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Het Nederlandse Rode Kruis

CBHFA and PHAST Integration Discussion paper

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Acronyms

BCC	Behaviour change communication
CBFA	Community based first aid
CBHFA	Community based health and first aid
CBM	Community based management
CVTL	Cruz Vermelha Timor Leste
GWSI	Global water and sanitation initiative
HHWTSS	Household water treatment and safe storage
IFRC	International Federation of Red Cross and Red Crescent
M&E	Monitoring & Evaluation
NLRC	The Netherlands Red Cross
NS	National Society
OD	Organizational development
O&M	Operation and Management
P&V	Principles & values
PHAST	Participatory hygiene and sanitation transformation
PRA	Participatory Rural Appraisal
PSO	Capacity building in developing countries
PSP	Psychosocial support
RC/RC	Red Cross / Red Crescent
TB	Tuberculosis
VCA	Vulnerability and capacity assessment
WatSan	Water and Sanitation

1. Summary

CBHFA lays the **foundation** for long-term health programming, with core elements such as dissemination of Red Cross principles & values, training in basic first aid, building skills on community need assessment, and mobilising the community for disease prevention and health promotion. The integration of CBHFA and WatSan programmes provides a good example of integrated health programming, reducing the fragmentation related to vertical programmes. This paper discusses the integration between CBHFA and PHAST, since the latter represents within the Red Cross the standard methodology for the implementation of software WatSan.

CBHFA and PHAST share a **similar ultimate goal**, transforming the communities so their members can actively protect themselves from diseases by committing to change and individual action.

The **critical differences** between CBHFA and PHAST can be seen as **complementary factors**. The linkage established from a CBHFA foundation to a more WatSan specialized programme is an opportunity for CBHFA in terms of bringing water and sanitation facilities to the most vulnerable communities, since hardware is a essential enabling factor for hygiene behaviour change. Other opportunities include sharing of existing materials between the approaches (e.g. pictures for PHAST steps, health community tools) and increased use of PHAST community monitoring tools (pocket chart, recording books, household observation forms, etc.) in the CBHFA process to improve monitoring of the impact and effectiveness of interventions.

Community need assessment is one of the core activities of CBHFA. The results of the assessment define the structure that future health activities will take in the community, customizing the programme to the community needs and priorities. For those communities where water and sanitation has been identified as a great concern, the link from CBHFA to PHAST and the development of hardware can be required. In an integrated health model CBHFA and PHAST would be implemented in a **sequential manner.** The sequence may vary according to the context as outlined in scenario 1 and 2.

Ideally, in those new communities where a health programme is to be implemented, CBHFA then becomes the entry point to more technical and sector-specific actions, like WatSan. This situation is presented in detail in **scenario 1** (page 9). The integration of CBHFA and PHAST would take different forms depending on the way the PHAST 7 steps cycle is anchored to the CBHFA programme. Scenario 1 presents three possible models of integration (model 1, 2 and 3). The difficulty relates to the duplication between the CBHFA community assessment and PHAST STEP 1 & 2.

In some situations and due to donor requirement, more traditional and vertical WatSan programmes need to be undertaken. In that context, PHAST acts as the entry point. This can be integrated under the CBHFA umbrella by linking the PHAST STEP 1 & 2 (implemented as a wider health assessment) to CBHFA modules 1, 2 and 3. Eventually, module 6 can be added in parallel to the PHAST cycle. This is outlined in detail in **scenario 2** (page 11).

2. Introduction

Improving vulnerable people's health through WatSan and community-based health interventions comprises one of the core areas for many National Societies (NS) within the Red Cross/Red Crescent (RC/RC) Movement. Recent developments in the area of community health within the RC/RC Movement have brought back the discussion on integrated health programming to the international agenda as this was identified ten years ago during the mid year review of the 2010 IFRC strategy. A major obstacle to progress in sustainably improving community health and resiliency has been, and still is, the present vertical programmatic approach to many of the health activities implemented by NSs.

In this current approach, different health sectors (WatSan, malaria, blood donation, psychosocial support (PSP), HIV AIDS, first aid, health in emergencies, etc.) are generally addressed separately. This results in lower impact, inconsistent messages, duplication of activities, perception of fragmentation and incoherence in the approaches. Over-expenditure and exhaustion of NS staff, RC/RC volunteers and beneficiaries are among the negative consequences of vertical programmes. Key partners within the Red Cross/Red Crescent acknowledged that a more comprehensive and integrated approach to disease prevention and health promotion at the community level was needed across all Movement levels (from IFRC global, zonal and country offices down to NSs).

