



Community-based health and first aid (CBHFA)

Global case study collection 2012

How we work



Strategy 2020 voices the collective determination of the IFRC to move forward in tackling the major challenges that confront humanity in the next decade. Informed by the needs and vulnerabilities of the diverse communities with whom we work, as well as the basic rights and freedoms to which all are entitled, this strategy seeks to benefit all who look to Red Cross Red Crescent to help to build a more humane, dignified, and peaceful world.

Over the next ten years, the collective focus of the IFRC will be on achieving the following strategic aims:

1. Save lives, protect livelihoods, and strengthen recovery from disasters and crises
2. Enable healthy and safe living
3. Promote social inclusion and a culture of non-violence and peace

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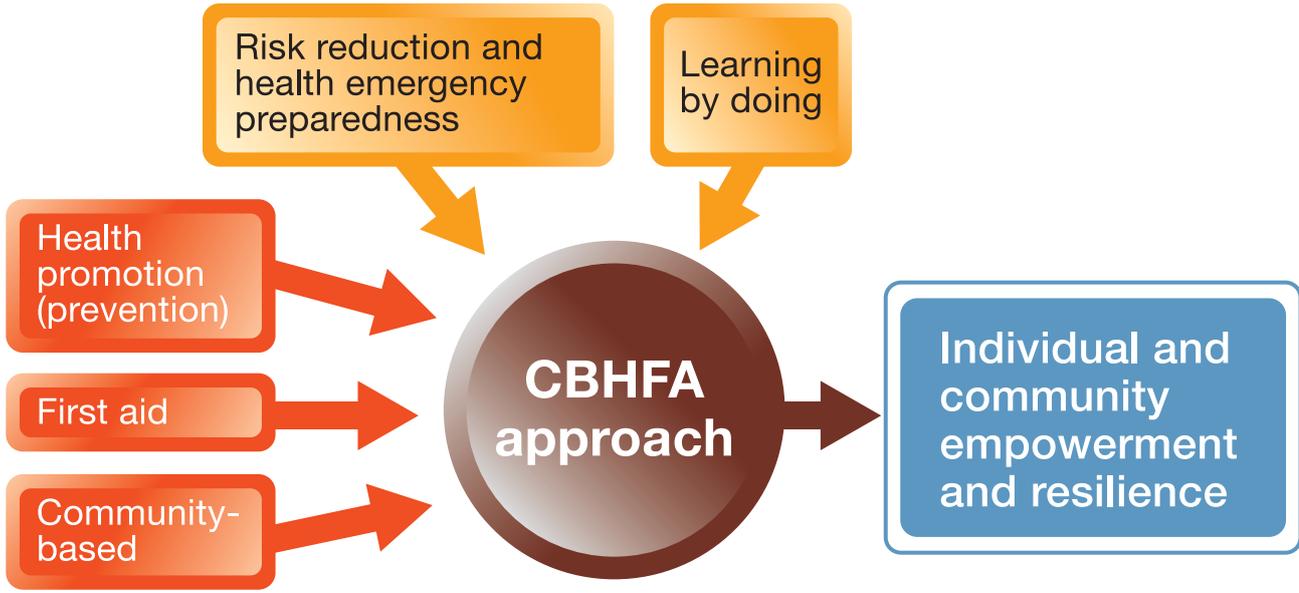
1 Introduction

The International Federation of Red Cross and Red Crescent Societies (IFRC) aims to effectively contribute to building resilience by meeting the basic health, shelter, education, food, water and sanitation needs of vulnerable people. The IFRC strives to eliminate health inequities for all, by ensuring that the social costs and benefits of health systems are fairly shared between and within countries, based on a human rights framework and respecting local values.

Community-based health and first aid (CBHFA) is the Red Cross Red Crescent approach to empower communities and their volunteers to take charge of their health. By using simple tools which are adapted to the local context, communities can be mobilized to address priority health needs.

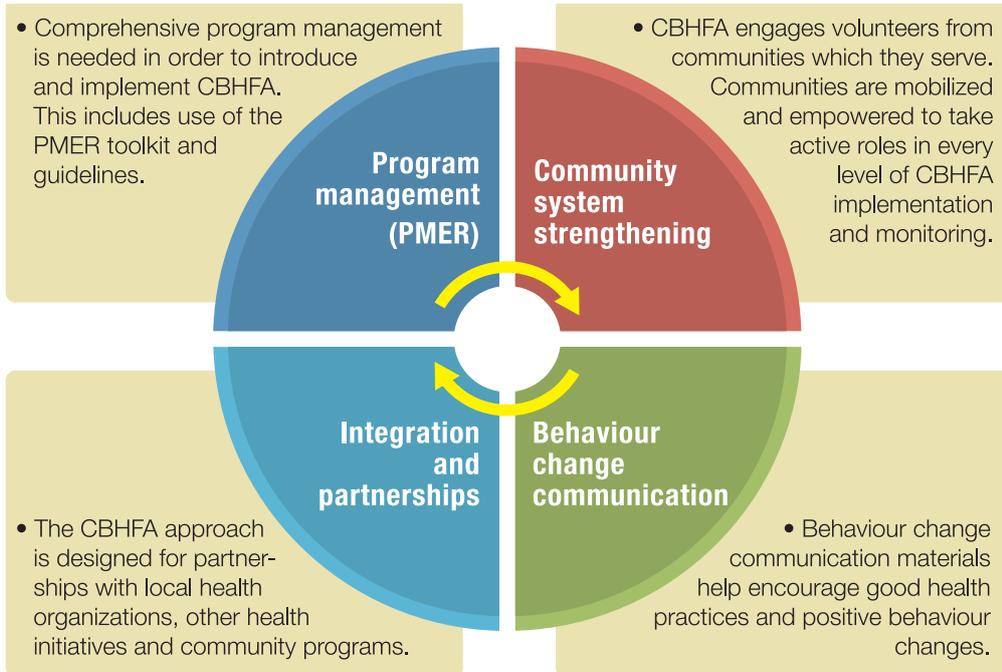
The CBHFA approach seeks to create healthy, resilient communities worldwide and is thus playing a vital part in *Strategy 2020*, and contributing to Millennium Development Goals 4, 5, 6 and 7.

National Societies, supported by the IFRC, have a long history of addressing first aid and health promotion. In the 1990s, Community-based first aid (CBFA) was the principal method of reaching communities. To increase community participation and focus on behavioural change, CBFA was revitalized starting in 2005. In 2009 the revised CBHFA approach and materials were launched and disseminated.

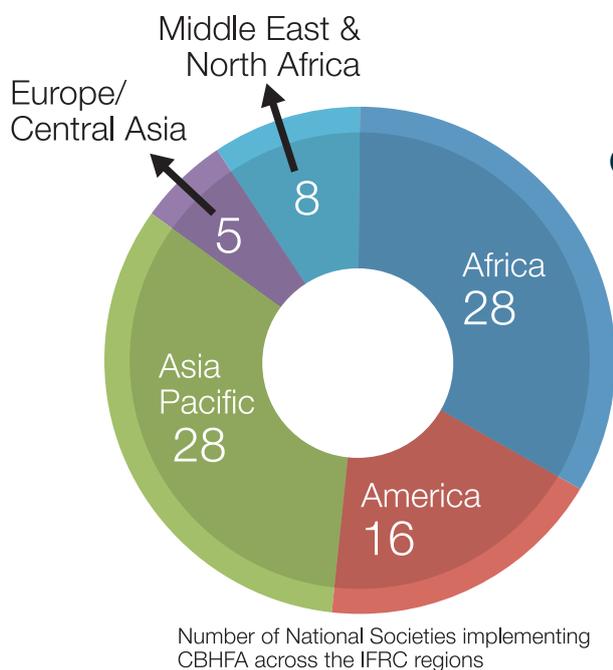


Components and aim of the CBHFA approach

CBHFA key principles



In 2011 the IFRC carried out a global mapping exercise to better understand how National Societies are utilizing the CBHFA approach. The mapping showed that 85 National Societies were implementing community level health programmes using the CBHFA approach, with the support of the IFRC and 18 Partner National Societies. The programmes were implemented by 23,434 volunteers, reaching 2,308,065 beneficiaries globally. The average cost per beneficiary per year was 4.71 Swiss francs.



CBHFA in figures (2011)

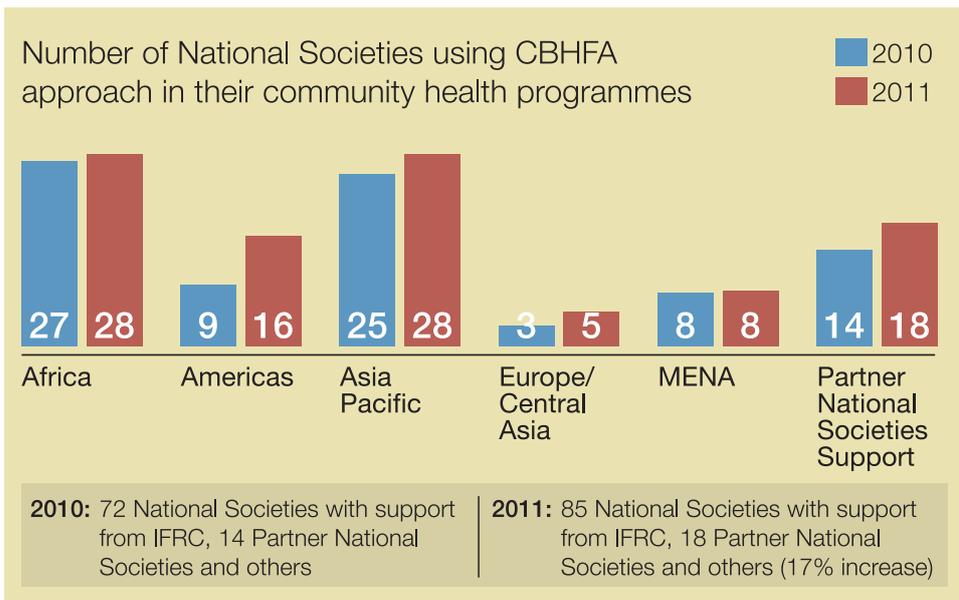
- 85 National Societies implementing 18 Partner National Societies, IFRC and others supporting
- 23,434 volunteers implementing community health programmes
- 2,308,065 beneficiaries reached
- Average cost per beneficiary per year: 4.71 Swiss francs
- Manuals in 39 languages

1 Introduction

CBHFA materials have been adapted to numerous local and country contexts, and translated into 39 languages. A Planning, Monitoring, Evaluation and Reporting (PMER) toolkit was published to support National Societies in ensuring good programme management and quality assurance at all levels.

Most National Societies link CBHFA with other programme areas such as disaster risk reduction (DRR), water and sanitation, emergency health, HIV, malaria, maternal, newborn and child health (MNCH) or non-communicable diseases (NCDs). Different technical areas are looking for ways of harmonizing their tools, especially in community-based participatory assessment. The common goal for community-based approaches is to reduce the vulnerabilities of the most disadvantaged and build individual and community resilience.

CBHFA mapping summary





2 Gender and CBHFA



Culturally accessible care in Afghanistan

Challenges of a poor health care system

Despite efforts made in Afghanistan to improve the health status of the population, and of vulnerable communities in particular, the standard is well below that of other countries in the region. More than three decades of ongoing conflict has caused long-lasting poverty, social injustice and damaged health infrastructure. There are poor health indicators in Afghanistan, with the majority of the population lacking access to basic health and sanitation services. There is an acute shortage of health facilities and trained staff, particularly women, in most rural areas.

Afghanistan has the highest maternal mortality rate in the world and ranks second highest for under-five mortality. Access to antenatal care and essential medicines is limited and attendance at birth by trained personnel is still remarkably low, particularly in remote areas in the eastern and south-eastern regions of the country. Poor and improper nutrition among women of reproductive age leads to a prevalence of pregnancy-related complications.



In addition, access to safe drinking water and adequate sanitation is limited, particularly in rural areas, and personal hygiene practices are generally considered to be extremely poor. Statistics portray a dismal picture of the country's health care system.

Taking such facts into account, Afghan Red Crescent Society (ARCS), with the support of Movement partners, has been focusing greater attention at the community level with a special emphasis on accessing women and engaging them in community health activities.

Recruitment of female facilitators

To address the many challenges of MNCH, as well as the social and cultural sensitivity of accessing and training female volunteers in such remote communities, ARCS needed to take a different approach. The CBHFA programme was considered the perfect entry point for recruiting female trainers in Afghanistan.

The community-based integrated approach in first aid and health involves engaging communities and their volunteers, who use simple pictures adapted to the local context in order to promote behavioural change in health, first aid and safety practices. More than just training, the community-based volunteers provide preventative, promotional and first aid services to the community in their catchment areas.

ARCS began the initiative by recruiting and training two female master trainers in the northern region of Afghanistan (Balkh, Sare Pul, Jawzjan, Samangan and Faryab). The two women, who were accompanied by male relatives as a condition of working, travelled to remote regions of the country and met with community leaders. The female master trainers discussed the benefits of involving women as volunteers in health promotion and solicited advice for recruiting female volunteers.

