

Community Based Health and First Aid in DPRL – final evaluation



8 November 2013



TABLE OF CONTENTS

ACKNOWLEDGMENTS 3

ABBREVIATIONS 3

EXECUTIVE SUMMARY 3

BACKGROUND 5

KEY FINDINGS AND RECOMMENDATIONS 7

OVERALL CONCLUSION 19

KEY RECOMMENDATIONS 19

ANNEXES 21

ACKNOWLEDGEMENTS

The evaluation team would like to thank the DPRK Red Cross Society for assistance during the evaluation, especially the health unit members Dr Kim Chol, Mer Ri Un Hye, Mr Ma Gyong Il who accompanied the team in the field and endured the bumpy roads and tire breaks together with us. The IFRC delegation in Pyongyang was always willing to assist and discuss. Mr Jari Koironen and Mr Kim Yong Nam joined in the field trip and spent long hours dealing with details with us, Ms Marianne Steinberg and Ms Pamela Maston provided ideas for integration with WatSan and DM and Mr Imran Husain assisted with the budget considerations. Freshly arrived HoD Mr Kari Isomaa ensured that we had access to all available support. Thanks also for RHoD Martin Faller and regional health delegate Hong Chen for taking time with us for debriefing dinner in Beijing.

ABBREVIATIONS

ARI	Acute Respiratory Infection
BCC	Behavior Change Communication
CBDRR	Community Based Disaster Risk Reduction
CBFA	Community Based First Aid
CBHFA	Community Based Health and First Aid
DOP	Developmental Operational plan
DPRK	Democratic People's Republic of Korea
DPRK RCS	DPRK Red Cross Society
EU	European Union
FA	First Aid
HHD	Household doctor
HQ	Headquarter
IFRC	International Federation of Red Cross and Red Crescent Societies
LTPF	Long Term Planning Framework
MNCH	Mother and Newborn Child Health
MoPH	Ministry of Public Health
NS	National Society, refers to DPRK Red Cross Society
PMER	Planning, Monitoring, Evaluation, Reporting
VNRBD	Voluntary non-Remunerated Blood Donation
WFP	World Food Programme

EXECUTIVE SUMMARY

The health and care programme of the Red Cross Society of Democratic People's Republic of Korea (DPRK) is led by the Health and Hygiene Policy from 2008 and the National Society Development Strategic Plan 2015 as well as Strategy 2020 of the International Federation of Red Cross and Red Crescent Societies (IFRC).

Community-Based Health and First Aid (CBHFA) is Red Cross Red Crescent approach empowering communities and their volunteers to take charge of their health. In DPRK context the approach builds on the existing community based network of volunteers and first aid posts and strong links with primary care facilities.

Red Cross Society health programming has undergone several reviews to reflect learnings and provide further guidance. The current evaluation is focused on evaluating the on-going community based program using CBHFA approach implemented by DPRK Red Cross Society since 2010 and supported by IFRC through annual appeal (funded by the Finnish Red Cross/Finnish Government).

The evaluation took place from 11 to 20 October 2013, with in-country visit from 12 to 18 October 2013 and covered a period of 2010-12, from the onset of CBHFA approach (together with European Union funded hospital support project).

According to the terms of reference of the evaluation, the objectives were:

- Review the effectiveness, efficiency and relevance of the project by reviewing the outputs achieved in relation to inputs provided, and the outcomes achieved as a result of project outputs delivered to date.
- Review how the CBHFA approach has been modified to local context and how the community-based approach has been implemented in the project communities?
- Provide recommendations for further improvement in the design, delivery, quality and resourcing of the project to increase effectiveness, efficiency, relevance or impact

The evaluation team covered 2 counties in South Hamgyong province, visiting beneficiaries, first aid posts, two Ri clinics and county hospitals as well as observing a community health promotion session by volunteers. The field visit covered only a fraction of the altogether 20 counties where CBHFA is being implemented or seriously planned.

Altogether, the evaluation team conducted semi-structured and in-depth interviews with 21 key informants, representing different levels of stakeholders and complemented observations and findings with a desk review of relevant materials.

The evaluation team found that CBHFA approach is highly relevant in the remote areas in DPRK but it needs to be properly adapted to fulfil all CBHFA minimum seven requirements. The program components were found to be appropriately adapted into local context, including translating health promotion material and using local health knowledge (herbal medication) as part of the messaging.

Evaluation team had difficulties to analyze the true coverage of the program implementation as the information provided was mainly on the trainings performed in each county. The selection criteria of the target counties were based on vulnerabilities but due to the unavailability of data this could not be verified or compared with other counties.

The evaluation team findings during the field trip do not support strong program efficiency. Personnel cost was 41% of the budget but the health staff time was mainly allocated to other health programming like medical distributions and EU program monitoring in 2010 – 2012, less time was spent to support the quality of CBHFA programming. Supplies provided in the program do not contribute directly into community actions, which is a key element in the CBHFA approach.

The effectiveness was hindered by variety of different outcomes and indicators for CBHFA program during the years resulting in non-existent solid logframe and plan of action. Introduction of IFRC long term planning framework 2012-15 contributed into this as the system does not encourage program specific plans.

The impact of the program cannot be determined as the baseline results from March 2012 study were not released from MoPH and thus endline exercise was not performed. Observations in the field revealed positive changes in e.g. decreasing incidence of diarrhea and less household doctors' visits due to first aid posts.

The management of the program from HQ suffers from shifting of personnel and heavy task load with other health programming, especially medicine distribution.

Based on these conclusions and its key findings from the evaluation, the team provided a total of 12 key recommendations for the Red Cross Society of DPRK and the IFRC country delegation to follow up during the next one to two year period. Key recommendations and immediate actions can be found at the end of this report.

BACKGROUND

This evaluation is focused on evaluating the on-going community based program using Community-based health and first aid (CBHFA) approach implemented by DPRK Red Cross Society and supported by IFRC through annual appeal (funded by the Finnish Red Cross/Finnish Government).

Community based first aid program (CBFA) was running in DPRK prior to introduction of CBHFA approach in 2010. CBFA consisted of first aid services through 2500 Red Cross first aid posts and health promotion for prevention of most common diseases. IFRC supported First Aid posts with FA kits and training.

The pilot phase of the new CBHFA approach started in 2010 together with EU funded hospital equipment support in two counties (Riwon, Hyangsan) in two provinces (South Hamgyon and North Pyongan respectively). The program expanded to cover 20 counties by 2012, at some sites starting with first aid training and then planning to expand to CBHFA. The program geographical locations and number of beneficiaries is shown in the Map 1.

In addition to community based health DPRK Red Cross Society runs an extensive essential medicine distribution to county hospitals and ri-clinics under *Improvement of medical services for maternal, newborn and child health (MNCH)* -program. The distribution covers almost half of the country and has been going on for the last 15 years. However, some medical kits were also distributed through CBHFA health program as money was saved during the year and reallocated to the medicine kits at the end of the year.

Map 1. CBHFA sites and beneficiaries in DPRK.

The evaluation took place from 11 to 20 October 2013, with in-country visit from 12 to 18 October 2013.