An opportunity for further developing that holistic and integrated approach rose during the revitalisation of the Community Based First Aid (CBFA) training package in 2005. CBFA has been in use since the 1990's within the RC/RC Movement as the principal method of establishing first aid activities in the communities. The revitalization process improved the traditional CBFA training materials and adapted the package to a more action-oriented approach where the community is at the centre of the process. This new package is called CBHFA and it allows a bottom-up decision making, flexibility and dynamic programme design according to community needs.

CBHFA is about community resiliency, empowering them whilst making them healthier and safer. But most importantly, CBHFA, as a new way of thinking for community-based health, provides to the RC/RC Movement for sustainable longer-term health and WatSan activities under a coherent and coordinated framework. This will ensure consistency in communities and also strengthen advocacy for integrated programming to partners and their back donors.

Participatory Hygiene and Sanitation Transformation (PHAST) is the standard software methodology to articulate WatSan interventions in the Red Cross Red Crescent Movement (IFRC WatSan policy, 2004). In the recent years, all long term developmental IFRC projects have been designed following the Global Water and Sanitation Initiative (GWSI) technical criteria of including a strong component of WatSan software based on the PHAST methodology. Through the seven steps in the PHAST methodology, communities are empowered to feel confident in their ability to take action, make water and sanitation situation improvements and to own their facilities.

1.1 Purpose of this paper

An introductory paper under PSO (Capacity Building in Developing Countries, The Netherlands) funding was developed in 2010 with title: 'Reflections on CBHFA within WatSan/HP'. Finding WatSan often at the core of RC/RC longer-term health programming, a second paper was proposed to discuss in detail the opportunities and challenges to connect WatSan programmes with the ongoing CBHFA initiatives worldwide and describe possible models for translating that integration into the field level.

Preliminary discussions on the integration of CBHFA and PHAST and detailed recommendations on how to translate it to the field level were held at the annual CBHFA zonal workshop for

Asia/Pacific (Bangkok, 27 September – 1 October 2011). Some of the deliberations and ideas included in this paper were drafted at that workshop.

Common questions generated in different RC/RC forums relate to the level of compatibility between the PHAST methodology and the CBHFA approach, as follows:

- *What are the linkages between CBHFA and PHAST?*
- *How can the operational integration between CBHFA and PHAST be made?*
- *What are the opportunities and the threats associated to that combination?*
- *Conclusions and next steps*

By answering these four questions, this paper summarises the learning, and experiences generated up to date on CBHFA vis-à-vis WatSan within the NLRC, the IFRC and some Asian NSs already exploring both approaches. It also presents technical recommendations and various models for integrating the PHAST methodology with CBHFA.

This paper intends to target two types of audience: 1) NLRC and other PNS delegates, IFRC delegates and NS staff so they can further understand the technical aspects of integrating WatSan vs. CBHFA health programming, and 2) donors and partners, so they have a clear view of NLRC and Federation's direction for the future.

3. Linkage between CBHFA and WatSan programmes

Ideally, National Societies working in new communities should apply an **integrated health approach** where the CBHFA lays the **foundation** for long-term health programming, including core elements such as dissemination of RC/RC principles & values, training in basic first aid, building skills on community needs assessment, and mobilising the community for disease prevention and health promotion.

The CBHFA **integrated health model** can be seen below in Figure 1 (a more detailed CBHFA outline can be found in Annex 1). CBHFA would first lay the long term foundation in the target community through the three core components or Modules 1, 2 and 3 (dissemination of RC/RC Principles & Values (P&V), community mobilization and assessment). The CBHFA package provides a wide menu of varied interventions from where CBHFA volunteers and facilitators can choose according to the results of the assessment. This menu comprises module 4, 5, 6 and 7 and covers topics such as first aid, health in emergency and basic health promotion in different sectors.

Community need assessment (Module 3) is a key core activity of CBHFA. Depending on the results of the assessment and the different health priorities as identified by the community, the programme can be customised to community needs by choosing the relevant modules and interventions from the CBHFA package. A CBHFA plan of action is then developed and implemented by volunteers and community members. For example, the outcomes of the community needs assessment may establish the base for more specialized programmes such as malaria, tuberculosis (TB), HIV/AIDS, WatSan, health emergency response, PSP, nutrition, mother and child health, immunization, or family planning.

Under this general model CBHFA becomes the **entry point** to more technical and sector-specific actions, directing funding, training and technical support to the communities that have actively invested their time looking for solutions to their present problems and have shown that are ready to take action.

