IFRC

Swiss Red Cross

COMMUNITY HEALTH MODULE

Understanding and supporting healthy behaviour in the community

ACKNOWLEDGEMENTS

Special thanks to the Swiss Red Cross, Finnish Red Cross and Netherlands Red Cross for their expertise, ongoing support, commitment and contributions to the development of the behaviour change guidance and application to the work of community health, health promotion and emergency response.

ABOUT THIS MODULE

This module helps you understand what shapes people's behaviour – and how you can support them in making positive changes when needed.

It explains what behaviour is and how to identify the main factors influencing a certain behaviour in a community. It also shows how to use this understanding to choose practical, respectful ways of supporting healthy behaviour change within communities, and how to monitor whether your efforts are making a real difference.

Lasting change happens when people feel understood, supported and motivated. As staff and volunteers, the role is not to tell people what they should be doing, but to listen, learn and create the right conditions for healthy change – making it easier for individuals and communities to take actions that improve their own lives.

The target audience for this module is anyone that wishes to understand more about behaviour change.

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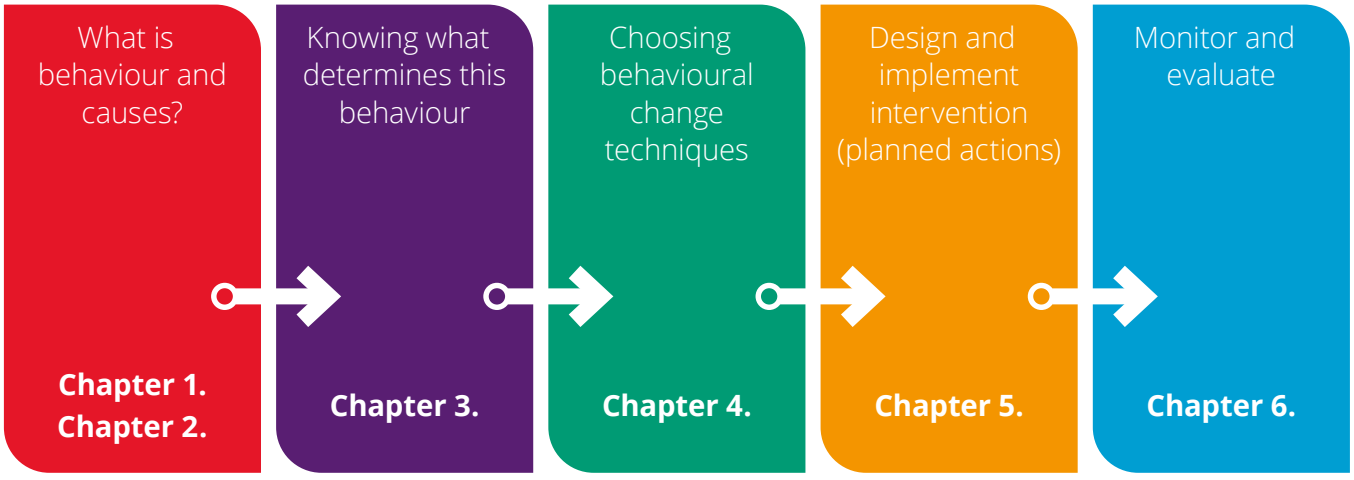


CHAPTER 1

What is behaviour?

Learning objectives

- **Understand what behaviour is in a community health context**
- **Recognize examples of healthy and unhealthy behaviours**
- **Differentiate between intentional and habitual behaviours**
- **Learn how to define a behavioural goal**

CRITICAL

Healthy behaviours are the foundation of good health, preventing disease and improving well-being. But supporting behaviour change is **not** as simple as telling or showing people the behaviours they should be doing. Real change happens when we understand **why** people behave the way they do – what **supports** or **prevents** healthier behaviours in their specific context. This means listening to communities, understanding their realities and working alongside them to empower them to choose healthier behaviours for themselves. When done well, this builds community ownership, community resilience and improved long-term health.

WHAT IS BEHAVIOUR?

Behaviour refers to specific observable actions people do that affect health and well-being[2]. These actions can be:

- **Beneficial** (healthy) or **Harmful** (unhealthy).
- **Personal** (affecting your own health) or **Communal** (affecting others).

Behaviours can also be **intentional or habitual (or alternate depending on context).**

- **Intentional:** are conscious choices, (e.g. choosing to exercise, vaccinate your child, attending a social event even when you are sick).
- **Habitual:** automatic, cued actions, (e.g. brushing teeth, unintentional snacking, washing hands with water only).

