



Epidemic Control for Volunteers Manual and Toolkit

Evaluation of rollout 2008-2010

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Acronyms

CBHFA	Community-based Health and First Aid
CREPD (Span.)	Red Cross Regional Centre of Reference for Disaster Preparedness
DM	Disaster Management
DREF	Disaster Relief Emergency Fund
ECHO	European Commission Humanitarian Office
ECV	Epidemic Control for Volunteers
EH	Emergency Health
H2P	Humanitarian Pandemic Preparedness
IEC	information, education and communication
IFRC	International Federation of Red Cross and Red Crescent Societies
LA & LC	Latin American and Latin Caribbean (countries)
MoH	Ministry of Health
MENA	Middle East & North Africa
NDRT/RDRT	National/Regional Disaster Response Team
NIT/RIT	National/Regional Intervention Team
NS(s)	National Society(ies)
PHE	public health in emergencies
RC	Red Cross/Red Crescent
WHO	World Health Organisation
CBHFA	Community-based Health and First Aid
CREPD (Span.)	Red Cross Regional Centre of Reference for Disaster Preparedness
DM	Disaster Management
DREF	Disaster Relief Emergency Fund
ECHO	European Commission Humanitarian Office
ECV	Epidemic Control for Volunteers
EH	Emergency Health
H2P	Humanitarian Pandemic Preparedness
IEC	information, education and communication
IFRC	International Federation of Red Cross and Red Crescent Societies
LA & LC	Latin American and Latin Caribbean (countries)

MoH	Ministry of Health
MENA	Middle East & North Africa
NDRT/RDRT	National/Regional Disaster Response Team
NIT/RIT	National/Regional Intervention Team
NS(s)	National Society(ies)
PHE	public health in emergencies
RC	Red Cross/Red Crescent
WHO	World Health Organisation

Executive summary

The Epidemic Control for Volunteers (ECV) manual and toolkit is an information and training package focusing on epidemic disease management. It was conceived for use by volunteers and their trainers in local branches of Red Cross and Red Crescent Societies, to both familiarize them with the most common epidemics that cause the most death and suffering, and to teach them how they could help limit the number of victims, act quickly and effectively and define their role in their communities before, during and after an epidemic.

At the date of this study (Q1 2011) the ECV has had limited uptake globally, with widespread use in several Latin American and Latin Caribbean (LA & LC) countries, some use after a wider training rollout in a number of African NSs, and individual country use in other places such as Tajikistan, Haiti and Afghanistan. Significantly there has been no uptake to date in any other Asian or Middle Eastern NSs, although there are reported to be plans for its introduction in South Asia and the Pacific.

There is broad consensus from those National Societies (NSs) where it has been used that this ECV package is an excellent concept, and it has been very well received by its intended audience at NS level, who recognize its usefulness and relevance to the challenges confronting them in their public health activities.

Due to a weak rollout process, its introduction into NSs has been patchy and slow, and it has really only been best introduced and utilized where a dedicated emergency health delegate has been tasked with leading the process. Insufficient guidance was given when the materials were distributed initially about what it was and what it could assist with, and it has taken time to improve on this.

The paragraphs below aim to offer a simple summary of the following pages in terms of 'where now and where next'. The package is still evolving and it is this evolution that keeps it current and relevant for National Society use. The Emergency Health team in Geneva may provide the guidance on its continuing uptake at a national level, but the responsibility to use it – and how – has to be a NS decision.

Keep it simple

The ECV package is not intended to be a highly specialized or advanced toolkit and must remain simple in order to reach further volunteers and to be able to replicate the knowledge at community level. It should be seen as part of a comprehensive public health tool bank offering different levels of knowledge depending on the audience. It must be seen as complementary to other IFRC and Red Cross guidelines and methodologies and used as such rather than as a stand-alone product. In the Americas it is also complementary to all the

institutional preparedness tools developed by CREPD as they are all based on the same learning and teaching methodology. It should be seen as one tool to work better with communities in prevention, mitigation and preparedness, and should draw on the range of other publications for supporting information and reference knowledge.

The teaching and learning methodologies should be adjusted and the knowledge should be complemented in order to keep the ECV as an easy-to-train and easy-to-use manual at both institutional and community levels, adapted to a wide range of volunteers. The development and inclusion of teaching plans would help facilitators target the appropriate level of information to the audience.

Keep it flexible

The original ECV package is acknowledged to allow flexible implementation in different specific country contexts (including covering gender issues and variations in cultural and social organization in various communities), as well as covering a range of identified diseases. It has been seen that regions or countries feel the need to make changes based on their local customs and context, and the materials have proved themselves to be flexible enough to allow this to be done.

The ECV package must retain this flexibility in term of scope of application and timeframe of implementation. This could include the development of online options also, although this will not always be practical for volunteers and should be seen more for refresher training rather than first-time training for branch level staff and volunteers.

National Societies need to consider this as their tool, not a Federation programme

The ECV package is not a stand-alone programme – it is a tool to help with specific activities that volunteers are very often doing already. The lessons learned from the Americas Zone shows that when the tool is acknowledged and accepted as appropriate and important for local use, the NSs take it on board to amend or improve it to suit local contexts. As can be seen from some of the quoted case studies, this has in some situations reaffirmed their working relationships with their own Governments, and has produced additional funding resources as a consequence. This is often dependent on whether the NS sees the epidemic control activities as an emergency response or a preparedness activity, and therefore what is expected of the NSs by their national health authorities at these times (amongst all other demands on them).

The challenge is to find ways for other NSs to learn from these examples, to acknowledge the importance of the materials available, and to ‘nationalize’ it for their own use. The prevalent and historical attitude of expecting to have associated funding to make it acceptable needs to be changed. Holding expensive workshops to introduce the tools and manual is the wrong way to proceed. The materials could be presented and explored at one of many regular regional gatherings, with an offer to support local amendments with a financial grant, and only if necessary follow-up training in country. It has

intentionally been kept simple to avoid the need for expensive trainings and delegate interventions!

Keep the training timeframe adaptable

In order to cope with the limited availability of volunteers and community members and also with limited funding opportunities, to the context, audience and availability of funds, the training must remain flexible. For instance, in an emergency response situation, NSs should be able to implement ECV through closely targeted ‘flash’ training in order to quickly mobilize its volunteers with enough basic knowledge to deal with the outbreak.

Improve advocacy and dissemination of the materials

Internally, the health delegates need to better promote the materials to all NSs, particularly those where its introduction could make a significant difference in epidemic control. Indeed there is a plethora of competing priorities for the NSs and the delegates, but the exclusively positive feedback received from those NSs who have already taken ECV on board would indicate that it would be equally relevant and important in many, many other Societies. It is not very hard to see that it would have a significant impact in many parts of Asia, but its rollout here – due to “lack of resources” – has not really occurred.

Externally, some work has been done on this subject and as has been mentioned above, a number of governments and external partners are positive about the materials, and in some cases have already amended them for their own use. But given the positive feedback, the materials can still be more widely known and shared, by the NSs and the IFRC. As has been proven in Bolivia and other countries, this can also bring unforeseen benefits of programme work and additional financial support.

Consider other options too – online training, offline CD etc

National Society responders highlighted that online training should not replace the existing training support. The main advantages mentioned are:

- **The wide range of cost-effective opportunities for individual training of basic skills and knowledge provided through short online courses that are web based and (theoretically) accessible from anywhere in the country;**
- **The opportunity to reach a wider audience;**
- **Sustainability of the training and opportunity to keep the learning current.**

Despite the high level of NS interest in the Americas Zone in having an online option to monitor and refresh knowledge, it is not considered appropriate for first-time training. The online training should therefore not replace any existing face-to-face training support, enabling taught implementation at branch level without internet access and in communities. Online access would be more relevant for allowing individuals at NS HQ level to update themselves,

and to keep the materials current and updated. A developed package could be added to the IFRC's online Learning Platform.

Purpose and Methodology of the Study

This study was commissioned by the IFRC's Health Department to consider the "use of the Epidemic Control for Volunteers Manual¹ and Toolkit in National Societies' and the IFRC's operations". The full Terms of Reference are attached as [Annex Two](#). Two external reviewers carried out the evaluation ~ the comments and opinions expressed below are those of the authors alone.

The study was undertaken only two years after the launch of the materials. The methodology included a desk review of the handbook and toolkit (both the original English version and the revised Spanish one) and other related documentation including workshop and delegate reports. The team also undertook numerous face-to-face and telephone interviews with key IFRC delegates and National Society staff in Geneva, Panama and other Zone offices, and numerous country offices and delegations. A list of interviewees and respondents is shown in [Annex One](#).

Questionnaires were prepared in English (sample at [Annex Three](#)) and French and emailed to the NSs in Africa that had been represented at the two regional trainings held during 2010/2011. Written feedback to these questionnaires was significant, particularly from the Francophone NSs in West and Central Africa. Another questionnaire was prepared in Spanish and emailed to pre-selected NSs in LA & LC countries, after which a number of telephone interviews were conducted with individuals within some of the National Societies.

With the exception of Afghanistan, no programme feedback was received from the delegations or NSs in the Asia/Pacific or MENA Zones.

The following pages will consider the development and rollout processes followed, how the toolkit is currently being used – which presently varies significantly from region to region – and how the National Societies see the future acceptance and use of the materials. Each chapter below presents some conclusions and, where relevant, some recommendations for future implementation.

The rationale

To address the issue of epidemic control practically, an information and training package to focus on epidemic management was conceived for volunteers and their trainers in local branches of Red Cross and Red Crescent Societies to both familiarize them with the most common epidemics that cause the most death and suffering, and to teach them how they could help limit the number of victims, act quickly and effectively and define their role in their communities before, during and after an epidemic. The ECV materials were also designed to provide volunteers with a basic understanding of the diseases

The foreword to the ECV manual states:

“Epidemics are a constant threat to the well-being of communities everywhere, especially in societies where resources are scarce. Managing epidemics - or preferably preventing them - is a priority for the International Federation of Red Cross & Red Crescent Societies (IFRC). Volunteers based at the community level carry out a large part of the international Red Cross and Red Crescent Movement’s response. However, it has become clear that these volunteers frequently lack the initial background information necessary for a quick and efficient response to epidemics, especially when they are located in areas that do not benefit from the support and guidance of health professionals. This is particularly the case in developing countries that often suffer from a shortage of sufficient health care facilities and staff.”

¹ Online link to the manual: <http://www.ifrc.org/Global/Publications/Health/epidemic-control-en.pdf>

that can easily turn into epidemics, as well as suggest ways to mitigate against their effects.

What is the ECV?

The training manual and the accompanying toolkit consist of a handbook of simple guidelines and a folder containing loose-leaf printed fact sheets called “tools”. The project’s design, simple illustrations and basic production were all intended to make reproduction possible at National Society HQ and branch levels at very low cost, via photocopying or simple printing of the tools with very little sophisticated equipment required.