Based on this advice, ARCS recruited and trained women in remote villages using a culturally sensitive approach. Female facilitators led the trainings and no male facilitators were allowed. One of the



Source: www.mapcruzin.com/free-afghanistan-maps.htm

General Facts: Afghanistan

Population	28.2 million
Growth rate	3.4%
Per-capita income	---
Literacy rate (men & women)	---
Health	
Fertility rate	6.5%
Contraceptive prevalence rate	22.8%
Maternal mortality rate	1,400/100,000
Infant mortality rate	134/1,000
HIV prevalence (adults 19-49 years)	---
Life expectancy (women)	50 years
Life expectancy (men)	47 years

WHO World Health Statistics 2011



main challenges of training volunteers was that most of the female volunteers were illiterate. In Afghanistan, 50 per cent of men and 85 per cent of women are illiterate. Red Crescent trainers therefore needed to develop innovative ways of teaching volunteers to ensure that they learned the key health messages accurately.

Project impact

Currently ARCS has 25 male and 11 female CBHFA master trainers and more than 22,000 trained volunteers, including more than 2,000 women, in 34 provinces. Of these, 7,000 volunteers in 12 provinces have been trained with the support of the IFRC.

Communities are already benefiting from the work of female ARCS volunteers. These volunteers deliver key health messages to women living in villages, train women in simple health interventions – such as diarrhoea treatment with home prepared or packeted oral rehydration solution – and refer women to health clinics for antenatal, postnatal care and family planning.

In a country with the compounded challenges of poor infrastructure, extreme poverty, high illiteracy and gender inequities, leadership is important to create an enabling environment toward equity and social cohesion. ARCS continues to work to empower women at the local level in order to encourage health-seeking behaviours and reduce maternal mortality.

The way forward

With the success of training female volunteers in remote areas of northern Afghanistan, ARCS has decided to expand the same approach to other geographical areas in the country.



Bangladesh: Risk reduction through the empowerment of women

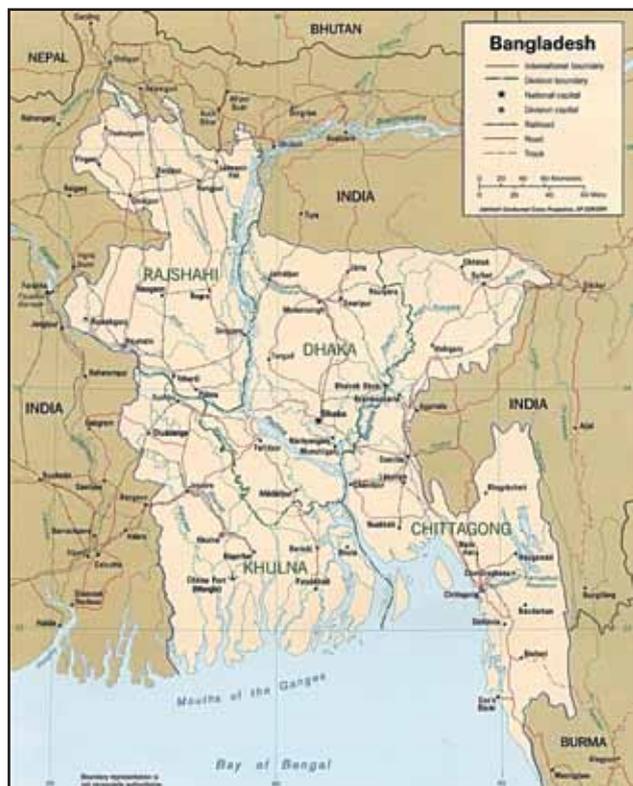
Bangladesh is one of the world's most densely populated nations and also one of the most vulnerable to the impacts of various disasters and climate change. Most of the population lives precariously close to areas prone to cyclones, floods and droughts, and more than 100 million people live in rural areas.

Two-thirds of the country is less than five meters above sea level, and in an average year, a quarter of the country is inundated with water. Every 4 to 5 years Bangladesh experiences severe floods that sometimes cover 60 per cent of the country, resulting in significant losses.

Despite the country's many recent economic advances, nearly half of the nation's population still lives below the poverty line. Maternal and child mortality rates remain extremely high, the quality of education is poor, gender discrimination continues and efforts to overcome poverty face numerous constraints.



2 Gender and CBHFA



Source: www.mapcruzin.com/free-bangladesh-maps.htm

CBHFA integration with disaster risk reduction (DRR) and gender aspects

The cultural norm of social seclusion of women in Bangladesh has particular consequences. Religious and social customs in coastal parts of Bangladesh confine women to their homes, restrict their social inclusion, and reinforce their dependence on men.

Male heads of households are frequently absent from the home, and because of cultural and religious connotations they will not approve the evacuation of women and children to shelters unless they are present. This has fatal consequences when a cyclone hits. For example, in the 1991 cyclone with some 140,000 fatalities, 90 per cent of the victims were women and children. Many women drowned because of their wrap-around clothing, which made swimming and escape from flood waters virtually impossible.

Low female literacy rates, teenage girls' marriage and pregnancies, along with divorce and widowhood have further consequences, and there are clear gender dimensions to poverty, health, nutrition and livelihoods in Bangladesh, with women and girls faring worse off in almost every respect.

The Risk Reduction through the Empowerment of Women (RREW) project has been designed to support vulnerable women from the wider community adjacent to six Bangladesh Red Crescent Society (BDRCS) mother and child health (MCH) centres. The chosen centres are situated along coastal areas in the south of Bangladesh. All communities are cyclone and flood prone.

This German and Canadian Red Cross-supported project involves a new approach for the National Society that involves standardizing DRR activities and contributing to the capacity of BDRCS to manage and sustain DRR programming. A central theme is the role of women in preparedness and management of disasters and as a means to reducing other underlying risk factors and vulnerabilities that affect communities.

General Facts: Bangladesh

Population	162.2 million
Growth rate	1.6%
Per-capita income	1,550 US dollars
Literacy rate (men & women)	55%
Health	
Fertility rate	2.3%
Contraceptive prevalence rate	55.8%
Maternal mortality rate	340/100,000
Infant mortality rate	41/1,000
HIV prevalence (adults 19-49 years)	<0.1%
Life expectancy (women)	66 years
Life expectancy (men)	64 years

WHO World Health Statistics 2011



Project overview

The RREW project directly targets close to 60,000 people, the majority of them women and children, and 119,000 indirect beneficiaries in the catchment area of 6 BDRCS coastal MCH centres.

Despite being prone to cyclones and floods, these communities are not organized to face them. Use and maintenance of existing cyclone shelters is poor, and women, for various reasons, often stay at home with their children instead of using the shelters in times of hazard. The same lack of preparedness is also evident at the household level. Women's awareness of cyclone warning signals and of household preparedness measures is low and this makes them especially vulnerable to the impact of cyclones.

The RREW project seeks to:

- renovate and upgrade existing MCH centres in the vulnerable coastal region to become disaster management hubs
- facilitate intersectional collaboration within BDRCS in the areas of health and disaster management, involving mainstreaming of DRR
- improve the knowledge and capacity of MCH staff, community health workers and volunteers in the related areas of DRR and aspects of CBHFA
- enhance community awareness and knowledge of actions to be taken in times of disaster, including self-help community measures
- promote community well-being by improving women's knowledge of locally important health issues and disease prevention
- provide guidance on nutrition and its relationship to health, particularly for children.

Project implementation

Implementation of the three-year project, which started in June 2011, follows the CBHFA approach. RREW project seeks to create "healthy women, resilient communities".

At the grass-roots level, 60 BDRCS volunteers provide basic information and services to 18 villages in the catchment area of the 6 MCH centers. Six community volunteer supervisors (CVSs) support the volunteers as well as the community midwife (CMW) at the MCH centre.

The project supports health promotion, including hygiene and sanitation. This involves local women and encourages them to be proactive in terms of their own health and the well-being of their family. The supervisors and midwives have been trained using aspects of CBHFA.



The renovation of MCH centres improves infrastructure. The centres provide antenatal care, handle pregnancy-related conditions and attend to children under the age of five. While almost exclusively visited by women and children, the centres are open to men. The centres are also likely to be used as community shelters when disasters strike.

Initial outcomes of the interventions

The renovated MCH centres have been visited more frequently. On the community level, baseline surveys have provided a clearer picture of the socio-economic, health and nutritional status of the communities and DRR issues. They have also provided profiles of school children and other relevant information, for example, gender issues.

Knowledge of nutrition and related practices have improved through cooking demonstrations and lessons, promotion of indigenous foods and resources at the community level, vegetable gardening, and seed production and multiplication. These small-scale initiatives have the potential to improve livelihoods and can possibly be adapted to deal with climate change.

Lastly, information, education and communications and visibility materials such as leaflets and posters on DRR and health, bags, umbrellas and aprons have been produced carrying the message of “healthy women, resilient communities”.

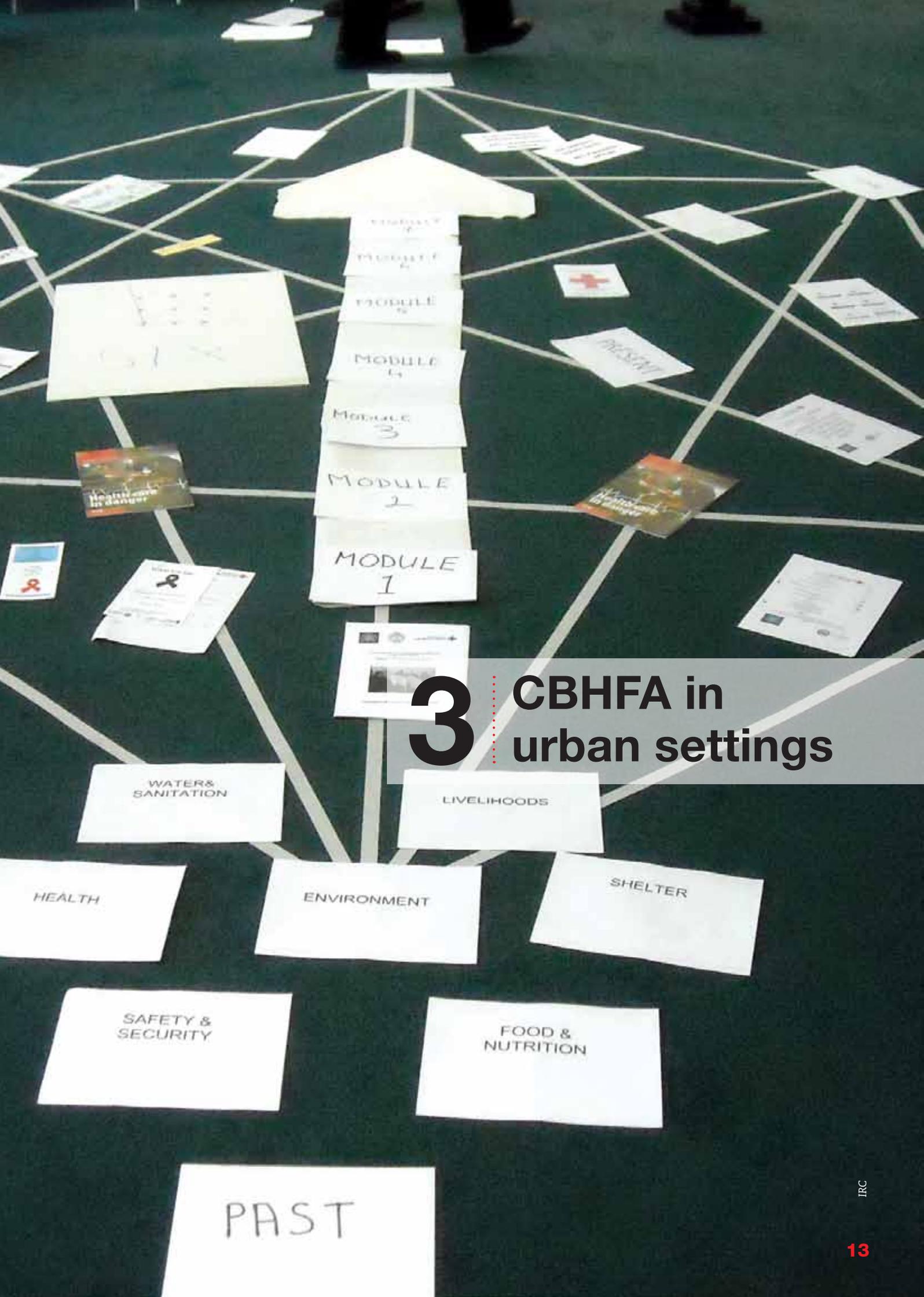
Lessons learnt

Even though the CMWs have many years of experience at MCH centres, many possess poor communication skills. The National Society will be offering communications training to develop the capacity not only of CMWs but also of CVSs and technical officers.

During training sessions, women were often reluctant to speak up while men were present. That being said, women have been accorded increased status as a direct result of taking part in the project.

The way forward

Supporting women in building knowledge on DRR and CBHFA facilitates a process of their empowerment. Through raised awareness and skills, the women gain self-confidence and will apply their knowledge and strengths for the benefit of the whole communities.



