MID TERM EVALUATION

of the

COMMUNITY BASED HEALTH AND FIRST AID PROGRAM in the OCCUPIED PALESTINIAN TERRITORY and LEBANON

Implemented by
the Palestine Red Crescent Society in the Occupied Palestinian Territory and
the Palestine Red Crescent Society Lebanon Branch in Lebanon
Co-funded by the Norwegian Red Cross and the Swedish Red Cross

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ABBREVIATIONS

AUB	American University of Beirut
BRC	Belgian Red Cross
CB	Community Based
CBDP	Community Based Development Program
CBH	Community Based Health
CBHFA	Community Based Health and First Aid
CC	Community Committee
CF	Community Facilitator
IFRC	International Federation of Red Cross and Red Crescent Societies
LC	Local Coordinator
LF	Logical Framework
MoH	Ministry of Health
NRC	Norwegian Red Cross
OD	Organisational Development
oPt	Occupied Palestinian Territory
PHC	Primary Health Care
PRCS	Palestine Red Crescent Society
PRCS/L	Palestine Red Crescent Society Lebanon Branch
RCRC	Red Cross Red Crescent
SpRC	Spanish Red Cross
SRC	Swedish Red Cross
UNRWA	United Nations Relief and Works Agency for Palestine Refugees
WB	West Bank

Preliminary Note on the Structure of the Evaluation Report

The report consists of an executive summary and the full evaluation report including four parts. While part I and II are discussing the evaluation and the CBHFA approach in general, part III and part V are specific for the oPt and Lebanon and can stand by their own.

EXECUTIVE SUMMARY

1. PROGRAM BACKGROUND

Palestinians in the West Bank and Palestine refugees in Lebanon are marginalized and deprived of many basic human rights and have limited access to state-provided services such as health, education, social services and the judicial system.

The **Community Based Health and First Aid Program** (CBHFA) in the oPt and Lebanon is implemented by PRCS and PRCS Lebanon Branch (PRCS/L) and supported by the Norwegian and Swedish Red Cross from 2009 to 2012. The programs are based on the IFRC's Community Based Health and First Aid in Action approach. The overall objective of the CBHFA program is to improve the health and well-being of the Palestinian population. In general the actions aim at raising awareness and enhancing knowledge on health and health related social aspects while at same time enabling the local communities to define and develop programs to respond to their health needs. Specific target groups include women (especially teenage girls, single women, women heading households), children and families in general.

2. PURPOSE OF THE EVALUATION

The Terms of Reference[1] describe the purpose of the evaluation as follows:
"… to assess the relevance, efficiency, effectiveness, impact and sustainability of the CBHFA program and to make recommendations for future support."

In the oPt the evaluation has been carried out from 7.to 28 September 2011 and in Lebanon form 16. to 29. October 2011. In country debriefing sessions were held at PRCS HQ and at PRCS/L Branch HQ. A presentation of the evaluation's key findings and recommendations on a short as well as on a mid to long term perspective for the program was given at NRC HQ on 14. November 2011.

3. THE CBHFA PROGRAM IN GENERAL

There are several aspects of the CBHFA approach and its implementation that are valid for the CBHFA program in the oPt and in Lebanon alike. This is of even more interest as the socio-geographical context, the entry point for the program and the experience in the implementation of community based interventions differ broadly: In the oPt the program is mainly implemented in rural areas, target communities have been broadly exposed to community based interventions, the entry point for the program where trained, operative community committees (so-called "Safe Motherhood Committees") and PRCS disposes of a sound experience in community based health interventions. In contrast to the oPt, the program is implemented in urban areas, target communities are not used to community based interventions, community committees had to be built at the beginning of the CBHFA program and PRCS Lebanon Branch has hardly any experience in community based health interventions.

3.1 Key Findings Applying to Both Programs

The CBHFA programs can be considered a successful approach for community based health interventions.

Program interventions have been and remain relevant for the target groups and within the overall context of the oPt and the Palestine refugee camps in Lebanon.

The programs cover a wide range of health and health related social topics applying a comprehensive definition of health. All interventions are based on the actual needs within the community.

[1] For details see Annex

Community Committees are an effective interface between the communities and their needs and the services and knowledge made available through PRCS / PRCS Lebanon Branch and the program.

While the overall number of people benefiting from the programs has increased considerably since the beginning of the program, still due to the cultural and socio-economic context, out reach to women is significantly higher than to men.

Highly participatory and effective capacity building methods for program staff, volunteers and beneficiaries have been introduced as specific components of the CBHFA program: Excellent Training of Trainers (TOT) curriculums have been developed; repeated focus group discussion have become a powerful tool to address topics that are culturally sensitive or a taboo; drama workshops are used as a tool for awareness raising and dissemination of knowledge.

It is of high value that logical frameworks are used as planning tools. Still in order to efficiently monitor and evaluate outputs, outcomes and impact as part of results based management, objectively verifiable indicators need to be revised. Monitoring according to objectively verifiable indicators needs to be improved.

One of the weaknesses in both program designs is that no measures for sustainability and potential phase out strategies have been included.

It is unfortunate that the excellent program implementation is hampered in both program locations due to a delay in budget transfer caused by the out of time audit reports of PRCS. While PRCS HQ is able and committed to finance program implementation in advance till being refunded, PRCS Lebanon Branch does not have the financial means to compensate outstanding program funds.

3.2 General Recommendations

It is recommended

- To train and guide program staff in project cycle management regarding the development of logical frameworks with a special focus on OVIs and how to apply them for monitoring.
- To ensure that sustainability measures and a phase out strategy are part of any program outline/proposal and that enough time is given for the implementation (at least to be started 10 months before the end of the program).
- Consequently – even if it is planned to continue with another program phase – it is recommended to use the last year of a program period to consolidate what has been achieved and, in case of continuation, to plan the next phase.

It is further recommended for NRC/SRC

- To mainstream organizational development for the Community Based Health and First Aid Programs or where NRC/SRC are supporting organizational development parallel to the CBHFA program to operationally link the CBHFA program to OD interventions at branch/community centre level.

4. THE CBHFA PROGRAM IN THE OCCUPIED PALESTINIAN TERRITORY

4.1 Key Findings

The CBHFA program has been set up successfully. Implementation is well on its way due to highly committed and skilled community committees who effectively reach out to their community members.

Program locations where implementation is not based on extended SMHCs but on newly established community committees need specific attention and intensified support.

There is an evolving need to further increase awareness and knowledge on sexual and reproductive health for adolescent youth, to further work on gender based and domestic violence and to continue to address early marriage, relative marriage and women's rights. In

order to do this effectively, the program's reach out to men and adolescent youth, that so far has been quite challenging, needs to be considerably increased.

The highly participatory bottom up approach adopted not only for working with the community but as well for general program management ensures transparency, continuous capacity building of volunteers and in the long term program ownership and self-reliance.

SMHCs have a high potential to continue to work for their communities more independently when closely linked to PRCS decentralized service structures and branches. The committees are not only highly skilled in the implementation of the CBHFA approach within their communities but as well in the general management of their interventions.

Close cooperation and collaboration of the committees with PRCS branches will be a key component for long-term sustainable community work. Their involvement in program implementation and their capacity to do so need to be actively furthered.

In order not to hamper the up to now so successful implementation of the program financial management should be improved regarding timely provision of PRCS' yearly audit reports and cost-efficiency of temporary support items for beneficiaries.

4.2 Major Recommendations – Short Term Perspective

The following recommendations are meant to be considered for the CBHFA program period of 2012:

- To improve the reach out to men it is recommended a) to carry out small planning sessions with the CCs on how they think men could best be reached (facilitated by the responsible nurse and/or social worker), b) to review within the CBHFA program where and when lectures for men would be useful to complement the lectures for the female population – particularly on topics where men and women depend on each other and c) to consider to train at least one male TOT linked to the community committees for disseminating knowledge to the male population. Regarding adolescent youth as a first step "repeated" focus group discussions could be established for teenage girls and teenage boys – an approach that has worked successfully in the CBHFA program in Lebanon. In addition PRCS youth volunteers at branch level could provide for one entry point to reach out to adolescent youth.
- Program locations where implementation is not based on extended SMHCs but on newly established community committees should be provided special support and additional capacity building, especially on communication skills.
- The CCs cross-linkage with branches should be furthered and branches supported in building their capacity for community based programs and initiatives.
- NRC/SRC are recommended to follow up on and support the ongoing process on how to integrate SMHCs into existing volunteer structures while at same time shifting more and mores responsibility towards the committees.

The **planned extension of the program to another 6 locations for 2012** should be reviewed taking into consideration different possible options:

- ***Option a)*** the CBHFA program is extended as originally planned into six new locations – in this case it is recommended to chose most vulnerable communities with remote infrastructure (no health centres) who did not benefit from services provided by Safe Motherhood Committees. If the program is extended into the most vulnerable communities implementation should be planned for more than one year and funds need to be secured beyond 2012.
- ***Option b)*** the CBHFA program is extended into villages neighbouring the current program locations. This would respond to the many communities' directly expressed wish to have a PRCS supported community based CBHFA program in their community as well. In this

case existing community committees could support neighbouring villages and synergetic effects could be created in one area.

- ***Option c)*** the CBHFA program in existing locations is consolidated rather than extended into new communities. This option would allow to focus on an increased reach out to men and adolescent youth, to intensify SMHCs and branches collaboration, to enhance SMHCs' capacity to work more independently, to strongly support the newly established community committees that are not based on a SMHC in their capacity building and last but not least to plan for sustainability measures and start phase out strategies in due time.

Considering that actual implementation in Gaza locations has only started in the second half of 2011, that new locations like Bardallah in WB and Deir al Ballah in Gaza have not been exposed to SMHCs' community work before and the need to increase the program's reach out to men and adolescent youth, program consolidation (option c) is recommended as being probably the most effective.

4.3 Major Recommendations Mid to Long Term Perspective

Regarding a possible implementation of the CBHFA approach beyond 2012 it is recommended to

- Focus on sexual and reproductive health for adolescent youth using a holistic approach that is sensitive towards the oPt's traditional and socio-cultural context. Such a program could be based on a peer education approach oriented on" life skill education" covering health topics as well as social and psychological issues. The program should be linked to the existing community committees and PRCS branches – branches providing for a natural entry point for youth programs through their volunteer structures. Due to the socio-cultural context it is not recommended to integrate a sexual and reproductive health for adolescent youth program into PHC clinics with specially trained doctors and/or nurses as a first step.
- PRCS branches should be actively involved in the implementation of any CBHFA approach to ensure long term sustainability. It is recommended to handover more and more responsibility to the branches, this would not only allow the community committees to work more independently and enhance their responsibility for their own communities' health but ensure an integrated approach for all PRCS community based programs. Program responsible branches are key to cost-efficiency and a smooth program phase out while keeping benefits and ensuring continuity. It is therefore recommended to mainstream the organisational development of branches for all community based programs.

5. THE CBHFA PROGRAM IN LEBANON

5.1 Key Findings

The CBHFA program has been successfully set up and implementation has to be judged as highly effective.

In all locations community centres have been established successfully and are used by the camps' inhabitants. They serve as a meeting point and a platform for community activities.

In the specifically challenging socio-political and difficult socio-economic environment of the Palestine refugee camps the establishment of a two-tier volunteer structure consisting of community committees and PRC/L volunteers has to be seen as a key success of the program. In difference to the CBHFA program in the oPt community committees and PRCS/L volunteers include men and women, thus allowing for a culturally sensitive access to women and men.

Community committees are in general not only committed to the program but have been capacitated to plan and implement a broad range of community activities due to an excellently designed training of trainers (TOT) curriculum.

Since the program started the overall number of people benefitting from CBHFA interventions increased considerably. Due to the cultural and socio-economic context out reach to women is higher than to men.

Although it is still very early to judge on impact an increased knowledge regarding health and the willingness to address culturally sensitive topics can be observed. According to the community committees the program definitely contributes to the empowerment of women. The probably biggest impact of the CBHFA program up to now concerns the increased knowledge of teenage girls on sexual and reproductive health.

5.2 Major Recommendations – Short Term Perspective

The following recommendations are meant to be considered for the CBHFA program period of 2012:

- Volunteer incentives should be changed from personal cash allowance for individual performance to incentives that benefit the community committees as a team and provide as well benefits for the community in general (e.g. training, computers for the community centres).
- The proposed cascade model where 1 or 2 TOTs and 20 to 40 volunteers are jointly taking care of 1.000 people should be put into practice to enhance the reach out to the community.
- An intensified capacity building in volunteer management at PRCS/L Branch HQ and at field level for staff and community committees should go hand in hand with the planned increase of the number of volunteers.
- For overall program coherency it would be essential to develop generally applicable PRCS/L guidelines on volunteer management and – as the number of volunteers is continually increasing – to build a volunteer information system. NRC/SRC are recommended to actively support this process.
- As it has shown that program process is best where the responsible social worker comes from the camp herself/himself, it is recommended to recruit staff who are or have been living or working in the resp. program camp (if possible).
- Program locations where implementation has started in 2011 (Mar Elias and Ein Helwe) should be provided special support.

Planned Extension of the CBHFA program in 2012

- According to the program proposal it is planned to extent the CBHFA program in the third year of the NRC/SRC supported program period to another 2 camps. The planned extension should be jointly reviewed. It is highly recommended to consolidate the program in existing locations rather than extending into new camps. This would allow to focus on the camps where implementation has started in 2011 only – especially Ein Helwe the largest of all camps; to thoroughly set up the planned cascade volunteer structure and further improve volunteer management; to increase reach out to adult and adolescent men; and to discuss and develop measures for sustainability and possible phase out scenarios.
- In case of an extension to Al Quasmieh and/or Nar El Bared as it has been discussed between PRCS/L and the NRC delegate in Lebanon, it is recommended to revise the current implementation approach for Al Quasmieh regarding the number of gatherings to be part of the program and the composition and location of the community committees.