The toolkit includes three kinds of tools:

- **Disease tools:** 17 separate one-page tools each include a definition, simple symptoms, prevention and epidemic management of a single disease; there is one sheet per disease so users can select the specific tools they need for any particular operation and do not have to carry the whole toolkit with them at all times. Each disease tool is cross-referenced with the most appropriate action tools for that scenario;
- **Action tools:** 35 separate one-page tools each include one action that should be done in relation to the relevant disease (e.g.: how to prepare oral rehydration solution, the promotion of breastfeeding or building an incinerator);
- **Community message tools:** 25 illustration-based pages each including a ready-to-use illustration and one single message to the community. These can be distributed as fliers, hung as posters, or used in community gatherings if prepared in advance.

Although no reference is made to it in the ECV materials, the package develops some of the materials which the IFRC developed in the late 1990s in the African Red Cross Health Initiative, or ARCHI, which is still in use today in many NSs on that continent as a community health outreach programme delivered by volunteers.

The development process

Staff from the Emergency Health Unit of the Health Department at the IFRC Secretariat conceived and developed the materials as a *response* tool during 2008 and a draft was field trialled in Nigeria with the Red Cross branches and volunteers, with various amendments made. An outbreak of cholera in Zimbabwe in late 2008 gave the Emergency Health Unit the opportunity to properly use the package for the first time. Working with the Zimbabwe Red Cross volunteers - who were in turn supporting the country’s National Health Service staff in the cholera campaign - the first ‘training of trainers’ workshop was held in April 2009 just as the specialized emergency response units (ERUs) were leaving the country. A ten-page Facilitator’s Guide was also developed at this stage. The materials were used a second time in Mozambique in 2009, with feedback specifically being gathered from the volunteers who had used

them. The manual at this time was not meant to be for the volunteers, but for the trainers.

The total cost of the initial writing, line illustrations and printing of the first 5,000 copies of the package was about 70,000 Swiss francs. These costs were met via support from the Norwegian Red Cross which considered that the materials covered an important gap in the tool library. Translation and layout to French, Spanish, Arabic and several other languages then followed. Subsequent translation and amendments to the materials have also been done – these are described later.

The rollout process

The IFRC then launched the package, in harmonization with the community-based health and first aid in action (CBHFA) approach, with initial support to Malawi, Uganda and Gabon in response to specific disease outbreaks.

Feedback from interviewees at all levels has indicated that the rollout of the materials and toolkit was generally considered to have been under-planned and under-resourced. The health department in Geneva dispatched the material to the various Zone Health Coordinators (ZHCs), and discussed its use individually with them. It was then up to the ZHCs to ensure it reached the various NSs or regional delegates in each Zone – but this did not happen in all Zones.

At the date of this study (Q1 2011) the ECV has had limited uptake globally, with widespread use in several Latin American and Latin Caribbean (LA & LC) countries, some use after a wider training rollout in a number of African NSs, and individual country use in other places such as Tajikistan, Haiti and Afghanistan. Significantly there has been no uptake to date in any other Asian or Middle Eastern NSs, although there are reported to be plans for its introduction in South Asia and the Pacific.

It is clear that in Africa and the Americas, where the rollout has progressed significantly, the process was actively led by dedicated emergency health delegates who were given specific tasks in their job descriptions to introduce the ECV materials (and other relevant tools) to the regional NSs. The emergency health (EH) delegate posted to the Africa Zone in early 2010 had in her job description a specific objective “to provide training on ECV to be rolled out to support NSs to plan for, mitigate and respond with best practice to emergency health and epidemic control”, and her colleague in the Americas Zone was tasked, amongst other duties, “to promote the ECV tools” with NSs.

Background to the rollout in Africa

The introduction of the ECV toolkit and manual in Africa was started via the original field testing, and then later in response to actual disease outbreaks in a number of countries. Some work had already been done in several countries in preparation for an anticipated influenza pandemic (the H2P project), and there was residual understanding and skills at volunteer level in several NSs. The introduction and use of the ECV toolkits aimed to build on this and other knowledge built up by the volunteers who had been implementing the ARCHI and CBHFA² programmes of recent years.

2 CBHFA = Community Based Health and First Aid

In most cases in Africa, the printed material arrived at Zone or Regional level with no explanation about its purpose or ways of integrating its rollout into other health or DM programming. In several early cases and to respond to specific outbreaks, materials were sent initially direct from Geneva to the NS in question. The EH delegate facilitated in-country trainings in each of these initial cases. Costs were covered by the use of funding from the Federation's Disaster Relief Emergency Fund (DREF), which had been allocated as part of wider emergency response operations in those countries.

In one NS, the materials were greeted somewhat unenthusiastically as "why another manual from Geneva", principally as there was no clarity on their optimal usage or linkages with other existing publications, and a feeling that the messages were inconsistent. In many NSs the material was not proactively taken up as it did not have any clear plans or guidance for introduction and use. Furthermore, it did not come "with funding". The strategy therefore evolved in Africa to work with those NSs in a response phase – when DREF funding could be accessed – and to rollout the material to other NSs via regional level workshops.

The EH delegate organized two regional workshops in 2010/2011, to introduce the package to 26 NSs at a senior level and to advocate with the participants for a greater take-up of the materials within their NSs. These workshops were funded from the central health budgets in Geneva Secretariat Health department. Most of these participants only received the information and manual of the ECV just prior to attending these workshops (although at least one participant had used the toolkit before as a member of a Regional Disaster Response Team (RDRT) in a neighbouring country). Although the feedback from these regional meetings was positive, it then fell to these NS staff to cascade the trainings down to branch and volunteer levels, amongst their numerous other priorities, and still with limited funding.

While many NSs would like to have been able to plan a wider rollout and training with branch level volunteers as a preparedness measure, their constraints to do so were apparently linked with limited availability of funding ... despite the fact that the training is meant to be replicable for a very low cost.

The majority of those countries where the ECV has been used in response to an outbreak have been supported in the training and rollout locally by funds from the Federation's DREF³. However it is clear that linking the introduction to a response operation was a positive – even if inevitable – process to get the materials into initial use at the intended volunteer level. Operational feedback suggests that the simplicity of the materials and the ability for health professionals to deliver appropriate training using the toolkits at these critical times was very relevant.

The subsequent regional workshops highlighted to those NSs that had not had direct exposure to the package up to this time the relevance and appropriateness of these new ECV materials. The presence at the workshops of several representatives of NSs who had had experience of using the ECV materials certainly helped get across the message that it was a valuable tool, and the feedback from the workshop participants was exclusively positive. Since then, a number of NSs have used the materials in operations within their own countries, and/or have current plans to do so. One NS used a current operation, where they were using the ECV via DREF funding, as a practical training experience for other branch managers from other parts of the country.

³ The use of DREF for such trainings is discussed in Section 7 below.

Despite its extensive use in response operations, many NSs still consider the materials as a valid preparedness tool, and have identified the need to hold extensive training sessions for volunteers, but require substantial financial support to do so.

Background to the rollout in the Americas

The approach taken in the LA and LC countries was significantly different. The ECV package was first introduced in the Americas alongside other key PHE tools being made available to regional NSs, such as the first PHE training for the NITs. The aims of the project were to introduce, adapt and validate the IFRC standard ECV manual and toolkit, to train trainers and volunteers and to implement trainings at community level.

In 2009, a 12-month preparedness project⁴ supported by ECHO funding allowed the development of a regional epidemic control capacity of four⁵ NSs of LA & LC countries, going beyond the previous donor-driven initiatives in epidemic control, and ultimately to be made available for all NSs in the Zone. In coordination with the Red Cross Regional Centre of Reference for Disaster Preparedness (CREPD in Spanish) based in El Salvador, and with the contribution of specialized focal points from the five NSs involved in the regional ECHO project and other NSs, the ECV materials were adapted for regional use. It remains unclear why the second Centre of Reference (for community education) had not been involved as its participation would have ensured better compatibility with the existing community based tools and methodologies and also better appropriateness for its use in the community.

Two technical meetings were held in May and June 2009 in order to work on the technical aspects of the content of the ECV manual and toolkit. The work produced a training module on ECV using the methodologies traditionally used in the RC movement in the Americas (coming from OFDA methodology). Following this, the ECV toolkit and training module were validated in two further regional workshops, where 46 ECV trainers were certified. The regional process established a framework and a trainers' network available for all Spanish-speaking NSs, which allowed and supported them to cascade the trainings down from national to branch levels. This training was geared towards the National Intervention Team (NIT) members who would be responding to the outbreaks, but also at branch level as stand-alone ECV training for local institutional preparedness, alongside other tools and methodologies for community preparedness undertaken by volunteers at branch level.

This regional rollout in the Americas was limited to the 20 Spanish-speaking NSs in the region, and not done in the other 35 English and French speaking NSs where the ECV was only introduced if funds were available.

This project was carried out during the influenza outbreak in the Americas, which had strong repercussions for NSs and national authorities. The pandemic preparedness (H2P) projects made funds available for building wide capacity at national and local levels and also allowed NSs to have a stronger position in the reinvigorated national coordination mechanisms. However it became clear that such a level of training and awareness would not remain sustainable by the NSs, and probably the ongoing needs were not there either.

⁴ Project title: "Enhancing the response capacity to epidemic outbreaks of malaria, dengue, hemorrhagic dengue, leptospirosis and yellow fever"

⁵ The countries were Bolivia, Colombia, Paraguay and the Dominican Republic

Some respondents questioned the relevance of developing nationwide ECV capacity as a general preparedness activity, but despite this the NSs have confirmed a comparative advantage that contributes to the perception of the NSs as strategic partners for community interventions before, during and after an epidemic outbreak.

In the Americas, the ECV is currently used in both contexts: preparedness and response. Most of the NSs were initially introduced to ECV through preparedness projects aimed at building up volunteers' and communities' capacities to prevent, prepare and respond to a disease outbreak. Its use has been oriented to volunteers, staff from national health systems, community members and at national level to the NIT and RIT members. With the onset of the influenza pandemic and the availability of preparedness funding, NSs developed wider ECV capacity in their branches (even those located in non-endemic areas). Even though such developments were probably relevant in a context of pandemic preparedness, nowadays NSs acknowledge certain difficulties in keeping the learning current at branch level. Rather than having all the volunteers trained in ECV, NSs focus the use of ECV in specific endemic areas where risk exists and is identified.

National Societies – in the Americas but also in Africa – have progressively included ECV in their strategic plans and have smartly channelled available resources into wider community messaging in order to fund ECV as a complementary preparedness tool. Nevertheless, it remains unclear how capable they are to keep the learning current and often the responsibility falls to the branches. Response operations and preparedness projects in epidemic prone areas remain the two main sources of funding identified by NSs.