3

CBHFA in urban settings

WATER & SANITATION

LIVELIHOODS

HEALTH

ENVIRONMENT

SHELTER

SAFETY & SECURITY

FOOD & NUTRITION

PAST



Uganda: Community-based health and first aid (CBHFA) implementation in urban slums

Background

Uganda is situated in the eastern part of Central Africa and shares borders with Kenya, Sudan, the Democratic Republic of Congo, Rwanda and Tanzania. The country has a prolonged history of insecurity due to political and inter-clan conflicts that has resulted in some affected areas in the north-eastern and Karamoja regions having the poorest communities and most underdeveloped health infrastructure.

Uganda has been cited as sub-Saharan Africa's success story for its efforts in reducing HIV prevalence. Nonetheless, HIV/AIDS continues to be a major health problem, with an estimated infection rate of 6.5 per cent with recent studies showing an increase to 7.2%.

Overall health indicators in Uganda are poor. Life expectancy is low, and child, infant, and maternal mortality rates are high. Malaria is the leading cause of morbidity and mortality and kills between 70,000 and 110,000 people each year, most of which are children under 5.



Uganda Red Cross Society CBHFA programme

As an auxiliary to the government, the Uganda Red Cross Society (URCS) has been instrumental in addressing the needs of vulnerable people in Uganda through various programmes at emergency and developmental levels. First aid is a core activity of nearly all the 51 URCS branches. This has led to a steady increase in the number of staff members and volunteers involved in first aid services, either through training the general public or in crisis situations. Previously, community-based first aid (CBFA) was the principal method of teaching first aid to communities.

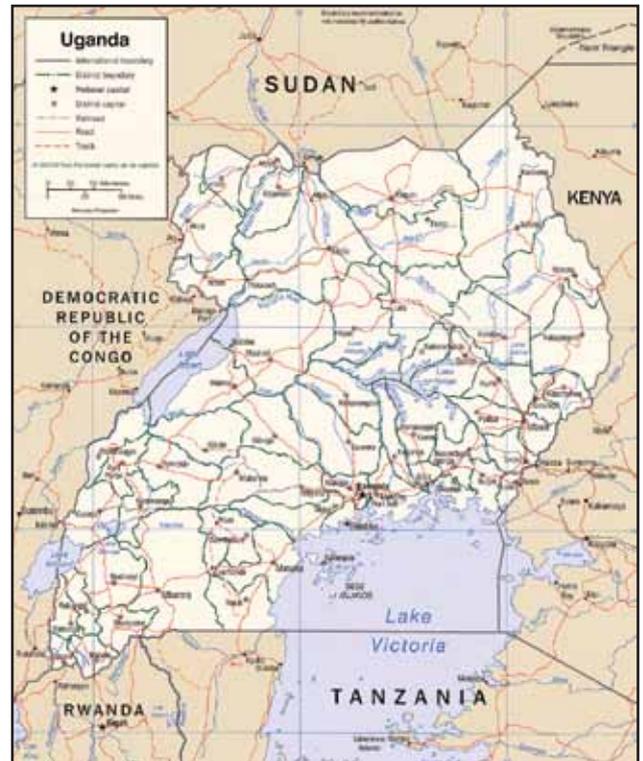
In 2010, CBFA was revitalized to include a broader and more comprehensive approach to injury and disease prevention and health promotion and the CBHFA *in action* programme was piloted in 15 Red Cross branches. Within a year, URCS had trained 1,769 volunteers in more than 58 villages and communities. Volunteers conducted 6,753 home visits and reached 23,462 beneficiaries with health messages on hygiene, malaria control, HIV prevention, cholera and meningitis prevention, as well as road safety promotion.

In 2011, the CBHFA programme focused on five branches in Eastern Uganda. The malaria control and social mobilization for immunization programme as well as HIV/AIDS prevention, care and support activities also merged.

Addressing public sanitation in Naguru parish, Kampala

As in many other major cities and towns, slums are a common feature in the capital of Kampala, where 27 per cent of the Ugandan population lives. Ten per cent of the city area is a slum. Here, the average population density is 14,112 people per square kilometre.

The majority (65 per cent) of Kampala residents live in rented housing and very few possess adequate latrines. This is related to the nature of drainage



Source: www.mapcruzin.com/free-uganda-maps.htm

General Facts: Uganda

Population	35.6 million
Growth rate	3.2%
Per-capita income	1,190 US dollars
Literacy rate (men & women)	75%
Health	
Fertility rate	6.3%
Contraceptive prevalence rate	23.7%
Maternal mortality rate	430/100,000
Infant mortality rate	79/1,000
HIV prevalence (adults 19-49 years)	6.5%
Life expectancy (women)	57 years
Life expectancy (men)	48 years

WHO World Health Statistics 2011



systems in the city, where swampy areas with high water tables affect latrine construction. As a result, construction costs are prohibitive and most landlords construct houses without toilet facilities.

The lack of land for construction of costly new latrines, coupled with the high level of poverty, make public toilets (only accessible with a fee) unaffordable for slum communities. Instead, residents cope by using polythene bags known as “mobile toilets”, which are usually thrown in drainage channels, rooftops or dustbins after use.

The URCS Kampala East branch chose to start addressing these serious community health issues through activities with the Naguru parish. Members of the parish were mobilized, and over a period of three days underwent training in the first three CBHFA modules. Through this exercise, the following key health priorities were identified in the community:

- Diarrhoeal diseases, in particular cholera outbreaks, are prevalent due to the lack of latrines and poor drainage and waste disposal methods.
- There is a high incidence of malaria.
- There is a high rate of HIV and other sexually transmitted infections.
- Substance abuse is prevalent. Many young people smoke marijuana and inhale aviation fuel, a result of unemployment and engagement in criminal activities.

The community and CBHFA volunteers developed an action plan to address the health priorities identified. The community agreed to hold a meeting with landlords and urge them to build pit latrines and provide proper drainage in the village or threatened to quit renting. At the same time, the communities themselves committed to get involved in weekly clean-up campaigns. Subsequently, CBHFA volunteers met with city council authorities and an agreement was reached for officials to follow up on the issue with the landlords.

CBHFA action leads to successful outcomes

This action led to the enforcement of the Public Health Act, where all landlords who build houses without the necessary sanitation-enabling facilities are served with a notice of closure of premises if no change is made after a defined time period. The CBHFA project officer explained that, “Faced with two threats, arrest by the authorities and loss of revenue from tenants, landlords had no option but to act. Within three weeks, all designated homes had functional pit latrines.”

Through continued dialogue with community members, largely tenants and local authorities, a by-law was passed and enforced stating that no house can be constructed without latrine facilities. Local leaders are continuing to help with enforcement of this by-law. The hygiene and sanitation conditions in Naguru parish have since improved.



Furthermore, CBHFA-facilitated community self-help efforts to curb waste disposal and drainage problems started with local initiatives to conduct routine community clean-up campaigns in Naguru and Banda markets in Kampala.

The trained CBHFA volunteers become part of the Government's Village Health Teams (VHTs) that are currently being engaged by the Ministry of Health and other stakeholders for community mobilization activities like polio and mass measles campaigns.

Lobbying has also ensured that the necessary health products for addressing the identified priority needs were provided by Government and partner agencies. The Government provided 5,000 long lasting mosquito nets for the URCS to distribute to the communities of Naguru parish, while in Busia (another Red Cross branch in eastern Uganda), the Red Cross lobbied with World Vision that supplied 151 mosquito nets for effective malaria control benefiting 73 households in the CBHFA communities of Marach & Arubaine villages.

Remaining challenges

While the CBHFA approach has proven successful in this context, communication difficulties exist. For instance, the high illiteracy rate in the slums meant very few volunteers in the communities were able to comprehend the content of both the CBHFA manual and toolkit. The cross-cultural setting of Kampala, a metropolitan area with many languages, further complicated interaction.

Community mobilization also proved to be difficult as people in urban areas have a variety of economic activities to attend to leaving little time for meetings. In Naguru in particular the community lacked a sense of togetherness as most people had migrated from other areas of the country to work in industries.

Use of local materials, e.g. empty tins or used cardboard boxes, in practical exercises like community mapping is generally seen as unacceptable since, given the poor sanitary conditions in many parts of Kampala, people associate these materials with the spread of diseases. The use of alternative aids like Manila papers, markers and chalk is costly.

Project staff and volunteers maintain that the CBHFA volunteer training manual is too bulky to use at the community level and needs to be reprinted in modules that can be easily used by CBHFA field volunteers.

There is a high rate of attrition of CBHFA volunteers in the urban areas since most of them do not have permanent homes in city suburbs and so frequently shift to new locations out of the project areas. This therefore requires frequent training of new CBHFA volunteers to replace the ones who left.



The way forward

According to URCS, to improve sustainability, CBHFA must deliver value.

“Communities need to see value in interventions before contributing and participating in programmes that improve overall sustainability,” said the CBHFA Programme Manager, adding that, “CBHFA assistance to communities should look at improving the value the programme provides to community members through a wide range of services.”

URCS believes that this can be done by CBHFA by broadening its scope and incorporating strategies to lobby for the creation of local policies and environmental changes that are universally considered as key contributors to the deteriorating community health conditions, as well as partnerships with other agencies and corporate bodies that can fill the resource gaps needed to provide the required health products for disease prevention in the communities.



Ireland: The impact of community-based health and first aid (CBHFA) on state prisons

Background

In June of 2009 Ireland became the first country in the world to introduce the CBHFA programme into a prison setting at Wheatfield Prison Dublin. The programme operates under a partnership between the Irish Red Cross (IRC), Irish Prison Service (IPS) and Vocational Education Committee (VEC).

The CBHFA pilot programme was a unique approach raising community health and hygiene awareness and first aid in prison communities through peer-to-peer education provided by 12 inmates working as IRC volunteers.

Following the success of the pilot programme in Wheatfield (a sentenced prison), in 2010-2011 it was extended to Cloverhill (a remand prison) and Shelton Abbey (an open prison). A remand prison caters to someone who is imprisoned before the start of his or her trial. An open prison has prisoners who are regarded as requiring lower levels of security. Evaluation of the three programmes at a lessons learnt workshop provided the information required to guide the programme in 2012 when it will be extended to another four prisons in the Mountjoy Complex in Dublin. It is hoped that it will extend to all prisons in the Irish state by 2014.



Source: www.mapcruzin.com/free-ireland-maps.htm

General Facts: Ireland

Population	4.5 million
Growth rate	1.9%
Per-capita income	39,507 US dollars
Literacy rate (men & women)	99%
Health	
Fertility rate	2.0%
Contraceptive prevalence rate	64.8%
Maternal mortality rate	3/100,000
Infant mortality rate	3/1,000
HIV prevalence (adults 19-49 years)	0.2%
Life expectancy (women)	82 years
Life expectancy (men)	77 years

WHO World Health Statistics 2011

Impact in the prisons

To date the programme has benefitted 1,200 prisoners directly and roughly 4,000 indirectly including staff and the families of the prisoners.

IRC volunteer inmates have actively contributed to improvements in healthcare through their roles as advocates for change including improved primary care and personal hygiene in all three prisons.

Improved personal and in-cell hygiene is a result of the use of instructional materials on good hand washing, and cleanliness around water sources and toilets. One prison is in the process of introducing a colour-coded mop and bucket system for use in various areas that is linked to industrial cleaning standards.

A prisoner-led hygiene audit in one prison is conducted at regular intervals as a means of maintaining high standards. The system has been shared with other prisons through a multi-prison lessons learnt workshop.

Volunteer-led smoking cessation programmes are operating in two of the three prisons with significant numbers of prisoners sustaining their changed behaviours. The Red Cross volunteers, the prison doctor and nurse all attend a smoking cessation facilitators' course. Any prisoner wishing to give up smoking need first to register with the inmate Red Cross volunteer support group and attend pre-smoking cessation classes. Only then does the doctor prescribe the smoking cessation aid. The support meetings include random checks with a carbon monoxide monitor to check compliance. The linking of prescription availability to volunteer support groups stops abuse of the smoking aids and increases the chances of success.

IRC volunteer inmates have also become regularly involved in various surveys aimed at improving health and hygiene as well as local knowledge about relevant health issues. In this way, they provide a voice for prisoners concerning their health and well-being.

The volunteers have played an important educational and advocacy role and have had a positive impact on reducing stigma and discrimination relating to HIV/AIDS and TB in all three prisons, which has been especially important due to a TB outbreak.

Following the success of the voluntary HIV rapid testing and anti-stigma campaign in Wheatfield in 2010, another campaign ran in Cloverhill Prison in 2011 where almost 50 per cent of the community availed of the opportunity to be tested.

All prisoner volunteers have expressed views of being personally empowered and recognizing changes in themselves as a direct result of the programme. For example, one inmate described the change in his behaviour: "I used to treat people the way they treated me and worked for myself independently. After volunteering I believe in myself, I can do better. I do more volunteer work and help others – money is not important. I am less selfish. I am loyal to the team. I value life!"

As a highlight the prison programme won the World Health Organization 2011 Award for Best Practice in Prison Health.

Lessons learnt

Mental health issues are a central health problem in all three prisons but were not prioritized in any of the course activities. This needs to be addressed in the future and can be a really useful role for the inmate volunteers to play. It is recommended that the community psychiatric nurse and psychiatrist attached to prisons are included in future developments of CBHFA for this aspect of project design.