- **Habits** are less effortful than intentional behaviours.
- Repeating intentional behaviours can make them habits.
- Bringing conscious awareness to habit behaviours can make them intentional again.

- **Changing intentional behaviour**, we mostly target our **conscious minds** – providing information, persuasion or training to provoke **a different behaviour to be chosen.**
- **Changing a habit**, we mostly target **our automatic minds** – requiring disruption of our routines or elements of our environment to **bring automatic actions back into our awareness**, then allowing **new behaviours to be chosen.**

EXAMPLES OF BEHAVIOUR
HEALTHY[1]
Handwashing with soap, sleeping under mosquito nets, attending health check-ups
UNHEALTHY
Open defecation, smoking, drinking unsafe water

[1] Healthy behaviour is defined as any action to promote, protect or maintain health focusing on physical, mental and social well-being. See also WHO factsheet: Everyday actions for better health – WHO recommendations

[2] While this module is intended for health and well-being, behaviour change can be applied to any behaviour not related to health such as for example corruption, purchasing, conflict and many more.

HEALTHY BEHAVIOURS IN THE COMMUNITY

Identifying a health problem and its related behaviours as well as defining the desired behaviours to reduce the health risk or problem need close collaboration and engagement with the community and individuals. Behaviour change can only come from the person themselves. If someone does not want to change, he or she will not change. Hence, community members themselves need to be the drivers of any behaviour change activity[3].

Healthy behaviour can involve **Doing** something healthy or also **Not doing** something harmful.

These behaviours may affect **individual** health or **broader community** health.

DEFINING A HEALTHY BEHAVIOURAL GOAL

Clearly defining the desired healthy behaviour you want to promote is the first step in change. We will go more into this in the next chapter. But to know for now, healthy behaviour change has three forms, involving either:

- **Adding** a positive behaviour
- **Removing** a harmful behaviour
- **Modifying** an existing behaviour

KEY TAKEAWAYS

- Behaviour can be intentional or habitual.
- Healthy behaviour involves doing healthy actions or avoiding harmful ones.
- Understanding behaviour and setting clear desired behaviour goals are foundational for change.

[3] See also the Community mobilization module.

CHAPTER 2

What causes behaviour?

Learning objectives

Identify root behavioural causes of community health problems

Understand individual determinants (factors that influence behaviour) using the COM-B model[4]

Explore other behavioural models briefly

[4] The behaviour change wheel: A new method for characterising and designing behaviour change interventions | Implementation Science | Full Text. See also: ModelThinkers - COM-B and Behaviour Change Wheel

ROOT CAUSE: DETERMINING THE DESIRED BEHAVIOUR

The desired behaviour can be determined either through method A or B.

A. STARTING FROM A COMMUNITY HEALTH PROBLEM

We ask:

- What is **causing** this problem?
- Are there **behaviours contributing** to this problem?
- Would **changing** these behaviours i**mprove the problem**?

This helps us determine if the issue has behavioural roots, and if improving health behaviours can improve the problem.

Sometimes this is clear, other times it needs investigation and thinking.

CASE EXAMPLE

PROBLEM

High child malnutrition in the community

HEALTHY

Healthy behaviour: Caregivers include more protein and iron-rich foods daily

UNHEALTHY

Unhealthy behaviour: Children eating mostly maize porridge, lacking nutrients

B. STARTING WITH DESIRED HEALTHY BEHAVIOUR

We do not always need to start with an identified problem; sometimes we can promote proactive **healthy behaviours** – based on **guidance** from the **World Health Organization (WHO), Ministries of Health, IFRC** training materials, etc.

- Regular exercise
- Routine vaccinations
- Preventive health check-ups
- Eating fruits and vegetables

The SMART goals checklist is a valuable tool to guide the development of clear and actionable behavioural goals. Ask yourself is the desired behaviour:

- **S**pecific?
- **M**easurable?
- **A**chievable?
- **R**elevant?
- **T**ime-bound?

