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Afghanistan

AFGHAN RED CRESCENT SOCIETY
MASTER FACILITATOR TRAINING ON EPIDEMIC CONTROL FOR VOLUNTEERS AND
HOUSEHOLD WATER TREATMENT AND SAFE STORAGE IN EMERGENCIES

Background and situation analysis

Afghanistan is a country that has experienced more than 30 years of war and conflict and is also prone to natural disasters and health emergencies such as disease epidemics and outbreaks. This is an area that had begun to escalate in recent years especially with regards to Diarrhea, ARI and Measles. Existing capacity in the area of emergency health preparedness and response has been identified by the MoPH in 2010 as a gap area that needs further investment in meeting the trends and needs of the populations.

In its role as auxiliary to the govt, Afghan Red Crescent Society has established strong relations with MoPH over the year across the country through its key activities carried out under its existing health programme. In assisting the MoPH to address the current gap in emergency health preparedness and response the ARCS currently provides support through its 10 EMUs and 20,000 youth volunteers all over the country which play a vital role in reduction of morbidity and mortality rates during epidemics. However consolidating skills and knowledge to be further aligned towards prevalent trends in Afghanistan so as to be able to respond much more efficiently and effectively was identified as an area of great potential for the ARCS that needed further investment.

A number of discussions were held between ARCS and IFRC which took into consideration as the recommendations of the internal evaluation of the EMU program in mapping out a much more strategic plan in strengthening the ARCS overall capacity in emergency health preparedness and response in a more integrated approach as opposed to thinking vertically. One of the key activities identified during this planning in moving forward was for the ARCS to conduct a masters training on ECV and HHWT with the support of IFRC.

Main objective of the training/workshop:

To enhance the emergency health preparedness and response capacity of ARCS by training a number of master facilitators in Epidemic Control for Volunteers (ECV) and Household water treatment and safe storage (HWT).

Specific objectives:

- To train CBHFA supervisors and selected CBHFA trainers as Master Trainers in regards to ECV and HWT
- To ensure that trainers are trained enough to replicate the learned skills in their specific regions.
- To ensure that the trainers can make epidemic response plans based on their context and trend of health emergencies.

The preparation

Selection of participant:

The selection was made based on needs. The national society based its experience and selected only the provinces which were more prone to disease outbreaks and public health emergencies. A total of 25 CBHFA supervisors, trainers, regional health officers covering five regions from 10 most at risk provinces were selected as the key participants for the workshop. (*refer to annex 1. List of the participants*)

The selection of venue:

The training workshop was organized by ARCS with the support of International Federation in the IFRC meeting room with all necessary administration and training relative materials in placed.

Pre-arrangements:

As the training was targeting CBHFA trainers and regional health officers to be trained as master facilitators, it was important before commencing the training that all materials required be translated and printed into both Pashto and Dari languages. Similarly, discussions were held in mapping out the methodology and role of each facilitator. The workshop was mainly facilitated by the ARCS PHiE focal point (Dr. Zulmai) and the health programme officer (Dr. Sailab) with the support of Federation health delegate and health manager.

Pre tests and post tests as well as several group works were prepared in the days before training so as to gain greater insight in to initial knowledge from participants on the topic and re-assess the level of knowledge gained following the training. (*refer to annex 2, agenda for the workshop*)

Methodology

The training was a 100% interactive in which the participants were actively involved throughout the training. There were presentation sides, instead the methodology consisted of group work in different styles, flip chart activities, using cards, role plays, and developing scenarios. The facilitators did exactly what a facilitator should be doing. They guided the participants and the participants were responding positively.

Based on the volume of content, the training was planned for five days with four days for the epidemic control for volunteers and toolkit and one day for household water treatment and safe storage.

