International Federation
of Red Cross and Red Crescent Societies

Community Based Health and First Aid *in Action*

Internal Evaluation Report

Jordan

December 2014

من الشعب الياباني

From the People of Japan

The CBHFA Project was funded by the Japanese Government

1 Project introduction

The project 'Enabling healthy and safe living in families affected by the Syrian crisis in Jordan' was implemented through Jordan Red Crescent (JRC) with the technical support of IFRC and funding from the Government of Japan. The activities were implemented from February 2014 until November 2014 in the governorates of Irbid, Mafraq, Jerash, Ajloun and Amman. A total of 20 communities and 6,000 beneficiaries were targeted.

The Federation's community health promotion approach, community based health and first aid *in action* (CBHFA) was introduced for the first time in JRC. The CBHFA approach seeks to create healthy, resilient communities worldwide. CBHFA comprises a comprehensive approach to primary health care, first aid and emergency health preparedness at community level. It mobilizes communities and their volunteers to use simple tools, adapted to local context to address the priority health needs of a community and to empower them to be in charge of their own development and health outcomes.

Project duration

The project was implemented over a period of 9 months from the 15 February until 15 November 2014.

Objective of the project and outcomes

Objective:

The adverse effects of the Syria crisis on the health of the affected population are reduced.

Outcome:

6,000 affected people in 20 communities in the Governorates of Amman, Ajloun, Jerash, Mafraq and Irbid have improved their health and well-being through Community Health and Psychosocial support.

Outputs:

1. Community-based disease prevention and health promotion, epidemic prevention and control measures are carried out through CBHFA.
2. 2,000 refugee children and their families in three out of the five targeted Governorates have access to psychosocial health services for improved psychosocial well-being.
3. JRC/IFRC capacity in community awareness and on community-based health and first aid is strengthened.

Main activities implemented within the project

Following the recruitment of the CBHFA Project Officer, identification of the communities and selection of volunteers, the first training in the CBHFA Modules 1, 2 and 3 took place in April. Forty community health volunteers (CHVs) from the 5 governorates were provided with information about the Red Cross Red Crescent (RCRC) Movement, how to assess their communities and community mobilisation.

One of their first tasks was to undertake a mapping exercise of existing services and community based organizations in their communities. This information was used to plan the target groups and activities in each community.

Before starting their community based activities, the volunteers were trained in the main health issues identified by community members. These included personal hygiene, respiratory infections, diabetes and heart disease. They were also provided with information about immunizations due to ongoing national immunization campaigns in Jordan to prevent an outbreak of polio, as had occurred in Iraq and in Syria.

A targeted baseline assessment was carried out in all communities after which the volunteers began their community based health activities. Schools were expected to be targeted but by the time the volunteers were ready to begin activities the schools were closing for holidays from June to September. The main types of activities they carried out are outlined in the table below.

Table 1: An overview of CHV activities

Activities per CHV	No. of HH/Groups	Frequency
Household Visits	40 per CHV	One visit per HH per month
Education sessions with already established groups e.g. women, men, youth, refugees	4 groups	Once per group per month
Meetings with health committees and health facilities	2 groups (or more)	Once per group per month
Organizing and/or supporting community campaigns e.g. immunizations, healthy lifestyles	1 (overall community)	Once per month
Attending trainings/meetings at branch office	1 (at branch level)	Once per month

Throughout the project implementation period the Field Officer Assistant, CBHFA trainers and volunteers received additional trainings in Violence Prevention, First Aid, Non-Communicable Diseases, Motivation and Youth as Agents of Behaviour Change.

At the end of the project an endline assessment was done and, questionnaires and focus group discussions were the key tools used in the community evaluations. Project wrap up workshops were then held with all CHVs and branches which had participated in the project. All information was compiled and shared with JRC and IFRC headquarter staff at the final project wrap up workshop.

2 Objectives of the evaluation

- To 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.
- To review how the CBHFA approach has been modified to the local context and how the community-based approach has been implemented in the targeted communities
- To provide recommendations for further improvement in the design, delivery, quality and resourcing of the project to increase effectiveness, efficiency, relevance or impact.

Methodology of the evaluation

Baseline and endline assessments (see Annex 1 for the questions)

The baseline assessments were conducted in June and each CHV was expected to conduct 20 questionnaires with 20 households each. Prior to the start of the baseline, a meeting was held with the 5 Field Officer Assistants (FOAs) to explain the process and a handout was developed and translated into Arabic to support the CHVs. The CHVs were then given a half day workshop on the overall process of conducting the baseline assessments in their communities. Paper questionnaires were used for the baseline.

Administering the baseline questionnaire, Irbid. Photo: JRC

The questions were based on the priority health issues identified by the communities. These included high blood pressure, diabetes, body mass index (or being overweight), nutrition and healthy lifestyles and personal hygiene.

For the endline assessment, tablets were used with the Open Data Kit (ODK) software installed. ODK is a tool which enables users to create questionnaires on mobile devices which allows for faster data collection and data analysis. With support from the IFRC Information Technology and database administration officer, the 5 Field Officer Assistants (FOAs) were trained in the use of the tablets. Then the FOAs, together with all volunteers in the different branches, attended half day workshops to learn how to conduct the questionnaires using the tablets. The majority of the CHVs found the process relatively easy due to the similarity of operating smartphones.

Community questionnaires (see Annex 2 for the questionnaire)

Home visit of a Syrian woman and her children, Ajloun. Photo: IFRC

Questionnaires were administered in 6 households per community which were visited during the project time frame. This was conducted by volunteers from outside of that community to decrease the possibility of bias.

There were 5 questions in total, two of which were open ended. The questions aimed to determine the perception of the home visits by the CHVs, the range of health topics discussed during the visits, their level of satisfaction with the visits, any additional information they would have liked to have learnt about and how the visits could be improved in the future.

Community focus group discussions (see Annex 3 for the FGD questions)

In each community the volunteers were asked to conduct between one and two focus group discussions with people who had been engaged in the project. These included staff from local health facilities, health committee members, representatives from Community Based Organizations (CBOs), youth centres, school principals, participants of community groups and any other groups the CHVs engaged with during the course of their community based activities.

The questions aimed to determine the level of awareness among the participants of the focus group discussion about the JRC community health programme in their community, how they were involved, what they thought was good about the programme and how they thought it could be improved for the future. Respondents were also asked how they thought the community might be able to continue with the community health activities once the project ended.

Project wrap up workshops at branch level (see Annex 4 for agenda)

The timeframe for the project wrap up workshops was as follows:

Ajloun & Jerash Branches	Wednesday, 5 November
Mafraq and Irbid Branches	Sunday, 9 November
Amman Branch	Monday, 10 November

The workshops were facilitated by the IFRC Health Coordinator and the JRC CBHFA project officer with the attendance of a translator who provided simultaneous translation and a note taker. It was an opportunity for volunteers, FOAs, CBHFA trainers and branch managers to conduct an analysis of the strengths and weakness of the CBHFA project, both from their own point of view and their perception of the communities' point of view.