5.3 Major Recommendations Mid to Long Term Perspective

- As the program has been successfully set up, is highly promising and behaviour change needs time, it is highly recommended to PRCS/L and NRC/SRC to extend the current CBHFA program period into a second program phase.

PART I
INTRODUCTION

Palestinians in the West Bank and Palestine refugees in Lebanon are marginalized and deprived of many basic human rights and have limited access to state-provided services such as health, education, social services and the judicial system.

The ***occupied Palestinian territory*** (oPt) is a highly complex environment in which its people are striving for statehood, peace, self-determination and development. The continued expansion of Israeli infrastructure (incl. the barrier, settlements and outposts) in the West Bank and the social and economic isolation of Gaza have led to a disruption of basic social services regarding health, water and sanitation as well as community services. With tight movement restrictions for Palestinians, access to knowledge, education and health services is severely hampered, especially for women and disadvantage population groups.

The ***Palestinian population in Lebanon*** is constituted of people that for over 60 years have been refugees. Palestine refugees are often deprived of their socio-economic or civil rights, such as the right to work, to practice certain professions, run businesses and own property. The majority is confined to camps or segregated settlements where they are partially dependent on humanitarian assistance and often live in dire socio-economic circumstances. All 12 official refugee camps in Lebanon suffer from serious problems such as poverty, overcrowding, unemployment, poor housing, insufficient infrastructure and limited access to social services.

The Community Based Health and First Aid Program (CBHFA) in the oPt and Lebanon is implemented by PRCS and PRCS Lebanon Branch and supported by the Norwegian and Swedish Red Cross from 2009 to 2012. The programs are based on the IFRC's Community Based Health and First Aid in Action approach. The overall objective of the CBHFA program is to improve the health and well-being of the Palestinian population. In general the actions aim at raising awareness and enhancing knowledge on health and health related social aspects while at same time enabling the local communities to define and develop programs to respond to their health needs. Specific target groups include women (especially teenage girls, single women, women heading households), children and families in general.

In the oPt the program is planned to be implemented in 24 communities. Currently the program is carried out in 15 communities in the West Bank and 3 locations in Gaza. Out of these 6 (3 in the West Bank and the 3 in Gaza) have been included in the CBHFA program in 2011 only.[2]

In Lebanon the program is planned to be implemented in 8 Palestine refugee camps by the end of 2012. Currently 6 camps are included in the program: Shatila (Beirut), Mar Elias (Beirut), Burj Al Shamali (Tyre), Al Buss (Tyre), Ein Helwe (Saida) and Wavel Camp (Baalbek / Bekaa).

[2] For more details on program locations see annex "Overview on CBHFA Project Locations and PRCS Health Related Programs at the Locations"

1. PURPOSE OF THE EVALUATION

The Terms of Reference[3] describe the purpose of the evaluation as follows:
"… to assess the relevance, efficiency, effectiveness, impact and sustainability of the CBHFA program and to make recommendations for future support."

In the oPt the evaluation has been carried out from 7.to 28 September 2011 and in Lebanon form 16. to 29. October 2011. In country debriefing sessions were held at PRCS HQ and at PRCS/L Branch HQ. A presentation of the evaluation's key findings and recommendations on a short as well as on a mid to long term perspective for the program was given at NRC HQ on 14. November 2011.

2. METHODOLOGICAL APPROACH

The assessment was done as participatory as possible, using a variety of methods and involved all relevant stakeholders.

Sample
In the **oPt** 7 program locations in the West Bank were part of the evaluation: 6 out of 12 locations where implementation started in 2009/2010 and 1 out of 6 locations[4] that started /are starting implementation in 2011. The sample was based on the following criteria:

- Start of CBHFA implementation in 2009/2010
- Locations with another health program/community based program and without
- The locations was not included in the CBDP evaluation

The community of Bardallah, where implementation started only this year, was given specific attention due to the fact that there had been no Safe Motherhood Committee operating before.

In **Lebanon** 5 CBHFA program camps and 1 gathering were visited: 4 out of 4 camps were the program began in 2009 and 1 out of 2 camps that started implementation in 2011. Al Quasmie gathering (PRCS/L Community Centre) where a Belgian Red Cross supported CBHFA program has been implemented was included to gain information on program coherency and to be able to reflect/discuss potential lessons learned.[5]

Stakeholders of the program in both countries taking part in the evaluation included:

- Beneficiaries
- Volunteers: Community committees and CBHFA program volunteers
- PRCS HQ staff, PRCS/L Branch HQ staff, PRCS and PRCS/L field staff
- SMHC members
- Representatives of the respective municipalities/local councils
- Community leaders
- Representatives of cooperating organisations/associations
- RCRC Movement representatives

Methods used for the evaluation:

- Review of program documents and statistical monitoring data available
- Semi-structured, in-depth interviews
- Focus group discussions visually supported by mapping and ranking methods
- SWOT Analysis with PRCS and PRCS/L field staff
- Observation of program activities

[3] For details see Annex
[4] 3 in the West Bank and 3 in Gaza
[5] For more details regarding the actual villages please see Annex

PART II
THE CBHFA PROGRAM IN GENERAL

This chapter is meant to provide a short overview on aspects of the CBHFA approach and its implementation that are valid for the CBHFA program in the oPt and in Lebanon alike. This is of even more interest as the socio-geographical context, the entry point for the program and the experience in the implementation of community based interventions differ broadly:

Context of the CBHFA Program in the OPT and in Lebanon	
PRCS / CBHFA OPT	PRCS/L / CBHFA Lebanon
Rural areas	Urban areas
Community used to community based interventions	Community not used to community based interventions
Entry point: trained operative community committees (SMHCs)	Community committees established for the CBHFA program
PRCS highly experienced in community based health interventions	PRCS/L little to no experience in community based interventions

1. KEY FINDINGS APPLYING TO BOTH PROGRAMS

- ***The CBHFA programs can be considered a successful approach*** for community based health interventions.
- ***Program interventions have been and remain relevant*** for the target groups and within the overall context of the oPt and the Palestine refugee camps in Lebanon. The programs' objectives and intended results are aligned with the strategic aims of the IFRC's Strategy 2020 "Saving Lives Changing Minds" "Community Based Health and First Aid in Action" guidelines and manuals. Community based health education, disease prevention and first aid are strategic priority areas of support for the Norwegian and Swedish Red Cross.[6]
- ***The programs cover a wide range of health and health related social topics*** applying a comprehensive definition of health. All interventions are based on the actual needs within the community.
- ***Community Committees are an effective interface*** between the communities and their needs and the services and knowledge made available through PRCS / PRCS Lebanon Branch and the program.
- While the ***overall number of people benefiting*** from the programs has increased considerably since the beginning of the program, still due to the cultural and socio-economic context, out reach to women is significantly higher than to men.
- ***Highly participatory and effective capacity building methods*** for program staff, volunteers and beneficiaries have been introduced as specific components of the CBHFA program:
  - Excellent *Training of Trainers (TOT) curriculums* have been developed based on the IFRC's CBHFA guidelines and manuals.
  - *Focus group discussions* for specific social groups are a CBHFA specific means of intervention. At the beginning of the program they have been used to gather qualitative baseline data. Carried out on a regularly basis with the same participants, FGDs are a powerful tool to address topics that are culturally sensitive or a taboo in the society. Repeated FDGs aim at recognizing own needs and potentials by sharing

[6] Reference: Norwegian Red Cross, Strategy for International Activities 2009 – 2014, 2009 and e-mail of 25.09.2011 by the Swedish and Norwegian Red Cross Programme Advisor for oPt outlining Swedish Red Cross strategies for support (no English SRC Strategy document was available)

information, reflecting on significant situations and identifying adequate solutions. Participants are encouraged to communicate, exchange opinions and comment on each others experiences, thus functioning as audience for each other.

- *Drama workshops* are used as a tool for awareness raising and dissemination of knowledge
- *IFRC's CBHFA manuals and community tools have been translated into Arabic* and are used by volunteers as basis for community work.

Challenges remaining include:

- Certain weaknesses in ***program design***:
  - *Sustainability measures* and a potential phase out strategy are not an integrated part of the program design.
  - The *extension of the program into new locations is planned for the last year* of the NRC/SRC supported program period, making high quality implementation in the new locations quite challenging, especially if funds for another program phase are not secured from the very beginning.
  - It is of high value that *logical frameworks* are used as planning tools. Still in order to efficiently monitor and evaluate outputs, outcomes and impact as part of results based management, objectively verifiable indicators need to be improved.
- ***In general both programs are managed*** well due to committed and skilled staff at PRCS HQ, PRCS/L Branch HQ and especially at field level. Challenges remaining include:
- ***Volunteer management within a community based approach*** concerning issues such as how to formalize newly created volunteer structures; hwo to integrate "new" volunteer groups into existing structures; how to create and maintain decentralized, mainly self-relying voluntary community committees in the long term
- ***Monitoring according to objectively verifiable indicators***
- ***Financial management*** - it is unfortunate that the excellent program implementation is hampered in both program locations due to a delay in budget transfer caused by the out of time audit reports of PRCS. While PRCS HQ is able and committed to finance program implementation in advance till being refunded, PRCS Lebanon Branch does not have the financial means to compensate outstanding program funds. In a highly complex socio-political environment as the refugee camps the unability to deliver activities jointly planned with the community can put the whole program at risk.

2. GENERAL RECOMMENDATIONS

It is recommended

- ***To train and guide program staff in project cycle management*** regarding the development of logical frameworks with a special focus on OVIs and how to apply them for monitoring.
- ***To ensure that sustainability measures and a phase out strategy are part of any program outline/proposal*** and that enough time is given for the implementation (at least to be started 10 months before the end of the program).
- Consequently – even if it is planned to continue with another program phase – it is recommended ***to use the last year of a program period to consolidate what has been achieved and – in case of continuation – to plan the next phase***.

It is further recommended for NRC/SRC

- To ***mainstream organizational development for the Community Based Health and First Aid Programs*** or
- Where NRC/SRC are supporting organizational development parallel to the CBHFA program to ***operationally link the CBHFA program to OD interventions at branch/community centre level.***

PART III
CBHFA PROGRAM IN THE OCCUPIED PALESTINIAN TERRITORY

1. PROGRAM BACKGROUND

The Community Based Health and First Aid Program is to be implemented over a period of 4 years from 2009 to 2012, with an allocated budget for the first three years of around 870.000,-USD. It is implemented by the Palestine Red Crescent Society and co-funded by the Norwegian and Swedish Red Cross (NRC/SRC). The action is based on the IFRC's Community Based Health and First Aid in Action approach and building on PRCS Primary Health Care Department's preceding community based health programs. The program is implemented alongside PRCS' Reproductive Health Care Program and Child Care Program, both programs being supported as well by NRC/SRC.

The program's ***overall objective*** is defined as:
"Improve health and quality of life for women, children and families at community level and disseminate the Red Crescent humanitarian goal for the Palestinian population."

Building on existing community based volunteer structures (Safe Mother Hood Committees) the action aims at raising awareness and enhancing knowledge on health, environmental and psychological issues. Target groups include women (especially teenage girls, single women, women heading households, women in refugee camps), children and families in general. It is planned to be implemented in 24 communities in the oPt. Currently the program is carried out in 15 communities in the West Bank and 3 locations in Gaza. Out of these 6 (3 in the West Bank and the 3 in Gaza) have been included in the CBHFA program in 2011 only.[7]

2. RELEVANCE AND QUALITY OF PROGRAM DESIGN

2.1 Relevance

The occupied Palestinian territory (oPt) has an estimated population of 4,048,403 people, with 2,513283 persons living in the West Bank and 1,535,120 in the Gaza Strip (PCBS 2010). Around 41% of the population is below 15 years and two thirds below the age of 25 (MoH 2010). Although recent economic progress in the WB and in Gaza Strip have provided some measure of relief for Palestinians living in the oPt, the protracted conflict, occupation and political uncertainty leave the population highly vulnerable to unemployment, food insecurity and poverty. Freedom of movement and access to basic social services regarding health, water and sanitation are severely constrained. ***The humanitarian situation has very specific gender dimensions***, with men and women, boys and girls being affected in different ways. While Palestinian men and boys are greatly exposed to unpredictable and arbitrary risks on their physical security, Palestinian women and girls bear a disproportionate burden of vulnerability to food insecurity, lack of access to knowledge, education and health services, and gender-based violence.[8]

Health Status of the Palestinian Population in the OPT

Effective ***provision of quality health services*** is hampered by the continued restriction on importation of medical supplies and equipment, including spare parts, and on movement of health staff between WB and Gaza. The situation described especially affects the ***health status*** of the most vulnerable population groups (women – particularly pregnant

[7] For more details on program locations see annex "Overview on CBHFA Project Locations and PRCS Health Related Programs at the Locations"
[8] Reference: UN OCHA, Occupied Palestinian Territory Consolidated Appeal 2011, November 2010

women, children, older people, people with chronic diseases, people with disabilities, people with mental illnesses). ***Infant and child mortality*** indicators have experienced little improvement overall and there is evidence that they have worsened in the poorest quintiles of the population (CAP 2011, MoH 2011). Recent years have as well been characterized by a dramatic increase of 31.1% in both incidence and prevalence of ***chronic diseases*** as well as ***disability and mental illness*** among the population (CAP 2011). A cross-sectional study published in 2010 shows that exposure to political violence is associated with increased odds of ***psychological, physical and sexual intimate-partner violence*** in the oPt. The paper outlines as well that ***early marriage and early pregnancy*** are consistently high with increased complication rates occurring among young pregnant women. In addition information, ***counselling and care among young people*** is mainly accessed through informal or peer networks – there is no information targeted at young people about their physical, sexual and mental health. (MOH 2011).