CASE EXAMPLE

HEALTHY

SMART goals, like "complete one hour of mild-moderate exercise two times per week", increase the effectiveness of interventions

UNHEALTHY

Vague goals like "improve hygiene" or "exercise more" lack clarity for action

[4] The behaviour change wheel: A new method for characterising and designing behaviour change interventions | Implementation Science | Full Text. See also: ModelThinkers - COM-B and Behaviour Change Wheel

EFFECTIVE DESIRED BEHAVIOUR

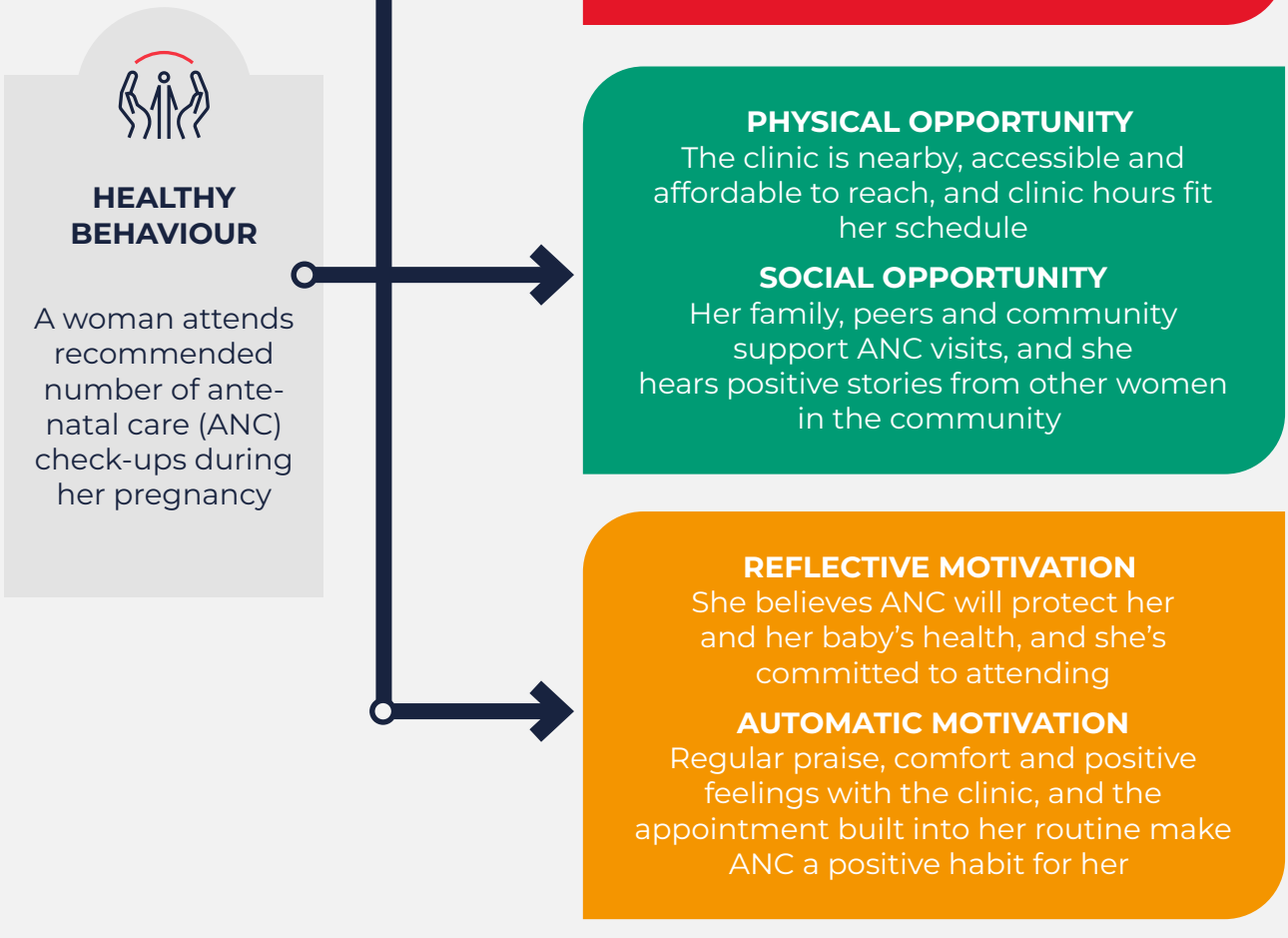
Next step: Understand what determines a health behaviour
The COM-B model offers a clear framework to break a behaviour down into its foundational influences.

To perform a behaviour someone requires:

The COM-B Model

EXAMPLE TO ILLUSTRATE THE DETERMINANTS OF BEHAVIOUR

Mapping out each possible determinant for your desired behaviour can be very helpful in comprehensively understanding the behaviour in your context.