Project wrap up workshop in Jerash. Photo: IFRC

Project wrap up workshop at Headquarters (see Annex 5 for agenda)

The final workshop was held for IFRC and JRC Management on Wednesday, 12 November. It was attended by 10 staff members from within the senior management of IFRC and JRC, including the IFRC Head of Delegation. German Red Cross also had 2 representatives present due to their CBHFA project in Irbid. It was facilitated by the IFRC health Coordinator and the JRC CBHFA Project Officer.

3 Findings of the evaluation

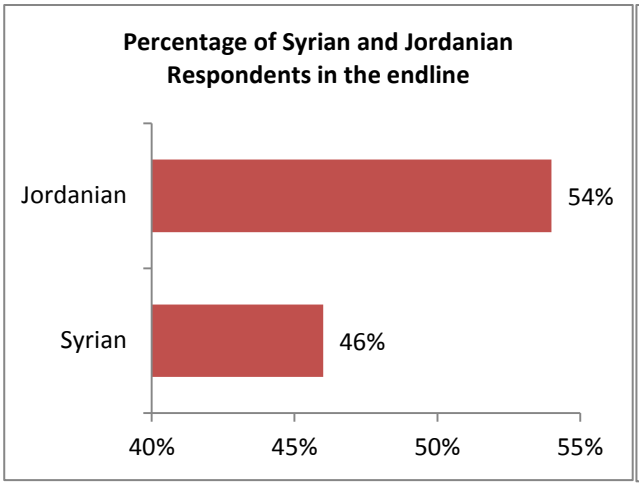
Baseline and Endline Results (see Annex 6 for the complete results)

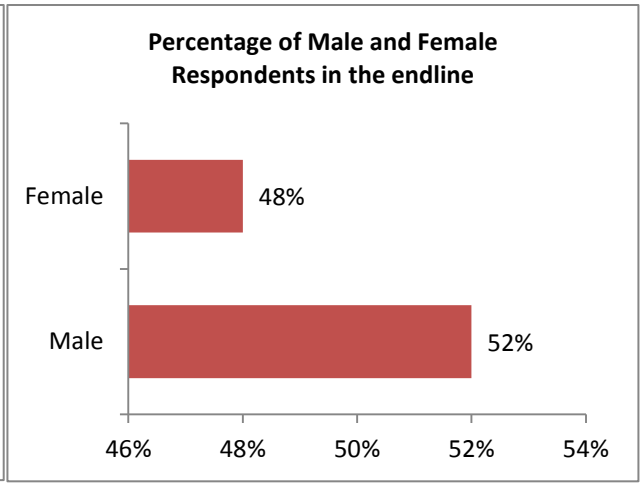
A total of 720 households were visited during the baseline assessment and 726 in the endline assessment. This was out of a possible 800 (40 households per community).

Although in Irbid there were 3 distinct communities, as all the areas were in central Irbid, the team only administered 40 baseline questionnaires out of an expected 120. However for the endline they administered 111 out of a possible 120.

During the endline assessment, in 3 out of the 8 communities in Ajloun governorate, 3 communities returned significantly less than expected completed questionnaires. This resulted in 250 questionnaires being administered out of a possible 320 for Ajloun Governorate.

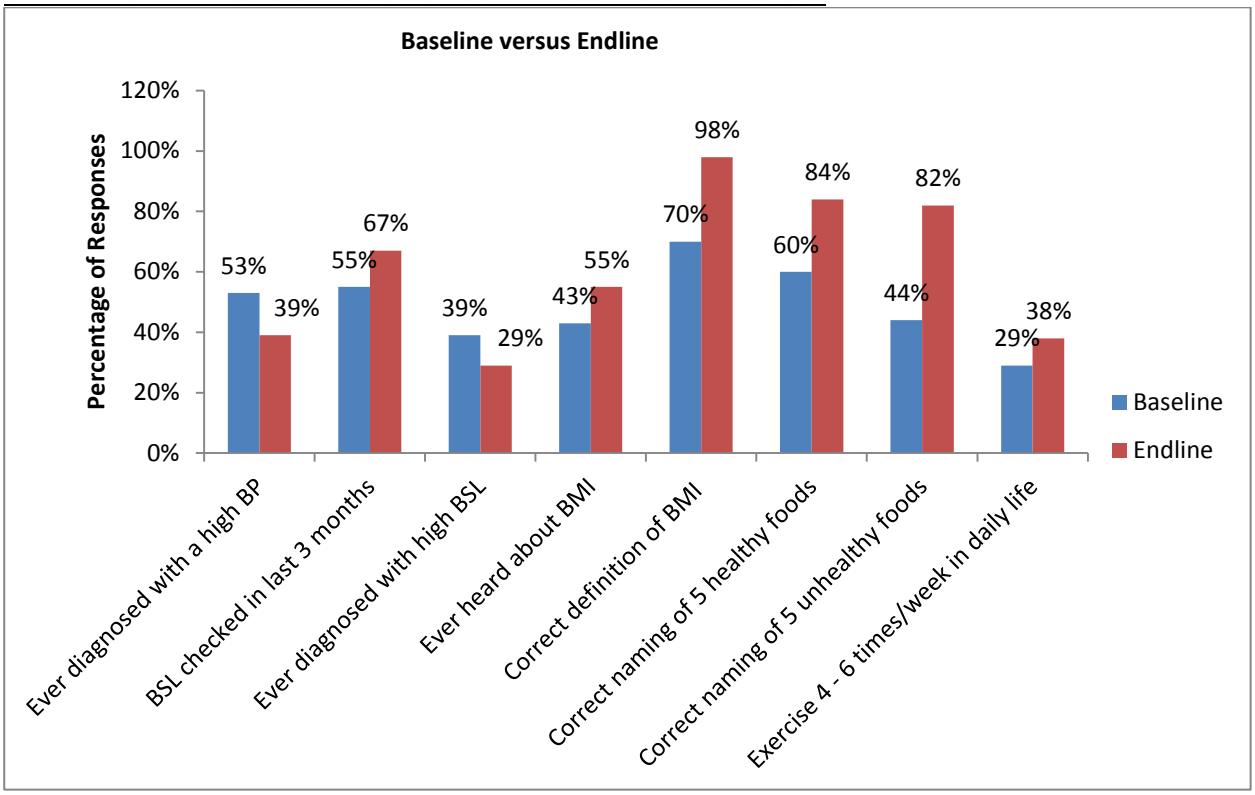
In the baseline the CHVs unfortunately omitted to record the sex and nationality of the respondents however it was recorded in the endline. Below is a summary presentation of some of the findings.