Beneficiaries

Based on the situation described above and the results of group discussions conducted with **committee members and beneficiaries** the topics and activities covered by the programme were judged to be of high value by the program's beneficiaries.[9]

National Health Policy

The ***MoH strategy for 2011 – 2013*** outlines concrete priorities to address the situation described above with its various programs – including mental and reproductive health, improved gender equity, equality and empowerment of women, and raising health awareness amongst youth and adolescents. It is stated in the strategy that "While acknowledging the negative impact of political and other factors in the wider context on health, the ministry believes that individuals and groups or communities can do things to improve their health and need to be better informed about health risks. Individuals and communities must be empowered to take responsibility for health...."[10]

2.2 Quality of Program Design

The CBHFA program for oPt has been developed during 2008. The action is based on preceding community health programs[11] and especially on the Community Based Development Program that were implemented by PRCS in 75 communities in the West Bank and Gaza Strip (including the CBHFA program locations) from December 2007 to end of May 2011. The CBHFA program is particularly building on the "so called" Safe Motherhood Committees – established and trained by the above mentioned programs – that provided for the ***action's entry point*** and became the core of the CBHFA approach.

As outlined in the program proposal 2009 to 2012[12], the CBHFA program is ***one component of the overall health interventions*** of the PRCS PHC Department supported by NRC and SRC – complementary to the action a reproductive health and a child health care program are implemented. A step by step approach regarding reach out into different communities was drafted, starting with 6 locations in the first program year and continuously expanding program implementation up to 24 locations by the end of the third year.

[99] For more details see the chapters effectiveness and impact

[10] Palestinian National Authority Ministry of Health, Palestinian National Health Strategy 2011 – 2013, Setting Direction - Getting Results, 2010, page 33

[11] Community Based Preventive and Promotional Health Activities in the Palestine Autonomous Areas and Occupied Territories; December 1999 – November 2003 and Primary Health Care Project West Bank / Gaza; August 2004 – October 2007; all three programs were financed through the EU and co-funded by GRC.

[12] PRCS, Project Proposal: Reproductive and Child Health Care & Community Based Health and First Aid, 2009

The CBHFA program's six ***pilot locations*** have been selected based on criteria set by the PHC department involving social workers and regional coordinators. Locations were selected according to the following criteria[13]:

- availability of PRCS branches
- staff motivated and creative
- SMHC willing to participate
- geographical distribution

With few exceptions program locations are linked to a health service station either run by PRCS or the Ministry of Health.[14]

The ***logical framework*** (2009 to 2012) is clearly designed. Activities and outcomes are coherent and can be achieved within the program' implementation period. Objectively verifiable indicators are precise and measurable, although most of them are output indicators. Assumptions and risk are stated and realistic.

The project design does not provide for measures ensuring ***sustainability and a phase out strategy.***

2.3 Conclusion

Relevance

The CBHFA program has been and ***remains relevant*** within the overall context of the oPt and especially for its main target groups and final beneficiaries. As expressed by the community members the continuous work of the Community Committees/SMHCs regarding health and social issues is of high value for the quality of life within their respective communities.

The action has been and is still aligned with Ministry of Health's national strategic plan for Palestine and interventions are ***clearly embedded in the national health priorities***.

Program Design

The program's design builds on existing community committees (SMHCs) that were created through PRCS PHC department's preceding community based projects. The planning process was participatory involving PRCS field staff, member of the SMHCs and RCRC Movement partners. The program locations chosen for implementation in 2009 and 2010 are communities that have strong health related community structures (HSS and branches), refugee camps and Bedouin communities – initially planned for – have not been included.[15]

The program is consistent and coherent in its approach and planning documents (narrative proposal, logical framework, implementation plan, budget) are clearly designed. The program's logical framework is of good quality, well structured and has a feasible vertical logic of objectives. Activities planned and the outputs and outcomes along are embedded logically within the hierarchy of the logical framework and consistent with the IFRC's CBHFA approach. Sustainability measures and a phase out strategy are not an integrated part of the program design.

3. EFFICIENCY OF PROGRAM MANAGEMENT

3.1 Implementation Structure

The CBHFA program in the oPt has a well-designed, though quite broad implementation structure from PRCS HQ via the regional level to community level. The responsibility for successful implementation of all health related activities is shared between PRCS staff and

[13] ibidem
[14] For details see Annex: PRCS/NRC/SRC – Overview on CBHFA Project Locations and PRCS Health Related Programs at the Locations
[15] See project proposal and 2009 reports of the SRC Health Delegate to the CBHFA program

voluntary community committees. While PRCS staff is responsible for overall program management as well as guidance, support of and supervision for the community committees, it is the committees members who assess their respective communities' needs and reach out to the program's target groups at community level.

Program staff at PRCS HQ includes the Director of the Primary Health Care Department, one project manager (since June 2011) and one program coordinator. At field level the program counts on a two-layered structure consisting of regional coordinators on one hand and nurses and social workers (as community facilitators) on the other hand.[17] Regional coordinators, nurses and social workers are highly committed, professional and possess large experience.[18] Nurses and social workers share everyday tasks in their work with the community as well as reporting and monitoring – a practice successfully established in preceding community based health projects.

PRCS Field Staff			
Operational Region	**Nr. Region. Coordinator**	**Nr. Nurses**	**Nr. Social Workers[16]**
WB North (8 villages)	0	7	3
WB Middle (4 villages)	1	3	1
WB South (3 villages)	1	2	2
Gaza is in the recruitment process for 1 Regional Coordinator (Sept.2011)			

The involvement of a ***SRC health delegate*** on a non-permanent basis was experienced as stimulating for both the PHC department as well as for the field staff and community committees. The delegate's technical input, especially regarding methodological approaches, has been considered of high value by all stakeholders.

3.2 Volunteer Management

Originally PRCS has a two-tier ***volunteer structure***: professional volunteers that are centrally managed by PRCS HQ and youth volunteers that are linked to and managed by PRCS branches. Currently community committees/SMHCs managed by PRCS PHC department with differing support by the branches (according to the respective branch's strength). It would be of value and highly appreciated if committee members would be provided with volunteer identification cards in addition to the PRCS vests. An excellent PRCS wide inter-departmental discourse on how to integrate community committees/SMHCs into the existing PRCS volunteer structures is on going.

Members of the ***community committees are highly committed to and convinced of voluntary community work*** – they work completely voluntarily without any cash incentives paid.

3.3 Planning of Activities

Planning for program implementation is done on a yearly, six months and monthly basis by the CBHFA program manager and the CBHFA program coordinator in collaboration with field staff and community committees. For 2011 the outline of the yearly plan has been presented in a logical framework. While six months action plans are drafted by PHC department providing for a thematic structure and guidance on major activities, detailed monthly plans are outlined at the community level by the community committees with facilitation of the nurses/social workers specifically addressing the assessed needs within the respective communities.

Although the socio-political context of the oPt has been and remains challenging (especially regarding movement of CBHFA staff), ***activities are implemented in a timely manner***.

[16] Out of the 8 persons working either as regional coordinators or as social workers, currently 4 are funded by PRCS and not through the NRC/SRC funds for the CBHFA program. Nurses, Social, Workers and Regional Coordinators are considered community facilitators and took part in the respective training.

[17] For a diagrammed overview on the implementation structure see annex

[18] Most of them have worked for 6 to 7 years in the PHC department's preceding community based programs.

3.4 Monitoring and Evaluation

A ***decentralized, participatory, truly community based monitoring and evaluation system*** has been established consisting of several components:

- Monthly reports on activities implemented by the community committees including description of activities and the number of people within each specific target group reached. The report is based on the information provided by the committees' members, drafted by the community facilitators (nurses/social workers) and passed on either to the regional coordinator or directly to the PHC department.
- Statistical data based on the monthly reports and other supervision formats are gathered and regularly updated by the project coordinator.
- A yearly narrative report on program progress including yearly statistical data reflecting outreach of the different CBHFA activities and a financial report is shared with program partners.
- Focus group discussion conducted with specific target groups provide for qualitative baseline data.
- Self evaluation sessions carried out by community committees and presented by them to the relevant stakeholders within their resp. communities.

Challenges remaining include:

- Monitoring is not always aligned with the OVI's outlined either in the overall logical framework or in the one specific for 2011.
- Statistical figures are only documented by year but not yet accumulated over the program's implementation period.
- Focus group discussions meant to provide for baseline data still need to be transcribed in order to actually provide basic information to evaluate change.

3.5 Financial Management

The memorandum of understanding and its yearly annexes between PRCS and NRC/SRC clearly defines the role and responsibilities of each partner regarding the transfer of funds. Yearly financial audit reports need to be provided by PRCS by end of April of the following year as a prerequisite for the ***transfer of program funds*** to PRCS. Unfortunately a delay in the provision of PRCS audit reports to its partners consequently caused a delay in the transfer of funds to PRCS. Although PRCS had the capacity for advance financing and therefore could continue implementation, delayed financial procedures bear a high risk of hampering implementation.

In certain points ***cost efficiency*** of the program could be reviewed resp. improved: temporary support items for beneficiaries accounting for more than 10% of the overall CBHFA program budget for 2011 are not cost efficient and unsustainable, especially if the program is further extended to other locations. This holds especially true for baby kits that are a valuable incentive for "first time" mothers to adhere to ante natal care and to traditionally appreciate their mother hood. It might be of value though to review their size and content and/or to replace some of the content by educational materials in order to decrease costs and enhance long term benefit.

3.6 Conclusion

Due to in general excellent project management, highly professional and committed staff and devoted members of the community committees all main activities have been carried out as planned and at high quality despite the difficult socio-political circumstances. The decentralized functional structure of PRCS from its HQ via the health centres and the community committees into the communities in combination with the underlying principle of

voluntarism has shown to be efficient. The highly participatory bottom up approach adopted not only for working with the community but as well for general program management ensures transparency, motivation of volunteers and in the long term program ownership and self-reliance. The main challenge remaining concerns financial management; it should be improved regarding timely provision of PRCS' yearly audit reports and cost-efficiency of temporary support items for beneficiaries.

4. EFFECTIVENESS

In general effectiveness is defined is as the contribution made by the project's results to the achievement of the project's objective(s). The overall objective and results to be achieved for the CBHFA program in the oPt are outlined in the logical framework 2009 to 2012 and reflected in the 2011 logframe.[19]

Overall Objective:
"Improve health and quality of life for women, children and families at community level and disseminate Red Crescent humanitarian goal for the Palestinian population."

Main results to be achieved include:
Result a: Capacities of staff and community members (volunteers) working locally with community based health methods are improved.
Result b: Community awareness regarding health, environmental and psychosocial issues is increased, particularly for women, children and families.
Result c: Community is empowered (especially women) through working with most vulnerable groups.
Result d: Red Crescent humanitarism is disseminated at local level.
Result e: The project is monitored and evaluated.

4.1 Voluntary Community Committees (Result b and c)

As mentioned above the program did not need to establish new community committees but build its community approach on the existing Safe Motherhood Committees. Originally the SMHCs consisted of a maximum of 12 members. For a more extensive reach out of the CBHFA program ***the number of committee members has been successfully increased*** – committees now consist of 20 to 40 members depending on the village.[20]

Altough the SMHCs have been addressed as Community Awareness Committees in the context of the CBHFA program it has to be remarked that this characterization does neither correspond with the committee members' own view nor with the committees' perception by the community. Based on the long history of the SMHCs providing knowledge, advice and services to their communities, up to now the ***committee members identify themselves as Safe Motherhood Committee –*** a "brand" that is trusted and respected by the people and standing for high quality of information and services delivered to the community members.[21]

Due to the excellent reputation of PRCS regarding the quality of their services and the high social status SMHC members gained within their communities, women were highly motivated to become a SMHC member themselves. ***Committee members personally benefit*** from acquiring knowledge, having the opportunity of intensive social interaction, gaining self-confidence and last but not least by a highly improved social status in their communities. According to the PHC department's annual program report a total of 347 women were

[19] As the CBHFA approach is only one component of PHC department's overall health interventions supported by NRC/SRC outlined in the logical framework 2009 to 2012 and CBHFA specific log frames have been drafted on a yearly basis, the formulation of results to be achieved is sometimes slightly differing in wording and order while keeping the general intention. Therefore for the evaluation report results have been formulated holistically to encompass all intended results. For details see the LF 2009 – 2012 and the LF 2011 in the annex.
[20] The aim was to have an average of 30 members per committee.
[21] Therefore in the report the committees are either named Safe Motherhood Committees (SMHCs) or more neutral community committee (CC).

rendering health and health related services to their communities in 2010.[22] SMHC members are highly committed to and convinced of voluntary work. ***They are skilled in assessing and addressing the needs of community members, trusted by their communities and highly respected for the services they deliver.*** It should be noted that the committees not only provide health and health related support but have become a key stakeholder in the overall development of their villages.[23]

All SMHC have linkages to other local institutions and or organisations. The size and quality of their networks vary broadly though. This holds especially true for their ***cooperation with and linkages to the respective PRCS branches***: In some villages SMHCs and branches support each other in their work and collaboration is close, but in other locations the linkage is very lose or not existing. Collaboration and mutual benefitting is best were the branch has strong capacity.

Challenges for the near future include:
Due to their history community committees consist entirely of women, making it sometimes difficult to ***reach out to adult men and to male youth***, especially for addressing culturally/traditionally sensitive issues (e.g. domestic violence). During the evaluation it became clear that the CCs members are open and willing to include men in their committees, to work together with men and to have male community members trained as TOTs.

The ***high number of members in each committee*** could become challenging when it comes to organisational matters – it is quite a difference if 12 people are working together or 40. Up to now the committees organised themselves successfully (with facilitation of the nurses and social workers) in rotating sub committees/groups along thematic lines (e.g. one sub group being responsible for working with the elderly, one for working with children in kindergartens, …).

The (further) strengthening of the committees' networks and ***enhancing their linkage to PRCS branches*** while at the same time involving branches and increase their capacity in dealing with community based programs**.**

4.2 Adressing Target Groups and Their Needs (Result b and d)

As outlined in the project proposal, the **target groups** of the program include:

- women (special focus on teenage girls, single women, women heading households, women in refugee camps)
- children (incl. children with special needs)
- the family in general
- Bedouins

Based on the regularly assessments carried out by and the knowledge of the CC members of the most vulnerable social groups within their villages, ***elderly people*** were added to the target groups that are addressed by the CBHFA interventions.