The majority of the NSs in the LA & LC countries acknowledged the ECV package very positively and highlighted its strong relevance to the challenge confronting them in their public health activities. Largely influenced by the active promotion of integrated management of diseases with epidemic potential, supported by the WHO and implemented by national health systems, many NSs have been progressively channelling available funds into interventions that do not only seek to build up volunteer networks with epidemic response capacity but also to build capacity to stimulate a culture of prevention and preparation at community level. In the Americas, the ECV is integrated into wider community messaging for prevention, mitigation and response purposes.

National Societies channel preparedness resources into comprehensive and integrated interventions with ECV capacity building in order to have access to more sustainable funding possibilities for ECV capacity strengthening. This also helps to ensure continuous hands-on practice and to keep learning current and valid for disseminating community messaging and respond to potential outbreaks.

Background to the rollout elsewhere

In the Europe Zone, due to the reduced public health role of the RCs in Europe generally, a proactive rollout of the materials was not considered a priority, although it was used in Tajikistan (see case study 1 on the next page) in response to a specific outbreak of polio.

Afghanistan is the only country in the Asia Zone that has taken up the ECV package to date, undertaking a number of workshops at branch level. Partner

NSs have supported this approach, actively led by the current health delegate in the country. In the rest of the Asia Zone, other priorities and lack of staff were given as the reasons for no rollout to date, and again apparent plans of uptake in South Asia and the Pacific – as reported by the Zone coordinator – were not shared with the review team.

In the MENA Zone, the Arabic version of the manual was only received in late 2010 and its distribution to the NSs has only recently begun. The reviewers were unable to get any further information from the MENA Zone regarding their plans to introduce it to the NSs in the region.

Conclusions

CASE STUDY 1: Tajikistan Red Crescent

In late April 2010, Tajikistan reported over 120 cases – including 10 paediatric deaths - of acute flaccid paralysis in 20 districts of the country, including the capital city of Dushanbe. The Red Crescent Society of Tajikistan (RCST) deployed its volunteers and medical instructors to conduct house-to-house surveys to gather information on the number of cases from each district on behalf of the state's health facilities. The RCST then mobilized 420 volunteers to support the government's national vaccination campaign and to raise public awareness through community health promotion, information and media campaigns in the affected districts.

Before starting the activities a one-day training on personal protection, water disinfection and social mobilization was carried out for the regional instructors from RCST. The training was conducted based on the ECV manual, downloaded from FedNet (on the advice of the IFRC's Europe Zone health coordinator). The main indicators of the disease, ways of transmission and prevention were overviewed (disease tool #4). The volunteers' actions during a polio outbreak, as well as community social mobilization methods during national vaccination campaigns were discussed. A representative from the Ministry of Health and an infectious diseases specialist gave presentations on the disease and prophylaxis.

Then a series of trainings was conducted at the same time at regional, district and village levels to ensure all 420 volunteers received personal protection training. Each volunteer received a personal protection kit consisting of medical masks, medical gloves, hygiene kits and water purification tablets. The social mobilization activities started right after the training of volunteers in every village of the 20 districts in close cooperation with community leaders, who helped in gathering people in one place and identification of families with children up to six years old.

There is broad consensus that the ECV package is an excellent concept and has been well received by its intended audience at NS level, who recognize its usefulness and relevance to the challenges confronting them in their public health activities.

Due to a weakly conceived rollout process, its introduction has been patchy and slow, compounded by the lack of a coherent strategy, and it has really only been best introduced and utilized where a dedicated emergency health

delegate has been responsible to lead the process. Insufficient guidance was given when the materials were distributed initially about what it was and what it could assist with, and it has taken time to improve on this.

There remains some ambiguity as to whether this package is meant principally for response to epidemics or for preparing volunteers in advance of them, or both. Different NSs have taken differing views on this, but it seems that these decisions and the various experiences are largely based on the availability of funding support to help the rollout and training processes. In the early days – and in many cases currently in Africa – the use of the manual has been exclusively for volunteers at a local level who were being asked to respond, and thus the costs could be covered from the response operation. Clearly there are possibilities for its use in either emergency response and/or preparedness phases of volunteers' work, these have very different funding possibilities, and NSs have to be realistic about how and to what extent this package can really be rolled out nationally, and be kept current and valid.

In the Americas, since its introduction, the use of the ECV package has been consistently focusing both on the emergency response itself and on prevention messages. Considering the difficulty in mobilizing funding for epidemic prevention and preparedness, most NSs adopted the ECV package as a complementary preparedness tool in epidemic prone areas where preparedness projects are already being implemented and funded. Response operations remain the second main funding source for using ECV volunteers in the Americas.

Considerable revision and amendments have been done to the package in different contexts. Particularly in the Americas, the package has been taken onboard by the regional Reference Centres to ensure its compatibility with other tools and methodologies. The regional process involving several NSs ensured its relevance and appropriateness for the local context and this approach has led to a significantly greater uptake than elsewhere. The validation process offered a certain level of guarantee of ownership by the NSs in the region, and has strengthened the likely sustainability and ongoing use of the tool. The Centre of Reference retains the responsibility to monitor and adapt the validated ECV manual and toolkit, rather than individual Federation delegates who come and go.

Recommendations

- R 1: The ECV package should continue to focus on both response and preparedness activities, but these have to be tailored to needs and capacities – notably of funding – in each national situation. It should be clearly rolled out as a tool and not as a programme in its own right.
- R 2: The development of a regional strategy for epidemic control would support NSs in defining their roles and responsibilities internally and externally, and consequently would help to develop standardized ECV framework.
- R 3: Consider future rollout and adaptation at regional (or sub-regional) level in order to produce a tool most relevant to that regional context which requires limited further adaptation at national level.

Presentation of the Manual and Toolkit (based on the English version)



There was consistently positive feedback from the NSs and health delegates that the toolkit was clear, straightforward and fully appropriate for its use and understanding at volunteer level. The NSs generally consider that the branch level volunteers should remain the focus for the training on RC epidemic control, and volunteers should therefore remain the target for the ECV toolkit and manual. This is based on the traditional acceptance that it is the branch level, rather than national level, which remains the focus of Red Cross work, particularly for monitoring health events in the community, mobilizing community action and local health and response systems.

Overall the text throughout the manual is clear and simple to understand. Although this is not so appropriate when delivered to medical professionals, who were reported to find it a bit simplistic and patronizing, the consensus from the feedback received was for keeping the level of technical language basic and adjusting the teaching methodologies according to the current audience.

There remains considerable duplication between sections of Session 2 and Session 3, particularly around the roles and expectations of volunteers. Feedback from many NSs has indicated that it is existing volunteers, often those used extensively in the CBHFA or similar programming, who would follow specific ECV trainings, and therefore having to repeat much of the basic volunteering messaging is probably unnecessary in these cases. The Latin version reorganized these into a single section covering the theme of “Volunteers’ Action in Epidemic Control” with three sub-sections: the role of the volunteers, the intervention cycle and the actions in epidemic control. This reorganization avoids duplication when the ECV is used alongside other tools, and thus is better adapted for the target audience. Also, the scope of action of the volunteers in epidemic control was slightly expanded, emphasizing the prevention and community health promotion roles.

It remains unclear why the introduction to the tool is provided in Section 4 of the manual, almost as an afterthought. The explanations of what the toolkit is, how and when to use it and the various lists and ways of using the tool cards would be better placed at the front of the booklet.

There was a wide range of feedback about the graphics and pen-and-ink drawings. Although they were acknowledged as clear and helping to get across the message, as well as easy to duplicate, there was widespread feedback that the pictures of people should be more culturally aligned to the local context, so that local communities could relate better towards the pictures and messages. If the picture is not something which the audience can easily relate to (for example, the ‘flush toilet’ bathroom in community message tool #9) the impact of the message is quickly lost, and it is these pictures/messages that would need to be adapted in certain circumstances. This could be extended to cover the depiction of people, their clothing, their environment or their

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access to resources. It is not realistic to accept that the global presentation will be appropriate everywhere without such adaptations.

Some even suggested the use of a picture of an Asian family on the front cover to be ‘inappropriate’ in some contexts. The evaluators consider this to be a rather narrow take on a global tool, but clearly this was significant for some responders and it underlines the comments that local adaptations will be required in most if not all situations to ensure the best impact.

Some interviewees suggested the possibility of developing a wider tool bank with advanced literature (specially in the case of NDRT/NIT trainings with a higher profile of participants - mostly with health backgrounds), although it is acknowledged that much of the proposed documentation already exists and simply needs to be made more available. A web-based catalogue of supporting information could be part of a virtual ECV platform, or the CD in the pack could contain them.

The various fact sheets in the toolkit called “action tools”, “disease tools” and “community messages tools” are not considered to be practical for regular use in the communities without being laminated (on both sides) to make them longer lasting.

Local adaptations

Despite the comments of overall suitability, most NSs’ and regional feedback indicated that in fact the original manual and toolkit needed to be made “more appropriate” for local situations. Firstly on language: the materials have been translated into several working languages beyond the original English to date: French, Spanish (for the Americas region), Dari and Pashto for Afghanistan, Russian for Tajikistan (in part) and Arabic; and it is currently undergoing the process for Haitian Creole¹. However, individual NSs have also indicated the need for a wider range of adaptations, and further translations into local/regional languages will also be required to support the volunteers and ensure full understanding at local community levels.

Most NSs reported that they had already made – or still need to make – further adaptations and ‘cosmetic’ changes to the original manual and toolkit. These changes were for a number of reasons ranging from ensuring the most prevalent diseases for the country were highlighted and others discounted, for cultural acceptance and appropriateness, for more relevant local messages, or to meet local regulations and/or to conform to standards as defined by the Ministry of Health or other official bodies. It is positive that the individual NSs want to effect such amendments, which should mean a more committed uptake within their own volunteer cadre. Nevertheless, in a good number of countries only ‘cosmetic’ and linguistic changes were made, as some of the NSs were happy to accept and make use of the standard materials as they were.