Key to driving projects emerging from CBHFA is the formation and operation of a Community Health Committee (CHC). While these exist in theory, these driving groups need to be used more aggressively in the future. It is essential that the CHC include governor-level representation.

The volunteer selection process needs to be improved to ensure that there is input from healthcare, education and discipline staff to reduce attrition rate and protect the Irish Red Cross.

In the open prison the programme suffered some degree of apathy from the prisoners. This was because the focus of CBHFA was mainly on those currently in prison when it would have been more pragmatic for it to have been future-focused to include those leaving prison.

The most effective way of supporting the volunteers both in their learning modules and practical projects is through the Cloverhill model where there is a close working relationship between the nurse, discipline officer and teacher.



Training of trainers for CBHFA in action is resulting in qualified volunteer inmates taking on the role of teaching new volunteers and supervising their project work, thus creating sustainability of the project in each of the three prisons.

The way forward

The IPS is going through a period of change where its Strategic Goals and Aims will make a dramatic change to how custodial care is administered in Ireland. The CBHFA programme fits very well into these goals with its community and voluntary service focus. The IRC will work towards identifying how inmate volunteers can continue to offer voluntary service in the community after they leave prison. It may also be possible to look at ways in which new plans to use community service as an alternative to imprisonment can be linked to the partnership between the IRC, VEC and the IPS.

Finally, at a time of fiscal constraint and shortages of healthcare staff, CBHFA provides the means by which IPS can still provide for health education and awareness as part of the 2004 Health Care Standards.

The IRC has agreed to have prisoners become special status IRC volunteer inmates within prisons. This is on the condition that upon release from prison, if the volunteer wishes to continue volunteering with the IRC, he or she must apply in the normal way as a member of the public through membership application and Garda (police) vetting forms. It will then depend on the nature of the criminal offence what action is taken in this regard.

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4 Working towards showing impact: baseline measurement



Cambodia: Baseline studies in Kratie

Background

In Cambodia, over 80 per cent of the population lives in rural areas. The country is largely exposed to drought and floods and the tropical monsoon climate promotes the spread of vector-borne diseases, in particular dengue fever and malaria. Water and sanitation related diseases such as diarrhoea and typhoid are also common in households during the rainy season.

The strategic priorities of the Cambodian Red Cross Society (CRCS) in health are implemented primarily through its community-based health development, water and sanitation, HIV/AIDS, and human pandemic preparedness activities.

Mother, newborn and child health (MNCH) is the focus of community-based interventions. In the coming years, CRCS is committed to building the operational capacity of its branches, and the capacity of its community volunteers and school-based youth. Organizational development is integrated into projects and programme implementation, as part of the key elements ensuring the sustainability of all CRCS projects and programmes.



Project overview

In April 2010, CRCS initiated a community health project using the community-based health and first aid (CBHFA) approach in the north-eastern province of Kratie. The project aims to improve the health status of target villages by reducing the number of deaths, injuries, and illnesses from diseases, disasters and public health emergencies.

The goal is to strengthen the capacity of communities, primarily through training volunteers, encouraging behavioural change by mobilizing communities and promoting the use of public health services. By using an integrated programme approach, members of the targeted communities will benefit from being able to better prevent, prepare for and respond to disasters. Improved sanitary measures are expected to decrease the incidence of water and sanitation related diseases among the targeted communities. The vulnerabilities of MNCH, in particular, have been taken into account.

The three-year project (2010 to 2012) is supported by the Finnish Red Cross and has been implemented in 16 target villages of Kratie province. The target villages include about 18,000 beneficiaries as well as 235 Red Cross volunteers.

Through a series of vulnerability and capacity assessments in eight villages, Red Cross volunteers identified health-related priorities including water and sanitation, acute respiratory infection and tuberculosis, diarrhoea, malaria, and MNCH issues.

Conducting the baseline study

The baseline process started in June 2010 with a two-day training session both in the classroom and in the field. Thirty-two volunteers became familiar with the questionnaires and practiced their interview skills.

Out of 2,243 households, 580 (26 per cent) were randomly selected for the baseline study. Data collection was conducted over a period of 3 days with each volunteer responsible for interviewing 20 households. Analysis of the full set of data was used to develop the baseline assessment.



Source: www.mapcruzin.com/free-cambodia-maps.htm

General Facts: Cambodia

Population	14.8 million
Growth rate	1.7%
Per-capita income	1,820 US dollars
Literacy rate (men & women)	78%
Health	
Fertility rate	2.9%
Contraceptive prevalence rate	40%
Maternal mortality rate	290/100,000
Infant mortality rate	68/1,000
HIV prevalence (adults 19-49 years; Ministry of Health, Cambodia)	0.8%
Life expectancy (women)	65 years
Life expectancy (men)	57 years

WHO World Health Statistics 2011



Achievements

To date, the main achievement of the CBHFA intervention in Kratie has been branch development, in particular capacity building of staff and volunteers. Well-equipped and better functioning branch and sub-branches offices are in place as are improved branch and project management structures.

Furthermore, the improvement of community capacities, a cleaner environment, proper use and maintenance of some 346 household latrines and anecdotal evidence of community practice and behaviour modification can be considered as additional results at the community level. The final outcomes of the project will be determined after the endline survey is completed in 2013.

Challenges and the way forward

Due to delays in obtaining the necessary software for data collection, the project team came up with a solution to develop its own data entry template that continues to be used.

More women and children than men participated in volunteer promotional activities, as most men were at work. To cover all target groups and ensure a gender balance, volunteers modified their dissemination methods by increasing the number of home visits and decreasing the village group meetings. Furthermore, villagers that attended meetings were encouraged to be peer educators, particularly when gathering in the workplace, for instance at rice fields, farms and orchards.

Given that the community volunteers were new and their skills poor, the project team visited them regularly. However, some of the villages were in isolated locations and difficult to access.

After the endline study it will be possible to evaluate how well the key messages were able to encourage communities to modify their behaviours and practices.



Mongolia: Comprehensive baseline survey in the Gobi

Background

Mongolia is a landlocked country in East Asia bordering China and Russia. Even though the country is large it contains little agricultural land. Much of the land area is covered by steppes (dry grass-covered plain), with mountains to the north and west and the Gobi Desert to the south. Approximately 30 per cent of the population is nomadic or semi-nomadic. Ulanbaatar, the capital and largest city, is home to about 45 per cent of the population.

In 2010 Mongolia Red Cross Society (MRCS) started a community-based health and first aid (CBHFA) pilot to further increase community-based interventions in an inclusive and developmental manner. Furthermore, the project aims to strengthen the capacity of the soums (sub-provincial administrative units) to both prevent and manage health problems and injuries in emergency and non-emergency situations.



4

Working towards showing impact:
 baseline measurement



Source: www.mapcruzin.com/free-mongolia-maps.htm

The baseline process

Twelve soums in four provinces in Southern-Mongolia, covered by the Gobi desert were selected for the three-year pilot CBHFA project (2010-2012). Approximately 6,500 families or 26,000 people reside in the selected soums, including 8,000 school children.

A comprehensive baseline assessment was performed initially to determine what the actual health needs are in the 12 communities and to assess the basic knowledge and practices of households. The baseline survey encompassed 17 health and disaster management issues: acute respiratory infections, basic first aid and injury prevention, care of a newborn, community mobilization in major emergencies, diarrhoea and dehydration, family planning, hepatitis A, hygiene and sanitation, HIV and sexually transmitted infections, immunization and vaccination campaigns, nutrition, reducing stigma and discrimination, road safety, safe motherhood, safe water, tuberculosis and voluntary blood donation.

The CBHFA baseline questionnaires were reviewed and adapted into the local context. The sample households covered the 4 targeted provinces and 15 per cent of total households from each province were randomly selected, with a total of 1,153 households.

Baseline survey guidelines were translated into Mongolian and distributed to Red Cross middle level branches as reference material for the interviewers. Branches then ran introductory sessions on CBHFA for the 66 facilitators and 240 volunteers and trained them on data collection using the questionnaires.

Baseline results

The 306 Red Cross facilitators and volunteers asked 41 questions in total and identified that the prevailing communicable diseases in the sample households were: sexually transmitted infections, diarrhoea, hepatitis, and tuberculosis. In addition, cardiovascular disease was a significant issue and accidental injuries were increasingly common.

General Facts: Mongolia

Population	2.7 million
Growth rate	1.2%
Per-capita income	3.330 US dollars
Literacy rate (men & women)	97%
Health	
Fertility rate	2.0%
Contraceptive prevalence rate	66%
Maternal mortality rate	65/100,000
Infant mortality rate	24/1,000
HIV prevalence (adults 19-49 years)	<0.1%
Life expectancy (women)	74 years
Life expectancy (men)	65 years

WHO World Health Statistics 2011



Communities also experienced frequent disasters such as extremely cold periods, duzds and floods, and there was a shortage of public knowledge on prevention measures. Underpinning these concerns were the larger issues of poverty and unemployment, in particular among the younger generation.

Results of the baseline survey indicated an obvious need for local people to increase their capacity to properly identify and tackle the priority risks and challenges in communities.

Lessons learnt and recommendations

Since the survey showed more or less the same results across targeted provinces, there was no need to take provincial differences into consideration during the planning and implementation process. Survey results should guide decisions on priority topics and time allocations for the various CBHFA modules.

The CBHFA teaching materials should be adapted for each community relying on survey results and focusing on incorrect and missing behaviours among beneficiary populations, particularly in modules five to seven, which target specific conditions and diseases.

The way forward

Household visits are the key activity for the CBHFA volunteers. In addition, MRCS plans to establish Red Cross Humanitarian Centres and youth clubs in each targeted soum centre to improve health promotion activities in the communities. The Centres will deliver health promotion messages for people from distant and scattered living settings coming to the soum centre to purchase food and other items.

To reduce local vulnerabilities to health and disaster risks, CBHFA facilitators and volunteers will contribute to local promotional campaigns and community interventions against different hazards.

In 2012, a workshop for sustainability will be held, aimed at increased ownership and community engagement. Key players will be invited to attend, including government and civil agencies like governor, health and school personnel. The CBHFA concept will later be introduced in urban centres such as Ulaanbaatar where vulnerabilities are increasing among local populations. Finally, an endline survey will be conducted in 2013 to measure the impact of the intervention.



GRCS

Ghana: Baseline survey and monitoring in community-based health and first aid (CBHFA)

Background

The Republic of Ghana in West Africa contends with health issues fairly similar to those endemic in other sub-Saharan nations with waterborne diseases, malaria, measles, cholera, typhoid and TB being the most common. HIV/AIDS also has a big impact on the population.

The level of health care services varies throughout the country and while urban centres are well served, rural areas often have no access to modern health care. In spite of a considerably reduced maternal mortality rate since 1990, reproductive health remains the source of many health issues for women in the country.

CBHFA in action approach

The Ghana Red Cross Society (GRCS) selected Abura-Asebu-Kwamankese district in the central region of the country to pilot *CBHFA in action*. The central region was identified as one of the poorest, struggling with a number of public health issues. The project is being implemented in three communities.



In the first phase, 60 volunteers were selected and trained in all 7 CBHFA modules to know how to address most health threats. A vulnerability and capacity assessment that included community dialogue was conducted to identify the most pressing needs in the communities. Altogether 15 health needs were identified, for example, lack of basic first aid skills and poor hygiene or sanitation practices. The assessment was followed by a baseline survey using the CBHFA approach.

The general objectives of the baseline survey were to highlight the current practices in public health problem areas in the targeted communities, and provide opportunities for correctly addressing them. The survey also aimed to build the capacity of volunteers by engaging them in a research exercise.

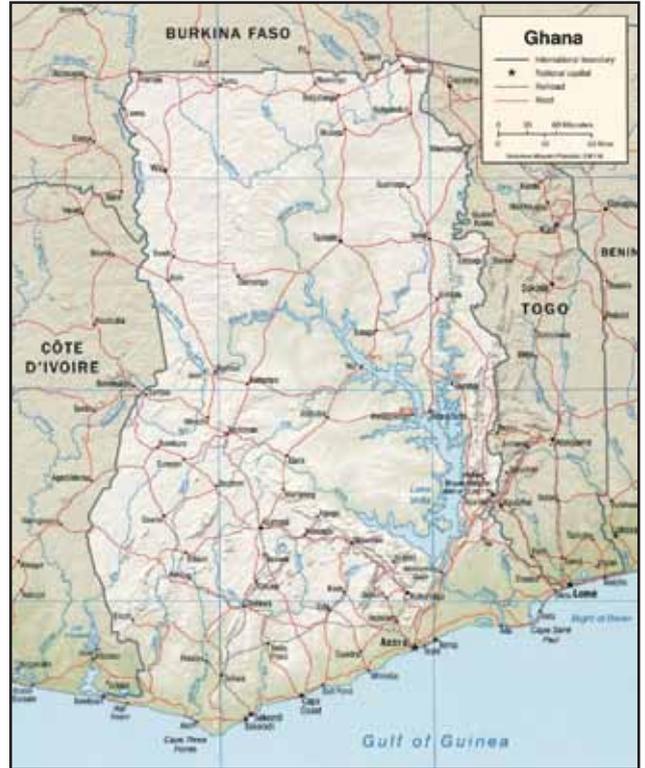
Conducting a baseline survey

Prior to conducting the survey, the volunteers attended a two-day training session. Training covered the ethics of data collection, sampling techniques, survey objectives, review of the questionnaire, practice sessions, and community entry.