In the course of the program it became as well quite clear that ***there is a need to work with men and adolescent youth specifically***. Although the program is highly respected by all community members and the committees have step by step managed to partly address men and youth with their activities, their active involvement remains challenging.[24] It is quite difficult to reach out to men as they have less time due to their role as the families' livelihood providers. In addition cultural barriers make it problematic for women to address men directly when they are not members of their family. Nevertheless in the socio-cultural context of the

[22] 12 program locations.
[23] For example in all CBHFA program locations having started implementation in 2009 or 2010 SMHCs run micro projects that render social services to the community (e.g. nurseries, gyms for women)
[24] For details on the number of male beneficiaries see annex: CBHFA PAL, Community Health Education Sessions Report - Total activities of the health education sessions of Community Committee Members

oPt initiating change of attitude to and behaviour of health related sensitive social topics (e.g early marriage, gender based violence) can in the long term only be successful when supported by men. Access to information on physical, sexual and mental health for young people is very limited as there are no institutions providing these specific services and traditionally these topics are not discussed within the family.

Bedouins and refugee camp communities are not yet addressed by the program.

Community Committee members cover a wide **range of relevant health and health related topics**, using different ways of **disseminating knowledge**:

Formal activities in formal settings include lectures held at schools, kindergartens, PHC clinics, community halls and community centres on one hand and dissemination /sensitization campaigns at special events (such as the World Health Day, International Day of the RCRC Movement, village cleaning campaigns, children summer camps etc.) on the other hand.

Informal activities in informal settings include the own family, home visits to neighbours/clients and private meetings.

While formal activities are scheduled, coordinated and following a specific topic for a chosen target group, activities in the informal setting are carried out as part of every day life often on a more or less "ad hoc" basis.

Focus group discussions for specific social groups are a CBHFA specific means of intervention to gain qualitative baseline data and to work in-depth on culturally sensitive topics. Up to now four main areas have been discussed in FDGs: health and people's live situation, gender and reproductive health, domestic violence and the women's specific role within the society. Beneficiaries highly valued the group discussions, saying that it not only gave them a possibility to share their ideas and feelings with others but also helped them to release psychological stress. 75% of the women participating expressed their interest to actively continue with FDGs as a method to release stress and to generally improve the quality of life.[25]

Overview on FDGs in 2011 (Status: Sep. 2011)			
Locations	**Target Group**	**#**	**Subjects**
Jaba'	Divorced + widow women	12	Exchange experiences, topics of cultural sensitivity, life situation
Qbatia	Single women	9	Gender, expression of feelings
Bedia	Women	12	Women's particular situation
Silwad	Divorced + widow women	15	Women's situation and family life
Dier Abu Meshal	Mothers in law	12	Sexual health education
Halhoul	Women heading households	17	Women's situation, sensitivity to men and women, reproductive health and domestic violence
Ramallah-HQ	ToT	18	Women' situations, sexual health education

Topics raised by the community committees are based on the actual needs within the resp. communities and cover a broad spectrum of specific health and health related social issues. Examples for ***health topics*** addressed are: maternal health, child care, personal hygiene (children and youth), reproductive health, sexual education, changes of the body during adolescence, diabetes, hypertension, HIV/AIDs, swine flue, nutrition, meno-pause, water conservation and sanitation,… Examples for ***social topics*** include: early marriage, relative marriage, inheritance rights of women, family relations ship, how to educate/deal with children, how to deal with adolescent youth, domestic violence, safety and security on the road,…[26] Dissemination of knowledge is supported by a variety of ***educational materials*** on

[25] Source: PRCS, PHC Department, CBHFA Focus Group Discussion Report 2011

[26] The list is not exhaustive but is meant to provide an overview on the broad spectrum of topics the program takes care of.

different health topics that are distributed to the target groups. Most of them are related to women's, children's and maternal health as well as to infectious diseases. According to the committee members and beneficiaries ***health topics and social topics are of equal value*** as they are often interlinked (e.g. understanding the development of the reproductive organs during adolescence and the possible negative consequences of a pregnancy with not fully grown reproductive organs is directly linked to the discussion about early marriage). ***Beneficiaries stated that they considered the issues addressed as relevant for themselves and that the quality of lessons is high***. Home visits and personal advice provided by the committee members are particularly appreciated. Since the program started in 2009 the overall ***number of people benefitting from CBHFA interventions increased considerably.***[27]

3 4.Training (Result a)

The main training component for building the capacity of PRCS field staff and volunteers in the CBHFA approach and methodology is the so-called **Training of Trainers** (TOT).

A ***training curriculum*** based on the IFRCs CBHFA guidelines has been developed. The training consists of two parts:

Part I: a theoretical training ("Basic TOT Training") of 90 hours that is conducted over a period of 18 days with training sessions held twice per week for 5 hours. The training qualifies field staff and volunteers as community facilitators (CFs) who will then in a next step train volunteers at community level.

Part II: a field training aiming at training further volunteers in the dissemination of knowledge on health and health related topics to the community. The field trainings is conducted by the CFs at community level and covers the same topics as the theoretical training.

Topics covered include: Introduction to the RCRC Movement and its principles (5 hours), communication skills in the community (5 hours), community needs assessment (5 hours), Leadership skills (5 hours), teamwork and change management (5 hours), planning and evalution (5 hours), adult training and methods (5 hour), volunteer work and solving problems (5 hours), Focus group discussions (5 hours), gender and survey (5 hour), first aid (15 hours), health messages (5 hours), how to deal with toxins (3 hours), health prevention (2 hours), mother health (5 hours), child health (5 hours) health and disasters (5 hours), sanitation (3 hours), building knowledge on HIV/AIDS.

Nurses, social workers and selected community committee members (2 to 4 persons per location) are participating in the theoretical training together. An approach that furthers in the long term teamwork, communication and mutual understanding and is highly appreciated by field staff and CC members. Participating CC members are selected by the committee on the basis of a criteria catalogue that includes: being over 18 years of age and strongly committed to PRCS voluntary work, having the ability to read and write, having a good reputation in and strong relations with the community, having the ability to move as well as flexibility in time.

Nr of People Trained as Community Facilitators (Status September 2011)

Year	Nurses	Social Workers	CC Members
2009	6	5	17
2010	5	5	27
2011	2	2	15
Total	13	12	59
Grand Total 84			

Up to know theoretical trainings have been either conducted by the SRC health delegate or by a professional trainer linked to PRCS. Each ***training is evaluated by the participants*** through a questionnaire at the end of the training. More than two-thirds of the participants of all trainings evaluated the training either as excellent or very good.

Community Committee members in new locations asked for more support and probably additional training in how to communicate with their communities.

[27] For details see diagram in the annex

As a basis for training and working in the community the ***IFRC's CBHFA tool package*** has been translated into Arabic and distributed to the community facilitators. Community Committee members especially appreciate the community tools, stating that it allows them to work more target group specific and improved the quality of their messages considerably.

Complementary to the Basic TOT Training **additional workshops on specific topics** were held for CBHFA field staff. Topics covered included CBHFA in action, focus group discussions, volunteer management, delivery and evaluation of health messages.

In addition to the TOT training **Basic First Aid Courses** of 20 hours of training were conducted in 12 CBHFA locations for CCs and community members in 2010.

4.4 Cross-Linkages to Other PRCS Programs

In most of the program locations the CBHFA approach is not the only community based program implemented by PRCS. Of special interest are three other programs due to their affinity in content and approach: the Community Based Development Program (CBDP), the Chronic Disease Program and the Community Based Disaster Risk Reduction Program.[28]

CBDP (December 2007 to June 2011)
This program has been implemented in all project locations starting CBHFA implementation in 2009/2010 by PHC Department. It was based on two preceding community health programs that were implemented form 1999 to 2007 and had two main components: to disseminate target group oriented health and health related education and the establishment of micro projects providing social services for the community – the micro projects have been set up and are run by the SMHCs. In all CBHFA program locations that started implementation in 2009/2010 the CBD program has been implemented. In these locations the CBDP's focus has been primarily on the establishment of micro projects though. The through the program established Safe Motherhood Committees provided the entry point for the CBHFA program. CBHFA staff and CBDP staff shared the responsibility for guidance and support of the SMHC/Community Committees.

Chronic Disease Program (CDP)
Is supported by the Spanish Red Cross and implemented in 5 out of 12 CBHFA locations in the West Bank (Bedia, Silwad, Biddo, Halhoul, Beit Fajjar) by PHC Department. It is linked to the PHC Centres and specifically focuses on prevention and the reduction of chronic diseases (hypertension and diabetes). A home based care component is part of the approach. The program has its "own" volunteers/volunteer groups but coordinates and links with the SMHC committees – 3 to 5 SMHC members were trained in specific skills needed for care taking of chroncsically ill persons (e.g. how to check blood glucose) through the chronic disease program. In addition SMHC members share responsibilities with program volunteers for home visits and inform on people suffering form chronic diseases. The chronic disease program employs own nurses collaborating with the CBHFA nurses regarding beneficiaries, coordination of activities, reporting and monitoring. In some locations the CBHFA program benefited regarding outreach and involvement of men – e.g. male diabetes clients of the CDP who managed to improve their health status are as well voluntarily working with the SMHCs providing lectures/ advice on nutrition or healthy living to men. Thus they increased the SMHCs out reach to men.

CBDRR Program (start May/June 2010)
Is supported by the NRC/SRC and GRC and implemented in one CBHFA program locations in West Bank (Idna) by the Disaster Management (DM) Department. As soon as the CBHFA approach is actually implemented in Gaza the two programs will be implemented side by side

[28] For details see annex "Overview on CBHFA Project Locations and PRCS Health Related Programs at the Locations"

in Jabalia. Cooperation between the DM and the PHC Department is working well and effectively. SMHCs provided one of the entry points for the CBDRR program that is highly decentralized and tightly linked to PRCS branches. Selected SMHC members are part of the CBDRR community based structures.

4.5 Self-Evaluation Sessions (Result e)

A decentralized, participatory bottom up M+E system has been established[29]. One of the system's key components – fully introduced in 2011 – are so-called self-evaluation sessions carried out completely by the community committees. Committee members review what they have achieved by their activities as a basis for necessary adaptations and future plans. Results are presented to and discussed with key stakeholders in an official meeting. Self-evaluation sessions allow the CCs to observe their own progress, further develop the CC members' capacities, create ownership, enhance cross-linkages with community institutions and organisations and shift program responsibility to the community. In addition the evaluation meetings provide for a platform where beneficiaries can actively share their views and ideas on the program.

Overview on Self-Evaluation Sessions		
Location	**Conducted on**	**Attendance**
Jaba	09.05.2011	Community leaders, municipality representatives, directors of schools, health supervisors of MoH, some CBOs, volunteers, beneficiaries
Kefel Hares	12.09.2010	
Anabta	15.09.2011	
Bedo	19.09.2011	

4.6 Conclusion

In general the program implementation has to be considered as highly effective. SMHCs/CCs have increased the number of voluntary members and have a good reach out into their communities. Volunteers are skilled and highly committed to their work.

Capacity of PRCS staff and volunteers to implement the CBHFA approach has been improved through a well designed TOT training that is appreciated by all participants. The joint training of field staff and volunteers is of special value to the program, enhancing mutual understanding and collaboration. Repeated focus group discussions are a powerful tool to work on and bring about change concerning culturally/traditionally sensitive topics. They should be carried out continuously and conducted by field staff and maybe at a later stage by community members that were trained as community facilitators.[30] Self evaluation sessions allow the CCs to judge on their own process and enhances program ownership for the volunteers as well as for the community in general.

Dissemination of knowledge and activities implemented are based on the actual needs in the communities. Topics addressed and lectures/advice provided by the volunteers are seen as relevant and of high quality by the community.

There is a need to further increase awareness and knowledge on sexual and reproductive health for adolescent youth, to further work on gender based and domestic violence and to continue to address early marriage, relative marriage and women's rights. To work effectively on these and other topics it is absolutely necessary to increase the currently quite limited (though slowly improving) reach out to men and male youth.

The linkage of the program to branches and their involvement in program implementation need to be actively furthered, especially with regards to sustainability.

[29] For details on the M+E system see chapter efficiency/program management

[30] In the CBHFA program in Lebanon in some locations FDGs are successfully carried out by community committee members.

5. IMPACT PROSPECTS

Due to the fact that the CBHFA program is embedded in the overall primary health care approach of the PRCS PHC department and the general community based work of PRCS, it is not easy to judge on potential impact that can be clearly ascribed to the CBHFA program. Direct impact of the CBHFA program might be most significantly seen, in highly vulnerable target locations without a health service station and where the implementation of the CBHFA approach is not based on a SMHC – e.g. Bardallah[31]. However there are certain aspects that indicate the project's potential wider effects and how the action contributes to improving the health and quality of life for its target groups.

5.1 Health

As a result of the educational sessions on health provided by the committee members and the close collaboration with the Health Service Stations/Primary Health Care Centres, community members – in particular women – are getting more and more ***engaged in preventive medical care*** for themselves and their families. This includes amongst others a variety of issues, such as breast cancer screening, antenatal and postnatal care, personal hygiene or healthier nutrition. People in the target communities are as well aware on how to protect themselves against infectious diseases and according to themselves take the necessary precautions.

First Aid training enabled the participants to treat small injuries and burns medically correctly – a capacity that is highly appreciated in a socio-political and socio cultural context where the access to and/or treatment at a HSS or hospital can be challenging.

Reproductive health for adolescent youth[32] is becoming more and more an accepted topic to be lectured at schools[33] thus considerably increasing the knowledge of teenagers regarding their physical, sexual and mental health. Mothers benefitting form the program reported that as a consequence of the lectures at school they feel now comfortable to address the topic at home and to provide advice on sexual and reproductive health to their daughters and sons.