In the Americas, the panel of experts and the CREPD made the following changes to the training manual:

- **The standard manual and toolkit were adapted to the Latin American and Caribbean context, with additional regionally-prevalent disease**

¹ Conversion of the texts and toolkits for use in Haiti goes way beyond the simple translation, but each picture, phrase and terminology has to be analyzed for acceptability and clarity in the Haitian context – this is a very long process.

sheets being added, such as for Chagas disease (American trypanosomiasis), and excluding other diseases which do not form part of the epidemiological profile in the Americas (such as Ebola and Marburg fevers);

- Highlighting the active promotion of integrated management of diseases supported by the WHO and progressively integrated by the MoHs, the Latin version was adapted to provide a more comprehensive approach to epidemic risk than the original IFRC global tool. Module 1 and the Module 2 address the wider concepts of vulnerability and epidemic risk and the reorganized Module 3 (“Role of the volunteers in epidemic control”) focuses on a wider role of the volunteers in the management of this risk, including health promotion, preparedness and response.
- Module 3 was reorganized to give a clearer picture of the roles and actions of the volunteers in the periods before, during and after an epidemic. This has helped to avoid duplication of volunteering messages when ECV is applied alongside other methodologies;
- An extra Module 5 was added with information related to the use of key response tools also included into the training module (sample situation report, action plan, data collection sheet and rapid assessment checklist);
- The learning manual - and its level of teaching - was upgraded to meet the average skill level of volunteers in the Americas.
- Small changes were made to the drawings in order to make them more culturally aligned to the local contexts.
- The final design and layout of the revised product is not in accordance with the IFRC corporate identity so work is currently ongoing to track the changes made in the Latin version of the ECV, and a consultant has been hired to identify and analyze these changes to align the product with IFRC standards.

Although this was an extensive process, it was supported by the former IFRC Zonal Emergency Health Coordinator), and it was considered to be necessary and cost effective by those interviewed. It was only the manual that was changed and not the toolkit (action tools, community message tools and disease tools) as the latter were considered appropriate by the technical panel involved in the introduction process. However, as mentioned above, some practitioners have suggested further adaptations to the tools (mainly the community message tools), and it is interesting to record that no discussion on the revision of the community action tools was held with the other Red Cross Centre of Reference for Community Education (CRECC, based in Costa Rica), which specializes in community preparedness. This Centre is specialized in developing methodologies and tools to be used at community level and its inputs to this revision and adaptation process could have brought an added value.

Consistency and correctness

Some of the technical pictures/texts are considered to be inaccurate or inconsistent with other messages within the pack or as promoted by the IFRC elsewhere. They should be better aligned and standardized across the range of IFRC publications. (Interestingly none of these other Red Cross publications has been referenced in this package as possible supporting reference documentation).

A number of issues came up, either from a study of the texts or as direct feedback from the respondents. Some of these were errors, some were inconsis-

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tendencies in the messaging, and some were areas where additional information could be given. For example:



- this diagram from page 14 of the manual: While the caption is “A mother bottle-feeding her baby” – neither advocating for nor against the practice – this is inconsistent with the positive encouragement of breastfeeding outlined in action tool #7 and community message tool #3, and at odds with the IFRC’s policy of promoting breastfeeding. It could lead to confusion for volunteers.
- from the manual, page 41: the penultimate paragraph states: “...and sometimes have swollen bellies caused by fluids in their abdomen (kwashiorkor)”. This implies that the swollen belly rather than the underlying malnutrition causes kwashiorkor, even though this is not what is actually meant. Again, this is somewhat confusing.
- at least one instance (manual, page 59) where ‘CBFA’ is used instead of CBHFA.
- page 22 of the manual, on detection of vaccine-preventable diseases: for ‘yellow fever’ it would be more helpful to state that the symptoms are fever/nausea/pain/headaches/red eyes (as shown on ‘Disease Tool #5’), rather than ‘...when many people get fever in a place where yellow fever exists’ which is of little help to anyone.
- Community message tool #6 does not show any hand washing facility in the picture of the latrines – if included, this would help volunteers promote the practice of hand washing more effectively, since diarrhoeal diseases are one of the most common problems.
- Action tool #6 (meningitis) asks questions about yellow fever on the reverse.
- The content of the action tool #22 (handling dead bodies) could be more detailed as to what role the volunteers should play, or if not then reference should at least be made to the ICRC’s manual on the subject: http://www.icrc.org/eng/assets/files/other/icrc_002_0880.pdf

- Action tool #29 (health promotion) should better emphasize the prevention role of trained volunteers and give additional guidance to volunteers on the types of messages to be delivered – particularly if the volunteers are not experienced in CBHFA activities.
- Action tool #30 (surveillance & reporting) should be further developed to give clearer guidance to volunteers.
- Action tool #31 (community mapping) gives very limited direction on how to plan and manage such a community tool. [NB: This action tool could be easily completed with the support of the GRECC which has already developed an interesting tool (for the Latin context) within its “Better to be Ready” methodology.]
- Action tool #32 (communication) is perceived as critical by practitioners and not adequately supported by the ECV package. Nevertheless, some NSs have developed interesting and practical IEC materials that could be easily standardized and integrated to an eventual amended ECV package (for instance, the Colombian RC has developed a card game in order to facilitate communication of health messages).
- The content of the action tool #34 (psychological first aid) could be expanded to address psychosocial support for the community as well as for individuals.
- Some errors, such as the pictures (manual page 24, community message tool #17) showing the incorrect use of a mosquito net lying loose on the floor rather than tucked under the mattress/sleeping have (apparently) already been corrected in later editions.
- One respondent suggested developing and including some health messages specifically targeted towards children, and using them as change agents to influence the wider families.

The Training Module of ECV

The purpose of the ECV training is “... to familiarize volunteers with the most common epidemics ... and to encourage them to use evidence-based approaches to prevent the spread of communicable diseases ...” The Spanish version of the manual has elaborated this a little more: “to provide participants with basic knowledge, techniques and tools for epidemic control, training and developing skills in volunteers to act before, during and after an epidemic, reducing the impact on communities”. It has included a performance objective for the training: “Given a hypothetical situation of a population is affected by an outbreak or epidemic, participants in working groups of six to eight members, with the necessary equipment and materials and within no more than four hours will be able to: (1) Make a rapid assessment of epidemics, (2) Prepare a progress report, and (3) Develop an action plan for epidemics.

Although this performance target is focused on an emergency context, many NSs have extended the use of ECV to preventive, health promotion and surveillance roles by trained volunteers and a wider performance objective would also be more appropriate.

In the Americas a specific training module was developed and later validated as part of the regional rollout process. The module is made up of ten sections utilizing different teaching and learning methods and includes classroom and practical teaching, case studies, rapid assessments and community practice. An additional module provides administrative tools for use during an operation (sample situation report, action plan, data collection sheet and rapid assessment checklist) and some flipcharts. The training module also contains

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an evaluation process for trainers and trainees. In addition, training modules on epidemic control for the National and Regional Intervention Teams (NITs/RITs) were completed, based on the ECV package, ensuring a compatibility and standardization between the various tools and their use. The training modules were validated in regional ToT sessions enabling their use at national level (in 2009 two regional ECV trainings were held, and 46 trainers and one NIT were certified).

In Afghanistan, the current health delegate designed a seven day training programme based on the “field school” concept², and has based the training on a suspected cholera outbreak. The agenda expands on the basic three day ECV schedule and includes practical field exercises and a wider exploration of factors around epidemic control, assisted by a variety of resources already available to the Afghan Red Crescent.

Feedback from those who have been through the ToT sessions indicate that they are comfortable with the materials if they have to present them to or train volunteers. One or two suggested that the support of an experienced emergency health delegate from the IFRC would be appreciated. However, feedback from those who have actually used the materials suggest that there is a need for additional guidelines for using the community tools (action tools and community messages) as well as a need for further IEC support on a range of subjects. Some of this support already exists in other RC manuals and resources. Without such additional material being available, delivery of the ECV package in the communities where there is no on-going health or preparedness project becomes more difficult, particularly in an emergency response context when there is little time to train on wider issues.

CASE STUDY 2: Uganda Red Cross

Paul Okot, Emergency Health Programme Officer, stated:

“I do think ECV is quite important and relevant to our NS because we have so far tested its effectiveness in the recent outbreak of Yellow Fever in Northern Uganda which is more or less a new disease in the country with a lack of residual experience and tools for tackling it. The generic ECV tools guided the development of specific information dissemination materials like factsheets, posters and banners that were used in the affected communities for social mobilization.”

For instance, there is no guidance on how to use the action tools in the community with the community members (e.g.: to undertake a community mapping exercise (as mentioned in the training manual and in action tool #34). There is also no strong background information on how to describe, for example, the

² The Field School is a training consisting of total immersion in a mission environment. The Field School has a focus on ‘learning by doing’, while participants are mentored by experienced facilitators on a 24-hour, seven-day-a-week basis. A practical two-week modular curriculum mirroring Red Cross/Red Crescent disaster response forms the basis of the approach. The mission places participants in conditions of physical and psychological stress similar to those they are likely to experience in the early stages of deployment to major disasters.

concept of 'good health' against 'disease', and on how to use the action tools practically. The impact of the ECV in prevention, promotion and preparation of the community becomes more limited. In branches with other health related or preparedness programming this lack of information can be completed with the use of other methodologies, but in a situation where there is no previous capacity or time to develop complementary knowledge, volunteers in the community feel that they do not have enough knowledge for using the tools at the community level

Most NSs in Africa, however, saw the problems of finding additional funding to be the major constraint to further rollout and implementation activities. Most would like to hold additional training sessions but had no specific plans to do so. Most indicated that they would like additional materials to be made available – although on the assumption that each NS still wants to 'nationalize' the materials this seems less than appropriate. It probably remains more realistic to see response operations to be the major vehicle of ECV delivery, at least in Africa, allowing training to be delivered to volunteers at affected community level, and/or in advance of potential outbreaks such as the threats posed by refugee movements etc.

Current volunteers to whom this training is most appropriate are those CBHFA volunteers already working at community level, and the NDRT or NIT members of a NS. Each NS seems to be taking a slightly different approach to the introduction, and to whom they should be targeting – this indicates an acceptance of the relevance of the materials but it is perhaps less realistic in terms of overall priorities, costs, and long-term impact on residual knowledge at volunteer level.

It is significant in reviewing the manual that there are no teaching plans or even guidelines included. Given the comments above regarding the wide range of people to whom the training is given, and the range of education and skill levels they have, it may be appropriate to consider the development of several basic teaching plans. There is a Facilitator's Guide (still in draft format) that gives a good overview of what the facilitator needs to be able to run the trainings, but its 'example training session' as Annex 1 is not very helpful as it gives scant detail. A series of teaching plans could assist the less experienced facilitator to target the right message at the right level to the collected audience, and highlight what materials to include or exclude depending on the aims of the session.

For example, if the materials were to be used in an emergency response situation for cholera, for a one-day training aimed at health professionals/skilled CBHFA volunteers, then exactly which 'tools' would be required and what (from the manual) would or would not need to be covered during the sessions, and which specific tools would be required. In one situation, a NS responded to an outbreak by calling the Emergency Health team in Geneva for advice. The response by the Team was to select the relevant tools for that disease and email them out for local replication and use. This was also the approach taken between the Zone health coordinator and Tajikistan (see case study 1 in the box). In an ideal situation, the NSs should be able to do this themselves for the materials on hand, and as they get better known and more widely utilized this should become more possible.