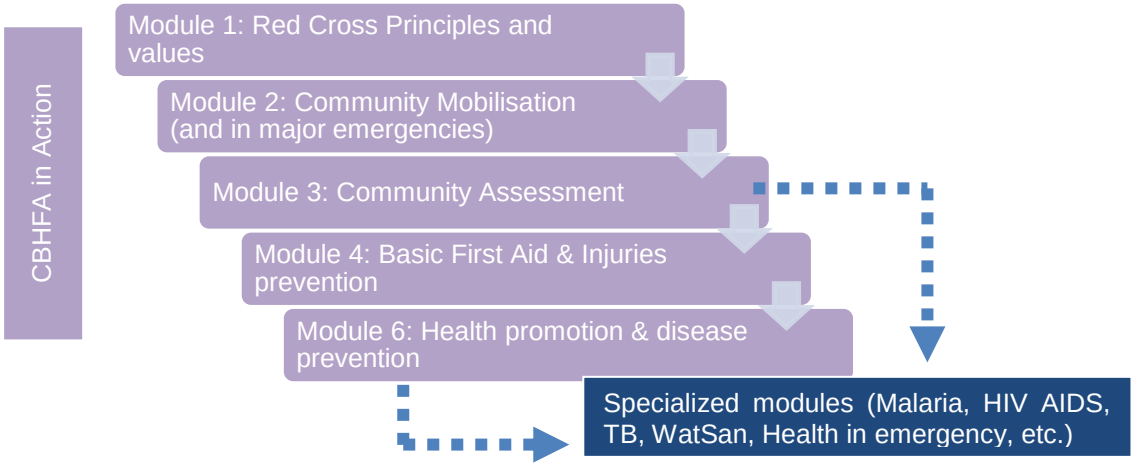

Figure 1.- Integrated health model: CBHFA represents the entry point to more specialized modules including WatSan.

The existing WatSan component of CBHFA includes basic promotional activities on handwashing, use of latrines, household water treatment and safe storage (HHWTSS), food hygiene and cleanliness of the house and environment, which are undertaken by volunteers using the CBHFA community toolkit and a variety of different communication techniques. This promotional package might be relevant to those contexts where basic facilities (water supply and toilets) are available and accessible to the majority of the community.

For communities which have identified water and sanitation-related issues as a priority, and there is a lack of basic hardware facilities, then the PHAST methodology should be used. PHAST has seven steps, which can be seen below in Figure 2 (see Annex 1 for more detail). The first five steps help take the community group through the process of developing a plan to prevent diarrhoeal diseases by improving water supply, hygiene behaviours and sanitation. The sixth and seventh steps involve monitoring and evaluation.

Figure 2.- PHAST 7 steps.

The special focus of PHAST is helping the communities to improve their hygiene behaviours, prevent diarrhoeal diseases and encourage the community to own their facilities by selecting themselves the most appropriate technology option and agreeing on its management system. Through the 7 steps, the community realizes the relationship between sanitary conditions in the community and the health status, empowering the community to plan for and carry out actions to improve the situation and to own and the infrastructure (including ongoing O&M requirements).

In the integrated health model, CBHFA and PHAST would be implemented in a **sequential manner,** implementing CBHFA first and then introducing the PHAST cycle (Figure 3).

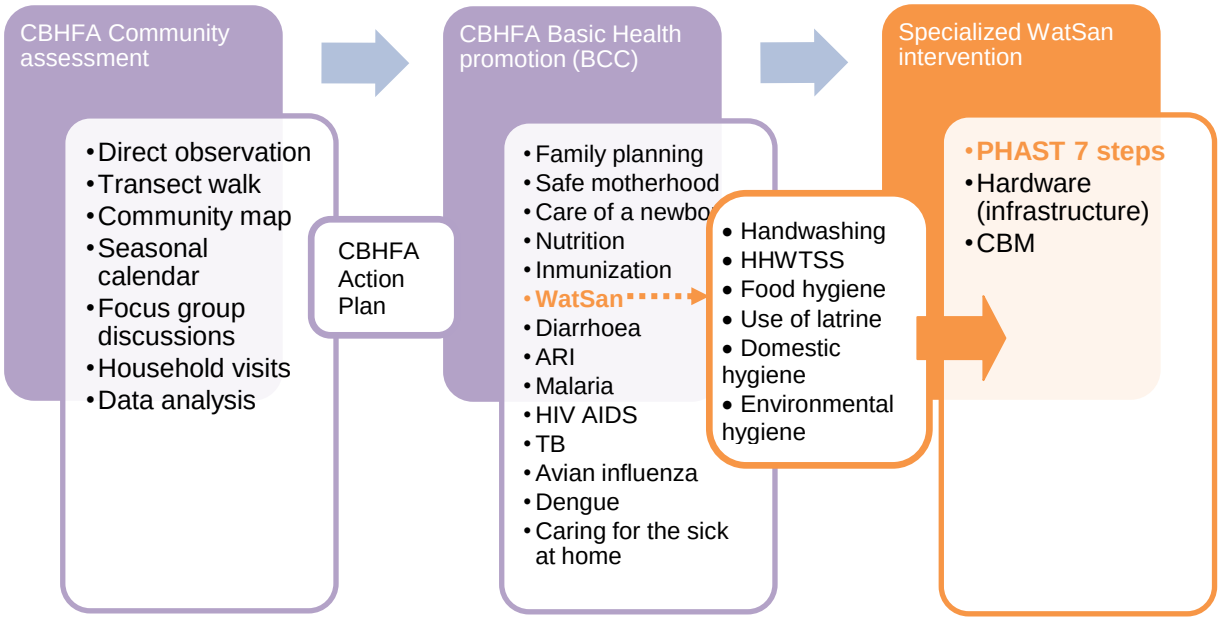

Figure 3.- Sequential integration of CBHFA and PHAST.