OTHER WAYS TO BREAK DOWN DETERMINANTS OF BEHAVIOUR

While we focus on COM-B in this module for its simplicity, it's important to know there are other models of behaviour that break down the determinants of behaviour slightly differently. These may offer more useful insights to explain behaviour in your context if you have the resources to investigate further. Notably:

- The theory of planned behaviour – focuses on attitudes, norms and self-efficacy, which predict an individual's behavioural intentions, which then predict behaviour[5]
- Health belief model – focuses on perceptions of risks, barriers and benefits, which determine our health behaviours[6]

KEY TAKEAWAYS

- Knowing the behavioural root causes is essential to effectively change behaviour.
- The COM-B model helps to understand behavioural determinants.
- Other behavioural models exist and can provide additional insights.

[5] Resources to find out more about the theory of planned behaviour – The Theory of Planned Behavior: Behavioral Intention; Theory_of_Planned_Behaviour.pdf

[6] Resources to find out more about the health belief model What Is the Health Belief Model? An Updated Look; The Health Belief Model (PDF)

CHAPTER 3

Changing behaviour – Part 1

Learning objectives

Identify which behavioural determinants to target in your context

Understand assessment methods like doer/non-doer analysis

Apply the Social Ecological Model (SEM) to understand influences

CRITICAL

By now you've identified a specific healthy behaviour you want to encourage, and you are familiar with tools like the COM-B model that can break down all the possible determinants of this behaviour. **But here's the critical part of behaviour change, not all determinants are equally important and relevant to target.** When you select a less relevant determinant to target, your intervention is much less likely to be successful.

CHOOSING THE CORRECT DETERMINANTS TO TARGET

Not every determinant from the COM-B model will be relevant in every situation. To focus your efforts effectively ask yourself:

- Does this determinant strongly influence the behaviour here?
- Can it realistically be changed through an intervention?
- Is there still room for improvement in this determinant?

Two example scenarios to illustrate this

CASE STUDY 1	CASE STUDY 1
CHILDHOOD VACCINATION	**MASK-WEARING DURING INFECTIOUS DISEASE OUTBREAK**
Goal Increase childhood vaccination rates	**Goal** Increase consistent mask use
Misstep Focusing on educating parents on importance of getting vaccinated (psychological capability)	**Misstep** Assumed people lacked masks and just distributed more (physical opportunity)
What was missed Parents already knew vaccines were important—real issue was distance to clinics and limited hours (physical opportunity)	**What was missed** Many believed the disease was spiritual , or felt no strong commitment to use masks (social opportunity, reflective motivation)
What worked Shifted clinic hours and launched mobile weekend clinics. Access improved, vaccination rates rose.	**What worked** Engaged trusted leaders to advise on spiritual beliefs and fostered community commitment in mask-wearing
Key insight Don't assume the barrier—investigate it before starting.	**Key insight** Behaviours aren't just about resources and access—they're about beliefs, intentions motivations etc.

TOOLS TO HELP YOU IDENTIFY KEY DETERMINANT TO TARGET

1. DOER/NON-DOER ANALYSIS

This is a method of analysis where you compare people in the community that do the desired behaviour and those that do not. Through short, structured interviews you explore the differences in their capability, opportunity and motivation between doers of the behaviour and non-doers of the behaviour. This comprehensive analysis helps uncover what's really driving or blocking the behaviour in your community.

- Download Doer/non-doer analysis tool
- Key is to get as diverse a sample of doers and non-doers as possible in the community.

2. COMMUNITY ENGAGEMENT

Sometimes comprehensive analysis and interviewing isn't possible. That's okay. Engaging informally with relevant people from the community still provides essential insight. Without this, you can end up like the above examples, providing an intervention which is inappropriate for the community. You can engage informally by:

- Speaking to the most relevant people (doing and not doing the behaviour)
- Asking them what they think helps them do the behaviour or prevents them from doing the behaviour (keeping in mind the COM-B determinants as you ask questions)

3. BEHAVIOURAL RESEARCH

A tool that can provide additional intervention guidance on top of community engagement is exploring previous interventions, evaluations and research from sources like WHO, Ministries of Health and IFRC.

- These may highlight effective ways to target specific determinants in community settings, reveal common challenges and offer lessons learned from prior interventions in similar contexts.