Two thirds of all respondents had had their **blood pressure** checked at least once in their life time which, whilst this is positive, it leaves one third of adult respondents who have never had their BP checked. The 14% decrease in those who had been who had ever been diagnosed with a high blood pressure is encouraging.

For **diabetes** there was a 12% increase in those who had had their BSL checked in the last 3 months and at the endline, 10% less respondents were told they had a raised BSL which was very positive.



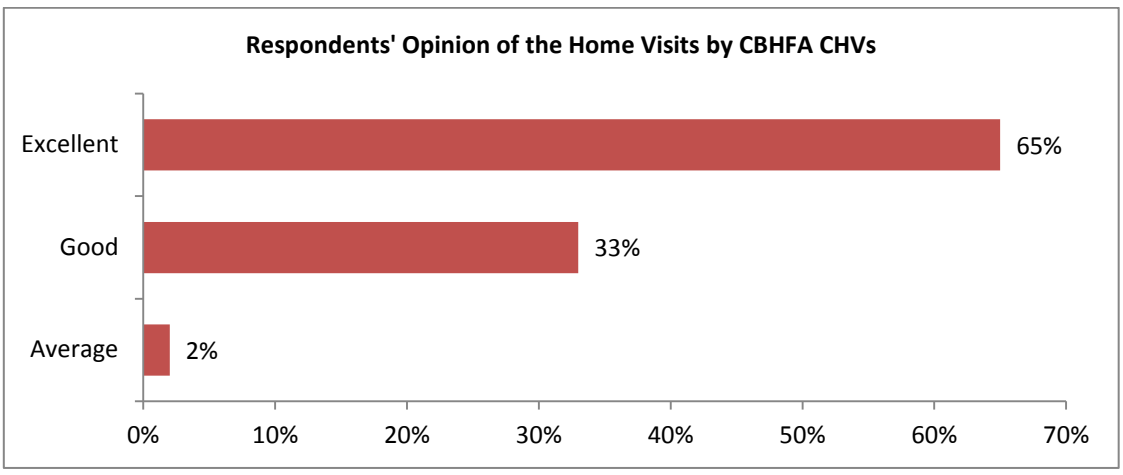
Knowledge about **Body Mass Index** (BMI) increased by 12% in the endline and the number of respondents who gave a correct definition of BMI increased dramatically by 28%. The percent of respondents who were told they were overweight also decreased from 34% to 28%.

In the **nutrition and healthy lifestyles** section, there was a 24% increase in respondents who were able to correctly identify 5 healthy foods and 42% increase in respondents able to correctly identify 5 unhealthy foods. Another positive result was that there was a 9% increase in respondents who said they exercise 4 to 6 times per week as part of their daily activities.

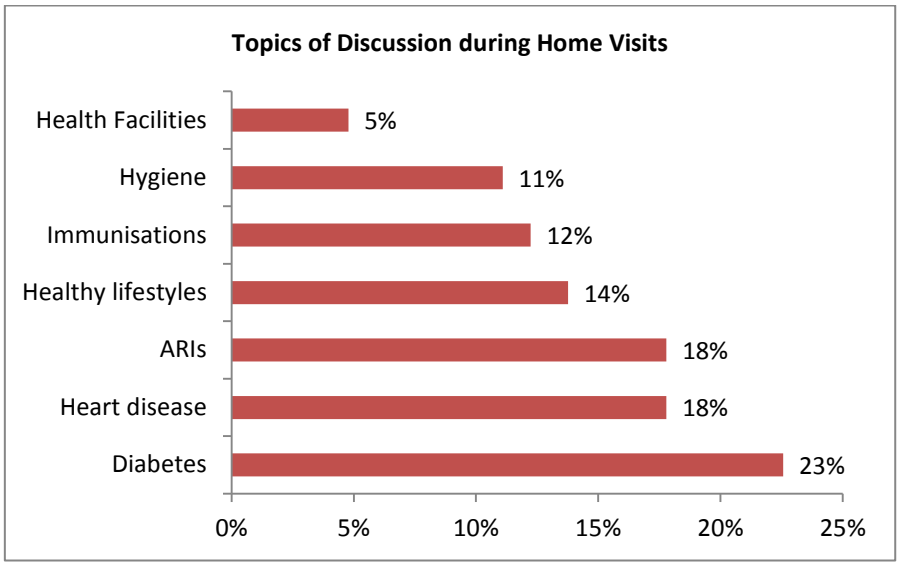
The results for the **personal hygiene** questions showed only a 1% increase in those who wash their hands after defecating but a 20% increase who wash their hands after urinating. There was an inexplicable decrease in the percent of those washing their hands before eating, from 16% to 5%, so this should be checked again in any further assessments.

Community questionnaire results (see Annex 7 for the complete results)

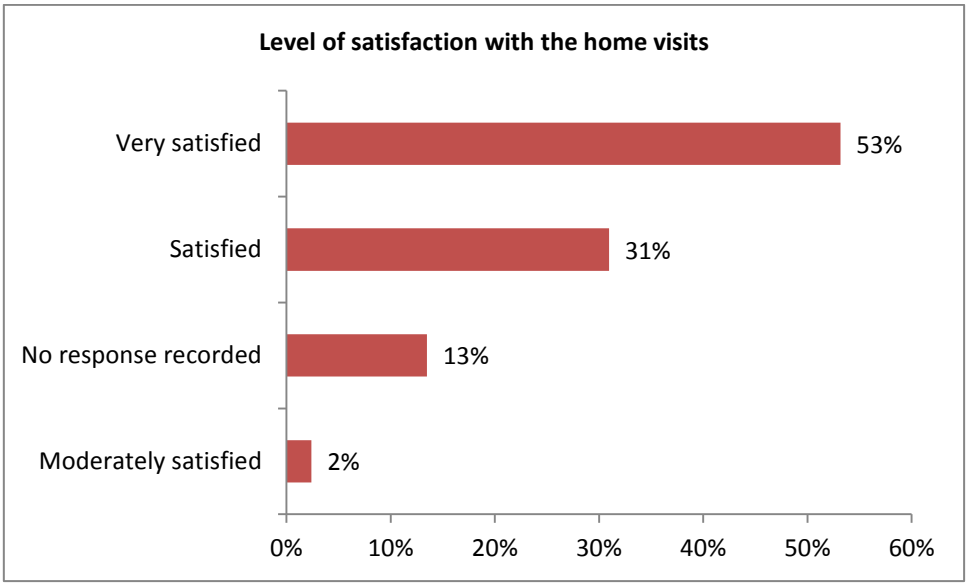
A total of 126 questionnaires were administered for all the 20 communities. A summary of the responses are below.



In response to which health topics the CHVs discussed during the home visits, the results are as below. Health facilities refers to informing beneficiaries about where they could seek care.



84% of respondents said they were either very satisfied or satisfied with the topics of discussion during the home visits as shown below.