Some NSs suggested that the epidemic control concept should address a more comprehensive approach to the management of diseases with epidemic potential, and some additional information could therefore be provided. For

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example, they identified the need to complement the basic knowledge of the ECV package with advanced literature on epidemic control and adapted learning methodologies, especially in the case of the PHE training with the NIT/NDRT teams. The eventual development of a wider epidemic control tool bank is seen as an opportunity to allow NSs to address more specialized health professionals and volunteers, reach a wider audience and also potentially to generate new external funding opportunities through training national health staff.

Online training possibilities?

The feedback to this question varied quite widely, and to an extent varied with who the intended audience for the training is considered to be. Responses from Africa generally indicated that it is not realistic to expect branch level volunteers to follow online trainings, due to limited availability of computers and poor internet access, which even at HQ level was often sporadic, so this option was not considered as widely appropriate.

In the Americas Zone, a platform already provides a space to exchange experiences, access up-to-date information on preparedness and risk reduction issues, learn through experiences/modules online and access resources. It could be used as an entry point for an online ECV module. By introducing the ECV module onto the platform, NSs would have a space to tell, share, exchange experiences and learn from other actors who work in epidemic control activities with the communities in the field. A regional virtual learning platform may be cost effective and a good way to keep the learning current, as well as to carry or enable access to advanced literature on epidemic control and different training methodologies. The NSs perceived that online training would give them opportunity to reach wider audiences with adapted methodologies and capture funding opportunities. A virtual platform already exists at regional level and could be used as a good support for online training.

Additionally, some NSs have already developed their own virtual learning platforms. The Bolivian RC, for example is launching an online ECV course based on its adapted version of the ECV available for community members and volunteers.

Conclusions

It is greatly appreciated that the content of the manual and toolkit is simple and non-technical, and this is valid for the intended primary audience of community level volunteers, and it is important that this simplicity is maintained. The simple and practical information provided by the ECV package is perceived as adequate in order to fit with its intended implementation to volunteers at the branch level. The ECV tool provides the flexibility to target the needs of different levels of implementation into a common institutional framework and to train a wide range of volunteers. However, as it is increasingly used at other levels and often with health professionals, some parts of the manual are seen as too simplistic or unnecessary. A series of simple 'lesson plans' would assist the trainers to deliver the right content at the right level to different audiences.

There was also consistent feedback that the ECV package is an easy-to-train action-oriented tool but not so easy to use at the community level, due to

insufficient explanations of methodologies and correct messages for the communities. The Centre of Reference for Community Education (CRECC) specializes in the development of community based tools and methodologies and could easily correct these limitations and give technical inputs to improve this aspect.

The development and inclusion of teaching plans in the manual, covering a range of situations/diseases and of audience, would strengthen the package and facilitate more focused training.

The validation process offered a certain level of guarantee of ownership of the involved RC NSs in the region. It also strengthens the likely sustainability and ongoing use of the tool as the Centre of Reference retains the responsibility to monitor and adapt the validated ECV manual and toolkit, rather than individual Federation delegates who come and go. As a result the training modules for volunteers and for the NITs and RITs were developed using standard learning and teaching methodologies of the IFRC in the Americas, ensuring a compatibility and standardization between the various tools and their use. Many NSs have made amendments to the standard materials to ensure its acceptance locally regarding cultural issues or local understandings, and of course translations into local languages. Some of these were minor changes, some more substantial. This is considered to be positive as the package then becomes more of an indigenous NS resource rather than another 'Geneva document'.

There are still numerous minor errors and/or inconsistencies in the generic materials, as well as suggestions for improvements or additions. As considerable work has been done in the Americas to amend and update the materials, many of these points may have been picked up already but they should be corrected before any subsequent version/edition is produced. Any revisions or amendments suggested to the community message tools could be developed with the input of the Reference Centre on Community Preparedness.

Some NSs felt that the ECV material needed to be enhanced with deeper information on a range of subjects, but to do this beyond some basic clarifications would lose the simplicity of the package. Instead, NSs should ensure they have a range of the related material available as a resource for reference, and not replicate information that already exists in other documents. It would be helpful to enclose in the manual a detailed bibliography of relevant materials.

Recommendations

- R 4: It is recommended to undertake a more detailed global mapping of experiences, good practices and lessons learned from the use of the ECV to date, in order to adapt the package to the current trends of epidemic management and to the NSs' needs and expectations, and to consolidate the 'best practices' developed by the different NSs.
- R 5: Wherever possible, it is recommended that the ECV manual and toolkit should be acknowledged as the base template, and it should go through a regional or national adaptation process to ensure a certain level of ownership and appropriateness for the local context. (This process could potentially be supported by Geneva budgets – see Recommendation 10 below).
- R 6: Additional guidance for community use should be developed based on the existing tools and methodologies. The CRECC in Costa Rica should be engaged in the process and their recommendations could be amended for use elsewhere.

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- R 7: Further work should be done on harmonizing the ECV content with other RC manuals and methodologies, correcting errors and inconsistencies, and adding references to supporting documentation to the toolkit. Teaching plans for different audiences should also be developed and included.
- R 8: Development of an online training package should be considered, though the primary training focus should remain on the simple and practical hardcopies as at present.

Current use of the ECV package

3

As stated earlier, feedback was consistently positive regarding the ECV package, seeing it as appropriate and necessary, easy to use and addressing the needs of the NSs concerned. In Africa it has been used to complement work done via the CBHFA trainings and methodology, inasmuch as it is the CBHFA volunteers who do much of the RC's community health work and to whom the additional ECV awareness is targeted. In the Americas, where the CBHFA has not yet been introduced, the ECV has been used to complement work done via other community based methodologies (health related or other) such as the World Health Organisation's (WHO) Integrated Management of Childhood Illness (IMCI), "Better to be Ready", etc).

However, it also is quite clear that some NSs see this as a programme in its own right or as a new and separate approach, whereas the reviewers consider it should remain simply as a tool – one of many – to be used as the need arises. This implies that instead of 'rollouts' and 'training plans' and 'funding' to enable an ECV programme to operate, the NSs should redefine their roles and responsibilities with their national authorities in terms of addressing epidemic management in their countries, identify their own programme support to allow those activities to happen, and use the ECV materials to support the interventions.

This suggests that, in many countries, the package will support response activities which are funded from other resources, including the Federation's Disaster Relief Emergency Fund (DREF), and preparedness activities may realistically be limited to a good awareness of the materials, having translations and other materials etc ready for use, and the ability to train volunteers updated. This, by itself, does not require up-front funding support once the materials are adapted and reproduced.

It is also clear that the ECV training can be a capacity building tool for volunteers not necessarily responding to an outbreak but through their work to prevent and promote health messaging related to epidemic control ~ this is particularly the case in the Americas where the ECV is used as the community health approach, in contrast to most African experiences where the CBHFA (or ARCHI) is the approach and the ECV is the add-on. These variations are both valid, but depend significantly on the expectations upon the Red Cross/Red Crescent in each situation, on their other activities, on their capacities and on their funding opportunities.

Several NSs identified the following as the benefits of the ECV training for the volunteers:

- To implement coherent and comprehensive community based health and preparedness strategies.
- To ensure continuous hands-on practice and keep learning current.

- To develop more sustainable funding solutions for long-term ECV capacity through longer term capacity strengthening and preparedness.
- To identify and address gaps in community based programme implementation.

The Guatemalan RC said: “Several activities are combined into one integrated community health activity and take advantage of similar surveillance functions, skills, resources and target populations”. Moreover, the low cost of the ECV training allows the training to cascade down into the communities or into neighbouring branches with limited funding required once the trainer network is set up.

The two regional workshops held for the African NSs during 2010/2011 provided an introduction to the materials based on the three-day training agenda. However, the attendees at these workshops were mostly the health directors or HQ staff members of the NSs, and any ongoing rollout will be reliant on these individuals cascading the training down to lower levels within their Societies. While all attendees felt that the information received was very valid and useful, many acknowledged that it had been most useful because it had enhanced their own skills and made them more useful for RDRT deployment. Indeed this thinking of the ‘deployability’ of the individuals was the overall targeting approach taken more recently in Africa. This seems to rather miss the point and remains fixed on the very traditional RC methodology – international workshop, hotels, flights and per diems etc all paid – which ultimately has a limited knock-on benefit at individual NS levels when needed unless the NS itself really identifies the need and finds the resources to move the work forward. It is almost certain that the costs of these workshops could have been more effectively used in a different way to achieve a wider impact at national levels.

In Afghanistan, a ‘field school’ type of practical workshop for 25 volunteers is scheduled for May 2011, based on the ECV, over a seven-day period.¹ While this will be practical and working directly with the branch level volunteers in Jalalabad, it is being supported via contributions from the various partner NSs’ health budgets, and therefore split between several donors. It is very positive that the donor Societies agree to support such an initiative, but is much less possible where NSs have limited partners and many other competing health priorities. The DREF option at times of emergency - in Africa or elsewhere – becomes the most likely source of funding for less well-supported NSs, but this then limits the training to response activities at times of need rather than in preparedness activities.

The relationships maintained between the various NSs and their governments inevitably vary considerably, as do the expectations of the roles and responsibilities of the Red Cross/Red Crescent in national public health programming. It is likely that until this relationship is well clarified, many NSs will recognize the value and validity of the ECV package but will still need to determine their expected role and capacity in using it. Some examples, such as in Guatemala and Bolivia (see case study boxes), show that this redefinition of role has fundamentally changed the RCs’ relationship with the national health authorities and opened up considerable new possibilities for the NSs.

Several NSs in Africa and the Americas have introduced the ECV and its related training into their national strategic planning, and in Uganda – which is affected by regular and widespread epidemic outbreaks – the NS has even

¹ Editor’s comment: This training was postponed and did not happen in May 2011.

CASE STUDY 3: Guatemala Red Cross

In accordance with the recent National Strategic Plan for integrated management of dengue prevention and control adopted and implemented by the Guatemalan national health system, the GRC focused its PHE actions on strengthening capacities at community level to prevent and reduce the epidemic risk and on strengthening institutional capacity for responding to potential outbreaks. The methodologies utilized by the GRC largely focus on behavioural change through the integrated PHE preparedness programme.

Dr Maria Teresa Estrada, Head of the Health Department in the GRC said: “Several activities are combined into one integrated community health activity and take advantage of similar surveillance functions, skills, resources and target populations. For example, surveillance activities for children under five and maternal health implemented through the IMCI strategy can address surveillance needs for diseases with epidemic potential. Thus, volunteers who routinely monitor health cases are also trained via the ECV training module to monitor other priority diseases, such as those with epidemic potential”.

established a stand-alone Emergency Health programme in its current five-year plan, utilizing the ECV methodology, to target the regularly-affected districts.