TOOLS TO HELP YOU IDENTIFY THE LEVEL OF ENGAGEMENT FOR KEY DETERMINANTS

Social Ecological Model (SEM)

This model helps you understand how behaviour is shaped by different levels of influence. It is also important to understand how individual determinants can exist and be changed on different levels.

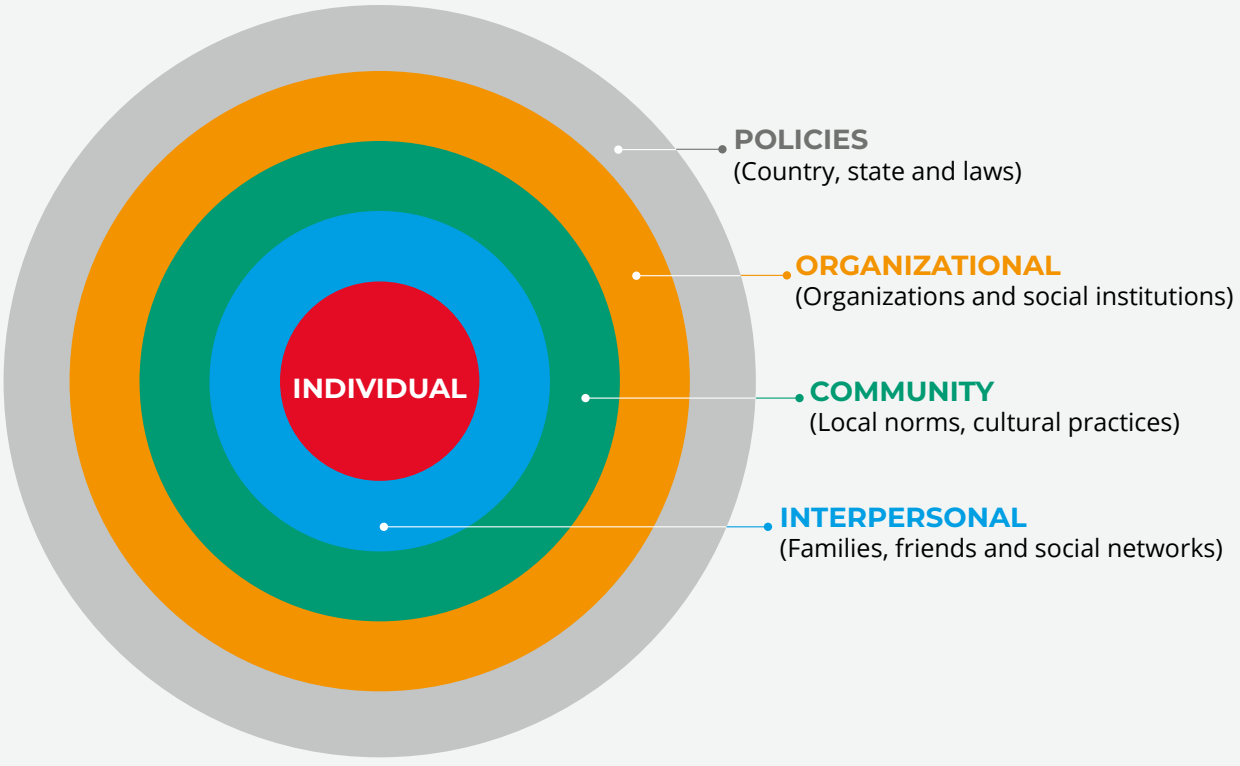
Example
Lack of knowledge (capability) – medication adherence behaviour

INDIVIDUAL
Unaware of health condition, consequences of no treatment and how medication works.

COMMUNITY
Misinformation or cultural beliefs undermine trust in medication.

INTERPERSONAL
Family also lacks knowledge and how they can support or remind of and encourage medication adherence.

ORGANIZATIONAL
Pharmacy/doctor doesn't explain clearly how to use medication. Instructions on medication too complex or in different language.



Addressing a determinant on a higher level can influence determinants under it. Even stronger, targeting a determinant across numerous levels multiplies the effectiveness and reach of your programme. However, know that typically targeting the higher levels of influence requires more resources and time to effect change, as it's more advocacy work to engage with organizations and governments.

KEY TAKEAWAYS

- Not all behavioural determinants matter equally – identify the ones that will have a strong impact on behaviour in your specific context.
- Tools like doer/non-doer analysis and community engagement exist to uncover the real barriers and enablers of behaviour.
- Consider what you can change and at what level you can change it using the Social Ecological Model.