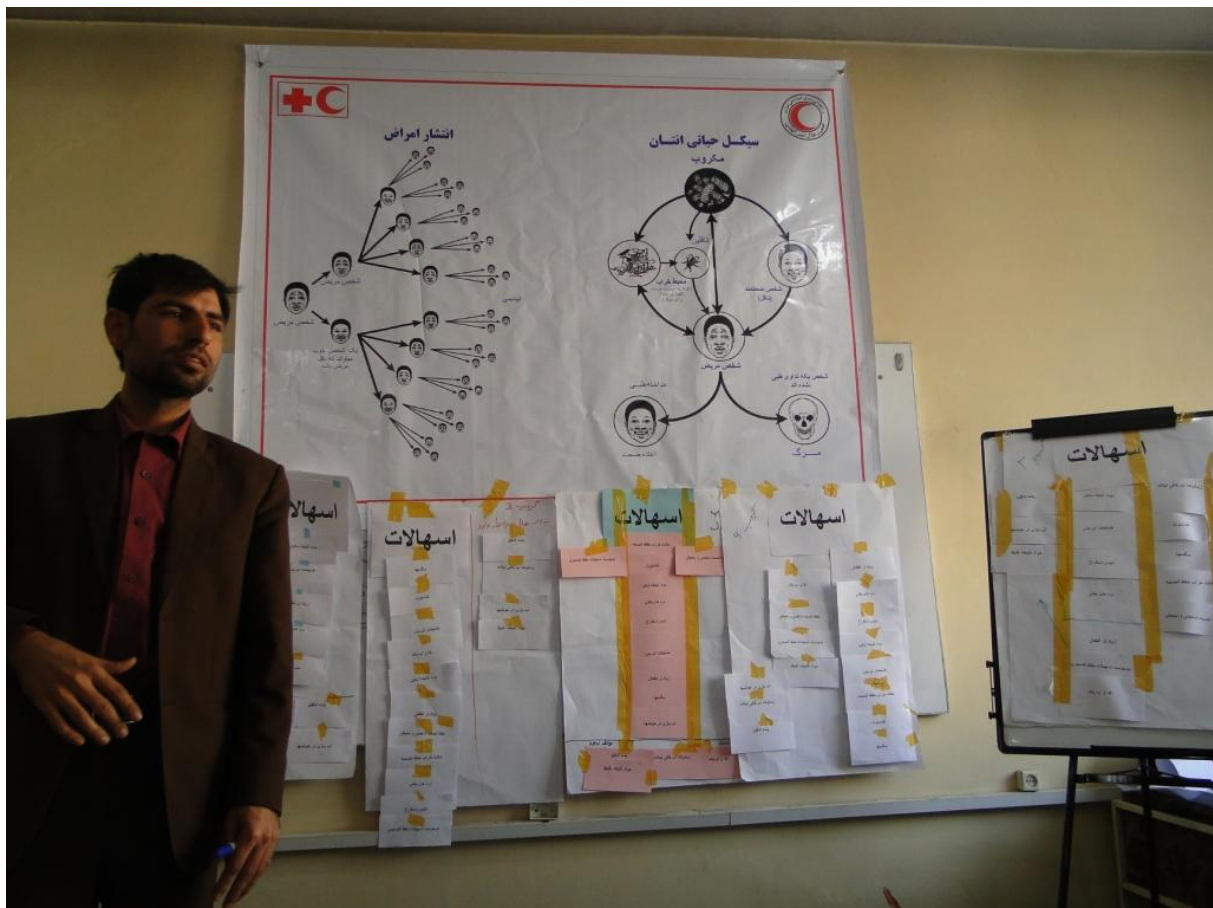
The training

Day one

The training started with an initial pre training test, which was checked by the facilitators straight after it was completed. It really helped the facilitators to understand the knowledge of participants in regards to key contents of the course. Based on that the facilitators organized themselves how to proceed further. Generally the result of the course was convincing and helped the facilitators where to focus more.

Day one was fully occupied with the sessions from Module 1. The facilitators could only cover definition of an epidemic, infection, germs, vectors. Meanwhile more time was allocated for infection cycle and the spread of disease as well as safeguarding.

In each session different methodologies were experimented with for example; definitions: the participants were given chance to come up with their own understanding about the subjects. Similarly flipcharts were distributed to each group to come up with their own definitions. This was a very nice exercise; the facilitators could adapt their sessions based on the current knowledge of the participants.



Day two:

The second day of the workshop was allocated for the disease groups which cause epidemics. In this particular session, the facilitators used a card game for each of the disease types. These cards included issues like things that relates to the disease (general definition, route of transmission, symptoms, ways of prevention, ways of detecting and dealing with the epidemics of that particular disease). The group were asked then to move around the room and see the other groups' work and add or remove some of the parts that they think are not correct. Each group presented their work and was assessed by the other four groups, which meant the participant could understand the level of their knowledge level after the group work was finished.

At last the facilitators filled the gaps and the areas which needed to be added to the sessions. This exercise not only helped the facilitators to know the level of knowledge of the participants, but also made it easy for them to give more focus to areas where the participants should actually be taught on. Throughout each session the facilitators emphasised guidance on practical implementation of each session for the trainers to take into consideration when carrying out the training in the future for the volunteers in their respective areas.