When respondents were asked what they would like to know more about, responses varied greatly and included:

Topics beneficiaries requested to know more about:	
Cancer	First Aid
Maternal and child health	Ebola
Physical exercise	How to address discrimination between Jordanians and Syrians
Nutrition	Home testing of blood sugar levels and blood pressure

Suggestions for improvement included:

- more frequent and longer home visits,
- to increase the number of CHVs and beneficiaries
- to limit each visit to 1 health topic only

- to include schools
- to distribute more brochures with health messages

Community focus group discussion results (see Annex 8 for the complete results)

A total of 28 focus group discussions were conducted in the 20 different communities. People in the focus group discussions frequently expressed a sound understanding of the CBHFA project, stating that the project was an awareness raising project focusing on prevention methods particularly for chronic diseases, as well as community violence. The respondents reported that it also taught people how to deal with injuries and basic first aid steps for burns.

Levels of participation by community members included support for the CHVs through identification of the needs and brainstorming sessions on how to address the needs. A number of respondents also said they were involved through sharing information they gained with friends, family and relatives. One group even reported that action was taken to spray rubbish containers in the community to reduce the number of seasonal insects.

Respondents appreciated the programme for raising awareness about non-communicable diseases and how to prevent them, the importance of regular health checks, it was inclusive of Syrians and that it was a programme which reached housewives.

All respondents expressed a desire for the programme to continue and for it even to become permanent. They also requested that the programme increases the number of CHVs and beneficiaries of the programme. More awareness campaigns were deemed to be important as well as the distribution of more brochures and to expand the number of health topics covered. Interest was also expressed in exercise activities, for domestic and community violence to be addressed more, for home testing of diabetes and hypertension and to offer more than health messages.

Project wrap up workshops outcomes (see Annex 9 for summarized information)

The feedback from the volunteers in all 5 branches was very positive. They felt empowered with knowledge and skills from the many trainings and appreciated the knowledge of the trainers, many stated they felt well supported by the FOAs and JRC and they expressed that the community members appreciated the awareness activities. The CHVs also said that they felt accepted by the communities because they came from there and that they liked the fact that their activities targeted both Syrians and Jordanians. The programme helped them to identify the needs of the community together with the health committees and other community members and this helped the communities to feel involved in the overall process.

Project Wrap up Workshop, Irbid. Photo: IFRC

According to the CHVs there was less acceptance by Jordanian beneficiaries than Syrians in some communities, some beneficiaries wanted to receive donations of needed items in addition to health information, people requested to have home screening of blood pressure and blood sugar levels and that topics such as personal hygiene were not always welcomed to be discussed. Specific challenges for the CHVs were that the number of CHVs per community was insufficient, the project implementation period was short, men were sometimes harder to reach because the

CHVs mainly found women and children at home and that in some situations there was more acceptance of female CHVs than male CHVs. The CHVs also expressed a need for more psychosocial support for the beneficiaries.

4 Challenges encountered during the evaluation

The main challenge of the baseline was that of having to manually enter all the results into the database which was a very long process that subsequently delayed the analysis of the results. During the baseline data entry and analysis, it was realized that the CHVs did not document the nationality and sex of the respondents and that some questions had less responses than expected with no explanations.

Although the exporting of endline results into an excel spreadsheet was very fast, close data analysis could not take place until after the end of the project. This is because the endline assessments were immediately followed by the project wrap up workshops and the winding up of the project. Once analysis took place it was realized once again that some questions had less responses than expected. Despite the CHVs stating and demonstrating their confidence with the use of the tablets at the trainings, it was felt that had there been more time, the endline would have been conducted in one community at a time, rather than all communities simultaneously. This would have allowed the FOA for each governorate, the IFRC Health Coordinator and the CBHFA Project Officer to directly observe the process and to check the results immediately afterwards.

The final challenge which proved to be very time consuming was the combination of the baseline and endline results into one database. In the future, by using ODK for both the baseline and endline assessments, the results can be entered into the same database.

Whilst the community questionnaires were well answered, when it came to the CHVs recording responses to open ended questions, the responses were not always as comprehensive as they could have been. This was also seen in the community focus group discussion responses. Though the CHVs were trained in conducting FGDs and conducted group discussions through the project period in their communities, the skills of probing and encouraging all participants to contribute to the discussion need further development.

5 Lessons learnt and recommendations

Knowledge and skills of the CHVs and Field Officer Assistants
Trainings: to have less trainings and more space between them to give more time to the CHVs to practice their new skills and knowledge
Communication skills: to retrain the CHVs and FOAs on communication skills for use in group discussions, administering questionnaires and in home visits
Supervision: to build the capacity of the FOAs in supportive supervision, monitoring of activities, reporting and basic data analysis
Psychological First Aid: to train the volunteers and FOAs in psychological first aid to better prepare them for their field work and for them to be able to provide more support to beneficiaries
Child Protection: for CHVs to receive additional briefings on child protection issues through the JRC Psychosocial programme
Briefings of CHVs and FOAs by other agencies: to arrange briefings on available health services for refugees by UNHCR and other agencies so that the CHVs are more aware of referral pathways
Monthly follow up meetings with each team of volunteers: monthly meetings and workshops with

CHVs and FOAs will allow the headquarter staff to update volunteers on any new health topics or health issues, to receive feedback from the volunteers and FOAs and to analyse their reports together
Activities
Community sensitization meetings with community leaders: Conduct community sensitization meetings again providing leaders/community members with feedback from last year's project wrap up workshops and outcomes of the community evaluations.
Community campaigns: together with the CHVs and FOAs, design effective community campaigns to be able to deliver health information to a wider audience
Activities in schools: if additional funding is secured, an official letter should be sent to the Ministry of Education as soon as possible requesting permission for health activities in schools, such as first aid training of students
Home visits: to visit more households but less frequently unless ongoing support is required. Targeted household visits should be conducted for pregnant women and newly delivered women to support them in the pre and post natal period.
Baseline & endline assessments: to carry out the baseline assessments one community at a time with the FOAs and CBHFA project officer to support and supervise the teams. Then to review and analyse the responses all together so that everyone involved fully understands and appreciates the process.
Reporting
Redesign reporting tools: ensure that age, sex and nationality is included in all reporting formats, make them all bilingual to reduce the time required for translation and give feedback to the teams each month
Communication Lines
Clarify for the FOAs and CHVs their reporting lines: FOAs and CHVs felt they reported to both the branch manager and the CBHFA project officer and sometimes there were miscommunications.
Human Resources
Translator for workshops and trainings: It is useful for the IFRC health coordinator to have a translator when possible at workshops and trainings to be able to follow discussions and to also be able to contribute
Ratio of CHVs to FOA: as much as possible there should be a maximum of 10 CHVs to every 1 FOA or volunteer supervisors who can provide support to the FOAs. This is because the Amman FOA felt that it was a hard task to communicate with twenty CHVs.
Finance and Administration
Pre-identification of suitable training venues: if this is done at the project onset it would save time searching for suitable venues at the time of the trainings
Training of branch managers and FOAs in financial regulations: to ensure that all information is received in a timely manner with all information necessary present in the first instance, it is important to train all staff involved in financial regulations. Time was taken up requesting missing financial information at various times.