CHAPTER 4

Changing behaviour – Part 2

Learning objectives

- **Choose effective techniques to target specific behavioural determinants**
- **Understand the Behavioural Change Technique Taxonomy tool**
- **Apply APEASE criteria to select appropriate and effective interventions**

CRITICAL

Choosing a technique to change the determinant

Once you've identified a key determinant to target with an intervention, choosing a technique that directly targets the change in that determinant is the next step. This will form the foundation of your intervention. **Importantly** – certain behaviour change techniques most effectively target each determinant, but **not all techniques can work for every determinant.**

CHOOSING A TECHNIQUE TO CHANGE THE DETERMINANT

Use the Behavioural Change Technique Taxonomy tool[7] to see all research-based approaches and for which determinants their use is effective.

For a briefer explanation of which techniques can be effective for each determinant targeted see below:

DETERMINANT	EXAMPLES OF EFFECTIVE TECHNIQUES (NOT EXHAUSTIVE, SEE BCT TAXONOMY)
Physical capability (e.g. physical strength, skills)	Physical skills training, use of assistive devices, physiotherapy
Psychological capability (e.g. knowledge, cognitive skills)	Education sessions, demonstrations of skills, visual aids
Physical opportunity (e.g. lack of access or resources)	Modify the environment, provide resources, mobile services
Social opportunity (e.g. social norms, social/divine support)	Peer support, community leader influence, role models
Reflective motivation (e.g. beliefs, goals, intentions)	Value-based messaging, implementation intentions, personal SMART goals
Automatic motivation (e.g. habits, emotional cues)	Reminders, rewards, environmental prompts, habit-chaining (linking new behaviours to existing habits)

[7] The Behavioural Change Techniques Taxonomy is a great resource if you are interested in finding out a comprehensive list of all the effective ways to change behaviour– see BCT taxonomy guide (in publication). Also external BCT taxonomy resources: BCTTv1_PDF_version.pdf; Welcome - BCT Taxonomy Training

CONSIDER APEASE CRITERIA WHEN FINALIZING THE TECHNIQUES YOU WILL USE IN YOUR COMMUNITY

APEASE criteria
Use these to assess the overall suitability and strength of your planned intervention:

- **Acceptability** – Is it culturally appropriate, ethical and welcomed by the community?
- **Practicability** – Can it realistically be implemented in this specific context with available staff, resources, time and logistics?
- **Effectiveness** – Is it likely to lead to real, measurable behaviour change?
- **Affordability** – Is it financially feasible for both implementers and participants, especially in low-resource settings?
- **Spillover effects and Equity** – Will it avoid harm and ensure fair, inclusive access and benefit for all groups, especially those often left out?

Following the **APEASE** criteria helps ensure your intervention is not only well-designed in theory, but realistic, ethical, and more likely to succeed and scale up in practice.

KEY TAKEAWAYS

- Match behaviour change techniques to specific behavioural determinants.
- Find a full list of techniques in the Behaviour Change Technique Taxonomy.
- Apply **APEASE** criteria to help assess the feasibility of interventions.

CHAPTER 5

Designing and implementing a behavioural intervention

Learning objectives

Translate chosen techniques into a practical intervention plan

Design interventions that are feasible, inclusive and contextually appropriate

Pilot implementing your intervention, to allow adaptations based on feasibility, unforeseen barriers and feedback

Apply additional lenses (Climate, migration and health, Mental health and psychosocial support [MHPSS], Protection, Gender and Inclusion [PGI]) to improve safety, inclusion, resilience and efficacy

FROM TECHNIQUE TO DESIGNING AN INTERVENTION

Following the choosing of the techniques, it's essential to build a clear and achievable plan to implement these techniques effectively in your context. This requires brainstorming from you, the team and community members or authorities (see also BCT taxonomy for inspiration regarding implementing a technique).

QUESTIONS TO GUIDE THE DESIGN OF YOUR PROGRAMME

- Who will deliver this technique? (e.g. volunteer, peer, health worker, etc.)
- How will it be delivered? (when? where? duration?)
- What are the potential barriers to implementing this, and how will you overcome these?
- Is this a repeated programme or a one-off delivery?
- Will there be multiple techniques incorporated into one intervention for efficiency?
- Can existing resources or interventions be modified or added for this new intervention?
- What are all the resources that are needed and how will you get them? (trainings, equipment, demonstration tools, communication resources, infrastructural resources, etc.)
- How will the intervention be inclusive and accessible to everyone in the community?
- Is there a more efficient or effective way to implement the technique than this?
- Think APEASE again in context of the full programme. Explain each APEASE criterion. Are they all fulfilled?
- What does implementing success of this programme look like? (e.g. how many people have engaged in behaviour change and/or how many people practise the healthy behaviour)

See Annex 1 for a short questionnaire to be filled out when designing behaviour change activities.