For the purpose of the evaluation is to cover the period 2010-12 since the EU funded project review (beginning of 2010), which also reviewed the CBHFA pilots in two locations (in Riwon county and Hyangsan county). The last DPRK Red Cross Society's health related review was in May 2009. The review findings and the NS response to them is annexed (annex 1).

The terms of reference for the evaluation team is in annex 2.

Evaluation team members:

1. Hannele Virtanen, Senior Health Advisor, Finnish Red Cross (Team Leader)
2. Terhi Heinasmaki, AP Zone Health Coordinator, (IFRC Asia Pacific Zone office)
with
3. Dr Kim Chol, Health Director, Red Cross Society of DPRK
4. Mr Ma Gyong Il, Health Officer, Red Cross Society of DPRK
5. Mrs Ri Un Hye, health coordinator
6. Mr Kim Yong Nam, IFRC health officer
7. Jari Koironen, Health Delegate, IFRC DPRK delegation

The evaluation team covered 2 counties in South Hamgyong province, Riwon and Hamju, the first one being one of the pilot counties and the latter a new site selected in 2012. During the field visit the team visited beneficiaries, first aid posts, two Ri clinics and county hospitals as well as observed a community health promotion session by volunteers

Altogether, the evaluation team conducted semi-structured and in-depth interviews with 21 key informants during the review, representing the views and opinions of Ministry of Public Health, the central and local health authorities, medical practitioners, DPRK Red Cross at headquarter, provincial and county branch levels, RC volunteers, program implementing staff (in DPRK Red Cross Society and IFRC country delegation), and international organizations (WFP) the country. Three members of community were interviewed in detail and one focus group discussion with 20 participants was held during the health promotion session.

Methodology used:

- Desk review of relevant documents: previous reviews, strategies, annual IFRC reports and health delegate reports as well as available external reports
- Key informant discussions (internal to RC):
 - DPRK Red Cross branch senior management and relevant technical staff at different levels (provincial and county/city);
 - DPRK Red Cross volunteers (individual discussions)
 - DPRK Red Cross national headquarters, senior management and program staff
 - Current and previous IFRC health delegate in Pyongyang
 - Finnish Red Cross program officer in Helsinki
 - Finnish Red Cross funded health delegate
- Key informant discussions (external):
 - Ministry of Public Health of DPRK;
 - Local health authorities at provincial, city/county and Ri levels;
 - Household doctors;
 - WFP representative in Pyongyang.
- Discussions with community members who benefited through these programs.

Constraints and limitations:

- Overall, the evaluation time was short but went smoothly. The preparations by the National Society for the field visits were well done. Interviews with community members were well arranged and the interaction with them was more relaxed than appears to have been in previous reviews. The staff in Pyongyang did their best to produce the relevant documents for the evaluation team.
- The main limitation relate to the unavailability of key documents like specific CBHFA plan of action, PMER system and budget. This is partly a structural issue as the introduction of LTPF and DOP were seen as plans. However, they cannot replace detailed project plans and budgets. Baseline results were not released from MoPH after the study was performed in March 2012 and the impact of the program can therefore not reliably be measured.
- The distances covered for the field visits were long, and most of the time was spent in a car on challenging roads. Tires were repaired three times during the trip. There was a small accident with a local bicycle rider, who was taken to a health post as the IFRC cars did not have first aid kits.
- Due to time constraints, the team did not visit the other provinces (South and North Pyongan) where CBHFA has started.

KEY FINDINGS AND RECOMMENDATIONS

PROGRAMME IMPLEMENTATION

The CBHFA program was started in two pilot counties (Riwon, Hyangsan) in 2010 and during 2010 six (6) more counties in South Hamgyon province were started with CBHFA training cycle (master trainers, trainers and volunteers) in CBHFA.

In 2011 the program expanded first aid training to 12 counties in South Hamgyon and North Pyongan provinces with the idea of expanding to CBHFA, which later happened partly in some of them. CBHFA approach was also utilized in Hygiene Promotion/WatSan programming in some counties. The process of this is not clearly described in the documents received by the evaluation team and it is unclear how community assessment in the sites was done if at all.

Site selection of CBHFA counties is done on a central level between the NS and MoPH according to criteria of vulnerability that were not revealed to the evaluation team and there was also not a possibility to get comparative data for other counties against those criteria.

The topics addressed in CBHFA pilot sites were acute respiratory infections (ARI), diarrhea, nutrition and first aid. The assessment methods are not clearly described, but they are based in secondary data from the health facilities and MoPH about the most common morbidities and some level of community participation.

During the evaluation period altogether 80 people were trained in Training of Trainers workshops and 800 volunteers were trained in Training of Volunteer –sessions, which lasted 3-4 days. The volunteers received the First Aid guide, volunteer manual and record books to be used in first aid posts. Together with MoPH one household doctor (HHD) training was arranged annually and altogether 400 doctors were trained. The curriculum of the HHD trainings is not available. In addition hospitals arranged refresher trainings to Red Cross volunteers on technical topics.

A baseline study was done in pilot areas (in Riwon, Hyangsan counties) and as comparison in non- CBHFA counties Kumya and Pyongwon in March 2012 in consultation with MoPH. The

questionnaire was given to the team in Korean and it had 47 questions including demographic data and indicator questions taken from CBHFA PMER toolkit on four priority topics (ARI, diarrhea, nutrition and First aid). According to NS statistics 8087 people in 2223 households were interviewed with this questionnaire. The sample size is very big and it is questionable that all of them were ever interviewed. The baseline results were submitted to MoPH for inspection but never received back to NS and hence endline is not planned.

The medical personnel in the county hospitals reported a decrease of diarrheal illnesses after CBHFA activities started. The provincial branch in South Hamgyon came up with a decrease of 14% of diarrheal disease, but the source of this percentage is not clear. Also volunteers and beneficiaries reported less diarrheas in their communities.

RELEVANCE AND APPROPRIATENESS

Relevance

Here we have analysed the extent to which an intervention is suited to the priorities of the target group.

CBHFA approach is highly relevant approach in remote areas in DPRK. However, the approach has not adapted properly in DPRK. To increase the capacity of the RC to implement CBHFA all CBHFA minimum seven requirements should be met somehow.

According to CBHFA implementation guide these requirements are:

1. Modules 1, 2 and 3

The first three modules are required learning for all CBHFA volunteers. All volunteers should complete Modules 1 (The Red Cross Red Crescent CBHFA in action volunteer), 2 (Community mobilization) and 3 (Assessment-based action in my community) of the CBHFA *in action* volunteer manual.

2. First aid and health as standard practice

Volunteers need to know first aid. Module 4 (Basic first aid and injury prevention) teaches all the required first aid topics and all relevant topics should be included in the training for volunteers. First aid standards must be based on current guidelines of a recognized international

Body. *First recommendations on life-saving techniques* and comply with national first aid framework, guidelines and legislation where available. Community health practices must be based on WHO and/or the national standards/guidelines. It is important, however, to consider good local practices and remedies which are approved by the local health authority. It is necessary to adapt practices so that they are culturally sensitive and respect diversity.