Government authorities in the Americas have moved forward with implementation of an integrated management of epidemic diseases, and have consequently been promoting the same approach among national stakeholders. The national health systems have mainly focused on strengthening epidemiological surveillance, improving access to people affected by disease, strengthening the capacity of laboratories and development of national risk communication plans. To complement these official activities, Red Cross National Societies have been in the forefront of the management of epidemics at community level. External partners increasingly acknowledge the quality of the RC training and many NSs have developed relevant experience in epidemic control, often after the introduction of the ECV training. Guatemala RC, for instance, offers ECV training to the government’s Disaster Response Units alongside the RC’s NIT teams.

In particular this has focused on:

- Ensuring effective and efficient preparedness for and response to disasters
- Addressing risk to reduce the impact of and mitigate epidemic outbreaks at community level by using other community based methodologies as entry points
- Facilitating durable and sustainable links between preparedness, response and development (often adapted for local usage)
- Developing household, community and National Society capacities as a whole and promoting behavioural changes.

The National Societies consider that the benefits of supporting the official interventions include allowing them:

- To implement coherent and comprehensive community based health and preparedness strategies
- To ensure continuous hands-on practice and keep learning current
- To develop more sustainable funding solutions for long-term ECV capacity strengthening (traditionally funded through short term emergency funding tools (appeals, DREF, etc)

CASE STUDY 4: Guatemala Red Cross

Since May 2008, the GRC has been extending its response actions to community needs in areas vulnerable to emerging and re-emerging diseases working in the western and northern regions through seven branches, using funds from the Ministry of Public Health. These activities were implemented with the support of community leaders and the MoH and in coordination with other organizations. The GRC is seen as a credible and relevant partner and has a vital role to play at the community level in lessening the effects of disease through social mobilization campaigns and linking with other agencies in prevention and surveillance.

- To identify and address gaps in community based programme implementation.

The main disadvantage has been the lack of autonomy of implementation of the ECV package at community level and the limitation of the scope of ECV implementation in branches where complementary projects are not done. Nevertheless, some branches are currently developing their experience for keeping the learning current, even without direct community based implementation.

Other external interest

Globally, the World Health Organization wants to include the ECV materials into its global public health tool library – after some ‘rebranding’. Realistically, they only support the Ministries of Health at a national level, and it would very often be the Red Cross of any country that implements the community level activity. However, an acceptance of the material at a global level will influence its approval at national levels too, and this can only be of benefit to the NSs.

A number of NSs reported that they had shared or promoted the ECV materials to partner agencies or their own Ministries of Health, with very positive responses. In some countries the Ministries had even ‘validated’ the materials. It was clear that many governments already see the value that a trained RC cadre of volunteers can offer in times of outbreak – and through community health activities at other times – and were supportive and encouraging of the ECV package. Often this had had to be validated to ensure the messages were in line with official policy, and in a number of cases this work was still ongoing.

This wider scope of implementation is perceived as crucial by NS responders because it gives the opportunity to NSs to work permanently with their national health systems in a comprehensive and coherent health promotion strategy, and to keep the volunteers’ learning current even if there is no epidemic outbreak. Some NSs are currently developing interesting experience along those lines, such as the Bolivian RC which is starting to build up a community based epidemiological surveillance system integrated into the national health system, led by RC volunteers trained with the ECV package (see case study #5).

In Gabon, the radio station ‘Africa Numero 1’ asked the GRC for a copy of the ECV materials so they could ensure their public health broadcasts, used at times of an outbreak, were in line with the other messages the RC and the MoH were putting out.

In Uganda, UNICEF requested an ECV package that they could possibly adapt for their village health teams. One NGO is also considering how the ECV materials could be appropriately adapted to address animal health issues using similar methodology.

Conclusions

There remains the widespread idea that the ECV is a programme (i.e. Federation-led, with associated funding), whereas it really is just a tool (i.e. at the disposal of a NS for use when needed).

National Societies need to determine how they can best use this package in response to their needs, capacities, resources and the expectations upon them. This could be primarily for outbreak response activities, and/or to try and roll it out more widely for general preparedness, and this is frequently based on resources available. Either or both options are valid depending on circumstances and resources:

for use in times of emergency outbreak or immediately prior to a potential outbreak, meaning identified volunteers and communities can be targeted, using funding linked to the response operation

CASE STUDY 5: Bolivian Red Cross

The Bolivian Red Cross is positioning its volunteer network in the national public health system in coordination with the Ministry of Health by establishing a community based epidemiological surveillance system, focusing on priority health issues identified by the ministry (i.e.: malaria prevention, occurrence of epidemics).

Bolivian Red Cross trains its volunteers in the use of the ECV package along with the use of MoH surveillance sheets developed in order ensure that its volunteers are permanently able to prevent infectious diseases, describe the situation according to their knowledge, and report to appropriate authorities using common methodologies. This surveillance activity is integrated in a coherent and integral community based preparedness intervention enabling Bolivian Red Cross to monitor and develop a coherent and integral community based preparedness interventions."

Dr José Michel, Coordinator of Risk Reduction and PHE focal point in Bolivian Red Cross: "The action oriented ECV toolkit is implemented as a complement to the 'community based health education' module (one of the 14 modules of the series "Better to be Ready") within the communities where Bolivian Red Cross works if an epidemic risk is identified via of the VCA exercise."

to build up capacity before an emergency by using other (funded) interventions in endemic areas and then use it as a refresher when the outbreak strike. In the Americas wider institutional or community based preparedness projects work as the vehicle for ECV implementation using other available resources.

Reconfirming the NS's expected roles and responsibilities in outbreak management vis-à-vis the national Ministry of Health will suggest how the NS can proceed. Case studies have shown that where this role is clear the governments may ask the RC to take on certain official roles, for which they

can be financially supported. Experience has also shown that ECV support is perceived as perfectly valid for prevention and intervention at all stages of a potential outbreak.

National Societies need to explore a range of funding options, which should include their Ministries of Health, other supporters and the PNS they work with. Other health programming can often be used as the primary vehicle for a wider ECV rollout.

Although there has been a range of external interest in the ECV package, it could be better profiled on global and national levels to assist the RCs' various partners and the Ministries of Health in their public health work. The RC will continue to be the first-line deliverer in many cases because of its volunteer network, but the introduction of the ECV has helped redefine in some cases the community roles of the RC volunteers and establish a more formal role for them to play.

Recommendations

Recommendations for this section are combined with those in Section 6.

Funding Support

4

Much of the process of rollout and the ongoing uptake of the ECV have been determined by the availability of funding. Most of the situations in Africa where the ECV training has been implemented at branch level have been in response to specific emergency operations, and the DREF has funded these trainings as a component part of the wider response work. Although DREF cannot be used to support general preparedness training, at times when volunteers are being mobilized for community work and where an epidemic threat is anticipated or developing, a portion of the DREF funds released for the wider emergency response activities can be accessed. For example, in Cote d'Ivoire (February 2011), as the possibility of large population movements was developing, emergency DREF funding supported ECV trainings for volunteers in this country and across the border in Liberia.

Constraints on funding are identified as major problems in many of the African NSs' health activities, and the only realistic means – at present – to increase the accessibility of the ECV materials is via such emergency funding. Indeed, most of the NS responses received as part of this study indicated that the only way the package could be more widely delivered would be if additional funding was also made available.

National Societies are used to combining and juggling different funding support streams, whether these be long-term support or emergency funding available at times of crisis. These various funding sources would ideally allow NSs to find ways to implement the ECV package in a comprehensive approach and with a wider scope of action over a continuous period. Medium term funding support (over 12 months) from both the IFRC and donor NSs has supported the setup of sustainable frameworks for epidemic control. Complementary PHE funding has supported the strengthening of emergency public health capacities, and especially epidemic control as part of a longer-term strategy. For example, the Norwegian Red Cross (with funding from NORAD) is promoting a three-year PHE preparedness project with a focus on epidemic control in seven NSs in the Americas Zone.

In 2009, the threat of the influenza pandemic in the Americas threatened to overwhelm existing systems, but also provided a vehicle to help rollout the ECV materials and helped identify potential new fundraising opportunities. The IFRC Secretariat, with USAID support, had launched the H2P project (human pandemic preparedness) in 94 NSs globally, including 24 in the Americas¹, aimed at reducing the risk of excess mortality from the influenza pandemic with a focus on institutional and community preparedness and humanitarian coordination. This project, implemented regionally in the Caribbean and nationally elsewhere, allowed a much wider introduction of

1 Six in South America, five in Central America, 13 in the Caribbean out of 35 RC NSs in the region

the ECV methodology and frameworks than the four countries covered till that point under the ECHO-supported project.

A large number of RC volunteers and staff from the various national health systems were trained in ECV, and in-country capacities were strengthened. Additionally, in some cases, the H2P funding gave opportunities to the NSs to validate the ECV manual with their MoH after eventual adaptation. It remains unclear how some of the NSs are going to sustain this capacity since no sustainability plan has been set up. Progressively, NSs reorient the use of ECV in endemic or epidemic prone areas, where risks and needs are identified and where the ECV trainings can be funded, as complementary tools for addressing gaps in traditionally funded programming.

Variations & possibilities

While it is realistic to expect such response operations to continue to be funded by DREF and to have an ECV component within them, the NSs need to consider other sources of funding to maintain their preparedness capacities and to continue their training inputs to the volunteers. Governmental funding support can also be accessed by NSs in some cases. In Colombia for example (see case study #8), the national authorities took full advantage of the CRC's branch network in endemic areas where their own coverage was limited, and the government financially supports the CRC to implement a comprehensive community health programme, including epidemic control initiatives.

In the African (and potentially Asian and Middle Eastern) contexts, instead of workshops as have been held in the past², it could be considered to introduce and promote the ECV materials at regular regional Federation meetings, but only in a general sense (e.g.: introduction and distribution, rather than a full run-through over three days). The Geneva EH budget could be used instead to make a small cash grant available to each NS to cover the costs of amending the basic package to make it more relevant and acceptable to their local use – this could be on language, on selecting only certain diseases, to improve on the illustrations, or to replicate and laminate the appropriate materials – would encourage local use and buy-in of the NSs. In reality much of this work has been done in one setting or another so this would not involve rewriting and redesigning the whole package, but would support and enable each NS to specifically tailor the package for its local requirements.