IMPLEMENTATION is the point where your plan turns into real-world action. Be ready to adapt based on what works, what doesn't, and what feedback you receive. Community involvement in the **how, when, where, who** and **how long** of your intervention is essential for success. Once again remember, this intervention is designed to best support the community's own journey towards choosing healthier behaviours. An intervention designed for the community must also be shaped with the community.

PILOTING – before rolling out your intervention in the community, test implementation on a smaller scale with a limited group. This helps you identify the feasibility of the planned activities, identify unforeseen barriers and challenges and gather community feedback to see how you can further adjust your intervention to make it more relevant and effective for the community.

ADDITIONAL LENSES

Even strong behaviour change interventions can miss things. Often, we get caught up in a specific behaviour to change and forget to view the community as a whole. Viewing your work through different lenses can reveal hidden risks and ways to better support your community.

Passing your intervention through these different lenses is especially important to make sure we are reaching those most at risk of being left behind, a fundamental principle of the Red Cross Red Crescent Movement.

CLIMATE, MIGRATION AND HEALTH LENS

- Does the intervention strengthen community resilience to climate change?
- Is it sustainable, or could it harm the local environment?
- Can it adapt and is it even appropriate in situations like floods, droughts or extreme weather?
- Is it accessible and adaptable for people who are displaced or on the move or those often excluded from local systems?

PROTECTION, GENDER AND INCLUSION (PGI) LENS

- Does the intervention support safety, dignity, and inclusion for all?
- Are any groups, including women, children, older people, people with disabilities, marginalized groups such as injecting drug-users, being unintentionally left out or negatively impacted at any point of the intervention?
- Is information, access and participation equitable across the community?

MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT (MHPSS) LENS

- Could the behaviour change cause emotional stress, social pressure or stigma?
- Is it likely to conflict with local social or religious norms?
- Could behavioural changes cause or bring up psychological difficulties for people and are there ways to offer mental and social support to these individuals should they need it?
- Is there support for volunteers and implementers of this intervention for whom this may be psychologically hard?

See also **Annex 2** for a short questionnaire to answer questions on the different lenses.

Ask yourself, do you know?

KEY TAKEAWAYS

- Guiding questions like who, how, when, where, are helpful when planning interventions.
- Piloting small scale implementation allows to check feasibility, identify challenges, hear community feedback and refine intervention accordingly.
- Apply additional lenses (PGI, MHPSS, Climate, migration and health) to make your intervention safer, more inclusive, more resilient, better serving your communities and especially those most likely to be left behind.

CHAPTER 6

Monitoring and evaluation

Learning objectives

Understand the purpose and value of monitoring and evaluation in behaviour

Identify practical ways to monitor progress in changing community behaviours

Adjust interventions based on community feedback and monitoring data

MONITORING AND EVALUATION

IMPORTANCE OF MONITORING AND EVALUATION

The final step of behaviour change is to monitor your intervention – understanding whether it is working as intended and how it can be improved. Once the programme is completed, an evaluation is also very important, to assess impact and recommendations for improvement areas for future interventions.

Monitoring isn't about proving failure or success – it's about learning. Discovering new barriers to change or techniques that are not effective in your context is valuable information, which then allows you to adapt and improve the intervention.

WHAT SHOULD WE BE MONITORING?

Were the techniques implemented as planned?

- Are the techniques being used, and used in the way intended?
- Are there barriers to putting them into practice in this context?

Example:

- Planned technique – door-to-door demonstration of proper handwashing
- Monitoring – revealed that volunteers were too few to realistically cover planned number of community households
- Adaptation – pivot of technique to demonstrate handwashing at public events on market weekend - while less comprehensive this will reach more people with the realistic level of volunteer resources

Are behaviours starting to change?

- Are non-doers becoming doers? Are we seeing change across the targeted levels of SEM (individual, interpersonal, community etc.)?
- Are new barriers or enablers to healthy change appearing as the intervention unfolds?
- Are other determinants becoming more relevant to target as the intervention progresses?