Some voices in the Red Cross Red Crescent movement have raised the question, whether CBHFA could replace PHAST. CBHFA cannot replace PHAST since it does not provide the frame for the development of water and sanitation facilities and their effective operation and maintenance (O&M) requirements. In the WatSan sector, it is widely recognized that behaviour change can only be addressed when promotional activities of safe hygiene practices are supported by the provision of hardware facilities.

In those communities where the water and sanitation needs are extremely acute (mostly associated to the lack of access to basic services or/and infrastructures), the situation may require a long term intervention in that sector. That intervention would include supporting the development of sustainable and affordable infrastructures, working with the community to set up a management system (CBM) for their technical options and moving forward the agenda for hygiene behaviour change at the community level.

The critical question to this theoretical statement is how compatible PHAST and CBHFA are and how coherent can the sequential implementation of both components be. In that respect, PHAST and CBHFA share common guiding principles that make them, in essence, extensively compatible:

1) They are both participatory, having the community as the centre of the action. PHAST is based on Participatory Rural Appraisal (PRA) methodology whereas CBHFA incorporates PRA but also behaviour change communication (BCC).
2) They both incorporate a process of community development and action of 'learning by doing'.
3) They are both facilitated by community-based volunteers, and encourage the community to form action groups.
4) They are both user friendly, adapted to a non-literate audience by using a wide range of visual aids toolkits.

CBHFA and PHAST share a similar ultimate goal, transforming the communities so their members can actively protect themselves from diseases by committing to change and community action. However the level of compatibility of CBHFA and PHAST can be better assessed when looking at the critical differences. Table 1 summarizes the main differences:

Table 1.- Critical differences between CBHFA and PHAST

CBHFA	PHAST
CBHFA is an approach. It provides a frame to	**PHAST is a method**. It details the procedures

the ideas, concepts or actions intended to deal with health problems in the communities. It provides guidance of how to work in a systematic and integrated way in the communities within the Red Cross Red Crescent Movement.	and steps for the prevention of diarrhoeal diseases in the community. It was developed by WHO/UNDP in the nineties.
CBHFA is comprehensive. It encompasses the main health problems in the community (family planning, maternal and child health, nutrition, WatSan, vaccination, communicable diseases, etc.) in a general way.	**PHAST is specific**. It tackles water, sanitation and hygiene problems in the community and particularly, the relationship between those problems and malaria, dengue and gender
CBHFA comes with no hardware. It disseminates messages about health and hygiene practices but rarely provides the supportive environment that enable people to initiate and sustain such practices.	**PHAST always comes with hardware**. In the Red Cross, PHAST is commonly associated to hardware (infrastructure development). PHAST provides the frame for the community to decide which technical options to apply and the management system of the facilities.
CBHFA is based on BCC. The CBHFA community toolkit is designed to promote dissemination of messages and information sharing. BCC can be engaging and participatory, but it presents the risk on focusing too much on messaging or one-way of communication.	**PHAST is based on participatory learning**. The PHAST tools are designed to promote discussion and engagement. It is definitely a methodology that encourages participation and community engagement, using two-ways of communication.
CBHFA is flexible. Practitioners can refer to CBHFA as a menu of multiple options, selecting different modules and topics that reflect the context and needs of their communities.	**PHAST is more rigid**. The 7 steps cycle of PHAST presents a more rigid format though different adaptations in the Red Cross have shortened the process and also presented it as an open menu of steps.

The critical differences between CBHFA and PHAST can be seen as **complementary factors**. The linkage established from a CBHFA foundation to a more WatSan specialized programme is the opportunity for CBHFA in terms of bringing water and sanitation facilities to the most vulnerable communities. It is also the opportunity to introduce truly participatory techniques in the community besides those provided by the BCC approach followed in CBHFA. On the other side, PHAST can benefit from the flexibility and comprehensiveness of CBHFA (for example exploring the linkages between WatSan and other sectors like nutrition, HIV AIDS, etc.). Though it is important to mention that there are examples in the RC/RC movement where other elements beyond WatSan (such as malaria and HIV AIDS prevention) have been integrated in the PHAST 7 step cycle.