Data was gathered on different dates as the supervising team needed to be in each community to oversee data collection. Each volunteer took a minimum of one hour to complete a set of questions. Supervisors divided themselves among the volunteers who visited the households and administered the questionnaire.

Sanitation was a major component of the project and volunteers were trained on the prevention and control of cholera as a part of their house-to-house education. Volunteers discussed the issues in the questionnaire with community members and advised them to adopt good hygiene and sanitation practices.

Each community had a team leader who assisted in mobilizing, supervising and monitoring the performance of volunteers conducting the survey. The team leader visited all communities to debrief volunteers and received challenges and suggestions from them.



Source: www.mapcruzin.com/free-ghana-maps.htm

General Facts: Ghana

Population	23.8 million
Growth rate	2.2%
Per-capita income	1,530 US dollars
Literacy rate (men & women)	66%
Health	
Fertility rate	4.2%
Contraceptive prevalence rate	23.5%
Maternal mortality rate	350/100,000
Infant mortality rate	47/1,000
HIV prevalence (adults 19-49 years)	1.8%
Life expectancy (women)	64 years
Life expectancy (men)	57 years

WHO World Health Statistics 2011



Outcomes

The baseline survey revealed many unhealthy practises in the communities. For example:

- Ninety per cent of people cannot correctly describe the management of minor injuries.
- Forty per cent of people do not immunize their children regularly.
- Fifty-eight per cent of people do not use long-lasting insecticidal mosquito nets.
- Fifty per cent of mothers can not identify the danger signs of diarrhoea.
- Seventy-six per cent of people practice open defecation.
- Sixty-two per cent of people obtain their drinking water from streams.

Households previously ignorant of existing health problems gained awareness of them during the interviews. After the survey, not one case of cholera was reported from the three communities in the recent outbreak of cholera.

The CBHFA baseline serves as the first reference of its type in the district as no other official baseline reports exist. The levels of capacity in terms of data collection and analysis have increased. Volunteers who previously could not easily approach people for questioning are now able to interact with households to collect information.

Challenges and lessons learnt

The CBHFA team expected that data collected from the survey would be processed and analyzed using a particular software. Since this was unavailable at GRCS, data analysis was completed manually.

Villagers surveyed were reluctant to comment on reproductive health issues such as condom use and family planning.

While volunteers had some level of education, the level of understanding of the questions improved when the questionnaire was translated into the local dialect.

Confirming the actual number of households before sample size calculation is needed to avoid readjusting size when in the field for the actual survey.

Monitoring during implementation

Monitoring skills gained during the baseline survey are used in implementation of the actual project. Volunteers conduct house-to-house education visits twice a week for two hours per day with each volunteer covering four households within the community.



Data gathered during these home visits is recorded in the field notebook. At the end of the month, data is transferred to the volunteer recording form. The district officer then collects these reports and collates an overall report for the regional manager. The health coordinator supervises the process from headquarters and visits the communities quarterly.

During the house-to-house visit, if for example, diarrhoeal diseases are the problem in the community, volunteers use the following questions:

- Do you know about diarrhoea?
- What would you do if your child suffered from diarrhoea?
- What are the causes of diarrhoea?
- Do you know how you can prevent diarrhoea?
- Do you know where to get an oral rehydration salts (ORS) sachet?
- Do you know how to make ORS at home?
- Once ORS is ready, how would you give ORS to the child?
- What other things can you give to the child, if he or she has diarrhoea?
- What food (solid or liquid) would you give to a child with diarrhoea?

Volunteers carefully clarify the issues after each question. They can also demonstrate the making of ORS or show mothers how to prepare well-balanced foods using local ingredients. Usually community members have little time to spend in finding solutions to problems that affect them. Therefore the input from volunteers is essential.

“Education aimed at highlighting how people’s behaviours affect their health encourages people to make their own choices for improved health,” says a volunteer about a successful health promotion exercise.



Philippines: Baseline survey on dengue fever

Background

The Philippines is an archipelago comprised of over 7,000 islands and is one of the most disaster-prone nations in South-East Asia, hit each year by an average of 20 typhoons and related natural disasters such as floods and landslides. While considered a middle-income country, poverty is dominant in rural areas and in unofficial urban settlements.

Moreover, diseases including dengue fever, tuberculosis, malaria, measles and HIV/AIDS continue to pose significant challenges. The country's population density and extreme poverty worsen the situation, making inhabitants more vulnerable to man-made disasters, natural disasters and health emergencies.

Indicators and baseline questionnaires

The Philippine Red Cross (PRC) introduced a community-based health and first aid (CBHFA) approach in 5 chapters and 25 communities throughout the country in 2009, at a time when no baseline tools were available. Two years later, a newly developed CBHFA planning, monitoring, evaluation and reporting (PMER) toolkit was piloted in 26 out of its 97 chapters and in more than



130 communities in the Philippines. The main entry point was at the 143 ongoing PRC health programmes including health in disaster, water and sanitation, immunization, primary health care and nutrition.

Easily adapted to any local context, the toolkit illustrates the basics of setting up and using a monitoring and evaluation system for CBHFA. At first, the use of indicators and baseline questionnaires posed a challenge to facilitators and implementers alike. “However, once we understood how the PMER tools complemented one another, we appreciated its use,” said Clarice Sarao, team member and CBHFA programme manager.

Using planning and evaluation tools

Dengue incidence in Philippines varies annually, but generally has grown dramatically in recent decades. Dengue constantly appears as one of the top five health priorities in community assessments.

The government’s dengue surveillance report revealed that last year’s dengue cases were mostly in CBHFA project areas, specifically in Metro Manila and the provinces of Bulacan, La Union, Pangasinan and Laguna. These chapters were already active in implementing dengue prevention activities.

The PRC team set out to investigate the reasons behind the increasing number of dengue cases in these areas.

The team then conducted a baseline assessment in 10 per cent of total households. Results of the baseline survey, together with the indicators, are normally used as the basis for planning activities, setting targets and evaluating the performance of community-based activities.

However, the assessment team believes that the use of baseline results as a tool for proper planning and targeting may have limited success, as results depend solely on the questions presented in the baseline questionnaire. For example, the baseline questionnaire on dengue prevention and control presented only two questions. This limited the



Source: www.mapcruzin.com/free-philippines-maps.htm

General Facts: Philippines	
Population	91.9 million
Growth rate	1.9%
Per-capita income	4,060 US dollars
Literacy rate (men & women)	94%
Health	
Fertility rate	3.0%
Contraceptive prevalence rate	50.7%
Maternal mortality rate	94/100,000
Infant mortality rate	26/1,000
HIV prevalence (adults 19-49 years)	<0.1%
Life expectancy (women)	73 years
Life expectancy (men)	67 years

WHO World Health Statistics 2011



team's ability to determine the community's actual level of knowledge and behaviour concerning dengue prevention and care.

Consequently, the team chose to expand the questionnaire and constructed additional questions on dengue. The community was then re-assessed. Results of the re-assessment helped CBHFA implementers to further investigate causes of the spread of dengue and guide the community in planning its activities.

Integrated baseline assessment

For issues such as diarrhoea and water and sanitation, the team opted to integrate the more detailed participatory hygiene and sanitation transformation (PHAST) baseline questionnaires into the baseline survey. This method proved useful in providing a clear overview of the knowledge, attitudes and practices of the community.

The PHAST approach and steps were implemented in the communities over a period of three months. This approach, with a set of seven steps and tools to be followed, appeared to be simpler, more logical and practical for both facilitators and volunteers. The first five steps helped guide the community group through the process of developing a plan to prevent diarrhoeal diseases by improving water supply, hygiene behaviours and sanitation. The sixth and seventh steps involved monitoring and evaluation.

The approach proved successful. "The participants enjoyed our activities. We showed them the pictures (flash cards) of unhealthy practices and some of them were shocked. I think it made them remember back when they were unaware of their practices. As we continued to discuss the effect of bad hygiene behaviours on their health, they became more aware and it has helped them avoid some illnesses," said PHAST volunteer Josephine Fernandez.

During monitoring visits, the use of tools such as the home visit guide, supportive supervision and community satisfaction checklists, and volunteer record book enabled the team to observe progress. These visits also provided the volunteers with a personal perspective on programme implementation, which added to personal motivation and job satisfaction.

Lessons learnt

Baseline results provide a good foundation for planning, educating and creating change in the community. By testing the questionnaires and adding supplementary questions the team could determine if questions were focused on the community's knowledge, attitude and/or practice. Subsequently, this helped with appropriate planning of activities.

The CBHFA team recognizes that baseline surveys can provide a reference point for formulating project design, guiding implementation, and targeting key health messages. To enhance the process they have proposed a two-step



method for new project design. First, a proposal is developed with broad indicators for approval purposes. Then, after approval, a more detailed plan of action is developed with the community, using baseline results as a reference for planning.

The way forward

The goal of community-based interventions is to change unhealthy behaviours through health education and other activities. At the end of implementation, the endline results will be used to measure change in the community.

PRC has started to draft a generic work plan and set of activities for acute respiratory infection, dengue and emergency health. The document aims to align activities that will help improve specific knowledge-related or behaviour-related issues that contribute to the health problems identified in the baseline data. Activities are not limited to health discussions but include a combination of participatory health activities and the creation of a supportive and enabling environment (for instance, equipping the community with infrastructure).



5 CBHFA as an integrated part of community-based approaches



Timor-Leste: Working towards integrated programmes in a fledgling nation

Background

Timor-Leste remains the youngest and one of the poorest countries in Asia. About 70 per cent of the population lives in rural areas where they are hardest hit by poverty.

The United Nations Development Programme *Human Development Report 2011* records substantial progress in many health areas such as infant and under-five mortality rates, antenatal care coverage, and treatment of TB cases. However, the country remains off-track in other aspects including the prevalence of underweight children under five years of age, maternal mortality rate, incidence of malaria, and the proportion of the population using improved sanitation facilities. These conditions, coupled with limited access to adequate basic health care facilities, offer huge challenges to the country and its people.

Cruz Vermelha de Timor-Leste (CVTL) programmes

CVTL, the National Society of the Red Cross in Timor-Leste, was established in 2002 and achieved formal recognition by the International Federation of Red Cross and Red Crescent Societies (IFRC) in 2005.



5

CBHFA as an integrated part of community-based approaches



Source: www.mapcruzin.com/free-east-timor-maps.htm

Over the past four years, CVTL has been implementing two important pilot projects in CBHFA and community-based disaster risk reduction (CBDRR). Together these projects enable CVTL to build the safety and resilience of vulnerable communities through community-based health promotion, disease prevention, disaster risk reduction and livelihoods and to develop its capacity to work effectively as a national organization.

Changing behaviours in traditional cultures

As a young National Society working in a country with a large illiterate population, CVTL recognizes that individual communities face inter-related challenges to community development. “It is sometimes hard to work with the communities as they are mostly illiterate and have traditional cultures. Therefore it is often difficult to change their behaviour,” said Sergio Freitas, CVTL’s CBHFA project officer.

He shared an example of the village of Saburai, in the district of Bobonaro, where the Red Cross was unable to build latrines as villagers believed that someone would die if construction took place. “The community considered the land holy ground,” explained Freitas. They also believed that big disasters would follow if latrines were built there. The National Society supported villagers in building some latrines not directly on their land but close enough for them to use.

Additionally, Freitas says that the participation of women in Red Cross activities is also challenging, as women are traditionally not given decision-making roles in Timor-Leste. “In our culture women are housewives and many are illiterate. Therefore it is difficult in communities where female volunteers are selected. Men often think that women don’t have the capability,” he said.

At CVTL, staff members are aware of these challenges and facilitate the inclusion of women in participatory assessment and planning processes through women-only focus groups, interviews,

General Facts: Timor-Leste

Population	1.13 million
Growth rate	3.3%
Per-capita income	---
Literacy rate (men & women)	---
Health	
Fertility rate	6.4%
Contraceptive prevalence rate	22.3%
Maternal mortality rate	370/100,000
Infant mortality rate	48/1,000
HIV prevalence (adults 19-49 years)	---
Life expectancy (women)	69 years
Life expectancy (men)	64 years

WHO World Health Statistics 2011



surveys and other activities. Placing an emphasis on equal numbers of female volunteers, CVTL provides comprehensive training and support using materials adapted to the Timor-Leste context to ensure that they are well prepared. Communities under the National Society's livelihood programmes often set up all-women groups to develop their income generating options.

Learning through a CBHFA pilot project

The three-year CBHFA pilot project (2010 to 2012), supported by IFRC and funded by the Finnish Red Cross, started with preparatory work through a community-based first aid (CBFA) programme in 2009. The pilot complements CVTL's water-led projects which also incorporate CBHFA activities, funded by the Austrian and Australian Red Cross Societies. Altogether, CBHFA and water-led CBHFA are being implemented in 7 of Timor-Leste's 13 districts.