Example:

- **What was intended** – Increase early care seeking when caregivers notice signs of serious illness in newborns, such as fever, difficulty breathing or poor feeding, to reduce delay in receiving urgent infant medical attention.
- **Monitoring showed** the improvements in the determinant that was targeted, knowledge (psychological capability) – caregivers were better at recognizing danger signs in infants and that these are serious. However, seeking care was still delayed. Caregivers still weren't committed to early care behaviours, waiting for male family approvals and traditional remedies first. Monitoring reveals low perception of positive consequences of early care (reflective motivation) and awaiting approval of male family member (social opportunity). Both need to be targeted now that knowledge has been improved.
- **Adaptation of intervention** – Local mother-led storytelling sessions were held in communities. Separate sessions were also held for men emphasizing the importance of early infant care. These techniques helped further strengthen motivation, family support and build trust and intention to get early infant care.

COMMON MONITORING TOOLS

- Repeat doer/non-doer interviews and analyses
- Surveys and questionnaires at baseline and follow-up intervals
- Community engagement and feedback sessions
- Observation of changes, particularly for higher level SEM levels, community changes, organizational practice and policy changes
- Health data such as service utilization, disease incidence, etc. at community, regional or national level

MONITORING AND EVALUATION

BE REALISTIC AND RESPONSIVE

Behaviour change is rarely quick and often multi-faceted. It takes time, especially for deeply rooted behaviours and even more so for changes community wide. Remember, this is about supporting people to improve their own health behaviours, not about you changing theirs. So, where change is inconsistent or very slow, you and the community are learning valuable information about their health behaviours and their propensity to change. This information helps us to better adjust our interventions to best serve their change.

Keep open communication with the community and listen to their feedback. Stay flexible and adapt behavioural goals, techniques and design as needed to best support them.

KEY TAKEAWAYS

- Monitoring is about learning and being able to adapt better to the community you are serving.
- Monitoring allows to check the progress of the behaviour change.
- Community feedback on the intervention is essential, both comprehensive analysis of changes and informal discussions on what the community members involved think.
- Behavioural change is slow, all about supporting people changing their own behaviours, so stay realistic and flexible.

ANNEX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ANNEX 1

QUESTIONS TO GUIDE THE DESIGN OF YOUR PROGRAMME

Questions	Explanations
Who will deliver this technique? (e.g. volunteer, peer, health worker, etc.)	
How will it be delivered? (when? where? duration?)	
What are the potential barriers to implementing this, and how will you overcome these?	
Is this a repeated programme or a one-off delivery?	
Will there be multiple techniques incorporated into one intervention for efficiency?	
Can existing resources or interventions be modified or added with this new intervention?	
What are all the resources that are needed and how will you get them? (trainings, equipment, demonstration tools, communication resources, infrastructural resources, etc.)	
How will the intervention be inclusive and accessible to everyone in the community?	
Is there a more efficient or effective way to implement the technique than this?	
Think APEASE again in context of the full programme. Explain each APEASE criterion. Are they all fulfilled?	
What does implementing success of this programme look like? (e.g. number of households reached, number of people in attendance, number of pieces of equipment delivered)	

ANNEX 2

ADDITIONAL LENSES

Questions	Explanations
Climate, migration and health	
Does the intervention strengthen community resilience to climate change?	
Is it sustainable, or could it harm the local environment?	
Can it adapt and is it even appropriate in situations like floods, droughts or extreme weather?	
Protection, Gender and Inclusion	
Does the intervention support safety, dignity, and inclusion for all?	
Are any groups, including women, children, older people, people with disabilities, marginalized groups such as injecting drug-users, being unintentionally left out or negatively impacted at any point of the intervention?	
Is information, access and participation equitable across the community?	
Mental Health and Psychosocial Support	
Could the behaviour change cause emotional stress, social pressure, or stigma?	
Is it likely to conflict with local social or religious norms?	
Could behavioural changes cause or bring up psychological difficulties for people and are there ways to offer mental and social support to these individuals should they need it?	
Is there support for volunteers and implementers of this intervention for whom this may be psychologically hard?	

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The **International Federation of Red Cross and Red Crescent Societies (IFRC)** is the world's largest humanitarian network, with **191 National Red Cross and Red Crescent Societies** and around **16 million volunteers**. Our volunteers are present in communities before, during and after a crisis or disaster. We work in the most hard to reach and complex settings in the world, saving lives and promoting human dignity. We support communities to become stronger and more resilient places where people can live safe and healthy lives, and have opportunities to thrive.