4. How to make operational the linkage between PHAST and CBHFA

The integrated health model in Figure 1 presents CBHFA as the entry point in the community. This model would be relevant for those NSs planning to undertake health programmes in new communities, where a fresh start would allow, firstly, setting up a long term foundation though the core CBHFA modules and secondly, building a health programme later on with more specific technical components, including WatSan.

But what about those communities where traditional WatSan projects (including the PHAST cycle), such the ones in the GWSI framework, are already in place? How can the NSs integrate those isolated projects or initiatives under the CBHFA umbrella, making them more integrated in a wider health programme?

Two different scenarios have been proposed for the effective and realistic integration of PHAST and CBHFA at the field level:

- *Scenario 1* (shown in figure 4) describes a sequential manner where the CBHFA acts as the entry point in the community, followed by the linkage to PHAST.
- *Scenario 2* (shown in figure 5), proposes an inverse sequence, since now PHAST and development of hardware are both the entry point in the community, followed by the linkage to CBHFA activities.

Scenario 1: CBHFA first, then PHAST

When looking at the operational details of ***scenario 1***, one can realize how complex the integration process is: after training volunteers in Module 1, 2 and 3, the CBHFA team would run a community assessment to identify priority needs of their communities and implement CBHFA in action. The CBHFA package provides a wide menu of different interventions from where CBHFA volunteers and facilitators can choose according to the results of the assessment. This menu comprises module 4, 5, 6 and 7 and covers topics such as first aid, health in emergency and basic health promotion in different sectors.

For those communities where water and sanitation has been identified as a great concern for the community, the link to PHAST and the development of hardware can be required. The integration would take different forms depending on the way the PHAST 7 steps cycle is anchored to the CBHFA programme.