Day three

These parts were also fully participatory as the facilitators started the session of epidemic assessment and the questions to be asked during epidemic. The participants were again divided into groups and were asked to come up with questions they think are needed for any epidemic assessment. Later on the facilitators added questions that were not highlighted by the participants. A group exercise was followed by whom would they ask their questions to in an emergency. The participants came up with target groups, which was practically done by giving the groups a scenario. A role play was carried out and the participants were required to ask the questions they had developed to specific beneficiaries. Following this they analysed the information gathered and presented back to the other groups what was the epidemic. The facilitators gave their feedback at the end of role play.



The other important issue during the day was the epidemic response cycle. Prior to the workshop we had already printed the epidemic response cycle on the large sheets (2 x 1 m). The illustration was displayed on the wall with the different phases of the cycle highlighted by the facilitators. Each part of the phase was worked on with flip chart group activities, where the groups were asked to come up with the activities that should be taken in each phase. The facilitators later on added the missing points in each of the phase. This was followed by another group work activity which focused on epidemic risk, risks of our country and communities, seasons and related epidemics. The participants drew a seasonal calendar and came up with the possible epidemics in each particular season. And finally the role of volunteers during the different phases of epidemics.



The third module was found more repetitive as most of the issues were covered during modules one and two. However what was given more attention as a result, in module three was the topics on surveillance systems and volunteers specific actions during different phases. The facilitators gave more focus on designing messages and how to communicate different messages to different target groups. The facilitators insisted on the quality and characteristics of a message and how and where to deliver it.

Day four

Day four was allocated for the epidemic control toolkit. Initially we were thinking that it will not as it looked very simple. In this session the facilitators explained the different tools and later on the participants were divided in different groups and were given a particular diseases to work on using the different tools. At the end of the exercise, we came to know that the participants were still struggling in using the tools. The facilitators then came of with a scenario and asked the different groups to work within the groups and respond to the situation using the tools kit. This exercise took longer time, but the result was excellent. The participant were well able to design a proper response to the (selected) epidemics (the selected epidemic was diarrhea).

Day five

Day five was used for households water treatment and safe storage in emergencies. This part was also a very participatory and the participants were tested of their knowledge in regards to water, water quality, why water is important and how to deal water storage during emergencies.

In this one day training on HHWT, the facilitators touched based different methods of water disinfection. However they focused more on the practical methods which is applicable in Afghanistan context. The facilitators practically taught the participants the use of different disinfectant materials, such chlorine tablets, waterguard solutions, chlorine solutions. This was followed by introducing the hygiene promotion kit to the participants. The contents of hygiene promotion kit were explained one by one to and how to use them during emergency and non emergency situations.





Final Evaluation

A final evaluation through a post test was done, which indicated that the knowledge of the participants improved from 40% to 80% percent which give us the indication that 80% of the participants gained almost 100% of knowledge in regards to epidemic control and HHWT training.

Similarly the participants reaction towards the training and methodology was very positive and they were happy from the course (mood chart was used to evaluate the level of happiness of the participants on daily bases).

The facilitator's perception and comments

The training materials were very comprehensive and easy to use in facilitating the training. Allocating four days for the ECV and toolkit was sufficient time and allowed for fruitful discussion when required, active participation and flexibility in giving ample time to sessions that required it. We perceived some parts of the modules in the manual as quite repetitive. However while organizing the training it should be made sure that the flow is very smooth so that the participants don't get bored.

Adding on an additional day to include the HHWT was also a great investment in terms of further increasing knowledge on a much more broader sense and is very much inter-related. The other good part of the training was that the gender was considered and there was an equal balance between female and male which created a very good working atmosphere. Changing the groups members on daily basis enabled maximum sharing of experiences and opinion among the participants in the group works.

Conclusion

The first ToT masters training on the epidemic control manual and household water treatment in emergencies for CBHFA trainers, CBHFA supervisors and other HQ staff in Afghanistan was a great success. The five days were very comprehensive experiences for both participants and facilitators.

The epidemic control manual for volunteers proved to be very easy to follow and provided the participants with tools to prepare their volunteers adequately for future epidemics. The manual and toolkit is self explanatory enough for volunteers to refresh their knowledge on an ongoing basis or upon the alert of an epidemic.

Apart from preparing the participants for the future the training also provided the optimal forum to initiate (through the ToTs) an improvement of the quality of hygiene messages around diarrhea and ARI that are currently given out by the Afghan Red Crescent volunteers throughout the country.