3. Customize CBHFA *in action*

The CBHFA *in action* volunteer manual is a needs-based construction of modules and topics. Modules 1, 2 and 3 are mandatory. Additional topics will be identified by the volunteer, community members, and others through community assessments. For example First Aid topics could be selected in line with identified common accidents in the community. The duration of the CBHFA *in action* volunteer's learning will be different in each community. The emphasis in CBHFA *in action* is to create change at the household and community level over time rather than simply completing a course in a short period. To complete the content, a minimum number of hours will need to be invested every week. The facilitator and his/her volunteers, in conjunction with the branch and National Society management, may have to adjust the time and frequency of each session depending on the skill levels and the

needs of volunteers. Volunteers must be equipped with the skills and knowledge required for the tasks that they are asked to perform.

4. Empower household groups

CBHFA *in action* volunteers will help form household and community groups consisting of their own household and neighboring households. The volunteers will promote injury and disease prevention, healthy lifestyles and positive behavior changes through regular visits using the community tools.

5. Integrate learning and action

Volunteers will engage in relevant community activities and projects. Project work and community activities can, and should, coexist with ongoing learning. In other words, as the volunteers are learning the content in the volunteer manual, they may also be performing activities and project work in the communities, putting into effect the “learning by doing” approach.

6. Adapt to crisis

During a natural disaster, health emergency or an epidemic the CBHFA *in action* programme will stop its routine learning. The facilitator, supported by additional professionals, will facilitate learning sessions from the appropriate topics of the volunteer manual or other sources related to the crisis. Under supervision, volunteers will assist in the emergency.

After the crisis, the facilitator will help the volunteers reflect on the experience and the learning process that they experienced. The routine CBHFA *in action* volunteer learning programme will be resumed.

7. Focus on impact

The CBHFA *in action* aims to reduce community vulnerability due to disease or disaster. Programme managers and FRC staff should ensure that monitoring and evaluation mechanisms are established. National Societies are encouraged to use global indicators toolkit “PMER toolkit for CBHFA”. By using baseline and endline surveys we can demonstrate the positive health differences, which the CBHFA *in action* is making in the communities.

DPRK Red Cross Society has succeeded in implementing first 3 requirements at the certain point. However, the rest of the seven requirements are not well met, especially the issue of the integrating learning and action and focusing on impact.

As a part of this program Red Cross runs First Aid posts, which provide treatments and first aid for minor health problems. They also serve as focal points in Red Cross disaster management programs. Evaluation team found these services highly relevant in the DPRK Red Cross

context and services provided helped also official health structures workload.

In terms of Ministry of the Health strategy and National Society’s strategy the approach is very relevant. More over the approach is fully in line with the Finnish Red Cross international strategy and Ministry of Foreign Affairs development framework. The approach fits also well in the Federation Strategy 2020. However, although the approach itself is relevant the implementation of the approach is weak and thus weakened the overall relevance of the program. . The DPRK RCS health program is a combination of different components from the relief programs like distribution of medical kits and some components of CBHFA approach. Medical kits, First Aid materials, blood donor recruitment materials are content wise relevant for the people, although they are not part of the CBHFA. These items also complement the MoH services in their weakest areas. Household doctors training, which is not normally included into the CBHFA approach complements also well the MoH work. The different health program components should be clearly defined in implementation to avoid CBHFA absorbing functions from other programs and being itself not well implemented.

Beneficiaries were selected by the government and Red Cross provincial officers. Counties were selected by the local authorities taken into the consideration other players in the similar area. The evaluation team is not in the position to give any justification about the relevance in regards of beneficiary selection.

Appropriateness: Here we analysed how different interventions within this project are tailored to local needs and context, and compliments other interventions from other actors.

All components of the program were adapted into the local context. Health promotion material were translated and adapted with the help of MoPH. Some of the health messages were adapted up to the extent which could be questionable in western medicine like health promotion of acute respiratory infection included an advice to use garlic in treatment (this advice was not written in the volunteer book, but disseminated during health promotion sessions). However, this doesn't make any harm and might help in some way, but at the same time the key messages of prevention (respiratory hygiene) was not included, which weakened the overall performance in health promotion. All medicines included into the program were basic medicines and appropriate to the needs complimenting health institutions efforts. Household doctors' trainings focused also on basic health problems in the DPRK context. Furthermore the First Aid post services met well the immediate first aid needs of the community members.

There have been no major changes in DPRK context which could have put pressure to change the implementation strategy during the program span. Even the positive prospects of government capacity to contribute more in kind to support health institutions didn't take place.

COVERAGE

Coverage refers to the extent population groups are included in or excluded from an intervention, and the differential impact on these groups. Evaluation of coverage involves determining who was supported by humanitarian action, and why.

Evaluation team had difficulties to analyze the true coverage of the program implementation as the information provided was mainly on the trainings performed in each county. For estimation of the selection criteria the field visit was not broad enough and the number of the beneficiary interviews was low. However, according to key informants target areas were chosen based on governmental and provincial authorities' recommendations. According to the recommendations, targets were chosen because no one else supported these areas and people living in the area were poor and health institutions were not in the best conditions. Poor people were defined to be those ones working in the farming section, being single headed households, having many children and owning no animals. In some locations there are more poor families than in the other locations. However, due to the unavailability of the data the evaluation team couldn't verify in any way at what extend the selected areas were considered to include more poor people or less healthy people than other areas.

EFFICIENCY

In this section, we consider the extent to which results have been delivered in the least costly manner possible.

The total budget of the CBHFA program 2010 – 2012 through IFRC appeals was 1'408'539 CHF. The total share of funding allocated from EU was CHF 210'856, which counts 15 % of the total budget. This allocation was contributed towards 2011 and 2012 activities covering non- delegate costs. Main funding resource was Finnish government with small contribution from the Finnish Red Cross. Please see the breakdown of expenditure by major categories in Annex 3.

41,1 % (CHF 583'717) of the total budget was spent to personnel cost, main part of the funds went to cover health delegate costs (salary and in-country costs). Funding covered also salaries of 23 National Society health staff, most of them were in the payroll around 3 to 4 months per year. Second biggest share of the budget 22,6 % (CHF 318'832) went to supplies including printing of new CBHFA manuals, First Aid kits, medical kits, household doctor's books, blood donor materials etc.

The evaluation team findings during the field trip do not support strong program efficiency, indeed the efficiency is very weak. Health delegate working time was mainly allocated to medical distributions and EU program monitoring in 2011 – 2012, less time was spent to support the quality of CBHFA programming. National Society health team has done few coaching visits on the county level. Most of the visits relate to the training activities on the provincial level. Workshop and exchange visits abroad do not seem to contribute into the improvements on health programming. In terms of supplies most of the supplies do not relate to the community actions, which is a key element in the CBHFA approach. However, supplies section covers also the printing of new CBHFA materials, which is an essential element in the program.