Conclusions

As stated previously, the ECV package needs to be accepted as a tool and not a programme, and funding does not – and should not – be 'tied' to its use by National Societies. Introducing it to the NS should anyway not require significant funding – the desire to train all community health volunteers for three days on the ECV package should not be confused with the need to be able to rollout the materials and training at a time of an outbreak. The latter situation can often be financed from DREF or other emergency funding options, the former situation will be more challenging. The knowledge and availability of the materials and the ability to deliver the training at a time of emergency should be the NSs' focus, rather than having all the volunteers

² The two regional workshops in Africa were funded by the Geneva Secretariat EH budget.

trained. Therefore, the use of DREF (or other emergency funding streams) to support such training and rollout is fully justified.

It is suggested that holding regional workshops to promote the materials is not the most effective way to continue the rollout of the ECV package. Federation health delegates should be able to promote it and encourage NSs to study it and decide on its use and relevance, in relation to the expectations upon them regarding their roles in public health activities. This implies clarity of purpose decided in consultation with the governments.

The Federation could support individual NSs to tailor the materials to local requirements – translations etc as discussed above in Section 4 – to ensure they are relevant and ready for national use. If the NSs then want to take it forward in different ways, as some of the quoted examples have shown, then they also need to explore the other opportunities for financial support that may be open to them.

Further advocacy work with governments and external partners should result in a wider acceptance of the materials and methodologies, should prevent ‘reinventing the wheel’, and should help NSs secure the necessary funding support from local sources when needed.

Recommendations

- **R 9: National Societies should continue to be encouraged to take up and use the ECV package, but need to ensure it is aligned with their own capacities and resources, and the expectations upon them.**
- **R 10: Further rollouts and adaptation should be undertaken at regional level in order to produce a tool relevant to the regional context, which would then require limited adaptation at national level.**
- **R 11: The Federation should consider making a limited financial package available to support NSs with adaptation work to align the ECV materials with local needs, but should not continue with expensive regional training workshops.**
- **R 12: All partners should continue to actively promote the materials at all levels – with governments and external partners also – which may open up new opportunities for programming and support.**

5 Linkages between the ECV and other RC trainings: CBHFA, RDRT, NDRT

The ECV package is considered to be one component of the broader CBHFA package, building more details onto what is only briefly mentioned in related CBHFA modules on the subject of epidemic control. The focus for the training of the ECV is targeted by many NSs onto their existing CBHFA volunteer cadre, reinforcing the community health messaging. The materials are also designed to be complementary to other standardized IFRC and NS (and external) tools and methodologies (CBHFA, the community health education module from the “Better to be Ready” modules, health in emergencies training for the NDRTs/NITs and other global RC tools, as well as others such as WHO’s IMCI). The community based methodologies and tools are often used as compatible entry points in order to reach the communities through comprehensive and coherent approaches to ensure better impact.

Linkage with CBHFA

Once again the feedback varies on this point. Where CBHFA has become well established, the ECV is clearly seen as an additional and more detailed module to the more comprehensive CBHFA package that the health volunteers are already delivering. There is though some concern that not all the health messages are totally aligned between the two sets of material.

In the Americas, where CBHFA has not yet been rolled out widely, the ECV process ‘piggy-backs’ on other community health activities via which wider health messaging is being delivered. The CBHFA was only recently introduced into the Americas (first ToT in the English Caribbean in November 2009 and in October 2010 in Latin NSs) and national rollouts are ongoing. Nevertheless, linking CBHFA with ECV in the future is perceived as an opportunity by NS health programme managers to develop more coherent and integrated health interventions ~ and especially for epidemic control. It is suggested, nevertheless, that the link with CBHFA must remain loose in order to keep the ECV training module flexible and autonomous.

Linkage with other RC training modules

The validation process of the ECV in the Americas and the development of the training modules, based on standardized learning and teaching methodologies by the CREPD, offered opportunities to easily complement other CREPD materials, and thus simplified the process of insertion. So far the special epidemic control training has been implemented through funding streams for institutional preparedness (PNS, ECHO regional and DIPECHO funding) and funding from response operation income (the earthquake response appeal in Chile, the dengue outbreak in Guatemala (ECHO funds), the dengue appeals

in Honduras and in Colombia, the cholera outbreak response appeals in Haiti and Dominican Republic, and similar examples). This combination of longer and shorter term funding streams ensures that the public health messages can be delivered consistently and helps ensure that the learning of the NIT members also remains current.

The specialized training in PHE for the NITs in the Americas was designed and developed in 2009 in response to a crucial need identified by the NSs. Initially a learning module focused on epidemiologic surveillance was already included in the training. In 2009, the wider rollout of the ECV in the Americas gave the opportunity to complement the existing training module with the ECV and thereby to strengthen the preparedness and response capacities of NSs in the management of epidemics. The 4½ day NIT training therefore added a further 1½ day for the ECV training.

The ECV materials are also used in training and resource materials for wider Federation global response tools, such as:

- For FACT team trainings, the ECV material is not provided as pre-reading for all team members but is covered in a general sensitization (over 1½ hours) on emergency health issues. It is accepted that the health delegate on the deploying FACT team would have much greater in-depth emergency health knowledge, and the ECV would be a reference tool available during the deployments
- In Africa many of the NDRT and RDRT members of NSs are the same ones who have to date been trained in the regional workshops, and thus have a good knowledge of the ECV package. It is assumed that at times of emergency response nationally or regionally these individuals will be utilized
- The ECV material is considered fundamental resource documentation for the trainings held for the community health delegates lined up for possible deployment in the *Community Health Module* with the ERUs, as well as for the delegates who will deploy with the *Basic Health Care ERUs*
- The ECV reference documentation and manual are given as some of the pre-reading materials for the *Red Cross Field School*, which is a field-based practical training course over two weeks, based around public health in emergencies. Specific follow-up modules are also covered during the two-week period.

Conclusions

The ECV package should be considered as complementary to the existing, wider community health programmes – ARCHI, CBHFA, and the IMCI from WHO etc – adding specific detail to one aspect of the health outreach activities. The ECV materials should not be seen as the principal vehicle to deliver the wider community health messaging.

Having a purely emergency response approach in responding to epidemics is costly and will not stop them from happening again. Only long-term action addressing the roots of the problem can robustly improve the situation. It is essential to inform communities about dangers and disseminate simple prevention messages that can save many lives. Working in partnership is also essential to reach lasting results. The ECV package could easily support this integrated and comprehensive intervention if better guidance is provided along with the community tools.

5 Linkages between the ECV and other RC trainings: CBHFA, RDRT, NDRT

The materials are well integrated into the training modules for the global and regional emergency response tools of the Federation, and are an important reference resource for the teams.

Recommendations

- **R 13:** The ECV should remain autonomous and so be available for stand-alone training as well as complementary to other methodologies. For such purposes, it is recommended to insert some additional modules, for instance from the CBHFA, that could be easily dropped out if ECV is delivered along with CBHFA programming.

Summary of Findings

6

The Epidemic Control for Volunteers package was developed to meet a specific need and to complement many other Red Cross/Red Crescent training materials in use in the community health field. It has been very positively accepted in a number of National Societies to date but more needs to be done to widen its uptake, particularly in Asia and the MENA Zones.

The ECV package should be considered as a complement to the broader health programming developed by the IFRC and in use in many countries already, and not be seen as a stand-alone programme unless specifically warranted by the conditions in individual countries. Response operations where ECV training can be covered with emergency funding will continue to increase its visibility and exposure, but its use in preparedness work as part of wider community health messaging is also very relevant, but more challenging to finance. National Societies need to identify the exact role they will play vis-à-vis their national health authorities in specific cases, and this will help position the NS in terms of whether the ECV is used as a response tool, a preparedness tool, or a combination of both. This positioning could also open up new financial support possibilities and a closer working relationship with the authorities in public health outreach.

Although developed as a global tool, it is inevitable that regional and local changes will be required by NSs as they start to use the materials, and this should be considered a positive move to improve their 'ownership' of the material. Much work on this has already been done in the Americas region. The Federation could perhaps support the NSs to amend and reproduce their packages, using funds that may otherwise be available for regional workshops or other similar meetings, which the reviewers consider to be less effective.

7 Summary of Specific Recommendations

The 13 recommendations proposed in this report are gathered in the following table in a tabular format to allow tracking of management follow-up.

Recommendation	Yes or No	Follow-up required
R 1: The ECV package should continue to focus on both response and preparedness activities, but these have to be tailored to needs and capacities – notably of funding – in each national situation. It should be clearly rolled out as a tool and not as a programme in its own right.		
R 2: The development of a regional strategy for epidemic control would support NSs in defining their roles and responsibilities internally and externally, and consequently would help to develop standardized ECV framework.		
R 3: Consider future rollout and adaptation at regional (or sub-regional) level in order to produce a tool most relevant to that regional context which requires limited further adaptation at national level.		
R 4: It is recommended to undertake a more detailed global mapping of experiences, good practices and lessons learned from the use of the ECV to date, in order to adapt the package to the current trends of epidemic management and to the NSs' needs and expectations, and to consolidate the 'best practices' developed by the different NSs.		
R 5: Wherever possible, it is recommended that the ECV manual and toolkit should be acknowledged as the base template, and it should go through a regional or national adaptation process to ensure a certain level of ownership and appropriateness for the local context. (This process could potentially be supported by Geneva budgets – see Recommendation 10 below).		
R 6: Additional guidance for community use should be developed based on the existing tools and methodologies. The CRECC in Costa Rica should be engaged in the process and their recommendations could be amended for use elsewhere.		