6 Conclusions

The project evaluation demonstrated the relevance of the activities to the target population. This was reflected in the positive responses in the questionnaires and focus group discussions as well and the requests for a continuation of the project, for a longer period of time and to involve more CHVs and beneficiaries.

Although the project time frame was too short to see a clear impact on behaviour change, it was very encouraging to observe some impact in positive behaviour change from the results of the endline assessment.

Branch trainings were delivered to 2 branches at a time to save on time and expenses. By making each of the volunteers part time it was possible to have 2 volunteers per community instead of just one volunteer working longer hours.

Partnership with local organizations, the Ministry of Health (MoH) facilities and other agencies working in response to the Syrian crisis was maintained through consulting them regularly for sharing of information. The CHVs supported the MoH immunization campaigns by delivering brochures announcing upcoming immunization campaigns and information education and communication materials were shared between agencies.

Project management was done by the JRC CHBFA project officer with the support of IFRC Health Coordinator and JRC management. An action plan was developed outlining all the trainings and activities to take place throughout the project period and this was regularly updated and shared with all involved.

The CBHFA project greatly contributed to the capacity building of JRC staff at headquarters, branch level, the CBHFA trainers and of the volunteers through the numerous trainings, regular meetings, and field visits. Documentation of the lessons learned in the project wrap up workshops demonstrated the engagement and understanding of the staff and volunteers in the project implementation and their commitment to its continuation and improvement it in the future.

Annexes

Annex 1: Baseline and endline questions

1. Background Characteristics of Respondent					
No.	**Questions**	**Responses**			**Skip**
1	Sex of the respondent: M/F				
2	Nationality of the respondent				
1. Hypertension: High blood pressure (for adults > 25 years of age)					
No.	**Questions**	**Yes**	**No**	**Other Answer**	**Skip**
1	Have you ever had your blood pressure measured by a doctor or health worker?				
2	If yes, when was the last time you had your blood pressure checked?			< 3 months 3 to 6 months > 6 months ago	
3	Have you ever been told by a doctor or other health worker that you have raised blood pressure?				
4	If yes, were you prescribed medication?				
5	If yes, do you take your medicine regularly?				
2. Diabetes: High blood sugar (for adults > 25 years of age)					
No.	**Questions**	**Yes**	**No**	**Other Answer**	**Skip**
1	Have you ever had your blood sugar level measured by a doctor or health worker?				
2	If yes, when was the last time you had your blood sugar checked?			< 3 months 3 to 6 months > 6 months ago	
3	Have you ever been told by a doctor or other health worker that you have a raised blood sugar level?				
4	If yes, were you prescribed medication?				
5	If yes, do you take your medicine regularly?				
3. Obesity: Overweight (for teenagers and adults)					
No.	**Questions**	**Yes**	**No**	**Other Answer**	**Skip**
1	Have you heard about Body Mass Index?				
2	If yes, do you know what it means?			Check knowledge to see if it is correct	
3	Have you ever had your BMI measured by a health worker?				
4	If yes, when was the last time you had this done?			< 3 months 3 to 6 months > 6 months ago	
5	Have you ever been told by a doctor				

	or other health worker that you are overweight?				
6	If yes, were you given health education about what you could do to reduce your weight?				

4. Nutrition and Healthy Lifestyles (for students and adults alike)

No.	Questions	Responses	Skip
1	Can you name 5 foods you consider to be healthy?		
2	Can you name 5 foods/food products you consider to be unhealthy?		
3	How often each week do you eat the food you consider to be unhealthy?	Almost never Up to 3 times a week Almost every day	
4	In a typical week, on how many days do you do exercise as part of your daily activities/work e.g. walking to the shops, gardening, housework?	Never 4 to 6 days per week Every day	
5	In a typical week, on how many days do you do sports, fitness or recreational activities (outside of daily activities/work)?	Never 4 to 6 days per week Every day	

5. Personal Hygiene

No.	Questions	Responses	Skip
1.	When do you normally wash your hands? MULTIPLE ANSWERS POSSIBLE **DO NOT READ RESPONSES**. RECORD ALL THAT ARE MENTIONED	1. AFTER DEFECATING 2. AFTER URINATING 3. BEFORE FOOD PREPARATION 4. BEFORE EATING 5. BEFORE FEEDING CHILDREN/BABY 6. AFTER CLEANING BABY/CHANGING NAPPY 7. AFTER HANDLING ANIMALS 8. AFTER CARING FOR AN ILL PERSON 9. NO SPECIAL TIME, WHEN THEY ARE DIRTY 10. AFTER EATING 11. BEFORE PRAYING 12. DON'T KNOW 13. OTHER (SPECIFY)	
2.	What do you normally wash your hands with?	1. Water only 2. With soap 3. Other	

Annex 2: Community questionnaire[1]

1. How did you find the home visits by the JRCS community health volunteers?
    a. None took place
    b. Poor
    c. Average
    d. Good
    e. Excellent
2. What did they discuss with you?
    a. Heart disease
    b. Diabetes
    c. Healthy lifestyles
    d. Immunisations
    e. Hygiene
    f. Respiratory infections
    g. Health facilities
    h. Other
3. Is there anything else you would have liked to have learnt about?
    a. Open ended (get at least 3 points if possible)
4. What is your level of satisfaction with the home visits?
    a. Very satisfied
    b. Satisfied
    c. Moderately satisfied
    d. Not satisfied at all
    e. No comment
5. How could we improve these visits in the future?
    a. Open ended (get at least 3 points if possible)

[1] These questions were translated into Arabic

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Annex 3: Community focus group discussion questions

1. Tell us what you know about the JRCS community health programme in your community
   هل تستطيع اخبارنا ما تعرفه عن مشروع الصحة من الهلال الاحمر بمنطقتك
2. How did you participate in this community health programme?
   كيف كانت مشاركتك بمشروع الصحة المجتمعي
3. What do you think was good about this programme?
   ما هو رأيك عن ايجابيات هذا المشروع
4. What would like to see improved about this programme?
   ماذا تود ان يتم تحسينه في هذا المشروع
5. What activities do you think the community can continue with after the programme ends?
   ما هي الانشطة التي تعتقد انه يمكن ان تستمر بعد انتهاء هذا المشروع