The CBHFA program and the preceding community based health related programs induced and furthered the ***acceptance of "non professionals" providing knowledge on health issues*** within the communities. By now ***men/husbands*** highly ***appreciate their wives knowledge on health***. The information provided is regarded useful and valuable as they trust in the quality of training lectures coordinated and supported by PRCS. More and more women are asked to pass on their knowledge to their husbands and gradually men start to attend lectures themselves.

5.2 Empowerment of Women

10 years ago when the members of the SMHC started to work on community based health most of the women had to overcome traditional gender barriers by leaving their family homes, often for the very first time and after long discussions with their husbands and families for permission to do so. Today SMHC members are not only perceived as key persons for education and advice on health and health related social topics but as well on issues concerning the overall development of their communities. ***A process that is maintained and enhanced through the CBHFA program*** through capacity building that not only focuses on technical knowledge but develops committee members' self-confidence, communication skills and problem solving competence. SMHC members have become a role model in and for their communities, attracting further women – not only from their own villages but as well from neighbouring communities – wanting to join the SMHcs.

[31] For the mid term evaluation Bardallah cannot be taken into consideration to judge on potenial impact as the implementation of the CBHFA program was started in 2011 only.
[32] Reproductive health lectures in this context focus on the physical change of the body during adolescence.
[33] Lectures for young men have mostly to be given by a male person.

Due to the benefits of the SMHCs' work for the family and the community, ***men*** do not only accept the "new role" of women in the community but have started to attend lectures provided by women and show interest to or actively collaborate with the SMHCs e.g. as a volunteer providing information to other men on healthy nutrition.

5.3 Social Integration

The CBHFA program actively furthers the social integration of elderly people, single women, divorced women and people with special needs by providing them with the opportunity to get involved in the program's activities either as volunteers or as beneficiaries of special events. Examples are manifold: summer camps were held as joint activity for healthy and handicapped children, women with special needs and elderly are active volunteers in community committees, special events are organised for elderly people, focus group discussions provide for a platform of communication for single women,…

5.4 Social and Cultural Change

The CBHFA program considerably contributes to a step by step change in attitudes and behaviour towards medically harmful traditional practices that are part of the socio-cultural context. For example:
Based on the knowledge that pregnancy at teenage age might lead to severe irreparable injuries during delivery, beneficiaries (men and women alike) stated that they would not allow their daughters an early marriage but want her to finish school education first.[34]
Another practice that is to about to be abandoned is the tradition of putting black charcoal around the eyes of a new born as it can cause damage to the babies eyes.

5.6 Conclusion

The CBHFA program actively contributes to the improvement of health and quality of life for women, children and families by building knowledge and capacity on health and health-related social issues that are put into practice by the beneficiaries. It is assumed that the knowledge created will continue to spread through the community volunteers, leading to further improvement of people's personal health. It is as well presumed that the positive socio-cultural changes regarding some medically harmful traditional practices, the role of women and the active integration of vulnerable social groups into the community will not only be hard to reverse but proceed and continuously improve the overall quality of life.

No negative side effects caused by the action's interventions could be observed.

7 POTENTIAL SUSTAINABILITY

6.1 Ownership

The program's ownership lies at community level. The truly participatory implementation approach and the respect gained for the services provided created a ***high degree of program ownership by the Safe Motherhood Committees***. As outlined before SMHC members are skilled in community work and actively involved in project management: They chose the focus of their work, plan, organise, carry out activities and evaluate the program's process by themselves. Committee members are highly committed to and convinced of voluntary community work. A good indicator for the responsibility they feel towards their community members is the integration of "informal" activities (e.g. home visits, providing advice) in their every day life routine. SMHCs are highly motivated to continue their work in the future – irrespective of how much support they receive by PRCS.

[34] Meaning that she would not be married before 17 years of age.

6.2 Institutional Sustainability

All SMHCs have cross-linkages to local institutions and/or other organisations. Where a PRCS branch exists, ***branches cooperate and collaborate*** with the committees. Cooperation though varies considerably in intensity, ***depending on the branches' ownership of the program and more important on the general capacity of the branch***. In some program locations the SMHCs' micro-projects are based within the branches and are financially supported by the resp. branch. In other locations where the branch has a sound youth volunteer structure, these volunteers support the SMHCs in the implementation of activities (e.g special events for elderly, organisation of self-evaluation sessions,…) In general ***branches highly value the cooperation with the committees,*** especially appreciating their needs-based reach out into the community. Still their role and responsibilities regarding the SMHCs and their work need to be further defined – a process that is ongoing at PRCS Headquarter.

Parallel an excellent PRCS wide, inter-departmental discourse ***on how to integrate SMHCs into existing volunteer structures*** while at same time passing on part of the responsibility to the SMHCs has been on going. A first workshop with representatives of SMHCs regarding their future role was conducted in July 2011. However details have not been outlined yet and no ultimate decisions were taken.

6.3 Economic and Financial Liability

The question of financial sustainability plays a role in two aspects:

a) At community level

As SMHCs carried out their CBHFA activities voluntarily without remuneration and are committed to their work less CBHFA program funds available should not have a big impact on their services provide to the community. In addition PRCS has decided to officially integrate them into the PRCS' volunteer structure and to integrate the committees were possible into other PRCS programs – an approach that has already been put into practice. Moreover it has been discussed to shift if possible step by step part of the responsibility for the SMHCs and their activities to the resp. local councils.

b) On the level of PRCS as an organisation

Given the present situation PRCS is not able to cover its running costs by itself. Staff and infrastructure of the Primary Health Care Centres are being financed and probably will continue to be financed by PRCS in partnership with donors.

6.4 Conclusion

CBHFA program ownership by community committees members and PRCS field staff is high. Community committees are truly motivated to voluntarily continue their work in the future – irrespective of the extent of support the receive. Their commitment to voluntarism will be the key factor for continuity of activities. SMHCs are not only highly skilled in the implementation of the CBHFA approach within their communities but as well in general management of their intervention. They have a high potential to continue to work for their communities more independently when closely linked to PRCS decentralized volunteer structure and branches .[35] The CBHFA approach and the health and health-related social issues addressed remain relevant for the beneficiaries and within the overall context of the oPt.

The high level of coordination and collaboration with relevant governmental and community based structures ensures that the project is embedded in institutional structures that will

[35] This holds not true for CBHFA program locations, where no SMHCs have been operative before.

continue to exist beyond the action's duration. Close cooperation and collaboration of the committees with PRCS branches will be a key component for long term sustainable community work. It will therefore be essential to shift responsibility more and more to the PRCS branches while at the same time capacitating them to adequately support the volunteers of the comunity committees. The commitment of PRCS to integrate the SMHCs in the existing volunteer structures and to actively involve the committees in PRCS' ongoing programmes and operations while at the same time passing on part of the responsibility for the SMHCs and their work to the branches and partly to the local councils is promising.

Based on the issues described above it is assumed that the knowledge created will continue to be applied after the current NRC/SRC supported program period has ended and community members will further on benefit from educational activities of the SMHCs.

7. OVERALL CONCLUSION

The CBHFA program has been set up successfully and remains relevant to its beneficiaries and within the overall context of the oPt. Implementation is well on its way due to highly committed and skilled community committees who effectively reach out to their community members.

Program locations where implementation is not based on extended SMHCs but on ***newly established community committees*** need specific attention and intensified support.

The program covers a ***wide range of relevant health and health related social topics*** based on the needs of the target communities. But there is a need to further increase awareness and knowledge on sexual and reproductive health for adolescent youth, to further work on gender based and domestic violence and to continue to address early marriage, relative marriage and women's rights. In order to do this effectively, the program's reach ***out to men and adolescent youth,*** that so far has been quite challenging due to the socio-cultural and socio-economic context of the oPt, needs to be considerably increased. A view that is shared by PRCS program staff and community committee members alike.

The ***highly participatory bottom up approach*** adopted not only for working with the community but as well for general program management ensures transparency, continuous capacity building of volunteers and in the long term program ownership and self-reliance.

SMHCs have a high potential to continue to work for their communities more independently when closely linked to PRCS decentralized service structures and branches. The committees are not only highly skilled in the implementation of the CBHFA approach within their communities but as well in the general management of their interventions.

Close cooperation and collaboration of the committees with ***PRCS branches*** will be a key component for long-term sustainable community work. Their involvement in program implementation and their capacity to do so need to be actively furthered.

In order not to hamper the up to now so successful implementation of the program ***financial management*** should be improved regarding timely provision of PRCS' yearly audit reports and cost-efficiency of temporary support items for beneficiaries.

Measures that ***ensure sustainability*** and a phase out strategy for long-term perspective should be discussed and planned for with all relevant stakeholders.

8. **RECOMMENDATIONS – SHORT TERM PERSPECTIVE**

The following recommendations are meant to be considered for the CBHFA program period of 2012:

Program Management

- If a yearly logical framework for 2012 is developed as planning tool, it might be helpful to include an activity level into the matrix to have fewer objectively verifiable out put indicators.
- As discussed with the SRC health delegate, it would be of importance to transcribe and analyse the early focus group discussions held to have qualitative base line data.
- It would be of high value to have statistical data not only presented per year but to have in addition figures accumulated over the whole implementation period. Accumulated figures would allow for an easy access to a general overview on the program's progress.
- In order to keep the program cost-efficient and financially sustainable it might be considered to review temporary support items for beneficiaries that account for more than 10% of the annual budget (e.g. content and size of baby kits).
- Delayed financial procedures bear a high risk of hampering implementation. It is therefore highly recommended that financial audit reports are finalised in due time.

Effectiveness

- As outlined earlier there is an evolving need to address men and adolescent youth specifically to holistically improve target communities' health and social well-being. It is therefore recommended for an improved reach out to men: a) to carry out small planning sessions with the CCs on how they think men could best be reached (facilitated by the responsible nurse and/or social worker), b) to review within the CBHFA program where and when lectures for men would be useful to complement the lectures for the female population – particularly on topics where men and women depend on each other and c) to consider to train at least one male TOT linked to the community committees for disseminating knowledge to the male population. Regarding adolescent youth as a first step "repeated" focus group discussions could be established for teenage girls and teenage boys – an approach that has worked successfully in the CBHFA program in Lebanon. In addition PRCS youth volunteers at branch level could provide for one entry point to reach out to adolescent youth.
- Program locations where implementation is not based on extended SMHCs but on newly established community committees should be provided special support and additional capacity building, especially on communication skills.
- The CCs cross-linkage with branches should be furthered and branches supported in building their capacity for community based programs and initiatives.
- NRC/SRC are recommended to follow up on and support the ongoing process on how to integrate SMHCs into existing volunteer structures while at same time shifting more and mores responsibility towards the committees.

Planned Extension of the CBHFA program in 2012

According to the program proposal it is planned to extent the CBHFA program in the third year of the NRC/SRC supported program period to another six villages. The planned extension should be reviewed taking into consideration different possible options:

- Option a) the CBHFA program is extended as originally planned into six new locations – in this case it is recommended to chose most vulnerable communities with remote infrastructure (no health centres) who did not benefit from services provided by Safe Motherhood Committees. If the program is extended into the most vulnerable communities

implementation should be planned for more than one year and funds need to be secured beyond 2012.

- Option b) the CBHFA program is extended into villages neighbouring the current program locations. This would respond to the many communities' directly expressed wish to have a PRCS supported community based CBHFA program in their community as well. In this case existing community committees could support neighbouring villages and synergetic effects could be created in one area.
- Option c) the CBHFA program in existing locations is consolidated rather than extended into new communities. This option would allow to focus on an increased reach out to men and adolescent youth, to intensify SMHCs and branches collaboration, to enhance SMHCs' capacity to work more independently, to strongly support the newly established community committees that are not based on a SMHC in their capacity building and last but not least to plan for sustainability measures and start phase out strategies in due time.

Considering that actual implementation in Gaza locations has only started in the second half of 2011, that new locations like Bardallah in WB and Deir al Ballah in Gaza have not been exposed to SMHCs' community work before and the need to increase the program's reach out to men and adolescent youth, program consolidation (option c) is recommended as being probably the most effective.

Sustainability

- Sustainability measures and possible phase out strategies should be discussed and developed involving all relevant stakeholders.

9. RECOMMENDATIONS – MID TO LONG TERM PERSPECTIVE

Regarding a possible implementation of the CBHFA approach beyond 2012 it is recommended to

- Focus on sexual and reproductive health for adolescent youth using a holistic approach that is sensitive towards the oPt's traditional and socio-cultural context. Such a program could be based on a peer education approach oriented on" life skill education" covering health topics as well as social and psychological issues. The program should be linked to the existing community committees and PRCS branches – branches providing for a natural entry point for youth programs through their volunteer structures. Due to the socio-cultural context it is not recommended to integrate a sexual and reproductive health for adolescent youth program into PHC clinics with specially trained doctors and/or nurses as a first step.
- PRCS branches should be actively involved in the implementation of any CBHFA approach to ensure long term sustainability. It is recommended to handover more and more responsibility to the branches, this would not only allow the community committees to work more independently and enhance their responsibility for their own communities' health but ensure an integrated approach for all PRCS community based programs. Program responsible branches are key to cost-efficiency and a smooth program phase out while keeping benefits and ensuring continuity. It is therefore recommended to mainstream the organisational development of branches for all community based programs.

PART IV
THE CBHFA PROGRAM IN LEBANON

1. PROGRAM BACKGROUND

The Community Based Health and First Aid Program is to be implemented over a period of 4 years from 2009 to 2012, with an allocated budget for the first three years of around 1,125,000,-USD. It is implemented by the Palestine Red Crescent Society Lebanon Branch (PRCS/L) and co-funded by the Norwegian and Swedish Red Cross (NRC/SRC). The action is based on the IFRC's Community Based Health and First Aid in Action approach. The CBHFA has been developed as one component of the overall Health and Care Program for the Palestine refugee population in Lebanon by PRCS/L jointly with their partners in 2008/2009. PRCS/L strategy 2005 – 2009 already planned to divert existing PRC/L health centres into community centres with the objective that these community centres would carry out community based activities, mainly related to health. In 2008, in a first phase, the health centres of Bourj Al Shamali and Shatila were diverted into community centres with the support of NRC/SRC.