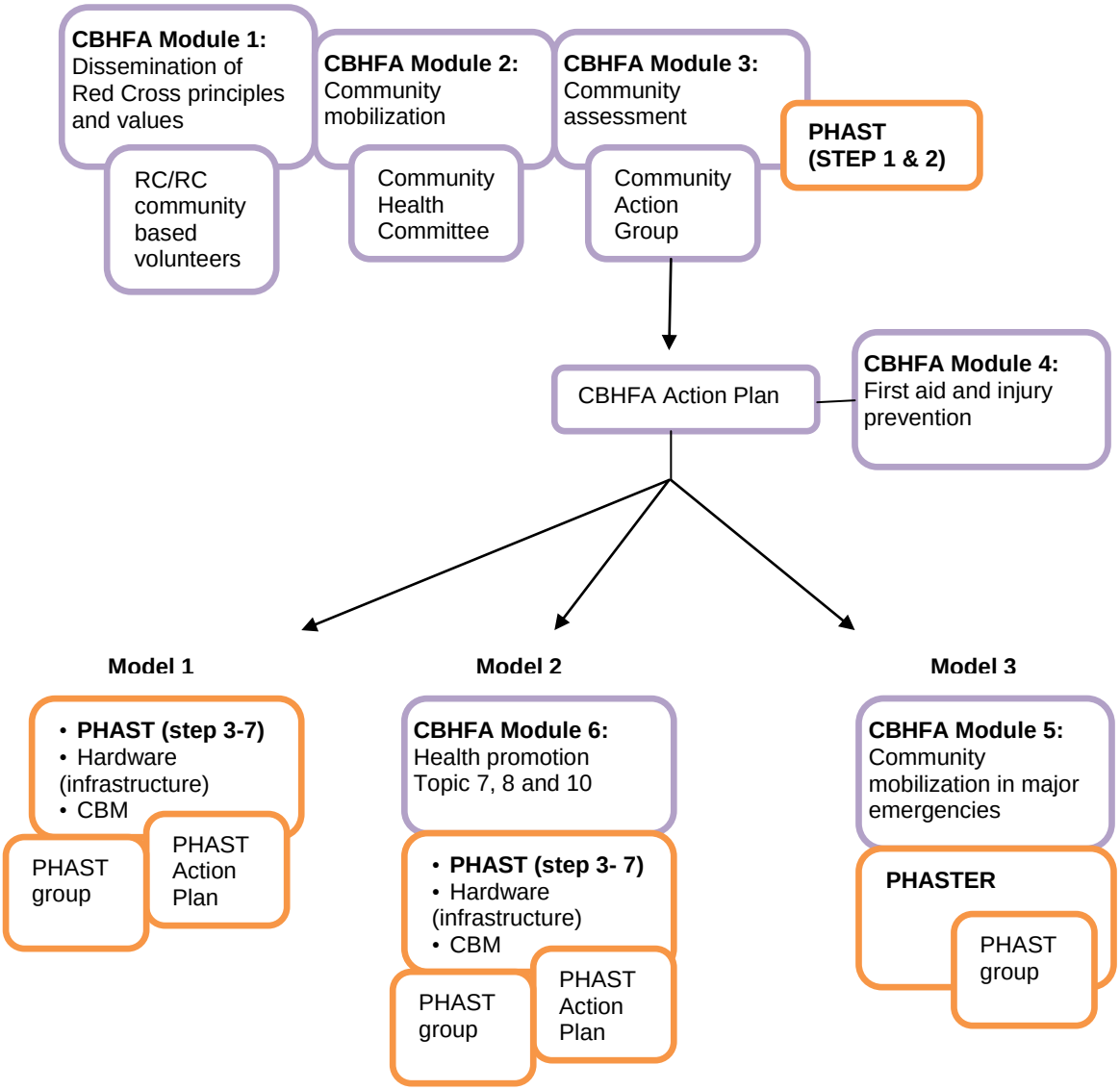

Figure 4.- Detailed models for the sequential integration of CBHFA and PHAST. CBHFA is first used as entry point then anchored to PHAST.

In model 1, the assessment of the water and sanitation situation in the community would result in the introduction of PHAST methodology directly as part of the CBHFA action plan. The elements of hardware and CBM would be perfectly anchored to the health programme through the PHAST cycle.

The difficulty of this model would be the sequential implementation of the CBHFA community assessment and the introduction of the PHAST 7 steps. STEP 1 and 2 in PHAST are also focused on community assessment. Despite those steps provide a more specific assessment, the process might be repetitive and uninteresting for the community. It is recommended, therefore, that PHAST STEP 1 & 2 are fully integrated into CBHFA module 3 and similar assessment techniques, such as community mapping, are not duplicated.

In model 2, the community assessment would result in the implementation of CBHFA module 6 on those topics related to the WatSan sector (topics 7, 8 and 10 on WatSan, diarrhoea, malaria and dengue) as part of the CBHFA action plan. General sensitization and awareness of the community in key hygiene messages would precede the implementation of PHAST cycle and the introduction of the elements of hardware and CBM.

In addition to the challenges faced on the assessment ground, this model would present the difficulty of integrating the PHAST cycle and the promotional activities associated to the CBHFA

module 6 (in particular, the topics 7, 8 and 10). For this situation, it is recommended to run those two processes in parallel, concentrating the majority of the promotional activities between PHAST step 4 and 5.

In model 3, the community assessment would reveal the importance of preparing the community for future health emergency events (such as epidemics) in those areas prone to disaster (floods, droughts, earthquakes, etc.) or with recurrent disease outbreaks. In those cases, the CBHFA action plan would integrate at first the CBHFA module 5 related to community mobilization in major emergencies, assisted by the Epidemic Control package (manual and tools). In those cases where the risk of outbreaks of water and sanitation borne diseases such as cholera, dengue or malaria would be elevated, it would be relevant to introduce a component of PHASTER (PHAST cycle adapted to emergency) as part of the preparedness plan in the community.

These three models of integration between CBHFA and PHAST proposed above can be applicable either to new communities where the NS is planning for a future Health / WatSan integrated programme**,** or in those existing communities where the NS in already implementing a vertical CBHFA programme but further connection to the WatSan sector is required. In both cases, CBHFA would provide the foundation from where integrating the PHAST cycle would be realistically possible.

Case study 1: Timor Leste

CVTL has set up a working model for the WatSan sector where CBHFA serves as the vehicle to conduct community assessment.

Those communities that identify WatSan needs through CBHFA are assisted to seek funding from external sources so a comprehensive package of software and hardware can be delivered.

CVTL has to face situations as well where WatSan needs are identified separately from CBHFA initiatives, following a more traditional, vertical approach, often backed-up by a specific donor interest and funding. These are denominated 'WatSan led' projects.

'WatSan led' projects are narrower in focus, but they must include a comprehensive health-oriented assessment and the minimum requirements of the CBHFA approach (module 1, 2 and 3).

Some of the challenges are related to coordination and management. CVTL is developing guidelines to assist partners in implementing this approach.

Scenario 2: First PHAST, then CBHFA

For ***scenario 2***, representing the context where an ongoing traditional long term WatSan programme is already in place (like those within the GWSI framework), but the NS is interested for programmatic reasons to include the intervention under the umbrella of CBHFA, the intervention between PHAST and CBHFA would be also easy to implement – though additional resources would be needed.