Annex 4: Agendas for the project wrap up workshops at branch level

Time of Session	Session	Session Methodology	Session Facilitator
0900 - 0930	Introductions		Sundus & Jacinta
0930 - 1000	Overview of the project so far: timeline of events	Plenary	Sundus & Jacinta
1000 - 1030	Analysis of the strengths and weaknesses of the CBHFA programme	Group work between CHVs, FOAs, trainers and branch managers	Sundus & Jacinta
1030 - 1100	Feedback on the strengths and weaknesses of the CBHFA programme	Each group to give feedback to the whole group	Group leaders with support from Sundus & Jacinta
1100 - 1130	**Morning Tea**		
1130 - 1200	Discussion about support received by supervisors/branch/headquarters	Open plenary in addition to the opportunity for people to document their point of view on paper anonymously	Sundus & Jacinta
1200 - 1300	Community evaluations • Focus group discussions & household questionnaires • Baseline versus endline • Routine activities	How was the process? What did they learn from the communities? How was CBHFA perceived by the communities?	Sundus & Jacinta
1300 – 1400	**Lunch**		
1400 - 1500	Lessons learned	Group discussion: What could or should we have done differently or in a better way?	Sundus & Jacinta
1500 - 1600	Planning for the future	What do people think the top 5 needs are for CBHFA based on what they learnt from the beneficiaries and the needs they saw in the communities?	Sundus & Jacinta
1600 - 1630	Workshop wrap up		Sundus & Jacinta

Annex 5: Agenda for the project wrap up workshop at Headquarters

Time of Session	Session	Session Methodology
0900 - 0930	Opening of the workshop Introductions & overview of the workshop objectives	Presentation
0930 - 1000	Overview of the project so far: timeline of events	Presentation Discuss the action plan (in the handout)
1000 - 1030	Preliminary feedback on the strengths and weaknesses of the CBHFA programme from the communities' point of view (focus group discussion and questionnaire results)	Presentation Group discussions
1030 - 1100	Preliminary feedback on the strengths and weaknesses of the CBHFA programme from the branch project wrap up workshops (including support)	Presentation Group discussions
1100 - 1130		
1130 - 1230	Support received from other JRC departments: • Psychosocial programme (15 mins) • Gender focal person (15 mins) • Volunteer department (15 mins) • First Aid (15 mins)	Presentations Group discussions
1230 - 1330	Lessons learned	Based on the above strengths & challenges, how can we improve how we do things for the future?
1330 – 1430	**LUNCH**	
1430 - 1530	Lessons learned continued	
1530 - 1600	Future planning and workshop closure	Priorities for CBHFA in the future

Annex 6: Baseline and endline results compared

Details of the respondents	Results	
	Baseline	Endline
% of male respondents	N/A	52%
% of female respondents	N/A	48%
% of Jordanian respondents	N/A	54%
% of Syrian respondents	N/A	46%
Questions		**Results**
Blood Pressure		
% of respondents who had ever had their blood pressure(BP) measured	68%	68%
% of respondents who had had their BP measured < 3 months	73%	67%
% of respondents who had had their BP measured between 3 to 6 months	21%	22%
% of respondents who had their BP measured > 6 months	15%	15%
% of respondents told by a health worker that they have a raised BP	53%	39%
% of respondents prescribed medication for raised BP	85%	78%
% of respondents who said they take their BP medication regularly	91%	86%
Diabetes		
% of respondents who had ever had their blood sugar level (BSL) measured	53%	59%
% of respondents who had had their BSL measured < 3 months	55%	67%
% of respondents who had had their BSL measured between 3 to 6 months	21%	21%
% of respondents who had their BSL measured > 6 months	23%	24%
% of respondents told by a health worker that they have a raised BSL	39%	29%
% of respondents prescribed medication for raised BSL	85%	80%
% of respondents who said they take their BSL medication regularly	96%	86%
Body Mass Index and Obesity		
% of respondents who had heard about Body Mass Index (BMI)	43%	55%
% of respondents who gave a correct definition of BMI	70%	98%
% of respondents who had ever had their BMI measured	36%	35%
% of respondents who had had their BMI measured < 3 months	63%	63%
% of respondents who had had their BMI measured between 3 to 6 months	29%	26%
% of respondents who had their BMI measured > 6 months	24%	15%
% of respondents told by a health worker that they are overweight	34%	28%
% of respondents given health education on what to do to reduce their weight	79%	78%
Nutrition and Healthy Lifestyles		
% of respondents who correctly identified 5 healthy foods	60%	84%
% of respondents who correctly identified 5 'unhealthy' foods/food products	44%	82%
% of respondents who said they almost never ate 'unhealthy' food in a week	8%	6%
% of respondents who said they eat 'unhealthy' food up to 3 times in a week	26%	29%
% of respondents who said they eat 'unhealthy' food almost every day	23%	21%
% of respondents who said they never do exercise as part of their daily activities	6%	5%
% of respondents who said they exercise 4 to 6 days/week in their daily activities	29%	38%
% of respondents who said they exercise every day in their daily activities	34%	36%
% of respondents who said they never do exercise outside of their daily	6%	7%

activities		
% of respondents who said they exercise 4 to 6 days/week outside of their daily activities	31%	32%
% of respondents who said they exercise every day outside of their daily activities	25%	28%
Personal Hygiene		
% of respondents who said they wash their hands after defecating	7%	8%
% of respondents who said they wash their hands after urinating	14%	34%
% of respondents who said they wash their hands before eating	16%	5%
% of respondents who said they wash their hands before praying	4%	16%
% of respondents who said they normally wash their hands with water only	32%	14%
% of respondents who said they normally wash their hands with soap	44%	81%

Annex 7: Community questionnaire results

Total number of responses		**126**	
Questions	**Responses**	**No.**	**%**
1. How did you find the home visits by the JRCS CHVs?	Average	2	2%
	Good	42	33%
	Excellent	82	65%
2. What did they discuss with you?	Heart disease	93	18%
	Diabetes	118	23%
	Healthy lifestyles	72	14%
	Immunisations	64	12%
	Hygiene	58	11%
	ARIs	93	18%
	Health Facilities	25	5%
	TOTAL RESPONSES	523	100%
3. What else would you have liked to have learnt about?	Cancers		
	Measuring blood pressure & sugar		
	First aid		
	Physical exercise		
	Maternal and child health		
	Ebola		
	Nutrition & healthy lifestyles		
	Non- discrimination between Jordanians and Syrians		
	War injuries		
4. What is your level of satisfaction with health topics discussed during the home visits?	No comment	17	13%
	Moderately satisfied	3	2%
	Satisfied	39	31%
	Very satisfied	67	53%
5. How could we improve these visits in the future?	More frequent visits		
	Longer visits		
	One topic only per visit		
	To provide testing for hypertension & diabetes		
	Increase the number of CHVs		
	To include more people in the communities		
	To have sports clubs for youth and women		
	To distribute more brochures with health messages		
	Include schools		