An estimated 8,500 people in 4 communities and 2 districts have been targeted under the pilot project. The communities were selected based on their vulnerability to diseases and the absence of other organizations. So far, 35 CBHFA facilitators have been trained. A CBHFA package of guidelines, tools and resource materials has been translated and adapted to Timor-Leste's context.

Following orientation on CBHFA in early 2011, local volunteers received training in the first 3 CBHFA modules (volunteers, community mobilization, and assessment-based action in the community) as well as module 6 on disease prevention and health promotion. Facilitating a participatory assessment, CVTL health staff assisted the community in identifying five health priorities (malaria, TB, asthma, diarrhoea and malnutrition) and developing a community action plan. A baseline survey of the five top health priorities was conducted, and volunteer training on these topics continued. "In our project we do a baseline survey before starting CBHFA and an endline after completion. A comparison of the data will show any changes in health behaviour in the communities," said Freitas. He acknowledges that change takes time and is difficult to measure.

The CBHFA approach has provided communities with more information and knowledge on health issues as well as ownership of the project. As Freitas explains, "With this new approach communities select their own volunteers and feel comfortable and confident with them." Health information for the villagers is also now readily available through the local publication *Lafaek*, radio programmes, dramas, drawings and brochures.

Pilot project review and the way forward

In July 2011, a midline review of the pilot was conducted to show the project's progress to date.

The review pointed out that while the CBHFA approach increased the community's capacities, there had not been enough strengthening of CVTL branch



capacity. The success of implementation is strongly linked to the commitment of the branches and there have been better results when the branches have been properly sensitized.

Prior to project inception, enhanced community selection and entry processes made the project more transparent and seemed to generate a stronger commitment from both the branches and the communities that have been involved in the pilot project.

Integrated approach – a solution to complex risks

One key lesson CVTL has learned from this and other pilots is that individual communities face complex sets of risks that are inter-connected and are best tackled together in a systematic and integrated way. This led to a commitment to an integrated approach in the current *Strategic Plan 2010-2014* and the development of a new programme framework. The new integrated community-based risk reduction (iCBRR) programme links provision of water and latrines with CBHFA, disaster risk reduction and livelihoods and enables them to deliver better, more complete outcomes for communities.

The overall objective of the iCBRR programme is to strengthen the capacities and resilience of the most vulnerable communities and households in Timor-Leste, to enable them to better cope with the hazards and risks they face.

Community resilience will be improved through community capacity building, joint vulnerability and capacity assessment, participatory planning, and implementation of a “full package” of carefully designed integrated risk reduction actions. This could include water, poor health practices and conditions, disease, poor waste management, natural hazards such as flood, drought, storms and landslides, and livelihoods.

Implementation of iCBRR will start in 2012 in three districts and, at the end of the year when the CBHFA pilot project has been completed, CVTL will be able to fully integrate this learning into the following year’s plan. With the support of in-country partners, CVTL hopes to implement iCBRR country-wide, in each of the 13 districts of Timor-Leste, by 2014.



Nepal: Integration of community assessments

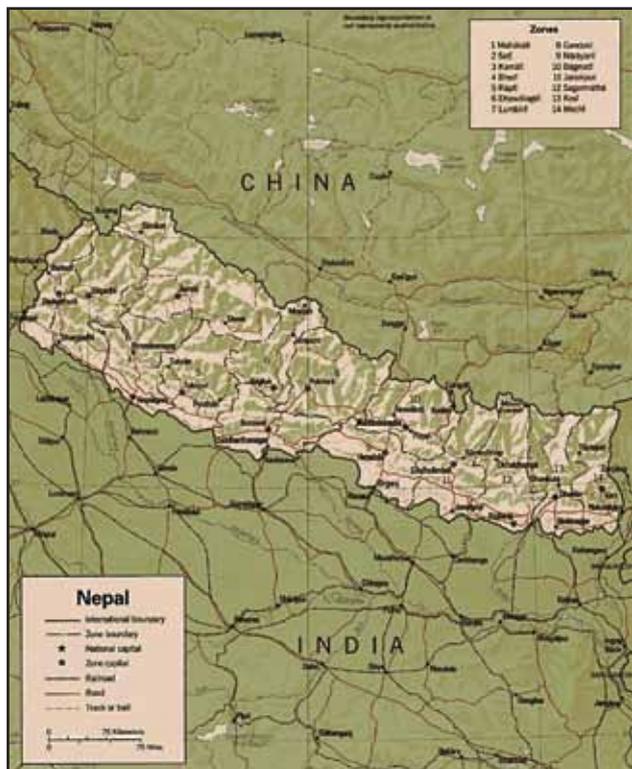
Background

Nepal is a landlocked country with over a quarter of the population living below the poverty line.

The prevalence of diarrhoeal diseases and acute respiratory tract infections is high and vector borne diseases such as malaria and dengue are common in the southern part of the country. Kathmandu valley is also vulnerable to earthquakes. Annual floods, landslides, fires and droughts add to the natural hazards of the country. Reducing risks and vulnerability in both rural and urban environments remains a high priority.

Community-based health and first aid (CBHFA) in the Nepal Red Cross Society

The Nepal Red Cross Society (NRCS) started a community-based first aid (CBFA) programme in the country in 1996, which served as an effective tool for promoting health education and delivering first aid services during emergency and non-emergency settings. CBHFA was introduced in 2010 and to kick-start implementation, NRCS initiated a pilot project in the Gulmi district of central Nepal.



Source: www.mapcruzin.com/free-nepal-himalaya-maps.htm

The aim was to understand the communities’ priorities in health and disaster threats and to provide vulnerability capacity assessment (VCA) knowledge and skills to Red Cross staff and volunteers.

Assessment implementation

Nine wards in the Gaudakot village development committee of Gulmi district were selected for the needs-based intervention. One component of the intervention comprised a CBHFA vulnerability and capacity assessment (VCA) learning-by-doing exercise. CBHFA master facilitators from other National Societies in South Asia (Bangladesh, Pakistan, India, the Maldives and Sri Lanka) attended the training and shared their lessons and experiences.

Teams of Red Cross volunteers conducted the VCA exercise with the support of health and disaster management staff from regional and national levels.

The assessment teams used various participatory tools including secondary data collection, mapping (both social and hazard), household surveys, semi-structured interviews, seasonal calendars, and historical profiles to collect data.

The main vulnerabilities, risks and hazards identified through the assessments were: the lack of health facilities, shortage of safe drinking water due to contaminated water sources, reproductive health problems, unemployment, landslides, bush fires and the lack of public toilets, which made open defecation a common occurrence.

Based on the VCA findings baseline indicators on these main vulnerabilities were set in a logical framework analysis. This helped to define the National Society’s priorities and plans for 2011.

Lessons learnt and recommendations

The Gulmi district exercise was one of the first VCAs conducted with both health and disaster risk reduction expertise both nationally and regionally.

General Facts: Nepal

Population	29.3 million
Growth rate	2.1%
Per-capita income	1,180 US dollars
Literacy rate (men & women)	58%
Health	
Fertility rate	2.8%
Contraceptive prevalence rate	48%
Maternal mortality rate	380/100,000
Infant mortality rate	39/1,000
HIV prevalence (adults 19-49 years)	0.4%
Life expectancy (women)	69 years
Life expectancy (men)	65 years

WHO World Health Statistics 2011

The assessment team concluded that it was essential to gain the trust of the community in advance of the VCA process and that the involvement of community representatives encouraged the community to participate in the process. Participation of community stakeholders was also important for optimal gathering of information.

The presence of female facilitators was necessary to ensure open interaction with women's groups in the community. Furthermore, the involvement of elderly groups was crucial obtaining accurate information, in particular when using CBHFA tools such as the historical profile. Youth issues also need to be given special attention.

CBHFA in Gaudakot

There is clear evidence that the CBHFA intervention has had an impact on communities in Gaudakot. For instance, as part of the VCA process, community members were trained in first aid skills. Today they are capable of providing immediate first aid services to those injured in road or other accidents. "Now the number of mild injuries admitted to the local health post has decreased," said CBHFA volunteer Bimala Thapa.

"It has not been a long time since the Gulmi Red Cross chapter introduced the CBHFA in Gaudakot," said another local CBHFA volunteer Namita Gyawali, "but it has brought a great change to the village." Various activities such as clean house and clean child competitions, street drama performances, health and first aid education classes, incentives for construction of sanitary units, and reproductive health counselling have produced signs of change.

Headmaster of Myalpokhari Secondary School, Bhim Bahadur Subedi, maintains that the approach has played an important role in bringing about change in his students' behaviour. "With the clean child competition, personal tidiness has increased and students are now coming to school in clean clothes and with their fingernails trimmed." Students, in turn, are teaching their parents. The mother of Himal Subedi, a first grader in Shree Maikasthan Primary School, says that her son reminds her to always wash her hands after using the toilet.

Sanitation habits in the village have undergone significant change. At the 12th National Sanitation Week, Gaudakot-5 was declared an open defecation-free ward. Field officer Deepak Pokhrel remarked that word is spreading about the positive changes in Gaudakot and other villages in the district are now requesting that the Red Cross introduce CBHFA in their villages.



Palestine: Initiatives in emergency health

Background

The Palestinian territory, divided physically into the West Bank and the Gaza Strip, is situated in a strategic location between Egypt, Israel and Jordan. Around 4.6 million Palestinians live in the territory or in Lebanon, Syria and Jordan. The living conditions of most Palestinians are extremely difficult and nearly 56 per cent live below the poverty line.

Palestine Red Crescent Society (PRCS) community-based programmes

The PRCS community-based approach started as a focused “safe motherhood” programme in 2002 and ran for four years. During this period, community-based first aid was also part of primary health care activities in all communities.

In 2009, these two programmes merged into community-based health and first aid (CBHFA) and the focus broadened to include several issues including emergency health, first aid, infectious diseases and vaccinations, public and reproductive health, and non-communicable diseases.

Through the CBHFA approach, PRCS aims to raise community awareness, empower women, improve community participation, improve community development and



resilience, and strengthen community members so that they are self-supportive during times of unrest.

Gaza crisis evaluation

The Gaza Crisis started in the densely populated Gaza Strip in December 2008 and claimed around 1,300 lives, mostly civilians. Some 400 of the casualties were children. Another 5,000 were injured, including 1,800 children and 800 women. After the conflict much of Gaza was left in ruins. With tens of thousands left homeless and the deterioration of infrastructure and basic services, a humanitarian crisis evolved. PRCS responded to this emergency.

PRCS conducted an evaluation with the support of IFRC and the German, Norwegian and British Red Cross Societies to assess its response to the crisis.

The evaluation recognized that CBHFA volunteers, based in about ten communities in Gaza, had been trained on health issues including emergency health and first aid. During the crisis, with limited or no outside support, volunteers used the emergency kits provided to stabilize patients and administer first aid.

Although PRCS has a strong ambulance service, it encountered challenges trying to reach those in need (including people injured directly by the conflict or due to daily emergencies) because of the lack of access during this period of war.

According to the external evaluator, “These community-based programmes allowed the community volunteers to further develop their existing capacities, induced a positive change in attitudes and behaviour regarding health care, cultural norms and traditional practices and significantly strengthened civil society.”

The evaluation concluded that it is essential for communities to know first aid and emergency health in conflict areas to be able to react immediately. One of the key issues for PRCS to follow up on after the evaluation is linking emergency health with the CBHFA approach and disaster risk reduction to ensure that the capacity exists at the community level to deal with health needs during conflicts.



Source: www.mapcruzin.com/free-palestine-maps.htm

General Facts: Palestine

Population	3.9 million
Growth rate	2.7%
Per-capita income (2008, est.)	1,359 US dollars
Literacy rate (men & women, 2007)	94%
Health	
Fertility rate	4.6%
Contraceptive prevalence rate (UNICEF, 2009)	50%
Maternal mortality rate	38/100,000
Infant mortality rate	25/1,000
HIV prevalence (adults 19-49 years)	---
Life expectancy (women)	73 years
Life expectancy (men)	70 years

WHO World Health Statistics 2011



HRC

Haiti: Introduction of community-based health and first aid (CBHFA) post earthquake and cholera outbreak: The importance of coordination

Background

The Republic of Haiti is a Caribbean country occupying the western portion of the island of Hispaniola, which it shares with the Dominican Republic. Haiti is the most populous state in the Caribbean and also the poorest country in the Americas according to the Human Development Index.

A 7.0 magnitude earthquake struck Haiti on 12 January 2010, affecting 3 million people. The earthquake caused over 222,000 deaths and 300,000 injuries. Widespread destruction in Port-au-Prince left over 1.5 million people homeless, and in Léogane and Gressier 70 per cent of homes were destroyed or damaged.

This devastating earthquake led to the deployment of an unprecedented number of Emergency Response Units (ERUs) by Partner National Societies. ERUs deployed to Haiti included field hospitals, water treatment plants, logistic bases, portable operational centres, emergency telecommunication infrastructure



and sanitation supplies. A total of 21 ERUs and 3 response teams were deployed to Haiti in order to deliver critically needed items and services to the affected families.

In the months following the earthquake, responding to the immense physical and psychological damage suffered by millions of Haitians took priority. During the first year of the operation, International Red Cross Red Crescent Society (IFRC) medical teams reached 230,000 people through the provision of emergency healthcare services.