The breakdown of different budget lines in 2010 was as follows:

In 2010 main budget lines were also personnel (CHF 228'190) and supplies (CHF 168'886). In 2010 the printing of CBHFA materials took place contributing into supplies. Total budget in 2010 was CHF 534'323.

Breakdown of 2011 budget

In 2011 supplies totalling CHF 133'283 including medical kits, First Aid bags, blood donor recruitment materials were included into the budget although most of them do not relate straight on CBHFA program. The total budget of 2011 was CHF 514'859.

The breakdown of 2012 budget is as follows:

In 2012 the share of supplies (CHF 16'663) was decreased as most of the hardware components were distributed during 2 previous years. The allocation for trainings and workshops was high (CHF 88'929) as it included household doctors 2 weeks trainings, which were funded through EU funded program in 2010 and 2011. These trainings were highly valued in EU program final evaluation. However, this is not considered normally as a component in the CBHFA programs.

EFFECTIVENESS

Effectiveness refers to the extent that the work has or is likely to achieve it's intended, immediate results.

The evaluation team couldn't analyse the effectiveness as the 3 years program didn't have any overall 3-year plan, CBHFA specific logical framework nor plan of actions. Furthermore the program monitoring, evaluation and reporting system (PMER) didn't exist despite of the fact that CBHFA tools have all these included and delegates and National Society health staff attended several workshops. The evaluation team found different kind of outcomes with some output indicators for every year IFRC webnet. These outcomes were mainly as a part of bigger IFRC DPRK appeal document, which should have as annexes individual logframes for each program, but these logframes were not found. Introduction of IFRC long term planning framework 2012-15 contributed into this as the system does not encourage program specific plans.

According to the evaluation team ToR the team was expected to evaluate following outcome and outputs:

Outcome: The capacity of DPRK RCS in building community safety and resilience through integrated community base approach is improved.

Outputs: The DPRK RCS staff and volunteers are trained in the use of IFRC community based tools and methodologies, adapted and applied to local context. Health and First Aid knowledge in CBHFA targeted communities is improved.

The above-mentioned outcome is more a goal than an outcome as the issue of safety and resilience include broad branch of different components, which need to be defined before starting the program. However, even if we take the outcome as it is we can clearly say that it was not reached as no integrated programming were observed on the field level or at the planning state. About the outputs the evaluation team can verify that staff and volunteers were trained on issues mentioned in the output. However, the team do not see training as a sufficient output in absence of program plan documents. On volunteer work level the guidance books (First aid guide, Volunteer manual) were translated and used in practise, which increase the positive side of the findings. The quality control of the use of the tools was also totally missing as well as the proper monitoring system. The other output in knowledge level has been in some extent reached as during the interviews people were able to demonstrate some good practises.

The findings in desk review of appeal documents confirm that all the activities included into the CBHFA program were also a mixture of CBHFA program components and former health relief program components. Some components were not mentioned in any documents and were most probably included into the program at the end of the year when the positive financial balances gave pressure to use the funds for example medical kits or blood donor recruitment materials. This kind of program management appears to be very unprofessional and non-acceptable as we as a Movement do have good tools for the quality monitoring and this issue has been taken up in the previous two DPRK health program evaluations (in 2009 and 2011). More over this program has allocated money for delegate and NS staff trainings. People attended trainings and exchange visits, but the knowledge from those was not cascaded into the program level. Only after Bangkok CBHFA workshop in 2011 the evaluation team could find evidence, that PMER workshop was held to the staff members in DPRK using the learnings from the workshop. The baseline survey was also done following this workshop. Otherwise the learnings did not go beyond the workshop i.e. putting in place a comprehensive monitoring system.

The amount of money used in this program was about 1,4 million CHF, which makes this sad finding even more sad. This needs actions from all players of the program including Finnish Red Cross HQs staff. There is an urgent need to look at the procedures of releasing funds for the programs against certain documents. The evaluation team believes that due to the other big health programs in DPRK like medicine distribution and EU funded hospital program, the efforts of monitoring went to those programs instead of CBHFA.

Unexpected Benefits

The evaluation team found that the First Aid posts play a key role also in disaster management as centres of social mobilisation.

IMPACT

Evaluation team was not able to verify the impact of the program as no baseline nor end line was done or results released. Baseline was collected but never released as Ministry of Health were not confident of the survey tools and methods. However, according to the limited number of the beneficiary interviews done by the evaluation team the impact results were observed. Beneficiaries reported that the number of the diarrhea case has decreased during the program time. According to the provincial Red Cross director diarrhea incidence has decreased by 14 % during the program time. Evaluation team question the impact results because no hard ware was included into the program and health promotion only is very often not enough to lead to impact. Also, no data was shown to back up the percentage.

During one volunteer health promotion session the team found that the messages delivered were not according to the CBHFA message guideline. In this case volunteer advised community members to use garlic to treat (and protect from) respiratory infections, but no information was given about respiratory hygiene as prevention method. Nutrition was addressed mainly on hygienic measures in the kitchen; no advice on e.g. nutritious foods was given.

PROGRAMME DESIGN AND MANAGEMENT

Design

CBHFA approach enlarges the previous CBFA to address also priority health needs in the community. The EU project in 2009-10 offered a suitable channel to pilot the approach in the same counties. CBHFA toolkit was translated in Korean, printed and disseminated in trainings. IFRC health delegate attended some of the trainings and coached her counterparts.

Management

The program is managed by the DPRK Red Cross health department at the national headquarters. IFRC DPRK health delegate, East Asia regional health manager and AP zone health coordinator provide technical support. Programme officer and relevant staff (i.e. regional representative, sectoral advisors) in Finnish RC monitor the funding issues together with DPRK delegation.

The NS health department is currently staffed by a staff of 10. The health director and one health officer are directly responsible for the implementation of CBHFA. Six monitors from HQs follow up the medicine distributions and are supposed to monitor also community based health program, when time allows. It appears that time rarely allows and the time of HQ staff is scarce for proper monitoring of CBHFA program.

The previous health manager was replaced in 2013, but the new one is familiar with CBHFA. The health coordinator and health officer are new to the post (2013) and have no health background. High turnover of staff has potential of affect negatively on the quality of the program implementation. The IFRC health delegate was changed in mid-2010 so the evaluation period was almost entirely covered by one delegate. However, the delegate needs to leave the country every 6 months for 4 weeks due to the visa arrangements, which disrupts the support given.

The provincial and county level Red Cross branches arrange the trainings of trainers and volunteers and compile the reports from volunteers.

The NS and the IFRC delegation coordinate with other organizations on a regular basis in Pyongyang interagency meetings. The organisations working in similar field in the country are such as the UNICEF, WHO, UNFPA, WFP and Save the Children. They also keep regular coordination meetings with the MOPH.

MONITORING AND REPORTING

Outcome and indicator definition

Monitoring and evaluation were found to be key obstacles in the program implementation. First of all there was a variety of CBHFA outcomes, outputs and indicators in different documents. The following gives an outline of all of them.