The program's ***overall objective*** is defined as:
"Improve health and well-being of Palestinian refugees' community in Palestinian camps in Lebanon."

The program aims at raising awareness and enhancing knowledge on health and social aspects while at same time enabling the local communities to define and develop programs to respond to their health needs. The CBHFA approach and its interventions are targeted at the Palestine refugee camps' population in general. Special attention is given tough to promotion of female education and the empowerment of women. The program is planned to be implemented in 8 Palestine refugee camps by the end of 2012. Currently 6 camps are included in the program: Shatila (Beirut), Mar Elias (Beirut), Burj Al Shamali (Tyre), Al Buss (Tyre), Ein Helwe (Saida) and Wavel Camp (Baalbek / Bekaa).

2. RELEVANCE AND QUALITY OF PROGRAM DESIGN

2.1 Relevance

At present 425,000 Palestinian refugees are registered with UNRWA in Lebanon[36] in the twelve official camps and forty-two gatherings across the country. However, according to the AUB Socio-Economic Survey[37] of December 2010 it is estimated that only between 260.000 and 280.000 are resident in the country. 50% of the population is below 25 years of age. According to the survey, two-thirds of Palestine refugees are considered to be poor (subsisting on less than US$ 6 per day), while 6.6% are classified as living in extreme poverty, meaning that they are unable to cover their basic daily food needs. Early school leaving and low levels of educational qualifications[38] coupled with restrictions in their ability to participate in the Lebanese labour force (56% are jobless) means that many families exist in a state of persistent economic insecurity.

[36] UNRWA Lebanon Field Office, Restoring Dignity: Responses to the Critical Needs of Vulnerable Palestine Refugees in Lebanon 2012 - 2016, September 2011
[37] American University of Beirut, Socio Economic Survey of Palestinian Refugees in Lebanon, December 2010
[38] 10% of refugees age 15 or above never attended school, 8% of refugees of school-going age are not enrolled in any school and only one-third of Palestinians have the Brevet, the official exam taken at the conclusion of Grade 9.

Health Status of the Palestine Refugee Population

The rates of chronic illness and disability among the Palestine refugee population in Lebanon are indicative of the overall health status of the community; both impact on the livelihoods of individuals and create a potential burden for the families affected. A third of the population is estimated to have ***chronic illness*** (double the national average) and 4% a ***functional disability***. Hypertension is particularly prevalent. According to the AUB survey a quarter of refugee households had an ***acute illness*** in the last six months; a third of these had a flue or common cold or respiratory tract illnesses. Acute illnesses pose a particular risk for the refugee population, since the often lead to extra-ordinary expenses and periods out of work. Considering that 95% of the refugee population are without insurance and most of them in precarious employment they are unlikely to receive indemnities or sick leaves, thus a single case of acute illness may push a household further into poverty. ***Mental health*** indicators are also alarmingly high, with 21% of refugees reporting that they experience depression or anxiety. In general women report higher incidence of chronic and psychological disorders and lower self-related score, while men are most likely to suffer functional disability. There is evidence for a high prevalence of ***gender based violence***, including domestic violence and child sexual abuse. According to research, around 30% of Palestine refugee women have been victims of violence at least once in their lives.[39] Young people's ***access to sexual and reproductive services and information*** is limited due to traditional and cultural sensitivities.[40] Decaying camp infrastructure, overcrowded living conditions and haphazard maintenance of housing cause ***environmental pollution*** (incl. lack of adequate drinking water through corroded sewerage pipes and garbage contaminated areas), contributing to poor physical and mental health of Palestine refugees.

Based on the situation described above and the results of the interviews and group discussion conducted with **community committee members and beneficiaries** the topics and activities covered by the programme were judged to be of high value by the program's beneficiaries.[41]

2.2 Quality of Program Design

The action's community based health approach is based on the IFRC's Community Based Health and First Aid in Action guidelines and manuals. The CBH program was developed as part of the overall Health and Care Program for the Palestine refugee population in Lebanon by PRCS Lebanon Branch jointly with their partners during 2008/2009. ***The program's planning process*** was highly participatory – involving main stakeholders (PRCS/L staff, existing PRCS camp community committees, relevant camp organisations, beneficiaries, IFRC, ICRC) and coordinated with PRCS PHC department in Ramallah to provide for a coherent CBHFA approach in Lebanon and oPt.[42]

The ***CBH program outline*** is integrated in the overall Health and Care Program plan for 2009 to 2012 as one component. This narrative Health and Care Program document is accompanied by an overall budget and a ***logical frame work*** for 2009 – 2012. The narrative program outline "Health and Care 2009-2012" states the overall objective for the community development program as follows: "The overall objective of the program is to enhance welfare of the Palestinian refugee community and alleviate suffering by improving the health status, promote female education, enhance empowerment of women and community capacity building for better coping with health hazards."

The overall goal in the logical frame work (LF) is defined as "The community based health and secondary health services in PRCS/L are improved in quality". The CBH program

[39] AUB/UNRWA
[40] Reference: DeJong Jocelin, El-Koury Golda, Reproductive Health of Arab Young People, British Medical Journal 333, October 2006
[41] For more details see the chapters effectiveness and impact.
[42] Reference: Anethe Ljunggren, SRC Health Delegate, Mission Reports for Lebanon 2008 to 2009

component is reflected under project objective 1 "The efficiency and cost effectiveness of health centres are improved" and result 1.1 "Community health programs and activities for 8 health centres were organized and created in health centres" as well as under result 1.2 and 1.3. Unfortunately the LF does not inform on how the community will benefit form the CBH programs interventions (as briefly outlined in the narrative document). There is no indicator at the project objective level to measure if the intended impact would have been achieved, thus making it difficult to objectively evaluate successfully initiated change. Planned activities are precise and consistent with the IFRCs' CBHFA approach. Assumptions and risks are clearly stated and refer mainly to the political-economic stability within the refugee camps and Lebanon.

LFs are as well used as yearly planning and management tools – one for 2010 and one for 2011. There is a ***CBH specific LF for 2011*** providing for a clear overall objective "Improve the well-being of Palestinian refugee's community in Palestinian camps in Lebanon", clear results and objectively verifiable and measureable indicators.

The project design does not provide for measures ensuring ***sustainability and a phase out strategy.***

2.3 Conclusion

Relevance

The CBH program has been and remains highly relevant within the overall context of the situation of the Palestine refugees in Lebanon and especially for its main target groups and the camps' communities benefiting from the program.

Program design

The ***program's planning process*** was inclusive and highly participatory, providing for a first step to create ownership of the program by all main stakeholders. The ***project outline*** and the ***logical frame work*** for the CBH program reflects well how the CBH program is embedded in the overall health activities of PRCS/L from 2009 to 2012 but is in the LF not very specific on the overall objective and project purpose of the CBHFA program. There should be a clear vision on how the targeted communities will benefit from the action. Accordingly indicators are mainly output indicators that resemble the activities. The CBHFA specific LF for 2011 could be used as basis to include a project purpose that defines how the target communities benefit from the program. Indicators for the whole program period should be revised to ensure that program impact can be made measurable and visible. ***Activities planned*** are clear, consistent with the IFRC's CBHFA approach and coherent to achieve the planned results. As community based program approaches are aiming at – with time and step by step – handing over full responsibility to the community, measures for ensuring ***sustainability and a phase out strategy*** should be integrated in the project design.

3 EFFICIENCY OF PROGRAM MANAGEMENT

3.1 Implementation Structure

The CBHFA program in Lebanon has a well-designed decentralized implementation structure from PRCS Lebanon Branch HQ via the newly established community centres to the Palestinian refugee population in the camps. Program staff at PRCS/L Branch HQ includes the director of medical services, a program coordinator and a social workers coordinator. At field level in each camp a social worker and a local coordinator are responsible for the

implementation of the program[43]. Job descriptions for CBHFA program staff have been developed.

In difference to the CBHFA program in the oPt where all CBHFA volunteers are organised in the resp. community committees within their villages, the Lebanon program is relying on ***a two-tier volunteer structure***: community committees that consist of 10 to 15 members and "PRCS volunteers" jointly working in each of the program camps. Both groups of volunteers are directly linked to the community centres that are located at the PRCS/L primary health care centres and supported by the responsible social worker in cooperation with the resp. centre's local coordinator. The CBHFA program coordinator, the social workers coordinator, the social workers and local coordinators in the program camps and the community committees jointly form the community based health task force.

The support and input of a ***SRC health delegate*** working on a non-permanent basis has been highly appreciated by PRCS/L staff, volunteers and beneficiaries.

3.2 Volunteer Management

As outlined above volunteers working for the CBHFA program consist of two groups: the community committees and PRCS volunteers. ***Community committee members*** include 3 to 4 staff of the PRCS/L PHC Centre, the social worker and the local coordinator, one member of the popular committee and community members who are working in the resp. camp's community institutions or associations. Community committees are responsible for planning and implementation of CBHFA activities and – in collaboration with the social worker – for guidance of volunteers. ***PRCS volunteers*** have been recruited in the beginning mainly through the community assessments that were carried out and later on through the first aid training and health conferences that were conducted.

Due to the difficult socio-economic situation in the refugee camps it has been seen necessary to provide ***cash allowances*** to community committee members as a means of motivation. Cash incentives are paid out to each member according to ones individual performance and reflected in the amount of money paid (the lesser the performance the smaller the amount received). Performance is rated and evaluated by the social worker on a monthly basis. Cash allowances paid through CBHFA volunteers are not the same in the different PRCS/Lebanon program locations: The single amount received by community committee members in CBHFA program locations that are supported by NRC/SRC are lower than the monthly amount a volunteer has been receiving in Al Quasmieh, where the CBHFA program has been supported by Belgian Red Cross.

Currently volunteers are managed through intensive personal contact of social workers/local coordinators – a practice that might become quite challenging when the number of volunteers raises. Social workers and community committees have expressed their need to have further training in general volunteer management.

3.3 Planning of Activities

Planning for program implementation is done on a yearly, six months and monthly basis by the CBHFA program coordinator and the social workers coordinator in collaboration with field staff and community committees. For 2011 the outline of the yearly plan has been presented in a logical framework specifically for the CBHFA program. While six months action plans are drafted at PRCS/L HQ providing for a thematic structure and guidance on major activities, detailed monthly activity schedules are developed at the community level by the social workers and local coordinators in collaboration with the community committees.

[43] In Ein Helwe camp two social workers are supporting the implementation of the CBHFA program due to the high population and the difficult socio-political and socio-cultural context.

3.4 Monitoring and Evaluation

A *decentralized monitoring system based on narrative reports has been established*. Monthly and quarterly field reports are drafted by the social workers and local coordinators and then provided to PRCS/L Branch HQ. Comprehensive half-yearly and yearly narrative reports on program progress reflecting the different CBHFA activities and their outreach are shared with program partners. Activities are closely monitored by regular follow up visits carried out by the social workers coordinator and the program coordinator to each program camp. Priority is given to locations that face particular challenges regarding implementation of activities. The 2011 logical framework defines clear and measurable OVIs to monitor program progress, their degree of achievement is though not yet reflected in the narrative reports provided. Out put figures are up to now only documented per year and not yet accumulated over the program's implementation period.

3.5 Financial Management

The memorandum of understanding and its yearly annexes between PRCS and NRC/SRC clearly defines the role and responsibilities of each partner regarding the transfer of funds. Yearly financial audit reports need to be provided by PRCS by end of April of the following year as a prerequisite for the ***transfer of program funds***. The repeated delay of transfer of program funds due to out of time audit reports, delayed or limited activities that are more cost intensive but highly important for the beneficiaries (e.g recreational activities for children outside the camp to release psychological stress). Other interventions were financed (according to the financial means available) in advance by the PRCS/L centres in the camps.

3.6 Conclusion

The program is managed highly efficiently due to a decentralized well-designed implementation structure that is adapted to the difficult socio-political and socio-economic context of the Palestine refugee camps in Lebanon. The participatory bottom up approach adopted ensures transparency, motivation of community committee volunteers and will in the long term actively enhance program ownership and self-reliance. Volunteer management is currently based on regular intensive contact between social workers/local coordinators and volunteers – this might become challenging when the number of volunteers is increased as planned. It would be of high value to further enhance the field staffs' and community committees' capacity in volunteer management through additional training. The current cash allowance system for volunteers rating the performance of individual community committee members bears the risk to create tensions between community members that might severely disrupt teamwork. The system should be reviewed to maintain the team spirit of the committees. The amount of cash allowances provided to community based volunteers should be the same for any program, regardless by which partner national society a program is supported. In the long-term perspective cash allowance are not sustainable. The delay in the transfer of budget funds due to out of time PRCS audit reports severely hampers program implementation: More cost intensive activities had to be delayed or cancelled. At some point the continuity of program could only be maintained due to the commitment of program staff and volunteers and with temporary financial support by the PRCS centres in the camps.

4. EFFECTIVENESS

In general effectiveness is defined is as the contribution made by the project's results to the achievement of the project's objective(s). The program's overall objective is precisely defined in the "Health and Care 2009-2012" program document. Results to be achieved can be found in the above-mentioned paper and are reflected – more process oriented – in the yearly logical frameworks and progress reports.[44]

Overall objective:
"Improve health and well-being of Palestinian refugees' community in Palestinian camps in Lebanon."

Main results to be achieved include:

Result a: Local communities are enabled to define and develop programs to respond to their heath needs. Community based committees have the capacity to plan and implement community based programs in their localities to respond to their local health needs by the end of the project.

Result b: Awareness and knowledge of the Palestinian refugees in the camps on educational, health and social aspects that are related to their social life are raised and behaviour regarding health and health related issues positively changed.