In that sense, CBHFA is a flexible tool, but it has some minimum requirement or core modules that need to be implemented in order to preserve the nature of the approach. Those modules are 1, 2 and 3, and they could be integrated following the **model 1** described below in figure 5 where those modules follow the implementation of PHAST 7 steps cycle (linking them to step 1 & 2). Furthermore, Module 6 could be implemented along the deployment of the PHAST steps in the community as described in **model 2.**

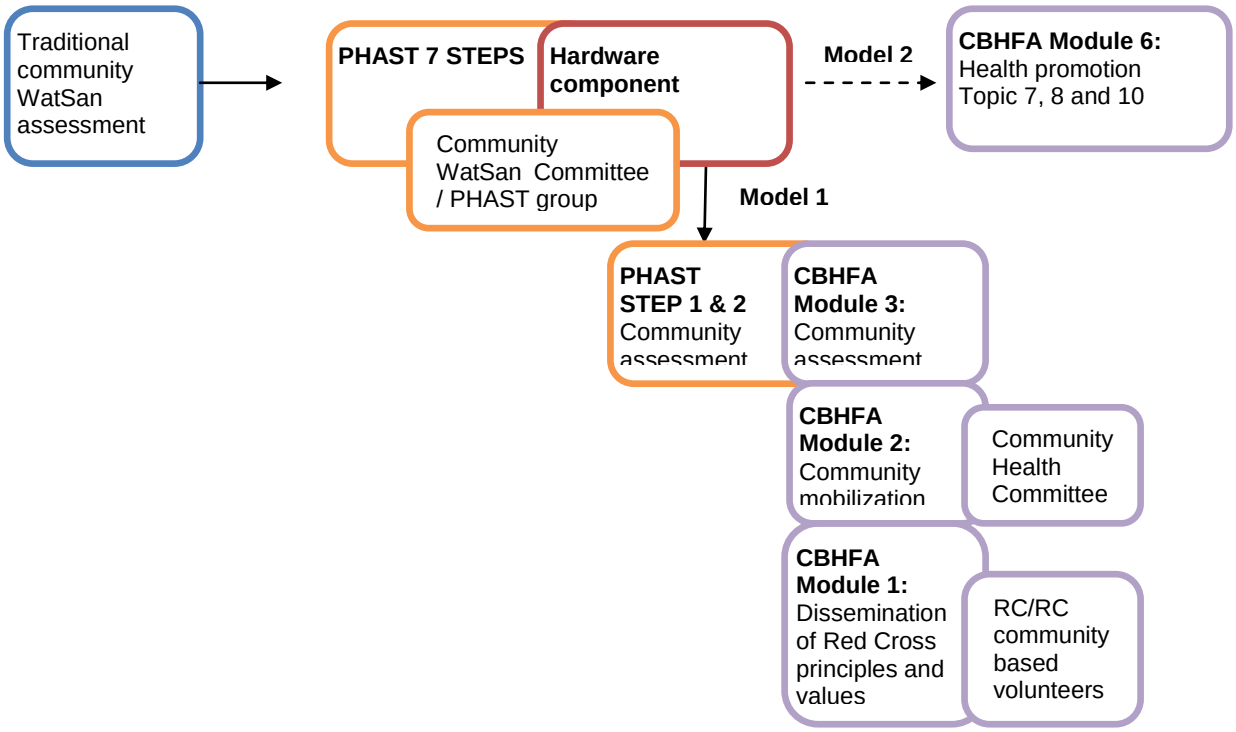

Figure 5.- Detailed model for the sequential integration of CBHFA and PHAST. PHAST is now used as entry point then anchored to PHAST.

5. Opportunities and threats

The analysis of the integration model reveals some key opportunities for developing forward the health agenda within the RC/RC movement and setting up the technical basis for more holistic and integrated health interventions. Some of the key opportunities or strengths derived from integrating CBHFA and PHAST are:

Table 2.- Opportunities / Strengths of the CBHFA and PHAST integration
1) The integration of CBHFA and PHAST would provide a framework where PHAST would never be a sector-specific action but an element of a more coherent, **broader community-based health programming**. Instead of looking at a problem (such as diarrhoea) from the side of the water and sanitation sector only, the integrated model would provide different views (for example form the nutritional perspective), and it would present a more coordinated approach to prevent diseases.
2) The CBHFA approach and PHAST methodology have been recognized separately as effective **exit strategies** for emergency response in the Health and WatSan sector respectively. The combination of both components after the emergency phase might provide a clear opportunity in terms of linking up the often disconnected health and WatSan emergency operations, setting up a common framework for **community recovery and development.**
3) The combination of PHAST and CBHFA might represent a good opportunity to provide clear guidance on how to bring **software in the first place** to the communities, preceding any development on hardware. This is a well recognised practice that seems to be critical to the sustainability of interventions. Recognizing the need for a bottom-up prioritization of the community needs, rather than a top-down (often donor-driven) planning, the integration of CBHFA and PHAST provides the opportunity to involve people into a participatory approach.
4) The integration of PHAST and CBHFA can be applied following a **flexible model** that may be adapted to different situations, selecting different modules and topics from CBHFA, and different steps and tools from PHAST, so it entirely reflects the context and needs of the community. This allows for

an accurate, customised response to genuine community problems.