The health and care logframe 2009-10 sets the outcome and indicators of CBFA as follows:

Outcome: *Communities are able to cope with and prevent deterioration of health and accidents through increased community based health promotion and first aid service at 2,500 first aid posts around the country.*

Indicators:

- 2500 Red Cross first aid posts operational with the provision of first aid refill kits
- 40 Red Cross trainers and 400 volunteers trained on updated CBFA knowledge and skills
- 200 Red Cross youth members trained in FA skills and equipped with first aid materials.
- Updated CBFA skills and knowledge informed to Red Cross branches and volunteers by distributing 200 CD and 5000 manual on first aid
- CBFA project reviewed

In 2011 annual report outlines the outcome of CBHFA as: *Communities and volunteers are prepared and able to respond to health and injury priorities in the communities by increasing their capacities.* The evaluation team had no access to the 2011 plan or logframe and has to assume that they do not exist.

The IFRC Long-term planning framework (LTPF) was introduced in 2011 and it groups community based health under Business Line 3: To strengthen Red Cross contribution to development. This business line contains other long-term developmental programs aside of health such as community based DRR (CBDRR), water and sanitation, voluntary non-remunerated blood donation (VNRBD) and organisational development (OD).

The LTPF 2012-15 for DPRK has a separate outcome (2) for CBHFA in business line 3: *The capacity of DPRK RC in building community safety and resilience through community-based health and first aid approach is improved.* It also lists two outputs and their targets:

Output 1: DPRK Red Cross staff and volunteers are trained in the use of IFRC community based tools and methodologies and have adapted and applied them to the local context.

Target: by 2015

- 20 % of RC branch officers are trained in PMER
- 90% of trained CBHFA volunteers active in targeted communities

Output 2: Health and First Aid knowledge in CBHFA targeted communities is improved

Target: by 2015

- % care takers of children under 5 years of age that can correctly identify at least 3 ways to prevent ARI
- % caretakers that can correctly identify at least 3 key signs of dehydration
- % caretakers with children under 5 years of age that can correctly identify at least 3 critical times to wash their hands.
- % people know basic steps of first aid in case of bleeding and burning

LTPF 2012-15 has a logframe where CBHFA activities are listed and can be considered as a plan:

- Conduct annual joint assessments and monitoring together with DM, health and watsan teams for joint selection of target communities
- Update, reprint and distribute 200 CBHFA manuals, based on review outcomes
- Train annually 20 trainers and 200 volunteers on updated CBHFA package
- Participation of 2 NS staff in international CBHFA meeting/workshop
- Conduct review of CBHFA programme every 2 years
- Conduct CBHFA baseline and endline survey in 2 pilot counties
- Exchange visits/workshops for CBHFA volunteers and trainers
- Training of provincial/county branch health officers on PMER tool kit and BCC

LTPF is further defined by annual Developmental Operational Plans (DOPs) with logframes and work plans. The evaluation team had access to logframe in 2012, which surprisingly lacks the LTPF outcome 2 mentioned above, which has been modified into a larger resilience outcome: *DPRK RC recognized as a valuable and integral actor in building community safety and resilience*. From different documents three indicators for CBHFA could be found

- # of people representing a social group or institute actively contribute to community assessments (VCA/CBHFA).
- # of volunteers trained in CBHFA package
- # of health sessions conducted by trained volunteers

According to previous health delegate she and the previous health manager in DPRK RCS prepared a 4 years plan. However, the evaluation team could not find it.

Due to confusing amount of outcomes and indicators the evaluation team is following the outcome and outputs set in the ToR:

Outcome: The capacity of DPRK RC in building community safety and resilience through integrated community base approach is improved.

Outputs: The DPRK RC staff and volunteers are trained in the use of IFRC community based tools and methodologies, adapted and applied to local context. Health and First Aid knowledge in CBHFA targeted communities is improved.

Monitoring

The volunteers in FA posts monitor their work with volunteer record book, which still has not been translated into Korean officially. They report to volunteer leaders, who then pass reports to the county RC branch when feasible.

The provincial branch attempts to visit the counties on a quarterly basis for quality control. The HQ staff visits branches mainly during trainings. The quality control visits from HQ have been scarce and not regular. The HQ officers responsible for health have been busy with other health programs, especially the medicine distribution and have been changed often so that overall monitoring of CBHFA implementation has been partly overlooked.

Reporting

The volunteer records are collected to provincial branch, where the information should be transmitted to HQ by telephone, but it is unsure whether this was regularly done. The branch level reporting was not presented to the evaluation team and the provincial level reports were received later on by the HQ health officer but not translated to the evaluation team.

In IFRC level the program has no separate reporting format for CBHFA as long term community based programs are all merged in resilience approach in LTPF and DOP. The IFRC county delegation produces technical reports which are done against the business lines, which are the building blocks for LTPF. This means that CBHFA activities need to be extracted from general health and resilience programming. Reporting is regular on monthly, semi-annual and annual basis. The financial reporting is carried out by the finance and administration delegate of the IFRC country delegation.

Previous health delegate conducted PMER training with her counterpart.. According to the staff members they were very keen on the topic. However, the establishment of the PMER system never took place as the previous counterpart moved to another job.

The latest review recommendations were elaborated with the HQ health staff. The NS acknowledges that improvement has happened in all key recommendation areas but there is room for improvement.

Finnish Red Cross program officer finds the existing IFRC planning and reporting challenging as it is difficult to meet the Finnish Red Cross and back donor planning and reporting requirements with the existing IFRC-standard planning and reporting documents. This applies to reporting of all principal aspects of the programme design (incl. the indicators). More over e.g. the reporting of cross cutting issues is also difficult. It must be noted that this is a general problem shared by many other IFRC multilateral operations and not limited to the operation in DPRK.

CROSS CUTTING ISSUES

Gender:

During the field visits the team learned that majority of the volunteers are females, as they are more often available for voluntary work. This likely reflects the Korean cultural perceptions that the care and nursing jobs are more appropriate to be done by women than men. Programs containing more hardware like the water piping in WatSan attract more male volunteers.

Reproductive health issues were discussed in hospitals and clinics. While the medical staff did not come forward with specific needs in reproductive health, e.g. stating that maternal mortality in the visited sites was non-existent; the statistics from elsewhere claim that maternal morbidity is still high in DPRK. For example, the WHO Country Cooperation Strategy estimates *maternal mortality* to be between 90 and 390 per 100,000. UNICEF states that the MMR in 2002 was still 87/100,000, which was higher than the figure for 1993 (54/100,000). The reconfirmation report of census of 2009 indicates that MMR is 85 per 100,000 live births, which is slightly lower than routine reporting data. Moreover, more than half of the maternal deaths occur at home. In the next cycle of assessment reproductive health should be given more consideration.

The gender balance of the participants of a CBHFA facilitator and volunteer trainings was not received, but according to previous reports the ratio has been more or less equal. The Red Cross branch staff members are predominantly men and during this evaluation all the branch staff members we met were men.

Environment: The program didn't include any special environmental component. However, the recycling and clean environment all over DPRK was observed.

Social inclusion: People with risk of social exclusion were not a specific target group, but the evaluation team could verify that some volunteers have taken people with disabilities and elderly people as a special target group in the community. Besides the health promotion they provided also psychological support by reading books for them and helping them in daily life.

