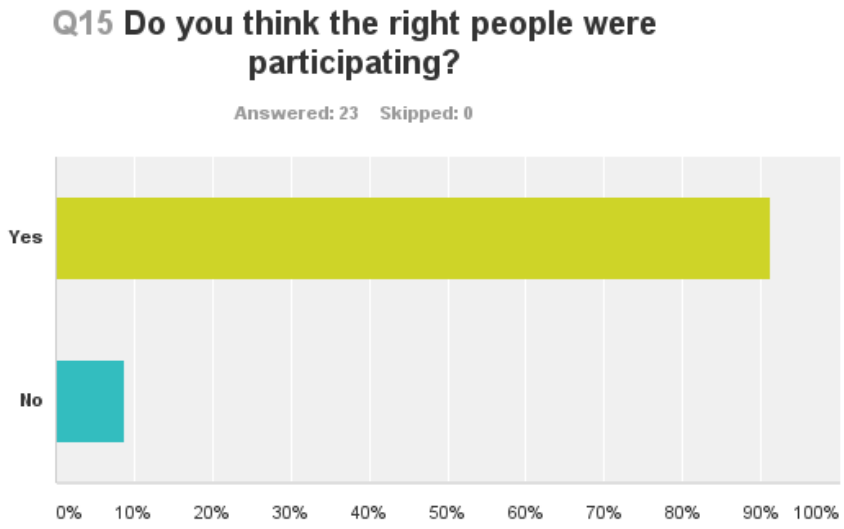
Q10 Do you think the gamification (same groups throughout, competitive aspect each day) was useful? Why or why not?	
Respondents	Response Text
1	yes, because it can motivate all participant to explore their knowledge
2	Yes, It add the learning environment more fun and participated.
3	Yes, Participant will be more active.
4	Yes, because that is good for the motivation of participants to be more active
5	Only in reviewing the survey one group made.
6	i think it could be done in a different way, like changing the participants in each group on daily bases
7	Yes, it makes fund and more focus of the participants, promote the admosphere
8	It motivates participants also energize them.
9	some are good but some are not
10	yes, took stress away from learning
11	yes. it encourage competition and learning environment
12	to be more active, enhance team spirit
13	It's jsut making the days more exciting but it's not that useful for learning.
14	Yes, somehow.
15	Yes. It made learning fun.
16	Yes and No. The gamification became more completive and social media fun not necessarily increasing the knowledge base
17	It's good Because It motivated all participants to attend all sessions of this workshop.
18	it can be but little bit because it was adult learning so every one were knowing that what id does mean and what is going on
19	No, it limited the opporunity to learn and mingle with other groups
20	Yes, people get to know others better and tasks as manager i.e could be circulated. Sometimes we have changed groups in case there has been difficulties in team work.
21	Yes

Q11 Please provide any other comments or feedback that can improve the quality of the future meetings and workshops	
Respondents	Response Text
1	give more time the topics that we are thinking that's very essential for participants
2	The overall of the workshop seems very good enough. I have no comments.
3	It is okay.
4	No comments
5	Pre-learning online should be compulsory. A workshop with the working staff from different sections like DM, WASH, RM would be much creative towards the more resilience oriented way of working.
6	Make it more intractive, participatory
7	More participation approaches
8	More interactive way and good time management.
9	no comments, all is good, I like it and met my expectations
10	balance of time allocation to important content
11	1. Need to give more time on discussion. 2. Punctuality
12	To provide brief handouts on the knowledge concepts that covered in ppt presenation, so that we can revisit it during the workshop. Sometimes, I want to jot down some of the contents and key points asociated with the ppt presenation.
13	Pre-reading and assignment is really helpful.
14	No other feedback. For me, the workshop was great.
15	More new leanings and Innovations from Expert such as in RAMP and RMS-resource Management ODK, GPS Google
16	May be the days can be extended,, more practical/interactive session can be arranged, group work can be emphasises during training as learning by doing process
17	Overall meeting was good. need to improve opporunity to mix and go out for some outing and travel
18	Good idea that groups have thema to focus when listening NS briefings.
19	This was a very good worshop.

Q12 How will you share the knowledge and skills gained during the workshop with your colleagues internally and externally?	
Respondents	Response Text
1	I will share my experience and knowledge to the department that work about this in my NS
2	I will share the workshop report to management and my colleagues
3	I will report back all the learning to my department as well as my leadership, and will discuss with the project team on how to develop our upcoming survey in the mobile (RAMP).
4	By organinizing meeting with my Colleagues.
5	Through conducting training, bilatral meeting and sharing of documments
6	Report. Have a meeting with the relevant teams.
7	by trainings in regards the CBHFA workshop
8	during official meeting as well as indivdual
9	Through coordination meetings and during project implementation
10	I am going to develop a report for MRCS and apply which I learned for my work.
11	going to discuss and deliver the info for them , develop the concept notes and proposal for request the grants
12	presentation at own NS
13	already wrote reminders. will use it in my work and will share whenever i have chances
14	- about RAMP - CBHFA+ - RMNCAH
15	Daily conversation, materials sharing with colleagues, maybe a sharing session.
16	Small training si scheduled to share with my colleagues and counterparts.
17	Do a report about the topics/issues discussed in the workshop to be shared to all staff and volunteers implementing CBHFA. And maybe set an orientation meeting with my colleagues about the updates in CBHFA, RAMP to further elaborate and discussed to them the outputs of the workshop..
18	Utilise in implementing - learning by doing.
19	I think I will conduct a meeting with all colleagues in my department to share knowledge and skills gained during the workshop.
20	off course what the knowledge and new things that we have gained will make be happened to be apply in our NS context what can be more applicable like the RAMP the VP and the NCDs
21	sensitization of directors of NS and IFrC
22	Session for staff and report to all colleagues.
23	Through whatever platform possible and at whatever level possible.

Q13 How will you share the workshop report and document with your colleagues?	
sponde	Response Text
1	do presentation in the meeting
2	I will share those documents through meeting and monitoring.
3	By Dbriefing meeting
4	When I am at home I will write a report and share it with our authorites and will write some thing about the agenda, methodology, my expection before training and out come of training, Also I will write some pragraph about my knowledge regarding the topic preior of the training and My competence after the training
5	Report. Have a meeting with the relevant teams.
6	Through email
7	Via meetings and e-mail
8	I am going to develop a report for MRCS and apply which I learned for my work. Interested colleagues can get it from the internal share.
9	going to discuss and deliver and share the info for them
10	email
11	i did. typed in my email and shared
12	Through email.
13	We will put it on server for everyone to download. Reminder email will be sent to you.
14	Send out the relevant info to the colleagues.
15	Thru email and USB/Hard drive.
16	Through the link and from USB and will share at the meetings.
17	I will share all document and the workshop report with my colleagues by email.
18	sure i will be developed report of this workshop for my NS upon completion of this workshop, and if it will be convenient i will share within all group i have email addresses and contact number of all colleagues as well.
19	making a presentation
20	Will be automatically distribted to whole team and will be available in the reports folder.
21	Through e-mail and the details through informal chats.





Comments:

- Need more NS to be involved in the learning process. IFRC delegates may have more of this already. The Geneva facilitators seem to have less knowledge and experience of the field work scenarios.
- More NS and delegate and manager should be separate

Q16 Would you like to participate or encourage others to participate in similar workshop/ meeting

Answered: 23 Skipped: 0