5) The integration model would offer a menu of varied techniques and methods for **behaviour change. Different elements such as BCC from CBHFA, more focused on knowledge transfer, and specific WatSan participatory techniques from PHAST (derived from PRA and focused on problem analysis and finding solutions) would be implemented in conjunction, reinforcing the transformation process in the community.**

6) CBHFA and PHAST both require a heavy involvement of RC/RC volunteers. Separately, both processes have extended organisational development (**OD**) implications since the success of their implementation at the ground level is directly related to the way volunteers are managed by the NS. The combination of both can lighten the processes of recruitment, training and **management of volunteers**, providing incentives for the volunteers since they can participate in general CBHFA training and then moving up in the NS structure for more specialized training.

7) Both CBHFA and PHAST practitioners have developed over the years similar sets of visual aids and IEC materials together with very comprehensive packages for **M&E**. All packages would need also to be merged and rationalize otherwise there is the risk of overwhelming volunteers and community members with similar promotional materials and M&E tasks.

While the integration of the CBHFA approach with the PHAST methodology can be a positive step toward holistic and comprehensive health programming, it is not however exempt from threats or challenges which need to be carefully addressed by implementer partners when planning for integration in the field. Key challenges or threats identified are:

Table 3.- Threats / Challenges of CBHFA and PHAST integration

1) PHAST and CBHFA are both complex and long processes that often start with training within the NS and then cascading through multiple layers down to the community. Over the years, it has been seen that translating training of volunteers into practice at the community level is a challenge in both contexts. The integrated combinations of PHAST and CBHFA may result in a **lengthy, expensive and arduous process** of training (ToT and volunteer level, translation of training materials) as well as the adaptation of visual aids and recruitment of project staff. Risks include overwhelming the community and a loss of interest and momentum. The need to **shorten the process** may result in breaking the participatory cycle and implementing one-off, isolated and disconnected activities with low impact in the communities.

2) PHAST and CBHFA both rely on the community to make decisions, working with the existing community groups or establishing new structures such as the PHAST group, the community action group (for CBHFA) or the WatSan committees. The risk of combining both components is the **duplication of structures** or responsibilities among different groups in the community.

3) For Scenario 1 of integration in this paper, model 1, 2 and 3 do not present details of which CBHFA topics and PHAST activities overlap, but it is foreseen that a substantial part of both need to be removed to avoid **duplication of activities** on the ground. It has been suggested, for example, to shorten PHAST by cutting off step 1 & 2 as some of these activities are included in CBHFA Module 3 (however, Module 3 may benefit from the integration of several specific PHAST tools such as 'good and bad behaviour' or 'investigating community practices').

4) A truly participatory approach as the one that would result from the combination of CBHFA and PHAST would lead the community to take decisions about programme design and implementation. Donors in the WatSan sector are not fully prepared to finance **open programmes** where the hardware facilities are not pre-defined in advance.

5) Management of budgets and reporting duties could be complex and very time-consuming in case of separate funding and donor back-up for each of the components.

6. Next steps

This paper intends to remain alive over time, changing according to the different experiences from those NS adhering to the health integrated approach. Case studies and technical guidance will be developed and shared across the members of the Red Cross Red Crescent Movement to ensure knowledge sharing and further dissemination of good practices in the health sector.

The IFRC with support of interested key partners will follow up the results of those field experiences and will collect evidence of appropriateness, replicability and effectiveness of the different scenarios and models presented in this paper through operational research on the existing projects texting the integration between WatSan projects and CBHFA.

Lessons learnt identified during the life of health programmes will be incorporated as a continuous process in the next coming years, documenting best practices and need for improvement or change.

Annex 1. CBHFA Modules

Module 1: RCRC volunteer in action

- 4 different topics including concepts on international RCRC and NS organization (local branches), CBHFA in action and volunteering.

Module 2: Community mobilization

- 4 topics including communicating and building relationships, organizing communities committees, social mobilization and community tools.

Module 3: Assestment based action in my community

- 8 topics inclusing assesment tools and methodologies, making sense of data, preparating an action plan and reporting.

Module 4: Basic first aid and injury prevention

- 20 different topics including shocking, bleeding, burns, poisoning, stroke, drowning, fever, bites, infection control, etc.

Module 5: Community mobilization in major emergencies

- 2 topics including community mobilization in major emergencies, and main public health issues in emergencies: preventing and responding to epidemics

Module 6: Disease prevention and health promotion

- 16 topics including nutrition, fammily planning, tuberculosis, avina flu, malaria, HIV AIDS, etc. Topics 7 and 8 is specific about water, sanitation and hygiene promotion.

Module 7: Supplementary topics

- 5 topics including road safety, safe blood donation, substance abuse and burial of the dead.

PMER tool

- Various tool