SUSTAINABILITY

CBHFA approach empowers people in case it's properly implemented. However, in this program the community assessments were not done properly with the community members. Community action plans were also missing. The idea of the community assessment and community action plan is to involve community members properly in finding solutions for their problems. It's believed that by doing so the program outcomes would also sustain longer period. However, as we couldn't measure the extent of outcome achievements we couldn't either prospect the sustainability of the results. The sustainability of the structure of delivering program outputs is also weak as there is no fundraising component in this program and the MoH has also difficulties to fund their basic work. In certain extend the co-operation with volunteers and household doctors supports possibilities of sustainability in this component. It might still take long time before truly sustainable Red Cross program are realistic in DPRK context.

OVERAL CONCLUSION

The evaluation team couldn't verify if the program has achieved it's objectives as the overall program plan was not found. In terms of output results it's also difficult to verify the correct number of different outputs during the program span. However, it was clear that some trainings have taken place, which have resulted to different health care promotion activities as well as to First Aid services benefitting community members. All the investments done by the program are relevant for people although they are not contributing systematically into the bigger development plan. As the community assessment followed by the community actions was lacking the evaluation team could not verify the effectiveness or efficiency of the program. The selected approach is highly relevant in DPRK context thus by using the existing global tools and putting the global workshops' results in action would easily improve the overall performance of the program.

KEY RECOMMENDATIONS

1. Revise the need assessment on community level using CBHFA module 3 information. Draft the community action plan with the community members ensuring their commitment by involving them thoroughly in problem solving. Consider including people with a risk of social exclusion like people with disabilities and elderly.
2. Consider to include hardware component into the community plan of action. However, keep it clear, that community actions like health promotion needs to be a part of the hardware component (instead of just supporting services). Examples of hardware components rose during the mission: latrines, communal food process machines, gardening devise.
3. Through assessment findings revise the health topics for the next year and revise the health promotion materials needed for Behavior Change Communication (BCC). Consider to use best possible BCC materials instead of top-down health education tools. Keep the First Aid components in the program.
4. Ensure the quality control of the program by regular visits. Field visits should be done by HQs health staff and IFRC health delegate to maximize the monitoring of the

- quality issues. Provide at least 2 quality assurance visits at county level yearly on top of the coaching visits on the provincial level.
5. Start to use immediately the IFRC PMER tools, especially logical framework, indicators guide and indicators tracking sheet. Seek assistance from AP Zone IFRC PMER unit for this considering the upcoming support visits.
 6. Conduct baselines in program areas by March 2014 and endline by end of 2015 in collaboration with MoPH. Use PMER tools and ask for support from IFRC and other departments, which have successfully conducted baselines.
 7. Consider carefully which international workshops and exchange visits really benefit the program implementation. In travel reports specify the action plan for implementing the results of the workshop/exchange visits.
 8. Consider to focus CBHFA on few counties with comprehensive CBHFA tool package. This includes baseline and joint assessment with integrated program set up with other technical areas. Revise the current action plan according to assessment findings.
 9. With the rest of counties which already have received CBHFA training continue the FA post activities including health promotion with the support of Household doctors and supply with consumables. However, at the same time emphasize empowering First Aid skills at the house hold level.
 10. Organize the First Aid master training course on the National level to update skills and support the capacity building of National Society. Workshop could be facilitated by the IFRC health delegate with external support if needed. The training can also be expanded to a regional one.
 11. Conduct new internal review about the implementation of the recommendations in one year's time to recommend about the in/excluding the program into the Finnish Red Cross / government funding frame 2016 – 2018.
 12. Finnish Red Cross should ensure that all the needed documentations are prepared before releasing funding for example log frame, plan of action, budget and PMER system.

IMMEDIATE ACTIONS STEPS:

1. Conduct the community assessments and draft the community action plans.
2. Prepare and conduct baselines.
3. Establish a proper PMER system using the CBHFA tools.

ANNEXES AND LITERATURE REVIEW

Annexes:

1. Compilation of recommendations from the previous review reports
2. Review Terms of Reference



3. Break down of expenditures
4. Checklist for Interviews
5. List of key informants
6. Literature Review

Annex 1

Compilation of recommendations from the previous review report

2009 Evaluation recommendations and their implementation status by today :

1. NS should identify clearly its own niche in health promotion in non-disaster times and clarify the role of Red Cross volunteers vis-à-vis household doctors.
The RC volunteers will have more visible and clear role by equipping people with FA skills.

HHdoctors works under MoH, RC volunteers support their work especially in remoted areas. Volunteers are supplementing and supporting HHdoctors work. HHdoctors train volunteers. The topics were identified by the RC with the consultation of HH doctors.

2. NS should revisit suitability of each of its FA posts and if necessary, find some other meaningful ways to use them. The RC volunteers will have more visible and clear role by equipping people with FA skills.

Now the FA posts serve also as health promotion sites and FAiders disseminate health messages in the nearby communities. FA trainings are increased and skills among public increased since 2009.

3. The quality of training needs to be improved. Revisit the content of the curriculum at different levels, using the new manual and toolkits of CBHFA as a basis.

CBHA facilitators and volunteers manual were printed and distributed. CBHFA content and curriculums are updated.

4. PMER component of this programme needs to be significantly strengthened in the next 2 years.

2 PMERs trainings conducted and translation of some of the standard reporting formats done. Implementation is still on the way.

5. Increase the supervision of the programme and reconsider the adequacy of staffing at various levels to match such increase.

Still room to be improved.

6. Develop mid- term plan for CBFA programme, with measurable targets for programme coverage and outcomes

Annual plan done using IFRC requirements.

7. For Federation, focus its support towards this programme in fewer counties/Ris to pilot a revised model of community based health and first aid. FA kit supplies and refills to FA posts should be gradually phased out and instead, give priority to supporting the capacity building at the branch level.

2 counties were in focus to pilot new CBHFA materials. The number of the FApost has been decreased from 2500 to 1700. However, the gvt is not yet able to support FA post with the consumables.

8. Include different thematic components on malaria, TB, avian influenza, etc as a part of one comprehensive CBHFA, instead of various single –issue programmes. The programme content and community activities should be based on community assessment.

Malaria topic continues in some places with the help of MoH in line with Gvt malaria control plan. TB is now a new topic through the consultation with MoH (as partner in global fund). Community assessment needs to be improved, but some steps have been initiated already.

Annex 2

Review Terms of Reference

Terms of Reference

Evaluation of Community Based Health and First Aid programme in Democratic People's Republic of Korea

1. Summary

1.1 Purpose: To analyse and comment on the achievement of the project and review the process of implementation of the CBHFA approach in Democratic People's Republic of Korea (DPRK) country context.