Annex 8: Community focus group discussion responses

1. **Tell us what you know about the JRCS community health programme in your community**
    a. It is an awareness programme that focuses on the health of people, spreads awareness and aims at reducing chronic diseases
    b. It educates people about treatment and prevention methods.
    c. It aims at increasing awareness on diabetes, high blood pressure, and respiratory diseases
    d. It increased awareness about community violence
    e. It works on reducing health problems through field visits conducted by JRC volunteers
    f. How to use healthy habits to prevent NCDs.
    g. It was an effective awareness that allowed the local community to come to know about health problems. It provided the volunteers with the required information
    h. How to deal with injuries, burns, domestic violence, personal hygiene, fractures, etc.
    i. The volunteers were informed about the most common diseases including types of treatment being received at the local medical centre
    j. They distributed brochures at the medical centre
    k. A well-organized and integrated program aiming at benefiting Syrian refugees

2. **How did you participate in this community health programme?**
    l. We supported the efforts of the team and provided them with ideas regarding the needs of the community
    m. I participated in brainstorming sessions and participated [in talks] about health and healthy lifestyle. I spread health awareness among my friends, family and relatives
    n. We raised the most common health problems in our community
    o. Every time I felt keen to attend and be part of the programme
    p. I loved listening to the female volunteers
    q. Cooperation with Red Crescent's volunteers
    r. By writing down all positive and negative points (in our community) and then trying to avoid the negative points. As a result, the number of rubbish containers increased in the area and it was sprayed by insecticides to get rid of seasonal insects.
    s. I tried to convey what I have learned to others
    t. I have learned a lot from this discussion and now I know how to keep myself healthy
    u. I spread awareness on vaccinating children under the age of 5 years old

3. **What do you think was good about this programme?**
    a. I became aware of non-communicable chronic diseases and prevention methods
    b. It encouraged people to check their health constantly
    c. It increased the awareness on healthy habits, and reduced the spread of diseases, including high blood pressure, diabetes and respiratory problems
    d. It included Syrian refugees and other members of the community
    e. It was very useful because it reached housewives
    f. It paid significant and direct attention to individuals suffering from chronic diseases.
    g. It convinced patients of the importance of prevention methods.
    h. It helped in spreading health awareness and identifying diseases.
    i. It identified risk factors and their relation to NCDs
    j. Educating patients with high blood pressure or diabetes about the importance of visiting the medical centre regularly.
    k. The importance of exercising, and having an appropriate diet.
    l. It is a very useful project as it educated people about the importance of public hygiene and that rubbish is a main cause of diseases
    m. The experience of volunteers with the municipality and the good cleaning

4. **What would like to see improved about this programme?**

a. I hope the program will continue; make it a permanent programme
b. To increase the number of volunteers and participants
c. More courses and awareness campaigns e.g. first aid trainings
d. It can be improved through including other community based activities
e. Provide means to demonstrate the topics e.g. distribute more brochures
f. Increase the topics that fall in the interest of the local community e.g. including Ebola, breast cancer, hepatitis, Alzheimer and HIV
g. Distribute diabetes measuring devices to families who have diabetes if there is a budget allocated for such a purpose. This will help families to follow up the disease regularly.
h. Organize health walk activities (to walk for a specific distance) to encourage people to exercise.
i. Conduct field visits to tackle domestic violence and community violence
j. Continue some sport activities and periodical checking every 3 months
k. To have more collaboration with different sectors from the local community, such as medical centres, sport clubs, youth centres, charity organisations, and voluntary groups to implement more initiatives
l. Conduct outdoor activities e.g. visiting elderly residences, visiting patients at the hospital
m. Training the volunteers to measure blood pressure, diabetes and to check them during the family visits
n. Prepare health brochures on healthy and unhealthy food.
o. Distribute brochures on the importance of exercising.
p. Encourage citizens of the area to take part in voluntary work e.g. street cleaning
q. Increase the number of focus groups discussions.
r. To address more subjects e.g. discrimination in schools, school violence and educate teachers about it
s. Projects dedicated to children. Beggars' protection
t. To offer more benefits and not to be limited to awareness
u. Provide health services and improve the way in which medical centres deal with people
v. To have an open day every month at the medical centre and to be supported by the JRC
w. Improve the family's ties and strengthen family's relation with the community
x. Publish banners in the crowded places, hospitals and parks where each banner has a short sentence and a chart
y. To cover more groups in the community through media outlets, lectures at public and private schools, street advertisements since the four diseases are a real threat for the community in Jerash.

5. What activities do you think the community can continue with after the programme ends?

a. Establish sport awareness centres to provide information on weight and healthy nutrition that serve women and children.
b. Participatory community talks to increase the number of beneficiaries and increase the number of health topics.
c. Encouraging people to exercise to maintain their health and prevent disease.
d. Visiting the doctor constantly, and measuring blood pressure, diabetes and weight.
e. Holding regular meetings in the medical centre
f. Keep distributing brochures that enhance the concept of public and personal hygiene.

Annex 9: Summarized information from the branch project wrap up workshops

Branch	Strengths	Challenges
Irbid & Mafraq	• The focus groups and home visits helped in identifying the needs of the local community • The Syrian families embraced this awareness because they felt they needed it • The community accepted the programme easily and it was not a problem to target women, men and children. • The volunteer had the freedom to choose the time of their work • The training courses were sufficient & enriched the knowledge of the CHVs, especially the life skills of YABC • The diversity of the targeted beneficiaries (Syrians and Jordanians). • The name of JRC encouraged people to welcome and accept the programme. • Building a social bridge and gaining experience at the personal level. • The strength and experience of volunteers and supervisors in respect to dealing with different parties. • Selecting volunteers from the same area • The right selection of areas and communities. • Having previous knowledge of the area and community helped volunteers to be more accepted and welcomed • The cooperation between the members of the team and the coordinator including the sharing of experiences • Harmony between all nationalities i.e. the Syrian volunteers were well received treatment by Jordanian families, and vice versa.	• Some Jordanian families did not accept the awareness because they believed awareness is supposed to address Syrian refugees • Lack of some programmes that the community needs such as employment, birth control and dropouts. • It was difficult to meet males as most of the persons in the house were women. This required returning in the evening to ensure males are available. • Some parties requested an official letter to authorize holding meetings or focus discussions. • Some people refused to accept some topics. For example, they refused to talk about personal hygiene. • There were no physical items to present such as blood pressure and sugar measuring devices. • Frequent home visits were not encouraged by all beneficiaries because there was no financial or in-kind assistance provided.
Branch	**Strengths**	**Challenges**
Ajloun & Jerash	• The program increased the awareness of people and served members from all age groups in the family. • The visits were regular and the families were informed of the home visit and purpose and the team in advance. • Volunteers have benefited from the program i.e. they have learned about prevention methods, first-aid, and disease prevention at the personal level. The program has enriched their knowledge. • Practical exercises are effective in delivering the information such as the calculation of body mass index.	• Some volunteers said that another useful method to reach more people is to invite families to public places. • The number of volunteers (2) in each area is insufficient and therefore it was difficult to always ensure there was enough time per family for delivery of health messages • The program focused on some main diseases while families inquired about other diseases such as Ebola and Corona-viruses. • The period of the program is not enough to reach all the groups in each area. • It is hoped that the program to continue and to provide hypertension and diabetes