Result c: Education for females is promoted and the empowerment of women enhanced.

Result d: People affected by conflict and other patients in need benefited from regular home based care.

Result e: 8 PRCS/L health centres are diverted to community centres/community based health centres by end of 2012.

4.1 Establishment of Community Centres (Result e)

PRCS/L strategy 2005 – 2009 already planned to divert existing PRC/L health centres into community centres with the objective that these community centres would carry out community based activities, mainly related to health. In 2008, in a first phase, the health centres of Bourj Al Shamali and Shatila were diverted into community centres.[45]

To date in all CBHFA program locations[46] the ***planned community centres have been established successfully*** – either replacing the PRCS/L health centre[47] or being combined with the health centre[48]. As the respective camps' communities were afraid of losing the possibility of medical treatment provided by PRCS, especially during emergencies/conflict, it took time and efforts for the community centres to be accepted and used by the population.

However, today the ***community centres serve as a meeting point and platform for community activities***, such as health conferences or focus group discussion. Students use the centres as a place to do their homework – especially since in most locations they receive assistance by volunteers. The installed ***toys libraries*** are opened regularly, providing educational entertainment activities for children and awareness sessions on general hygiene and nutrition for children and mothers.

4.2 Community Based Volunteer Structures (Result a and c)

A two-tier community based volunteer structure consisting of community committees and volunteers ***has been successfully set up***. All CBHFA program locations have a community committee established and PRCS/L volunteers linked to the community centres in the camps. During the last year the number of volunteers has increased by around 50%[49] – according to

[44] As the CBHFA approach is only one component of PRCS/L overall "Health and Care" Program for 2009 - 2012 and CBHFA specific log frames have been drafted on a yearly basis, the formulation of results to be achieved is sometimes slightly differing in wording and order while keeping the general intention. Therefore for the evaluation report results have been formulated holistically to encompass all intended results. For details see the LF 2009 – 2012 and the LF 2011 in the annex. Reference is as well made to the narrative "Health and Care" report for 2010 and the CBHFA "Health and Care" report for January to June 2011.

[45] Supported by NRC and SRC

[46] Including Al Quasmieh were the CBHFA approach has been supported by Belgian Red Cross

[47] Ein Helwe, Al Quasmieh

[48] Shatila, Mar Elias, Bourj Al Shamali, Al Buss, Baalbek

[49] Reference: Anethe Ljunggren, SRC Health Delegate, Mission Report May/June 2011

the statistical data provided by PRCS/L for the evaluation, there are currently around 200 volunteers[50] active in the NRC/SRC supported CBHFA locations. Community Committees and PRCS/L ***volunteers include men and women*** (in the majority) from young to mature age. This allows for effective access to women and men.

It has to be remarked though that the ***current volunteer structure is still under development***. The size of the CCs and the number of volunteers working within the camps[51] as well as their commitment to the program varies considerably for different reasons. In general recruitment of volunteers and commitment is best where the social worker and all community committee members are from the camp themselves. In this regard Mar Elias camp faces specific challenges.

In order to enhance the effectiveness of the volunteer's out-reach the following ***models*** have been discussed:

a) 1 TOT[52] would be responsible for every 1.000 inhabitants by using a cascade system. The TOT would train and coordinate around 20 volunteers. Each of the 20 volunteers could be then responsible for 50 people living in the camp. With an average family size of 4 to 5 persons[53], this would mean that on volunteer takes care 10 families. In a neighbour hood as urban and close as in the camps this should be manageable.
b) 2 TOTs being responsible for 40 volunteers per 1.000 inhabitants – meaning that each of the volunteers is taking care of 25 people (resp. 5 to 6 families).

In the specifically challenging socio-political, socio-economic environment ***the establishment of the above described volunteer force has to be regarded as a key success*** of the program.

4.3 Addressing Target Groups and Their Needs (Result b, c and d)

As outlined in the program proposal the CBHFA approach and its interventions are aimed at the ***Palestine refugee camp's population in general***. Special attention is given tough to women, young people, children and elderly persons. Currently the NRC/SRC supported CBHFA program is implemented in 6 camps: Shatila (Beirut), Mar Elias (Beirut), Baalbek (Bekaa), Bourj Al Shamali (Tyre), Al Buss (Tyre) and Ein Helwe (Saida). In Mar Elias and Ein Helwe the program has only been started this year.

Knowledge is disseminated through a variety of channels specifically addressing different target groups:

- ***conferences*** (lectures)[54] at the community centres, in schools and kindergardens
- ***conferences in a smaller, less official context*** in private houses together with neighbours.
- ***First Aid training***
- ***repeated focus groups discussions***[55]: In 4 camps regular focus groups discussions have been held continuously since 2010 for teenage girls and their mothers. Discussions are hold jointly or separated and are carried out either by social workers or by community committee members depending on the camp. In addition single focus group discussions were held with young men, moderated by the SRC health delegate or by the project coordinator. Stable focus groups of adolescent male are in the process of being established.

All interventions and topics addressed by the program are based on the ***assessment of actual needs*** of the respective camp communities. For each camp a comprehensive community profile has been elaborated. In addition small surveys on specific topics (e.g. smoking, hygiene) were carried out.

[50] This figure does not include the members of the community committees. For more details see annex "PRCS/L Overview on CBHFA Project Locations".
[51] For more details ibidem
[52] Here TOT refers to a volunteer/community committee member who has successfully completed the Training of Trainers course.
[53] According to the AUB study 2010 the average household size is 4.5 members.
[54] The term conferences is used by volunteers and beneficiaries alike – it stresses the importance of the vivid discussions that are an essential part during the "lectures" provided.
[55] For details see annex "Overview on Repeated Focus Group Discussions

Activities going on according to evaluated needs include:

- ***lectures / conferences*** on chronic diseases, cancer, nutrition, environment, hygiene, early marriage, anti smoking. In Baalbek reproductive health lectures for teenage girls are provided at one of the camps' schools. For the next year these lectures will as well be given for teenage boys.
- ***home visits*** to elderly, mothers with new borns, families with particular problems
- ***focus group discussion*** addressing culturally sensitive topics, e.g early marriage, problems within the family
- ***physical training***, e.g. walking groups, football, mini marathon competition
- c***ampaigns*** regarding sanitation and environment
- ***special events / celebrations***, e.g. 5th May, 1st December, 8th March, Mothers Day
- ***toy library***: entertainment activities for children, children's and youth handicraft sessions, homework support

Beneficiaries met during the evaluation, stated that they considered the issues addressed as relevant for themselves and that the quality of information provided is high. Still they had some ***suggestions for topics/issues*** that should either be introduced to the program or intensified:

- How to raise children / how to deal with adolescent youth
- Improvement of family relationships
- More health issues specifically regarding women's health
- Psychological support
- Computers in the community centres (including access to internet) and lectures on how to use computers (for adults and teenagers)
- English classes for mothers to enable them to help their children at school
- Renovation of gyms that are located in some of the PRCS health/community centres but are out of order (volunteers and beneficiaries were willing to actively contribute to the renovation, e.g. by painting walls themselves)

Since the program started the ***overall number of people benefitting from CBHFA interventions increased considerably.[56] Due to the cultural and socio-economic context out reach to women is higher than to men.***

4.4 Capacity Building of PRCS/L Staff and Volunteers (Result a and c)

The main training component for building the capacity of PRCS/L field staff and volunteers in the CBHFA approach and methodology is the so-called ***Training of Trainers (TOT).***

For the TOT a training curriculum based on the IFRC's CBHFA guidelines has been developed. The training consists of three theoretical parts building on each other and going hand in hand with practical application of the knowledge acquired in the community:

TOT I: Comprises of 27 hours theoretical training and 35 hours practice in the community. Topics covered include RCRC Movement, communication and teamwork, community work and voluntarism, first aid, water and sanitation.

TOT II: Comprises of 28 hours theoretical training and 35 hours practice in the community. Topics covered include RCRC Movement, community work and voluntarism, communication and teamwork, gender, volunteer management system, drama, mother and child health, STDs & HIV/AIDS and a follow up on practical community work.

TOT III: Topics covered include RCRC Movement, communication and teamwork, focus group discussions, how to make a small survey, communicable diseases and working with elderly.[57]

[56] For details see annex "CBHFA Lebanon / Activities and Number of Beneficiaries"

[57] Unfortunately the number of hours for each topic is not included for all topics in the curriculum.

In 2011 a three days ***drama training*** has been added to the TOT in order to use "edutainment" as a means of transporting health messages to the community members.

Once all three parts of the TOT are completed participants receive a ***training certificate*** and are supposed to continuously train community committees and PRCS/L volunteers in their respective communities. The training is jointly conducted by the SRC health delegate, the project coordinator and the social workers coordinator, with more and more responsibility handed over by the delegate to PRCS/L Branch HQ staff to ensure sustainability.

Local coordinators, social workers and community committee members are participating in the theoretical training together – an approach that furthers teamwork, communication, and mutual understanding and is highly appreciated by staff and CC members. In 2010, 25 persons completed a full TOT cycle – 5 from each CBHFA location (Shatila, Baalbek, Al Buss, Burj Al Shamali and Al Quasmieh that has been included to ensure a coherent CBHFA program approach for PRCS/L). A second TOT cycle has been started in 2011 and is ongoing, including staff and community members from the newly integrated locations, Mar Elias and Ein Helwe.

It is unfortunate that the ***IFRC's Arabic CBHFA tool package*** has only been partly made available to PRC/L Branch. As a consequence volunteers had to be provided with xerox copies that are less durable when regularly used.

In addition quarterly ***refresher trainings / workshops*** for all persons having completed the TOT cycle have been introduced in 2011. Topics covered included: evaluation of two years work and how to go forward; moderating empowering FGDs; drafting an activity plan with budget in order to improve understanding for this as a steering instrument and motivate/improve financial responsibility; the transformation of health clinics to community health awareness centre; community/volunteer management and possibility for sustainability. In the future it is planned to carry out refresher courses only once per year.

Participants highly valued the quality and content of the training. In the course of the evaluation social workers and CC members expressed their wish to have more training on volunteer management.

In addition to the TOT training community based ***First Aid Sessions*** were provided to community committees, PRCS/L volunteers and community members. It is especially these first aid training that are not only highly appreciated by the community members but as well ***create trust in the program and serve as a platform for recruiting more volunteers***.

Number of Participants in First Aid Training[58]

Camp	# of participants 2010	# of participants 01. to 06.2011	
Shatila	200	200	
Mar Elias		150	
Al Buss	290	159	
Bourj Al Shamali	302	220	
Baalbek	250	250	
Total	1.042	979	
Grand Total			**2.021**

4.5 Cooperation with Other Organisations (Result a)

An ***in general well-working cooperation and coordination with other organisations/community associations*** working in the camps has been established by the community committees. This is in considerable part due to the fact that community committee members are or have been working with different organisations/ associations and are highly linked within the communities of their respective camps. All committees (except in the two new locations) are cooperating with other organisations and structures, although this can be quite challenging due to the complex political context in the camps. Representatives of

[58] Source: PRCS/L report 2010 and PRCS report January to June 2011

cooperating organisations met during the evaluation highly valued the CBHFA program and stated that they preferred the cooperation with PRCS to their cooperation with other organisations/institutions.

4.6 Cross-linkages with Other Programs

As outlined before the ***Belgian Red Cross*** is supporting/has been supporting the implementation of a ***CBHFA approach in Al Quasmieh*** and its surrounding gatherings from September 2009 to December 2011. Due to the different socio-political context (a gathering instead of a camp) and the geographical area covered, the established community committee is differently structured. The committee is composed of 1 to 2 community members from each of the targeted gatherings. Creating team spirit and program ownership is therefore more challenging than in the camps. As outlined in the chapter on efficiency of program management the amount of cash allowances provided to the Al Quasmieh CC members differs from the ones the CC members of the NRC/SRC supported CBHFA program. Coherency in the methodological approach has been significantly enhanced through the joint TOT training of all local coordinators, social workers and representatives of the community committees.

Once the scheduled ***Community Based Disaster Risk Reduction Program*** (CBDRR) has started full implementation the inter-linkage between the CBHFA approach and the CBDRR (especially the linkage between community committees and the DRR camp focal groups)) needs to be carefully planned in order to achieve effective synergies.

4.7 Conclusion

In general program implementation has to be judged as highly effective. Even more so as the target communities have not been exposed to an intensive community based approach before and trust in the value of the program had to be built step by step by PRCS/L.

In all locations community centres have been successfully established and are used by the camp's community. Community Centres serve as a meeting point and a platform for community activities. The integrated toys libraries provide a "protected space" for children outside their homes where they benefit from educational entertainment activities and homework support.

In the specifically challenging socio-political and difficult socio-economic environment of the Palestine refugee camps the establishment of a two-tier volunteer structure consisting of community committees and PRC/L volunteers has to be seen as a key success of the program. Community Committees and PRCS/L volunteers include men and women, thus allowing for a culturally sensitive access to women and men. Based on the excellently designed Training of Trainers course, community committees have developed thorough capacity to plan and implement needs based health and health related activities while being guided by the social workers and local coordinators. Although the number of PRC/L volunteers has been continuously increased, the proposed cascade model where 1 or 2 TOTs and 20 to 40 volunteers are jointly taking care of 1.000 people needs to be put in practice to enhance the reach out to the community. An intensified capacity building in volunteer management at PRCS/L Branch HQ and at field level for staff and community committees should go hand in hand with the planned increase of the number of volunteers.

Dissemination of knowledge and activities implemented are based on the actual needs in the communities. The ongoing repeated focus group discussions with teenage girls and their mothers are a highly effective approach not only to bring about change regarding culturally sensitive health and health related social topics but as well for the empowerment of women. Topics addressed and lectures/advice provided by the volunteers are seen as relevant and of high quality by the community. According to the beneficiaries there is an urgent need for

psychological support. PRCS/L's first aid training is especially appreciated by the camp's communities.