1.2 Audience: DPRK RC, FRC, IFRC, MFA (Finland)

1.3 Commissioners: This evaluation is commissioned by the Finnish Red Cross (FRC) and International Federation of Red Cross and Red Crescent Societies (IFRC)

1.4 Time frame: Late October 2013

1.5 Location: DPRK

2. Background

Since beginning of 2010 the Finnish Red Cross (FRC) has been a signatory Partner to Cooperation Agreement Strategy (CAS) for DPRK. During the development framework period with Ministry of Foreign affairs (MFA), FRC has been focusing on supporting health programmes of DPRK RC, through IFRC, mainly the Community Based Health and First Aid (CBHFA). The pilot project for rolling out CBHFA activities in two target counties (Hyangsan county, North Phyongan province and Riwon county, South Hamgyong province) started in early 2010. For the new locations, the baseline survey was conducted in early 2012.

This review is focused on reviewing the progress to date the nationwide CBHFA programme of the DPRK RC, supported by the IFRC through annual appeal (funded by the Finnish Red Cross/Finnish Government).

The outcome of CBHFA programme:

- The capacity of DPRK RC in building community safety and resilience through integrated community based approach is improved

The outputs of CBHFA programme:

- The DPRK RC staff and volunteers are trained in the use of IFRC community based tools and methodologies, adapted and applied to local context
- Health and First Aid knowledge in CBHFA targeted communities is improved

3. Purpose and Scope of the Evaluation

The purpose of the evaluation is to analyse and comment on the achievement of the project and



review the process of implementation of the CBHFA approach in DPRK's country context. The evaluation will identify significant factors that are facilitating or impeding the implementation of the community-based health project and the delivery of its outcomes. Evaluation is expected to lead to recommendations and lessons learned for the future. Evaluation upholds FRC and IFRC commitment to accountability and organizational learning and will be used while programming new community based initiatives in the field of health and social services.

The evaluation will cover a period of 2010–2012 and will be conducted in two pilot project areas taking into consideration relevant time and logistics limitations. Inclusion of all participants, either directly or through their true representatives, is considered essential hence the evaluation methods will be varied accordingly to facilitate this participation.

Evaluation outcomes will be shared with FRC, IFRC and DPRK RC who in turn will take the responsibility of disseminating the outcomes to relevant interested parties. FRC will be responsible of sharing the outcome with the MoFA of Finland. The outcomes are expected to provide lessons learned and concrete recommendations to guide FRC and DPRK RC future programmes and to influence the ways of working and promote the best practice in using the CBHFA approach.

4. Evaluation Objectives and Criteria

4.1. Objectives

The main objectives of the evaluation are:

- Review the effectiveness, efficiency and relevance of the project by reviewing the outputs achieved in relation to inputs provided, and the outcomes achieved as a result of project outputs delivered to date.
- Review how the CBHFA approach has been modified to local context and how the community-based approach has been implemented in the project communities?
- Provide recommendations for further improvement in the design, delivery, quality and resourcing of the project to increase effectiveness, efficiency, relevance or impact.

4.2. Evaluation criteria and specific evaluation questions

1. Relevance

- How relevant is the project regarding the beneficiary requirements, local context and needs?
- How well was the target groups identified?
- How do beneficiaries view the comprehensiveness of package of services – training, information spreading, household visits, and awareness raising campaigns, IEC materials – offered to or directed towards them?
- How does the project compliment intervention of other actors, most importantly relevant Government departments?
- How has the project contributed to the DPRK RC strategic plans and aims?

2. Effectiveness

- Were the objectives achieved on time?
- Were the activities conducted in a planned and timely manner throughout the project?
- Were the supervision and management mechanisms on all levels sufficient in relation to project needs and expectations?
- Were quality standards defined, and are activities achieving high levels of quality in implementation?
- How satisfied with the project are project beneficiaries? What is the stakeholders' viewpoint related to the performance of the project? What are the main issues raised regarding satisfactions with the project?
- How satisfied is DPRK RC – including local branches – with the project? What are the main issues raised regarding satisfactions with the project?

3. Efficiency

- How well were the inputs (funds, people, materials and time) used to produce results?
- Has the scale of benefits been consistent with the cost?
- Cost-efficiency:
 - a) To what extend has the funding been utilised to directly assist beneficiaries
 - b) Has the project support and operational costs been reasonable (%) compared to entire budget and beneficiary assistance



4. Impact of intervention

- Did the project address the needs of all intended beneficiaries in a consistent manner as per project design?
- Did the project achieve its intended impact?
- Has there been any unforeseen or indirect positive or negative impact (to the communities, volunteers, NS)?

5. Sustainability

- Is there sufficient community ownership regarding the project?
- What are the main factors affecting, either positively or negatively, the sustainability of project outcomes?
- Do lessons from implementation of this project indicate any changes in design in the future to ensure better sustainability?

In addition, this evaluation should examine the level of gender and diversity mainstreaming i.e. how issues specific to groups of men and women of different age and social backgrounds should be taken into account in future, to ensure proper needs assessment and improve effectiveness.

5. Evaluation Methodology

The evaluation will use the following data sources:

Project proposal, log frame, budget

Project reports (quarterly, annual), monitoring reports

Baseline and end line survey results where applicable

Specific project related documentation: programmes of organised trainings etc.

Reference documents:

IFRC CBHFA framework

Methodology:

The evaluator must adopt a consultative and participative approach. Methods of data collection and analysis to be discussed and defined by the evaluation team, however they should include at least:

Briefing at the FRC, IFRC and partner NS to discuss the TOR and the time schedule

Document analysis/review; a critical review of agreed documents

Baseline and end line study comparison

Interviews with key stakeholders including HQ and project staff and volunteers, relevant authorities and other stakeholders

Field visits and beneficiary interviews

All findings should be evidence based and methodology used and possible limitations explained in the final evaluation report.

6. Deliverables

The evaluation team will provide:

1. **A debriefing on findings** - in country to the IFRC and the DPRK RC management and project staff at the end of the mission to discuss the initial findings, conclusions and recommendations.
2. **A draft final evaluation report** – after returning from the field visit. The draft will be shared with the FRC, IFRC, DPRK RC and other relevant stakeholders for comments.
3. **A final (corrected) evaluation report** - The report will have a maximum length of 20 pages, including an Executive Summary. The approval for the report from the FRC, IFRC and DPRK RC.

7. Proposed Timeline

Desk review: October 2013

In country evaluation: 11.-18. October 2013

Debriefing at the IFRC and DPRK RC in Pyongyang on to present the main findings, conclusions and recommendations: 18. October 2013

The draft final evaluation report for comments from FRC, IFRC and DPRK RC: End October 2013

Comments for the draft report during 15. November 2013

Submission of the final evaluation report: End November 2013

8. Evaluation Quality and Ethical Standards

The evaluator should take all reasonable steps to ensure that the evaluation is designed and conducted to respect and protect the rights and welfare of people and the communities of which they are members, and to ensure that the evaluation is technically accurate, reliable, and legitimate, conducted in a transparent and impartial manner, and contributes to organizational learning and accountability. Therefore, the evaluation team should adhere to the evaluation standards of the IFRC.