The cholera epidemic in Haiti began in October 2010. The number of cases reported throughout Haiti during the first 12 months was roughly equal to 4 per cent of the national population. This is the highest incidence of cholera ever documented anywhere in the world.

Since early December 2011, the reported incidence of cholera in Haiti has dropped to less than 500 cases per day nationwide. This number, which would be considered exceptionally high in most countries, is relatively low and manageable in comparison to the earlier waves of outbreak. If cholera in Haiti begins to behave as it has in other countries where the disease has become endemic, the annual incidence should eventually fall to 1 per cent or less of the levels seen during the first year of the epidemic.

CBHFA as a methodology of choice in community health

Haiti's health threats are not just earthquake and diarrhoeal diseases: Malaria, HIV and AIDS and tuberculosis have long had devastating effects on vulnerable Haitian communities. In fact, Haiti's disease burden, which was alarming pre-earthquake, is now considerably worse. Evidence points to a significant increase in the rates of diseases due to a number of issues including increased poverty, mass displacement, overcrowded living conditions, decreased government capacity to deal with the myriad of problems facing the country, and an increase in social problems manifested by increasing levels of violence – in particular gender-based violence.

The Haitian Red Cross Society (HRC), working as an auxiliary to the Ministry of Health, has always played an important role in offering targeted health services to vulnerable populations, with a particular focus on social mobilization and prevention activities. This support was significantly scaled up in 2011 as Haitian Red Cross health programmes focused on strengthening the capacity of

General Facts: Haiti

Population	10,033,000 (2009)
Growth rate	-5.4%
Per-capita income (2011, est.)	1,200 US Dollars
Literacy rate (men & women, 2005 – 2010)	49%
Health	
Fertility rate	3.3% UNICEF 2010
Contraceptive prevalence rate	32.0
Maternal mortality rate	670/100,000
Infant mortality rate	25/1,000
HIV prevalence (adults 19-49 years)	1,823/100,000
Life expectancy (women)	64 years
Life expectancy (men)	59 years

WHO World Health Statistics 2011



communities to prevent and manage common health problems with a focus on maternal, newborn and child health, HIV and AIDS, prevention of malaria and other vector-borne diseases and psychosocial support.

In February 2011, the Movement developed the Federation-Wide Strategic Framework for Haiti, the health section of which was developed in close collaboration with all partners – at that stage 14 Movement partners. After analyzing health threats and collective capacity, four thematic areas became the focus:

1. Community Health (including maternal, newborn and child health)
2. Emergency Health
3. Psychosocial Support Programme
4. HIV and AIDS.

The methodology of choice in community health was CBHFA given that it was already specifically mentioned as such in the Haitian Red Cross strategic plan written in August 2010.

Coordinating partners in CBHFA

Many of the partners began introducing CBHFA in and around the geographical locations where they had positioned their ERUs and Cholera Treatment Centers. Given the level of interest from Partner National Societies in supporting the introduction of CBHFA in Haiti, the coordination of the collective effort became extremely important. By March 2012 the following Partner National Societies were working on multi-year CBHFA projects:

- **Leogane:** HRC, IFRC and Spanish Red Cross (6,425 households)
- **Petit Goave:** HRC and Norwegian Red Cross (4,000 households)
- **Jacmel:** HRC and Canadian Red Cross (10,748 households)
- **Saut d'Eau:** HRC and Finnish Red Cross (9,000 households)
- **Arcahaie:** HRC and German Red Cross (20,000 households)
- **Gressier:** HRC and Italian Red Cross (just beginning)
- **Port au Prince JMV (Jean Marie Vincent) IDP Camp:** HRC and British Red Cross (more than 20,000 households).

Given the number of partners, coordination is key. In late 2011 a National CBHFA Working Group was formed consisting of technical staff from the HRC, IFRC, Partner National Societies, Ministry of Health and the School of Community Health. This group has met five times since its inception and now consists of a representative from each Partner National Society working on CBHFA. The topics analysed in the meetings are varied and have resulted in consensus thus far, meaning that CBHFA is being rolled out across all seven geographical sites in a consolidated manner.



Source: Haitian Red Cross Society

For instance, the February 2012 meeting included discussions on the planning for and selection of consultants to conduct a national CBHFA baseline which will happen in two phases: the experimental phase that will take place in the south-east of the country (the zone of implementation supported by the Canadian Red Cross), and then, after validation of tools and training, the expansion of the survey to other zones. The coordination of visibility materials such as caps, backpacks, and t-shirts to be used uniformly in all sites was discussed. The decision was also made to translate the community tools and volunteer manual into Creole. Volunteer motivation and uniform policies for treating volunteers (both Red Cross and community volunteers) were also addressed. It is important to note that the Ministry of Health is an equal partner in these deliberations as is the School of Community Health.

The operation in Haiti has resulted in many staff, daily workers and volunteers being engaged in various activities. In order to better manage this situation Haitian Red Cross with support from the IFRC, ICRC and PNS drafted the Haitian Red Cross Volunteer Policy in October 2011. This policy defines the differences between daily workers and volunteers and clarifies roles and responsibilities as



well as the payment and incentives each group can expect from the organization. Volunteers for example will, once the policy is adopted, work between two and ten hours a week and will receive only out of pocket expenses. This return to “true volunteerism” will no doubt lead initially to a slight fall off in volunteer numbers but we have seen in the psychosocial support programme that approximately 70% of the volunteers remained once this policy was enacted.

Lessons learnt and the way forward

So far the following advantages in having a strong and inclusive national coordination mechanism for CBHFA in Haiti have been observed:

- commonality of approach across all seven geographical areas in respect of roll-out
- standardized training of project staff and volunteers across all locations – including planning, monitoring, evaluation and reporting (PMER) toolkit
- the leading role the Haitian Red Cross plays as convener and chair of meetings
- economies of scale made in areas such as the printing of material and contracting of baseline consultants
- the involvement of the Ministry of Health from the beginning in roll-out and its leading role in decisions on, for instance, the acceptability and quality of translated material
- consensus reached across geographical areas on, for instance, volunteer motivation, visibility and incentives.

Challenges do still exist, especially the fact that external partners are not present in many of the meetings despite being invited and encouraged to actively participate. Possible solutions include rotating meetings, or having them on alternative months at the Red Cross headquarters and the Ministry of Health headquarters respectively.



6 New challenges for communities: non-communicable diseases



6

New challenges for communities:
non-communicable diseases



Sri Lanka: Chronic non-communicable disease prevention

Background

Sri Lanka is an island in the Indian Ocean. Two decades of civil war hindered socio-economic development, but since 2009 reconstruction has been undertaken swiftly. Sri Lanka has a well developed, free public health system, but primary health care is under-utilized.

According to the World Health Organization (WHO), an estimated 30 per cent of deaths in Sri Lanka are the result of cardiovascular disease. Diabetes has also become one of the most daunting challenges to public health in South Asia with the highest prevalence found in Sri Lanka. The social and economic implications of these diseases are immense.

In addition to genetic liability, behavioural risk factors are responsible for the rising number of non-communicable diseases, including an increase in tobacco and alcohol consumption, unhealthy diets and physical inactivity.

Tobacco consumption (both smoking and chewing) has gone up in the last decade, particularly among the female population. There is a high level of alcohol dependence in the population among males over 25 years of age with urban centres showing a higher pattern of consumption than rural areas.



Statistics also reveal that 80 per cent of young people in the 10 to 18 year age bracket have inadequate or no physical activity during their leisure time. Nearly 80 per cent of school-going children also do not consume the recommended daily servings of fruits or vegetables.

Red Cross community-based approach

The Sri Lanka Red Cross Society (SLRCS) has been implementing community-based health interventions for several years. Nearly 900 staff members and volunteers were trained as facilitators and trainers in 13 branches from 2007 to 2009. This has built up a decent capacity level of the volunteers who are more confident and self-assured in conducting community assessments and reaching out to community members with preventive health messages. Many branches have developed a good standing in the communities they serve.

SLRCS follows the government's overall objective to reduce premature mortality (less than 65 years) due to non-communicable diseases (NCDs) by 2 per cent annually over the next 10 years. The National Society has played an important role in recognizing the threat of NCDs, advocating for policy and environmental changes and influencing community and individual norms and behaviour.

Red Cross non-communicable disease strategy

SLRCS has recognized that NCDs are a major cause of morbidity and mortality in the country and has developed a strategy to deal with them, which sets out to:

- develop a long-term community based programme that includes non-communicable disease prevention interventions
- advocate for NCDs
- develop information, education and communication campaigns targeting different audiences – general public, schools and communities



Source: www.mapcruzin.com/free-sri-lanka-maps.htm

General Facts: Sri Lanka

Population	20.2 million
Growth rate	0.8%
Per-capita income	4,720 US dollars
Literacy rate (men & women)	91%
Health	
Fertility rate	2.3%
Contraceptive prevalence rate	68%
Maternal mortality rate	39/100,000
Infant mortality rate	13/1,000
HIV prevalence (adults 19-49 years)	<0.1%
Life expectancy (women)	76 years
Life expectancy (men)	65 years

WHO World Health Statistics 2011



Reaching high-risk individuals in Colombo

The Sri Lankan National NCD Programme is still clinical in nature rather than preventive, focusing on treatment of diabetes and cardiovascular disease. In 2010, SLRCS developed and implemented a small pilot project in partnership with MoH and WHO on NCD prevention.

Under the project, volunteers from the Colombo Branch joined in surveillance activities, visiting households and inviting high-risk individuals (as defined by the MoH/WHO guidelines) to attend the screening programme at the nearest government health centre. The screening tests included testing for blood pressure, blood sugar and cholesterol. Individual risk profiles were then defined on the basis of the results using WHO protocols.

The branch also conducted community awareness interventions through the distribution of information materials in the target areas and set up a gym, as part of its plan to encourage people to exercise and thus lead a healthy lifestyle. The gym was equipped and is staffed by a qualified instructor. Users are charged a minimal fee.

Project outcomes

About half of the persons invited to the screening attended, with more women participating than men. Initial results of the household screening, shown in the following table, were interesting.

	No. invited for screening	No. attended	No. identified as having diabetes	No. detected for the first time as diabetics	No. identified as having hypertension	No. detected for the first time as being hypertensive
Male	365	164	47	36 (77%)	43	15 (35%)
Female	835	455	146	121 (83%)	131	70 (53%)
TOTAL	1,200	619	193	157 (81%)	174	85 (49%)

Some 81 per cent of the identified diabetics were unaware of their status until the screening process, with a higher percentage of these being women. In addition, 49 per cent of people identified as hypertensive were unaware of their status until they were screened, and again a higher percentage was female.

Overall participation to the screening was slightly more than 50 per cent of those invited, with more women participating than men. There is insufficient awareness of NCDs, and members of the community may underestimate the risk factors of NCDs, suggesting a need for more IEC and health promotion.

Primary prevention in Homogama

Primary prevention includes methods to prevent the biological onset of disease. Primary prevention is recognized as the most effective tool for reducing the NCD burden. Because NCDs begin at an early age, the best target groups for primary prevention are children and adolescents.



In June 2011, SLRCS piloted another NCD intervention, this time in the semi-urban area of Homogama in the Colombo District. The goal of the six-month project was to contribute towards healthy lifestyles in the community.

This NCD prevention project implemented its activities by mobilizing different community members as volunteers. The project trained 50 volunteers from the SLRCS Units (30), Youth Circle (10) and parents of the school children (10) of the target schools.

The volunteers promoted the communities' awareness through monthly community information sessions and house-to-house campaigns, which also included school children. IEC materials were prepared in line with the culture, customs, values and norms of the target audience. Mass scale awareness was created through radio quizzes and billboards, where issues such as healthy food habits and the importance of exercise were promoted.

The activities in schools included a 'Quiz Competition' on non-communicable diseases and first aid. Twelve schools entered this competition and teachers guided their students with additional books and reading materials. School Health Promotion Committees were formed to promote health education of the students.

A medical doctor in charge of preventive health was a key person addressing the target community members under this project. He was able to convey the importance of the messages to the participants.

At the end of the project the following evidence of lifestyle changes to avoid NCDs were observed:

- An increased number of community members use the gymnasium set up at the Colombo Branch.
- An increased number of people, specifically working parents, are willing to serve traditional food instead of junk food.
- An increasing number of adults over the age of 40 get regular health check-ups.

Moreover, since the majority of the participants for the awareness sessions were female, NCD risk factors will most likely be addressed at the household level.

The way forward

Noncommunicable diseases are incorporated in the integrated programme for community safety and resilience, which adopts a holistic approach harmonising health prevention, disaster preparedness and risk reduction to build safety and resilience of the most vulnerable communities in the country. The target for 2012 is to engage with 50 communities in ten districts prioritized through vulnerability and capacity assessments, expanding to 100 communities by 2015.

Qatar Workers Health Centre: A model of community-based non-communicable disease (NCD) prevention

Background

According to the last official census conducted in 2010 (Qatar Statistics Authority), 75 per cent of the total population of Qatar is foreign guest workers. Driven by immigration, Qatar's population grew nearly 128 percent between 2004 and 2010.