	• Focus group discussions helped volunteers to identify health problems in each community • The community embraced the volunteers given they are from the same community. • The community showed interest in receiving comprehensive health awareness and would more diseases in the program to be included. • The community and volunteers would like the program to continue to include all the members of the community. • The method of home visits is effective as it made it possible to reach out to certain groups in the community who appreciated the proposed topics and made some people feel that some attention is paid to them. This approach helped us to reach out groups that cannot leave their homes such as old people and disabled people. • Interaction with health committees helped volunteers to identify health priorities in the community and focused on chronic diseases. • The role of facilitators was very good and it was easy to communicate with them to answer our queries. JRC staff were very cooperative and did not hesitate to provide any information. • The local community accepted the idea of the Red Crescent to spread health awareness and allow the volunteers to enter their homes.	measuring devices. • In some situations, the community accepted female volunteers more than male volunteers.
Branch	**Strengths**	**Challenges**
Amman	• The programme was completed despite the tight time frame. • The team showed serious commitment and had a high level of coordination and cooperation amongst themselves and with the FOA and the trainers. • The trainer delivered the theoretical and practical aspects in a simple way and he was very cooperative and understanding • The knowledge of trainees increased after attending these training courses. • The programme meets the needs of the community • Families requested that family visits and awareness efforts continue. • Learned how to deal with the members of communities. • People benefited from the awareness programme with regard to hyper tension, blood sugar, hygiene and First aid • Communication with the community through the home visits	• The period of the programme is short. • Some families refused to receive the volunteers because they did not provide any aid e.g. blankets and heaters. • It was sometimes difficult to gather people in focus discussions. • No blood pressure and sugar measuring devices • Inability to offer sick people a card to visit hospitals • Psychological support is highly demanded. • There were many trainings to attend • There is a need for having intensive VP courses and psychological support.

International Federation of Red Cross and Red Crescent Societies

Annex 10: Terms of reference for project evaluation

End of Project Evaluation (Internal)

Community Based Health and First Aid Programme

Jordan, 2014

Summary

Purpose: The purpose of the CBHFA final evaluation was to account for the IFRC/JRCS support provided to Syrian refugees living in host communities and vulnerable Jordanians. This evaluation was also being done to draw lessons that will be useful in the improvement of future programme implementation. The evaluation is expected to contribute to knowledge and recommendations on the appropriateness of similar programmes.

Audience: The evaluation will be used by JRCS, IFRC and other ongoing CBHFA programmes being implemented as part of the RCRC Movement. This will benefit in terms of the good practices and challenges that are documented in this evaluation

Commissioners: This was an internal evaluation commissioned and funded by the Japanese Government in compliance with the IFRC evaluation framework.

Duration of evaluation: The overall process took about 6 weeks, which included 4 days for field work, 4 days for project wrap up workshops and approximately 4 weeks for data analysis and finalization of the report.

Time frame: From November to December of 2014

Location: Field work was carried out in the Governorates of Amman, Ajloun, Jerash, Mafraq and Irbid

Background

The Jordanian Red Crescent Society (JRCS) was established on 27 December 1947, recognized by the ICRC in 1948 and admitted to the IFRC in 1950. It focuses its work on disaster management, health, peace building and social development. JRCS is the lead agency in Jordan in the event of a major disaster and is a member of the High Council for Disaster Response. It has played a vital role dealing with the influx of refugees during past conflicts including running relief operations, organizing camps for evacuees and providing humanitarian assistance.

This CBHFA Project is a pilot and was funded by the Japanese Government for 9 months with a budget of USD 500,000. The pilot project was being implemented by the JRCS CBHFA Project Officer, who had responsibility for overall management. The officer was supported by 5 Field Officer Assistants (FOAs) and 70 JRCS volunteers. Overall coordination was led by the IFRC Health Coordinator in Amman.

The overall objective of the programme was to reduce the adverse effects of the Syria crisis on the health of affected population. Specifically, the objectives were as follows:

Outcome:

- 6,000 affected people in 20 communities in the Governorates of Amman, Ajloun, Jerash, Mafraq and Irbid have improved their health and well-being through Community Health and Psychosocial support.

Outputs:

- Community-based disease prevention and health promotion, epidemic prevention and control measures are carried out through CBHFA.
- 2,000 refugee children and their families in three out of the five targeted Governorates have access to psychosocial health services for improved psychosocial well-being.
- JRCS/IFRC capacity in community awareness and on community-based health and first aid is strengthened.

Purpose and Scope of the Evaluation

The purpose of the CBHFA final evaluation was to account for the Japanese Government support provided to IFRC and JRCS as well as to identify lessons learned that will be useful in the improvement of future programme implementation.

IFRC is committed to a rigorous evaluation of this programme. IFRC main purpose is to determine:

- Project relevance
- Project effectiveness and impact
- Project efficiency
- Partnership
- Project management
- Project sustainability

Results of this final evaluation will be used to make recommendations regarding the implementation of a similar programme approach in the future.

Evaluation Objectives and Criteria

Objectives

- 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 the local context and how the community-based approach has been implemented in the targeted communities
- Provide recommendations for further improvement in the design, delivery, quality and resourcing of the project to increase effectiveness, efficiency, relevance or impact.

Evaluation criteria and specific evaluation questions

Relevance

- How relevant is the project regarding the beneficiary requirements, local context and needs?
- How well were 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?

Effectiveness

- Were 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 qualities 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 JRCS – including local branches – with the project? What are the main issues raised regarding satisfactions with the project?

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 extent has the funding been utilized to directly assist beneficiaries (b)Has the project support and operational costs been reasonable (%) compared to entire budget and beneficiary assistance

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)?

Sustainability

- Is there sufficient community ownership regarding the project?
- How well has the phase out been planned and managed?
- 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 improved effectiveness.

Evaluation Methodology

The evaluation will use the following data sources:

- All project related documentation such as project plans, budgets, financial and narrative reports, guidance documents, etc.)
- Monitoring formats and monitoring data compilation
- IEC and BCC materials developed by the project

Reference documents:

- Project proposal
- CBHFA modules
- CBHFA PMER toolkit

Methodology

- Document analysis/review of all project related documents, IEC materials, success stories, any other monitoring or evaluation report for the same project
- Project data consolidations – baseline data, end line data, regular project monitoring data etc.
- Focus Groups Discussions with beneficiaries
- Field/household visits and beneficiary interviews
- Photography

- Project wrap up workshop reports

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

Deliverables
A final evaluation report will be drafted and shared with all partners.

Proposed Timeline
The whole evaluation process will take 6 weeks

Evaluation Quality and Ethical Standards.
The evaluation team 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 and 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 and 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