The IFRC Evaluation Standards are:

1. **Utility:** *Evaluations must be useful and used.*
2. **Feasibility:** *Evaluations must be realistic, diplomatic, and managed in a sensible, cost effective manner.*
3. **Ethics & Legality:** *Evaluations must be conducted in an ethical and legal manner, with particular regard for the welfare of those involved in and affected by the evaluation.*
4. **Impartiality & Independence:** *Evaluations should be impartial, providing a comprehensive and unbiased assessment that takes into account the views of all stakeholders.*
5. **Transparency:** *Evaluation activities should reflect an attitude of openness and transparency.*
6. **Accuracy:** *Evaluations should be technical accurate, providing sufficient information about the data collection, analysis, and interpretation methods so that its worth or merit can be determined.*
7. **Participation:** *Stakeholders should be consulted and meaningfully involved in the evaluation process when feasible and appropriate.*
8. **Collaboration:** *Collaboration between key operating partners in the evaluation process improves the legitimacy and utility of the evaluation.*

It is also expected that the evaluation will respect the seven Fundamental Principles of the Red Cross and Red Crescent: 1) humanity, 2) impartiality, 3) neutrality, 4) independence, 5) voluntary service, 6) unity, and 7) universality. Further information can be obtained about these principles at: www.ifrc.org/what/values/principles/index.asp

TOR prepared by

Annex 3

Break down of expenditures

2010 – 2012	CHF	%
Supplies	318832	22,6
Logistics	60448	4,3
Personnel	583717	41,4
Workshops and trainings	236619	16,8
General Expenditures	126776	9,0
Indirect Cost	66634	4,7
Pledge Specific Costs	15513	1,1
Total	1408539	100,0

2010	CHF	%
Supplies	168886	31,6
Logistics	15985	3,0
Personnel	228190	42,7
Workshops and trainings	81173	15,2
General Expenditures	8503	1,6
Indirect Cost	25814	4,8
Pledge Specific Costs	5772	1,1
Total	534323	100,0

2011	CHF	%
Supplies	133283	25,9
Logistics	43186	8,4
Personnel	211954	41,2
Workshops and trainings	66517	12,9
General Expenditures	28865	5,6
Indirect Cost	24660	4,8
Pledge Specific Costs	6394	1,2
Total	514859	100,0

2012	CHF	%
Supplies	16663	4,6
Logistics	1277	0,4
Personnel	143574	40,0
Workshops and trainings	88929	24,7
General Expenditures	89407	24,9
Indirect Cost	16160	4,5

Pledge Specific Costs	3347	0,9
Total	359357	100,00

Annex 4

Check lists for interviews

BRANCHES CHECK LIST (STAFF/VOL.)

(Give introduction to the objective of the interview – Key informants)

1. Who do you see as your main partners in this program?
2. What is the level of coordination/Collaboration with MOH/ and other partners /stakeholders with regard to the Project?
3. How is the project being monitored?
4. How do you report project progress? (Who do you report to? How frequently?)
5. What kind of training have you received for the project?
6. Lessons Learned
Ref. activities + holistically
Elaborate more on the learning aspect
7. Good practices
Ref. activities + holistically
8. Benefits of the project to the branch
9. Unexpected benefits of the project
10. Recommendations

For changes of the remaining period

For the future beyond the Project period

For replication in other chapters/communities

CHECK LIST FOR BENEFICIARIES

Moderator: Give small introduction to who you are, what you are doing and how.
Encourage the key informants to discuss freely, ensure the participants about the importance of their discussion

Beneficiaries

1. Do you know about the project that your community is doing with Red Cross? (Do you know RC principles)
Probe: Explain the type of activities you are doing with support from Red Cross
 2. What have you learnt from the RC volunteers?
What kind of activities you have done in the RC program?
 3. To what extent have these activities made a change in the community.
- When did someone in your family have diarrhea ? What did you do to treat diarrhea? Have you done any measures to prevent diarrhea? Have you seen any changes in the diarrhea outbreaks? Have discussed about diarrhea with the RC volunteers?
 Same in ARI, but added by a question of Was some hospitalized because of ARI?
 Describe your main meals. How many times you/your children eat by day?
4. Do you think the activities should continue in your community?



- (If yes, how should they continue and which one should continue and why
If no, why should they not continue
If they should not continue, what else should be done)
5. What is the biggest problem in your community ? and
 6. What new changes would you like to see in your community in the future.
 7. What do you see as a good practice
 8. How would you like to be more involved in this program and in which part of the program?

Take a walk with them and talk about CBHFA and DM issues.

Thank them for coming and for their time. Tell that it will benefit other communities

Annex 5.

List of key informants

1. Ri Ho Rim, Secretary General, DPRK Red Cross Society
2. Ryu Gi Chol, Director of the Riwon county Hospital(M/ 54)
3. So Un Hui, Head nurse of the Riwon county Hospital(F/ 30)
4. Sin Ung Gwol, Director of the Guup- ri Hospital(M/ 56)
5. Kim Jong Ran, Volunteer of First-Aid Post, Guup- ri (F/34)
6. Kim Song Ho, Farmer, Guup- ri (M/ 32)
7. Rim Ok Hui, Volunteer of Guup- ri(F/40)
8. Kim Chun Sam, Director of the Ryonpo – ri Hospital(M/ 53)
9. Han Chong Muk, Vice- chairman of Hamju county branch(M/ 63)
10. Paek Gum Hyok, RC staff of Hamju county branch(M/ 33)
11. Ryu Myong Chol, Chairman of Hamju county branch(M/ 48)
12. Mun Myong Pok, Beneficiary of Ryonpo-ri (F/ 35)
13. Ju Song Guk, Beneficiary of Ryonpo-ri (M/ 49)
14. Won Jong Chol, Secretary of South Hamgyong provincial RC Branch(M/46)
15. Kim Ju Dok, Health staff of South Hamgyong provincial RC Branch(M/60)
16. Ri Chang Hyok, Deputy director of MoPH(M/53)
17. Kim Yun Chol, National Malaria program manager(M/ 47)
18. Jong Song Guk, National staff of GF(M/39)
19. Kim Hyon Ok, National staff of GF(F/ 32)
20. Kim Un Jong, National staff of GF(F/ 27)
21. Kim Hyon, National staff of GF(M/28)
22. Hannaleena Rasanen, WFP, Pyongyang
23. Annamari Raikkola, previous IFRC health delegate in DPRK
24. Hong Chen, IFRC East Asia health manager
25. Martin Faller, IFRC East Asia Head of Regional Delegation

Annex 6

Literature Review

1. Synthesis of Federation DPRK program updates and reports for 2010-2012
2. LTPF DPRK 2012-15 and logframes



3. Findings and recommendations related to CBHFA from Federation's previous health reviews (Strategic review 2005, CBFA review 2009, WatSan review 2009, EU project review 2011)
4. Health and Hygiene Policy of the DPRK Red Cross Society, October 2008
5. National Society Development Strategic Plan 2015, DPRK Red Cross Society
6. Strategy 2020
7. Technical reports and mission reports of IFRC delegates
8. Studies: Food and Nutrition Security in the DPRK, Food Security analysis
9. Medium term strategic plan for the development of the health sector in DPRK 2010 - 2015.