Since the program started the overall number of people benefitting from CBHFA interventions increased considerably. Due to the cultural and socio-economic context out reach to women is higher than to men.

5. IMPACT PROSPECTS

As actual impact can best be measured ex-post or at the end of a program period and with two locations where implementation has only started this year, it is still early to judge on the program's impact. How ever there are certain aspects that indicate the program's potential wider effects and how the action is likely to contribute to an improved health and well-being of Palestinian refugees in the Palestine refugee camps in Lebanon.

5.1 Health

According to the community committee members, the CBHFA program's beneficiaries and the representative of organisations working in the camp, the ***general awareness on personal health and the knowledge on communicable and chronic diseases have increased considerably***. As a result of the educational sessions on health provided through the program community members – in particular women – are getting more and more ***engaged in preventive medical care.*** This includes amongst others a variety of issues, such as antenatal and postnatal care, personal hygiene or healthier nutrition. Women especially appreciated conferences on ***health topics specifically addressing women's' health.*** The fact that female beneficiaries have asked during the evaluation process repeatedly for more information regarding these topics can be considered as one indicator on how the awareness on the importance of personal health care has changed to the positive. Beneficiaries in the target locations are as well aware on how ***to protect themselves against communicable diseases*** and according to themselves take the necessary precautions for themselves and their families.

First Aid training has capacitated community members to ***actively take medical correct action in case of burns, fractures and other small injuries as well as in emergency cases***. Women reported that they do not only have the knowledge to treat burns and small injuries but that they have now as well the self-confidence to do it.

The probably biggest impact of the CBHFA program up to now concerns the ***knowledge of teenage girls on sexual and reproductive health***. A topic that is culturally/traditionally tabooed and not addressed within the family but discussed in the repeated focus groups. According to one community committee member who is moderating one of the ongoing focus groups for teenage girls, in the beginning out of 12 small teenage girls only one girl knew about the physical and hormonal changes that occur during adolescence. In one of the UNRWA schools in Wavel camp (Baalbek) reproductive health lectures for adolescent girls are provided regularly by community committee members. The lectures are appreciated alike by school staff, pupils and their parents and have become so accepted that next year reproductive health lectures for adolescent boys will be added to the program.

The CBHFA program induced the ***acceptance of "non professionals" providing knowledge on health issues*** within the communities. Although it took some time, by now the information provided is regarded useful and valuable and there is trust in the quality of conferences and focus group discussions coordinated and supported by PRCS/L. Some lectures are now attended by women and men together.

5.2 Social and Cultural Change

The CBHFA program not only successfully addresses health issues but equally ***generates a continued discussion within the target communities on culturally sensitive or tabooed social issues***, such as early marriage, family relationships, domestic violence, school drop out, misuse of drugs, the role of women, … Community Committee members reported that they have carefully started to provide advice to families facing specific problems (e.g. domestic violence). According to the mothers and teenage girls participating in the focus group discussions, their participation has improved the relationship between mothers and daughters as well as within the family, motivated teenage girls to continue their education and released psychological stress.

Exchanging experience on a personal level, the ability to name taboos and an open discussion climate concerning culturally sensitive social issues are an essential first step to induce a general change in adverse, culturally rooted social behaviour patterns.

5.3 Empowerment of Women

The traditional sole role of women is being the main care taker of the family, a responsibility that largely confines women to the house. The CBHFA program provides women (as volunteers) with the ***opportunity to overcome traditional gender barriers*** and to have an increased intensive social interaction within the community. In general women benefit from the knowledge they acquire, develop better communication skills, improve their problem solving competence and gain self-confidence. They actively contribute not only to the well-being of their families (e.g. by taking care of small injuries) but visibly to an improvement of the situation in the camps (e.g. through environmental clean up campaigns). According to the program volunteers and beneficiaries the women's increased knowledge on health and women's active participation in the CBHFA program interventions have become respected and valued by men, leading to active support of the men for the women's activities.

5.4 Conclusion

The CBHFA program actively contributes to the improvement of health and well-being of Palestinian refugees' community by building knowledge and capacity on health and health-related social issues that are put into practice by the beneficiaries. Women are empowered through the training and education they receive and the active role they have in the overall implementation of the program. In addition to the health education provided the program generates a continued discussion within the target communities on culturally sensitive or tabooed social issues that is in the long term assumed to induce a general change in adverse social behaviour patterns.

No negative side effects caused by the action's interventions could be observed.

6. POTENTIAL SUSTAINABILITY

6.1 Ownership

Program ownership by PRCS/L Branch HQ, CBHFA field staff and in general by the community committees is high, taking into consideration that neither PRCS/L nor the target communities had experience with an intensive community based health approach before. In most locations community committees and volunteers are committed to and convinced of voluntary community work.

Community ownership and the communities' general understanding of the value of a community based health approach is gradually developing since fears that PRCS/L would stop to provide primary health care services could be removed and trust has been built. Still

there is ***need for more advocacy and continued efforts to enhance the communities' ownership***. Especially challenging in this regard is Mar Elias camp where the first community committee quit and the members of the newly established community committee seem only to be partly living within the camp. Program progress and genuine program ownership have been proven to be best, where field staff and community members are from the camps themselves and well connected with the respective community.

6.2 Institutional Sustainability

All ***community committees cooperate with the resp. camps' relevant institutions and community based structures***. Cooperating institutions and community associations highly value the cooperation with the PRCS/L supported committees. The size and quality of the their resp. networks vary broadly tough. While in some camps (e.g. Baalbek, Shatila) cooperation is close and synergetic, others have not yet managed to be seen as an important partner in the provision of services to the community (Mar Elias). The embedding of the CBHFA approach in the newly established ***PRCS/L community centres*** provides a thorough basis for potential continuity of the program and the opportunity to constantly create tangible benefits for the camps' population (e.g. as a meeting point for discussions, toys library activities).

6.3 Economic and Financial Liability

The question of financial sustainability plays a role in tow aspects:

a) On community level

The principle of voluntarism is a key factor in achieving sustainability of community based activities. As experience has shown in the oPt, it can be assumed that volunteers will continue to render their services (probably on a lower level) to the community – irrespective of how much support the receive by PRCS/L, provided that activities are addressing actual needs and volunteers' personal benefits gained by voluntary work are of high value and not based on cash allowances.

b) On the level of PRCS/L as an organisation

Due to the present political and economic context PRCS/L is currently not able and cannot be expected to cover its running costs by itself. Staff and infrastructure will continue to be financed in partnership with donors.

6.4 Conclusion

Given that neither PRCS/L nor the target communities had experience with a community based approach before, the program ownership by PRCS/L, field staff and community committees is high. Community ownership and the communities' general understanding of the value of a community based health approach is gradually developing but more advocacy and continued efforts are needed to genuinely root the program in the target communities. The newly established community centres provide a thorough basis for potential continuity of the program by constantly providing direct tangible benefits for the target communities. The cash allowance based volunteer management system needs to be revised to create a stable volunteer force providing services to their resp. communities. Due to the present situation the need to financially support PRCS/L for its staff and running costs will remain.

7. OVERALL CONCLUSION

The CBHFA program has been successfully set up and is highly relevant for its beneficiaries and within the complex socio-political and difficult socio-economic context of the Palestine refugee camps in Lebanon. The program is well on its way and ***implementation has to be judged as highly effective.*** Even more so as target communities have not been exposed to an intensive community based health approach before and trust in the value of the program had to be built carefully by PRCS/L. Still it has to be remarked that the program progress is not the same in all locations, some camps are progressing more than others. Especially Mar Elias and Ein Helwe, both having started the CBHFA program in 2011 only, need to be given special attention and intensified support.

In all locations ***community centres*** have been established successfully and are used by the camps' inhabitants. They serve as a meeting point and a platform for community activities.

In the specifically challenging socio-political and difficult socio-economic environment of the Palestine refugee camps ***the establishment of a two-tier volunteer structure consisting of community committees and PRC/L volunteers has to be seen as a key success of the program***. In difference to the CBHFA program in the oPt community committees and PRCS/L volunteers include men and women, thus allowing for a culturally sensitive access to women and men. The proposed cascade model where 1 or 2 TOTs and 20 to 40 volunteers are jointly taking care of 1.000 people needs to be put in practice to enhance the reach out to the community. The cash incentive based volunteer management system should be revised in order to ensure long term program sustainability.

Community committees are in general not only committed to the program but have been capacitated to plan and implement a broad range of community activities due to an excellently designed training of trainers (TOT) curriculum.

Since the program started ***the overall number of people benefitting from CBHFA interventions increased considerably***. Due to the cultural and socio-economic context out reach to women is higher than to men.

Although it is still very ***early to judge on impact*** an increased knowledge regarding health and the willingness to address culturally sensitive topics can be observed. According to the community committees the program definitely contributes to the empowerment of women. The probably biggest impact of the CBHFA program up to now concerns the increased knowledge of teenage girls on sexual and reproductive health.

Measures to ensure ***program sustainability*** need to be discussed and planned for.

8. RECOMMENDATIONS – SHORT TERM PERSPECTIVE

The following recommendations are meant to be considered for the CBHFA program period of 2012:

Program Management

- It might be of high value to develop a logical framework specifically for the CBHFA in order to efficiently monitor and evaluate program progress. The log frame should include a clear project purpose, measurable results and defined activities. Objectively verifiable indicators could be fewer than in the current matrix but should be key indicators that are maintained over the whole program period and monitored against.
- It would be as well of high value to have statistical data not only presented per year but to have in addition figures accumulated over the whole implementation period. Accumulated figures would allow for an easy access to a general overview on the program's progress.

Coherency of data should be paid special attention. NRC/SRC are recommended to technically support capacity building of CBHFA program staff in monitoring procedures.

- In order to simplify data management for the social workers coordinator a training in Excel program is recommended – if possible training could be done PRCS/L internally. Training should be provided as soon as possible.

- Volunteer incentives should be changed from personal cash allowance for individual performance to incentives that benefit the community committees as a team and provide as well benefits for the community in general (e.g. training, computers for the community centres). Performance evaluation of the community committees should be based on jointly developed criteria and accepted by the CCs.
- If cash allowances are provided to volunteers as a motivation incentive, allowances should be the same amount for all CBHFA projects regardless by which PNS the project is supported.
- For overall program coherency it would be essential to develop generally applicable PRCS/L guidelines on volunteer management and – as the number of volunteers is continually increasing – to build a volunteer information system. NRC/SRC are recommended to actively support this process.
- As communicated by PRCS/L field staff and CC members, further capacity building on volunteer recruitment, motivation and management is needed. An intensified capacity building in volunteer management at PRCS/L Branch HQ and at field level for staff and community committees should go hand in hand with the planned increase of the number of volunteers

- The IFRCs CBHFA toolbox in Arabic should be made accessible for PRCS/L in a higher number.

Effectiveness

- The proposed cascade model where 1 or 2 TOTs and 20 to 40 volunteers are jointly taking care of 1.000 people should be put into practice to enhance the reach out to the community.
- As outlined above, currently out reach to women is higher than to men. In order to address men more effectively it is recommended a) to carry out small planning sessions with the CCs on how they think men could best be reached (facilitated by the responsible social worker and the local coordinator), b) to review within the CBHFA program where and when lectures for men would be useful to complement the lectures for the female population – particularly on topics where men and women depend on each other.
- As it has shown that program process is best where the responsible social worker comes from the camp herself/himself, it is recommended to recruit staff who are or have been living or working in the resp. program camp (if possible).
- Program locations where implementation has started in 2011 (Mar Elias and Ein Helwe) should be provided special support.

Sustainability

- Sustainability measures and possible phase out strategies should be discussed and developed involving all relevant stakeholders.

Planned Extension of the CBHFA program in 2012

- According to the program proposal it is planned to extent the CBHFA program in the third year of the NRC/SRC supported program period to another 2 camps. The planned extension should be jointly reviewed. It is highly recommended to consolidate the program in existing locations rather than extending into new camps. This would allow to focus on the camps where implementation has started in 2011 only – especially Ein Helwe the largest of all camps; to thoroughly set up the planned cascade volunteer structure and further improve volunteer management; to increase reach out to adult and adolescent men; and to discuss and develop measures for sustainability and possible phase out scenarios.
- In case of an extension to Al Quasmieh and/or Nar El Bared as it has been discussed between PRCS/L and the NRC delegate in Lebanon, it is recommended to revise the current implementation approach for Al Quasmieh regarding the number of gatherings to be part of the program and the composition and location of the community committees.

9. RECOMMENDATIONS – MID TO LONG TERM PERSPECTIVE

- As the program has been successfully set up, is highly promising and behaviour change needs time, it is highly recommended to PRCS/L and NRC/SRC to extend the current CBHFA program period into a second program phase.

ANNEX

Annex 1: Terms of Reference
Annex 2: Evaluation Schedule and List of Persons Met oPt
Annex 3: Evaluation Schedule and List of Persons Met Lebanon
Annex 4: Bibliographie

Annex 5: CBHFA oPt / Overview on Project Locations and PRCS Health Related Programs at the Locations
Annex 6: CBHFA oPt / Implementation Structure
Annex 7: CBHFA oPt / Community Health Education Sessions 2010 – Statistical Overview 2010
Annex 8: CBHFA oPt / Beneficiaries 2009 and 2010
Annex 9: CBHFA oPt / Reproductive and Child Health Care & Community Health First Aid Logical Framework 2009 - 2012
Annex 10: CBHFA oPt / Logical Framework PHC CBHFA 2011

Annex 11: CBHFA Lebanon / Overview on CBHFA Project Locations
Annex 12: CBHFA Lebanon / Activities and Number of Beneficiaries
Annex 13: CBHFA Lebanon / Overview on Repeated Focus Group Discussions
Annex 14: CBHFA Lebanon / PRCS/L Health and Care Logical Framework 2009 – 2012
Annex 15: CBHFA Lebanon / PRCS/L Health and Care Program Logical Framework 2011