Recommendation	Yes or No	Follow-up required
<p>R 7: Further work should be done on harmonizing the ECV content with other RC manuals and methodologies, correcting errors and inconsistencies, and adding references to supporting documentation to the toolkit. Teaching plans for different audiences should also be developed and included.</p>		
<p>R 8: Development of an online training package should be considered, though the primary training focus should remain on the simple and practical hardcopies as at present.</p>		
<p>R 9: National Societies should continue to be encouraged to take up and use the ECV package, but need to ensure it is aligned with their own capacities and resources, and the expectations upon them.</p>		
<p>R 10: Further rollouts and adaptation should be undertaken at regional level in order to produce a tool relevant to the regional context, which would then require limited adaptation at national level.</p>		
<p>R 11: The Federation should consider making a limited financial package available to support NSs with adaptation work to align the ECV materials with local needs, but should not continue with expensive regional training workshops.</p>		
<p>R 12: All partners should continue to actively promote the materials at all levels – with governments and external partners also – which may open up new opportunities for programming and support.</p>		
<p>R 13: The ECV should remain autonomous and so be available for stand-alone training as well as complementary to other methodologies. For such purposes, it is recommended to insert some additional modules, for instance from the CBHFA, that could be easily dropped out if ECV is delivered along with CBHFA programming.</p>		

Annex 1: List of National Society and IFRC staff interviewed

FEDERATION	
<i>Viviane Nzeusseu</i>	<i>Regional Health Coordinator, IFRC Yaoundé, Cameroon</i>
<i>Nuran Higgins</i>	<i>Emergency Health Delegate, Kabul, Afghanistan</i>
<i>Michael Charles</i>	<i>Acting Africa Zone health delegate, Johannesburg</i>
<i>Jim Catampongan</i>	<i>Asia Zone Emergency Health Coordinator, Kuala Lumpur</i>
<i>John Fleming</i>	<i>Health Coordinator, Haiti Delegation (and formerly in Southern Africa)</i>
<i>Ina Bluemel</i>	<i>Former Emergency Health Delegate for Africa</i>
<i>Aissa Fall</i>	<i>Regional Health Officer for West Africa</i>
<i>Pierre de Rochefort</i>	<i>Training focal point, Disaster Support Department, Geneva</i>
<i>Panu Saaristo</i>	<i>Senior Emergency Health Officer, Geneva</i>
<i>Hossam Elsharkawi</i>	<i>Director of Emergency Response, Canadian RC, Ottawa (formerly at Norwegian RC)</i>
<i>Tammam Aloudat</i>	<i>Senior Emergency Health Officer, Geneva</i>
<i>Dorothy Francis</i>	<i>Senior FACT Officer, Geneva</i>
<i>Maryam Omar</i>	<i>Health Delegate, Somalia Delegation</i>
<i>Sonja Tanevska</i>	<i>Health and Care Coordinator, Europe Zone Office, Budapest</i>
<i>Djamila de Vaulgrenant</i>	<i>Health Programme Manager, IFRC Tajikistan Representation</i>
<i>Marta Trayner</i>	<i>Americas Zone Emergency Health Coordinator, Panama</i>
<i>Yazmin Castillo</i>	<i>Former Health Officer in Lima, Peru</i>
<i>Ayham Alomari</i>	<i>Senior Health Officer, Health Department, IFRC Geneva</i>
NATIONAL SOCIETIES (some responses by email)	
<i>David Stephens</i>	<i>Head of Training, South Africa Red Cross</i>
<i>Thomas Aapore</i>	<i>Ghana Red Cross</i>
<i>Joss Razafindrakoto</i>	<i>Malagasy Red Cross</i>
<i>Twahiru Yuma</i>	<i>Red Cross of the Democratic Republic of Congo</i>
<i>Alexis Konoumi</i>	<i>Coordinateur National Santé Communautaire, Croix-Rouge de Côte d'Ivoire</i>
<i>Fernand E Gbagba</i>	<i>Head of Health Department, Croix-Rouge Centrafricaine</i>
<i>Isaac Nduricimpa</i>	<i>Head of Health Projects, Croix-Rouge de Burundi</i>
<i>Marc Assouguena</i>	<i>Health Coordinator, Croix-Rouge Camerounaise</i>
<i>Battah Kuami</i>	<i>Croix-Rouge Togolaise</i>
<i>Gaëtan Gatsimbanyi</i>	<i>Croix-Rouge Rwandaise</i>
<i>Boteya D Lambert</i>	<i>Head of Health Department, Croix-Rouge Congolaise</i>
<i>Okot Paul Bitex</i>	<i>Programme Officer, Emergency Health, Uganda Red Cross</i>
<i>Maria Teresa Estrada</i>	<i>National Health Director, Guatemala Red Cross</i>
<i>Fermin Cojón</i>	<i>Emergency Health Coordinator, Guatemala Red Cross</i>

NATIONAL SOCIETIES (some responses by email)	
<i>Rafael Garcia</i>	<i>Training Officer, CREPD, El Salvador</i>
<i>Francisco Moreno</i>	<i>National Health Director, Colombian Red Cross</i>
<i>Jose L. Imbachi Franco</i>	<i>Emergency Health Coordinator, Colombian Red Cross</i>
<i>Mercedes Suarez</i>	<i>PHE RIT, Colombian Red Cross (currently Health Delegate in Chile Earthquake Operation)</i>
<i>José Michel</i>	<i>National Coordinator for RRD and focal point for PHE, Bolivian Red Cross</i>
<i>Jorge J. H. Mamani</i>	<i>PHE RIT, Bolivian Red Cross</i>

Annex 2: Terms of Reference for the study

Consultant Terms of Reference

Evaluation of the *Epidemic Control for Volunteers Manual and Toolkit* of the International Federation of Red Cross and Red Crescent Societies

A. Background

The Epidemic Control Manual for Volunteers (ECV) is an IFRC tool that has been developed specifically for volunteers and their trainers at local branches of National Societies that are prone to outbreaks of communicable diseases. The training is unique because it provides volunteers with a basic understanding of the diseases that can easily turn into epidemics should certain conditions in their environment change. The material is harmonized alongside the Community Based Health and First Aid in Action approach.

Over the past two years since its release, the ECV Manual and Toolkit has been used extensively in the Americas (in Spanish) and in Africa (in French and English). Additionally, there are versions in Dari, Pashto and Haitian Creole.

Purpose

To assess the outcomes of using the ECV on improving NSs ability to prepare for and tackle epidemics.

There are different approaches to the use of the training package, and - after 2 years of implementation – substantial experience of the implementation that deserves to be compiled, analysed and consolidated leading to improvement in the substance and usage of ECV. Possible outcomes of the consolidation are a printed and/or online implementation guide and a trainer's guide.

Objectives:

To evaluate the use of *Epidemic Control for Volunteers Manual and Toolkit* in National Societies and Federation projects/operations. The evaluation should be presented in a written report including analysis and recommendations. The evaluation should pay special attention to the different approaches to training and rollout of the training kit.

Scope of work:

An evaluation of ECV roll-out and its use in NS:

What is the ECV Manual and Toolkit? (when to use it, what are the outcomes, what are the characteristics, what is it not, key messages targeting RCRC governance and senior managers, short case studies to highlight good practice experience, linkages to CBHFA, linkages to DM and DRR)

ECV and CBHFA (practice and experience)

Preparing for ECV trainings (practice and experience)

Principles of ECV implementation on community level (participation, accountability, working with communities, sustainability and exit etc.)

Recommendations on future implementation of ECV.

Primary audience

The primary audience for the will be Program Managers in the IFRC and its member NS, who would have responsibilities for the planning and management of Epidemic Control training and implementation activities.

D. Methodology:

Literature review (key resources and training materials)

Key informant interviews with various NS engaged in the use of ECV, with IFRC/NS staff who have been engaged in the roll-out of ECV and with IFRC Secretariat technical departments (Geneva) and Zone Health staff.

Deliverables/outputs:

The final document will be up to 50 pages in length and the text should be interspersed with visual aids wherever possible and the typeset and layout should be clear and uncluttered. The report should outline:

The findings of the evaluation of ECV implementation in NS and IFRC;

The consultants' recommendations for continuing the process of the implementation of ECV (implementation guide, on-line training module). It should note limitations from this piece of work and any gaps or areas where organisational positioning is required. Learning captured from stakeholder interview should be documented and attached as an annex to the report.

Timeframe

Start date: 15 January 2011

End date: 30 March 2011

Annex 3: Sample questionnaire

(Similar questions - with a covering email introducing the study - also sent out in French and Spanish to National Societies and to IFRC delegates)

For National Society staff:

Please give your name and National Society name:

(All feedback will be kept confidential)

Re: Evaluation of the Epidemic Control for Volunteers (ECV) Manual and Toolkit

If you can, please provide feedback to the following questions:

What are the main epidemics your country has experienced in recent years, or considers a serious threat?

How were the ECV materials presented to you initially – were they sent to your NS from Geneva, or did you only know about them when you were asked to go to the workshop?

Why was the training initially rolled out in your country/region (i.e.: as part of a wider response operation to a specific outbreak, or another reason (e.g.: preparedness planning))?

Do you think the ECV initiative is important and relevant for your NS?

Are the current 'global' materials (the ECV manual and the toolkit) suitable for your use, or have they been adapted for local needs? What sort of adaptations to the materials has been made?

What else may need to be changed or added? Please think of specific examples

If you followed the Training of Trainers course, would you be comfortable delivering ECV training with these materials? If not, what more would you want?

Does your NS have plans to deliver more training sessions to volunteers?

Who is the training targeted towards in your NS; what are the profiles of the trainees?

How sustainable is the ongoing delivery of the training? What resources does your NS have, or need, to continue with them?

Can you explain how this ECV training is linked with other related trainings your NS does – e.g.: CBHFA, NDRT/RDRT, DM trainings.

Are you aware of the level of interest and support from other partners (government, agencies etc) to the ECV materials?

Any other comments or suggestions about the ECV initiative?

We also need to identify several CASE STUDIES to highlight some good practice and active linkages with other initiatives (CBHFA) or operational areas (DRR/DM), and would be open to discussing any ideas you may have on these. This could be a very positive or surprising development, or could be a situation where things did not go as expected. Either would be good to hear about if we can draw learning points from them. If you have suggestions we can perhaps explore that in more detail later.

The Fundamental Principles of the International Red Cross and Red Crescent Movement

Humanity / The International Red Cross and Red Crescent Movement, born of a desire to bring assistance without discrimination to the wounded on the battlefield, endeavours, in its international and national capacity, to prevent and alleviate human suffering wherever it may be found. Its purpose is to protect life and health and to ensure respect for the human being. It promotes mutual understanding, friendship, cooperation and lasting peace amongst all peoples.

Impartiality / It makes no discrimination as to nationality, race, religious beliefs, class or political opinions. It endeavours to relieve the suffering of individuals, being guided solely by their needs, and to give priority to the most urgent cases of distress.

Neutrality / In order to enjoy the confidence of all, the Movement may not take sides in hostilities or engage at any time in controversies of a political, racial, religious or ideological nature.

Independence / The Movement is independent. The National Societies, while auxiliaries in the humanitarian services of their governments and subject to the laws of their respective countries, must always maintain their autonomy so that they may be able at all times to act in accordance with the principles of the Movement.

Voluntary service / It is a voluntary relief movement not prompted in any manner by desire for gain.

Unity / There can be only one Red Cross or Red Crescent Society in any one country. It must be open to all. It must carry on its humanitarian work throughout its territory.

Universality / The International Red Cross and Red Crescent Movement, in which all societies have equal status and share equal responsibilities and duties in helping each other, is worldwide.



International Federation
of Red Cross and Red Crescent Societies
www.ifrc.org **Saving lives, changing minds.**

Panu Saaristo

Senior Officer, Emergency Health Coordinator

Water, Sanitation and Emergency Health Unit

Health Department

International Federation of Red Cross and Red Crescent Societies

Chemin des Crêts 17 | 1211 Petit Saconnex | Geneva | Switzerland

Tel. +41 (0)22 730 4317 | Fax +41 (0)22 733 0395 | Mob. +41 (0)79 217 3349

Email panu.saaristo@ifrc.org | Skype psaaristo