The majority of migrant workers come from South Asia, the Philippines and other Arab countries. Growth is expected to continue as Qatar embarks on a number of huge infrastructure projects, such as preparation for the 2022 World Cup and a nation-wide railway network.

The New Industrial Area is one of several locations in the country that accommodates labourers.

Respiratory problems are the main health issue in Qatar due to the dust and sand in the air. Other non-communicable diseases, particularly among migrant workers, are also on the rise. Free or subsidized health care is provided to all residents of Qatar.

The Qatar Red Crescent Society (QRCS) and Workers Health Centre

QRCS works to assist vulnerable communities through the provision of medical services and disaster relief.

Most of the industrial area workers in the country encounter health problems. Roughly 15 per cent are reported to have problems with NCDs such as hypertension, diabetes and occupational asthma. These health problems are mostly connected with lifestyle habits that include tobacco smoking and chewing, poor diet and lack of health-related knowledge. Most workers are also illiterate and live in sub-standard living conditions that make them more vulnerable to developing non-communicable diseases.

The Workers Health Centre was opened in December 2010 by QRCS in collaboration with the Qatari Ministry of Health and the Ministry of Labour and selected private companies. The Centre is working towards identifying risk factors and minimizing the number of NCDs through health promotion and education as well as disease prevention.

Representatives of private companies have been invited to visit the Centre and volunteer to help their workers improve their health-related knowledge and reduce NCDs. As of July 2011, 12 teams from 5 private companies have volunteered at the Centre.

Volunteers attended a three-day seminar on identifying the specific risk factors and health problems in their companies. The three major NCDs identified among the workers were hypertension, diabetes and occupational asthma. Plans focusing on disease prevention and control have been developed to reduce NCDs in each company according to their specific occupational exposure. For example, one cement company was noted to have more respiratory problems, while workers at another company, which employs drivers for buses and taxis, had more problems with hypertension.

As part of the intervention, companies printed leaflets in different languages and conducted separate information seminars for their workers. Health Centre staff check progress by conducting site visits to company premises and by confirming if workers' understanding and knowledge have increased.

Project outcomes and challenges

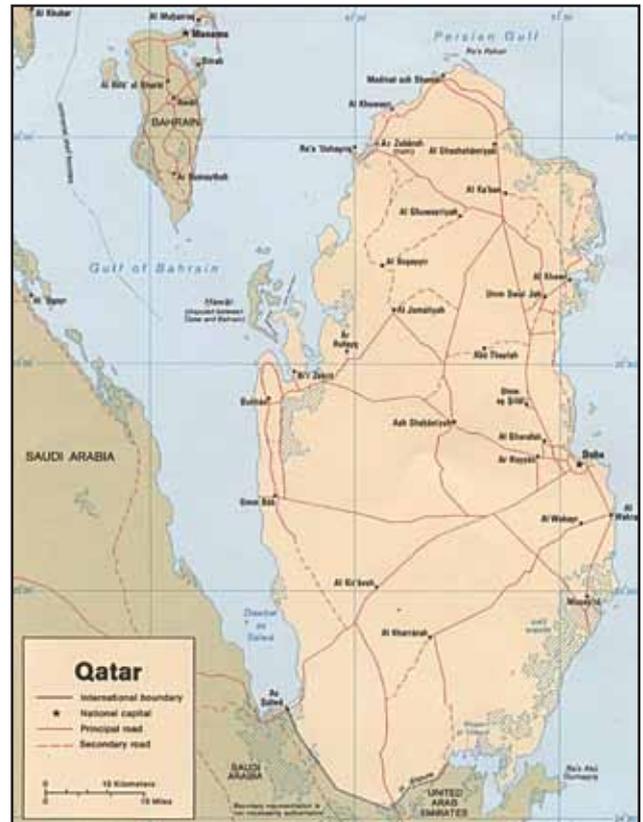
The volunteer system has shown some positive results, with more industrial area workers now aware of their health status and potential problems and more volunteers willing to help educate and promote the health of their peers. More evidence-based results will be shared subsequently according to the assessment of the pilot project.

Lessons learnt and the way forward

QRCS has learned a great deal through the programme. Language is one major barrier to communication between workers and programme staff, another is ensuring the Centre adapts to different the cultures and nationalities found in the New Industrial Area. Lack of education among the workers also poses difficulties.

Going forward, another challenge for QRCS is expanding the project to ensure that the programme reaches all workers in the New Industrial Area. Currently the programme needs more volunteers and staff. The Centre is planning to expand the volunteer system to a further 10 to 15 companies.

While still in the early stages, QRCS hopes the Workers Health Centre will serve as a model that can be replicated or scaled up in other countries and regions.



Source: www.mapcruzin.com/free-qatar-maps.htm

General Facts: Qatar

Population	1.7 million*
Growth rate	8.7%
Per-capita income	---
Literacy rate (men & women)	93%
Health	
FFertility rate	2.4%
Contraceptive prevalence rate	---
Maternal mortality rate	8/100,000
Infant mortality rate	7/1,000
HIV prevalence (adults 19-49 years)	<0.1%
Life expectancy (women)	79 years
Life expectancy (men)	78 years

WHO World Health Statistics 2011



7 Terms and clarifications

What is assessment?

Mapping the main health problems in a community is the first step towards implementing health programmes. This can be done by using assessment tools such as VCA, CBHFA module 3, PRA¹ or PHAST² assessment step. Through these methods a community should be able to identify its priority health problems. This information must be backed up by secondary data from either the national health authorities other international agencies like the World Health Organization.

At times, the perception of health priorities differs in the community and in official statistics. Moreover, while communities may feel they have genuine issues (for example, back pain) to address, the Red Cross Red Crescent is only able to focus on public health issues. The assessments should result in addressing three to five key health issues. Sometimes the community prefers to get information on several pressing health concerns but the impact on behaviour change is likely to be less with widespread or numerous interventions.

There are overwhelming public health concerns such as TB, malaria, HIV, MNCH and emerging health threats including NCDs and road safety that are often pre-selected as the topics for a health programme and given earmarked funds. These issues can be addressed through the CBHFA approach without an initial assessment by immediately making use of available tools (such as a baseline survey), and then continuing with the process.

After identification of the priority areas, a baseline study is conducted to ascertain how much the community knows about the issues identified (dengue, diarrhoeal diseases, immunization and so on) and what common behaviours are. The baseline is done in a fraction of the community (called a “cluster”), which is supposed to represent the entire community. There are several ways of determining the sample size (cluster).

Some baseline methodologies are cumbersome and, for larger projects, if feasible, the Red Cross Red Crescent is encouraged to use an external consultant who understands statistical methodology, such as an academic. If the project is small and the timeline tight the simplest way is to select a proportion (for example 5-10 per cent) of households to be assessed by the baseline. The bigger the percentage sampled the better the confidence interval is of the baseline, that is to say how reliably the sample size represents the population.

At the end of a project (which should run for a minimum of two to three years) an endline assessment is performed in the same fashion as the baseline, covering the same topics. It is important to use the same methodology and sample size for the baseline and endline evaluation. The change in behaviours and/or practices revealed in this assessment is considered the impact of the project. For example, if 20 per cent of people first knew how to protect themselves from dengue and the

¹ Participatory rural appraisal

² Participatory hygiene and sanitation transformation

endline assessment was 85 per cent, then this shows an increase of knowledge. Measuring behaviour change is often complicated.

What is Participatory hygiene and sanitation transformation (PHAST)?

PHAST is a participatory learning methodology that aims to empower communities to improve hygiene behaviours, prevent diarrhoeal diseases, and encourage community management of water and sanitation facilities. It is the standard software methodology used to articulate water sanitation interventions in the Red Cross Red Crescent Movement (IFRC Water Sanitation policy, 2004).

PHAST was introduced by the World Health Organization and uses a participatory approach to community learning and planning that follows a seven-step framework. It works on the premise that as communities gain awareness of their water, sanitation and hygiene situation through participatory activities, they are empowered to develop and carry out their own plans to improve this situation.

What is Participatory rural appraisal (PRA)?

PRA evolved from rural rapid appraisal – a set of informal techniques used by development practitioners in rural areas to collect and analyze data. It is a label given to a growing family of participatory approaches and methods that emphasize local knowledge and enables local people to make their own appraisal, analysis and plans. Participatory methods include mapping and modeling, transect walks, matrix scoring, seasonal calendars, change analysis, well-being and wealth ranking and grouping, and analytical diagramming. PRA work intends to gather enough information to make the necessary recommendations and decisions.

What is Participatory approach to safe shelter awareness (PASSA)?

PASSA is a participatory tool that allows communities to improve their living environment, build safer shelters and design better settlements. It aims to raise awareness among vulnerable people to the everyday risks related to their built environment and to foster locally appropriate safe shelter and settlement practices. It was developed by the IFRC together with the British Red Cross.

What is Vulnerability capacity assessment (VCA)?

A vulnerability capacity assessment is concerned with collecting, analyzing and systemizing information on a given community's vulnerability to hazards in a structured and meaningful way. It contains similar participatory methods as PRA.

What is integration/harmonization?

Integrated/harmonized community-based programming within the Red Cross Red Crescent has been widely discussed recently. Vertical approaches in long-term health, water and sanitation and disaster preparedness/risk reduction

programming has been seen as a major obstacle delivering sustainable results in communities.

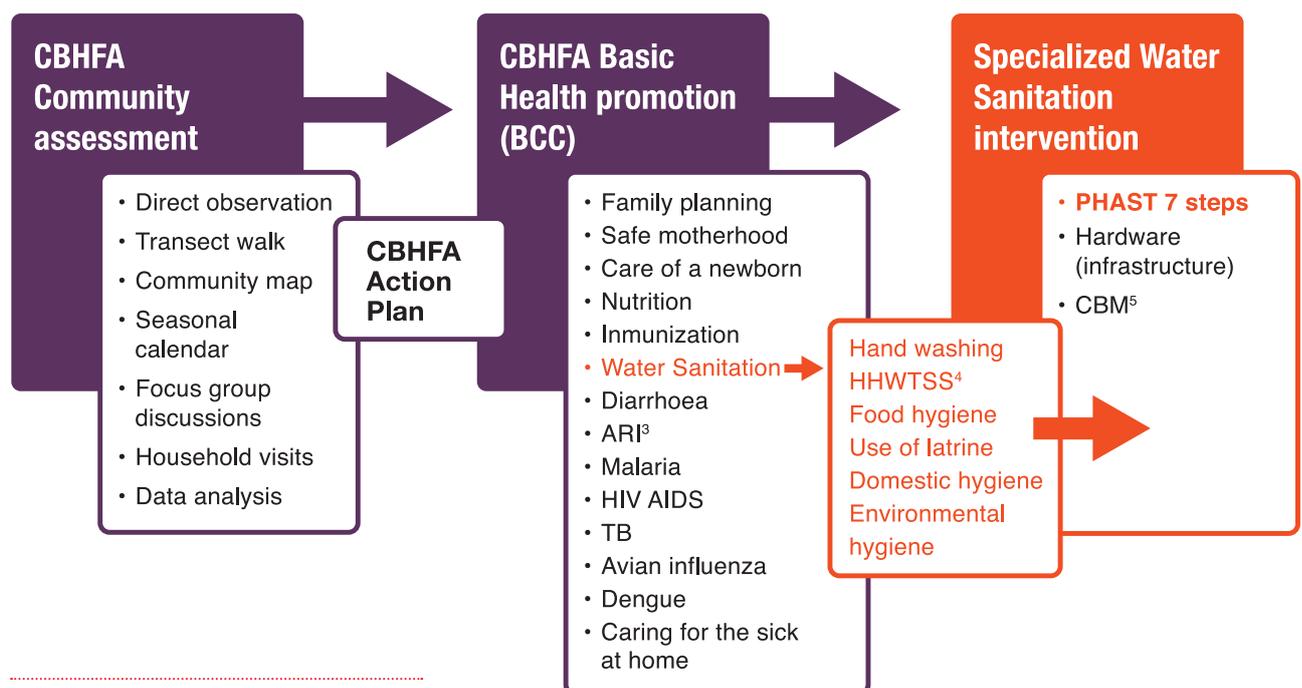
The current non-integrated approach results in lower impact, inconsistent messages, duplication of activities, over-expenditure, and exhaustion of National Society staff, volunteers and beneficiaries. A more comprehensive and holistic approach in communities is needed across all levels of the Movement.

The problem of silos and lack of integration tends to be worse at the IFRC secretariat level, whereas in National Society community level interventions tend to be more integrated for reasons of practicality and/or scale.

Recently there have been attempts to bridge the integration gap. Frameworks have been developed for health, organizational development and disaster management that contribute to building resilient communities. Implementation of the frameworks attempt to make the best use of existing community-based programming tools and inclusive joint assessment tools (such as VCA, CBHFA module 3, and PHAST) with simple indicators for cross-sectoral planning.

An example is the integrated health model with CBHFA and PHAST, which in one model could be implemented in a sequential manner, implementing CBHFA first and then introducing the PHAST cycle (Figure 1).

Figure 1: Sequential integration of CBHFA and PHAST



³ Acute respiratory infections
⁴ Household water treatment and safe storage
⁵ Community-based management



The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.

For further information, please contact:

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